International Journal of Law and Society
2026, Vol. 9, No. 4, pp. 517–521
https://doi.org/10.11648/j.ijls.20260904.18

Research Article

Reassessing India's Medical Termination of Pregnancy Framework After the 2021 Amendment: A Doctrinal and Rights-Based Analysis

Zara Bajaj*

Department of Humanities, The Gera School, Goa, India

Abstract

The Medical Termination of Pregnancy Act (MTP) is the act that governs the rules and regulations behind aborting a fetus in India. It was first enforced in 1971. Since its enactment, the Act has been amended to reflect changing social attitudes, medical developments and the evolving circumstances surrounding reproductive healthcare in India. While it has made progress from its enforcement in 1971, its current framework still needs to be reviewed and reformed. Through an analysis of the clauses of Medical Termination of Pregnancy Act, 2021, and its implementation, this analysis argues that further reform is necessary since the Act still criminalises abortion, is ambiguous in many clauses and is doctor-centric rather than rights centric. This legal analysis will also consider whether the safeguards established in the Medical Termination of Pregnancy Act, 2021 are able to balance the protection of the patients health and reproductive autonomy. It will also examine the practical consequences of the Act. This includes the availability of trained medical practitioners, social stigma and health care access. Counterarguments concerning the need for medical oversight, legal restrictions and safeguards against unsafe abortions will also be considered. Ultimately, this legal analysis suggests reforms aimed at shifting the framework of the Medical Termination of Pregnancy Act, 2021 towards greater individual autonomy and a rights-centric approach without compromising the safety of the patient. This paper uses a doctrinal and normative legal approach to examine India's Medical Termination of Pregnancy Act, 2021. The primary legal materials used are the Medical Termination of Pregnancy Act, 1971, as amended in 2021, the Protection of Children from Sexual Offences Act, 2012, and judicial decisions relevant to the topic at hand. Secondary materials include policy reports, articles and scholarly commentary on reproductive rights, medical decision-making and the implementation of abortion law. The analysis considers material available up to 2024. The ethical framework employed is principlism, specifically focusing on respect for autonomy, beneficence, non-maleficence, and justice.

Keywords

Medical Termination of Pregnancy Act, Reproductive Autonomy India, Abortion Law Reform India, GESTATIONAL Limits India, Decriminalisation of Abortion

*Correspondence: Zara Bajaj (zarabajaj11@gmail.com)

Received: 29 September 2026; **Accepted:** 27 October 2026; **Published:** 13 November 2026

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1. History

The Medical Termination of Pregnancy Act is India's primary legislation governing the legality of the termination of certain pregnancies - it specifies the conditions under which a registered medical practitioner may lawfully terminate the pregnancy, as well as the procedural requirements attached. Under the initial act in 1971, terminating a pregnancy as a person who is not a registered medical practitioner was a punishable offence. Additionally, the termination of pregnancy was only legally permitted under the condition that the pregnancy had not lasted more than 12 weeks under the guidance of one medical practitioner. With the opinion of 2 medical practitioners the termination of the pregnancy could occur until the fetus was 20 weeks old. If the pregnant individual carrying the fetus was susceptible to physical harm, the gestation period was permitted to be elongated. Furthermore, the termination of pregnancy was legal only on the grounds that the fetus was a product of rape, failure of contraception as a married pregnant individual, being a minor or being a 'lunatic' - the Indian Lunacy Act describes this as 'an idiot or a person of unsound mind' under section sub-section 5. [2, 3, 11] This was amended in 2002 and then enforced in 2003 where the usage of 'lunatic' as a description for the person was updated to 'mentally ill'.

In 2021, Dr. Harsh Vardhan from the Bharatiya Janata Party suggested an amendment to the MTP, 1971 (*The Medical Termination of Pregnancy (Amendment) Bill, 2020*, n.d.). This amendment increased the legally permitted gestation period with the opinion of 1 medical practitioner from 12 weeks to 20 weeks. It also did the same where the gestation period with the opinion of two doctors increased from 20 weeks to 24 weeks. The amendment also authorised the termination of pregnancy for unmarried pregnant individuals who experienced a malfunction with the contraceptive used during sexual intercourse. The amendment additionally called for a medical board consisting of a gynaecologist, radiologist and paediatrician to evaluate terminations for foetal abnormalities beyond 24 weeks. Lastly, the medical practitioner cannot disclose the identity of the pregnant individual seeking to terminate their pregnancy. [13, 20].

In 2021, the termination of pregnancy was still legally permitted only for special categories - survivors of rape or incest, women with disabilities, minors, individuals experiencing change in marital status, contraception malfunctions and women with fetal anomaly. [13, 20].

2. Introduction

In 2022 during X v. Principal Secretary, Delhi, the SC ruled that pregnant individuals are equally eligible for abortions up to 24 weeks - this ended a long-standing legal fight on how unmarried pregnant individuals were being discriminated against. Moreover, the Supreme Court questioned why terminating a fetus after 24 weeks is only legal if it is a fetal abnormality. It questioned why minors, victims of rape and victims of incest aren't provided with the same legal protection and right. [6].

While it is apparent that steps have been made to reform the MTP act to better suit the norms of today's society, there are many changes that are yet to happen. The reality is that abortion can be seen as a taboo topic in India. India is filled with resistance to accepting the normality of pre-marital sex, the judgement and ostracisation of individuals who want an abortion [4] Additionally medical practitioners may be unwilling to carry out the procedure on the basis of cultural values instead of medical reasoning.

Social context may not be able to change swiftly; but the law certainly can and should. Therefore my thesis is: it is certainly necessary to further reform the MTP Act 2021; the Act still criminalises abortion, is ambiguous in many clauses and is doctor-centric rather than rights centric.

3. The Need to Reform the Criminalisation of Medical Termination of Pregnancy

3.1. Positive Rights

A positive right is an entitlement that obligates another person, group, or the government to provide you with a specific good, service, or resource. The medical termination of pregnancy - rather abortion - is technically a conditional legal exception rather than a positive right since our own criminal laws i.e. the BNS treat abortion as a criminal offence unless permitted under the MTP act [7-10]. This means it is illegal for a person to abort a fetus in any circumstance that does not conform to the specified special cases. The MTP Act creates a provision for criminal liability rather than providing a positive right to abortion. While abortion is certainly a widely contested concept, there are many arguments for legalising abortion in all contexts - provided that the gestational period does not extend post the 24th week.

One being that providing a pregnant individual with the positive right to abortion is a clear link to Article 21 from India's constitution - the right to protection of life and personal liberty. Not allowing a pregnant individual bodily autonomy is certainly deprivation of their personal liberty - individuals should be given the choice legally and judicially before venturing into social and economic constraints.

3.2. Doctor Centred Act

The MTP is structured in a manner that places importance

on the protection of the Medical Practitioner instead of the individual who has decided to terminate her pregnancy. The Act requires a Registered Medical Practitioner's opinion at every stage which not only undermines the wants of the pregnant individual but it also acts as a gatekeeping feature.

A pregnant individual cannot get an abortion simply by choice; they must have the approval of one or more doctors that they fit specific statutory conditions - the patient being a minor, the patient being mentally ill etc. This means the decision is based on the 'good faith' of a medical practitioner. [20] Since the legal liability is solely on the doctor - doctors are less likely to perform abortions in fear of being prosecuted under strict statutory boundaries which can lead to the wants of many individuals being denied. Again a contradiction to Article 21 of the Indian Constitution.

Additionally after 24 weeks the decision is taken away from both the pregnant individual and her primary doctor, handing it over to a multi-member, state-level board. This leads to long bureaucratic waiting periods, red tape and delays in evaluations which can be detrimental to an individual's health.

3.3. POCSO Discrepancy

Section 2(d) of the Protection of Children from Sexual Offences Act, 2012 (POCSO) specifies that a child is any person under the age of eighteen. Section 3 of POCSO defines sexual assault as the penetration of a child's mouth, urethra, vagina, or anus. Therefore, having sex under the age of 18 is illegal under POCSO, consensual or not. [14].

This creates a significant tension with the Medical Termination of Pregnancy Act, 1971 (MTP Act). If a minor wants to abort a pregnancy it may simultaneously constitute an offence under POCSO. Section 19(1) of POCSO requires knowledge or apprehension of such an offence to be reported to the police, while Section 5A of the MTP Act protects the confidentiality of the person undergoing the procedure. [14] However, it is acknowledged that in X v. Principal Secretary (2022) that an RMP must report under POCSO Section 19 but, on the request of the minor and guardian, need not disclose the minor's identity or personal details, and is exempt from disclosing identity in subsequent criminal proceedings. [6] Nevertheless, this arrangement does not resolve the fundamental conflict between compulsory reporting and private access to reproductive healthcare. From a perspective focused on autonomy, the possibility of police involvement might lead to privacy concerns and deter certain minors from obtaining prompt medical help. The concern, then, is not just if the law allows an exception for disclosure, but if the relationship between the two legal frameworks sufficiently protects minors' dignity, confidentiality, and meaningful access to abortion services.

4. Counter-Arguments and Rebuttals

Nevertheless, the case for reform should not be understood as requiring the wholesale removal of the MTP Act's existing safeguards. The gestational period is necessary and scientifically grounded. As the fetus develops, abortions tend to have more physical risks associated with late term terminations (termination of a pregnancy that has reached 41 weeks of gestation). In *Suchita Srivastava & Anr vs Chandigarh Administration on 28 August, 2009 [1]* the court itself recognised the potential physical risks of terminating a pregnancy at 19-20 weeks, while also affirming the importance of the pregnant individual's consent. This suggests that gestational thresholds are highly selected and act as a protective function which also must be taken into consideration alongside the pregnant individual's consent.

Additionally, the safety of the person is upheld through the implementation of a Medical Board during the decision of late term termination of pregnancy. Medical practitioners are licensed and almost always have more expertise than their patients. A multidisciplinary board consisting of a gynaecologist, paediatrician, and radiologist is required by the Medical Termination of Pregnancy (Amendment) Rules, 2021, which were later changed in 2024, due to the complexity and risk of late-term abortions. Rule 3A deals with the Medical Board's authority and duties; Rule 3B enumerates categories that can be terminated within 20 to 24 weeks; and Rule 3B guarantees that judgements are made based on medical considerations. This shields the individual from possible coercion as well as health hazards. [20].

However, the need for medical safeguards do not warrant the justification of the restrictions imposed by the MTP act. While medical practitioners do have the expertise to assess medical risks - this does not mean that they should have the final say over an individual's reproductive choices. The principles of beneficence and non-maleficence support measures that protect the pregnant individual from medical harm, but autonomy requires that their wishes and circumstances are also considered. Justice requires us to consider whether rigid gestational limits placed on minors, survivors of sexual violence and those who face barriers to healthcare put them at a particular disadvantage. The risks of terminating a pregnancy must therefore be considered alongside the physical, psychological and social consequences.

5. Proposed Reforms

While the MTP Act 1971 and its subsequent amendments represent legislative progress, the gaps argued above display that the current framework is still lacking. The following reforms are therefore proposed:

The MTP act should be amended further wherein terminating a pregnancy is not a criminal offence in any context up till the gestation period of 24 weeks. Individuals should be eligible for an abortion up to 24 weeks even if they aren't classified under the 'special cases' of the MTP Act. The rest follows the same amendment where if there is a biological issue, the gestation period can be upward of 24 weeks. This legislatively provides a positive right to individuals around the country to

have the option of abortion without being penalised for having bodily autonomy.

Additionally, the MTP act should be amended to remove gestational limits for survivors of rape, incest and minor cases. The current framework creates a grave distinction - termination beyond 24 weeks is permitted for fetal abnormalities but not for child rape survivors. [5] The legislation claims that fetal abnormalities are more grave than sexual assault. The Supreme Court reviewed this distinction in A (Mother of X) v. State of Maharashtra (2024) INSC 371. The Court examined the treatment of pregnancies with significant fetal abnormalities compared to those arising from rape or incest under the MTP framework, calling the distinction prima facie unreasonable or "potentially questionable," while keeping the wider constitutional matter unresolved. This observation underscores the possible rigidity of the legal framework when it comes to young survivors of sexual violence, whose situations may not be sufficiently addressed by its gestational constraints and eligibility criteria. [12].

Finally, POCSO needs to be amended in order to resolve the POCSO-MTP conflict. POCSO should be amended to introduce an exception to its mandatory reporting obligation under Section 19. It should exempt Medical Practitioners from disclosing the identity of the minor seeking the termination of her pregnancy. In this case, Medical Practitioners are not exposed to criminal liability for non disclosure which may result in more access for minors. Minors may feel more confident to seek safe abortions due to the new sense of anonymity.

6. Implementation

Although the MTP Act provides a legal framework for abortion in India, its effectiveness is significantly constrained by problems in implementation. The existence of the legal right provided by the Medical Termination of Pregnancy Act does not guarantee that women can exercise it in practice. As previously stated, Indian society stigmatises the concept of abortion. This can be seen in a 2018 survey that was conducted in Assam and Madhya Pradesh - it found that nearly 62% of 500 young women respondents believed that abortion was a “sin.” This suggests that attitudes towards abortion may discourage women from seeking medical assistance, even when they are legally entitled to terminate a pregnancy. [16].

This stigma is also reinforced by aspects of medical education which may influence a Medical Practitioner's view on the concept of abortion. The NLSIU report argues that medical jurisprudence textbooks have historically been grounded in patriarchal assumptions about women’s sexual and reproductive behaviour. For instance, a medical textbook from 2014 raised issues regarding how terminating a pregnancy as a widow, single woman, or wife could affect “family honour.” Such representations can reinforce the idea that abortion is associated with female immorality or social shame, potentially discouraging medical practitioners going through with the procedure on women seeking an abortion. [17].

Indian society faces another problem - the shortage of trained medical providers. Although India, according to a study in 2019, has approximately 700,000 MBBS doctors, only around 100,000 were reportedly trained to provide abortion services, in addition to approximately 30,000-40,000 OB-GYNs. Therefore, while legal availability of aborting a pregnancy exists, it does not translate to geographical or practical accessibility. Women may be unable to find an authorised provider, particularly in areas with limited healthcare infrastructure. [18].

These factors result in substantial consequences. A 2018 Lancet study estimated that 78% of the 15.6 million abortions conducted in India in 2015 took place outside health facilities which indicates a significant lack of support and services for individuals seeking to terminate their pregnancy. Consequently, effective implementation requires more than solely legislation. It requires a sufficient supply of trained professionals, accessible healthcare facilities and steps to eradicate the stigma surrounding abortion. The MTP Act therefore demonstrates that legal reform alone cannot guarantee meaningful access to reproductive healthcare [15, 19].

7. Conclusion

In conclusion, while the MTP act has made progress by extending gestational periods, recognising contraceptive failure as a ground for termination and introducing safeguards - gaps in its framework still remain.

The considerable authority afforded to medical practitioners in determining access to abortion and the emphasis on avoiding criminal liability over affirmatively protecting reproductive autonomy all warrant further consideration. Addressing these issues through reforms would help ensure that India's abortion laws have a more rights-based approach that respect bodily and reproductive autonomy while prioritising the medical safety of the pregnant individual.

Abbreviations

MTP	Medical Termination of Pregnancy Act
BNS	Bharatiya Nyaya Sanhita
POCSO	Protection of Children from Sexual Offences Act

Author Contributions

Zara Bajaj: Conceptualization, Resources, Writing – original draft, Writing – review & editing

Conflicts of Interest

The author declares no conflicts of interest.

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