IMPLEMENTATION OF THE MEDICAL TERMINATION OF PREGNANCY ACT IN INDIA: A CRITICAL ANALYSIS OF WOMEN'S REPRODUCTIVE HEALTHCARE RIGHTS

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ABSTRACT

The history of the development of reproductive rights in India, the shift of a punitive and morality-based approach to a rights-based approach based on the Indian Constitution, is impressive. The given paper is a critical analysis of the nature, extent and practice of reproductive rights in India and specifically on the Medical Termination of Pregnancy (MTP) Act, 1971 and its amendments. It follows the history of reproductive autonomy, comprising the right to choose whether to give birth, use contraception and use medical services as a component of the right to life and liberty in Article 21 of the Constitution. It discusses the change in the criminalization of abortion according to the Indian Penal Code to legalization, but with some conditions, according to the MTP Act and emphasizes its progressive character and restrictions. It also analyzes the implementation problems like infrastructural gap, decision-making by providers, stigma and inequalities in healthcare provision by regions. Criminal cases, including that of forced sterilisation and unsafe medical procedures, are examined to show the role of the judiciary in improving reproductive rights and accountability. It also looks at legislative changes and government initiatives aimed at improving reproductive health and its failure to do so. The study indicates that despite the tremendous progress, a comprehensive rights-based model is required to reduce the disparity between the rights on paper and their availability.

Key Words: - *Reproductive Rights, Healthcare, MTP Act*

I. INTRODUCTION

Human rights include reproductive rights, which involves the right to autonomy of the body when it comes to health and well-being. The reproductive rights discourse in India has been through a transformative process that has been shaped by the constitutional principles, legal reforms and judicial interpretations. Basically, reproductive autonomy incorporates the right to choose whether and when to have children, access to contraceptive use, and access to safe and legal abortion. These rights are directly related to the basic rights to dignity, privacy and liberty which are provided in Article 21 of the Constitution.

Historically, the reproductive law of India was framed within the criminal law, mostly under the Indian Penal Code which vehemently forbade abortion. Such a strategy was a representation of the conservative social and moral beliefs that prioritized the unborn child over the rights of women. However, the rising numbers of unsafe abortion and maternal mortality demanded a change of policy leading to the Medical Termination of Pregnancy Act, 1971. Despite the fact that this law was a step in the right direction to allow abortion in some cases, it still gave the profession precedence over the autonomy of women.

Later, social changes, technological changes in the medical field and the understanding of the necessity of gender equality have resulted in the amendments like the MTP (Amendment) Act, 2021. Simultaneously, the judiciary has been instrumental in expanding the scope of reproductive rights by establishing them as fundamental rights. Nevertheless, there are still major challenges such as social stigma, infrastructure and unbalanced implementation. This paper will critically analyse the legislative and policy processes in the reproductive rights sector in India, and its achievements and challenges.

II. CONCEPT AND SCOPE OF REPRODUCTIVE RIGHTS IN INDIA

Reproductive rights in India are very broad and are directly connected to human dignity, freedom, and autonomy over their bodies. This includes the right to decide on the reproduction or not, the right to contraception, the right to decide the number and spacing of children, and the right to reproductive healthcare. Knowledge of these rights is based on the fact that reproductive autonomy is not a medical or biological issue, but a human right. However, in India, the socio-cultural traditions, religion, and patriarchy have influenced the practice of reproductive rights

and have tended to limit the autonomy of women. These rights have gradually been realised in the law, though the transformation of a control to a rights-based system is not yet complete. The reproductive rights are also beginning to be viewed as part of the constitutional rights, particularly under Article 21, which entails the right to privacy, dignity and autonomy. Nevertheless, the process of translating these rights into practice is a challenge, which is impeded by social stigmatisation, ignorance and inequality.[1]

III. EVOLUTION OF LEGAL FRAMEWORK: FROM CRIMINALIZATION TO CONDITIONAL LEGALITY

The reproductive rights regulation of India was first initiated by the Indian Penal Code that criminalized abortion (Sections 312-318) except when it was required to save the life of the mother. This was a conservative stand in accordance to the moral and social values of that time, which placed the life of the unborn child higher than the rights of the mother. However, unsafe abortions and maternal deaths demanded a change in the law. This led to the Medical Termination of Pregnancy Act, 1971 that permitted more liberal and conditional approach to abortion. Some of the reasons that were allowed in this law to terminate included risk to the life of the woman, serious harm to physical or mental health, pregnancy conceived by rape, and fetal anomalies. Despite the fact that the Act was a progressive move, it still involved the opinion of the registered medical practitioners and limited the autonomy of women. Subsequent amendments, including the 2021 Amendment, have expanded abortion access by eliminating gestational restrictions and expanding it to unmarried women. Nevertheless, the law still has clauses that create conditions and procedural barriers that can slow or restrict access as a compromise between law reform and abortion.[2]

IV. IMPLEMENTATION OF MTP ACT

An example of the interaction between progressive reform and practical constraint is the implementation of the Medical Termination of Pregnancy (MTP) Act in India. The purpose of the MTP Act that was introduced in 1971 was to establish a legal basis to offer safe abortion

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[1]"India's Push-and-Pull on Reproductive Rights," *available at:* https://verfassungsblog.de/indias-push-and-pull-on-reproductive-rights/ (last visited March 31, 2026).

[2]"Sexual and Reproductive Rights in India: Social Movements and Legal Battles - DAY 2 - Centre for Law & Policy Research," *available at:* https://clpr.org.in/blog/sexual-and-reproductive-rights-social-movements-and-legal-battles-day-2/ (last visited March 31, 2026).

services with the main aim of preventing deaths caused by unsafe and illegal abortions. Since then the Act has been subject to progressive reform especially with the 2021 Amendment, to make it more inclusive by raising the gestational limits and recognizing the rights of single women. However, even with the progressive changes in the law, the implementation of the Act is limited, which hinders its effects.[3]

One of the most important features of the MTP Act is the provider-based approach that empowers the registered medical practitioners (RMPs) to a large extent. This is so as to guarantee medical safety, but this frequently results in restricted access. To the women who want to abort a fetus, they have to consult one or more RMP, according to the stage of pregnancy and this may take time especially when there is an emergency. This is especially troublesome in the rural and semi-urban areas where the trained medical practitioners are lacking. This is compounded by the lack of trained doctors and certified facilities, which means that women have to travel a long way or find unsafe ways.[4]

The other issue that is important in the implementation of the Act is the stark inequality in the healthcare infrastructure. Approved abortion facilities and trained professionals are more likely to be found in cities and semi-urban areas but not in rural areas, which might lack sufficient reproductive health services. This creates a sharp inequality that is disproportionately affecting women of marginalized and poorer groups. The government has not been doing enough in an attempt to correct these imbalances through the National Health Mission because of the inefficiencies in infrastructural and administrative systems.[5]

Social stigma and lack of awareness are also a major obstacle to the implementation of the MTP Act. Although abortion is legally acceptable in some situations, the social attitude towards abortion, in particular, to single women, is still conservative. Women who want to abort are afraid of being judged, discriminated against, and their confidentiality being compromised by the health care providers and are therefore not willing to use the services of formal health care providers. This is particularly the case with the youths and unmarried women who might not be

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[3]"Reproductive Rights AndThe Law: A Legal Analysis Of Abortion Laws In India," *available at:* https://www.juscorpus.com/reproductive-rights-and-the-law-a-legal-analysis-of-abortion-laws-in-india/ (last visited March 31, 2026).

[4]Anuvi Sinha and Ratnesh Sinha, "Recent Amendment in the Medical Termination of Pregnancy Act in India: Empowering Women's Health," 68 *Indian Journal of Public Health* 130–2 (2024).

[5]*Ibid.*

well informed of the law or they might be afraid of being stigmatized. This means that most of the abortions in India are still carried out illegally, which poses health risks and even death to women.[6]

The work of medical workers is essential but also problematic. RMPs make decisions at their own will, and this is why the law may not be applied uniformly. Sometimes, their faith, ethical objections or ignorance regarding the stipulations of the Act can influence their decision making and they will not be able to provide services even when legally they can. Moreover, the fact that termination can only be made after a specific point in the pregnancy is reached (according to the 2021 Amendment) by the medical board has contributed to the bureaucratic obstacles. The fact that there are no time limits of getting this approval may lead to delays where the pregnancy may be carried to late stages where it may be dangerous to the health of the person.[7]

It also has some ambiguity and inconsistency in the interpretation of some provisions of the Act. The definition of such terms as grave injury to mental health and substantial risk is subject to interpretation. This may be beneficial in terms of making the law apply to different situations, yet it may lead to confusion and inconsistency. In addition, the focus of the law on some categories and situations continues to create a conditional attitude towards abortion, as opposed to recognizing it as an inalienable right, and limits access.[8]

The other consideration that will affect the implementation of the MTP Act is that it interacts with other acts, including the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act that is meant to reduce sex-selective abortions. Despite the objective of the PCPNDT Act to discourage gender discrimination, strict implementation of this act has sometimes created an atmosphere of fear among the doctors hence a fear of offering abortion services. This is an

[6]Annik Mahalia Sorhaindo and Antonella Francheska Lavelanet, “Why does abortion stigma matter? A scoping review and hybrid analysis of qualitative evidence illustrating the role of stigma in the quality of abortion care,” 311 *Social Science & Medicine (1982)* 115271 (2022).
[7]Anna L. Altshuler and Natalie S. Whaley, “The patient perspective: Perceptions of the quality of the abortion experience,” 30 *Current Opinion in Obstetrics and Gynecology* 407–13 (2018).
[8]Mridul Dhar, Yashwant S. Payal and Vamshi Krishna, “The Pre-Conception and Pre-Natal Diagnostic Techniques Act and its implication on advancement of ultrasound in anaesthesiology; time to change mindsets rather than laws,” 62 *Indian Journal of Anaesthesia* 930 (2018).

unintended outcome contributing to the access barriers and emphasizing the need to adopt a holistic approach that supports reproductive rights and gender justice.[9]

The implementation needs a multi-faceted approach to improve. The access to healthcare, particularly in the rural areas, is of importance. Access can be enhanced by increasing the number of trained healthcare providers and facilities list. In addition, there is the need to educate the masses about their rights and to destigmatise abortion. Discrimination can also be minimized through sensitization of health-care professionals to provide non-discriminatory services.[10]

V. JUDICIAL RECOGNITION

In the case of "*Devika Biswas* v. *Union of India"*[11], the Supreme Court of India took up the serious problem of forced sterilization and the denial of reproductive rights of marginalised women. The Court took action due to the claims of unhygienic and unsafe sterilization camps that were organized by the state where women were pressured into sterilization without their free and informed consent, medical precautions and after-care. These practices were highly criticized by the Court which said that they violated the right to life and personal liberty as stipulated in Article 21. It emphasized that the rights to informed bodily autonomy are included in the category of reproductive rights, and that coercion and inducement of sterilization procedures are illegal. It emphasized the importance of informed consent, counselling and medical protocol. It also demanded that the government should come up with standard operating procedures, improve medical facilities and hold people accountable of abuses. More importantly, the decision expanded the area of reproductive rights to accommodate the dignity, safety and autonomy in health care practices. The Court strengthened the constitutional protection of autonomy by its criticism of the coercive population control programs and by establishing the right to reproductive autonomy, which is not subject to government interference.

[9]"An Analytical Study OfThe MTP Act, 1971 And PCPNDT Act, 1994: Balancing Women's Reproductive Rights With Gender Justice In India," *available at:* https://www.ijllr.com/post/an-analytical-study-of-the-mtp-act-1971-and-pcpndt-act-1994-balancing-women-s-reproductive-rights (last visited March 31, 2026).
[10]"Impact of pre–natal diagnostic technique (PNDT) act implementation on child sex ratio in India," *available at:* https://www.researchgate.net/publication/315499810_Impact_of_pre-natal_diagnostic_technique_PNDT_act_implementation_on_child_sex_ratio_in_India (last visited March 31, 2026).
[11] (2016) 10 SCC 726 / 733.

The case of "*Ramakant Rai* v. *Union of India*"[12] is yet another landmark judgment that seeks to protect reproductive rights, specifically in relation to sterilization practices under family planning programs. In this matter, the Supreme Court of India scrutinised the variations and non-uniformity in sterilisation procedures across states. The Court observed that the non-standardization of practices has caused unsafe surgeries, negligence and violation of patient rights. Given the possible implications of such shortcomings, the Court gave specific guidelines on how to make sterilization procedures standardized, safe and ethical. These guidelines were to establish quality assurance committees, follow standard medical practices, educate medical practitioners, and the need to have informed patient consent. The Court also emphasized the necessity of documentation and regular audits to make sure that the norms are followed. By these instructions, the Court sought to avoid abuse and promote the dignity and welfare of sterilized individuals. This ruling is a good example of how the judiciary can be used to find loopholes and make sure that reproductive healthcare services are offered in a manner that promotes the constitutional values and human rights ideals.

VI. POLICY FRAMEWORK AND STATE INITIATIVES IN REPRODUCTIVE HEALTHCARE

Policy frameworks and schemes that are dedicated to the promotion of maternal and reproductive health also regulate the enjoyment of reproductive rights in India. The State has introduced a variety of programs, including Janani Suraksha Yojana, Pradhan Mantri Matritva Vandana Yojana, Janani Shishu Suraksha Karyakram and the RMNCH+A strategy that are designed to lower the maternal mortality rate, promote institutional births, and enhance access to health care.[13] These programs show how the State is trying to meet its constitutional obligation in Article 21 of the Constitution to provide health care. Moreover, the National Population Policy gives priority to the access to contraception, family planning and reproductive health education. The application of these policies is, however, hampered by the following factors; scarcity of resources, inadequate qualified medical practitioners and geographical disparities. Moreover, the history of population control policy has sometimes led to coercive actions, violating the freedom

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[12] (2009) 16 SCC 565.

[13] "Overview on National Programme Related to Maternal Health," *available at:* https://www.researchgate.net/publication/361708749_Overview_on_National_Programme_Related_to_Maternal_Health (last visited March 31, 2026).

of reproductive choice. The absence of a strong legal framework of contraception and reproductive health care also affects the effectiveness of these policies. Therefore, despite the positive effects that policy interventions have had on fertility and reproductive health outcomes, the issue of access and autonomy to reproductive decision-making requires a more holistic and rights-based approach.[14]

VII. CHALLENGES, GAPS, AND THE WAY FORWARD

Although there is a significant development in legal and judicial reform, there are problems in the implementation of reproductive rights in India. One of the major obstacles is the social stigma and patriarchal culture, which restrict the exercise of the rights of women. The absence of information concerning legal rights and services adds to the problem, particularly in rural and marginalised regions. MTP Act provider-centred approach is an obstacle and the discretion given to health care providers has led to delays or service refusals. Absence of infrastructures and accountability mechanisms also hamper law and policy implementation. Indeterminacy in the law, especially on gestational age and medical board authorization is a source of confusion and denial of access to abortion services.

Moreover, the history of the coercive policies of population control, such as forced sterilisations and other disincentives like the two-child norm, must be discussed to support the reproductive rights. Even though the judiciary has been involved in correcting such practices, a significant overhaul of the legislation is required to eliminate such practices. In the future, there is a need to embrace a human rights approach, which focuses on the agency of women. These are informed consent, enhancing health infrastructure, raising awareness and educating and eliminating social and cultural barriers. Realigning domestic laws with international human rights treaties and making them accountable will be critical towards the achievement of full reproductive rights in India.

VIII. CONCLUSION

[14] R. Jagannath and Vasudha Chakravarthy, "The impact of Pradhan Mantri Matru Vandana Yojna scheme on access to services among mothers and children and their improved health and nutritional outcomes," 11 *Frontiers in Nutrition* 1513815 (2025).

The history of reproductive rights in India shows that there has been a gradual change in the approach of reproductive rights which has been a paternalistic approach to a more rights based approach. Reforms in the law including the Medical Termination of Pregnancy Act, 1971 and the amendments to this act have played a significant role in increasing access to abortion and expanding reproductive rights to women who are not within the institution of marriage. Similarly, judicial statements have expanded the rights by categorically subjecting the reproductive autonomy to the jurisdiction of Article 21, thus validating the principles of dignity, privacy and personal freedom.

In spite of these efforts, the rights exercise is uneven. The prevailing provider-oriented model, inadequate infrastructure and procedural barriers remain some of the factors that restrict access to safe and legal abortion. These are made worse by cultural stigma and patriarchal ideologies, particularly among single women and those with disadvantaged backgrounds. In addition, the past experience of forced population regulation and arbitrary power of medical practitioners justify the necessity of improving the protection of informed consent and autonomy.

Government programs and policy changes have contributed to the improvement of reproductive health, but the results are negated by the implementation issues and obstacles. In order to deal with these issues, a multi-dimensional strategy focusing on awareness, access and accountability is essential. The enhancement of healthcare facilities, legal clarity and medical practitioner training are key in effective implementation.

Lastly, the issue of reproductive rights needs to be safeguarded not only conditionally, but within a system of rights, whereby women should be given the autonomy to make their own choices. It is only with a continuous legislative change, judicial activism and social change that India will see a real implementation of reproductive autonomy in all.