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**Title ; The MTP Act 2020: A Step Towards Liberation**

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**Conflict of interest:** The authors declare no conflict of interest.

**Author contributions:** Both the author contributed equally

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**Abstract**

The modification of the laws for abortion in favor of the well-being of pregnant women is one aspect of the removal of discrimination against women. MTP act 1971 was a breakthrough legislation in this regard as it brought about an immense reduction in the rate of illegal abortions. With advancements in ultrasonography and genetic technologies, many fetal malformations and genetic disorders were being diagnosed after 20 weeks of gestation. This had caused great distress to the pregnant women and highlighted the need to increase the upper limit of termination of pregnancy. The MTP Bill 2020 has come as a breath of fresh air extending the term limit to 24 weeks for certain categories of women and removing the limit for abortion in the presence of a significant fetal abnormality. The amendments recently approved by the Lok Sabha (Indian Parliament), have to be passed by the Raj Sabha and consented to by the President before they become law. This paper presents the proposed changes and their implications for obstetric, ultrasound and fetal medicine practice. The abortion laws in neighboring countries are also briefly discussed.

**Keywords: MTP, Amendments, MTP act 2020, Malformations, India, Lok Sabha,**

**Abortion laws, Different countries**

**INTRODUCTION**

The laws for abortion vary in different countries, as they represent an interaction of society, religion, law and the rights of women. Article 15 of the Indian constitution lays down that the state shall not discriminate any citizen on the grounds of sex **[1].** Despite this, discrimination against women is widespread in India and has existed from times immemorial. To do away with this disparity against women action is required on many fronts – social, economic and legal. The modification of the laws for abortion in favor of well-being of women is one aspect of this reform. In this paper, we trace the history of abortion laws in India starting from the pe-MTP era, the MTP Act of 1971 **[2],** its revision in 2002 **[3],** and continuing into the Medical Termination of Pregnancy (Amendment) Bill 2020 **[4].** We examine the various sections of this new Bill and show how it will change the landscape of abortion in favor of women, and will inevitably improve the practice of obstetrics, ultrasonography and fetal medicine. We also briefly review the abortion laws in operation in other countries.

**THE PE-MTP ERA**

In 1860, The Indian Penal code **[5]** was enacted by the British. Under IPC 312-316 it declared that induced abortion was illegal. It provided that any person performing it would be subject to imprisonment for three years and/or payment of a fine. If the woman had felt quickening, then the imprisonment would be for seven years and payment of a fine. The same penalty applied to a woman who induced her miscarriage. The only exception being if the abortion was performed to save the life of the woman. This penal code was changed in Great Britain in 1967, but not in India until 1971. Countless women died as a result of illegal abortions due to the existence of this penal code **[6-8].** It was the combination of this mortality and the increasing population that made the country reconsider its initial stance in 1971. There was a need to improve the maternal health scene by preventing unsafe abortions and decreasing subsequent maternal morbidity and mortality.

**THE MTP Act, 1971: BENEFITS AND CHALLENGES**

The original MTP Act was passed in 1971 to permit abortion by law and to prevent untoward deaths occurring as a result of illegal abortions, especially by unauthorized and untrained persons **[2].** The Act stated that “Subject to the provisions of sub-section (4), a pregnancy may be terminated on the advice of one registered medical practitioner if the length of the pregnancy does not exceed twelve weeks; or on the advice of two medical practitioners if length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks. The registered medical practitioners should be of the opinion, formed in good faith, that (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The act was legislated by Parliament on 10th Aug 1971 and was enforced nationwide on 1st April 1972 (except in Kashmir and Mizoram, where it was adopted in 1980). It relaxed the indications for termination of pregnancy, specified the place of termination and the training of the person performing it. The Act was amended in 2002 to allow termination of pregnancy up to 20 weeks of gestation to facilitate better and more universal implementation and increase access for women, especially in the rural areas [**3].** This amendment also clarified the definition of certain terms, simplify approval of facilities performing abortions, and to keep pace with medical advances such as the use of abortion pills.

However, the Act did not keep up with the advances in technology in diagnosing the health of the fetus and in obtaining an abortion for an unwanted or abnormal fetus **[9, 10].** Singh and colleagues reported that about 15.6 million abortions took place in India in 2015, of which 22% were in health care facilities while 73 % were outside the health care facilities and 0.8 % were outside the health care facilities using methods other than medications **[11].** It was estimated that abortions accounted for almost 1/3 of all pregnancies, and that half of all pregnancies were unintended.

**NEED FOR AMENDMENT**

With the passage of time and advancing medical technologies such as ultrasonography and genomics, the MTP Act of 1971 failed to safeguard the rights of women and their families. A common scenario was a pregnant woman consulting an obstetrician or fetal medicine specialist around 18- 20 weeks after detection of a fetal abnormality on the level II ultrasound. If the abnormality was severe and incompatible with life e.g. anencephaly, the pregnancy could be terminated before 20 weeks gestation. If the abnormality was not lethal but could cause a serious degree of physical or mental handicap, additional tests were required to prove this point, such as the presence of intrauterine infection, a chromosomal or a monogenic disorder. The tests would take time and by 23 or 24 weeks of pregnancy, it would be discovered that the fetus does have a disabling abnormality. To avoid the socioeconomic burden of bearing and looking after such a baby, the couple would desire an abortion. The current law does not permit this and the couple would have to approach the court for permission, which may or may not be granted. A few cases will further illustrate such challenging situations.

**Illustrative Cases:**

1. ***Fetus with Down syndrome****:* In 2017, family X. was denied permission to abort a fetus with Down syndrome at 26 weeks of pregnancy, because the 20-week mark specified in The Medical Termination of Pregnancy Act of 1971 had been crossed **[12].** The family already had a child with special needs and was not in a position to care for another child with developmental delay and medical problems. Such a denial led to additional distress to the family and generated mistrust in the judicial system. A well-formulated Act and one which was ahead of its time at inception seem not to have kept pace with technology and needed change.
2. ***Fetu with abnormal cerebral ventricles***: A couple with a history of two miscarriages sought consultation at 19 weeks of pregnancy with both cerebral ventricles measuring around 10mm (borderline value). They could not afford genetic testing and were asked to follow up with a scan at 22 weeks. At that time the ventricles were 14mm in size, and the couple opted for genetic testing which showed the fetus to have an unbalanced translocation between chromosomes 14 and 21. The couple desperately wanted to discontinue the pregnancy as they did not have sufficient means to raise a differently-abled child, but no obstetrician was willing to terminate the pregnancy. The woman went on to deliver a child with multiple malformations, global developmental delay and autistic features.

iii) ***Genetic disorders detect din 3rd trimester***: There are detectable only in the third trimester, e.g. achondroplasia, primary microcephaly or lissencephaly. Couple B. presented with a history of two neonatal deaths due to microcephaly, seizures and retarded growth. The woman attended a clinic at 19 weeks of pregnancy with a normal level II scan. She was told that diagnosis by molecular tests was not possible because that would require knowledge about the causative gene and the mutation, which were not known. The only alternative would be to follow fetal head growth by ultrasound after 3 weeks. But this would be too late for termination. She took a chance but unfortunately on ultrasound study the fetus was detected to have microcephaly and suffered the same fate as the previous siblings.

***(iv*** *A****ppeals to the court by rape survivors*:** The NGO Pratigya-Campaign for Gender Equality and Safe Abortion examined 194 such cases of rape survivors that appeared between June 1, 2016, and April 30, 2019, before the Supreme Court and various High Courts, seeking permission to terminate the pregnancy **[13].** The Courts rejected pleas by rape survivors to allow abortion beyond 20 weeks of pregnancy in nearly 20% of the cases - this was despite previous instances where judgments interpreted Medical Termination of Pregnancy (MTP) Act, 1971 such that the mental and physical trauma caused to a sexually assaulted woman was considered a grave threat to her life. The reasons cited for denying permission varied - pregnancies crossing the statutory 20 weeks threshold; abortion being unsafe for the survivor; and even rejecting the survivor’s plea that her pregnancy caused mental agony on grounds that she had not disclosed the incident of rape sooner, among others. In a landmark judgment by the Bombay High Court in the Shaikh Ayesha Khatoon Vs. State, allowed the petitioner to terminate her fetus 27 weeks into the pregnancy due to abnormalities. The court’s judgment referred to mental health cited in Section 3 and personal liberty, by conflating these with Section 5 and implying that termination was necessary to save the petitioner’s life.

(v) ***Inconsistent reports by medical boards***: In as many as 75 cases where the courts permitted termination beyond 20 weeks they did not rely totally on the opinion of the medical boards. The plea was accepted that rape constituted a grave threat to the mental health of the survivor and not allowing termination would be a threat to the woman’s life. The study highlighted ten consistencies in the report submitted by chemical boards.

Chandrashekar **[13],** pointed out that women with pregnancies even below 20 weeks gestation were going to the court to seek permission for MTP. These cases defy the provisions of the MTP Act and represent major problems in access to abortion. These women have to further face a long and tiring process, where they are subject to examination before the medical boards, despite having consulted their providers. The entire process adds to the trauma for women and girls and is a violation of their rights.

**The MTP BILL 2020: PROVISIONS**

As time elapsed advances in technology occurred both in ultrasonography and genetics, enabling prenatal diagnosis of a large number of foetal disorders. For various reasons diagnosis of a fetal anomaly is often made after 20 weeks of gestation and calls for increasing the upper gestational limit for terminating pregnancies for helping such women. Keeping in view the steady increase in the number of writ petitions filed before the courts seeking permission for the termination in the presence of severe fetal abnormalities the obstetricians and fetal medicine specialists and ultrasonologists have been representing to the Ministry of Health and Family Welfare to bring necessary changes in the Act to keep in line with international thinking. Therefore the MTP Act 2020 made significant amendments to MTP Act of 1971, and would come as a big relief to the specialty of fetal medicine as well as patients when it becomes law.

**.** The Medical Termination of Pregnancy (Amendment) Bill number 55 of 2020, was passed by the Lok Sabha on17 March 2020. It is now awaiting approval by the Rajya Sabha and then the President, followed by notification in the Official Gazette before it becomes a law**.** It is a very crucial Bill for the specialty of obstetrics, fetal and reproductive medicine and ultrasonography. It was passed in The Lok Sabha without much fanfare and went almost unnoticed by the medical fraternity. It is essentially an amendment to the MTP Act of 1971, which was a comprehensive legislation.

The Act extends the limit for termination of pregnancy to *20 weeks on approval by one registered medical practitioner*, and up to *24 weeks on approval by two registered medical practitioners*.

Unfortunately, these provisions *do not apply to all women* but *only to special categories of women as prescribed by rules under this a****ct***. These categories are:    
(i) Women in whom the continuation of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical and mental health.

(ii) Women who have a substantial risk that if the child is born it would suffer from any serious physical or mental abnormality.

(iii) Women who have a pregnancy as a result of the failure of any device or method used by the woman or her partner for limiting the number of children or preventing pregnancy the anguish caused by such pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman. In such cases, the MTP would be permitted up to 20 weeks of pregnancy. It may be noted that the word used here is a partner and not husband presumably to include live-in couples and even pregnancy in a casual sex relationship.

(iv) Women whose pregnancy has been caused by rape. In such cases, the anguish caused by the pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

***Application of bill if the fetus has a fetal abnormality***

A far-reaching amendment is that in case the *fetus has any substantial fetal anomaly the upper limit of termination shall not apply to the termination of pregnancy*. This means that *termination can be carried out up to any gestational a*ge. However, this has to be *approved by the medical board which* will be set up especially for this purpose. It will consist of a gynecologist, a physician, a radiologist or ultrasonologists and such other number of members as may be notified in the Gazette by the State Government or Union Territory.

***Other provisions of the Bill***

Other important provisions of the bill are as follows:

1. The norms for the registered medical practitioner whose opinion is required for the termination of pregnancy at different gestational ages will be such as may be prescribed by rules under this act.
2. Another significant clause is that no registered medical practitioner shall reveal the name or other particulars of a woman whose pregnancy has been terminated under this act except by a person authorised by law for time being in force. Any contravention of this provision shall be punishable with imprisonment which may extend up to one year or with fine or both.

**ABORTION LAWS IN OTHER COUNTRIES**

The challenges in the implementation of abortions are universal. It has different cultural, social, religious and political contexts in each country. Therefore, the laws related to abortion are different around the world. The United Nations and WHO periodically publish the abortion policies throughout the world, as documented in the Global Abortion Policies Database [**15].**

The developed countries have more liberal abortion laws. *The only ground for an abortion that is acceptable in all countries is the one where the woman’s life is in danger because of the ongoing pregnancy* [**15].** Further, abortion up to 12 weeks is allowed in most countries, Sweden allows it to 18 weeks, Netherland to 22 weeks, and UK to 24 weeks. Authorizations are often required for a legal abortion. Consent of one of the parent/guardian is required in 25 European countries if the woman is below the age of majority. Authorizations are sometimes required for a legal abortion. In 25 European countries, consent is required from a parent or guardian for a woman who has not reached the age of majority. In France, another adult can substitute for parents if a woman under 18 cannot obtain parental consent [**16**]. In other countries (Italy, Denmark, Norway, Spain), this role is played by a commission. In 37 states in the USA consent form one of the two-parent is required if the woman is requesting abortions under 18. Abortion rules are quite restrictive. In Africa and Latin America. It is totally banned in 9 African countries although 6 of these countries have exceptions to the rule.

Following the May 2018 Irish referendum largely in favour of abortion, only two European countries, Malta and Andorra, still do not give women the right to decide to end a pregnancy in the first weeks. In 2017, among the 43 countries of Europe, 29 allowed an abortion at the woman’s request (covering 72% of European women of reproductive age), and four allowed it on social and economic grounds.

The legislative landscape varies a lot more in Asia. Vietnam was the first country in Asia to legalise abortion as early as 1945, not long before China in 1957. Nepalese law was drastically changed and now allows abortion at the woman’s request up to 12 weeks of gestation, up to 18 weeks in case of rape, and for any duration, if the woman’s life or health is in danger **[17].** Thus, even in a global context, the abortion rules in India have liberalised to a large extent and is a definite step towards women liberalisation.

**China**

There are no provisions in the Criminal Code of China (enacted by the National People's Congress on 1 July 1979) under which abortion with the consent of a pregnant woman constitutes an offence. Government of China provides abortion as a public service.  A woman receives 14 days of paid sick leave for a first-trimester abortion or 30 days if the pregnancy is terminated after the first trimester.  In China, an abortion can be performed up to 6 months of gestation

**Indonesia**

The Indonesian Criminal Code, enacted in 1918 by the Dutch colonial Government, adopts a restrictive view of abortion. Under section 348 of the Code, any person performing an abortion is subject to imprisonment for five and one-half years. Under section 346 of the Code, a woman wilfully inducing miscarriage is subject to imprisonment for up to four years. Although the Code contains no exceptions to its general prohibition on the performance of abortions, in 1970s an “understanding” was reached by medical professionals, on the advice of the Chief Justice of the High Court, that abortions could be performed to preserve a woman’s life or health. However, actual reform of the abortion law did not take place until 1992 when the Government enacted Health Law 23/1992, which specified that “in the case of emergency and to save the life of a pregnant woman or her foetus, it is permissible to carry out certain medical procedures”.  The abortion must be based on the guidance of a team of experts, must have the consent of the pregnant woman or her husband or family. The abortion has to be performed by an obstetrician/gynaecologist. In cases of fetal impairment, and cases of rape, additional authorization is required **[18].**

**Pakistan**

Until over two decades ago, induced abortion was permissible only to save a woman’s life. The Pakistan Penal Code (PPC) largely draws from the colonial Indian Penal Code of 1860. But in 1997, an additional clause was added to Chapter XVI, Section 338 of the PPC to permit : induced abortion before the limbs or organs of the baby have been formed for necessary treatment. This stipulation, regarding limbs and organs is based on Islamic law **[19],** which states that induced abortion is permitted until the quickening of the foetus up to 20 weeks gestation, according to Pakistani medical practice. Induced abortions that fall outside these conditions may be punished with prison sentences ranging from three to ten years but, there have been no cases of imprisonment for abortion-related offences.

Necessary treatment is not defined in the PPC, however, and the law does not specify situations when a woman would need an abortion, leaving it up to service providers and medical professionals to interpret the clause as they please. Those people who want to encourage abortions would encourage service providers to interpret it broadly, to mean not just the physical health of a woman, but also her emotional and mental health. Depending on where a woman falls within the legal exception, doctors should be a providing abortion, and all wards in government hospitals should have abortion facilities**.**

**Bangladesh**

Bangladesh has one of the highest rates of child marriage. Early marriage leads to early pregnancy. UNICEF Bangladesh finds that one-third of teenage girls aged 15 to 19 are mothers or are already pregnant. In Bangladesh, only the Penal Code 1860 talks about abortion or miscarriage. Sections 312-316 lay down the punishment for causing miscarriage. Section 312 states that whoever causes miscarriage to a pregnant woman shall be imprisoned for three years, or with fines, or both, and if the fetus has been fully developed, the punishment may extend to seven years. A woman who performs an abortion on herself is subject to the above penalties. Bangladeshi law permits a woman menstrual regulation for up to 12 weeks of pregnancy - the method of vacuum aspiration if a woman misses her period. This was introduced as part of the government’s family planning program, and not considered as an abortive measure. It may be regarded as a euphemism for early pregnancy termination **[20].**

**Sri Lanka**

Sri Lanka has some of the strictest abortion laws in the world, where abortion is only permitted if the mother’s life is at risk, as per Section 303 of the [Penal Code of 1883](file:///C:\Users\sgrh\Desktop\MTP\3D%22http:\hrlibrary.umn.edu\research\srilanka\stat=). The punishment for causing a miscarriage is a fine and/or up-to 3 years imprisonment. Despite these laws, the number of abortions taking place daily was 658, as reported by the Ministry of Health in 2016. Contrary to common belief most of these women are married and they already had 203 children. The most common reason given for abortion was the conception too soon after the last delivery. [There have been several](file:///C:\Users\sgrh\Desktop\MTP\3D%22https:\groundviews.org\2017\09\13\the-abortion-debat=) to reform these archaic laws in Sri Lanka, but opposition groups have continuously rejected all proposals. Attempts were made to decriminalise abortion in 1995, 2011, 2013 and most recently in 2017 a committee under Justice Aluvihre to allow abortion in cases of rape, incest, pregnancy in a girl < 16 years, and severe foetal impairment, but the religious groups blocked all attempt [**21].**

**Malaysia**

Just like other Southeast Asian countries, abortion in Malaysia is restricted. However, since 1989, abortion may be performed through an exemption that was granted by law and will only be allowed provided that the following circumstances are met: There is a risk to the physical health of the woman, or the mental health of the woman.

**Thailand**

Abortion laws in Thailand, originally imported from Europe in the nineteenth century, criminalise women seeking an abortion, punishing them with imprisonment of up to three years, or a fine of up to 6000 Bahts (about USD 180), or both. As for the abortion provider, he or she could be imprisoned for up to five years, or fined 10,000 Bahts (about USD 300), or both. The law was first amended by adding section 305 in 1949, allowing a physician to carry out an abortion for certain medical conditions, in rape cases, and children under the age of 13 years.

The case of an obstetrician who had been arrested in February 2018 for providing abortions was brought before the Constitutional Court. On 19th February 2020, one year later the Court ruled that existing laws criminalising abortion are unconstitutional and ordered the government to amend the law. This was to be done within one year – by 219 February 2021. This historic ruling will hopefully take women in Thailand another small step towards equality and freedom of choice. However, this remains optimistic speculation for now and we will have to wait for the new law to be formulated and written.

**DISCUSSION**

There is little doubt that this amendment by advancing the upper limit of termination for pregnancy has provided great relief for women who require an abortion. Many organizations and experts have argued that the amendment does not go far enough in recognizing the autonomy of the woman to decide whether to continue or discontinue her pregnancy **[14]**. However, it is generally agreed that this is a very welcome amendment which helps women to experience a stress-free pregnancy and have a baby without major malformations.

For abortion, up to 20 weeks of pregnancy only approval by one registered medical practitioner is required. Earlier a registered medical practitioner could approve abortion only up to 12 weeks of gestation. The obstetrician of the pregnant woman is readily available to approve abortion and support her in taking the correct decision. For termination, up to 24 weeks, the second medical practitioner could well be the fetal medicine specialist or the ultrasonographer or a senior obstetrician colleague. Some people have argued that there is already a shortage of doctors and there would be difficulty in getting the necessary nod from second medical portioners in rural areas, and this will entail hardship for women. Others have suggested that training may be given to practitioners of Ayurveda and homeopathy to ease the situation in rural areas. However, this requires careful consideration as the various medical associations have always disapproved such suggestions.

A major objection is that this extension of the upper limit of termination is *only for special*

*category of women* and *not for all women*. However, the categories for which this act would apply is fairly widely applicable, e.g. the clause that “women in whom the continuation of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical and mental health” would cover many situations. Similarly the clause “women who have a pregnancy as a result of the failure of any device or method used by the woman or her partner for limiting the number of children or preventing pregnancy the anguish caused by such pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman” would apply to many situations requiring an abortion.

Some have expressed apprehension regarding fixing the upper limit for abortion in cases of rape. They point out that the procedural delays in the police station as well as the courts, and feel that there should have been further relaxation of the upper limit.

The greatest beneficiaries would be women who are worried about having an abnormal baby or one with malformations. This amendment to the MTP Act has done away with the upper limit for termination of pregnancy with a substantial fetal abnormality. Some experts have suggested that the word ‘substantial’ should have been defined more precisely. Still, the amended act will provide the obstetrician and the fetal medicine specialist time to testing for abnormalities. The patient i.e. the pregnant woman would accept and opt for knowing that the results will bring about a change in the management of the pregnancy. It will relieve the already overworked laboratories of the pressure to generate reports in 2 weeks, resulting in increased accuracy. Finally, and most importantly, it will generate confidence in the health care system, provide safety to distressed women and allow them to enjoy not only birth but also the myriad of responsibilities that come with nurturing a new-born baby.

The discussions by the members of parliament on the Amendments to the MTP Act have been briefly described in ref **14.** Most of the discussions are variations on the themes presented above. The Minister of Health and Family Welfare, who had presented the Bill in the Lok Sabha, replied that many of the apprehensions that have been expressed during discussion in Parliament will be taken care of when the Rules and regulations are drafted. Once this Bill is approved and becomes law in the country it will enable India to join the progressive group of nations that recognize the rights of women to decide about their pregnancies. Although it does not provide full freedom it is a step in the right direction.

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