Civil Society Recommendations on making the Medical Termination of Pregnancy (Amendment) Bill 2020 a Rights Based Legislation

We welcome the move to amend the Medical Termination of Pregnancy Act 1971 and the government's intention to ensure "safe, affordable, accessible abortion services" and that "advancement of medical technology for safe abortion" becomes a reality for women of India as mentioned in the Statement of Objects and Reasons of the MTP Amendment Bill 2020. In order to strengthen the proposed amendment and make it a piece of progressive and rights-based legislation, we would strongly urge the government to consider the following:

1. The amendment to Clause 3 be changed:
    a. to allow abortions up to twelve weeks (first trimester) *at will of the pregnant person*
    b. the extension of gestation limit from 20-24 weeks be applicable to all pregnant persons and not be restricted to only "certain categories of women"
    c. opinion of a single provider for gestation up to 24 weeks (instead of two providers for 20-24 weeks gestation).

2. The provisions of sub-section (2) of Clause 3 relating to the length of the pregnancy and upper gestation limit should be extended to include survivors of sexual abuse/rape as well as those who face a change in circumstances, and not just restricted to the diagnosis of substantial foetal anomalies. The change in circumstances referred to here has been elaborated in Annexure II.

3. To ensure confidentiality is safeguarded, the proposed clause "5A" should be changed to say that the provider should not disclose any particulars of the pregnant person whose pregnancy has been terminated, unless directed by a court of law. The current proposal which allows particulars to be disclosed "to a person authorized by any law for the time being in force" can potentially be misused to harass people and providers compromising the safety of pregnant persons.

4. Medical Boards" should not be constituted. Requiring pregnant persons to be examined by a medical board violates the rights to dignity, privacy, and decisional autonomy of the pregnant person. Multiple invasive examinations of the pregnant person by the Board can be intimidating and humiliating. These boards are a form of third-party authorization that is highly burdensome, especially due to the financial drain on persons needing to appear before the Board repeatedly, and they also lead to substantial delays in abortion access.

5. We propose that the term 'abnormalities' be replaced by the word 'anomalies' as 'abnormalities' reinforces the notion that foetuses with potential disabilities or medical conditions are undesirable. The term implies that persons with disabilities are 'abnormal' and those without disabilities are 'normal' and therefore more valued and wanted.

6. We propose that the term 'woman' in the Bill be replaced by 'person' or 'pregnant person' in order to include transgender people. Access to abortion services is necessary for transgender, intersex and gender-diverse persons. This is in line with the 2014 NALSA judgment and the Transgender Persons (Protection of Rights) Act 2019 which recognise the principle of self-determination of gender identity. Any legislative framework on abortion must ensure that *all* individuals have access to safe, affordable and legal services

7. As per the MTP Rules 2003, Medical Abortion (MA) drugs are approved for use only up to seven weeks of gestation, while the Drug Controller General of India has approved the MA combipack up to nine weeks. The MTP Amendment Bill 2020 should eliminate this inconsistency and approve Medical Method of Abortion in line with the WHO recommendation.

8. When the MTP Rules are framed/revised, we would urge that widespread consultations are held with civil society organizations, providers and legal experts so that the rules keep the interest of the pregnant persons at the centre.

9. The Bill must be referred to a Standing Committee and public comments must be invited in order to ensure that all stakeholder perspectives are taken into consideration.

The above suggestions are based on existing evidence and experience of abortion provision in India and globally. Annexure I provides the detailed evidence and rationale. Annexure II provides Clause-by-Clause Comments and suggested changes to the proposed amendments. Annexure III provides some general recommendations for the Bill and Annexure IV lists a few important opinion articles on this issue.

Supreme Court of India's jurisprudence upholds the right of pregnant persons to exercise reproductive choices without any interference. In the landmark case of *Suchita Srivastava v. Chandigarh Administration* (2009), the Court expressly stated that reproductive choices can be exercised to procreate as well as to abstain from procreating. In the 2017 privacy judgment, *Puttaswamy v. Union of* India, Justice D.Y. Chandrachud noted that reproductive choice should be read as an essential ingredient of reproductive rights, within the personal liberty guaranteed under Article 21. The decisions in *Navtej Johar v. Union of India* (2018) and *Joseph Shine v. Union of India* (2019) also recognise the importance of sexual autonomy and its linkages to reproductive and decisional autonomy.

We recommend that the proposed changes to the amendments be considered by the Government of India, so that the new law is in line with the Supreme Court jurisprudence and the Statement of Objects and Reasons of the MTP Amendment Bill 2020. This will ensure dignity, autonomy, confidentiality and justice for anyone who needs to terminate their pregnancy.

Annexure I: Evidence/Rationale for Suggested Changes to the MTP Amendment Bill 2020
Annexure II: Clause-by-Clause Comments and Suggested Change
Annexure III: General Recommendations for the Bill
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Annexure I: Evidence/Rationale for Suggested Changes to the MTP Amendment Bill 2020

S. No	Proposed Amendment in tabled Bill	Suggested Changes	Rationale
1a.	(------)	Abortion in the first trimester should be made the right of a pregnant persons, allowing them to seek abortions at will of the pregnant person.	-The Draft 2014 Amendment Bill had proposed that termination of pregnancy up to 12 weeks should solely be "on request of a woman" -66 countries around the world including Canada, Nepal, Netherlands, Sweden, South Africa and Vietnam allow abortion at will of the pregnant person.[1]
1b.	Upper gestation limit extended from 20 to 24 weeks for 'certain categories of women'	The increase in gestation limit from 20-24 weeks should be extended for all pregnant persons.	-Several developmental and structural foetal anomalies can be detected only between 20-24 weeks and the decision to abort can be delayed. 53% of women who sought judicial intervention for foetal anomalies were in the 20-24 weeks gestation. [2] -Countries like Finland, Netherlands, Singapore, Spain and UK allow women to access abortion up to 24 weeks on social grounds or for foetal anomalies -Countries like Ethiopia, allow it for over 24 weeks gestation. Countries like Vietnam and Canada do not prescribe any gestation limit for abortion and allow women on social grounds and at will of the pregnant person.
1c.	Requirement of opinion of one provider for termination of pregnancy up to 20 weeks and two providers between 20-24 weeks gestation.	Opinion of only one provider should be applicable for 20-24 weeks gestation.	-The requirement of opinion of two providers may make it difficult for many pregnant people to access 20-24 weeks abortion, particularly those in rural areas and small towns due to the following: -There is an acute shortage of specialists (Obstetrician and Gynaecologists) who are approved MTP providers for second trimester and above (over 12 weeks). -A majority of these specialists are concentrated in urban areas. -A single provider can perform the

[1] https://reproductiverights.org/sites/default/files/documents/World-Abortion-Map.pdf
[2] Assessing the Judiciary's role in Access to Safe Abortion https://pratigyacampaign.org/wp-content/uploads/2019/09/assessing-the-judiciarys-role-in-access-to-safe-abortion.pdf

			procedure. -Only 12-23% of facilities providing abortion are in the public sector and of these abortion providing facilities, only 13-40 % provide second trimester abortion. Many of these may have only one provider and will not be able to provide services for 20-24 weeks gestation.[3] -In private sector only 15-54% of facilities providing abortions provide second trimester abortion.
2.	(----)	The gestation limit for vulnerable groups specifically for survivors of sexual assault, rape, minors and incest should be removed entirely and they should be allowed access to abortion post 24 weeks.	-The mental trauma of carrying to term a pregnancy that has been a result of rape is immense and violates right to life and dignity. -About 41% of vulnerable women (rape survivors) beyond 20 weeks who sought judicial intervention in the last few years had crossed the 24 weeks gestation.[4]
3.	Medical practitioner shall not reveal the particulars of any woman whose pregnancy has been terminated except to a person authorised by law.	Medical Provider should not disclose any particulars of a pregnant person whose pregnancy has been terminated, unless directed by a court of law. The right to privacy of a pregnant person who seeks abortion services should be clearly enumerated in the Act.	-The MTP Regulations 2003 state that the particulars of the woman, along with details in the admission register, are to be kept secret and not disclosed to **any person**. -The 2017 *Puttaswamy* judgment held that privacy is a fundamental right. -On ground conflation of the MTP Act with PCPNDT Act results in officials asking for documentation of women who seek abortion. Allowing any person authorized by law to ask for details may compromise a pregnant person's privacy and safety. [5]
4.	Upper gestation limit not to apply in cases of substantial foetal abnormalities diagnosed by Medical Board	-The opinion of the doctor regarding substantial foetal abnormality should be sufficient. -Medical board should not be constituted to decide on such cases.	-Subjecting pregnant persons whose provider has diagnosed substantial foetal anomaly, to additional and repeated medical assessments by Medical Boards is a violation of their rights and agency. -Decision making by medical boards can be delayed, humiliating and can negatively

[3] Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs https://www.guttmacher.org/report/abortion-unintended-pregnancy-six-states-india

[4] Assessing the Judiciary's role in Access to Safe Abortion https://pratigyacampaign.org/wp-content/uploads/2019/09/assessing-the-judiciarys-role-in-access-to-safe-abortion.pdf

[5] Availability of Medical Abortion Drugs in the Markets of four Indian States https://pratigyacampaign.org/wp-content/uploads/2019/09/availability-of-medical-abortion-drugs-in-the-markets-of-four-indian-states-2018.pdf

			impact the mental health of a pregnant person. -As per the bill, medical boards should consist of a) a Gynaecologist b) a Paediatrician c) a Radiologist or Sonologist and any other member as notified by the state governments. Though, the powers and functions of the boards will be prescribed in the rules; the availability of such specialists in many district headquarters in public sector is very limited. -Repeated invasive exams by unfamiliar doctors on medical boards can be stigmatizing. -The setting up of the medical boards goes against the spirit of the MTP Act which relies on the opinion of the pregnant person's healthcare provider as opposed to boards. -A *Pratigya Campaign* study found that that courts rely largely on these medical board opinions to approve terminations. Boards take into account various factors, including viability of the foetus, a consideration that is not present in the Act, thereby completely neglecting the health risks of continuing an unwanted pregnancy. [6]
5.	(--)	Use of the term 'anomalies' instead of 'abnormalities' throughout the Act	The term 'abnormalities' reinforces the notion that foetuses with potential disabilities or medical conditions are undesirable. With such language, the legislation continues to advance eugenic rationale.
6.	(--)	The use of 'woman' in the Bill be replaced by 'person' or 'pregnant person' in order to include transgender people.	Access to abortion services is necessary for transgender, intersex and gender-diverse persons. This is in line with the 2014 NALSA judgment and the Transgender Persons (Protection of Rights) Act 2019 which recognise the principle of self-determination of gender identity.
7.	(--)	Expansion of provider base to include Nurses, ANMs and AYUSH doctors as first trimester abortion providers including for	Given the advancement in medical technology – availability of medical abortion and manual vacuum aspiration, other cadres of health care workers like Nurses, ANMs, AYUSH doctors can be trained to provide

[6] Assessing the Judiciary's role in Access to Safe Abortion https://pratigyacampaign.org/wp-content/uploads/2019/09/assessing-the-judiciarys-role-in-access-to-safe-abortion.pdf

		medical abortion	first trimester abortions. World Health Organisation recommends this in their 2015 guidelines 'Health Worker roles in providing safe abortion care and post abortion contraception'. -Countries like Vietnam, South Africa, Bangladesh (for menstrual regulation), Sweden etc. permit these cadres to provide first trimester abortion. -Expanding the provider base would improve access to abortion care, particularly rural in rural areas and have a huge impact in terms of reducing maternal mortality and morbidity.
8.	(----)	Medical Method of Abortion should be approved in line with WHO recommendation and up to the gestation limit in the MTP Act.	- WHO in 2019 included MA drugs in the Core List of Essential Medicines (previously it was in the Complementary list).The earlier list had advisory stating "that close medical supervision is required for use of mifepristone-misoprostol for medical abortion". This advisory is not mentioned in WHO's latest list of essential medicines, which clearly indicates that MA drugs can be used with minimum level of medical supervision and the risks associated with it are minimal.

Annexure II: Clause-by-Clause Comments and Suggested Change

Clause No.	Clause Text	Comment	Suggestion/Alternative
2	In the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as the principal Act), in section 2,— (i) after clause (a), the following clause shall be inserted, namely:— '(aa) "Medical Board" means the Medical Board constituted under sub-section (2C) of section 3 of the Act;';	The problems with constitution of a Medical Board have been detailed below.	We strongly urge that Medical Boards not be constituted as they are a violation of the pregnant person's rights to dignity, privacy and autonomy.
2	(ii) after clause (d), the following clause shall be inserted, namely:— '(e) "termination of pregnancy" means a procedure to terminate a pregnancy by using medical or surgical methods.'.	(--)	(--)
3	In section 3 of the principal Act, for sub-section (*2*), the following sub-sections shall be substituted, namely:— "(*2*) Subject to the provisions of sub-section (*4*), a pregnancy may be terminated by a registered medical practitioner,— (*a*) where the length of the pregnancy does not exceed twenty weeks, if such medical practitioner is, or (*b*) where the length of the pregnancy exceeds twenty weeks but does not exceed twenty-four weeks in case of such category of woman as may be prescribed by rules made under this Act, if not less than two registered medical practitioners are, 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	While this amendment is progressive as it increases the overall gestational limit to 24 weeks, it is still inadequate as it leaves out many persons who may need abortions but are not covered within the categories that the Rules may prescribe. The termination of pregnancy up to 20 weeks is still based on the opinion of one registered medical practitioner, while between 20-24 weeks, the opinion of two medical practitioners is required. This is an additional barrier to abortion access. The Draft 2014 Amendment Bill had proposed that termination of pregnancy up to 12 weeks should be "on request of a woman".	We propose that Clause 3 be reframed as follows: In section 3 of the principal Act, for sub-section (*2*), the following sub-sections shall be substituted, namely:— "(*2*) Subject to the provisions of sub-section (*4*), a pregnancy may be terminated by one registered medical practitioner,— (a) at will of a pregnant person, where the length of the pregnancy does not exceed twelve weeks; (b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty-four weeks, if the registered medical practitioner is, of the opinion, formed in good faith, that—

	child were born, it would suffer from any serious physical or mental abnormality. *Explanation* 1.—For the purposes of clause (*a*), where any pregnancy occurs as a result of failure of any device or method used by any woman or her partner for the purpose of 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. *Explanation* 2.—For the purposes of clauses (*a*) and (*b*), where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by the pregnancy shall be presume to constitute a grave injury to the mental health of the pregnant woman.	The Explanations require reframing in order to include many more vulnerable persons and to expand access to abortion services for transgender persons. This would bring it in line with the principle of self-identification recognized by the NALSA judgment and the Transgender Persons (Protection of Rights) Act 2019. Explanations 1 and 2 restrict abortion access to cases of contraceptive failure or to those who are survivors of rape. There are many other reasons why a person may need to terminate an unwanted pregnancy. An unwanted pregnancy (for reasons other than rape or contraceptive failure) can also severely impact a person's mental and health. Abortions should not be limited to these grounds. All pregnant persons should be entitled to avail of abortion services up to 24 weeks, in consultation with their RMP. It is safe to conduct abortions after 24 weeks.	(*i*) the continuance of the pregnancy would involve a risk to the life of the pregnant person or of grave injury to her physical or mental health. Explanation 1.—For the purposes of clause (*b*), the anguish caused by an unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant person."
3	(2A) The norms for the registered medical practitioner whose opinion is required for termination of pregnancy at different gestational age shall be such as may be prescribed by rules made under this Act.	(--)	(--)
3	(2B) The provisions of sub-section (2) relating to the length of the pregnancy shall not apply to the	Given that that termination of pregnancy can be carried out safely post-24 weeks,	Medical Boards should not be constituted.

	termination of pregnancy by the medical practitioner where such termination is necessitated by the diagnosis of any of the substantial foetal abnormalities diagnosed by a Medical Board. (2C) Every State Government or Union territory, as the case may be, shall, by notification in the Official Gazette, constitute a Board to be called a Medical Board for the purposes of this Act to exercise such powers and functions as may be prescribed by rules made under this Act. (2D) The Medical Board shall consist of the following, namely:— (a) a Gynaecologist; (b) a Paediatrician; (c) a Radiologist or Sonologist; and (d) such other number of members as may be notified in the Official Gazette by the State Government or Union territory, as the case may be."	there is no rationale for limiting it only to cases where the foetus has been diagnosed with substantial "abnormalities". We propose the inclusion of pregnant persons from vulnerable groups within this clause, and recommend that it not be limited to cases of substantial foetal "abnormality". We also strongly urge that **Medical Boards not be constituted**. There have been documented difficulties which cause substantial delays in access to MTP services such as early or forced marriages, lack of knowledge regarding contraception, rape or sexual violence, delay in recognizing the pregnancy, delay in decision making due to lack of autonomy, intimate partner violence, difficult family circumstances, and lack of mobility especially in case of persons with disabilities, or institutionalized persons. The Statement of Objects and Reasons of the Bill also points to the need for increased gestational limit as many survivors of sexual violence have been compelled to approach the courts seeking abortions. A change in circumstances may also lead to a pregnancy becoming unwanted after 24 weeks, such as when there is separation from or death of a partner, or a change in	For abortions post-24 weeks, the opinion of one gynaecologist (whom the pregnant person has been consulting), in consultation with no more than one other medical practitioner, may be required. Hence, we submit that the following clause be inserted in Section 3, sub-section (2) "(c) The provisions of sub-section (2) relating to the length of the pregnancy shall not apply to the termination of pregnancy by the medical practitioner where such termination is necessitated for survivors of rape or sexual violence, or by the diagnosis of substantial foetal anomalies, or due to a change in circumstances, as assessed by the pregnant person's gynaecologist, in consultation with one other registered medical practitioner if required. We also suggest that the term 'abnormalities' be replaced by the word 'anomalies' as 'abnormalities' reinforces the notion that foetuses with potential disabilities or medical conditions are undesirable.

		financial situation. The requirement of Medical Boards in order to diagnose 'substantial foetal abnormalities' that necessitate termination **violates the rights to dignity, privacy, and decisional autonomy of the pregnant person**. These boards are a form of third-party authorisation that is highly burdensome and leads to substantial delays in abortion access. Diverse composition of the Board with three or more members means that it will be impossible to reach a decision quickly. The Boards would also act as a serious barrier for pregnant persons needing their approval since the expert composition required for such a Board may exist only in the metro areas. For those living in rural areas, there would be substantial costs and delays involved. Moreover, multiple invasive examinations of the pregnant person by the Board can be intimidating and humiliating. Many individuals may resort to unsafe abortions instead. Finally, the problems inherent in third-party authorisation have been highlighted at the international level. The *UN Human Rights Special Procedures Working Group on the Issue of Discrimination*	

		against Women in Law and in Practice released a statement in 2017 asserting that any legislative requirements for abortion should not cause delays that would prevent the carrying out of termination before the pregnancy becomes too advanced. Similarly, the *Committee on the Elimination of Discrimination against Women* has raised concerns about third-party authorisation requirements, and the *World Health Organization* has acknowledged that third-party authorisation requirements undermine women's autonomous decision-making. Thus, the requirement of Medical Boards for diagnosing fetal "abnormalities" is unnecessarily bureaucratic.	
4	After section 5 of the principal Act, the following section shall be inserted, namely:— "5A. (1) No registered medical practitioner shall reveal the name and other particulars of a woman whose pregnancy has been terminated under this Act except to a person authorised by any law for the time being in force. (2) Whoever contravenes the provisions of sub-section (1) shall be punishable with imprisonment which may extend to one year, or with fine, or with both.".	The exception that allows 'a person authorized by any law' to obtain the particulars of the woman whose pregnancy has been terminated violates the spirit of the provision which is meant to ensure strict confidentiality and protect the privacy of the person undergoing termination. In light of the *Puttaswamy* judgment which stated that privacy is a fundamental right and in the spirit of the MTP Regulations 2003 which stated that the particulars along with the admission register would be kept secret and not disclosed to any person, this amendment needs to be revisited.	The right to privacy of a pregnant person who seeks abortion services should be clearly enumerated in the Act. We also propose that the section be re-framed as follows: "5A. (1) No registered medical practitioner shall reveal the name and other particulars of any person whose pregnancy has been terminated under this Act. (2) Whoever contravenes the provisions of sub-section (1) shall be punishable with a fine."

		Penal provisions create a chilling effect on the provision of abortion services. The confidentiality clause should be framed similar to the provisions of the MTP Regulations which prohibited disclosure of any details.	
5	In section 6 of the principal Act, in sub-section (2), after clause (a), the following clauses shall be inserted, namely:— "(aa) the category of woman under clause (b) of sub-section (2) of section 3; (ab) the norms for the registered medical practitioner whose opinion is required for termination of pregnancy at different gestational age under sub-section (2A) of section 3; (ac) the powers and functions of the Medical Board under sub-section (2C) of section 3."	The recommendations for (ac) and (ab) have already been given above. For (aa), as stated previously, the amendment is inadequate as it does not include many vulnerable groups of people.	We propose the inclusion of Adivasi and Dalit persons, nomadic persons, migrant workers, sex workers, internally displaced persons, victims of intimate partner violence, persons with disabilities, institutionalised persons, girls with forced and early marriages, transgender persons and all those who are all vulnerable to delayed diagnosis, lack of adequate information and access to abortion services resulting in seeking termination of pregnancy beyond the 24 week gestation limit of the Act.

Annexure III: General Recommendations for the Bill

1. Gestational Limit and Requirement of RMP Opinions

The Bill proposes that for pregnancies up to 20 weeks, the opinion of one RMP is required to terminate. For pregnancies between 20-24 weeks, the opinion of two RMPs is required.

We submit that up to 12 weeks' gestation, the termination should be allowed solely at the will of the pregnant person in consultation with their doctor. The consent of the pregnant person must be paramount here. From 12-24 weeks, one RMP is sufficiently qualified to determine the safety of termination procedure and perform it. Abortions should be available for all persons regardless of the reason. The anguish caused by an unwanted pregnancy can be severely detrimental to a person's mental and physical health and ought to be taken into consideration. Hence, abortions should not be limited to the grounds of contraceptive failure or sexual violence or to certain categories of women only. . It is safe to conduct abortions after 24 weeks. All pregnant persons should be able to avail of abortion services up to 24 weeks, without needing to fulfil any restrictive conditions. It would create unnecessary barriers to abortion service to require the opinion of two RMPs at this stage.

Post the 24-week limit, a panel of two RMPs (gynaecologists) may be constituted to determine whether the termination can be performed. . It is safe to conduct abortions after 24 weeks. Any more than two RMPs would contribute to delays and lead to greater anguish for the pregnant person.

2. Third-Party Authorization

There should be no third-party authorization, including judicial authorization, for termination of pregnancies.

Medical Boards are a form of third-party authorization and have been recognized at the international level as violative of the human rights of pregnant persons. Articles 3 and 17 of the ICCPR provide that the "right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, concerning intimate matters of physical and psychological integrity". The unnecessary layer of authorization added by a Board (or the judiciary) are contradictory to the values of autonomy and dignity that the Indian Constitution also espouses.

Furthermore, we submit that RMPs are qualified to determine whether an abortion can be performed safely post-24 weeks. We propose, therefore, that the pregnant person's consent and the opinion of their gynaecologist be the main considerations for terminations post-24 weeks. If required, the gynaecologist may consult one other doctor.

3. Conflict with POCSO Act

The Protection of Children from Sexual Offences (POCSO) Act 2012 considers all sexual activity between minors (under the age of 18) to be a sexual offence. This means that consensual sexual activity between adolescents will be treated as an offence, and as per Section 19 of the Act, must be mandatorily reported to the police or the Special Juvenile Police Unit. The

mandatory reporting requirement deters many adolescents from seeking abortion services due to the fear that they or their partner will face criminal sanctions. The requirement also conflicts with the proposed confidentiality provision in the Bill. It is crucial that pregnant adolescents are able to approach doctors for safe abortions or even to obtain information about these services. Not removing the mandatory reporting requirement criminalizes adolescent sexuality and results in many adolescents resorting to risky, unsafe abortion methods.

4. Expansion of Provider Base

In order to enable large number of pregnant people to benefit from "advancement in medical technology for safe abortion", we urge that qualified and trained nurses, as well as other suitably qualified healthcare providers, be included in the list of abortion providers to provide early abortion, especially medical method of abortion. Recommendations of the World Health Organization with regard to who can provide an abortion should be seriously considered.

5. Need for Consultation

For the MTP Act to adequately address the barriers to abortion access faced by women and girls, consultation with all the stakeholders is necessary and indispensable. Widespread consultations ought to be conducted with healthcare providers, lawyers, activists, Dalit and Adivasi rights advocates, sex workers, disability rights advocates, transgender persons and other vulnerable groups. The Bill should be revised and re-drafted in light of the consultations.

Annexure IV: Important Opinion Articles on the MTP Amendment Bill 2020

1. The amendments in the MTP Act bill are flawed |Hindustan Times- oped by Vrinda Grover- https://www.hindustantimes.com/analysis/the-amendments-in-the-mtp-act-bill-are-flawed-analysis/story-H0DZJUAWWopQZKPzbLXyJL.html

2. Are we truly advancing women's rights? | The Pioneer- oped by VS Chandrashekar- https://www.dailypioneer.com/2020/columnists/are-we-truly-advancing-women---s-rights-.html

3. The above oped was reproduced in Business World - Does The MTP Amendment Bill 2020 Really Advance Women's Rights?

4. Proposed Changes to Abortion Law Continue to Sideline Pregnant Persons | The Wire- oped by Dipika Jain - https://science.thewire.in/health/proposed-changes-to-abortion-law-continue-to-sideline-pregnant-persons/

Annexure V: Coalition of Civil Society Organisations