

Legal Barriers to Accessing Safe Abortion Services in India: A Fact Finding Study

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National Law School of India University,
Nagarbhavi, Bengaluru – 560 072

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Published By: National Law School of India University, Bengaluru

ISBN: 978-93-91111-05-2

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Acknowledgements

This report is the product of a collaboration between the Center for Reproductive Rights, the Centre for Constitutional Law, Policy, and Governance (CLPG), National Law University, Delhi, and the National Law School of India University, Bengaluru. The authors of this study are Aparna Chandra, Associate Professor of Law, National Law School of India, University, Bengaluru (NLSIU), Mrinal Satish, Professor of Law, NLSIU, Shreya Shree, Assistant Professor of Law, NLSIU and Mini Saxena, currently a graduate student at SOAS University of London. The authors were at the Centre for Constitutional Law, Policy, and Governance, National Law University, Delhi when the study commenced in 2018, and when the field-based fact-finding study was undertaken in 2019. The final phase of the project, involving writing and editing the Report was undertaken in 2020-21, when three of the authors were associated with NLSIU. We thank National Law University, Delhi (NLU Delhi) and National Law School of India University (NLSIU), particularly their Vice Chancellors, Prof. Ranbir Singh (Vice Chancellor, NLU Delhi until September 2020), Prof. P. Srikrishna Deva Rao (Vice Chancellor, NLU Delhi from September 2020) and Prof. Sudhir Krishnaswamy, Vice Chancellor, NLSIU, for their support.

From the Center for Reproductive Rights, Brototi Dutta, Advocacy Advisor for Asia, and Prabina Bajracharya, Capacity-Building Manager for Asia, contributed to drafting and coordinated the Report's publication. Payal Shah, former Acting Director for Asia conceptualised this study with the lead authors.

We are also grateful to Jihan Jacob, Senior Legal Advisor for Asia and Maria Alejandra Cardenas, Deputy Director of the Global Legal Program at the Center for Reproductive Rights, for their review of the report drafts. This publication could not have been finalised without the support of other Center for Reproductive Rights colleagues, including Jamie Hanson, Program Associate and Mahendra Panta, Program Coordinator for Asia. A special thanks to Shreya Munoth, former Consultant for Center for Reproductive Rights, Asia for steering this publication through its initial stages.

When the project was conceptualised in late-2018, a group of experts were consulted for their feedback on the issues identified for the study, and the sites for the study. We thank Amba Salelkar, Anubha Rastogi, Dr. Jayashri Gajaraj, Kavya Kartik, Ratna Appender, Rupsa Mallik, Dr. Sampath

Kumari, Dr. Suchitra Dalvie, Dr. Suneeta Mittal, Swagata Raha, V.S. Chandrashekar, Vidya Reddy, and Vrinda Grover for their feedback and advice. Amba Salelkar, Dr. Suchitra Dalvie, Swagata Raha, and V.S. Chandrashekar peer-reviewed the report. Dr. Alka Barua, Rupsa Mallik, Vidya Reddy, and Vrinda Grover provided comments on the findings and recommendations of this study. Their contributions have significantly enriched this publication, and we thank them for their support.

The fact-finding study was conducted in four states – Delhi, Jharkhand, Maharashtra, and Tamil Nadu. This would not have been possible without the assistance of a number of people. Dr. Pallavi Vats, Souvik Pyne, Shveta Kalyanwala, Dr. Sonali Raj Singh, Dr. Sneha Banerjee, Sushanta K. Banerjee, and Vinoj Manning, helped us with the field study in Delhi. Akila R.S., Amba Salelkar, Bhuvaneswari Sunil, V. Dhandapani, Geeta Ramaseshan, M. Shankar, Dr. P. Balasubramanian, P. Kausalya, Pushpa Narayan, Rukmini Srinivasan, Selvaraj C., Dr. Subha Sri, Sudha Ramalingam, Dr. T. K. Sundari Ravindran, and Vidya Reddy assisted us with the field study in Tamil Nadu. Ali Haider, Babita Sinha, Javed Rabbani, Laxmidhar Singh, Mayuri Karna, Nasreen Jamal, Nilesh Kumar, Reshma Singh, Rosa Ali, Rupsa Mallik, Sandeep Shankh, Shivnath Shankh, Suchismita Mandal, provided invaluable assistance with the field study in Jharkhand. Dr. Anita Saxena, Dr. Jaydeep Tank, Kajal Jain, Manisha Gupte, Manisha Kunjir, Nikita Sonavane, Padma Deosthali, Shireen Jejeebhoy, Vasvi Agarwal, and the Mumbai and Pune offices of the FPAI, assisted with the field study in Maharashtra. We thank all of them for their incalculable support, without which this study would not have been possible. We interviewed around 300 respondents across the four states for this study. We are grateful to all of them for being incredibly generous with their time. We are not naming them here, and in the Report, since most of them requested anonymity.

Malavika Parthasarathy, who was then a Fellow at CLPG, travelled to Tamil Nadu for the fact-finding study, and conducted interviews in Tamil, where required. She also assisted in translation and transcription of the Tamil interviews. We are grateful to her for her assistance. We are also grateful to Ameya Bokil for transcribing interviews that were conducted in Marathi. We were assisted by a group of committed student interns – Abhinav Hansa Raman, Adrija Ghosh, Aishwarya Gupta, Anant Sangal, Anupriya Dhonchak, Anushka Pandey, Ashutosh Chandra, and Yash Mittal, whose responsibilities ranged from research, assisting in the field, to transcription of interviews. We thank all of them for their valuable contributions.

Adrija Ghosh copy-edited the publication, and Pallavi Agarwala designed the report. We are grateful to them, as well as to the staff at the National Law University, Delhi and the National Law School of India University, Bengaluru for their logistics and administrative support.

Table of Abbreviations

CAC	Comprehensive Abortion Care
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW Committee	Committee on the Elimination of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CHC	Community Health Centre
CRC	Committee on the Rights of the Child
CrPC	Criminal Procedure Code, 1973
CRPD	United Nations Convention on Rights of Persons with Disabilities
CWC	Child Welfare Committee
DCC	Drugs Consultative Committee
DGHS	Directorate General of Health Services
DLCS	District Level Committees
EPR	Emergency Police Report
FIGO	International Federation of Gynaecology and Obstetrics
FIR	First Information Report
FOGSI	Federation of Obstetric and Gynaecological Societies of India
HRC	Human Rights Committee
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IPC	India Penal Code, 1860
JJ Act	Juvenile Justice (Care and Protection of Children) Act, 2015

MA	Medical Abortion
MoHFW	Ministry of Health and Family Welfare
MTP Act	Medical Termination of Pregnancy Act, 1971
MTP Amendment Act, 2021	Medical Termination of Pregnancy (Amendment) Act, 2021
MTP Regulations	Medical Termination of Pregnancy Regulations, 2003
MTP Rules	Medical Termination of Pregnancy Rules, 2003
National Trust Act	National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999
OGSSI	Obstetric and Gynaecological Society of Southern India
PCPNDT Act	Preconception and Prenatal Diagnostic Techniques Act, 1994
PHC	Primary Health Centre
POCSO Act	Protection of Children from Sexual Offences Act, 2012
POCSO Rules	Protection of Children from Sexual Offences (POCSO) Rules, 2020
RCOG	Royal College of Obstetricians and Gynaecologists in the United Kingdom
RMP	Registered Medical Practitioner
RPWD Act	Rights of Persons with Disabilities Act, 2016
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UNTMBS	UN Treaty Monitoring Bodies

1 Introduction

I BACKGROUND AND CONTEXT

Of the 48.1 million pregnancies that occur in India annually, approximately half are unintended.¹ A third of all pregnancies are aborted.² 12.3 million abortions, accounting for 78% of all abortions are illegal as per the terms of the Medical Termination of Pregnancy Act, 1971 (“**MTP Act**”) – even though they may otherwise be safe – solely because they occur outside of health care facilities.³ However, at least 800,000 of these abortions are unsafe,⁴ and unsafe abortions account for 10% of maternal mortality in India.⁵ Women and girls who are impoverished, not literate, live in rural areas, or belong to minority religions or oppressed castes, are at a significantly higher risk of having unsafe abortions and abortions outside of facilities, thus placing them at a heightened risk of adverse health outcomes as well as criminal liability.⁶

The World Health Organisation (“**WHO**”) recognises that while restrictive abortion laws do not significantly reduce the rates of abortion,⁷ they do place substantial barriers to accessing safe abortions, and that rates of unsafe abortion are higher where access to safe abortion is legally restricted.⁸ Such restrictive abortion laws not only result in significant mortality and morbidity in pregnant women, thus impacting their right to health, but also limit their ability to realise their rights to life and liberty, bodily integrity, sexual and reproductive autonomy, privacy, and equality.⁹

In India, the Indian Penal Code, 1860 (“**IPC**”) criminalises voluntarily “causing miscarriage” even when the miscarriage is with the pregnant woman’s consent, except when the miscarriage is caused to save the woman’s life.¹⁰ A woman who consents to her own miscarriage or causes herself to miscarry is also criminally liable.¹¹ In 1971, the MTP Act was enacted to “liberalise” access to abortion,¹² and to provide access to safe abortion services.¹³ The Act provides certain exceptions to the prohibition in the IPC and lays down the conditions under which abortion can be provided legally. However, the MTP Act is not a rights-based legislation. It permits abortion only on certain specified grounds and only upon the approval of registered medical practitioners (“**RMPs**”).¹⁴ The Act also lays down other conditions that have to be fulfilled for a pregnancy to be terminated legally.¹⁵ Further, the Medical Termination of Pregnancy Rules, 2003 (“**MTP Rules**”) and other legislations, most notably, the mandatory reporting requirement in the Protection of Children from Sexual Offences Act, 2012 (“**POCSO Act**”) and the Criminal Procedure Code, 1973 (“**CrPC**”),¹⁶ the Preconception and Prenatal Diagnostic Techniques, 1994, (“**PCPNDT Act**”) and state and national level drug regulations, create additional legal barriers for women seeking access to safe abortion services, both directly, and through the stigmatisation of abortion and the consequent chilling effect on seeking and providing safe abortion services.

Through a field-based study in four states, this report aims to understand and document whether and how these laws operate as barriers to accessing safe abortion care. This study is a collaboration between the Centre for Reproductive Rights, the Centre for Constitutional Law, Policy and Governance, National Law University, Delhi and the National Law School of India University, Bengaluru. Our collaboration and this report build on our recent work, together and separately, on the issue of reproductive justice in India, including the Center for Reproductive Rights' 2018 Report on case law analysis of legal and procedural barriers to post-20 weeks abortions,¹⁷ and a jointly published 2019 casebook on Reproductive Justice in India.¹⁸ In addition to highlighting the restrictions imposed in law and procedure, we wanted to understand from the experiences and perceptions of abortion seekers, abortion service providers, civil society organisations, academics, and legal service providers, how these legal barriers impact women' and girls' access to abortion and the health consequences that they are compelled to face. We seek to center women within this complex interplay between the law, the medical space, and the courts, with the aim of providing a comprehensive picture of the legal barriers experienced by women in accessing safe abortion services.

Over the last few years, various attempts have been made at reforming the law on abortions in India, both legislatively and through judicial intervention.¹⁹ A motivation for this study was to facilitate evidence-based abortion law reform, by investigating the impact of abortion restrictive laws on access to safe abortion in India. While we were in the process of completing this report, the Indian Parliament legislated the most wide-ranging abortion law reform that India has witnessed in the last 50 years.²⁰ However, we believe that the recent reforms fail to address some of the key legal barriers to accessing safe abortion services that we document in this report.²¹ Further, the Government of India must draft new rules before the amendments can be brought into force. The constitutional concerns raised in pending Court cases challenging the MTP Act have also not been addressed.²² Therefore, we believe that there is continuing need for generating evidence of the legal barriers faced by women and service-providers in accessing and providing such services, and the harm caused to women due to such barriers. Based on our findings, the report suggests measures for rights-oriented law reform.

In this introductory chapter, we first discuss the normative framework for evaluating access to safe abortion services. We locate this framework within a range of human rights and constitutional safeguards that are implicated in accessing safe abortion services. We then explain the methodology of the study, and the structure of this report.

II. NORMATIVE FRAMEWORK

A. ABORTION IN INTERNATIONAL HUMAN RIGHTS LAW

In international human rights law, the right to abortion is an aspect of the right to life and liberty,²³ the right to health,²⁴ privacy and autonomy, equality and non-discrimination,²⁵ the right not to be subjected to torture or other cruel, inhuman, or degrading treatment or punishment,²⁶ as well as access to sexual and reproductive health, education, and information.²⁷ A series of documents signalling global political commitments like the 1994 International Conference on Population and Development (“ICPD”) and the 4th World Conference on Women in Beijing (Beijing PFA+), have also explicitly linked governments’ duties under international treaties to their obligations to uphold reproductive rights.²⁸

Over the years, UN Treaty Monitoring Bodies (“UNTMBs”) and Special Procedure mandate-holders have established and reaffirmed the connection between criminalisation and restrictive abortion laws, on one hand, and violation of human rights norms, on the other. In its most significant recognition of criminalisation of abortion as violating the right to life under the International Convention on Civil and Political Rights (“ICCPR”), the Human Rights Committee (“HRC”) in its 2019 General Comment No. 36 emphasised that States should not apply criminal sanctions to those who undergo abortion or to medical service providers who assist them in doing so, and should also not criminalise unmarried pregnancies.²⁹ The Committee noted that criminalising unmarried pregnancy or applying criminal sanctions to women and girls seeking abortion compels them to resort to unsafe abortions, consequently putting their lives in danger.³⁰

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“(r)estrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering that violates article 7 of the Covenant, discriminate against them or arbitrarily interfere with their privacy.”
- Human Rights Committee, General Comment No. 36 (2019).

The Committee on the Elimination of Discrimination against Women (“CEDAW Committee”) has also found criminalisation of abortion and forced continuation of pregnancy to be forms of gender-based discrimination and violence,³¹ and to constitute systemic violations of rights under the Convention on Elimination of All Forms of Discrimination Against Women (“CEDAW”).³² Besides forcing women and girls to unsafe abortions that threaten their life and dignity, the CEDAW Committee has highlighted the ways in which criminalisation of abortion prevents them from exercising any real choice in their physical and mental health, and also contributes to underreporting of rape and sexual violence for fear of prosecution. Women and girls are further denied full enjoyment of sexual and reproductive health because of lack of access to contraceptive information and services within a penal legal regime. Taken together, these violate their rights to equal protection of the law, to health, and to decisional autonomy.³³ They have also drawn attention specifically to the disproportionate and devastating impacts of criminalisation on marginalised

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“The State party is also under an obligation to take steps to prevent similar violations in the future. To that end, the State party should amend its law on the voluntary termination of pregnancy, including if necessary its Constitution, to ensure compliance with the Covenant, ensuring effective, timely and accessible procedures for pregnancy termination in Ireland, and take measures to ensure that health-care providers are in a position to supply full information on safe abortion services without fearing they will be subjected to criminal sanctions...”
- Human Rights Committee in *Mellet v. Ireland* (2016).

peoples, which amounts to violation of their human rights.³⁴ The Committee on the Rights of the Child (“CRC Committee”) under the Child Rights Convention has called on States to decriminalise abortion to ensure adolescent girls’ access to safe abortion and post-abortion care as well as to respect their abortion-related decisional autonomy.³⁵

UN human rights mechanisms have also reiterated that even when legal, abortion must be available, accessible, affordable, acceptable, and of good quality. This means that along with expanding access, States should remove existing barriers to safe abortion and not impose additional ones.³⁶ The UN Special Rapporteur on Health noted that “[c]riminal laws penalising and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realisation of women’s right to health and must be eliminated.”³⁷ He highlighted the connection between denial of decision-making in an area as intimate and important as person’s reproductive capacity with their rights to dignity and autonomy, which require that individuals are free to make personal decisions without State interference.³⁸ Further, the Special Rapporteur also noted that “marginalisation and vulnerability of women as a result of abortion-related stigma and discrimination perpetuate and intensify violations of the right to health including their mental health by creating a chilling effect amongst skilled service providers, adversely affecting quality health interventions, and leading to denial of care.”³⁹ Further, emphasising State obligations to take positive steps to realise the right to safe and legal abortions, the Special Rapporteur’s report notes that “safe abortions will not immediately be available upon decriminalisation unless States create conditions under which they may be provided.”⁴⁰

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“The stigma resulting from criminalization creates a vicious cycle. Criminalization of abortion results in women seeking clandestine, and likely unsafe, abortions. The stigma resulting from procuring an illegal abortion and thereby breaking the law perpetuates the notion that abortion is an immoral practice and that the procedure is inherently unsafe, which then reinforces continuing criminalization of the practice.”
- U.N. Special Rapporteur on Health (2011).

The UN Working Group on Discrimination against Women and Girls also noted that States have an obligation to ensure that abortion-related laws and policies recognise the pregnant person’s ability “to make a judgment call regarding their reasons for not being able to continue the pregnancy.”⁴¹ Therefore, conditions like third-party authorisations from courts and medical boards generally, and specifically for adolescents, persons with disabilities, based on marital status and other circumstances, undermine the right to autonomy.⁴²

UN human rights mechanisms have severally called on India to uphold its international obligations to respect, protect, and fulfil Sexual and Reproductive Health Rights (“SRHR”), including access to safe abortion. In 2014, the CEDAW Committee expressed its concern over high death rates from unsafe abortions and urged India to “provide women with access to high-quality and safe abortion services.”⁴³ The CRC Committee has also expressed its concern over parental consent requirements for adolescents seeking abortion services⁴⁴ India has received a further recommendation in its

third Universal Periodic Review to redouble its efforts towards maternal, sexual and reproductive health,⁴⁵ building on an earlier recommendation “to ensure all women without any discrimination [have] access to adequate obstetric delivery services and sexual and reproductive health services, including safe abortion and gender-sensitive comprehensive contraceptive services.”⁴⁶

B CONSTITUTIONAL SAFEGUARDS AND ACCESS TO SAFE ABORTION

The Supreme Court of India has not ruled directly on the constitutionality of abortion restrictive laws for violating human rights of pregnant persons, although some such challenges are pending before the Court.⁴⁷ However, court pronouncements on the scope of fundamental rights guaranteed by the Constitution provide a normative framework for locating the right to access safe abortion services, and the harms caused due to abortion restrictive laws. The Indian Supreme Court has recognised that the right to life and liberty under Article 21 of the Constitution encompasses the right to reproductive autonomy which includes the right to make “reproductive choices ... to procreate as well as to abstain from procreating.”⁴⁸

The decision to procreate or abstain from procreating is also protected by the right to life with dignity and the right to privacy under Article 21 of the Constitution. The Supreme Court has recognised that:

*“[p]rivacy of the body entitles an individual to the integrity of the physical aspects of personhood. The intersection between one’s mental integrity and privacy entitles the individual to freedom of thought, the freedom to believe in what is right, and the freedom of self-determination. When these guarantees intersect with gender, they create a private space which protects all those elements which are crucial to gender identity. The family, marriage, **procreation** and sexual orientation are all integral to the dignity of the individual. Above all, the privacy of the individual recognises an inviolable right to determine how freedom shall be exercised.”⁴⁹*

Explaining the importance of recognising and giving effect to the right to reproductive autonomy, the Bombay High Court has held that:

“[a] woman’s decision to terminate a pregnancy is not a frivolous one. Abortion is often the only way out of a very difficult situation for a woman. An abortion is a carefully considered decision taken by a woman who fears that the welfare of the child she already has, and of other members

*of the household that she is obliged to care for with limited financial and other resources, may be compromised by the birth of another child. These are decisions taken by responsible women who have few other options. They are women who would ideally have preferred to prevent an unwanted pregnancy, but were unable to do so. **If a woman does not want to continue with the pregnancy, then forcing her to do so represents a violation of the woman's bodily integrity and aggravates her mental trauma which would be deleterious to her mental health.***"⁵⁰

The court also recognised the importance of access to safe abortion for realising the rights to life, liberty, and health for women. It held that:

*"Pregnancy takes place within the body of a woman and has profound effects on her health, mental well-being and life. Thus, how she wants to deal with this pregnancy must be a decision she and she alone can make. The right to control their own body and fertility and motherhood choices should be left to the women alone. Let us not lose sight of the basic right of women: the right to autonomy and to decide what to do with their own bodies, including whether or not to get pregnant and stay pregnant."*⁵¹

Responding to concerns about the "rights" of the foetus vis a vis the rights of the pregnant women, the Court held that:

*"According to international human rights law, a person is vested with human rights only at birth; an unborn foetus is not an entity with human rights..... Woman owns her body and has right over it. Abortion is always a difficult and careful decision and woman alone should be the choice maker. A child when born and takes first breath, is a human entity and thus, unborn foetus cannot be put on a higher pedestal than the right of a living woman. Thus, fundamental right under Article 21 of Constitution of India protects life and personal liberty which covers women."*⁵²

The right to reproductive autonomy and to life with dignity are also available to minor girls. In *Independent Thought v. Union of India*,⁵³ the Supreme Court recognised minor girls' reproductive autonomy and right to bodily integrity and noted that, "[t]he discussion on the bodily integrity of a girl child and the reproductive choices available to her is important only to highlight that she cannot be treated as a commodity having no say over her body."⁵⁴

The right to health, including the right to reproductive health, is also a facet of the right to

life under Article 21 of the Indian Constitution. The Supreme Court has defined the right to reproductive health as “the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour.”⁵⁵

The Constitution also expressly prohibits discrimination on grounds of sex.⁵⁶ While the courts have not directly engaged with the implications of restrictions on abortion for the right to equality and against sex based discrimination, they have recognised that the disparate and unequal impact of laws based on sex, or on the basis of gender stereotypes, is a violation of the right to equality under the Constitution.⁵⁷ Courts have also recognised that differential treatment on grounds of pregnancy can violate the right against sex discrimination.⁵⁸ This is especially relevant in the context of abortion restrictive laws which place significant limits on the realisation of a life with dignity, right to liberty and right to health for women, as noted above. The Bombay High Court has described the unequal burden placed upon women by restrictive abortion laws as follows:

“A woman irrespective of her marital status can be pregnant either by choice or it can be an unwanted pregnancy. To be pregnant is a natural phenomenon for which woman and man both are responsible. Wanted pregnancy is shared equally, however, when it is an accident or unwanted, then the man may not be there to share the burden but it may only be the woman on whom the burden falls. Under such circumstances, a question arises why only a woman should suffer. There are social, financial and other aspects immediately attached to the pregnancy of the woman and if pregnancy is unwanted, it can have serious repercussions. It undoubtedly affects her mental health.”⁵⁹

Taken together, international human rights norms and constitutional safeguards provide the normative framework for evaluating legal provisions and state actions and failures relating to securing women’s rights to accessing safe abortion services. We proceed to do so in the subsequent chapters through a field-based study on the barriers to accessing safe abortion services.

This study is based on field research conducted between March and November 2019. The study adopts a qualitative fact-finding method, with the aim of collecting and documenting evidence pertaining to legal barriers faced by women in accessing safe abortion services. The field-based research utilised a combination of research tools, primarily semi-structured individual interviews, and focused group discussions with six types of stakeholders to understand the legal barriers faced or perceived by them in accessing or providing abortion services; and the harm caused by such barriers. The objective of such fieldwork was to understand from:

- **Women who have sought abortion services:** the legal barriers they have faced (or perceived) in seeking abortion services; the harm (mental, physical, emotional, social, familial, etc), if any, caused to them because of such barriers.
- **Abortion service providers (including doctors, nurses, ASHA workers, pharmacists, and other intermediaries):** the legal barriers they face (or perceive they face) in providing safe and comprehensive abortion services, and the harm caused by such barriers;
- **Government officials, bodies and committees:** their role as monitoring bodies and decision-making bodies under the MTP Act and PCPNDT Act, which prohibits sex determination and the use of pre-natal diagnostic techniques for that purpose, and their views on legal barriers to access to abortion;
- **Activists:** their assessment of the problems that minor and adult women face in accessing abortion services, and the harm that such barriers cause;
- **Lawyers:** their insights into cases filed in courts for accessing abortion, and their views on legal barriers to accessing safe abortion generally;
- **Academics:** their comments on the 'big picture' concerns regarding these legal barriers and proposed solutions thereto.

The field research was conducted in four States that represent a broad diversity in geographic location, as well as social and economic context. These states are: National Capital Territory of Delhi, the national capital city-state in the north; the eastern state of Jharkhand, which has the sixth largest tribal population of all states in India; the western state of Maharashtra, the second most populous state in the country; and the southern state of Tamil Nadu, the sixth most populous state, with roughly equal urban and rural populations.

Table 1: Relevant Indicators for the States under study

State	HDI ⁶⁰	Rural Population % ⁶¹	TFR ⁶²	MMR ⁶³	Unmet Need for Family Planning for married women aged 15-49 (%) ⁶⁴	Married women aged 15-49 using any method of contraception (%) ⁶⁵	Literacy Rate for Women (%) ⁶⁶	Pregnant girls aged 15-19 (%) ⁶⁷	Geographic Region
India	.647	68.84	2.2	113	12.9%	53.5%	68.4%	7.9%	NA
Delhi	.746	2.5%	1.57	55 ⁶⁸	15%	54.9%	80.9%	2.1%	North
Jharkhand	.598	75.95%	2.5	71	18.4%	40.4%	59%	12%	East
Maharashtra	.697	54.78%	1.7	46	9.7%	64.8%	80.3%	8.3%	West
Tamil Nadu	.709	51.6%	1.6	60	10.1%	53.2%	79.4%	5%	South

In each state, the field sites included an urban district (usually the state capital) and a rural district. In Delhi, we visited facilities and localities based in urban as well as semi-urban areas of the city including Mangolpuri, Chattarpur, Yusuf Sarai and Central Delhi. In Jharkhand, our field work was carried out in Ranchi, in villages of West Singhbhum district including Rungsai, Kotua and Pampada, and in health facilities in Saraikela Kharsawan district. In Maharashtra, we did our field research in Mumbai as well as in rural areas of Pune district including Parinche village and Mandhar village in Purandur Taluk. In Tamil Nadu, our field research took place in Chennai as well as in villages in two taluks in Dharmapuri district.⁶⁹

Overall, we interviewed 280 individuals and conducted 14 focus group discussions with various stakeholders. The focus of the study is on access and provision of safe abortion services within the public healthcare system. However, since the bulk of abortions in India are provided in the private health care sector,⁷⁰ the report examines service provision by private sector as well.

We also organised two rounds of expert consultations. The first one, in December 2018, was organised to receive feedback on the scope, objectives and methods of the study. Another round of expert consultations was organised in February and March 2021, to receive feedback on the findings of the report, and recommendations made herein. Chapters of the report have also been peer-reviewed by experts in specific domain areas.

All interviewees were informed about the nature of the study and their consent to be interviewed was expressly obtained. Interview questionnaires and schedules, consent forms, and other documents were submitted for an ethics review before the university ethics review board at the

National Law University, Delhi, where this project was initially located. The university ethics review board approved the project.

Due to the stigma surrounding abortion, as well as potential criminal liability for seeking and providing abortion, many interviewees for this study requested anonymity as a condition for speaking with us about their experiences and opinions. Public officials were also often hesitant about going on the record due to potential professional repercussions. Where interviewees requested anonymity, we have anonymised any information that may identify them in this report.

The field research for this study was conducted in 2019, and much of the report was written in the year 2020 and early parts of 2021. Since then, the law relating to abortion has changed significantly. In 2021, Parliament enacted the Medical Termination of Pregnancy (Amendment) Act, 2021 (“**MTP Amendment Act, 2021**”), through which it amended various parts of the MTP Act. However, we find that the legal barriers that we discuss in this report are by and large unaddressed by these amendments. Our findings therefore, remain relevant despite the amendments to the MTP Act. In the concluding part of this report, we have discussed the 2021 amendments and the extent to which they do or do not address the legal barriers to accessing safe abortion services that have been identified in this report. We also discuss other concerns with the MTP Amendment Act, 2021 which are likely to impose additional barriers upon women in accessing safe abortion services.

This study was conducted before the pandemic induced lockdown in March, 2020. While various other studies have shown the worsening outcomes for women’s access to safe abortion during the pandemic,⁷¹ this issue is outside the scope of the present study.

Finally, in many parts of this report, we have referred to pregnant persons as pregnant women (and where relevant, girls). We recognise that abortion restrictions can have profoundly devastating impacts, not only on the lives of women, but also on those of transgender men, and nonbinary individuals who have the capacity to become pregnant. We will use gender-neutral language to describe groups who may require abortion services during their lifetimes. At the same time, we acknowledge that globally, abortion restrictions, historically, and at present, are rooted in discriminatory stereotypes and control of cisgender women and girls, targeting the intersection of their biological ability to bear children and their gender identity as women and girls who are predestined to fulfil the role of a mother. Since perceived transgressions of this simultaneous biological and gendered imperative continue to motivate States to erect strict abortion bans or other access restrictions, it is critical that we consistently combat the gender and sex-

based discrimination against women and girls that lies at the centre of so many harmful and dehumanising restrictive abortion regimes. Further, in referring to the legal provisions under the MTP Act and especially, the operation of the criminal law, we have used ‘women and girls’ seeking abortion to reflect the current legal position.

IV STRUCTURE OF THE REPORT

In this introductory chapter, we have sought to provide the factual and normative contexts needed to understand legal barriers to accessing safe abortion in India. We also introduce the study that forms the basis of this report.

In **Chapter 2**, we describe the statutory framework on abortion contained in the IPC and the exceptions to these provisions contained in Section 3 of the MTP Act. We examine how these provisions impact access to safe abortion services. Section 3 of the MTP Act governs abortions up to 20 weeks of gestation. Beyond this time period, an abortion is permitted only when it is immediately necessary to save the life of the pregnant woman. In **Chapter 3**, we discuss abortions that are sought post 20 weeks of gestation, and the legal and institutional barriers that women face in accessing such abortions. The MTP Act provides that adult women who are not mentally ill, do not require the consent of any other person, apart from a RMP (or two RMPs as the case may be) to terminate her pregnancy. However, as we discuss in **Chapter 4**, service providers routinely require spousal, parental or even state consent or judicial authorisation, and extensive documentation, as a condition for providing abortion services. These requirements place additional barriers for women in accessing safe abortion services under conditions of confidentiality, particularly in the case of women who may not have appropriate familial support, those who are undocumented, and for women with disabilities who are often deemed, both by the law and in practice, to not have the capacity to consent to their own abortions.

The MTP Act and Rules mandate a range of infrastructural and logistical requirements for abortions to be provided legally. Other allied laws, including state level policies, and the implementation of the PCPNDT Act impose additional conditions on the provision of abortion services. These requirements and their implications for access to safe abortion services are discussed in **Chapter 5**.

When the MTP Act was enacted in 1971, pregnancies were terminated primarily through surgical methods. Since that time, with the advancement of medical technologies, the bulk of abortions can safely be provided using medications, especially in the early gestation period.⁷² Medication abortion

has expanded access to safe abortion, but has also met with increasingly stringent regulatory response to curtail access to the required medicines. This issue is discussed in **Chapter 6**.

Chapter 7 examines the implications of provisions of the POCSO Act on access to safe abortion services for adolescents. The prohibition of all sexual activity under the age of 18, coupled with a requirement to mandatorily report all underage sexual activity to the police, places significant barriers for adolescents in accessing sexual and reproductive health services in general, and abortion care in particular. The impact of POCSO Act on adolescents' access to safe abortion is discussed in this chapter.

Chapter 8 is the concluding chapter which summarises the findings of the study, discusses them in the context of the MTP Amendment Act, 2021 and provides recommendations for rights-oriented reform to enhance access to safe abortion services.

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- 1 Susheela Singh and others, 'The incidence of abortion and unintended pregnancy in India, 2015' (2015) 6(1) *The Lancet Global Health* e111 <<https://www.thelancet.com/action/showPdf?pii=S2214-109X%2817%2930453-9>> accessed 9 July 2021 (reporting that in 2015 there were 144 pregnancies per 1000 women in the 15-49 age group, of which 70 pregnancies per 1000 women in this age bracket were unintended).
- 2 *ibid* (finding that of the 48.1 million pregnancies per year in India, 15.6 are aborted).
- 3 *ibid*. Section 4 of the MTP Act provides that no pregnancy can be terminated under this Act except in the health care facilities provided in the Act or notified in the Rules. Therefore, all pregnancies that are terminated outside of health care facilities are per se illegal.
- 4 *ibid*. The World Health Organisation ("WHO") defines unsafe abortion as an abortion which is "carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both." WHO, 'Preventing Unsafe Abortion' (25 September 25 2020)) <<https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion>> accessed July 9 2021. We state that at least 0.8 million abortions are unsafe because the study in supra note 1 finds that this number of abortions were carried out outside health facilities using methods other than medication abortion. As per the estimates of this study, 11.5 million abortions take place outside of health facilities using medication abortion. According to the WHO, with proper information and access to a health care provider should the need arise, such an abortion is not per se unsafe. See WHO, 'Medical Management of Abortion' (2018) 39-40 <<https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1>> accessed 9 July 2021. However, without such access, a portion of these medication-based abortions outside of health facilities are also likely to be unsafe. See eg, Timothy Powell-Jackson and others, 'Delivering Medical Abortion at Scale: A Study of the Retail Market for Medical Abortion in Madhya Pradesh, India' (2015) 10(3) *PLoS ONE* 10-11 <<https://doi.org/10.1371/journal.pone.0120637>> accessed 9 July 2021.
- 5 Ann Montgomery and others, 'Maternal Mortality in India: Causes and Healthcare Service Use Based on a Nationally Representative Survey' (2014) 9(1) *PLoS ONE* <<https://doi.org/10.1371/journal.pone.0083331>> accessed 9 July 2021. As per the last available official figures (from 2003) unsafe abortions accounted for 8% of maternal mortalities. See Registrar General, India and Centre for Global Health Research, University of Toronto, 'Maternal Mortality in India: 1997 – 2003, Trends, Causes and Risk Factors' (2006) 15 <<http://www.cghr.org/wordpress/wp-content/uploads/RGI-CGHR-Maternal-Mortality-in-India-1997%E2%80%932003.pdf>> accessed 9 July 2021.
- 6 Ryo Yokoe and others, 'Unsafe Abortion and Abortion-Related Death Among 1.8 million Women in India' (2019) 4(3) *BMJ Global Health* 1, 11 <<http://dx.doi.org/10.1136/bmjgh-2019-001491>> accessed 9 July 2021.
- 7 WHO, 'Abortion' <https://www.who.int/health-topics/abortion#tab=tab_3> accessed 9 July 2021.
- 8 WHO, 'Preventing Unsafe Abortion' (n 4).
- 9 See *infra* "Normative Framework".
- 10 Indian Penal Code 1860 ("IPC"), s 312.
- 11 IPC, s 312, Explanation.
- 12 Medical Termination of Pregnancy Act 1971 ("MTP Act"), Statement of Objects and Reasons.
- 13 Medical Termination of Pregnancy (Amendment) Act, 2021 ("MTP Amendment Act, 2021"), Statement of Objects and Reasons (referring to the objectives of the original Act).
- 14 MTP Act, s 3.
- 15 See eg, MTP Act, s 4.
- 16 Protection of Children from Sexual Offences Act, 2012 ("POCSO Act"), ss 19 and 21; Code of Criminal Procedure, 1973 ("CrPC"), s 357C.
- 17 Center for Reproductive Rights, Ensuring Reproductive Rights: Reform to Address Women's and Girls' Need for Abortion after 20 Weeks in India (2018), <<https://reproductiverights.org/wp-content/uploads/2020/12/Post-20-Week-Access-to-Abortion-India-0218.pdf>>
- 18 Aparna Chandra, Mrinal Satish and the Center for Reproductive Rights, Securing Reproductive Justice in India: A Casebook (2019).
- 19 See eg Draft Medical Termination of Pregnancy (Amendment) Bill, 2014; *Nikhil Datar v UOI Civil Appeal No 7702 of 2014*; *Swati Agarwal v Union of India WP (C) 825/2019*.
- 20 Medical Termination of Pregnancy (Amendment) Act, 2021.
- 21 See Chapter 8.
- 22 See eg, *Swati Agarwal v Union of India WP (C) 825/2019* (challenging the constitutionality of the MTP Act, 1971).
- 23 Citing the risk to women's lives, the United Nations Human Rights Committee ("HRC") has criticised laws that prohibit abortion where a woman's life or health is in danger or in cases of rape or severe foetal impairment, and existing barriers to abortion. Human Rights Committee, Concluding Observations on Chile, para 8, UN Doc CCPR/C/CHL/CO/5 (2007); Human Rights Committee, Concluding observations on the fourth periodic report of Ireland, para 9, UN Doc CCPR/C/IRL/CO/4 (2014); Human Rights Committee, Concluding observations on the 7th periodic report of the United Kingdom of Great Britain and Northern Ireland, para 17, UN Doc CCPR/C/GBR/CO/7 (2015); Human Rights Committee, Concluding observations on the seventh periodic report of Poland, paras 23 and 24, UN Doc. CCRR/C/POL/CO/7 (2016). The HRC has also recognised the burden and hardship women may face when prohibitive domestic laws on abortion force them to cross borders to access abortion services elsewhere. See *Siobhán Whelan v. Ireland*, Human Rights Committee, Communication No 2425/2014, paras 7.5-7.9, UN Doc CCPR/ C/119/D/2425/2014 (2017). See also discussion on criminalisation of abortion as a violation of the right to life in Human Rights Committee, General Comment No 36, Article 6 (Right to Life), para 8, UN Doc CCPR/C/GC/35 (2019). The Committee on the Elimination of Discrimination against Women ("CEDAW Committee") has emphasised that restrictive abortion laws lead women to obtain illegal and unsafe abortions, which then violates women's right to life. See CEDAW Committee, Concluding Comments: Chile, paras 19-20, UN Doc CEDAW/C/CHL/CO/4 (2006); CEDAW Committee, Concluding Observations: Colombia, paras 393-4, UN Doc CEDAW/A/54/38 (1999).
- 24 The right to health is protected under the International Covenant on Economic, Social and Cultural Rights ("ICESCR") and the Convention on the Elimination of All Forms of Discrimination against Women ("CEDAW") offers legal protection against discrimination in the enjoyment of women's right to health, including non-discrimination in access to healthcare. In its 2018 report of inquiry into reproductive health of women in Northern Ireland, the CEDAW Committee held that intentional obstruction of access to abortion services may amount to violation of women's rights to health, self-determination, and protection from cruel, inhuman and degrading treatment. CEDAW Committee, Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, paras 65-6, UN Doc CEDAW/C/OP.8/GBR/1 (2018). Emphasizing the indivisibility of human rights, the Committee on Economic, Social and Cultural Rights ("CESCR") has noted that lack of access to safe abortion services is a violation of the rights to equality, non-discrimination, and the core obligations to the right to highest attainable standard of health, which includes sexual and reproductive freedoms. Denial of safe abortion can lead to maternal mortality and morbidity, which constitutes a violation of the right to life. CESCR, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), paras 10, 40, 41, 49, 57, UN Doc. UN Doc. E/C.12/GC/22. 2 (2016).
- 25 In its General Recommendation 24, the CEDAW Committee noted State obligations under Article 12 of the Convention to remove discriminatory laws/policies/practices such as not legally providing for certain reproductive health services for women including alternatives in case of conscientious

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- objections, requirements of spousal/parental/third party authorisations, and criminalisation of medical procedures that only women are likely to undergo. CEDAW Committee, General Recommendation No. 24: Article 12 of the Convention (women and health), paras 11, 14, UN Doc HRI/GEN/1/Rev.9 (Vol. II) (2008). The CEDAW Committee has further observed that the failure by the State to adopt legislative, administrative and judicial measures that protect, guarantee and ensure the right of access to health under conditions of equality, in the context of therapeutic abortion, violates arts 2 (c) and (f), 3, 5, 12 and 16(e) of the LC v. Peru, CEDAW Committee, Communication No 22/2009, paras 8.6-9, UN Doc CEDAW/C/50/D/22/2009 (2011).
- 26 In 2005, in the first case on safe abortion to be decided by the HRC, it held the State party responsible by reading the right to safe abortion access into the rights to privacy, and freedom from inhumane and degrading treatment, in the absence of an explicit right to health under the ICCPR. *KL v. Peru*, Human Rights Committee, Communication No. 1153/2003, paras 6.1-7, UN Doc CCPR/C/85/D/1153/2003 (2005). It held that the complainant's suffering was foreseeable and it amounted to cruel, degrading, and inhumane treatment as well as to failure to take special care of a minor.
- 27 In its General Comment No 22, the CESCR has emphasised the State obligation to ensure that information about abortion and post-abortion care is available and accessible, which also requires that requires that personal health data and information is treated with privacy and confidentiality. CESCR, General Comment No 22 (2016) on the Right to Sexual and Reproductive Health, paras 6, 12, 18, 19, UN Doc E/C.12/GC/22 (2016); Further, the Committee on the Rights of the Child ("CRC") has highlighted the need for States to include within mandatory school curriculum as also for out-of-school adolescents, age-appropriate, comprehensive and inclusive sexual and reproductive health education, based on scientific evidence and human rights standards, that is developed participatorily. CRC, General Comment No 20 (2016) on the Implementation of the Rights of the Child during Adolescence, para 61, UN Doc CRC/C/GC/20 (2016).
- 28 "The consensus statements created at these conferences touch on women's right to abortion, and thus provide additional support for the notion that women's reproductive rights are human rights." Christina Zampas and Jaime H Gher, 'Abortion as a Human Right: International and Regional Standards' (2008) 8(2) *Human Rights Law Review* 249, 252.
- 29 HRC, General Comment No. 36, (n 23) para 8 (the 'chilling effect' of penalties and abortion law restrictions on pregnant persons and medical professionals has also been noted when calling upon States to ensure access to reproductive health information and services); WHO, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (2nd ed, 2012) 94 < http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1 > accessed 9 July 2021.
- 30 HRC, General comment no 36, (n 23) para 8.
- 31 CEDAW Committee, General recommendation No. 35 on Gender-based Violence Against Women, Updating General Recommendation No. 19, paras 18, 31(a), UN Doc CEDAW/C/GC/35 (2017); CEDAW Committee, General Recommendation No. 24, (n 25) paras 11, 14 as cited in Center For Reproductive Rights, 'Breaking Ground: Treaty Monitoring Bodies on Reproductive Rights' (2020) 12 <<https://reproductiverights.org/wp-content/uploads/2020/12/Breaking-Ground-2020.pdf>> accessed 10 July 2021.
- 32 See CEDAW Committee, Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland, (n 24).
- 33 *ibid*; See also CEDAW Committee, General Recommendation No. 24, (n 25) paras 14, 18, 21, 23, 31(c). The CEDAW Committee has drawn specific attention to the need to repeal discriminatory and penal laws and urged States to remove negative gender stereotypes in access to healthcare.
- 34 For instance, in *Mellet v. Ireland*, the HRC recognised criminalisation of abortion as a violation of international human rights law and called on Ireland to consider constitutional reform to address this. See *Mellet v. Ireland*, Human Rights Committee, Communication No. 2324/2013, para 9, UN Doc. CCPR/C/116/D/2324/2013 (2016).
- 35 CRC, General Comment No. 20, (n 27) para 60.
- 36 United Nations Treaty Monitoring Bodies ("UNTMBs") have highlighted the State obligation to remove barriers to safe abortion access including mandatory waiting periods, biased counselling requirements, and third-party authorisation requirements. See HRC, General comment no. 36, (n 23) para 8; CESCR, General Comment No 22, (n 27) para 41; CEDAW Committee, General Recommendation No. 24, (n 25) para 14; See also Center for Reproductive Rights, *Breaking Ground*, (n 31) 14.
- 37 United Nations General Assembly ("UNGA"), Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, para 21, UN Doc A/66/254 (2011).
- 38 *ibid*.
- 39 *ibid*, para 34.
- 40 *ibid*, para 29.
- 41 UN Working Group on the Issue of Discrimination Against Women in Law and in Practice, Position Paper on Women's Autonomy, Equality, and Reproductive Health in International Human Rights: Between Recognition, Backlash, and Regressive Trends (October 2017) 6 <<https://www.ohchr.org/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf>> accessed 10 July 2021.
- 42 CESCR, General Comment No. 14, (n 24) para 12(b) ("[H]ealth facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds").
- 43 CEDAW Committee, Concluding Observations: India, paras 30-31, UN Doc CEDAW/C/IND/CO/4-5 (2014).
- 44 CRC, Concluding Observations: India, para 66(b), UN Doc CRC/C/IND/CO/3-4 (2014).
- 45 See Human Rights Council, Report of the Working Group on Universal Periodic Review: India, UN Doc A/HRC/36/10 (2017).
- 46 Human Rights Council, Report of the Working Group on Universal Periodic Review: India, para 138.153, UN Doc A/HRC/21/10 (2012).
- 47 See e.g., *Swati Agarwal v Union of India* WP (C) 825/2019. In *Nand Kishore Sharma v Union of India*, AIR 2006 Raj 166, the constitutionality of the MTP Act was challenged for violating the "rights" of the unborn child under Article 21 of the Constitution. In this context, the Court upheld the validity of the MTP Act, stating that "[t]he object of the Act being to save the life of the pregnant woman or relieve her of any injury to her physical and mental health, and no other thing, it would appear the Act is rather in consonance with Article 21 of the Constitution of India than in conflict with it. While it may be debatable as to when the foetus comes to life so as to attract Article 21 of the Constitution of India, there cannot be two opinions that where continuance of pregnancy is likely to involve risk to the life of the pregnant woman or cause grave injury to her physical and mental health, it would be in her interest to terminate the pregnancy."
- 48 *Suchita Srivastava v Chandigarh Administration*, (2009) 9 SCC 1.
- 49 *Justice K.S. Puttaswamy (Retd.) and Anr v Union of India and Ors* (2017) 10 SCC 1 (emphasis supplied).
- 50 *High Court on Its Own Motion v State of Maharashtra* 2017 Cri LJ 218 (Bom HC) (emphasis supplied).
- 51 *ibid*
- 52 *ibid*.
- 53 *Independent Thought v Union of India* 2017 SCC OnLine SC 1222.
- 54 *ibid*.
- 55 *Devika Biswas v Union of India* (2016) 10 SCC 726, citing WHO, *Sexual Health, Human Rights and the Law* (2015).
- 56 Constitution of India, art 15.

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- 57 NALSA v Union of India (2014) 5 SCC 438; Navtej Johar v Union of India (2018) 10 SCC 1 (Chandrachud J.).
- 58 Inspector (Mahila) Ravina v Union of India Writ Petition (C) 4525 of 2014 (Del HC) (6 August 2015); Navtej Johar v Union of India (2018) 10 SCC 1 (Chandrachud J.) (critiquing the judgment in *Air India v Nergesh Meerza* AIR 1981 SC 1829).
- 59 High Court on Its Own Motion v State of Maharashtra 2017 Cri LJ 218 (Bom HC).
- 60 Global Data Lab, 'Sub-National HDI (India) 2019' <https://globaldatalab.org/shdi/2019/human-development/IND/?levels=1%2B4&interpolation=1&extrapolation=0&nearest_real=0> accessed 10 July 2021.
- 61 Office of the Registrar General & Census Commissioner, 'Census of India (2011)' <https://www.censusindia.gov.in/2011census/PCA/PCA_Highlights/pca_highlights_file/India/Chapter-1.pdf> accessed 10 July 2021.
- 62 Total Fertility Rate; See Ministry of Health and Family Welfare, Government of India, 'Fourth National Family Health Survey (NFHS-4) (2015-16)' (December 2017) <http://rchiips.org/nfhs/factsheet_NFHS-4.shtml> accessed 10 July 2021 (refer to factsheets pertaining to each state).
- 63 Maternal Mortality Rate; See Ministry of Health and Family Welfare, 'Maternal Mortality Rate (MMR) (SRS 2016-18)' <<https://www.pib.gov.in/PressReleasePage.aspx?PRID=1697441>> accessed 10 July 2021.
- 64 NFHS-4 (n 62) "Unmet need for family planning" refers to married women in the age group 15-49 who do not wish to stop or postpone having children but are not using contraception.
- 65 *ibid.*
- 66 *ibid.*
- 67 *ibid.* This figure includes girls who were in the age group 15-19 at the time of the survey and who had already been pregnant or were pregnant at that time.
- 68 Government of NCT of Delhi, 'Annual Report on Registration of Births and Deaths in Delhi -2019' (November 2020) 18 <http://des.delhigovt.nic.in/wps/wcm/connect/4ac53080409a01a58f3ebfa50c073453/vital_annual_19.pdf?MOD=AJPERES&mod=108668931&CACHEID=4ac53080409a01a58f3ebfa50c073453 &Annual%20Report%20of%20Registration%20of%20Births%20and%20Deaths%20in%20Delhi%202019> accessed 10 July 2021.
- 69 We have not mentioned the names of these taluks since doing so will identify the persons, especially RMPs and public officials, that we spoke to in these places.
- 70 Susheela Singh and others, 'Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs' (2018, Guttmacher Institute, IIPS and Population Council) 8 <https://www.guttmacher.org/sites/default/files/report_pdf/abortion-unintended-pregnancy-six-states-india.pdf> accessed 10 July 2021.
- 71 See eg, IPAS, 'Compromised Abortion Access due to COVID-19: A Model to Determine Impact of COVID-19 on Women's Access to Abortion' (2020) <<https://www.ipasdevelopmentfoundation.org/publications/compromised-abortion-access-due-to-covid-19-a-model-to-determine-impact-of-covid-19-on-women-s-access-to-abortion.html>> accessed 10 July 2021.
- 72 See Susheela Singh, 'The incidence of abortion and unintended pregnancy in India' (n 1) (finding that 11.5 million of the 15.7 million annual abortions in India are carried out through medication abortion).

2 Legal Factors Mediating Women's Access to Safe Abortion

In 1994, at the International Conference on Population and Development, 179 countries, including India, agreed that:

“Reproductive rights are the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence.”⁷³

However, as this chapter demonstrates, neither the provisions of the MTP Act, nor its implementation in practice is located within this framework of reproductive rights.

I STATUTORY FRAMEWORK

The IPC criminalises voluntarily “causing miscarriage” even when the miscarriage is with the pregnant woman’s consent, except when the miscarriage is caused to save the woman’s life.⁷⁴ A woman who consents to her own miscarriage or causes herself to miscarry is also liable under this section.

The MTP Act creates an exception to this criminalisation. This law was enacted to “liberalise” abortion, since Parliament was of the opinion that the overly restrictive penal provisions were leading to “an avoidable wastage of the mother’s (sic) health, strength, and sometimes, life.”⁷⁵ This was because women who could not legally abort due to the prohibition in the IPC were using extremely unsafe methods for aborting the foetus and doctors were confronted with “gravely ill or dying pregnant women whose pregnant uterus [had] been tampered with, with a view to causing an abortion and consequently suffered very severely.”⁷⁶ To address this concern, the MTP Act was legislated with the following objectives:

- | | |
|------------------------------------|---|
| <i>“(1) as a health measure</i> | <i>where there is a danger to the life or risk to physical or mental health of woman;</i> |
| <i>(2) on humanitarian grounds</i> | <i>such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic woman, etc.; and</i> |
| <i>(3) eugenic grounds</i> | <i>where there is substantial risk that the child, if born, would suffer from deformities and diseases.”⁷⁷</i> |

Parliamentary debates on the MTP Act reveal that legislators were concerned that a “liberal” abortion law would promote sexual promiscuity amongst women. Addressing this concern, the government, through its ministers, assured Parliament that “by far the greatest number of women who seek abortion are married.”⁷⁸ Married women seek abortion because they “do not want to bear children that they could not support, or to whom they could not give their full love and affection.”⁷⁹ The Statement of Objects and Reasons appended to the MTP Act, 1971 also states that “most of these mothers (sic) are married women, and are under no particular necessity to conceal their pregnancy.”⁸⁰

The MTP Act was legislated in this context. It states that:⁸¹

“Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.”

Section 3 of the MTP Act lays down the conditions under which abortion can be provided. Prior to its amendment in 2021,⁸² it stated that an abortion could be terminated by a RMP in the following circumstances:⁸³

- (1) Where the pregnancy is under 12 weeks gestation, one RMP, and if the pregnancy is over 12 weeks but under 20 weeks, two RMPs, are of the good faith opinion that:
 - a. “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
 - b. 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”.
- (2) In making this determination, the law presumes that when a pregnancy results from rape, or from the failure of contraception in a married couple, the anguish caused to the pregnant woman constitutes a “grave injury to her mental health.”
- (3) In making the determination in (1) above, the RMP is required to take into account “the pregnant woman’s actual or reasonably foreseeable environment.”

Section 5 of the Act provides that for pregnancies over 20 weeks, an abortion can be performed

only when it is “immediately necessary to save the life of a pregnant woman.”

The woman’s consent is required for an abortion. If the woman is a minor or is mentally ill, then, in addition to her own consent, her guardian’s consent is also required.⁸⁴

From these provisions, it is clear that:

- (1) The MTP Act operates within a framework of criminalisation such that providing and seeking abortion is a criminal offence, unless it falls within the exceptions relating to “health,” “humanitarian grounds” and “eugenics” set out in the MTP Act. Only when the pregnant woman and the service provider can meet these criteria and other conditions set out in the MTP Act is the abortion legally justified and not subject to criminal penalty.
- (2) The MTP Act is a provider protection law, that seeks to shield the RMP from criminal liability, and as such it does not centre the pregnant woman’s needs, reproductive autonomy, and agency. Access to abortion is not at the will of the pregnant woman. It is a highly regulated procedure whereby the law transfers the decision-making power from the pregnant woman to the RMP and provides great discretion to the RMP to determine whether abortion should be provided or not.
- (3) This transfer of decision-making power operates within a framework of criminalisation, such that RMPs who choose to provide the abortion service potentially open themselves up to criminal prosecution for violating the terms of the MTP (and thereby falling outside the protection of the Act). A RMP who chooses to deny abortion care however, faces no consequences.

In this chapter we discuss the factors that shape RMPs’ decisions to provide or deny abortion care. We detail the contexts in which RMPs exercise the decision-making power over abortion granted to them by the law, and how they exercise this power.

II **DECISION-MAKING BY REGISTERED MEDICAL PRACTITIONERS**

As noted above, section 3(2) of the MTP Act recognises “risk to the life of the pregnant woman or of grave injury to her physical or mental health,” as grounds for terminating her pregnancy. The MTP Act also states that, “in determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman’s actual or reasonably foreseeable environment.”⁸⁵ Therefore, the Act recognises that the decision to terminate a pregnancy is not just a medical decision, but also implicates a

range of other social, economic, familial and other factors specific to the woman seeking abortion. Despite this recognition, the MTP Act locates the power to decide whether the pregnancy should be terminated not with the pregnant woman, but with a medical practitioner (the RMP).

Thus, when a woman approaches a RMP for termination of a pregnancy, the discretion to terminate the pregnancy lies with the RMP. Women's access to safe abortion depends on the RMP's understanding of the grounds under Section 3 of the Act. We find that this discretion is exercised in a manner that often has little to do with concerns over the woman's health and well-being, her right to make her own decision in this regard, or even with the legal provisions under the MTP Act; and has much to do with the providers' apprehension about consequences for themselves, their views about the morality of abortion, as well as their beliefs about women's role and place in society. We discuss these in turn, below.

A FEAR OF THE LEGAL PROCESS

The law does not recognise the absolute right of a woman to terminate a pregnancy. Her choice is subject not only to criminal sanction, but also to civil consequences, such as divorce on the grounds that the abortion was carried out without the husband's knowledge or consent. Doctors may be sued for damages by the husband,⁸⁶ or may be summoned as witnesses in divorce proceedings.⁸⁷

Women's access to safe abortion is mediated by the fact that providers are perennially in fear of any interface whatsoever with the criminal, or even civil, legal system. This fear acts as a chilling effect on service providers' willingness to provide abortion services. Further, given the overarching criminal law framework for abortion under the IPC,⁸⁸ as well as the stigma surrounding abortion, there is widespread (mis)understanding amongst service providers that anything to do with abortion may be unlawful, resulting in a fear of the legal process. In view of the legal system's reputation for being expensive, time-consuming, and inconvenient, most providers make decisions to avoid any interaction with the law or its enforcers. As explored throughout this report, this includes denying abortion services to women, especially to those under the age of 18, those in their second trimester of pregnancy, and those who have had more than one girl child previously. When abortion is provided, providers often make women unnecessarily jump through hoops, such as seek enhanced consent, documentation, and third-party authorisations, to protect themselves from legal action. Apart from this, when women seek abortion after the 20-week gestation period, RMPs are reluctant to use Section 5 of the Act despite there being a protection for actions taken by RMPs in good faith.⁸⁹

For instance, at a government hospital in Mumbai, in any “suspicious” case of abortion, an Emergency Police Report (“EPR”) is filed with the local police station. When we inquired as to what “suspicious” would mean, we were told that EPRs are not required for couples who are married, and for cases of foetal abnormality. EPRs are filed in cases where an unmarried woman seeks an abortion, because the medical officers believe that such sexual intercourse outside marriage might be “illegal,” or the woman may later file a case alleging assault.⁹⁰ The EPR, according to them, was required to create a record of the abortion.⁹¹ Note that unless there is an allegation of rape, or unless the woman seeking abortion is under the age of 18, the law does not require RMPs to file a police report before or after conducting an abortion.⁹² The filing of EPRs appears to be pre-emptive and misplaced compliance with the mandatory reporting requirement under Section 357C of the CrPC, which requires that if a woman alleges rape, all hospitals have to provide her necessary therapeutic care and “shall immediately inform the police of such incident.”⁹³

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GF: “When we suspect a foul play, then only we go ahead with a EPR [Emergency Police Report]....Unmarried female who comes down, UTP positive, it has to be done...”

Interviewer: ...[] n those cases where they are over 18 years old but they are unmarried...

GF: “Yes, unmarried is illegal, right? It is illegal.[F]irst they get it terminated and then later put a case on it. Later they come again and say I want to file a complaint We should have some kind of record on it.”

- Interview with GF, medical officer at a tertiary care government hospital in Mumbai, Maharashtra.

Anecdotal stories of legal action against service providers abound, resulting in further reluctance on the part of providers to provide abortion services. Instances of medical practitioners facing legal consequences, or even getting entangled in the legal process as a witness, are repeatedly recounted in any conversation around abortion. For instance, we were told of a case where an unmarried pregnant girl obtained a termination, but the pregnancy was ectopic (a pregnancy where a fertilised egg attaches somewhere outside the uterus), and a fallopian tube had to be removed. However, her parents wanted the fact of her pregnancy to be concealed, and asked the doctor to record the procedure as the removal of a cyst. Later, after the woman married, she was unable to conceive. Her in-laws and husband took her to a different doctor, who found that one of her tubes had been removed. Her in-laws and husband took action against the first doctor; and apparently, this case is now before the Supreme Court.⁹⁴ These kinds of accounts, which circulate widely amongst the medical community, but are hard to corroborate, add to the insecurities of the service providers in providing abortion care. This is not to say that all such stories are mere rumours. Newspaper reports indicate many instances of doctors being arrested for performing abortions, especially when the abortion comes to light in the course of another investigation.⁹⁵

In Chennai, women approaching private practitioners after 12-14 weeks of pregnancy are often referred to government hospitals, and/or another signatory is required as a witness for the abortion service to be provided. As per the MTP Act, there is no requirement for an additional witness/signatory to an abortion for an adult woman who is not “mentally ill.”⁹⁶ However, providers state that late first trimester and second trimester abortion-seekers are mostly unmarried women who come unaccompanied, and in such cases, providers fear that the law may not support them.⁹⁷

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"[P]atient's signature is enough. We do get husband's signature always just to avoid trouble, and just so he is aware."
- JF, doctor formerly at a government tertiary care centre in Tamil Nadu, and member of OGSSI.

"In case of consent [for MTP for unmarried women], we ask their friends-the boyfriends to come and sign. Not that it is legally valid. Not that it causes any problem. We are doing this for our own protection."
- HE, doctor at a private hospital in Pune, Maharashtra.

A member of the Obstetric and Gynecological Society of Southern India (“OGSSI”) also said that while the woman’s signature is enough to provide an abortion, the husband’s signature is also always obtained to avoid “trouble.”⁹⁸ At a New Delhi Municipal Corporation hospital in Delhi, when a foetal anomaly is found during ultrasound/blood tests, abortion is not provided so as to avoid any possibly legal liability; instead, women are sent to the Central Government-run All India Institute of Medical Sciences.⁹⁹

This fear of any interaction with the legal system was succinctly summarised by a private practitioner in Pune. He narrated the story of a married woman who had approached him for an abortion. A year later, a police inspector informed him that the woman had filed for divorce and as part of the divorce proceedings had alleged that she had been forced into an abortion. The Head of Department in the hospital (who was the practitioner’s mother) was asked to report to the Dhulia police station, about 800 km from their place of practice. The practitioner stated that in such situations doctors frequently become soft targets who can be exploited for bribes. This creates an “atmosphere of panic” and makes them feel unsafe.¹⁰⁰

To counter this “atmosphere of panic,” RMPs undertake a range of defensive moves. They may either deny abortion services outright or ask the pregnant woman to fulfill a range of extra-legal requirements, including counselling the woman to continue with the pregnancy, imposing cooling off periods or waiting times, seeking additional consent and third-party authorisations, and asking for a range of documentation. These strategies are discussed throughout this report.¹⁰¹

B ABORTION STIGMA AND PATRIARCHAL VALUES

Abortion stigma and patriarchal assumptions about women’s sexual, reproductive, and decision-making capabilities also limit women’s access to abortion. Since the law empowers service providers to act as gatekeepers to abortion access, their views on the morality of abortion shapes women’s access to safe abortion services. RMPs’ views on the morality of abortion are shaped by a range of factors including general abortion stigma, RMPs’ own religious views, as well as their understanding of women’s place and role in society.¹⁰² For example, a leading gynaecologist in Chennai told us that she thinks abortions are “ethically not advisable.”¹⁰³ A private practitioner in Pune informed us that since the foetus is not the “property of the woman,” no woman has the right to demand an abortion.¹⁰⁴ Such views about the morality of abortion, and about women’s rights over their bodies, colour the exercise of discretion by RMPs.

→
“The growing life inside may not be a legal entity but that cannot be the property of the woman... She cannot abort it because she wants to.”
- HE, doctor at a private hospital in Pune, Maharashtra.

Some RMPs discourage women from going through with the abortion, by telling them that abortion is wrong and the pregnancy should be carried to term, that God is watching, and that they will suffer for the rest of their lives if they get an abortion.¹⁰⁵ Women, especially unmarried ones, are also often shamed for their sexual behaviour when they seek abortion services.¹⁰⁶

Even RMPs who are open to providing abortions, often make their own determination, beyond what the MTP Act requires them to do, as to whether women's reasons for seeking an abortion are sound. For example, women who seek an abortion because they want to space the birth of their children,¹⁰⁷ or women who seek abortion in the second term onwards for reasons that the RMP does not consider good enough, are often discouraged from going through with the abortion.¹⁰⁸

Many RMPs find the MTP Act to be too liberal, and the grounds to be too broad. For example, though failure of contraception is recognised as a ground for terminating pregnancies for married women,¹⁰⁹ many service providers find it problematic that this ground can be interpreted very broadly, particularly given that there is no requirement to furnish proof of failure of contraception.¹¹⁰ Similarly, many providers expressed concern about how broadly the health grounds for abortion can be interpreted, since there is no definition of physical or mental distress under the Act, and no indication of what amount of distress is sufficient to satisfy the requirements of the Act. Mental health, in particular, is seen as difficult to quantify and prove, and therefore so vague that "anything can fall under it."¹¹¹ The gynaecologists at a government hospital in Ranchi complained that 75% of their cases can potentially fall under this clause because of its "breadth and vagueness."¹¹²

RMPs' personal objections to abortion are often couched in the language of medical science and/or health concerns, but are in fact driven by their own views on abortion and on women's place in society. For instance, a senior government official in Tamil Nadu expressed anxiety that being able to avail abortions with total privacy would encourage promiscuity and women having multiple partners, leading to the spread of STDs and infections.¹¹³ In other instances, such objections are couched in seemingly neutral health terms, while the underlying reason remains moral. For example, women who are pregnant for the first time are often discouraged from abortion on the ground that there may be complications later, while there exists no scientific evidence for this assertion, as explained in detail below.¹¹⁴ Previous cases where abortion has led to complications or the inability to conceive again are also recounted to discourage women from abortion.¹¹⁵ Apart from general stigma around abortion, one reason for denying abortion care on these grounds is the failure to adequately train service providers in providing safe abortion services.¹¹⁶

IA: "Self-consent for any MTP, even in 2nd trimester should be there."

IB: "But would not total privacy and secrecy mean encouraging promiscuity?"

IA: "Not your business to do moral policing."

IB: "I am a mother and that is why I have the instinct to police. If this happens there will be so many STDs spreading."

- Conversation during interview between IA and IB, government officials associated with National Health Mission, Chennai, Tamil Nadu.



RMPs' views on the morality of abortion shape their decision to both deny abortion care, as well as to provide it. Below we discuss some of the reasons that emerged from our study for denying or providing abortion care based on RMPs' moral outlook.

III REASONS FOR DENYING ABORTION SERVICES

A FIRST PREGNANCY

Married women who are pregnant for the first time are often asked if the couple intends to have children at a later point in time. If the answer is yes, the couple or woman, as the case may be, is strongly “counselled” to continue the pregnancy.¹¹⁷ Not wanting children at that time is seen as a “superficial”¹¹⁸ reason, without acknowledging the woman/couple's personal wishes and context. An ostensible health reason provided for this denial is that an abortion may lead to complications later, such as infertility,¹¹⁹ fibrosis, blocking of tubes, infections, or cervical stenosis,¹²⁰ and the woman may not be able to conceive again,¹²¹ or may find it difficult to do so.¹²² However, there are no proven associations between induced abortion for the first pregnancy and subsequent complications such as ectopic pregnancy or infertility.¹²³ Denial of abortion services under such circumstances completely undermines a woman's reproductive autonomy.

B REPEATED ABORTIONS/ABORTION AS A SUBSTITUTE FOR CONTRACEPTION

Failure of contraception is a widely used ground for married women seeking abortion. However, many service providers argue that the ground is used repeatedly by women, despite it being (in their opinion) factually impossible for contraceptive failure to occur multiple times.¹²⁴ Many also state that the ground is often used not when contraception fails but when no method of contraception was used at all.¹²⁵

In our interviews, service providers also expressed the concern that women will use abortion as an alternative to contraception, if abortion on request is permitted. This is viewed as inadvisable from a health perspective. Resident doctors at a hospital in Ranchi opined that there should be a numerical cap on the number of abortions a woman can have.¹²⁶ Women are often told that repeated abortions are not advisable, and are required to use contraception to prevent pregnancies.¹²⁷ Once again, this denial of services under the garb of health risk entirely undermines reproductive autonomy. Further, India has a significant unmet need for contraception. 12.9% of married women in the age group of 15-49 who wish to avoid pregnancy, do not have access to contraception.¹²⁸ Only 53.5% of married women in this age group use any method of contraception.

Given this lack of access to contraception as well as contraceptive choice, limiting women's access to abortion only disadvantages them; the solution must be to provide better access to contraception rather than limit access to safe abortion.

Even when women do obtain a safe abortion, it may come with conditions attached. For example, women going to a government hospital in Ranchi are provided an abortion only if they are ready to use contraception going forward; and thus, women cannot obtain an abortion without contraception.¹²⁹ This is associated with providers' anxieties around repeated abortions and using abortion as contraception.

The conditionalities attached to the provision of abortion care are also mediated by women's socio-economic status. Doctors in a hospital in Ranchi informed us that repeated abortion is used as contraception by a "certain class of patients," (implying women from economically weak backgrounds) necessitating the use of contraceptive methods that preclude further conception, such as intrauterine contraceptive devices.¹³⁰ While the doctors there admit that most women do not agree to get an Intrauterine Device implanted or to undergo ligation, the doctors still believe that abortion should be provided along with contraception.¹³¹ Resident doctors at a hospital in Ranchi informed us that when the woman seeking abortion does not wish for contraception, "we counsel her so much that she will accept it."¹³² Women are informed that repeated abortions will lead to bodily complications, which in turn will lead to their husbands marrying someone else. Providers told us that while the threat of complications does not seem to affect women, the argument of their husbands deserting them makes an impact.¹³³

Further, permanent methods of contraception are advised when providers deem the woman's family to be "complete", which is after two or three children.¹³⁴ Government campaigns such as "*hum do, hamare do*"¹³⁵ contribute to service providers' conception of when families are complete. Many providers are also under the misconception that there is a government/legal prohibition on providing abortion without some form of contraception.¹³⁶ Making women's access to abortion conditional on contraception is in clear violation of women's right to access contraception and contraceptive choice, which has been deemed to be within the right to privacy.¹³⁷ This finding also highlights the need for appropriate and adequate training for service providers which is geared towards providing rights-oriented and sensitive abortion services.

C LATE DETECTION

Many women are denied an abortion if the pregnancy is detected late – generally in or after the second trimester. This overlaps with concerns around the PCPDNT Act and the fear that the abortion being sought might be for purposes of sex-selection. For example, even though failure of contraception is a ground for providing abortion,¹³⁸ if a married woman seeks an abortion later in the pregnancy based on failure of contraception, some providers refuse both because they are concerned about sex-selection and because they are of the opinion that if the unwanted pregnancy was indeed a result of contraceptive failure it should have been recognised earlier.¹³⁹

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“[W]e do early abortion..... Failure of contraception should be realized within 2-3months of pregnancy. If she knows contraceptive was used she should know failure and should be able to come to us early in the pregnancy, so we provide abortion early in the pregnancy for such cases.”
- DG, government doctor at a tertiary health care centre in Ranchi, Jharkhand.

However, there are many situations that could lead to a late detection of pregnancy,¹⁴⁰ such as lactational amenorrhea,¹⁴¹ or rape in the case of minors who either do not get to know that they are pregnant, or do not reveal it until the pregnancy becomes visible (due to fear of the stigma and shame associated with rape in the family and community).¹⁴²

Women are also denied second term abortions on the ground that an advanced gestational age increases the health risks of carrying out an abortion.¹⁴³ As per the WHO, however, abortions are safe irrespective of gestational age, if they are done by methods appropriate to the gestational age and if the person providing or supporting the abortion is trained.¹⁴⁴

IV HIERARCHY OF REASONS FOR PROVIDING ABORTION CARE

While there is a general stigma associated with abortion, and a reluctance amongst service providers to provide abortion care, morality, sympathy, and societal considerations can sometimes also work in favour of women obtaining abortions when the reasons for seeking abortion align with hetero-patriarchal and ableist social constructs. Gayle Rubin, in her essay, *Thinking Sex*, argued that society creates a hierarchical valuation of sex acts, wherein sexuality that is “good,” “normal,” and “natural” should ideally be heterosexual, marital, monogamous, reproductive, and non-commercial, and any sex acts that violate these rules, such as sex that is homosexual, unmarried, promiscuous, non-procreative, or commercial, is “bad,” “abnormal,” and “unnatural.”¹⁴⁵ A similar hierarchy is evident in how service providers evaluate the reasons provided by women for seeking abortion. Women’s reasons for seeking an abortion are always investigated by service providers, and are appraised according to a hierarchical system based on societal norms governing sexual behaviour and gender roles, as well as ableist notions. While abortion is stigmatised in general, it is most likely to be seen as “valid” for pregnancies resulting from heterosexual marital relations.¹⁴⁶ We examine this hierarchy of reasons below.

A FOETAL ABNORMALITY

At the top of the hierarchy are pregnancies that result from heterosexual, marital, reproductive sex, which are sought to be terminated because of foetal abnormalities, even at an advanced gestational age.¹⁴⁷ Courts too, are more likely to permit abortion sought on grounds of foetal abnormality than any other ground.¹⁴⁸ Apart from being at the top of the hierarchy of “good” sex acts, this rationale is also ableist in viewing foetal anomaly as the most legitimate reason to seek an abortion. After all, the MTP Act, self avowedly had “eugenic” aims, and sought to provide for abortion “where there is substantial risk that the child, if born, would suffer from deformities and diseases.”¹⁴⁹ That apart, this rationale also relies on the “proper” role of women in society as nurturing, caring mothers.¹⁵⁰ As we discuss below, women who want to fulfil their roles as mothers through an intended pregnancy that was subsequently discovered to have foetal anomalies, are seen as most “deserving” of abortion.

While many abnormalities are detected late,¹⁵¹ most women can obtain abortions in cases of late detection of foetal anomalies, unlike late requests for abortions in other situations, such as late detection of pregnancy or reporting failure of contraception at a later stage. Where foetal anomalies are detected beyond 20 weeks, service providers either seek judicial authorisation for abortion,¹⁵² or in some cases, perform the procedure even without such authorisation because abortion on this ground is seen as legitimate and providers view carrying such a pregnancy to term as pointless if the future child will lead an uncomfortable life.¹⁵³ This is particularly striking because Section 5 of the MTP Act allows RMPs to terminate a post-20 week pregnancy only where it is immediately necessary to save the life of the pregnant woman, and not on grounds of foetal anomaly alone. This widespread acceptability of abortions on grounds of foetal anomaly is based on the societal perception, and providers’ personal views, that a child who is deemed “abnormal” can be aborted,¹⁵⁴ as well as their sympathy for the woman carrying such a foetus.¹⁵⁵

Overall, as a youth volunteer in Chakardharpur who provides support services to women seeking abortion, told us,

“If a woman is suggested abortion because of foetal abnormality, the doctors do it easily; there is absolutely no difficulty at all. They do it at any point of time irrespective of gestational age. ... The problem is only when the woman herself says she does not want the child. Then there is more problem, if she decides herself. If the doctor suggests because of abnormality or because it is affecting her health or mental health then it is fine. It is only an issue when she decides herself.”¹⁵⁶

RMPs have expressed concerns about the interpretation of the term “substantial risk” of disability in Section 3 of the MTP Act. Providers are unclear as to whether, for example, the mere presence of medical treatment for the relevant anomaly is enough to conclude that the anomaly is not substantial, and whether the availability of treatments where the outcome is poor would disqualify a foetus with anomalies for abortion.¹⁵⁷ For example, in a case before the Bombay High Court, a woman requested termination of her post 20 weeks pregnancy as a serious cardiac anomaly had been detected in the foetus. The court referred the case to a leading government hospital in Mumbai and ordered the formation of a medical board to examine the request for termination. The board included a cardiac surgeon, who mentioned in the medical report that in situations with this kind of anomaly, the outcomes would be very poor even after surgery; the child may not survive, or may survive for one or two years but with great difficulty. However, the other doctors on the board stated that if treatment for the anomaly is available, it should be followed and termination cannot be recommended. In fact, the report stated that requesting an abortion in such situations amounts to “reproductive materialism”.¹⁵⁸ The pregnant woman’s own wishes in the matter were not taken into account.

On the other hand, there are concerns grounded in rights of persons with disabilities regarding the widespread acceptability of this ground to provide abortion, given the potential for using this ground for eugenic aims. In the absence of a clear interpretation of which types of anomalies are covered by the section, concerns were expressed that the ground may be used even in situations where there is a cleft lip or nose, an organ missing, vision or hearing impairments, or other less severe and treatable disabilities.¹⁵⁹

These concerns are valid but arise because the law forces women to articulate their reasons for seeking abortion on one of the limited grounds under the MTP Act, instead of allowing them to determine for themselves whether they want to continue with the pregnancy regardless of their reasons. By justifying abortion only on limited grounds, the law itself creates a hierarchy of legitimate reasons for abortion, foetal anomaly being one of them. Thus, this exceptions-based regime of permitting abortions only under limited circumstances creates the tension between the rights of women to their reproductive autonomy and the rights of persons with disabilities to not be stigmatised as leading less worthy lives.

At the same time, the concern that women are aborting foetuses even in cases of easily correctible impairments, and are therefore making frivolous decisions, is not backed by any evidence.¹⁶⁰ These concerns around women’s decision-making add to the policing of women’s bodies based on a

hierarchy of what is a normal body and what is not, imposing judgment on women, and mistrusting their ability to make informed choices.

B COMPLETE FAMILY/ SPACING OF CHILDREN

Another seemingly ‘acceptable’ reason for seeking abortion is that given by married women with young children or “complete families,” whose ability to nurture their existing children will be compromised by having to care for another child. As mentioned above, providers have their own conceptions of when a married couple’s family is complete; most believe that this is after two or three children. Therefore, if a married woman already has two or three children, it is easier for her to obtain an abortion, as providers are also invested in ensuring that she does not have an expanded family, which may limit her ability to care and provide for her existing children.¹⁶¹ However, this is not usually the case if the previous children are female, due to suspicions of sex-selection.¹⁶²

Spacing too, is seen as a relatively legitimate reason for a married woman to request an abortion. As noted earlier, this may be due to widespread government campaigns advocating for spacing children. If the woman already has a young child at home, it is relatively easy for her to obtain an abortion.¹⁶³ However, as discussed above, if a woman seeks abortion for this reason in the second term, some providers express doubts about the woman’s intentions since she did not report contraceptive failure earlier in the pregnancy.

C MARRIAGEABILITY

1 RAPE

Next in the hierarchy are abortions sought by unmarried women whose “marriageability” will be compromised by giving birth outside of marriage. This is particularly the case with rape survivors who are considered not at “fault” for conceiving outside of marriage, and therefore evoke sympathy for having their future (i.e., chances of getting married) destroyed.¹⁶⁴

Under Section 357C of the CrPC, and Section 19 of the POCSO Act, RMPs are required to immediately inform the police in cases of rape (irrespective of the choice of the woman).¹⁶⁵ This is why many women, and service providers, are unwilling to use this ground (especially if one of the other grounds can be used instead) as women do not always want to report rape.

Some providers attempt to work around this requirement to ensure that the pregnancy can be terminated without exposing the pregnant woman to the criminal justice system. A leading

private practitioner in Pune mentioned that when a woman approaches him seeking an abortion on grounds of rape, he provides the service, but he also counsels her and takes her signature and consent on a statement indicating that he has counselled her and she has herself said that she does not want to report the matter to the police. He then informs the police station that he is performing an abortion on a woman who is a victim of rape but does not want her name to be disclosed. He asks them to record a First Information Report (“FIR”) but leave the name of the victim as unknown. While he was unsure whether this is a legally viable way to provide the abortion, he felt that his approach provides him some measure of protection while protecting the confidentiality of the pregnant woman.¹⁶⁶

However, most practitioners,¹⁶⁷ and the law itself, do not give the woman the discretion to decide whether the rape should be reported. In the context of minors, where POCSO Act prohibits all sexual activity under the age of 18, and imposes a mandatory reporting requirement, access to safe abortion has become severely restricted as a result of this law.¹⁶⁸ Several providers are also under the impression that court authorisation is required when a woman seeks an abortion on ground of rape at any stage of gestation,¹⁶⁹ despite courts having repeatedly clarified that this is not the case.¹⁷⁰

We also found that there is a fairly prevalent view amongst service providers that the shame and stigma that comes with being a rape survivor can be overcome if the woman marries suitably (either her rapist or another man), in which case, the pregnancy need not be terminated.¹⁷¹ For example, we were informed that in Jharkhand’s tribal areas such as Chaibasa, the village panchayat (assembly) may effect a “compromise,” in the form of the woman being married off either to the rapist or her partner, or to another man.¹⁷² The service providers we interviewed felt that in such cases, the pregnancy should not be terminated.¹⁷³

2 CONSENSUAL SEXUAL INTERCOURSE BEFORE MARRIAGE

Women who engage in sex outside of marriage by choice and conceive as a result, are at the bottom of the hierarchy of valid reasons for seeking abortion. The unmarried status of women often works against them when it comes to accessing abortion in part due to the stigma surrounding sexual activity outside marriage. There is a surprising but widely shared view amongst service providers that sex outside marriage is itself *illegal*.¹⁷⁴ This opinion was voiced most openly in our discussions with service providers on contraception for women who are not married. Many providers opined that contraception is not intended for unmarried women, because providing them with contraception will eradicate the fear of pregnancy and lead to a decline in marriages, and is therefore, incorrect social messaging. At a leading government hospital in Ranchi, the

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“Unmarried pregnancy is the illegal pregnancy and in such cases we have to give police information. We have to give, no? How will you

manage the illegal at a legal place? This is a government institution and is a legal place. Here any illegal case has to be reported to the police. We have also studied a subject on forensic medicine. We also know a lot of sections [of the law]. In this case, unmarried is illegal, no?"
- CY, medical officer in-charge of a community health centre in Ranchi, Jharkhand.

nurses said that contraceptive information is not meant for unmarried women because their family is not complete.¹⁷⁷

We find that many service providers operate on the basis of an ingrained classification that categorises sex before marriage as ‘illegal’ and sex within marriage as ‘legal.’¹⁷⁸ Forensic medicine textbooks that are used in medical education also contain such (false) categorisation, and further entrench the stigma around pre-marital sex and associated reproductive needs.¹⁷⁹ As a consequence, unmarried women are often denied abortions due to a perception that their pregnancy itself is “illegal,”¹⁸⁰ and therefore requires interfacing with the legal process, such as reporting to the police or filing a case.

The stigma surrounding sex before marriage also shapes how service providers behave towards unmarried women who seek abortion services. Women are routinely shamed for their sexual behaviour, scolded, and belittled. This is particularly the case in the public healthcare system, a factor that contributes towards pushing women away from such facilities.¹⁸¹ As youth leaders, who provide support services to women who want to terminate their pregnancies, told us,

“[Doctors and nurses] will scare and threaten you. When they go for check-ups, the nurses scold the girls, and the behaviour at the hospital is not right. The counsellors, doctors, nurses and other staff have a completely different attitude if a pregnant unmarried girl comes. They say you roam around anywhere, can’t take care, you do things in any place and then come here and say it was forceful....[The women] then say they won’t get it done from the doctor, and they start looking at jadi booti [traditional medicine] solutions. They say they will use their own methods and go to someone they are familiar with – the quacks who sit in the villages and who give traditional remedies.”¹⁸²

This perceived “illegality” of sex by an unmarried woman sometimes leads to the impression that the abortion cannot be carried out in a government institution and the woman must be referred elsewhere.¹⁸³ A doctor at a NDMC hospital in Delhi stated that unmarried women do not approach the facility to seek abortion as everyone knows it is a government setup.¹⁸⁴

However, in some situations, concern for an unmarried pregnant women’s reputation and chances of marriage in the future, override the stigma surrounding pre-marital sex and make it possible for them to obtain abortions. Further, service providers in tertiary medical facilities, which are perceived as a last resort given the distances that are often involved in travelling to them, are

sometimes of the opinion that if the abortion is not provided there, the woman may resort to unsafe and illegal methods to obtain the abortion.¹⁸⁵

Abortions sought by trans persons and sex workers are almost absent from the public health conversation surrounding abortion.¹⁸⁶ When they are included in the narrative, stereotypes about these identities inform providers' perceptions and decisions. For instance, providers may disbelieve sex workers who seek abortion on grounds of rape, assuming that sex workers "cry rape" only when a client does not pay them.¹⁸⁷

V CONCLUSION

Overall, the denial or provision of reproductive health care, including contraception and safe abortion, become ways in which the medical profession controls women's bodies and sexual (and life) choices. The MTP Act allows RMPs to police women's life choices by empowering them to decide whether or not to provide abortion care, and to deny – with impunity – such care, where they are so inclined. Women thus, have differential access to safe and comprehensive abortion services depending on where they fall within sexual and gender hierarchies. Almost entirely absent from service providers' consideration is the woman's own desire to not continue with the pregnancy, or the consequences for her general well-being, including her mental health, from being made to carry an unwanted pregnancy to term.

We find that while the law prescribes certain grounds under which women can obtain abortions, given the wide differences in the way these grounds are interpreted, as well as the absolute discretion given to service providers under the law, access to safe abortion services often turns on considerations that have little to do with either the law or with the pregnant woman's health or rights.

The fear of getting caught up in the legal process operates as a strong disincentive to provide abortion care. The criminal law framework within which the MTP Act operates puts the RMPs' own interests at odds with the best interests of the patient. Further, RMPs' decisions to provide or deny abortion are also shaped by a range of extra-legal factors, including their own moral and ethical beliefs, societal stigma against abortion, and their views on the place and role of women in society. The woman's agency, and decision is not centred in providing abortion service. To the contrary, women's decisions are either side lined or second-guessed at every stage. This is particularly exacerbated in the public healthcare sector, where a majority of women who approach providers for abortion come from socio-economically disadvantaged backgrounds, resulting in a vast power

differential between the pregnant woman and the provider. Providers can influence the woman's decision because of the power differentials between doctors and patients due the perceived expertise of the former and the lack of information with the latter.¹⁸⁸

Taken together, in shifting the decision-making power over abortion from a pregnant woman to an RMP, the law puts her constitutional, statutory and human rights at the mercy of a chance encounter with a willing service provider.

At the same time, an unexpected finding was that even where providers are personally against providing abortion services due to stigma against abortion, they feel constrained by the law to provide these services. For example, a leading service provider in one of the largest government hospitals in Mumbai believes that abortions are akin to a “death sentence”, but provides abortions because the law necessitates consideration of the circumstances of the woman and provides for abortion up to 20 weeks.¹⁸⁹ As detailed in this chapter, we often found that providers believed the law to be too liberal in allowing abortions. Given this stigma against abortion shared by many service providers, combined with the criminalisation of abortion under the IPC, we find that there is there is a need for an affirmative right to abortion, which explicitly protects both abortion seekers as well as service providers, and imposes positive duties on the State to provide rights-oriented training to service providers.

Interview with GG, government doctor in tertiary health care facility, Mumbai, Maharashtra:

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“GG: I would not [increase the gestation limit for abortion] to 24 weeks. I don't think it should be there – the concern is just that the child is normal. Then why not give it a chance to live? Who are we to put death sentence on a child?”

Ideally life starts when baby is an embryo – that means when the male and female gametes meet. Ideally speaking, 1st and 2nd trimester abortions are also death sentence for normal/good child. Issue is that the law says we have to consider mother and her problems. So law says 20 weeks is acceptable time limit for abortion.”

Interviewer: “Life begins at the stage of embryo: is this a part of medical science textbooks?”

GG: “Yes yes yes yes yes. When male and female gametes meet, zygote is formed. When zygote turns to embryo, it starts multiplying. That thing which multiplies is a living thing”

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- 73 United Nations, Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, para 7.3, UN Doc A/CONF.17/1113/Rev.1 (1995).
- 74 IPC, s 312.
- 75 MTP Act, Statement of Objects and Reasons.
- 76 *ibid.*
- 77 *ibid.*
- 78 Rajya Sabha Debates, 'The Medical termination of Pregnancy Bill, 1969' (3 December 1969) 2718 <https://rsdebate.nic.in/bitstream/123456789/494269/1/PD_70_03121969_13_p2716_p2732_12.pdf> accessed 12 July 2021 (Minister of State, S Chandrashekar while introducing the Bill in the Rajya Sabha).
- 79 *ibid.*
- 80 MTP Act, Statement of Objects and Reasons.
- 81 MTP Act, s 3(1).
- 82 For a discussion on these amendments see Chapter 8.
- 83 MTP Act, ss 3(2) and 3(3).
- 84 MTP Act, s 3(4).
- 85 MTP Act, s 3(3).
- 86 See eg, Dr Mangla Dogra v Anil Kumar Sharma ILR (2012) 2 P&H 446 (where the doctor was sued by the husband for terminating his wife's pregnancy). Interview with HE, doctor at a private hospital in Pune, Maharashtra (stating that this concern about being implicated in divorce cases shapes how service providers respond to married women who seek abortion without the husband's consent).
- 87 Samar Ghosh v Jaya Ghosh (2007) 4 SCC 511 (stating that terminating a pregnancy without the husband's consent amounts to cruelty against the husband and is a ground for divorce). For cases, and a discussion on reproductive decision-making in matrimonial laws, see Aparna Chandra, Mrinal Satish and the Center for Reproductive Rights, *Securing Reproductive Justice in India: A Casebook* (2019) 319-362.
- 88 IPC, ss 312-316.
- 89 MTP Act, s 8.
- 90 Interview with GF, medical officer at a tertiary care government hospital in Mumbai, Maharashtra.
- 91 *ibid.*
- 92 CrPC, s 357C and POCSO Act, s 19 require mandatory reporting of sexual offences committed against adult women and all children, respectively.
- 93 CrPC, s 357C.
- 94 Interview with IX, doctor at a private hospital in Chennai, Tamil Nadu. Since the doctor we interviewed did not know details of the case, neither have these facts, nor has the fact of the case being before the Supreme Court been verified independently by us.
- 95 See eg, Diwakar Sharma and Shirish Vaktania, 'Mumbai Crime: Doctor nabbed for illegally aborting minor girl's foetus' (18 January 2021, Mid-Day) <<https://www.mid-day.com/mumbai/mumbai-crime-news/article/mumbai-crime-doctor-nabbed-for-illegally-aborting-minor-girl-foetus-23156070>> accessed 10 July 2021; Vivek Waghmode, 'Doctor among 3 arrested for attempt to conduct abortion on minor girl' (25 February 2019, The Times of India) <<https://timesofindia.indiatimes.com/city/kolhapur/doctor-among-3-arrested-for-attempt-to-conduct-abortion-on-minor-girl/articleshow/68149503.cms>> accessed 10 July 2021; George Mendonca, 'Nerul doctor held for aborting minor rape survivor's 16 week-old foetus', (25 September 2014, The Times of India) <<https://timesofindia.indiatimes.com/city/mumbai/nerul-doctor-held-for-aborting-minor-rape-survivors-16-week-old-foetus/articleshow/43358014.cms>> accessed 10 July 2021; 'Doctor held for carrying out abortion of minor girl in Maharashtra' (3 June 2012, The Indian Express) <<https://indianexpress.com/article/india/crime/doctor-held-for-carrying-out-abortion-of-minor-girl-in-maharashtra/>> accessed 10 July 2021.
- 96 MTP Act, s 3(4).
- 97 Interview with JH, government doctor at a tertiary care centre in Chennai, Tamil Nadu.
- 98 Interview with JF, doctor formerly at a government tertiary care centre in Tamil Nadu, and member of OGSSI.
- 99 Interview with AS, government doctor at a hospital in Delhi.
- 100 Interview with HD, doctor at a private hospital in Pune, Maharashtra.
- 101 See especially, Chapter 4.
- 102 Interviews with JH, government doctor at a tertiary care centre in Chennai, Tamil Nadu; interview with EP, doctor at a private hospital in West Singhbhum district, Jharkhand; interview with BL, member of civil society organization in Ranchi, Jharkhand.
- 103 Interview with JH, government doctor at a tertiary care centre in Chennai, Tamil Nadu.
- 104 Interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 105 Interview with IF, doctor and government official at the National Health Mission, Tamil Nadu; interview with KL, a student at private nursing college in Dharmapuri, Tamil Nadu.
- 106 Group discussion DV, with seven youth leaders (who act as intermediaries) working with IPAS in Chakardharpur, West Singhbhum district, Jharkhand.
- 107 *ibid.*
- 108 Interview with DG, government doctor at a tertiary health care facility in Ranchi, Jharkhand.
- 109 MTP Act, s 3(2). The MTP (Amendment) Act, 2021 broadened this to include unmarried women as well.
- 110 Interview with AZ, senior resident at a tertiary government hospital in Delhi; interview with CS, government doctor at an urban primary health centre in Ranchi, Jharkhand; interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 111 Interview with HG, doctor at a private hospital in Pune, Maharashtra.
- 112 Interview with DB, DE and DC, government doctors in a district hospital in Jharkhand.
- 113 Interview with IB, government official with National Health Mission, Tamil Nadu.
- 114 Interviews with JC, JD and JH, government doctors at tertiary care centres in Chennai, Tamil Nadu; interview with IU and IW, doctors at a private hospital in Chennai, Tamil Nadu; interview with HF, doctor at a private hospital in Pune, Maharashtra; group discussion HL, with nurses at a government secondary health care facility in rural Pune, Maharashtra; interview with DG, government doctor at a tertiary health care facility in Ranchi, Jharkhand; interview with FD, government doctor in a district hospital in Jharkhand; interview with AQ and AS, government doctors at a hospital in Delhi; interview with IG, public health consultant and former government doctor, National Health Mission, Tamil Nadu.
- 115 Interview with CP, CQ and CR, ANMs at a rural primary health centre, Ranchi, Jharkhand.
- 116 Expert consultation with Dr Alka Barua, Independent Consultant and Researcher on Women's Rights, Steering Committee, Common Health. See also, discussion on medical textbooks' treatment of abortion in Chapter 3.
- 117 Interview with IW, doctor at a private hospital in Chennai, Tamil Nadu.
- 118 Interview with AQ, government doctor at a hospital in Delhi.
- 119 Interview with HK, government doctor at a secondary health care facility in rural Pune, Maharashtra.

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- 120 Interview with AQ and AS, government doctor at a hospital in Delhi.
- 121 Interview with AT and AU, government doctors at a tertiary health care facility in Delhi.
- 122 Interview with AQ and AS, government doctor at a hospital in Delhi.
- 123 See PI Frank and others, 'The Effect of Induced Abortion on Subsequent Pregnancy Outcome' (1991) 98(10) *British Journal of Obstetrics and Gynaecology* 1015 <10.1111/j.1471-0528.1991.tb15340.x> accessed 10 July 2021; Jasveer Virk and others, 'Medical Abortion and the Risk of Subsequent Adverse Pregnancy Outcomes' (2007) 357 *New England Journal of Medicine* 648 <<https://www.nejm.org/doi/full/10.1056/nejmoa070445>> accessed 10 July 2021.
- 124 Interview with DG, DH, and DI, government doctors at a tertiary health care facility in Ranchi, Jharkhand.
- 125 Interview with HG, doctor at a private hospital in Pune, Maharashtra.
- 126 Group discussion DK with residents at a government hospital in Ranchi, Jharkhand.
- 127 Interview with DB, DC, and DE, government doctors at a district hospital in Jharkhand; interview with FD, government doctor in a district hospital in Jharkhand; interview with DG, government doctor at a tertiary health care facility in Ranchi, Jharkhand; interview with AT, government doctor at a tertiary health care facility in Delhi.
- 128 NFHS-4 (n 62).
- 129 Interview with DB, DE, and DC, government doctors at a district hospital in Jharkhand.
- 130 *ibid.*
- 131 Interviews with DG, DH, and DI, government doctors at a tertiary health care facility in Ranchi, Jharkhand.
- 132 Group discussion DK with residents at a government hospital in Ranchi, Jharkhand. 133 Interview with DB, DE, and DC, government doctors in a district hospital in Jharkhand.
- 134 *ibid.*; interview with CX, sahiya at a rural community health centre in Ranchi, Jharkhand.
- 135 "Hum do, Hamare Do" is a popular government campaign which loosely translates into, "Two of Us, and Two of Ours." The campaign attempts to raise awareness about the benefits of small families comprising two opposite-sex parents and two children. Nirmala Buch, 'Law of Two-Child Norm in Panchayats: Implications, Consequences and Experiences,' (2005) 40(24) *Economic and Political Weekly* 2421 <https://www.jstor.org/stable/4416748?seq=1#metadata_info_tab_contents> accessed 10 July 2021.
- 136 Interview with CY, medical officer in-charge of a community health centre in Ranchi, Jharkhand.
- 137 Justice K.S. Puttaswamy (Retd.) and Anr v Union of India and Ors (2017) 10 SCC 1.
- 138 MTP Act, s 3(2).
- 139 Interviews with DG, DH, and DI, government doctors at a tertiary health care facility in Ranchi, Jharkhand; interview with HG, doctor at a private hospital in Pune, Maharashtra.
- 140 Suchitra Dalvie, 'Second Trimester Abortions in India', (2008) 16(31) *Reproductive Health Matters* 37, 38 <[https://doi.org/10.1016/S0968-8080\(08\)31384-6](https://doi.org/10.1016/S0968-8080(08)31384-6)> accessed 10 July 2021; Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 141 Suchitra Dalvie, 'Second Trimester Abortions in India', *ibid.*
- 142 *ibid.*, 41.
- 143 Interview with LB, a rape survivor who tried to access abortion but was denied, Dharmapuri, Tamil Nadu.
- 144 WHO, 'Abortion' (n 7).
- 145 See Gayle Rubin, 'Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality' in Carole Vance (ed), *Pleasure and Danger: Exploring Female Sexuality* (1984).
- 146 These concerns were also raised in Parliament and find place in the Statement of Objects and Reasons of the MTP Act. See Chapter 1.
- 147 See eg, Interview with KR, ANM at a primary health centre in Dharmapuri, Tamil Nadu; interview with KZ, staff nurse at a government hospital in Tamil Nadu; interviews with DG, DH and DI, government doctors at a tertiary health care facility in Ranchi, Jharkhand.
- 148 Anubha Rastogi and Raunaq Chandrashekar, 'Assessing the judiciary's role in Access to Safe Abortion: An Analysis of Supreme Court and High Court Judgements in India from June 2016–April 2019' (2019, PratiGYa Campaign) 14, 18 <<https://pratiGYacampaign.org/wp-content/uploads/2019/09/assessing-the-judiciarys-role-in-access-to-safe-abortion.pdf>> accessed 10 July 2021.
- 149 MTP Act, Statement of Objects and Reasons.
- 150 See generally, Kristin Luker, *Abortion and the Politics of Motherhood* (1984); Reva Siegel, 'The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions' (2007) 3 *University of Illinois Law Review* 991 <https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=2127&context=fss_papers> accessed July 10 2021.
- 151 For example, several cardiac and neurological foetal anomalies, anencephaly, hydrocephaly etc. are only detected with ultrasound scans at 21-22 weeks, beyond the 20-week deadline. Interviews with DG, DH, and DI, government doctors at a tertiary health care facility in Ranchi, Jharkhand.
- 152 See Chapter 3.
- 153 Interviews with GE, doctor at a tertiary health care facility in Ranchi, Jharkhand; group discussion DK with residents at a government hospital in Ranchi, Jharkhand.
- 154 *ibid.*
- 155 *ibid.*; Interview with CT, medical officer in-charge of a community health centre in a rural district in Jharkhand.
- 156 Group discussion DV, with seven youth leaders (who act as intermediaries) working with IPAS in Chakardharpur, West Singhbhum district, Jharkhand.
- 157 Interview with GC, doctor at a private hospital in Mumbai, Maharashtra.
- 158 Interview with FT, lawyer practicing before at the High Court of Bombay at Mumbai, Maharashtra; interview with GC, doctor at a private hospital in Mumbai, Maharashtra.
- 159 Interview with GE, doctor at a private hospital in Mumbai, Maharashtra; interview with GC, doctor at a private hospital in Mumbai, Maharashtra; interview with HD, doctor at a private hospital in Pune, Maharashtra; interview with JA, medical intern at a tertiary level government health care facility in Chennai, Tamil Nadu.
- 160 In our interviews, we came across instances of women choosing to carry a pregnancy to term even when anomalies were detected. For instance, in Dharmapuri, a woman whose scan showed that her child would have a cleft palate was advised by those around her to get an abortion. However, she decided against an abortion, and gave birth to the child who will be operated upon at the age of three. Group discussion KT, with ANMs at a primary health centre, Dharmapuri, Tamil Nadu.
- 161 Interviews with DG, DH, and DI, government doctors at a tertiary health care facility in Ranchi, Jharkhand.
- 162 See Pritam Poddar and others, "'If a woman has even one daughter, I refuse to perform the abortion": Sex Determination and Safe Abortion in India,' (2015) 23(45) *Reproductive Health Matters* 114 <10.1016/j.rhm.2015.06.003> accessed 10 July 2021.
- 163 Interview with DG, government doctor at a tertiary health care facility in Ranchi, Jharkhand.

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- 164 Group discussion HN, with married adult women in a village in Pune, Maharashtra; interview with JH, government doctor at a tertiary health care facility in Chennai, Tamil Nadu; interview with AP, doctor at a private hospital and former government doctor in a tertiary health care facility, Delhi; interview with KY, government doctor at a tertiary care centre in Tamil Nadu; interview with AU, government doctor at a tertiary health care facility in Delhi.
- 165 CrPC, s 357C.
- 166 Interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 167 Interview with AX, AY, AZ, and BA, residents at a tertiary government hospital in Delhi.
- 168 See Chapter 7.
- 169 Interview with II, lawyer practicing before the High Court of Madras, Tamil Nadu.
- 170 *Bashir Khan v State of Punjab* AIR 2014 P&H 150.
- 171 Interview with IE, doctor and government official, National Health Mission, Tamil Nadu; interview with FA, family planning counsellor at a district hospital, Jharkhand.
- 172 Interview with FA, family planning counsellor at a district hospital, Jharkhand; interview with DT, youth leader working with IPAS, Chaibasa, West Singhbhum district, Jharkhand.
- 173 Interviews with JC and JD, government doctors at a tertiary care centre in Chennai, Tamil Nadu.
- 174 Interview with CT, medical officer in-charge of a community health centre in a rural district in Jharkhand; interview with FD, government doctor in a district hospital in Jharkhand; interview with CY, medical officer in-charge of a community health centre in Ranchi, Jharkhand; interview with KL, a student at private nursing college in Dharmapuri, Tamil Nadu; interview with KZ, staff nurse at a government hospital in Tamil Nadu; interview with KR, ANM at a primary health centre, Dharmapuri, Tamil Nadu; interview with KN, Head of a private nursing college, Dharmapuri, Tamil Nadu.
- 175 Discussion DJ, with nurses at a government tertiary health care facility in Ranchi, Jharkhand; interview with FD, government doctor in a district hospital in Jharkhand; interview with EX, medical officer in-charge of a community health centre in Saraikela-Kharsawan district in Jharkhand; interview ET, with two ANMs at a health and wellness centre in West Singhbhum district, Jharkhand; interview with ES, sahiya at a health and wellness centre in West Singhbhum district, Jharkhand.
- 176 Interview with FD, government doctor in a district hospital in Jharkhand.
- 177 Discussion DJ, with nurses at a government tertiary health care facility in Ranchi, Jharkhand.
- 178 Interview with BB, public health specialist and member of JHPIEGO, Jharkhand; interview with KZ, staff nurse at a government hospital in Tamil Nadu.
- 179 See discussion in Chapter 3.
- 180 Interview with KR, ANM at a primary health centre, Dharmapuri, Tamil Nadu.
- 181 Interview with KI, a student at a private nursing college in Dharmapuri, Tamil Nadu.
- 182 Group discussion DV, with seven youth leaders (who act as intermediaries) working with IPAS in Chakardharpur, West Singhbhum district, Jharkhand.
- 183 Interview with CY, medical officer in-charge of a community health centre in Ranchi, Jharkhand.
- 184 Interview with AQ, government doctor at a hospital in Delhi.
- 185 Interview with AM, member of a civil society organisation working on health-related issues, and former head of department at a government tertiary care facility, Delhi.
- 186 Interview with HX, LGBTQA rights activist based in Chennai, Tamil Nadu.
- 187 Interview with AX, AY, AZ, and BA, resident doctors at a government tertiary health care facility in Delhi.
- 188 Group discussion DV, with seven youth leaders (who act as intermediaries) working with IPAS in Chakardharpur, West Singhbhum district, Jharkhand.
- 189 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra.

3 Barriers to Accessing Abortion Post-20 weeks of Gestation

Section 3 of the MTP Act places a 20-week gestational limit on abortions. Post this time frame, there is no provision for abortion, except when it is “immediately necessary to save the life of the pregnant woman.”¹⁹⁰ This comes from Section 5 of the MTP Act, which provides that requirements pertaining to gestational limits for termination of pregnancy and the opinion of two RMPs shall not apply in case a RMP opines that such termination is “immediately necessary to save the life of the pregnant woman.”¹⁹¹ As per the text of the provision, this decision to terminate a pregnancy exceeding 20 weeks of gestation can be made by one RMP with the consent of the woman (or her guardian wherever necessary). The MTP Act itself does not place this decision with any other person or authority. However, as discussed below, courts have created an elaborate structure of third-party authorisations for medical terminations of pregnancies post-20 weeks.

The Supreme Court has given a broad construction to the expression “life” under Section 5 to include the physical and mental health of a pregnant person, beyond immediate survival.¹⁹² Through this interpretation, courts have permitted post-20 weeks terminations of pregnancies resulting from rape.¹⁹³ The Court has also recognised substantial foetal impairment as a ground for terminating pregnancies post-20 weeks under Section 5.¹⁹⁴ According to the Supreme Court, the “overriding consideration” in such a case is the woman’s right to preserve her own life and protect her mental and/or physical health from risks arising from an unwanted pregnancy.¹⁹⁵

While a majority of these petitions involve diagnosis of foetal impairment or pregnancy resulting from rape,¹⁹⁶ there are several other circumstances where continuation of a pregnancy could be detrimental to her life, or physical or mental health. Recognising this, the Bombay High Court in *High Court on its Own Motion v. State of Maharashtra*¹⁹⁷ stated that all pregnant women have the “same rights in relation to termination of pregnancy,” and forcing any woman to continue with any unwanted pregnancy would result in “violation of [her] bodily integrity and [...] would be deleterious to her mental health.”¹⁹⁸ It clarified that presumptions in Explanations I and II to Section 3 (2)¹⁹⁹ do not limit the range of circumstances in which continuation of pregnancy may cause mental injury to the woman. In doing so, the High Court acknowledged that there may be “social, financial and other aspects” immediately associated with pregnancy, which may impact pregnant women’s health and well-being.

Reproductive autonomy, or the right to make one’s own reproductive choices has been recognised as part of the right to personal liberty under Article 21 of the Constitution of India.²⁰⁰ In *High Court on its Own Motion*, the Bombay High Court categorically stated that how a woman wants to deal with her pregnancy “must be a decision she and she alone can make,” as it is a basic right of women

to “decide what to do with their own bodies.”²⁰¹ The MTP Act, however, designates service providers as gatekeepers controlling the exercise of this right by women.

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“It is legally impermissible to provide an abortion beyond 20 weeks... Over 20 weeks we say we have to produce the baby.”
- AP, Former government doctor in a tertiary health care facility, Delhi, and now a private practitioner.

Many service providers view 20-weeks as the threshold beyond which it is “legally impermissible” for them to provide abortion services.²⁰² Therefore, women are denied abortions or are asked to procure the court’s permission for terminations post-20 weeks.²⁰³ Having to approach the courts for permission to terminate a pregnancy post-20 weeks results in an additional level of authorisation, which leads to delays and sometimes denials.²⁰⁴ In addition, when courts are petitioned for accessing abortion, they set up medical boards (discussed in detail below) which adds yet another level of approvals and permissions before a requested termination is authorised.²⁰⁵

This section discusses the barriers encountered by women seeking termination of pregnancies over 20 weeks of gestation, and highlights the harms caused to them while navigating the medical and legal systems. The first part provides an overview of the key reasons why women may seek abortion post the gestational limit of 20 weeks, and the challenges faced by those seeking abortion in approaching the Courts. The second part describes the various stages of the court process, and the constitution and functioning of medical boards. It examines in detail the different factors or considerations that influence formation of medical opinion in favour of or against termination of a pregnancy. The third part focuses on women’s experiences in the courtroom and before the medical board, and the hurdles that persist even after the Court permits termination of pregnancy.

I ACCESSING ABORTION POST-20 WEEKS: REASONS, EXPERIENCES, OUTCOMES

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“We are seeing cases over 20 weeks. See, legally, we are permitted only up to 20 weeks. So after that we are not supposed to do.”
- IW, Doctor at a private hospital in Chennai.

Women approach service providers seeking termination of pregnancy post-20 weeks for a range of reasons. In its previous work, the Centre for Reproductive Rights found that such delays in accessing services are caused by legal/procedural barriers, as well as due to the discovery of the pregnancy itself or pregnancy-related risks after the 20-week mark.²⁰⁶ A majority of the service providers that we interviewed, however, do not provide abortion services to women. However, a majority of the service providers that we interviewed do not provide abortion services to women post-20 weeks of gestation, on the misconceived notion that “abortion is allowed only up to 20 weeks.”²⁰⁷

In case of foetal anomalies that surface only after 19-20 weeks of gestation, seeking abortion post-20 weeks is inevitable.²⁰⁸ Physical barriers such as inaccessibility of facilities providing diagnostic

ultrasonography services or second trimester abortion services, may also hinder timely detection of anomalies and termination of pregnancy. For instance, in Maharashtra, AA, a woman who could not afford private healthcare, approached a government health facility for ante-natal care but was given an ultrasound appointment after a month. Her lawyer recounted AA's experience:

“By the time AA could go for ultrasound, it was already 20 weeks. There were significant anomalies that were not correctible ... there were conjoint twins, one heart, no cranium, other anomalies – it was just not sustainable.

She was [at] 27 weeks [of gestation] when the case was finally taken up for hearing in a Court. The delay was caused in obtaining medical records from the hospital. By the time she reached us, AA was in her 26th week.

When we reached the Court, the doctors were of the opinion that termination of pregnancy through c-section [as vaginal delivery was not feasible] at 27 weeks could pose significant risk to AA's life. We, therefore, informed the Court that we would not press the matter further.

AA carried the pregnancy to term and delivered the conjoint twins. They were in the ICU and they died within two days [of their birth].”²⁰⁹

Lawyers from Human Rights Law Network, a leading human rights lawyering organisation that has litigated a majority of the post-20 weeks abortion cases in Indian courts, state that in their experience, a majority of women who have approached the Supreme Court and High Courts with post-20 week cases were in very impoverished circumstances “all struggling to make ends meet, [...] all dependent on public health services.”²¹⁰ A woman, in such circumstances, is more likely to cross the 20-week limit due to unavailability of public healthcare services providing second trimester abortion at the local level. For instance, T was diagnosed with foetal anomalies at 18 weeks. Her local Primary Health Centre (“PHC”), which did not provide abortion services, also failed to provide her a “positive referral” to a facility where she could avail the services. As a result, T “went from here to there for two weeks,” and was past 20 weeks before she reached the civil hospital where second trimester abortion services were available.²¹¹

These are not isolated cases. The National Family Health Survey-4 found that 18% of women had their first antenatal care visit as late as the fourth and fifth month of pregnancy, and 7% first received antenatal care in the sixth month or later; the median number of months of pregnancy at

the time of the first ante-natal care visit was 3.5 months.²¹²

Aside from cases involving foetal anomaly, unawareness of the pregnancy or gestational age, particularly in case of minors or breast-feeding women with lactational amenorrhea, may contribute to the delay in approaching health facilities in the early stages of a pregnancy. Moreover, fear of social stigma, lack of mobility, and lack of physical access to health services may further restrict access to abortion services, particularly in the case of unmarried women and survivors of rape.

Minor rape survivors face additional barriers in accessing early abortion as they may not realise that they are pregnant or may not disclose it to anyone due to threats from their abuser.²¹³ They are, therefore, more likely to seek abortion post 20 weeks.²¹⁴ Adult women too often do not reveal pregnancies resulting from sexual assault, till it is not possible to hide the fact. For adult and minor survivors of rape, the inability to access abortion post 20 weeks is therefore, linked to foreseeable and preventable physical and mental health harm.²¹⁵

Deosthali and Rege note instances where women could not reveal sexual assault, mostly due to threat from their abuser (an acquaintance), until they had reached advanced stages of gestation and were visibly pregnant.²¹⁶ These women were not provided abortion services as they had crossed the 20-week limit. Although marital rape of an adult woman has not been criminalised, their study documents the sexual violence inflicted within marriage and barriers faced by those unwilling to bear the resulting unwanted pregnancy. They note:

“Seven women disclosed marital rape when we interviewed them at the time of their first antenatal registration at the public hospital, which was at 20 weeks of pregnancy. They did not attend the health facility earlier because their husbands were controlling their movement and forbid them to access the health service. None of the seven women wished to continue their pregnancy, but all of them were denied an abortion because the pregnancy was beyond the legal 20-week limit.”²¹⁷

Further, other circumstances may arise during the pregnancy, such as risk of financial and psychological strain from raising a child, that may lead women (particularly from lower socio-economic groups) to seek abortion post-20 weeks.²¹⁸ For example, P, a resident of a village in Pune District, in her early 40s, already had two children, when she became pregnant again. Her sister-in-law, who did not have children, had agreed to adopt the child. However, by the time P was 4 months

pregnant, the sister-in-law had changed her mind. P approached the ASHA seeking abortion. The ASHA referred P to the Rural Hospital, 20 kms from her village. However, P could not afford the travel. After two months, P again approached the ASHA for the termination. At this advanced stage of the pregnancy, P was advised that the termination could no longer be performed at the Rural Hospital, and that private clinics would charge anywhere between Rs. 10,000-20,000. The ASHA referred her to a government hospital, 50 kms away from the village. However, there was no one to accompany P to the hospital, causing a further delay. Ultimately, P's mother went along with her and her pregnancy was terminated at 6 months.

Though the pregnancy was unintended, P would have continued with it, if the sister-in-law had agreed to adopt the child, and bear the expenses of the pregnancy. P herself did not have the economic capacity, nor was she physically or mentally prepared for another child.²¹⁹

The service providers in P's case considered the health as well as the socio-economic consequences of the pregnancy and provided abortion services post-20 weeks. However, this may not always be the case. For instance, a medical officer posted at the Rural Hospital that P was advised to approach initially opined that there was “nothing in the law to facilitate post-20-week abortion, except in case of anomal[ies] [and that too] with court order.”²²⁰ He added that, “even if a woman has hypertension, she has to carry the pregnancy.”²²¹ The fear of criminal prosecution further deters service providers from conducting abortion, even in cases where they would have advised it. The medical officer explained, “there are 2-3 cases happening in [redacted] against doctors who did abortion with proven anomalies just above 20 weeks” and fearing a similar outcome, out of abundant caution for their own safety, many service providers refuse termination even when the pregnancy is under, yet close to, 20 weeks (such as 19 weeks and 6 days).²²²

Some service providers may “try to help out” women when they know that she “needs it.”²²³ For instance, in the case of unmarried women, rape survivors or in the presence of foetal anomalies which can be diagnosed only after 20 weeks, they may provide services while resorting to “LMP [last menstrual period] or date adjustments,”²²⁴ recording the case as spontaneous abortion or “bleeding,”²²⁵ or not maintaining records at all.²²⁶ A senior gynaecologist described the circumstances which necessitate such a “humanitarian” approach:

“[...] Some of the anomalies are detected late, or sometimes missed. Not everybody is proficient in a scan. People also come with pregnancy to us late and we are not able to offer services. But in government hospitals at least these are all poor people and we know we have to help.

[...] Cut-off of 20 weeks is a problem. Even 24 weeks is sometimes too early [...] So when they come to us beyond 20 weeks, for example at 24 weeks, we write it as 20 weeks and try to help [...] because if they cannot get the service at a government hospital, they will not be able to go anywhere else.”²²⁷

Some women may approach private facilities for abortion, which could be financially exploitative and unsafe. For instance, before P approached the government hospital where her pregnancy was terminated, the ASHA took her to a private doctor who agreed to charge a “lower sum” of Rs. 10,000 for the procedure as P was poor. The charges would be higher for the “rich.” While she could not “name them” for lack of “proof,” the ASHA shared that “[private doctors] do it when there are genuine problems.”²²⁸ Otherwise, women may either be advised to continue with an unwanted pregnancy and place the child (if born alive) for adoption²²⁹ or obtain a court order permitting abortion. The decision, either way, places the women in a precarious situation. As a young unmarried woman told her lawyer in Delhi, “I don’t want to go to Court...If I do I will be stigmatised forever.”²³⁰

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“While drafting petition, young [unmarried] woman was sitting here. First thing she said: I don’t want to go to court if I would have got this service. If I don’t, I will be stigmatized forever”
- AK, Lawyer, High Court of Delhi.

Those who are able to approach the courts are not only worried about the “public eye” and uncertainty of the court process, but also apprehensive about whether they would be able to “proceed normally” with their lives after that.²³¹ Overwhelmed by such concerns and their familial circumstances, many women decide against approaching the court for termination of pregnancy. For instance, when XX, a woman in her late 40s approached her doctor for delayed menstruation, the doctor initially assumed she was menopausal. A few months later, XX found out that she was pregnant. She did not want to carry the pregnancy to term, but also did not want to go to court. She did not return to her doctor after that, who surmised that since “courts never have given permission in these kinds of cases ... she must have delivered or gone to quacks.”²³²

II THE COURT PROCESS

In cases where women overcome the various barriers and eventually approach courts, lawyers and activists noted that the ensuing process is riddled with uncertainty and involves considerable delay, causing irreparable harm to the mental and physical health of the woman, with each passing day of the pregnancy.²³³ Further, oscillating between the medical and judicial system, and making a convincing case before each of them, is often a traumatic and exhausting experience for the woman.

A STAGE OF ADMISSION: PRE-SCREENING

Once a case is admitted in court, a multi-specialty team of doctors (“**Medical Board**” or “**Medical Committee**”) constituted by the court examines the woman and gives its opinion on whether termination of pregnancy should be allowed or not. In most cases, the court’s decision is based “wholly on the opinion of the board,”²³⁴ which it considers “near final.”²³⁵

However, admission of the case and grant of urgent hearing depends on the judges’ interpretation of the law, legal precedents in post-20 week cases, and the strength of the present case in comparison to the precedents where termination has been allowed by the courts. Therefore, lawyers may themselves pre-screen and filter cases where courts have not previously allowed termination in a similar case, or “where the [medical committee] is unlikely to give a positive order.”²³⁶ In the latter type of cases, the rationale is to avoid “corruption of jurisprudence,”²³⁷ that is, setting an adverse precedent in courts, that may impact future cases. Therefore, “borderline” cases where it is fairly certain that the “baby [sic] is not going to make it” are not sent to the Court.²³⁸ Thus, the decision to file a case may often be preceded by a determination made by lawyers, in consultation with service providers, on whether the petition is likely to succeed on both medical as well as legal grounds.

The petitions filed in court are bolstered with legal precedents and multiple medical reports prepared by different doctors supporting termination. This means that the pregnant woman is required to undergo multiple rounds of medical examinations even before she appears before the medical board. In one such case, the petition included three reports confirming the condition of the woman’s pregnancy, out of which two were from the very same government hospital in which the Court subsequently ordered the medical board to be constituted.²³⁹

Securing an urgent admission hearing for a case may also be challenging. For instance, in a case before the High Court of Madhya Pradesh seeking termination of pregnancy of a minor rape survivor N, the writ petition could be heard only a week after its filing.²⁴⁰ This can further lessen the chances of the woman being able to successfully terminate her pregnancy, since the pregnancy is quite advanced by the time the Court has to make a decision on whether to permit the abortion.

One of the lawyers interviewed for this study noted that in the courtroom, an admission hearing may proceed in three ways. First, judges may look at the precedent and if it is a “circumstance in which the courts have previously allowed [termination],” the Court may admit the case and constitute a medical board.²⁴¹ The second manner in which a case may proceed, according to

the lawyer, involves “extremely invasive” questioning by the Court, requiring the petitioner’s lawyers to explain the reasons for seeking termination, often through graphic descriptions in case of anomalies,²⁴² or causes leading to breach of the 20-week limit. In cases where termination of pregnancy is sought on grounds of rape, the lawyer said that judges sometimes question the veracity of the allegation or insist that a FIR be filed.²⁴³ D’s case is illustrative.

D, an adult woman, had approached the Bombay High Court seeking termination of her pregnancy of over 20 weeks on the ground that the pregnancy resulted from rape. She had alleged that the perpetrator had sexual intercourse with her on the pretext of a false promise to marry. In the courtroom, the judges questioned the veracity of her allegations, as the woman had not registered an FIR. The courtroom interaction was described to us by the lawyer who was present in the Court, in the following terms:

*“Judge: What proof do we have that it was rape?
Woman’s lawyer: She says she did not consent but did not want to file an FIR.
 It is her decision whether or not to file one.
Judge: But then how do we believe you?
Woman’s lawyer: FIR is only an allegation of the commission of that offence.
 I am making the allegation right now.”*

The Court remained in disbelief and insisted on filing of an FIR, leading D to withdraw the matter.²⁴⁴

The third instance according to the lawyer involved judges hearing the case narrowly reading the law or legal precedent and refusing to admit the case. For instance, aside from cases such as rape, where the MTP Act presumes that continuation of pregnancy constitutes a grave mental injury to the woman,²⁴⁵ courts may be unreceptive to the argument that a woman can terminate her pregnancy because the pregnancy was unintended or undesired and that forcing her to continue with the pregnancy affects her mental health (much less her right to reproductive autonomy or bodily integrity). As the lawyer told us,

“Medical committees have not in a single case recommended termination of pregnancy on the ground of mental trauma alone. In fact, those cases do not even reach the committee because the Court itself will say that this does not fall into any of those categories...”²⁴⁶

B**DETERMINATION BY MEDICAL BOARD**

“Primarily speaking, under law of land only gynecologists are qualified to opine on termination. Then how can court or government go beyond law of land and suddenly appoint other doctors (pediatrician, neurologist, cardiologist, psychiatrist, radiologist etc.) to opine on termination matters? Have they ever done termination? As MBBS – you are not allowed or trained in doing that. You are only supposed to know about it. If you are qualified in obstetrics and gynecology, then only are you trained. Cardiologist not trained in termination as policy or procedure, and you are putting him on the committee to decide whether termination should be done or not. 9 people are there, of which 8 are unauthorized to do or opine on termination under law. Only 1 is authorized to decide on termination – so he is in minority. You are creating a defunct mechanism!”
 - Dr Nikhil Datar, a leading gynecologist in Mumbai.



If a petition seeking permission to terminate a pregnancy beyond twenty weeks is not dismissed outright by the court, the petitioner is referred to a medical board for its opinion. Before the 2021 amendment, the MTP Act did not require or provide for such a procedure. The Act placed the decision of termination of post-20 weeks pregnancy with a single RMP. The setting up of medical boards for medical opinion on a pregnancy is a court-led initiative, which as the Center for Reproductive Rights’ 2018 Report notes, effectively entrusts final decision-making regarding the pregnancy to a panel of health care providers which does not include the pregnant woman’s own doctor.²⁴⁷ To begin with, courts used to order the constitution of medical boards for this purpose on a case-by-case basis. However, based on a nudge from the Supreme Court,²⁴⁸ in 2017 the Central Government issued a circular, advising all states to constitute permanent medical boards to which cases can be sent as and when the Court directs.²⁴⁹ After the 2021 amendment, the MTP Act further formalises this process by providing legislative sanction to the creation of medical boards to evaluate post 20-week terminations.²⁵⁰

Medical boards are constituted in tertiary care institutions, typically comprising seven to nine medical experts. A medical board is usually headed by a gynecologist and its other members include a pediatrician, radiologist, physician, psychologist, and in cases of foetal anomalies, the specialist from the relevant field of medicine.²⁵¹ Its composition depends on the hospital’s protocol, or the court order by which the board is constituted, where the hospital has not constituted a permanent medical board in accordance with the circular issued in 2017. Dr. Nikhil Datar, a leading gynecologist who routinely refers his patients for seeking court authorisation for terminating the post 20 weeks pregnancies, told us that “medical board[s] run contrary to the scheme of the MTP Act under which only a gynecologist can form an opinion on termination of pregnancy. However, the medical boards have other doctors “not authorised to [make such determination] by law,” placing the “[gynecologist] who can decide in the minority.”²⁵²

For the pregnant woman, examination by the medical board brings a new set of challenges. The guidelines under the circular issued in 2017 state that permanent medical boards should be established at “premier tertiary level government medical institutes” of the State.²⁵³ The tertiary care institutions in which the boards are constituted are usually based in district headquarters. Therefore, physical accessibility to the medical board may itself constitute a major challenge. However, depending on the availability of facilities to conduct the required examination and tests locally, the courts may direct constitution of the medical board closer to the petitioner’s place of residence.

Further, the process of medical examination by eight or nine different specialists on the board may cause further agony to the woman. FU, a lawyer in Mumbai, pointed out that overworked doctors in government hospitals often view this medical examination as an additional workload, and “make the women jump through hoops, run around or wait unnecessarily.”²⁵⁴ In fact, in one case, FU’s client was unable to bear the exhausting processes and stopped going for the medical examination. Ultimately, FU lost contact with the client and had to withdraw the petition filed before the court. According to FU:

“[My clients] were living really far off in Bombay, maybe 2 hours from [redacted] Hospital, and they were asked to come back three times. Every day [the Board] would only do one examination and they kept asking them to come back...[They] were so fed up, they had called me about it, and at the time I [told them] “Listen you have to, I do not know what else to do” – and then eventually they stopped going to the board and they stopped answering my calls. So, the case had to be withdrawn because I had no instructions...We all know that when someone wants to do something, they will find a way to do it.”²⁵⁵

At times, depending on their own views on the morality of abortion, the members of the board discourage or dissuade women from seeking an abortion for reasons other than risks to her own health, and in patently offensive ways, such as asking the woman, “do you want to kill your child [sic]?”²⁵⁶

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“What happens is, see, sometimes what the medical board says that itself makes a lot of difference. There have been cases where the medical board has been very supportive. There have been cases where the someone on the medical board asks the woman – do you want to kill your child.”
- AK, Lawyer, High Court of Delhi.

In Maharashtra, which has the highest number of court cases for seeking termination of pregnancies,²⁵⁷ service providers highlighted their own challenges in convening a medical board. These include coordination with heads or senior members of different departments on the board, and returning the medical opinion to the Court within the short timeline provided by the Court. Recommending that the task should be “outsourced,” a senior gynecologist described the hassle – and inadvertently his opinion on late term abortions – as:

“We leave our big OPD [out-patient department] aside and concentrate on one woman who had forgotten that she had a child [sic] inside her for 4-5 months ...We internally decided...she can wait for 3 more days for the board to respond.”²⁵⁸

C**FORMING THE MEDICAL OPINION: RELEVANT FACTORS**

In their orders to the medical board, courts seldom outline the questions that the board should respond to, even when lawyers submit draft terms of reference to the court.²⁵⁹ As a consequence, the medical opinion provided by the medical board to the court varies widely from case to case, especially with respect to the factors that it considers in forming its opinion. For example, medical board opinions often state the risks to the woman from the termination of the pregnancy, but are silent on the comparative risks from delivery at term. This can skew the perception of risks associated with the termination.

In some cases, the medical opinion may be drafted vaguely, which passes the buck to the court. In such circumstances, it is not uncommon for women to undergo multiple re-examinations before different medical boards constituted by the court. For instance, in *R v. State of Haryana*,²⁶⁰ the Punjab and Haryana High Court had to constitute three medical boards to opine on R's request for medical termination of pregnancy.

R, a 14-year-old rape survivor, was 21 weeks pregnant when her pregnancy was first detected. However, the service provider refused to perform an abortion due to fear of prosecution.²⁶¹ By the time the High Court passed an order for R's medical examination by the first medical board, two weeks had lapsed and R was 23 weeks pregnant. The first medical board examined R for two days and opined that termination of pregnancy was harmful to her life without expressly stating the reasons. It further added that under the MTP Act, termination of pregnancy could be carried out only up to 20 weeks of gestation.²⁶²

R's lawyers contended that the medical opinion should also indicate whether continuance of pregnancy was harmful to R. The High Court constituted a second medical board comprising three senior gynecologists, a clinical psychologist, and a psychiatrist to examine whether there was a serious threat to R's life from the abortion and the likely effect of non-termination of pregnancy on R's psychological health. Once again, R underwent a physical examination, radiological examination, and psychological and psychiatric assessment. The second medical board opined that R's pregnancy of 23 weeks could not be terminated owing to the gestational limit under the MTP Act. It, however, acknowledged that the social and emotional consequences of continuing the pregnancy could be harmful to R.²⁶³

The High Court ordered the same medical board to reassess R's case in a "holistic sense," taking into consideration R's mental state and that she was contemplating suicide if forced to

continue with the pregnancy. The medical board again opined that R's pregnancy could not be terminated as it had crossed 24 weeks, at which there was a likelihood of foetus being viable and the risks of termination had increased.²⁶⁴ Based on this, the Punjab and Haryana High Court did not permit the termination.²⁶⁵

However, the High Court criticised the medical boards' refusal to carry out termination of pregnancy due to fear of prosecution. The court emphasised that it was necessary to extend the 20-week limit within the MTP Act, and advised that the Act be amended such that doctors who perform abortions beyond 20 weeks in good faith and in line with the rules in situations where such abortion is necessary to save the rape survivor's life or prevent grave injury to her physical and mental health must not be prosecuted.²⁶⁶

In July 2019, a case similar to R's came before the High Court of Madhya Pradesh. We followed the case of N, a 13-year-old girl, who was 24 weeks pregnant when her family became aware of her pregnancy. By the time her writ petition was heard, she was into the 26th week of pregnancy. N was examined by three different medical boards as she pursued her writ petition and subsequent appeal before the High Court.

N was first examined by a medical board comprising three doctors who observed -wrongly- that "MTP Act [...] provide[s] for termination of pregnancy within 24 weeks [sic]," and since N's pregnancy was at 26 weeks, it could not be terminated.²⁶⁷

As the medical board did not consider the impact of an unwanted pregnancy on N's physical and mental health, the Court ordered a re-examination by a medical board comprising four senior doctors, which included a psychiatrist. However, the second medical board similarly recommended continuation of pregnancy stating that N's pregnancy was at 26 weeks and 6 days and termination was not possible under the provisions of the MTP Act. N's writ petition was dismissed based on this 'medical' opinion.

An appeal was preferred before the Division Bench of the High Court, which constituted a third medical board for N's examination. This medical board opined that termination as well as continuation of pregnancy both posed equal risk to N's health, and that "the Court [could] take a decision in the matter considering the findings of the Medical Board."

The Division Bench considered N's age and the trauma caused to N from carrying the

*pregnancy resulting from rape. It allowed termination of pregnancy subject to an undertaking given by N's guardian and herself accepting full responsibility for the risk from the abortion.*²⁶⁸

"They ask us to form committee. Suppose there is a congenital anomaly in the head. So we ask a neurosurgeon, psychiatrist, neurologist, and Head of Dept of sonology to confirm what was sent from outside (scan) and then we do the examination. We conclude whether baby compatible with life or whether it will require many surgeries on this basis. Depending on which organ is affected, we call the concerned specialist and ask him whether compatible with life or lots of surgeries. And what will be the percentage of survival as normal human being even after the surgeries – is there morbidity or mortality involved? Former – will it be vegetable? Latter – Will it die? For proper congenital anomalies we usually say yes, you can terminate because it is an extra burden both financially and mentally on mother and father to see plight of the child like that."
- GG, Government Doctor in tertiary health care facility, Mumbai, Maharashtra.



Opinions from medical boards that are worded vaguely or fail to respond to the questions posed by the court are another reason for women having to face multiple rounds of examination.

X, a woman seeking abortion post 20 weeks after a diagnosis of foetal anomalies, had to appear before three medical boards one after the other. X's lawyer narrated their experience as follows:

*"Everyone gave cryptic responses. It was impossible to understand what the medical boards said – whether termination should be allowed or should not be allowed, what is the nature of abnormality. The judge agreed ... that the medical opinions were cryptic and said that they could send the women to five medical boards if she wants, and even if ... one positive opinion, they will allow [termination]. But this is just harassment for the women!"*²⁶⁹

The only consideration in law for termination of pregnancy post-20 weeks is the impact of continuing with the pregnancy on the life of the woman. Courts have interpreted this widely: in **Meera Santosh Pal v. Union of India**,²⁷⁰ the Supreme Court emphasised the right to bodily integrity and reproductive autonomy, adding that a woman may take any necessary step to preserve her own life. On this basis, it allowed termination of a pregnancy that posed a health risk to the pregnant woman. Similarly, in **High Court on its Own Motion v. State of Maharashtra**,²⁷¹ the Bombay High Court stated that carrying to term any unwanted pregnancy "represents a violation of the woman's bodily integrity and aggravates her mental trauma which would be deleterious to her mental health."

However, medical boards often rely on a range of factors not relevant to this issue. They discount the impact on the life of the woman from carrying an unwanted pregnancy to term. In the absence of a clear mandate, the members of the medical board often opine on the "condition of the baby [sic] and its incompatibility with life"²⁷² or "whether [born child] will require many surgeries."²⁷³ It is pertinent to note that the MTP Act does not envisage a foetus' compatibility with life as a ground for not permitting abortions.²⁷⁴

In other cases, opinions of medical boards may reflect the inherent biases of its members, in "unsolicited observations" made by them.²⁷⁵ For instance, in **Nandini Tushar Rawool v. State**,²⁷⁶ the woman seeking court permission to terminate her pregnancy was declined such permission on the

basis of the medical opinion that the condition of the baby could be managed, and if the pregnancy was terminated it may result in a live birth, leading to an ethical dilemma for doctors as to whether to resuscitate. Often, these biases are also reflected and confirmed in the court's decision. In *Nandini Tushar Rawool*, the Court went on to state that seeking an abortion on the ground that raising the child would be inconvenient amounts to "reproductive materialism."²⁷⁷

The guidance note issued by the Ministry of Health and Family Welfare also does not provide medical boards with much guidance on the factors that should be considered in deciding a request for termination of pregnancies over 20 weeks. The guidance note retains focus on the impact of foetal anomaly on the child when born and fails to consider the impact on the pregnant woman's life from carrying such pregnancy to term and raising the child born. In setting out the responsibility of the medical board in cases of foetal anomaly, it states that, "[the] Medical Board [should] determine if the foetal abnormality is substantial enough to qualify as either incompatible with life or associated with significant morbidity or mortality in the child if born."²⁷⁸

The guidance note also provides a list of major foetal anomalies for the medical board's reference.²⁷⁹

D FOETAL ANOMALY

A woman carrying a foetus diagnosed with anomalies incompatible with life or "lethal anomalies" is most likely to be approved by the medical board for termination of pregnancy. In *Meera Santosh Pal v. Union of India*,²⁸⁰ and *X v. Union of India*,²⁸¹ the Supreme Court noted that a woman has the right to preserve her own life and that a pregnancy can be terminated when carrying the pregnancy to term would cause mental or physical injury to the woman. In both these cases, the foetus had fatal impairments as noted in the medical opinion, and the medical board in each case opined that carrying the pregnancy to term would risk the woman's mental and physical health.²⁸² Similarly, in *Mamta Verma v. Union of India*,²⁸³ the Supreme Court permitted a post-20 week abortion on the ground that the foetus had impairments that were incompatible with extra-uterine life. In *Shaikh Ayesha Khatoon v. Union of India*,²⁸⁴ the Bombay High Court permitted termination of a 27-week pregnancy on the basis of several foetal impairments that would cause low chances of independent survival post-birth. The Court also stated that to advance the cause of justice as well as meet the objectives of the Act, the conditions for termination under Section 3(2)(b)(i) and (ii) should be read into Section 5(1) for termination after 20 weeks. Therefore, the mental injury caused to a woman by carrying a pregnancy to term with foetal impairments would be sufficient ground for termination, and denying such termination would contravene the right to personal liberty under Article 21.²⁸⁵

However, even in cases of severe foetal anomalies, the board may not recommend termination, if the pregnancy has crossed a certain gestational limit. This limit may vary, but is usually in the range of 24-28 weeks, and arguably pertains to the “age of viability” of the foetus. For instance, a senior gynaecologist and member of multiple medical boards in Maharashtra, told us that he did not recommend termination of pregnancy after 24 weeks of gestation as a rule.²⁸⁶

Additionally, denial may also be on the ground that termination at this stage may be risky or “involve unnecessary c-section.”²⁸⁷ However, normally the risk of abortion at any stage is lower than the risk of delivery at term,²⁸⁸ as in Y’s case below:

In Y’s case, the foetus was diagnosed with “Type II malformation,” a neurological abnormality. She was in the 28th week of her pregnancy when she appeared before the medical board. The medical board opined that termination of pregnancy was not possible at 28 weeks as the “foetus [could] come out live” and that “termination at advanced gestational age [was risky].” However, the medical board’s opinion was silent on whether the termination was riskier than delivery. Based on the medical board’s opinion, the Court denied the request for termination.

As a result, Y was forced to continue with the pregnancy. At full term, the foetus could not be delivered as its “head had become very big due to waterlogging” and Y went beyond the due date. A c-section was not carried out as the foetus was unlikely to survive. Ultimately, foetal head was pierced to reduce its size for passage through the perineum. Y delivered, however, “[the delivery] was very difficult and tardy.”

As the child was born alive, it was shifted to NICU. Overtime, as was the prognosis, the condition of the child worsened leading to infection in its brain. No one including Y was allowed inside the NICU [...] After 3-5 days, Y and the child were “packed home.” She was told, “You can’t occupy a bed. Baby is not getting better.”

*Y looked after the child for 10-15 days and the child ultimately died.*²⁸⁹

A senior gynaecologist at a tertiary care hospital in Mumbai, Maharashtra, told us that in cases of “non-lethal” abnormalities the decision of the medical board is based on its assessment of the foetus’ compatibility with “normal” life, and what medical intervention or surgeries may be required for it upon birth.²⁹⁰ For instance, in *Tapasya Umesh Pisal v. Union of India*,²⁹¹ the Supreme Court permitted abortion of a 25-week pregnancy only because the foetal anomaly was linked to high

mortality after birth and limited life span, and would require multiple corrective surgeries on birth. Notably, in such determination, the impact of the pregnancy on the life of the woman, which includes her physical and mental health, or her social circumstances, are completely overlooked.

*Z was 27 weeks pregnant, when she approached the Bombay High Court with a plea for termination of pregnancy, on the ground of risk of grave injury to her mental health from continuing with the pregnancy. The foetus was diagnosed with a chromosomal disorder (Klinefelter's syndrome) and she had been informed by her doctor that the upon birth, the child could have physical and psychological abnormalities that may affect the heart, development of motor skill, external genitalia, or cause auto-immune disorders.*²⁹²

Z placed the doctor's report before the court and sought permission for terminating her pregnancy stating that raising a child with such condition would cause "immense mental stress and financial burden" to her. The High Court set up three consecutive medical boards to decide Z's request for MTP.

Speaking to us, a member of the medical boards opined that a child born could face problems of infertility but could otherwise lead a "normal life." The member recounted that the issue before their medical board as was that: "the mother [Z] said she did not want the child. But on what grounds was she saying that she did not want the child?"

*The medical board did not authorise abortion stating that "people [with infertility issues] could live a normal life [...]" and therefore, there was no need to terminate Z's pregnancy.*²⁹³ *The case was referred back to the medical board for reconsideration as it had not addressed the court's question on the "psychiatric impact" of continuation of pregnancy and raising a child born [with the said condition] on Z. However, the second medical board returned a "similar opinion."*²⁹⁴

*As the two medical boards did not give a conclusive opinion on the likely impact of continuation of pregnancy on Z's mental health, the High Court went on to set up a third medical board. However, by this time, Z was in the 31st week of pregnancy and she refused to appear before the board citing "anxiety and mental exhaustion."*²⁹⁵ *Ultimately, the High Court rejected Z's request for termination of her pregnancy.*

E ROLE OF MENTAL HEALTH EXPERT

Z's case and others prompt the question of the necessity of a psychologist/psychiatrist on the medical board, and whether it amounts to over-medicalisation of mental health as a factor to be considered with respect to termination of pregnancy, contrary to the scheme of the MTP Act.

The MTP Act recognises a “risk of grave injury” to the mental health of a woman as a ground for termination of pregnancy. It is pertinent to note that it does not require a mental health expert (psychiatrist or psychologist) for such assessment. For terminations under the 20-week gestational limit, such decisions are made by RMPs, by taking into account the “actual or reasonable foreseeable environment” of the woman.²⁹⁶

However, the court-constituted medical boards in the post 20-week cases, do include a psychologist or a psychiatrist. While a few members of medical boards that we interviewed were unsure of the mandate for the psychologist, others defined it as to “evaluate whether a woman is psychologically stable or not”; or to opine on the impact of pregnancy on the mental health of the woman, and whether she is making the decision in the right frame of mind. A psychologist may also be needed for counselling the woman in case she exhibits symptoms for any mental illnesses.

Reports of the medical board, however, reflect that “so far, [the role] has been to only determine whether the woman suffers from some kind of psychological issue” or her capacity to make a decision.²⁹⁷ The opinion does not determine the risks to woman's mental health from continuing the pregnancy or “undergoing the abortion procedure.”²⁹⁸ For instance, in Z's case, after “constantly prodding her about her mental state,” the medical board's opinion “simply said that she [was] not suffering from any psychological issue [at that time].”²⁹⁹

Even in cases involving minor rape survivors (where the law presumes injury to mental health),³⁰⁰ the medical board's report does not discuss the effect on a woman's mental health from continuation of the pregnancy.³⁰¹ For instance, in N's case, the psychiatrist on the second medical board constituted by the single Judge of the High Court opined that her pregnancy may be continued on the basis of the following observations:

“...she is not suffering from any mental disease and is having an average mental health. [She] is feeling anxiety at times and uneasiness but she is having normal sleep and appetite. [She] is also having insight and not suffering from any delusion and hallucination...[She] may be given medical counselling.”³⁰²

The mental trauma suffered by the 14-year-old N from the sexual assault and the resultant pregnancy did not find a mention in the board's report.

F RAPE SURVIVORS

Explanation I to Section 3 (2) (b) of the MTP Act presumes that the anguish caused by a pregnancy resulting from rape constitutes “a grave injury to the mental health” of the woman. The Ministry of Health and Family Welfare has issued *Guidelines & Protocols on Medico-Legal Care for Survivors / Victims of Sexual Violence 2014*, which recommends that a survivor of sexual violence “is to be given the option of undergoing an abortion,” following the protocols for medical termination of pregnancy.³⁰³ Despite these, medical boards have opined against termination even in the case of rape survivors on the grounds that the foetus may be born alive, or upon considering the ability of the survivor (based on factors such as her age) to carry the pregnancy to term. In doing so, the medical opinion discounts the physical and mental trauma faced by the survivor, a ground that would make termination of her pregnancy “legally permissible”³⁰⁴ as per the judicial interpretation of Section 5 of the MTP Act.³⁰⁵ For example, the Kerala High Court in *Ms. X v. State of Kerala*,³⁰⁶ permitted a termination for a survivor of rape by extending Section 5 to situations where carrying the pregnancy to term would lead to grave mental stress for the woman and a change in her normal life for which she is not prepared.

Concerns of viability of the foetus, otherwise not envisaged in the law, have found their way into the courtroom through reports of medical boards. The foetus is often personified, and its compatibility with life is debated and weighed against the harms of carrying a pregnancy resulting from rape to term. For instance, in a case before the Supreme Court involving a 13-year-old rape survivor, who was 31 weeks pregnant (detected at 27 weeks), the medical board had accepted that given her age, “the pregnancy itself was a problem.”³⁰⁷ However, a suggestion was still floated by the medical board that if she continues the pregnancy for six more weeks then “the foetus [may] survive childbirth, [making it a] win-win situation.” In this case, termination of pregnancy was ultimately allowed by the Court. However, the survivor was already in labour by this time, and delivered a live child.³⁰⁸

A lawyer recounted her courtroom experiences to highlight the difficulties which may arise in seemingly “easy cases” where the medical opinion focuses on “gains” from continuation of pregnancy rather than the “harms” to the pregnant person who is forced to carry it.³⁰⁹ A senior gynaecologist who was called upon by the Bombay High Court to explain the medical board's recommendation, stated as follows:

“One girl was 16 years old. Unmarried. I was called by the judge to explain why I refused termination. She was 28 weeks pregnant. Baby may survive after termination. A pre-term baby [would require] NICU care, lots of money would be involved. So, it is better to carry to term. Child can be adopted.”³¹⁰

In another case where the rape survivor was 12 years old, the medical board recommended the termination of pregnancy at 24-26 weeks “even though [she was carrying] a “normal child” [sic].”³¹¹ A member on the board said that the decision was made keeping in mind the “mother’s” health, and complications due to “young maternal age”, and was quick to add that, “If the age was 16-18 years, [they] could have advised carrying the pregnancy.”³¹² It is in this situation that health of the “mother” or minor rape victim/survivor weighs over the extra-legal factors considered by medical boards to deny termination of pregnancy.

In the case of a 10-year-old rape survivor from Chandigarh, the intervenors³¹³ before the Supreme Court had placed expert opinions by gynaecologists with expertise in third-trimester abortion, which emphasised that termination of pregnancy was in the best interests of the child and was not riskier than delivery at term.³¹⁴ The anguish with the Court’s denial remains fresh in the minds of experts on reproductive health care, who argue that abortion should be regarded as part of treatment in case of sexual assault. Expressing his disagreement with the Court’s decision, a senior gynaecologist stated that “for a 12-year-old, abortion at 32 weeks is much safer than delivery at term.”³¹⁵ He added that third term pregnancies can be safely terminated by injecting digoxin or potassium chloride to stop the foetal heartbeat, followed by induction of labour.³¹⁶

III HURDLES IN THE COURT AND AFTER OBTAINING A FAVOURABLE ORDER

The court process to obtain judicial authorisation for termination of pregnancy often instills “terror, fear, apprehension about the court system” among women.³¹⁷ Most women and their families are unaware of the law and the experience of “dealing with the medical board, having to wait for the court to decide, visiting a lawyer,” is often intimidating and extremely frustrating.³¹⁸

From the stage of admission, a woman has to juggle between the court and the medical board, making a convincing argument for permission to terminate her pregnancy. For the lawyers representing her in the Court, this may require preparedness to help the judges “visualise... how serious the matter is,” whether it is a foetal abnormality or the image of a “13-year-old girl being

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“ [Patients] are in absolute distress and they are in dire straits when you have to tell them they have to go to court. They have their own apprehensions and reservations about the legal system. As things stand today, no one wants to approach court – if it

can be done sitting at home, they don't have to physically go anywhere. Free of cost so they don't want to go and it's hard for them. Their initial reaction is of tremendous terror and fear.”
- HG, doctor at a private hospital in Satara, Maharashtra.

forced into motherhood.”³¹⁹ For the woman appearing before the medical board, she may be required to exhibit or perform “mental trauma” likely to ensue from continuing with her pregnancy.³²⁰

Women, and/or their lawyers, may also struggle to obtain a copy of the medical board's opinion to prepare for their next steps. The medical report is confidential and is submitted to the court in a sealed cover. Sometimes the Court may “allow [them] to glance through the report and ask right there what the [women] wants or sometimes in an hour's time.”³²¹

In case the medical board mentions the “risk of live birth,” questions may also arise as to who bears the responsibility for the child.³²² In 2019, a Division Bench of the Bombay High Court placed this responsibility on the State if the parents were unwilling to take responsibility or unable to provide for the child.³²³

The challenges faced by women in the above situations multiply with delays at every level of the process: obtaining an urgent hearing, examination by medical board, receipt of medical opinion by the Court, and the final decision.³²⁴ N's case illustrates these challenges.³²⁵

In N's case, the writ petition seeking permission for termination of her pregnancy of around 24 weeks was filed on 25 June 2019. N's lawyers made multiple requests for an urgent hearing. However, the first hearing took place on 1 July 2019, a week after the case was filed.

N was examined by two medical boards and was 26 weeks and 6 days pregnant, when the High Court passed the order dated 3 July 2019 denying N's request for abortion.³²⁶ The lawyers received a copy of this order the next day and filed the writ appeal on 6 July 2019. However, even at this stage N could not secure an urgent hearing, and the appeal was first heard on 17 July 2019. Upon N's re-examination by the medical board, the High Court passed an order allowing termination of her pregnancy on 19 July 2019.

However, a Court order authorising termination of pregnancy does not mark the end of the battle as women may still not be able to access abortion. Service providers may refuse to carry out the termination or the woman may face further delays in accessing abortion services. Often the delay caused by bureaucratic hurdles³²⁷ or unavailability of facilities for providing late-term abortion services,³²⁸ which may make termination risky, force them to carry the pregnancy to term.

In N's case, the pregnancy was terminated a week after the High Court granted permission for MTP. N's lawyers told us,

“[N] was admitted to the hospital only on 24 July 2019. There was [a] delay because the hospital authorities were waiting for intimation from the office of the chief medical health officer, who was in turn waiting to receive the court order. [As per] N’s sonography [...] conducted two days before they carried the procedure [by inducing labour], she was at 29 weeks and 4-5 days [of pregnancy].”³²⁹

In another case, X, a minor rape survivor was compelled to continue her pregnancy to term despite the court’s authorisation for abortion.

X, a 12-year-old girl, was found to be pregnant at 28 weeks of gestation. Her parents approached the Bombay High Court seeking termination of her pregnancy on ground of rape, and the risk of physical and mental trauma from the pregnancy owing to her young age. The Court constituted a medical board, which acknowledged the psychological impact of the pregnancy on the minor, and recommended termination “although there was no abnormality.” Further, the medical board said that termination may be carried out after stopping the foetal heartbeat, as desired by the minor and her mother.

The Court took the medical board’s opinion on record and allowed the termination of pregnancy. However, in the absence of a “clear direction” from the Court permitting the “method of termination” of pregnancy, the service providers at the first hospital refused to provide her the services. She was shunted from one hospital to another, and even approached private providers. However, 2-3 weeks had passed in this process and she was ultimately advised [by the service providers] to continue the pregnancy to term.³³⁰

It may be recalled that Section 5 of the MTP Act envisions termination of pregnancy in such cases by a single RMP. However, pregnant persons are often forced to approach the court nonetheless because they are denied abortion services, due to service providers’ underlying fear of becoming embroiled with the legal processes, in particular the criminal justice system. Further, service providers continue to hold the key to women’s right to safe abortion services, whether as persons on the medical board or while executing the court’s order of termination of pregnancy. The fear of criminalisation is a background condition that shapes all interactions, and influences the denial of services.

Little is known of the women who are unable to obtain court permission, or who are forced out of safe abortion services, exasperated by the processes. Most of them become uncommunicative and

do not wish to remain in contact with their lawyers or healthcare providers.³³¹ Some women end up carrying an unwanted pregnancy to term, while others may “come up with alternative ways.”³³²

*B's foetus was diagnosed with Down's Syndrome. Her husband was a tailor and earned little money. They had times when they did not have money to feed themselves. She kept saying, "If I have this child, I will die. I will commit suicide because I do not know how to take care of it." Yet the court refused to give her the choice. She was compelled to continue the pregnancy to term and is struggling to raise the child.*³³³

IV CONCLUSION

Women are pushed to seeking terminations post 20 weeks of gestation for a variety of reasons but due to the unwillingness of service providers to provide termination beyond 20 weeks (despite a provision for this being present in the MTP Act), they have to seek judicial authorisation. However, not all such cases reach the court. Given concerns around “corruption of jurisprudence,” courts are more likely to grant permission in cases of foetal abnormality and in some cases of pregnancy resulting from the rape of a minor. Therefore, such women make up a large proportion of litigants before courts rather than those women who do not fall within these categories but seek abortion post 20 weeks.

The court constitutes a medical board consisting of multiple specialists to examine the woman and her fitness for termination of pregnancy. The medical opinion takes into account various factors that have little to do with either the woman's health or her reproductive autonomy. While there is a mental health expert present on the board, the woman's mental health and impact on it if the pregnancy is continued to term is not usually significant for the board. Further, examination of the woman by this entire team of doctors, sometimes over multiple rounds, is traumatic, time-consuming and stressful. Even if a favourable order is obtained, there are often further hurdles in the court itself, or providers' further unwillingness despite the court order. Many women do not return to their legal advisors or treating doctors, likely pushed to illegal and unsafe methods of abortion.

Therefore, the requirement to seek authorisation from a third party restricts women's autonomy to make their own reproductive decisions.³³⁴ Additionally, legal discourse around pregnancy tends to minimise the harm to the woman from carrying an unintended or unwanted pregnancy. An unwanted pregnancy is seen by courts and medical boards as a “mere” nine-month episode, with no lasting impact; this is also evident in the oft-quoted “solution” to women's inability to access

safe abortion as being to deliver and give the child up for adoption. However, the physical and psychological impact of carrying an unwanted pregnancy to term on the woman (and also on her other children, if she has any) is well documented. A study in the United Kingdom with 12,462 partnered mothers, a third of whom reported that their pregnancy was unintended, found that forced motherhood was linked to higher risk of psychological distress at 9 months after giving birth, especially among women who had felt unhappy or ambivalent in the beginning.³³⁵ Another 60-year study out of the University of Wisconsin-Madison documented long-term negative mental health outcomes for about 2,500 married Wisconsin women who had pregnancies before abortion was legalised, more than one-in-five (22%) of who reported unwanted pregnancies. The study found that even 20-30 years later, the women who carried unwanted pregnancies to term showed persistent negative mental health effects,³³⁶ including more depressive symptoms and a greater likelihood of a significant episode of depression (even after accounting for other factors that could contribute to both mental health and unintended pregnancy). In another study, investigators at the University of California, San Francisco, have been studying almost 1,000 women who sought abortions. This study compares two groups of women: those who received the abortions they sought and those who were denied abortions due to being slightly over a clinic's gestational limit. Those denied abortion reported higher levels of initial anxiety. Women who had abortions were more than six times more likely to report meeting aspirational one-year goals such as educational or employment goals, than women who were denied an abortion and had to carry the pregnancy to term and raise children.³³⁷ In general, unwanted pregnancies lead to higher risk of negative health consequences during and after such pregnancies.³³⁸ Unwanted pregnancy has consistently proven in several studies to be one of the main risk factors associated with lower levels of psychological well-being during pregnancy, postpartum and in the long-term.³³⁹ While these studies are not in the context of India, there is no evidence that women in India are likely to face better health outcomes from unintended pregnancies.

"Why should section 5 not be self-explanatory. I understand that in our cases it is a question of whether it is 'immediately dangerous' but why is the court involved here at all! Why should lawyers be wasting their time in the courts because a woman wants to exercise her right to autonomy"
- AK, Lawyer, High Court of Delhi.



As noted in the Center for Reproductive Rights' 2018 report, post-20 week cases reflect the dichotomy in India's legal framework on abortion, with judges on one hand recognising reproductive rights to be "sacrosanct,"³⁴⁰ and on the other establishing a third-party authorisation procedure that arbitrarily interferes with pregnant women's and girls' reproductive decision making and may lead to the forced continuation of pregnancy.³⁴¹ A woman should not have to go to Court to assert her right to personal liberty, bodily integrity and reproductive autonomy³⁴² and several service providers and lawyers believe that the decision for termination should rest with her and her doctor. However, some deem it to be the only option for such women until the law recognises a woman's bodily integrity and self-determination.³⁴³

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- 190 MTP Act, s 5.
191 *ibid.*
192 Aparna Chandra et al, Securing Reproductive Justice in India (n 18) 112-113.
193 *ibid.*, 113-114.
194 Tapasya Umesh Pisal v Union of India (2018) 12 SCC 57, Sonali Kiran Gaikwad v Union of India WP(C) 928/2017 (Order dated 9 October 2017) (Supreme Court), Sarmishtha Chakraborty v Union of India (2018) 13 SCC 339; Shaikh Ayesha Khatoon v Union of India 2018 SCC OnLine Bom 11 (Bom HC), XYZ v Union of India WP 10835 of 2018 (Order dated 3 April 2019) (Bom HC). See generally, Aparna Chandra et al, Securing Reproductive Justice in India (n 18) 113.
195 Meera Santosh Pal v Union of India (2017) 3 SCC 462; Sarmishtha Chakraborty v Union of India (2018) 13 SC 339; Mrs X v Union of India (2017) 3 SCC 458.
196 Center for Reproductive Rights, Ensuring Reproductive Rights: Reform to Address Women's and Girls' Need for Abortion after 20 weeks in India (2018) 18.
197 2017 Cri LJ 218 (Bom HC).
198 *ibid.*, para 16 ("Women in different situations have to go for termination of pregnancy. She may be a working woman or homemaker or she may be a prisoner, however, they all form one common category that they are pregnant women. They all have the same rights in relation to termination of pregnancy").
199 MTP Act, s 3(2). Explanation I and II presume that 'anguish' caused by a pregnancy resulting from rape or failure of contraception in case of married women (respectively) constitutes a grave injury to the mental health of the woman, which is one of the grounds for termination of pregnancy under s 3(2).
200 See Suchita Srivastava v Chandigarh Administration (2009) 9 SCC 1; Justice K.S. Puttaswamy (Retd.) and Anr. v. Union of India and Ors (2017) 10 SCC 1.
201 High Court on its Own Motion v State of Maharashtra 2017 Cri LJ 218, para 15.
202 See interview with AP, doctor at a private hospital and former government doctor in a tertiary health care facility, Delhi; interview with IW, doctor at private hospital in Chennai, Tamil Nadu.
203 See Pratigya Campaign, 'Assessing the judiciary's role in Access to Safe Abortion' (n 148) (highlighting that 194 writ petitions were filed before the Supreme Court and High Courts seeking termination of pregnancy during the period of the study. Out of these, 129 cases were filed after crossing the 20-weeks threshold).
204 *ibid.*, 16 (Graph No 4), 23. This recent study of MTP cases filed before the courts between June 2016 and April 2019 indicates that the Supreme Court took an average of 12 days to decide a case, and in case of select High Courts, the average time for decision ranged between 7 to 23 days. The study analysed the time taken by High Courts that had adjudicated five or more MTP cases between June 2018 and April 2019. These included Bombay High Court (9 days), Punjab and Haryana High Court (17 days), Gujarat High Court (7 days), Karnataka High Court (7 days), Madhya Pradesh High Court (11 days) and Madras High Court (23 days).
205 Center for Reproductive Rights, Ensuring Reproductive Rights (n 17) 18-19.
206 *ibid.*, 12.
207 Interview with JG, government doctor at a tertiary care facility in Chennai, Tamil Nadu; interview with IW, doctor at private hospital in Chennai, Tamil Nadu; interview with AP, doctor at a private hospital and former government doctor in a tertiary health care facility, Delhi.
208 Interview with AY, resident at government tertiary care hospital in Delhi.
209 Interview with FU, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra, and AA's lawyer in the instant case.
210 Interview with AK, FT and FU, lawyers practicing before the High Courts of Bombay and Delhi.
211 Interview with AK, lawyer practicing before the High Court of Delhi, and T's lawyer in the instant case.
212 Indian Institute of Population Sciences, 'National Family Health Survey (NFHS-4), 2015-16: India' (December 2017) 203 <<http://rchiips.org/nfhs/nfhs-4Reports/India.pdf>> accessed 10 July 2021. National aggregates and state level data for some of the states that we are studying, were not available at the time of writing this report.
213 Centre for Constitutional Law, Policy and Governance, NLU, Delhi ("CLPG"), 'Case Study on W.A. 1161 of 2019 and W.P. 12098 of 2019 (High Court of Madhya Pradesh)' (October 2019) (unpublished).
214 *ibid.* See for instance, X v State of Maharashtra WP 12054 of 2019 (High Court of Bombay) (Order dated 29 November 2019) (X was in the sixth month of her pregnancy by the time her parents came to know about it).
215 Ensuring Reproductive Rights (n 17) 14.
216 Padma Deosthali and Sangeeta Rege, 'Denial of Safe Abortion to Survivors of Rape in India' (2019) 21(2) Health and Human Rights Journal 189, 193-4 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6927364/pdf/hr-21-02-189.pdf>> accessed 10 July 2021.
217 *ibid.*, 193.
218 Interview with JG, government doctor at a tertiary care facility in Chennai, Tamil Nadu.
219 Group discussion HH, with two ASHA workers and a community worker in Pune, Maharashtra.
220 Interview with HJ, medical officer at a secondary level government hospital in rural Pune, Maharashtra.
221 *ibid.*
222 *ibid.*
223 Interview with IU, doctor at a private hospital in Chennai, Tamil Nadu.
224 Interview with JF, doctor formerly at a government tertiary care centre in Tamil Nadu, and member of OGSSI.
225 Interview with JH, government doctor at a tertiary care facility in Chennai, Tamil Nadu.
226 Interview with IX and IW, doctors at a private hospital in Chennai, Tamil Nadu.
227 Interview with JF, doctor, formerly at a government tertiary care centre in Tamil Nadu, and member of OGSSI.
228 Group discussion HH, with two ASHA workers and a community worker in Pune, Maharashtra.
229 Deosthali and Rege (n 216) 193; interview with HM, government doctor at a tertiary care facility in Pune Maharashtra; Group discussion HH, Pune District (The group comprised two ASHA workers and a community worker); and Group discussion DV, with seven youth leaders (who act as intermediaries) working with IPAS in Chakardharpur, West Singhbhum district, Jharkhand.
230 Interview with AK, lawyer practicing before the High Court of Delhi.
231 Interview with AK, lawyer practicing before the High Court of Delhi; Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra.
232 Interview with GC, doctor at a private hospital in Mumbai, Maharashtra.
233 Pratigya Campaign, 'Assessing the judiciary's role in Access to Safe Abortion' (n 148) 22-4.

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- 234 *ibid.*, 22.
- 235 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra; interview with HM, government doctor at a tertiary care facility in Pune Maharashtra (HM, a medical board member, stated that “the only question [posed to the board] is whether it advises termination or not. Court accepts our decision [...] They agree with us and pass the order accordingly); Interview with GC, doctor at a private hospital in Mumbai, Maharashtra (“It is a very mundane process. The court says go to [medical board] and follows whatever [it] says. There is no legal point”).
- 236 Interview with HD, doctor at a private hospital in Pune, Maharashtra.
- 237 *ibid.*
- 238 *ibid.*
- 239 Court proceedings in WP (App) 28536 of 2019 before Bombay High Court observed by CLPG (6 and 11 November 2019).
- 240 CLPG, ‘Case Study’ (n 213).
- 241 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra; Court proceedings observed by CLPG (n 232).
- 242 Interview with AK, lawyer practicing before the High Court of Delhi (“If we describe the ailment or defect in [medical terms], they do not understand. They have to visualise in their heads how serious it is”); Interview with AL, lawyer in Delhi (“[In one instance] the judge asked us a question about the fetus and we had to be gory. We said that [it] will not have a head or [its] kidney will fall out”).
- 243 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra
- 244 *ibid.*
- 245 MTP Act, s 3(2), Explanation I.
- 246 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra.
- 247 Ensuring Reproductive Rights (n 17) 19.
- 248 Alakh Alok Srivastava v Union of India WP (Civil) No 565 of 2017 (Order dated 28 July 2017) (Supreme Court); Krishnadas Rajagopal, ‘SC Rejects Abortion Plea of 10-year-old’ (28 July 2017, The Hindu) <<https://www.thehindu.com/news/national/sc-rejects-plea-seeking-nod-for-10-year-old-rape-survivors-abortion/article19377784.ece>> accessed 10 July 2021 (“[The Bench went on to urge the government [...] to consider setting up permanent medical boards across the States so that women, especially child rape victims, could receive expedient access to medical care”); Center for Reproductive Rights, Ensuring Reproductive Rights (n 191) 19.
- 249 Ministry of Health and Family Welfare, ‘Circular for Establishment of Permanent Medical Board’ D.P. No. M12015/58/201-MCH (2017). Subsequently, the Ministry issued a guidance note to the medical boards for termination of pregnancies over 20 weeks of gestation in cases referred by the Courts (Guidance Note). See Annexure B, ‘Guidance Note for Medical Boards for Termination of Pregnancy Beyond 20 weeks (In cases referred by the Courts)’ of the Compliance Affidavit dated 11 September 2019 submitted by Union of India in Nikhil Datar v UOI Civil Appeal No 7702 of 2014 (Supreme Court).
- 250 MTP Act, ss 3(2-C) and 3(2-D).
- 251 Interview with HM, government doctor at a tertiary care facility in Pune Maharashtra.
- 252 Interview with Dr Nikhil Datar, doctor practicing in Mumbai, Maharashtra.
- 253 Ministry of Health and Family Welfare, Circular for Establishment of Permanent Medical Board, D.P. No. M12015/58/201-MCH (2017).
- 254 Interview with FU, a lawyer practicing before the High Court of Bombay, Mumbai, Maharashtra.
- 255 *ibid.*
- 256 Interview with AK, lawyer practicing before the High Court of Delhi.
- 257 See Pratigya Campaign (n 148) 16.
- 258 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra.
- 259 Interview with AK, lawyer practicing before the High Court of Delhi.
- 260 2016 SCC OnLine P&H 18369.
- 261 Center for Reproductive Rights, Ensuring Reproductive Rights (n 17) 16.
- 262 2016 SCC OnLine P&H 18369, para 33.
- 263 *ibid.*, para 36.
- 264 *ibid.*, para 38-39
- 265 *ibid.*, para 101.
- 266 *ibid.*, paras 95, 97, 100.
- 267 It should be noted that Section 5 of the MTP Act does not place a gestational limit for termination of pregnancy and courts have allowed termination of pregnancy beyond 24 weeks. See for instance Murugan Nayakkar v Union of India 2017 SCC OnLine SC 1092; X v State of Maharashtra WP 12054 of 2019 (Bom HC) (Order dated 29 November 2019); Geeta Devi v State of Himachal Pradesh 2017 SCC OnLine HP 1574; Sarmishtha Chakraborty. v Union of India 2017 SCC OnLine SC 897.
- 268 CLPG, ‘Case Study’ (n 213).
- 269 Interview with AK, lawyer practicing before the High Court of Delhi.
- 270 (2017) 3 SCC 462.
- 271 2017 Cri LJ 218 (Bom HC).
- 272 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra.
- 273 *ibid.*
- 274 High Court on its Own Motion v State of Maharashtra 2017 Cri LJ 218 (Bom HC), paras 15, 22.
- 275 Pratigya Campaign (n 148) 24.
- 276 Writ Petition No 8313 of 2018 (14 August 2018) (Bom HC) as cited in Pratigya Campaign (n 148) 28.
- 277 *ibid.*
- 278 Guidance Note (n 249), Annexure B.
- 279 *ibid.*
- 280 (2017) 3 SCC 462.
- 281 (2017) 3 SCC 458.
- 282 See also Sonali Kiran Gaikwad v Union of India WP (C) 928/2017 (Supreme Court) (Order dated 9 October 2017).
- 283 2017 SCC OnLine SC 1150.
- 284 2018 SCC OnLine Bom 11.
- 285 See also Siddamma Golsar v Union of India WP No 766/2017 (Bom HC) (permitting abortion post-20 weeks relying on Shaikh Ayesha Khatoun).
- 286 Interview with HM, government doctor at a tertiary care facility in Pune Maharashtra.
- 287 *ibid.*

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- 288 Interview with Dr Suchitra Dalvie, Asia Safe Abortion Partnership. See also Elizabeth Raymond and David Grimes, 'The Comparative Safety of Legal Induced Abortion and Childbirth in the United States' (2012) 119(2) *Obstetrics & Gynaecology* 215 <[10.1097/AOG.0b013e31823fe923](https://doi.org/10.1097/AOG.0b013e31823fe923)> accessed 10 July 2021.
- 289 Interview with GC, doctor at a private hospital in Mumbai, Maharashtra; Jyoti Shelar, 'Malformed Baby Born to City Woman Denied Abortion by Supreme Court Dies' (25 August 2017, *The Hindu*) <<https://www.thehindu.com/news/cities/mumbai/malformed-baby-born-to-city-woman-denied-abortion-by-supreme-court-dies/article19556226.ece>> accessed 10 July 2021 (A news report covering the traumatic experience that Y had to undergo).
- 290 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra.
- 291 (2018) 12 SCC 57.
- 292 Rosy Sequeira, 'Bombay High Court Denies Abortion Plea for Foetus with Gene Defects' (24 December 2018, *The Times of India*) <<https://timesofindia.indiatimes.com/city/mumbai/hc-denies-abortion-plea-for-fetus-with-gene-defects/articleshow/67222931.cms>> accessed 10 July 2021.
- 293 Interview with GG, government doctor at a tertiary care facility in Mumbai, Maharashtra, who was on the medical board in the instant case.
- 294 *ibid*.
- 295 Rosy Sequeira, 'Bombay High Court Denies Abortion Plea for Foetus with Gene Defects' (24 December 2018, *The Times of India*) <<https://timesofindia.indiatimes.com/city/mumbai/hc-denies-abortion-plea-for-fetus-with-gene-defects/articleshow/67222931.cms>> accessed 10 July 2021.
- 296 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 297 CLPG, 'Case Study' (n 213).
- 298 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 299 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra.
- 300 MTP Act, s 3, Explanations I and II.
- 301 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra; CLPG, 'Case Study' (n 213) (see order passed by the High Court on 3 July 2019).
- 302 CLPG, 'Case Study' (n 213) (see order passed by the High Court on 3 July 2019).
- 303 Ministry of Health and Family Welfare, 'Guidelines and Protocols – Medico-Legal Care for Survivors of Sexual Violence' (2014) 34 <<https://main.mohfw.gov.in/sites/default/files/953522324.pdf>> accessed 10 July 2021.
- 304 Interview with HJ, medical officer at a secondary level government hospital in rural Pune, Maharashtra (stating that it is legally impermissible to terminate a pregnancy except with a court order in case of anomalies).
- 305 *Murugan Nayakkar v Union of India* WP(C) No. 749 of 2017 (Supreme Court) (Order dated 6 September 2017).
- 306 (2016) 4 KLT 745.
- 307 Interview with AK, lawyer practicing before the High Court of Delhi.
- 308 *Deosthali and Rege* (n 216) 194.
- 309 Interview with AK, lawyer practicing before the High Court of Delhi.
- 310 Interview with HM, government doctor at a tertiary care facility in Pune Maharashtra.
- 311 Interview with GG, government doctor at a tertiary care facility in Mumbai, Maharashtra, and a member of the medical board in this case.
- 312 *ibid*.
- 313 The intervention was filed by CommonHealth (a coalition for reproductive health and safe abortion) along with other groups working on women's health rights. See International Campaign for Women's Right to Safe Abortion, 'India – Sexual Abuse of Girls Followed by Refusal of Abortion: Adding Insult to Injury' (4 August 2017) <<https://www.safeabortionwomensright.org/india-sexual-abuse-of-girls-followed-by-refusal-of-abortion/>> accessed 10 July 2021.
- 314 *ibid*.
- 315 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 316 Guidance Note (n 249) 4-5.
- 317 Interview with HG, doctor at a private hospital in Satara, Maharashtra.
- 318 Interview with FU, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra.
- 319 Interviews with AK and AL, lawyers practicing before the High Court in Delhi.
- 320 CLPG, 'Case Study' (n 213).
- 321 Interviews FT, FU and FV, lawyers practicing before High Court of Bombay at Mumbai, Maharashtra.
- 322 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra (A medical board that GG was part of recommended that parents should bear the responsibility of the child in the case of a live birth).
- 323 *XYZ v Union of India* WP 10835 of 2018 (Bom HC) (Order dated 3 April 2019); *X v State of Maharashtra* WP 12054 of 2019 (Bombay High Court) (Order dated 29 November 2018).
- 324 PratiGya Campaign (n 148) 22-24, Interview with FT and FU, lawyers practicing before the High Court of Bombay in Mumbai, Maharashtra; CLPG, 'Case Study' (n 213) (N's pregnancy was terminated 5 weeks after her petition was filed).
- 325 CLPG, 'Case Study' (n 213).
- 326 *ibid*.
- 327 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra (Since the court orders do not mention the woman's name, if she approaches a hospital other than the one where her medical examination was conducted, verification of the woman's identity contributes to further delay)
- 328 CLPG, 'Case Study' (n 213).
- 329 CLPG, 'Case Study' (n 213).
- 330 *X v State of Maharashtra* WP 12054 of 2019 (Bom HC) (decided on 29 November 2019).
- 331 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra.
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- 340 *Sarmishtha Chakraborty v Union of India* (2018) 13 SCC 339. Referring to the Court's earlier judgment in *Suchita Srivastava v Chandigarh Administration* (2009) 9 SCC 1, the Supreme Court in this case noted that, "the right of a woman to have reproductive choice is an integral part of her personal liberty, as envisaged under Article 21 of the Constitution. She has a sacrosanct right to have her bodily integrity."
- 341 *ibid.*
- 342 Interview with AK, lawyer practicing before the High Court of Delhi.
- 343 *ibid.*

4 Consent and Documentation Requirements as Barriers to Abortion Services

The MTP Act and MTP Rules prescribe certain requirements around consent and documentation that are to be fulfilled by RMPs and medical facilities providing abortion services. Section 3(4)(b) of the MTP Act sets out the pregnant woman's consent as a precondition for an abortion. Where the pregnant woman is a minor or has a mental illness,³⁴⁴ consent of her guardian is also required.³⁴⁵ A guardian may be any person "having the care of such pregnant woman."³⁴⁶

The MTP Rules mandate that the consent of the woman, and her guardian, where applicable, be recorded in Form C prescribed under the Rules.³⁴⁷ Further, RMPs must certify their medical opinion and record their reason(s) for recommending termination, in Form I, within 3 hours of termination of the pregnancy.³⁴⁸

The MTP Rules also require registered facilities to maintain an "admissions register" as per Form III, under which the name and other particulars of the pregnant woman are recorded, along with a unique serial number.³⁴⁹ Thereafter, any reference to the woman in other documents maintained by the facility is to be made only using the assigned serial number.³⁵⁰ Further, the admission register is not open to inspection by anyone, except when authorised by law.³⁵¹

The consent form, opinion of the RMP and admission register are classified as "secret" documents and must be maintained in safe custody.³⁵² Additionally, the Medical Termination of Pregnancy Regulations, 2003 ("**MTP Regulations**") require registered facilities to send a monthly statement to the Chief Medical Officer of the State providing only numerical data of medical termination of pregnancies conducted at the facility, and the reasons for such termination, in Form II.³⁵³

Courts have in multiple judgments recognised a woman's autonomy with respect to sexual and reproductive health related decisions. In *Suchita Srivastava v. Chandigarh Administration*,³⁵⁴ the Supreme Court held that a woman's right to make "reproductive choices" is part of her right to personal liberty under Article 21 of the Constitution of India.³⁵⁵ The Court ruled that restrictions on reproductive autonomy violate the right to privacy, dignity and bodily integrity guaranteed under the Constitution of India.³⁵⁶

While interpreting Section 3(4)(a) of the MTP Act in the context of minor girls, the Madras High Court in *Marimuthu v. Inspector of Police*³⁵⁷ ruled that the requirement of a guardian's consent to conduct an abortion for a minor cannot be interpreted as dispensing with the consent of the minor herself.³⁵⁸ Affirming the right to autonomy and bodily integrity of minor girls, the Court stated that pregnancy cannot be terminated on a guardian's request against the wishes of the minor.³⁵⁹

The Supreme Court, in *Independent Thought v. Union of India*,³⁶⁰ has confirmed that the right to reproductive autonomy is inherent in all minor girls, irrespective of their marital status.³⁶¹

The position in *Suchita Srivastava* has been endorsed by a nine-judge Bench of the Supreme Court in *K.S. Puttaswamy v. Union of India*,³⁶² which declared the right to privacy a fundamental right. Significantly, the Court conceptualised privacy as an “essential facet” of an individual’s dignity, grounded in individual autonomy and the ability to control “vital aspects” of one’s life.³⁶³ The Court expressly stated that privacy at its “core” includes “the preservation of personal intimacies, the sanctity of family life, marriage, **procreation** [...]” (emphasis ours).³⁶⁴ Further, it recognised decisional autonomy and informational privacy as components of the right to privacy.

Despite existing statutory safeguards and judicial affirmation, the ability to exercise reproductive rights is curtailed through additional consent or documentation requirements, not envisaged under the Act. These include service providers asking women to obtain judicial authorisation for termination of pregnancies less than 20 weeks of gestation, insisting on spousal or parental approval, and requiring proof of identity or residence. These requirements are not mandated under the MTP Act or its Rules but may be guised as such. Further, data revealing reproductive health-seeking behaviour of women may be recorded or reported to authorities, in breach of their right to privacy and statutory guarantee of confidentiality. In this section, we discuss the barriers created by these additional requirements concerning consent, documentation, and reporting of MTP cases. The distinctive barriers faced by persons with disabilities have been discussed separately in the concluding part of this section.

I JUDICIAL AUTHORISATION FOR TERMINATION OF PREGNANCIES OF LESS THAN 20 WEEKS GESTATION

Section 3 (2) (b) of the MTP Act is unambiguous that pregnancies below 20 weeks of gestation can be terminated by a medical practitioner if conditions specified therein are satisfied. Consent of the woman remains paramount. A guardian’s consent is only required in cases where the abortion seeker is a minor or is “mentally ill,” as defined in the Act.³⁶⁵ High Courts have, on multiple occasions, emphasised that there is no requirement to obtain authorisation of any authority (other than the RMP), when pregnancies are terminated following Section 3 of the MTP Act.³⁶⁶

Yet, a significant share of cases where judicial authorisation was sought for termination of pregnancies involved, were under 20 weeks of gestation. A recent study revealed that 40 out of 173

cases filed before various High Courts seeking permission for termination of pregnancy between June 2016 and April 2019 involved pregnancies having a gestation period of under 20 weeks.³⁶⁷ Out of these 40 cases, 30 cases were filed by minors whose pregnancies resulted from rape. The remaining cases concerned adult victims of rape, and women carrying pregnancies with foetal anomalies.³⁶⁸

A ACCESS TO ABORTION SERVICES FOR ADULT VICTIMS OF RAPE

We found that often a woman seeking termination of pregnancy under 20-weeks approaches a court at the service provider's behest, since the service would not be provided otherwise. Take for instance, R's case.

R was an adult woman whose pregnancy was a result of rape. She had a severe developmental disability and was around 17-18 weeks pregnant when her family came to know of her pregnancy. Both R and her family wanted to terminate the pregnancy. However, service providers at a major government hospital in Chennai insisted on judicial authorisation to proceed with terminating her pregnancy. They asked for a "certificate" from a court. The lawyer who represented R before the Madras High Court recounted the service providers' response on the necessity of approaching the Court:

"[The doctors] said that, "there is no medical reason but we always want a judicial confirmation of some kind. In most of these cases, even if it is rape, later the families will do some kind of compromise – get victim married off to the perpetrator then they will come and ask us why did you abort. We will be answerable."

The doctors feared that they would be attacked or that someone else may question them for whatever reason.

We told them there is a clear consent form [...] [and that they] were not going to face any liability issue. But they are afraid of social pressure from families. They were just being risk-averse."³⁶⁹

Section 3 (2) (b) (ii) of the MTP Act presumes that rape causes "grave injury" to the mental health of the pregnant woman, and consequently permits termination on that ground. However, providers seek judicial authorisation prior to terminating a pregnancy out of a fear of backlash from the

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“Court order is required for sexual assault (minor or major). If they come directly without going to court, we will examine and admit the patient. We also give treatment... We do the required examinations, take the smears and give her the treatment... If she comes to us directly...we make it medico-legal case. We inform police – through police the process starts. Police gets the court order I think.”
- JG, government doctor in a tertiary care facility in Chennai.

pregnant woman's partner or family. They are also apprehensive of being dragged into criminal proceedings if the woman is a rape victim. A senior gynaecologist in Chennai stated that “a court order [was] required for all MTP cases where the pregnancy [was] an outcome of rape.”³⁷⁰ Judicial authorisation may also be insisted on in “special cases” such as those where the woman is “psychologically” unstable.³⁷¹

Notably, in R's case, the Court directed her to present an affidavit expressing her voluntariness and consent to undergo the abortion. The affidavit was in addition to a consent form filled by her and a letter issued by the hospital stating that R and her family had consented to the termination of pregnancy. According to her lawyer,

*“We got the affidavit. R was quite mentally agile and very clearly stated that she wanted termination. [...] But we were not seeking a discretionary order. We can interpret a medical certificate in particular ways, or law in any way, but in this case there was a consent form – it was an open and shut case.”*³⁷²

Although in such cases a permission for termination of pregnancy is usually granted,³⁷³ the extra-legal requirement of judicial authorisation, and the consequent delay in termination of a pregnancy, causes significant physical and mental agony to women. For rape victims, this prolongs the trauma of sexual violence.³⁷⁴ The lawyer noted that the process was traumatic for R and her family. They were not from Chennai but were forced to spend their limited resources for their stay in the city for the entire period when this legal battle was underway.

*“Ultimately, we got the Court order but the process itself was so traumatic for us also. It would have been even worse for the people concerned who are fairly poor, have limited resources, come away from their town to Chennai for this entire period, with no extended support system.”*³⁷⁵

Acknowledging the harm caused to women who are forced to undergo unnecessary court processes by medical establishments, High Courts have emphasised the need for handling these cases with sensitivity and urgency.³⁷⁶ In June 2019, the Madras High Court in **X v. State**³⁷⁷ issued a clear directive that in all cases of unwanted pregnancy, where the pregnancy does not exceed 20 weeks, termination should be carried out in accordance with Section 3 of the MTP Act. It categorically stated that a victim of rape should not be referred to a medical board or be forced to seek judicial authorisation. However, the practice continues despite the order.

B ACCESS TO ABORTION SERVICES FOR MINOR GIRLS

In the case of minors, third party authorisation is sometimes sought from the Child Welfare Committees (“CWC”) constituted under Section 27 of the Juvenile Justice (Care and Protection of Children) Act, 2015 (“JJ Act”).³⁷⁸ The reason, ostensibly, is the lack of clarity with respect to the role assigned to the CWC under the POCSO Act and the JJ Act.³⁷⁹ The case below illustrates this lack of clarity.

In 2018, the CWC in Gurgaon, Haryana issued a show-cause notice to service providers, who terminated the pregnancy of a minor girl without seeking prior approval from the CWC. The girl was around eight weeks pregnant at the time of termination. The pregnancy had been terminated with the consent of the girl and her guardian. However, the CWC contended that under the JJ Act such “decision can only be taken following magisterial orders [...] issued by the CWC.”³⁸⁰

The CWC’s role in the case of sexual abuse of children is limited only to cases where the child is “in need of care and protection” as defined in Section 2(14) of the JJ Act. In the context of sexual abuse, this is confined to a few situations. These are: first, where the child is residing with the abuser, and hence, needs to be placed in a childcare institution or a foster home or with a fit person/facility; second, where the child is living in a child care institution and is without parental support, and third, where the child is found to be without any home and parental support. In these situations, the CWC is required to determine whether the child needs to be taken out of the custody of its family or shared household and placed in a children’s home.³⁸¹ However, due to confusion regarding their role, CWCs intervene even in cases where the JJ Act does not envisage a role for them. In fact, Rule 6(7) of the Protection of Children from Sexual Offences (POCSO) Rules, 2020 (“POCSO Rules”) require the RMP to counsel the child and her parents about options available under the MTP Act. It clearly does not envisage the CWC’s intervention unless the situation falls within the circumstances mentioned in Rule 4(4) of the POCSO Rules, or if there is a conflict between the views of the child and the parent, and the child is in a child-care institution. The intervention of the CWC in such situations creates an extra-legal barrier for accessing sexual and reproductive health services, including abortion services.

II THIRD PARTY AUTHORISATION FROM FAMILY OR ACQUAINTANCES

Besides judicial authorisation, abortion service providers may seek consent from third-parties, such as from the family, or even acquaintances of the woman seeking abortion. Depending on her marital status, the woman's access to abortion services could even be contingent on spousal or parental consent.

We found that while most service providers were aware that a woman's consent (except in case of minors and women with mental illness) is sufficient for termination of pregnancy under the MTP Act, they still insisted on third-party authorisation to allay their fears and apprehensions which include:³⁸²

- a. The fear of implication or involvement in any legal proceedings;
- b. The fear of backlash (towards the provider or the woman herself) from the family for terminating the pregnancy without their consent;
- c. The concern that women may need assistance in case of any medical emergency.

A FEAR OF THE LEGAL PROCESS

Termination of pregnancy is considered a “legal issue” and the overarching fear of legal processes leads service providers to exercise extra caution in such cases.³⁸³ However, the legal issues anticipated by services providers vary depending on the marital status of the pregnant individual. A service provider in Pune succinctly described the concerns voiced by several providers across states regarding terminating pregnancies without spousal consent:³⁸⁴

“As a lady, you are empowered to go to a doctor and get your MTP done if you do not wish to continue [the pregnancy]... [The law does not require the doctor to take the consent of the husband]. If I [seek and take the husband's consent], it is actually contravening the Act. But then what happens is I do a MTP, the husband [is present, but] I do not take [his] consent. Later on, after 2-3 years they are into a divorce case and the husband implicates me for no reason. He says that my wife and the doctor were together and they conspired and they aborted my child.

Other way around, the woman can say that the husband and the doctor confided [sic] in each other and forcefully administered anaesthesia and got the MTP done. So, I get implicated in a criminal case. I will be saved in the Court but I have to pay for my lawyer and go there and come back again. Nobody takes that chance.”³⁸⁵

A private practitioner stated that Form C for recording consent under the MTP Act was inadequate, and therefore, at his facility women are required to give consent multiple times, in different ways, to build evidence for any legal proceeding that may arise in future. Further, the consent form of the facility records signatures of three other persons, besides the woman. This includes the doctor performing the termination of pregnancy, a relative and another witness, who is usually an employee of the hospital.

“How do I tell the court that she has signed there, she is an adult and she is educated or if she is not educated? [sic] So, we establish consent in six different ways:

- A) *She had [an appointment/visited the hospital].*
- B) *She gave blood for investigation [in preparation for a MTP].*
- C) *She went for an ultrasound, which was again [in preparation for a MTP].*
- D) *She [expressly consented to the procedure] in writing.*
- E) *Then she is usually [asked to go home] and will not [be given] the pills in the same sitting. We [ask her to return] the next day. [The purpose is that we can assert that] she went home and had the time to think about it.*
- F) *[When she returns the next day]... we again explain the procedure to [her, and ask her again] if [she] [wants to go ahead with the termination of the pregnancy]. [If she replies in the affirmative], we give [her] the first tablet. She takes the first tablet and [returns]... home.*
- G) *She [is asked to come back 48 hours later], [which is when she] takes rest of the tablets.*

So, these multiple visits ... and her consenting to ...investigations, and ultimately consenting to [the termination of pregnancy] in writing – all of this, I think, constitutes consent”³⁸⁶

Many service providers seek to avoid involvement in any legal proceedings, including divorce proceedings where they may be called to testify.³⁸⁷ In matrimonial cases, courts have held that termination of pregnancy without seeking spousal consent amounts to “cruelty” against the husband, constituting a ground for divorce under personal laws.³⁸⁸ However, a cause of action does not arise against doctors who terminate pregnancies of a woman, where her husband’s consent has not been taken. In fact, the Supreme Court dismissed an appeal filed by a husband against a High Court decision rejecting his claim for damages from his wife and her doctors on account of termination of his wife’s pregnancy without his consent.³⁸⁹ The Court stated that after hearing the counsel they were not inclined to entertain the appeals, which had questioned the correctness of

the decisions and reasoning of the High Court.³⁹⁰ The High Court in that case – *Dr. Mangla Dogra v. Anil Kumar Malhotra*,³⁹¹ reiterated that the MTP Act requires the doctor to obtain the consent of the woman before terminating her pregnancy, and not of her spouse. Hence, the husband did not have a cause of action against the doctors who terminated his wife’s pregnancy without his consent.³⁹² However, despite this legal position, doctors fear being dragged through the legal process even if they are ultimately victorious.

The fear of legal processes can often be greater in the case of unmarried women. This is because many service providers consider sexual activity and pregnancy outside of marriage as not only morally wrong, but also illegal.³⁹³ Medical jurisprudence textbooks, commonly used in medical education in India and as reference material by practicing doctors, contain patently wrong statements about the law, grounded in patriarchal assumptions about women’s sexual and reproductive behaviour, which are then imbibed by medical students and colour their approach to abortion services. These textbooks reinforce abortion stigma and the common perception amongst service providers that terminating the pregnancy of an unmarried woman amounts to “criminal abortion.”³⁹⁴ Take a look at a few examples.

“Criminal miscarriage or abortion is common in India as in other countries. It is resorted to mostly by widows, and in a very few instances by single women to get rid of the products of conception from illicit intercourse. Sometimes, it is resorted to by married women to avoid additions to their families, but this is not so common in India as in Western countries”: Jaising P. Modi, *A Textbook of Medical Jurisprudence and Toxicology* (1st edn, 1920)³⁹⁵

“In India, abortion was believed to be resorted to mostly by widows [...] and in a few instances, by unmarried women to get rid of the product of conception from pre-marital sex. It is sometimes practiced by married women, to limit the size of their families. [...]”: K Kannan (ed), *Modi: A Textbook of Medical Jurisprudence and Toxicology* (26th edn, 2018).³⁹⁶

“In India, criminal abortion is resorted to mostly by widows who are prevented from remarriage by social customs, by unmarried girls who have pregnant from illicit intercourse, or when family honour is at stake”: BV Subrahmanyam (ed), *Parikh’s Textbook of Medical Jurisprudence, Forensic Medicine and Toxicology* (2014).³⁹⁷

“[Unjustifiable/criminal abortion] is abortion induced in defiance of the MTP Act. Resorted to mostly by widows and unmarried women”: Krishan Vij, *Textbook of Forensic Medicine and*

It is not surprising then that several service providers ranging from RMPs to ANMs, nurses, etc, across states used the term “illegal pregnancy” and “criminal abortion” in the context of access to abortion services by unmarried women.³⁹⁹ This highlights the need for audit of health care education and training to rid the curriculum of gender biases and to inculcate a rights-oriented understanding of the health care needs of pregnant persons.

A related but distinct concern of providers is the fear of interacting with the criminal justice system, should the unmarried woman allege rape against her partner in the future.⁴⁰⁰ As a result, in some private facilities in Chaibasa, Jharkhand, unmarried women, irrespective of their age, cannot access abortion services unless accompanied by their parents.⁴⁰¹

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“If she does not want to tell her parents, in that condition, we [say] no [to providing her abortion services].”
- EQ, Manager of a private nursing home in West Singhbhum District, Jharkhand.

While explaining the reasons behind this requirement, one of the service providers shared his experience during police investigation in a rape case filed by a woman who had undergone abortion at their clinic:

“About 6-7 years ago, B, an adult woman, approached us seeking abortion. She was about 6 weeks pregnant. She came with her boyfriend. We took the names and signature of both. Initially, she said she was married but then after a lot of questioning, she said that she was about to get married. Around 2 years later, when her boyfriend refused to marry her, she filed a case against him. She also said that she had a MTP and therefore, we (myself and the gynaecologist) [came into the picture].

We were asked if we [performed] the MTP ... We said [that] we did not remember. The police searched our register. The police assumed that it was an illegal case and therefore, we must not have recorded it. Our gynaecologist refuted the assumption... We [ultimately] found the reports. The police said the girl [was] unmarried [and asked for her] parents’ statement. We said she told us he was her husband. [We told the police that we do not do MTPs for] unmarried [women].”⁴⁰²

Fear of backlash from the spouse or other family members of the woman seeking abortion leads providers to insist on spousal consent before agreeing to provide an abortion.⁴⁰³ A youth leader in rural Jharkhand shared Y’s experience in accessing abortion services, which illustrates the manner in which the fear of backlash translates into providers requiring a third-party to “take responsibility of the act [MTP]:”⁴⁰⁴

“Y, a young woman from a village in [redacted] district, approached the village sahiya (ASHA worker) and [me], saying that she wanted to terminate her pregnancy. She was about 3 months [pregnant] and as opinion of two RMPs is required for abortion in the second trimester, we approached the District Hospital. At the District Hospital, the doctor refused to provide abortion stating that Y was unmarried. Actually, Y was married and she was at her mother’s home. She had come to the hospital with her mother. She did not want the child. But the doctor thought that it was an unmarried case (sic). Her mother got her back again and told the doctor that she was married.

The doctor then said, “If I do the abortion today, tomorrow her husband will come to me and say how did you abort my child.” The doctor asked Y and her mother to bring the husband. In the counselling session, Y was threatened and told that abortion could pose risk to [her] life as she was young. She was advised to keep the child and later give it up for adoption.

The Sahiya knew [that the District Hospital would seek spousal consent] so they had first approached a private clinic. However, the private clinic demanded Rs. 14,000-15,000 for abortion.

With the intervention of a civil society organisation and the Civil Surgeon, Y was able to get the abortion, albeit a month after she had first approached the district hospital.”⁴⁰⁵

Where there is a difference of opinion between the spouses on whether they want an abortion, providers may either push them to resolve the matter between themselves, or outrightly deny abortion.⁴⁰⁶

“We take consent of both the husband and wife. If the wife says ‘No, my husband is not here and I have got problems with my husband’, I say ‘Thank you very much. I do not do it’.”
- HE, doctor at a private hospital in Pune, Maharashtra.

B ASSISTANCE IN CASE OF MEDICAL EMERGENCIES

A few service providers told us that the presence and consent of another adult was necessary to take care or take responsibility for the woman in case of emergencies, in particular for surgical abortion involving administration of anaesthesia.⁴⁰⁷ However, one service provider insisted on third-party consent for both medical and surgical abortion, and reasoned as follows:⁴⁰⁸

“We need somebody to sign for her. She has to get at least her friend or someone who is above 18. It is required even if just pills are being prescribed. Consent requires [sic] that the woman and somebody [who would be there] to help her both must sign.

In case she is bleeding a lot, someone has to get her back to me. She might not be in a state to come back. So, we ask someone above 18 and sensible to sign, for her safety more than anyone else's. It is only her decision, not influenced by anyone else like mother or in-laws.”⁴⁰⁹

C ADDITIONAL DOCUMENTATION

The MTP Act does not place the responsibility on service providers to confirm the identity of the person seeking an abortion before performing one. It also does not require them to seek or collect any kind of documentary proof of identity. However, many providers exercise extra caution and seek proof of identity not only from the woman seeking abortion, but also from third parties who consent to the procedure. In some cases, women seeking abortion are asked to produce documentary proof of their relationship with these third parties, usually their spouses or parent(s). A private service provider in Pune explained the reason behind this practice:

“If there is a case later, how will I remember? If somebody insists that “why are [you] taking my photo ID”, I say do not do the MTP with me. I have that right of refusing you.”⁴¹⁰

At a government hospital in Mumbai, the senior-most gynaecologist explained the practice of seeking identity proof and its underlying reason:

“I prefer to ask for an Aadhar card, for any operation or admission. Because when I go to a hotel, they ask me for a voter ID or Aadhar card. Why should not I ask? Everybody is now registered with an Aadhar card.⁴¹¹ I ask them for an Aadhar card even though the MTP Act does not mention anything like this.

...

I don't want to be in any problem. If you say you are married, then show me your marriage certificate. [...] It is not asking something, but I am not trying to make it tough for them but doing my duty.”⁴¹²

At a maternity hospital we visited, the signage at the registration window of the hospital read as follows:

- “1. Pregnant women should get their and their husbands [sic] Aadhar Card or any other ID proof.*
- 2. A joint photograph of both of them in which their name is also written.
- By order of Medical Superintendent”*

A service provider at this hospital explained that this requirement made it easier to “trace [the husbands],” citing cases where husbands may abandon their spouses after childbirth. However, as this is a general requirement for all pregnant women seeking medical services at the hospital, those registering for abortion services would also have to comply.

A private service provider in Pune said that they retain the photo ID and signature of the “boyfriend” in order to prevent him from fleeing. The provider admitted that the consent of the woman’s partner was not “legally valid,” but that it was still obtained for the woman’s “own protection”.⁴¹³

“Then if something goes wrong or if there is any complication or if [we] want to ask [the relative to get medicine or give consent, we have no one. That’s the reason why I take his [boyfriend’s] photo ID and his signature so that he’ll never run away. I want somebody to take care of the girl.”⁴¹⁴

At one of the major private facilities providing abortion services in Chaibasa, Jharkhand, unmarried women seeking abortion are required to produce their Aadhaar card, as well as that of both their parents. Signatures of all three persons are obtained, or a declaration form is signed, before any abortion service is provided.⁴¹⁵ The rationale was explained to us thus:

“Suppose a girl comes and says this person is my mother or brother, how do we prove [sic] the brother or the mother? First, she should give some identity proof that she is her mother...”⁴¹⁶

Another service provider in Chaibasa followed a similar practice, and often refused to provide abortion services to unmarried persons where it was difficult to obtain their “correct address proof.”⁴¹⁷

D HARM CAUSED BY ADDITIONAL REQUIREMENTS: T’S CASE

Unnecessary and additional consent and documentation requirements which are couched in the language of the law or justified on health grounds negate the constitutional guarantee of right to life and personal liberty. Denial of individual autonomy with respect to bodily decisions undermines the constitutionally guaranteed right to dignity and privacy. The onerous nature of these requirements and lack of confidentiality in availing abortion services at registered facilities may force people to undergo unsafe, or less safe, abortion procedures.

Moreover, these requirements disproportionately affect those without familial support or without any documentary proof of their identity and relationship to their spouses or other family members. T's experience of accessing abortion services at a government hospital in Mumbai, narrated by her support persons, provides a glimpse into the challenges that people in a similar situation may encounter:

“T, an adult woman, had run away from home. When we [civil society organisation working with destitute women in Mumbai] came in touch with T, she was pregnant and wanted an abortion. She did not have any documents with her.

At first, she had approached the hospital herself, however, they did not [comply with her request].

When I went with her, they said that the pregnancy was around 4 months and it could not be aborted. I asked them, “Why not?,” because according to the law they should. They replied that because there were no documents, and no one to sign the papers...The doctors said that someone from T's family should sign. [According to the doctor, we] as an organisation could not sign.

I explained to them that she had left her home and there was a problem in the family and we could not contact the family. Besides, T was very clear that she wanted an abortion and she had clearly stated how old she was and was consenting [to the abortion]. But they refused.

This has not happened once; it has happened several times with us now.”⁴¹⁸



REPORTING REQUIREMENTS AND TRACKING REPRODUCTIVE HEALTH SEEKING BEHAVIOUR

The MTP Rules and MTP Regulations set out certain record-keeping and reporting obligations for RMPs and facilities providing abortion services. Service providers are required to maintain an admission register recording the distinct serial number assigned to the pregnant woman, consent form for termination of pregnancy, and the certified medical opinion of the RMP(s). These records are confidential and are required to be maintained in safe custody in the manner prescribed in the MTP Regulations.

Registered facilities are required to provide a quantitative assessment (in Form II) of the MTPs conducted and the reasons thereof, to the Chief Medical Officer of the State.⁴¹⁹

In practice, however, service providers may maintain additional records containing identifying details of the pregnant woman and the abortion service provided either on their own or pursuant to a government order or directive directing them to do so. Further besides the mandatory reporting obligation in cases of rape or sexual assault,⁴²⁰ service providers may also report other MTP cases to the police or government authorities; for instance, cases where the pregnant woman is an unmarried adult, or cases of spontaneous abortion or second-trimester abortions.⁴²¹

The objective behind such additional record-keeping and reporting appears to be two-fold. First, as discussed above, to build evidence to exonerate the service provider of any liability in any legal proceeding that may arise in future. Second, to aid the government authorities in tracking sex-selective abortion, through compliance of orders or directives issued in this regard.

The gynaecology department at a major government hospital maintains a few other registers, including an “unmarried register,” in addition to the admission register (or “regular MTP register”).⁴²² The “unmarried register” is meant for cases where the woman seeking abortion services is unmarried.⁴²³ Amongst other details, it records the “case history” as narrated by the woman to the resident staff.

“There are unmarried woman or minors who are quite adamant and refuse to give reasons or even the history or how the pregnancy came about. In such cases we interrogate them for over hours, or even four days (in one particular case) before they start revealing what the actual case is. Even in that case, if the woman’s story appears unreliable, we make a mention to that effect in the police intimation. Then it is up to the police. Our job is done once we finish recording the whatever it is.”⁴²⁴

Police are informed irrespective of the woman’s age and even in the case of adult women.⁴²⁵

“We intimate the police. Once the police come[s], if the girl does not want to register a formal complaint – [which] in my experience [is] quite often – then the police does not register a complaint. They record the reasons for not registering the complaint so that later the girl does not come back [for DNA samples of abortus] to prove paternity. We make her sign all documents stating that she is undergoing the procedure out of own free will.”⁴²⁶

In Mumbai, a medical officer at a major government hospital stated that an EPR⁴²⁷ is made in cases where they suspect “foul play.” Examples cited included:

“...where there is no husband or [...] female patient says I was physically assaulted and we suspect foul play...If a couple comes down, married in legal way, an EPR is not made.

Yes, [in case of] unmarried. Unmarried is illegal, right? It is illegal...”⁴²⁸

In T’s case discussed earlier in this chapter,⁴²⁹ the service providers at the government hospital reported the case to the police, who recorded her statement. The overriding concern of the service providers, according to T’s support person, was fear of prosecution under the PCPNDT Act for sex-determination, in case the aborted foetus was female.

“I went to the hospital again; this time having read the MTP Act. I told the doctor that I knew it was legal to get the abortion. Even after this T was made to record her statement before the police, before the abortion was conducted.

[After the abortion]

Not just one case, in all cases... You don’t want to see it [abortus] but they insist saying “No no, you have to see it and then sign.”

They talk in such a bad way. They even lift up its leg to show whether it is a boy or a girl.”⁴³⁰

A senior gynaecologist at this government hospital stated that the only instance in which the police is not informed or involved where the woman seeking abortion is unmarried, is if she is an adult and is accompanied by another person over the age of 18.⁴³¹ In all other cases of unmarried women seeking abortion services,⁴³² a police intimation is sent as a matter of course. Note that none of this is mandated by the law, and is a practice that the hospital seems to have evolved since they believe that informing the police will save them from legal liability.

A police officer stationed at the same hospital explained the role that the police played. The officer said that a FIR is registered in case of pregnancy resulting from rape or involving minors. Additionally, the police record the statement of the doctor, and the minor “husband and wife” stating that they understand what the doctor is saying and have decided to undergo abortion.

“There is no format (for the FIR). It is basically a report that the doctor remains protected and satisfaction of the fact that the [couple seeking abortion services] have completely understood.”⁴³³

A REPORTING CASES OF INCOMPLETE ABORTION OR SPONTANEOUS ABORTION

In Maharashtra, senior gynaecologists at two major government hospitals stated that a police intimation (what they referred to as the EPR or “medico-legal case”) is also made in cases where a woman approaches the facility for removal of retained products of conception, following an incomplete induced abortion or spontaneous miscarriage.

“They are bleeding, and inside they have retained products of conception, which means she has attempted it. So, we have to subject them to curettage again. But before that we have to inform police by doing EPR, saying that [the woman is] in such state. EPR has to be done regardless of her status (age or marital status). [The woman has come] bleeding, and we do not know who [terminated the pregnancy] for her. That is the police’s look out. [Since the] [a]bortifacients [were not administered in the hospital] EPR [needs] to be done.”⁴³⁴

While it is not possible to distinguish a spontaneous miscarriage from an induced abortion, the service providers rely on the history narrated by the woman to make such assessment.⁴³⁵ A private practitioner in Pune remarked that while a “miscarriage” does not require reporting, off late all cases where dilation and curettage (D&C) is done, service providers inform the civil surgeon:

“If it has come from a proper place – which was recognised or she was given tablets by a recognised doctor, then she has been already reported as an MTP case – for me, it is a case of incomplete abortion and I manage it accordingly. If not then – again there is a legal issue... Whether I am supposed to inform and whom to inform in such cases – the law is silent on this, there are no guidelines. At the moment of time, we inform the authority (Pune Municipal Corporation). Not everybody does that. Those who do not do, does not mean they are doing anything wrong.”⁴³⁶

Notably, in Delhi, an order to the same effect was issued by the Special Protection Officer, PCPNDT in 2015⁴³⁷ requiring that “all D&C” cases should be “reported and documented” in a register called the “D&C Register.” This register records the name of the woman, the MCTS (Mother and Child Tracking System) number,⁴³⁸ her address, indication of D&C performed and whether any drugs had

been taken orally to terminate the pregnancy.

B REGISTRATION REQUIREMENTS AND CONFIDENTIALITY CONCERNS

The registration requirements put in place for providing reproductive health care services and maternity benefits under government schemes, or the requirement for presenting identity proof with the abortion seeker's address (or relative's address) for diagnostic tests⁴³⁹ are geared towards preventing sex selective abortions.⁴⁴⁰

Like the MCTS, Tamil Nadu maintains a register/database called Pregnancy and Infant Cohort Monitoring and Evaluation (PICME) to facilitate and monitor delivery of pre-natal and post-natal care to pregnant women, as well maternity benefits under various government schemes.⁴⁴¹ PICME registration has been made mandatory for obtaining the birth certificate of the new-born child.

The Hindu, a leading national daily reported a recent case in Tamil Nadu, where using the mobile number provided by a woman for PICME registration, the authorities in Tamil Nadu obtained the call records of the woman, which led to them tracing a case of “illegal abortion.”⁴⁴² The woman missed a pre-natal check-up (at around 8 weeks of pregnancy), and the software sent an alert. When the village nurse visited her, as is the protocol, it was found that the woman had undergone an abortion, because of which the authorities began to investigate the case.

“The medical officer reported the incident to us, and we decided to use the details of her ante-natal registration to find out what had happened [...] We decided to trace her call records.”⁴⁴³

These reporting and registration requirements run counter to the guarantee of confidentiality under the MTP Act, severely undermining the fundamental right to privacy, in denying decisional autonomy and informational privacy to persons seeking abortion. Surveillance through tracking systems, linked with Aadhaar, acts as “a technique of power and method of social control” over women's bodies and their reproductive choices.⁴⁴⁴ Further, seeking Aadhaar or any other identify proof acts as a barrier where women do not possess either of them.

While the pressing concern of the authorities may be to track sex-selective abortion, “social surveillance” of this nature, coupled with the stigma associated with abortion pushes women away from safe and legal abortion services.⁴⁴⁵

“Disability” under the Rights of Persons with Disabilities Act, 2016 (“RPWD Act”) is understood as a “long-term physical, mental, intellectual or sensory impairment” which, in interaction with barriers, restricts a person’s “full and effective participation in the society equally with others.”⁴⁴⁶ The term “barrier” is defined broadly as any factor which prevents such participation in any manner, and includes “communicational, cultural, economic, environmental, institutional, political, social, attitudinal or structural factors.”⁴⁴⁷

The RPWD Act affirms the equal right to life with dignity of persons with disabilities and recognises their individual autonomy and independence.⁴⁴⁸ It is based on the principles of equality and non-discrimination and places the responsibility on the government to ensure reasonable accommodation of persons with disabilities.⁴⁴⁹

In the sphere of healthcare, the RPWD Act requires the government to ensure barrier-free access to all healthcare for persons with disabilities, and in particular, promote sexual and reproductive health of women with disabilities.⁴⁵⁰ The reproductive rights of persons with disabilities entitle them to have access to information regarding “reproductive and family planning.” Further, any “medical procedure that leads to infertility” can only be conducted with the “free and informed consent” of the person with disability.⁴⁵¹

Section 92 (f) of the RPWD Act criminalises termination of the pregnancy of a woman with disabilities without her express consent, except in cases where the woman has severe disability, in which case the pregnancy can be terminated with the consent of her guardian.⁴⁵² The section prescribes a minimum imprisonment of six months for terminating a pregnancy without “express consent,” and a maximum punishment of five years coupled with fine.

The Parliamentary Standing Committee on the RPWD Bill, 2014 recommended reframing of the clause (what is now Section 92(f)) to include obtaining the consent of women with “severe disabilities” as well, before her pregnancy is terminated. The Committee noted that taking away the woman’s right to consent undermines her dignity. Responding to this recommendation, the Ministry of Women and Child Development stated that the proposed clause contemplated a situation where a woman might “not be in a position” to consent, and termination of pregnancy would be necessary to save her life.⁴⁵³ Hence, it was ultimately retained and enacted into law.

The RPWD Act does not define “severe disability.” However, the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (“National Trust Act”) defines “severe disability” as “disability with eighty per cent or more” of one or more disabilities.⁴⁵⁴

A ACCESS TO ABORTION SERVICES

The experiences of persons with disabilities in accessing sexual and reproductive healthcare in general are invisible. A 2018 working paper highlights the lack of statistical data on women with disabilities accessing abortion services.⁴⁵⁵

Amba Salelkar, a lawyer and disability rights activist, identifies two distinct barriers faced by women with disabilities in accessing reproductive health services:

“One is access to reproductive services. Second is that we have to deal with restrictions on our reproductive rights against our will.”⁴⁵⁶

Ms. Salelkar noted that many speculate that for women with disabilities “abortion may be easily obtainable,” given the stigmas associated with disability and dominant social construction of motherhood.⁴⁵⁷

“...standards of understanding issues relating to motherhood or being a ‘fit parent’ are much higher [for women with disabilities].”⁴⁵⁸

However, women with disabilities face additional barriers in accessing abortion services. The issue of access includes both physical access as well as informational access. Medical facilities, diagnostic or scan equipment, and even medication, may be inaccessible for women with disabilities, depending on the nature of disability. For instance, women with visual impairment face difficulties in accessing urine pregnancy tests, emergency contraception, and abortion pills as braille signage is not available on these medication/test kits.⁴⁵⁹ Most public healthcare facilities are ill-equipped and lack resources to communicate information on “reproductive and family planning” to the diversity of persons with disabilities.

The inaccessibility of the medical system means that women with disabilities are constrained to bring a support person of their own, who in most cases, is a family member. This takes away their privacy and prevents them from seeking services confidentially.⁴⁶⁰ Ms. Salelkar noted:

“...confidentiality, safe spaces, ease of access are all no goes for women with disabilities because they are expected to bring their own support system [along with them].”⁴⁶¹

Further, the presence of an attendant often results in dismissal or disregard of the autonomy of the women with disabilities to make decisions about their own reproductive health. The routine infantilisation of women with disabilities and societal perceptions around their decision-making capacity results in a failure to recognise them as autonomous individuals.

“...Then the doctor speaks to the [attendant], and not to [the woman with disabilities] This is similar to paediatricians talking to parents and not the child.”⁴⁶²

Therefore, despite recognition of their autonomy in decisions pertaining to their sexual and reproductive health, and express prohibition of sterilisation without their “free and informed” consent under the RPWD Act, women with disabilities are subjected to forced sterilisation and non-consensual birth control. They are denied exposure to necessary information and resources required for decision-making.⁴⁶³

B

CONSENT OF WOMEN WITH MENTAL ILLNESS

In the case of women with mental or intellectual disabilities, the issue of consent becomes far more complex. Section 3(4) (a) of the MTP Act requires a guardian’s consent for terminating the pregnancy of a woman with a mental illness.⁴⁶⁴ A woman is considered “mentally ill” if she is in need of treatment for any mental disorder except “mental retardation.”

In *Suchita Srivastava v. Chandigarh Administration*,⁴⁶⁵ the Supreme Court recognised the personal autonomy of women with “mental retardation,” to make decisions with respect to continuation or termination of pregnancy.⁴⁶⁶ It observed that the MTP Act intended to treat women with “mental retardation” differently from women with mental illness, and therefore, a guardian could not make the decision or provide consent for termination of pregnancy of women with mental retardation.⁴⁶⁷

As the MTP Act does not define “mental retardation,” the Court drew upon the National Trust Act, 1999 and Persons with Disabilities Act, 1995 (now repealed),⁴⁶⁸ which defined it as “a condition of arrested or incomplete development of mind of a person which is specially characterised by sub-normality of intelligence.”⁴⁶⁹

Under the RPWD Act, “mental retardation” is replaced by the term “intellectual disability.”⁴⁷⁰ Mental illness excludes intellectual disability and is understood as a “substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life.”⁴⁷¹

More recently, following *Suchita Srivastava*, in *Z v. State of Bihar*,⁴⁷² the Supreme Court upheld the personal autonomy of a woman with “mild mental retardation” to undergo an abortion, and directed the State authorities, who had insisted on a guardian’s consent, to compensate her for negligence in discharging their statutory function.⁴⁷³

It is pertinent to note that while mental illness and intellectual disability may operate differently under the MTP Act, the rights and entitlements under the RPWD Act 2016 are the same for persons with either form of disability. Even in practice, as was the case in *Suchita Srivastava* and in *Z*, the distinction between mental illness and intellectual disability is often blurred, leading to restrictions on decisional autonomy of women in all cases. Moreover, in some instances, in addition to guardian’s consent, service providers also seek the consent of a psychiatrist or even the Court. For example, most senior gynaecologists practising in government hospitals in Chennai stated that “consent of the psychiatrist”⁴⁷⁴ or “psychiatric opinion”⁴⁷⁵ is obtained in cases of “[women with] mental retardation or [who are] mentally sub-normal [sic].”⁴⁷⁶ This is despite the MTP Act and judicial decisions clearly stating that consent requirements for women with intellectual disabilities are the same as that of other women prescribed under Section 3 of the MTP Act.⁴⁷⁷ While, at one hospital, women were required to approach the district mental health co-ordination committees for consent,⁴⁷⁸ in another, they were asked to obtain a court order in addition to a psychiatrist’s opinion.⁴⁷⁹

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“Mental retardation or mentally subnormal women (sic) have been brought... We have to get their consent from the psychiatrist where they have to go to the board and get it approved.”
- IG, public health consultant and former government doctor, Tamil Nadu.

The justifications for seeking additional consent, outside the requirement under the MTP Act, vary. A service provider reasoned that a psychiatrist’s opinion was necessary to determine the woman’s “fitness” to undergo the procedure for termination of pregnancy.⁴⁸⁰ Infantilisation of persons with intellectual disability, and rejection of their capacity and autonomy to engage in sexual activity and exercise their sexual and reproductive health rights is ostensibly the reason for providers’ insistence on an order from a court. For instance, service providers at a government hospital which insists on obtaining a psychiatrist’s opinion, explained their position as follows:

“...[T]he procedure is the same but they cannot give consent. Their case is similar to that of a minor. Mother will give consent. Pregnancy in such cases may also happen due to social causes. So, we get

psychiatrist's opinion and proceed with court order...In such cases, we always got the court order and waited.”⁴⁸¹

A service provider in Mumbai pointed that consent to sexual relationships in the case of “mentally challenged” women was a “tricky” issue, and when in doubt, a police intimation is made to highlight possibility of rape.⁴⁸²

“[...] There is no way a rightful consent would be obtained from a mentally challenged individual to have consensual sexual relationship. Depends upon how much is the disability of course, but it would really be very difficult. Then whether it gets categorised as sexual assault or not, is something of a grey area. It is a hugely grey area.

There we take help of psychiatrist. We usually check [the individual's] IQ level, which they have most probably done in the past. If it comes as sub-normal (sic), then as a precautionary measure I have done a police information report in one case that such and such individual has come for abortion [...] and we have doubts over the legality of the consent which has been given for sexual relationship. Then it becomes rape. I have done that. Unfortunately, the patient also absconded and police never gave a follow up and I have no right to ask for a follow up.

It is highly confidential when you communicate such things because the person who comes for abortion – you are not supposed to reveal it to anybody, including the police.”

The distinction between mental illness and intellectual disability under the MTP Act fails to appreciate the diversity of human existence,⁴⁸³ or to recognise the reproductive autonomy and right to privacy, dignity, and bodily integrity of individuals with mental illness as being at par with others. It also runs counter to the scheme of the RPWD Act and the Mental Healthcare Act, 2017, both of which were enacted to fulfil India's obligations under the UN Convention on Rights of Persons with Disabilities (2006) (“CRPD”).⁴⁸⁴ Under the CRPD, disability is understood as an evolving concept,⁴⁸⁵ however all persons with disabilities are recognised to have the inherent legal capacity to make decisions on an equal basis with others, and to have the right to support to make those decisions.⁴⁸⁶ It vests in all persons with disabilities the personal liberty to decide the number and spacing of their children..⁴⁸⁷

The Mental Healthcare Act expressly recognises the capacity of persons with mental illness to make decisions with respect to their mental healthcare or treatment, with support of their

nominated representative where required.⁴⁸⁸ It gives all persons the right to be provided with adequate information on any mental illness diagnosis, as well as any proposed treatment, in a language and form that the person understands, in order to enable them to provide informed consent to the same.⁴⁸⁹ A determination of mental illness or a decision taken by a person with mental illness that is perceived by others as “inappropriate or wrong” does not imply that the person lacks capacity.⁴⁹⁰ A person with mental illness is said to have capacity if they understand the information relevant for decision making, appreciate the reasonably foreseeable outcomes of the decision, and are able to communicate their decision in any manner (speech, expression or gesture).⁴⁹¹

It should be noted that the Mental Healthcare Act calls upon the government to integrate “mental health services into the general healthcare services.”⁴⁹² It categorically states that persons with mental illness should be treated as equal to persons with physical illness in the provision of all healthcare. It further adds that any other healthcare services that are provided to persons with physical illness shall be provided to persons with mental illness in the “same manner, extent and quality.”⁴⁹³

NOTES FOR CHAPTER 4

- 344 MTP Act, s 2(b) (A mentally ill person is defined as “a person who is in need of treatment by reason of any mental disorder other than mental retardation”).
- 345 MTP Act, s 3(4)(a).
- 346 MTP Act, s 2 (a).
- 347 Medical Termination of Pregnancy Rules, 2003 (“MTP Rules”), r 9.
- 348 Medical Termination of Pregnancy Regulations, 2003 (MTP Regulations), reg 3; MTP Act, s 3.
- 349 MTP Regulations, reg 5.
- 350 MTP Regulations, reg 7 (“[N]o entry shall be made in any case-sheet, operation theatre register, follow-up card or any other document or register other than the Admission Register maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference to the pregnant woman shall be made therein by the serial number assigned to the woman in the Admission Register”).
- 351 MTP Regulations, regs 5 and 6.
- 352 MTP Regulations, regs 4, 5, and 6.
- 353 MTP Regulations, reg 4 (5) and Form II, para 6.
- 354 (2009) 9 SCC 1.
- 355 *ibid*, para 22.
- 356 *ibid*.
- 357 2016 SCC OnLine Mad 10175
- 358 *ibid*, paras 39–40.
- 359 POCSO Act, s 41 states that “[t]he provisions of Sections 3 to 13 (both inclusive) shall not apply in case of medical examination or medical treatment of a child when such medical examination or medical treatment is undertaken with the consent of his parents or guardian”. The section is unclear as to whether the child’s consent is required for such medical examination or treatment in addition to the guardian’s consent. However, in light of the rulings in *Marimuthu and Independent Thought*, *vis-à-vis* right to bodily integrity of minor girls, it is arguable that consent of the child in such case would be indispensable. See Report submitted by Dr Aparna Chandra, Amicus Curiae on behalf of the Committee constituted by Delhi High Court through order dated 31 July 2018 in WP(C) 6371/2018 and 6514/2018, 44–45.
- 360 (2017) 10 SCC 800.
- 361 *ibid*, 838–840.
- 362 (2017) 10 SCC 1.
- 363 *ibid*, 509.
- 364 *ibid*.
- 365 MTP Act, s 3(4)(a).
- 366 *Bashir Khan v State of Punjab* AIR 2014 P&H 149; *Kamla Devi v State of Haryana* CWP 2007 of 2015 (P&H HC) (Order dated 9 February 2015); *X v State* Crl OP 14506 of 2019 and Crl MP 7043 of 2015 (Mad HC) (Order dated 19 June 2019).
- 367 *Pratigya Campaign* (n 148) 17; Judicial authorisation in post-20 weeks cases is discussed in Chapter 2 of the report.
- 368 *ibid* (Out of these, 3 cases involved adult rape victims and 7 were concerned with foetal anomalies).
- 369 Interview with LM, lawyer practicing before the High Court of Madras at Chennai, Tamil Nadu.
- 370 Interview with JG, government doctor at a tertiary care facility in Chennai, Tamil Nadu.
- 371 Interviews with JC and JD, government doctors at a tertiary care centre in Chennai, Tamil Nadu; interview with KY, government doctor at a tertiary care centre in Tamil Nadu (KY stated that judicial authorisation is required in cases which are very “sensitive”, such as cases of rape or sexual assault, or where the woman is unmarried. Further, KY added that “if the patient is very hesitant, [they] ask [her] to get a court order, as that is safer for them.”).
- 372 Interview with LM, lawyer practicing before the High Court of Madras at Chennai, Tamil Nadu.
- 373 Interview with JC, government doctor at a tertiary care centre in Chennai, Tamil Nadu (“Generally, the court permits if [the pregnancy is] within the gestational age that is legal”); *Pratigya Campaign* (n 148) 17 (noting that in all cases involving pregnancies below 20 weeks of gestation, the High Courts granted the permission of termination of pregnancy).
- 374 Interview with LM, lawyer practicing before the High Court of Madras at Chennai, Tamil Nadu.
- 375 *ibid*.
- 376 *Bashir Khan v State of Punjab* AIR 2014 P&H 149; *Kamla Devi v State of Haryana* CWP 2007 of 2015 (P&H HC) (Order dated 9 February 2015).
- 377 Crl. OP No. 14506 of 2019 and Crl. M.P. No. 7043 of 2019 (Mad HC) (Order dated 19 June 2019).
- 378 Interview with AY, resident at government tertiary care hospital in Delhi (At the public hospital where AY worked, a letter of authorisation from CWC was required for termination of pregnancy in case of minors).
- 379 Interview with Vidya Reddy, TULIR – Centre for the Prevention and Healing of Child Sexual Abuse, Chennai, Tamil Nadu.
- 380 See Chetna Choudhry, ‘Abortion without CWC Nod, Doctors Face Probe’ (3 June 2018, *The Times of India*) <<https://timesofindia.indiatimes.com/city/gurgaon/abortion-without-cwc-nod-docs-face-probe/articleshow/64432729.cms>> accessed 10 July 2021.
- 381 POCSO Rules, r 4(4).
- 382 Interview with DU, a youth leader working with IPAS in Chaibasa, West Singhbhum district, Jharkhand; interview with AR, government doctor at a hospital in Delhi (AR informed us that the husband’s signature was required in the Form for MTP in use at the concerned hospital. However, the Form produced by AR was identical to Form C under the MTP Rules and only required the signature of the woman seeking MTP. Responding to our follow up questions, AR confirmed that husband’s signature was also obtained, however, there were also cases where women came alone for abortion).
- 383 Interview with GD, government doctor at a tertiary care facility in Mumbai, Maharashtra. See also interview with EO, doctor at a private nursing home in West Singhbhum district, Jharkhand.
- 384 Interview with AQ, government doctor at a hospital in Delhi; interview with AU, government doctor at a tertiary health care facility in Delhi. (At the public hospital where AU worked, written consent for abortion was also obtained from the husband. For ease of purpose, the hospital used ink-stamps of the statement of consent mentioning both the husband and wife); interview with DU, a youth leader working with IPAS in Chaibasa, West Singhbhum district, Jharkhand; interview with EO, doctor at a private nursing home in West Singhbhum district, Jharkhand; interview with ER (ANM) and ES (ASHA worker), at a health and wellness centre in West Singhbhum district, Jharkhand; interview with EZ, health care worker in West Singhbhum district, Jharkhand; and group discussion FC, with sahiyas attached with a government hospital in West Singhbhum district, Jharkhand.
- 385 Interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 386 Interview with HD, doctor at a private hospital in Pune, Maharashtra.
- 387 *ibid*.
- 388 Aparna Chandra et al, *Securing Reproductive Justice in India* (n 18) 313. See *Samar Ghosh v Jaya Ghosh* (2007) 4 SCC 511 (where abortion without the husband’s consent was listed as one of the circumstances which may amount to cruelty); *Sushil Kumar Verma v Smt Usha* AIR 1987 Del 86; But see also

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- Dr Mangla Dogra v Anil Kumar ILR (2012) P&H 446 (where the Punjab and Haryana High Court clarified that consent of the husband is not required for termination of pregnancy under the MTP Act or its Rules); Anil Kumar Malhotra v Ajay Pasricha and others Civil Appeal 004704 of 2013 (Order dated 27 October 2017) (SC) (where the Supreme Court dismissed the appeal filed against the aforementioned order of the Punjab and Haryana High Court).
- 389 Anil Kumar Malhotra v Ajay Pasricha and others Civil Appeal 004704 of 2013 (Order dated October 27, 2017).
- 390 *ibid.*
- 391 ILR (2012) 2 P&H 446.
- 392 *ibid.*, paras 21-22.
- 393 See interview with CY, medical officer in-charge of a community health centre in Ranchi, Jharkhand; interview with FD, government doctor in a district hospital in Jharkhand; interview with GF, medical officer at a tertiary care government hospital in Mumbai, Maharashtra; interview with HM, government doctor at a tertiary care facility in Pune Maharashtra; group discussion JK, with representatives of civil society organisations and journalists in Dharmapuri, Tamil Nadu (At least three participants referred to sexual activity outside of marriage as “illegal contact”. A participant explained that an “illegal pregnancy” is any “pregnancy arising out of sexual contact with someone other than husband or pregnancies before getting married”); interview with KJ, KK, and KL, students and interns at a private nursing college in Dharmapuri, Tamil Nadu; interview with KN, Head of a private nursing college, Dharmapuri, Tamil Nadu; interview with KP, former nurse at a private health facility and member of a civil society organisation in Dharmapuri, Tamil Nadu (describing sexual activity outside of marriage as “illegal contact” and children thus born as “illegal babies”); interview with KR, ANM at a primary health centre, Dharmapuri, Tamil Nadu; interview with KZ, staff nurse in a government hospital, Tamil Nadu.
- 394 Jaising P. Modi, *A Textbook of Medical Jurisprudence and Toxicology* (1st edn, 1920) 254-255; K Kannan (ed), *Modi: A Textbook of Medical Jurisprudence and Toxicology* (26th edn, 2018) ch 35 < <https://advance.lexis.com/api/permalink/1d44d376-4165-433c-a2f9-ed54aa23f9d6/?context=1523890> accessed 10 July 2021.
- 395 Jaising P. Modi, *ibid.*
- 396 K Kannan (ed), *Modi: A Textbook of Medical Jurisprudence and Toxicology* (26th edn, 2018) ch 35 < <https://advance.lexis.com/api/permalink/1d44d376-4165-433c-a2f9-ed54aa23f9d6/?context=1523890> accessed 10 July 2021.
- 397 BV Subrahmanyam (ed), *Parikh's Textbook of Medical Jurisprudence, Forensic Medicine and Toxicology* (2014) 415-416.
- 398 Krishan Vij, *Textbook of Forensic Medicine and Toxicology* (6th edn, 2014) 364. See also KS Narayan Reddy and OP Murty, *The Essentials of Forensic Medicine and Toxicology*, (34th edn, 2017) 312, 317; Gautam Biswas, *Review of Forensic Medicine and Toxicology* (3rd edn, 2015) 341.
- 399 Interview with CT, medical officer in-charge of a community health centre in a rural district in Jharkhand; interview with FD, government doctor in a district hospital in Jharkhand; interview with CY, medical officer in-charge of a community health centre in Ranchi, Jharkhand; interview with KL, a student at private nursing college in Dharmapuri, Tamil Nadu; interview with KZ, staff nurse at a government hospital in Tamil Nadu; interview with KR, ANM at a primary health centre, Dharmapuri, Tamil Nadu; interview with KN, Head of a private nursing college, Dharmapuri, Tamil Nadu.
- 400 Marital rape is not an offence under Section 375 of the IPC, if the age of the woman is over 18 years.
- 401 Interview with EQ, manager of a private nursing home in West Singhbhum district, Jharkhand.
- 402 Interview with EO, doctor at a private nursing home in West Singhbhum district, Jharkhand.
- 403 Interviews with AQ and AR, government doctors at a hospital in Delhi. (“But in India, this will lead to a chaos”); interview with AT and AU, government doctors at a tertiary health care facility in Delhi; interview with JF, doctor formerly at a government tertiary care centre in Chennai, Tamil Nadu, and member of OGSSI (“We get husband’s signature. After all, the woman has to go live with him post-abortion. Better to think of them as family unit. [...] We do get husband’s signature always just to avoid trouble, and just so that he is aware”); interview with JA and JB, medical interns at a tertiary level government hospital, Chennai, Tamil Nadu (“Professors would always say get husband’s or family’s consent as an extra precaution”); interview with IU, doctor at a private hospital in Chennai, Tamil Nadu (“We tell them that whatever decision they make, we will help them. We send them home and ask them to think about it. [...] Only the woman has the right to decide but she has to go back and live with the family”); interview with IW, doctor at private hospital in Chennai, Tamil Nadu (“Married woman you know that they come without the husband’s knowledge. It is fine but you know we have had one or two instances where the husband was very mad, and came and fought with the doctor saying how can you terminate the pregnancy without my consent?”); interview with JC and JD, government doctors at a tertiary care centre in Chennai, Tamil Nadu (“Individual alone is enough to give consent for MTP because she has her own rights as per law but we try to ask the husband to come”); interview with HJ, medical officer at a secondary level government hospital in rural Pune, Maharashtra; interview with GD, government doctor at a tertiary care facility in Mumbai, Maharashtra (“I do not do any abdominal or vaginal surgery without the husband [...] because what if there are complications”); interview with HG, doctor at a private hospital in Pune, Maharashtra; interview with HE, doctor at a private hospital in Pune, Maharashtra. (“I take consent of both woman and the partner. If there is a conflict, I do not do it”); interview with HP, a married woman who had sought an abortion in Pune Maharashtra.
- 404 Interview with DU, a youth leader working with IPAS in Chaibasa, West Singhbhum district, Jharkhand.
- 405 *ibid.* See interview with KY, government doctor at a tertiary care centre in Tamil Nadu (“We cannot just treat pregnancy, because we have to treat her socially also. For MTP we require an attender. Elders should know and should be alert so that she does not do it again.”)
- 406 Interview with HE, doctor at a private hospital in Pune, Maharashtra; See also group discussion FE, with unmarried women in the age group of 18-22 years and a youth leader working with IPAS in Chaibasa, West Singhbhum district, Jharkhand.
- 407 Interview with HE, doctor at a private hospital in Pune, Maharashtra. Note that it is unclear whether this is a general protocol in all surgical or emergency medical procedures. However, this was specifically stated in case of MTPs.
- 408 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra.
- 409 *ibid.*
- 410 Interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 411 This was the opinion of the doctor. It is not true that everyone has an Aadhar card or is required to have one.
- 412 Interview with GD, government doctor at a tertiary care facility in Mumbai, Maharashtra.
- 413 Interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 414 *ibid.*
- 415 Interview with EO, doctor at a private nursing home in West Singhbhum district, Jharkhand.
- 416 *ibid.*
- 417 *ibid.*; group discussion FC, with sahiyas attached with a government hospital in West Singhbhum district, Jharkhand. The sahiyas stated that a woman would not have any difficulty in seeking abortion “if someone from the family is there, like her mother.”
- 418 Interview with FK, FL and FM, members of a civil society organisation for homeless women in Mumbai, Maharashtra.
- 419 MTP Regulations, reg 4(5).
- 420 See Chapter 6 on POCSO Act and Mandatory Reporting.
- 421 Interview with HM, government doctor at a tertiary care facility in Pune Maharashtra; interview with GG, government doctor in a tertiary health care facility,

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- Mumbai, Maharashtra; interview with HE, doctor at a private hospital in Pune, Maharashtra; interviews with KX and KY, government doctors at a tertiary care centre in Tamil Nadu.
- 422 Interview with JE, resident at a tertiary care government hospital in Chennai, Tamil Nadu (The registers maintained at the hospital included “medico-legal cases” register (“MLC register”), “unmarried” register, first trimester register, and second trimester register).
- 423 It could not be clarified whether this meant only woman who have “never married,” or single woman who had been previously married.
- 424 Interview with JE, resident at a tertiary care government hospital in Chennai, Tamil Nadu.
- 425 *ibid.* Under the POCSO Act, all sexual activity under the age of 18, whether consensual or not, is criminalised and marital status does not matter. When an adult woman alleges rape, Section 357C of the CrPC requires mandatory reporting by service providers.
- 426 Interview with JE, resident at a tertiary care government hospital in Chennai, Tamil Nadu.
- 427 The intimation sent to the police was referred to as “emergency police report” or “medico-legal case.”
- 428 Interview with GF, medical officer at a tertiary care government hospital in Mumbai, Maharashtra.
- 429 Interview with FK, FL and FM, members of a civil society organisation for homeless women in Mumbai.
- 430 *ibid.*
- 431 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra.
- 432 Interview with GF, medical officer at a tertiary care government hospital in Mumbai, Maharashtra (stating that EPR is done only in “foul” cases and not in all cases).
- 433 Interview with GH, Police Sub-Inspector at a police station attached to a tertiary care government hospital, Mumbai, Maharashtra.
- 434 Interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra.
- 435 *ibid.*; interview with HM, government doctor at a tertiary care facility in Pune Maharashtra.
- 436 Interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 437 Directorate of Family Welfare NCT of Delhi, ‘Maintaining of Ante-Natal Care Records’ F No 9 (4)/3/PNDT/DFW/04/Pt. File/11759-11781 (11 December 2015) < <http://health.delhigovt.nic.in/wps/wcm/connect/65f818004aef25289271f7b3c8582d9a/ANC0001.pdf?MOD=AJPERES&mod=1623463097&CACHEID=65f818004aef25289271f7b3c8582d9a>> accessed 10 July 2021 (directing all doctors providing ante-natal care services to “maintain records of ante-natal cases and a duplicate copy of referral slip.” The directive further stated that no ultrasound should be “advised without indication”).
- 438 Mother and Child Tracking System (MCTS) was launched in 2009 to improve the delivery of maternal and child health services. MCTS uses a name-based tracking system and records data of healthcare services sought by pregnant women from conception up to 42 days after delivery, and child health and immunisation of newborn children up to 5 years. Besides ensuring timely delivery and improved coverage of these services, the MCTS is also deployed for transferring benefits under maternity benefits schemes. MCTS was launched in 2009 and has subsequently been linked with Aadhaar. More recently, Reproductive and Child Health Portal has been launched to replace MCTS. An augmented version of MCTS, the RCH will track the health seeking behaviour of women throughout their reproductive life cycle. The portal will facilitate tracking of ‘eligible couples and their contraceptive usage, aside from tracking pregnant women, infants and children.’ See generally Ministry of Health and Family Welfare, ‘RCH Portal Data Entry User Manual V1.1’ <https://www.nhmmp.gov.in/WebContent/IMP_Notice/Draft_Revised_Data_Entry_User_Manual_ver_1_1-RCH.pdf> accessed 10 July 2021.
- 439 Directorate of Family Welfare, NCT of Delhi, ‘Identity Proof with Address Mandatory for Ultrasonography and Pre-Natal Diagnostic Tests and Procedures in Antenatal Cases (Pregnancy) under PCPNDT’ F No 9 (4)/3/PNDT/DFW/04/Pt. File/11804-11822 (11 December 2015) <<https://cdn.s3waas.gov.in/s3c06d06da9666a219db15cf575aff2824/uploads/2019/05/2019050747.pdf>> accessed 10 July 2021 (In the absence of ID proof, the women may not be denied the medical services however, a record of the same has to be maintained); See also Vicky Pathare, ‘Now link Aadhaar to Avail Sonography’ (2 January 2018, Pune Mirror) <<https://punemirror.indiatimes.com/pune/civic/now-link-aadhaar-to-avail-sonography/articleshow/62328701.cms>> accessed 10 July 2021 (noting the government’s plan to link MCTS numbers with Aadhaar and other ID proofs of the pregnant women. The objective behind consolidating the records of pregnant women under one system is to make it easier to track the history of the woman and track gender-biased sex-selection).
- 440 Ambika Tandon, ‘The Mother and Child Tracking System – Understanding Data Trail in the Indian Healthcare Systems’ (18 October 2019, The Centre for Internet and Society) <<https://cis-india.org/internet-governance/blog/privacy-international-ambika-tandon-october-17-2019-mother-and-child-tracking-system-understanding-data-trail-indian-healthcare>> accessed 10 July 2021 (“In 2016, Union Minister of Women and Child Development suggested strict biometric based monitoring to discourage gender biased sex-selection”).
- 441 Directorate of Public Health and Preventive Medicine, ‘Pregnancy and Infant Cohort Monitoring and Evaluation’ <https://picme.tn.gov.in/picme_public/> accessed 10 July 2021.
- 442 Serena Josephine M, ‘Registration Software Helps Unearth Illegal Abortions in Tiruvannamalai’ (30 May 2019, The Hindu) <<https://www.thehindu.com/news/national/tamil-nadu/registration-software-helps-unearth-illegal-abortions-in-tiruvannamalai/article27297750.ece>> accessed 10 July 2021.
- 443 *ibid.*
- 444 Aparna Chandra, ‘Privacy and Women’s Rights’ (2017) 52(51) Economic and Political Weekly 46, 48; See generally Vidyut, ‘AP Govt Leaks Mobile, Aadhaar and Pregnancy Info of 20,71,913 Women’ (30 April 2018, MEDIUM) <<https://www.medianama.com/2018/04/223-ap-govt-leaks-mobile-aadhaar-pregnancy-info/>> accessed 10 July 2021 (reporting the leak of data collected through MCTS portal in Andhra Pradesh); Ambika Tandon, ‘The Mother and Child Tracking System’ (n 440).
- 445 Aparna Chandra, ‘Privacy and Women’s Rights’ (n 444) 48; Rakhai Gaitonde, ‘Registration and Monitoring of Pregnant Women in Tamil Nadu’ (2012) 20(39) Reproductive Health Matters 118 <10.1016/S0968-8080(12)39619-5> accessed 10 July 2021.
- 446 Rights of Persons with Disabilities Act, 2016 (“RPWD Act”), s 2(s).
- 447 RPWD Act, s 2(c).
- 448 RPWD Act has been enacted in furtherance of India’s obligations under UN Convention on the Rights of Persons with Disabilities 2006 (“CRPD”).
- 449 RPWD Act, s 2(y) (“[...] necessary and appropriate modification and adjustments, without imposing a disproportionate or undue burden in a particular case, to ensure to persons with disabilities the enjoyment or exercise of rights equally with others”).
- 450 RPWD Act, s 25.
- 451 RPWD Act, s 10(2).
- 452 RPWD Act, s 92(f) (The exception reads as “where the termination is done in severe cases of disability and with the opinion of a registered medical practitioner and also with the consent of the guardian of the woman with disability”).
- 453 Standing Committee on Social Justice and Empowerment (16th Lok Sabha), ‘Report on Rights of Persons with Disabilities Bill, 2014’ (15th Report, May 2015), 92-93 (discussing clause 105(f) of the Bill on offences and penalties, which corresponds with Section 92(f) of the RPWD Act).
- 454 National Trust Act, 1999, s 2(o).
- 455 Tarshi, ‘Sexuality and Disability in the Indian Context’ (2018) 166 <<https://www.tarshi.net/downloads/SexualityandDisabilityintheIndianContext.pdf>>

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- accessed 10 July 2021.
- 456 Interview with Amba Salelkar, lawyer and disability rights activist, Chennai, Tamil Nadu.
- 457 Tarshi (n 455) 162-166.
- 458 Interview with Amba Salelkar, lawyer and disability rights activist, Chennai, Tamil Nadu.
- 459 *ibid.*
- 460 Tarshi (n 455) 38.
- 461 Interview with Amba Salelkar, lawyer and disability rights activist, Chennai, Tamil Nadu.
- 462 *ibid.*
- 463 *ibid.*; Tarshi n (455).
- 464 MTP Act, s 3(4)(a).
- 465 (2009) 9 SCC 1.
- 466 *ibid.*, paras 28-30.
- 467 *ibid.*
- 468 Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation Act), 1995 (now repealed), s 2(r); National Trust Act, s 2(g).
- 469 (2009) 9 SCC 1, para 28.
- 470 RPWD Act, s 2(zc) (“specified disability”); RPWD Act, Schedule, para 2 (“Intellectual disability: a condition characterised by significant limitation both in intellectual functioning (reasoning, learning, problem solving), and in adaptive behaviour, which covers a range of every day, social and practical skills, including specific learning disabilities [...] and autism spectrum disorder [...]”) and s 2(1)(s) (which defines ‘person with disability’).
- 471 RPWD Act, Schedule, para 3.
- 472 (2018) 11 SCC 572.
- 473 *ibid.*
- 474 Interview with IG, public health consultant and former government doctor, National Health Mission, Tamil Nadu.
- 475 Interview with JG, government doctor at a tertiary care facility in Chennai, Tamil Nadu.
- 476 *ibid.*
- 477 *Suchita Srivastava v Chandigarh Administration* (2009) 9 SCC 1; *Z v State of Bihar* (2018) 11 SCC 572 (Note that the MTP Act uses the term “mental retardation”).
- 478 Interview with IG, public health consultant and former government doctor, National Health Mission, Tamil Nadu; See Health and Family Welfare Department Government of Tamil Nadu, ‘District Mental Health Co-ordination Committees’ <<http://www.tnhealth.org/dmhcc.htm>> accessed 8 Jan 2021. In Tamil Nadu, district-level mental health coordination committees were first set up in 1997 for implementing the objectives of the Mental Health Act, 1987 and the National Mental Health Programme. These committees function under the Tamil Nadu State Mental Health Authority (See Mental Health Act, 1987, s 4 (now repealed); Mental Healthcare Act, 2017, s 45).
- 479 Interviews with JC and JD, government doctors at a tertiary care centre in Chennai, Tamil Nadu.
- 480 Interview with JG, government doctor at a tertiary care facility in Chennai, Tamil Nadu.
- 481 Interviews with JC and JD, government doctors at a tertiary care centre in Chennai, Tamil Nadu.
- 482 Interview with GE, doctor at a private hospital in Mumbai, Maharashtra.
- 483 CRPD, art 3 (general principles).
- 484 Mental Healthcare Act, 2017, Preamble; RPWD Act, Preamble.
- 485 CRPD, Preamble, para 5.
- 486 CRPD, art 12; See also Committee on the Rights of Persons with Disabilities, General Comment on Article 12: Equal Recognition Before the Law, UN Doc CRPD/C/11/4 (2013).
- 487 CRPD, art 23(1)e(b).
- 488 All persons with mental illness shall have capacity to make mental healthcare or treatment decisions but may require varying levels of support from their nominated representative to make decisions. See RPWD Act, s 14(9).
- 489 Mental Healthcare Act, 2017, ss 2(i) and 22(d) (Informed consent is defined as “consent given for a specific intervention without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to a person adequate information including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person”).
- 490 Mental Healthcare Act, 2017, s 3(5).
- 491 Mental Healthcare Act, 2017, s 3(4).
- 492 Mental Healthcare Act, 2017, s 18(5)(a).
- 493 Mental Healthcare Act, 2017, s 21(e).

5 Legislatively
Mandated
Logistical and
Infrastructural
Requirements
as Barriers
to Abortion
Services

The MTP Act and its Rules lay down the experience and training requirements needed for a doctor to be authorised to provide abortion services, as well as the infrastructural requirements for a facility where abortion services can be provided. Only an RMP, as defined under Section 2(d) of the MTP Act, is authorised to provide abortion services. For a person to be a RMP, they are required to: (a) possess a recognised medical qualification as defined in the Indian Medical Council Act, 1956; (b) have their name entered in a State Medical Register; and (c) have experience and training in gynaecology and obstetrics as prescribed by the MTP Rules. The result of this requirement is that approximately 60,000-70,000 medical practitioners are estimated to be sufficiently qualified to provide abortion services in the entire country.⁴⁹⁴ This is less than 1% of allopathic doctors registered to practice in India as of June 2020.⁴⁹⁵ While these requirements were introduced with the aim of reducing maternal deaths and morbidity by “eliminating abortion by untrained providers and in unhygienic conditions,”⁴⁹⁶ a dearth of RMPs and facilities restrict the ability to access safe abortion services. The Rules were also designed for an era where abortions were performed through surgical procedures. With advancement in medical technology, surgical abortion has become safer, and the bulk of abortions are through medication alone.⁴⁹⁷ In this chapter, we demonstrate the barriers that these conditions create for women seeking abortion services. We also discuss how the implementation of the PCPNDT Act in a manner that is not nuanced, is also creating a barrier for women seeking abortion services.

I AVAILABILITY OF ACCESSIBLE, QUALIFIED, TRAINED, AND EQUIPPED SERVICE PROVIDERS AND FACILITIES

Section 3 of the MTP Act lists the requirements for a pregnancy to be terminated. Before the MTP Amendment Act, 2021 this section provided that if the pregnancy is of twelve weeks gestation, but less than twenty weeks, and a minimum of two RMPs opine in good faith that the grounds mentioned in Section 3 are satisfied, such pregnancy may be terminated.⁴⁹⁸ In several medical facilities, particularly those at the primary or community level, two RMPs are usually not available. Many facilities have only one medical practitioner, who may not meet the entire set of eligibility criteria of a RMP, as defined in the MTP Act and Rules. Hence, they cannot provide abortion services. This tends to be the case particularly in rural areas.⁴⁹⁹ In several areas, gynaecologists are only available at the district or sub-divisional hospital level. For instance, in Chaibasa, in the West Singhbhum District of Jharkhand, a gynaecologist is available at the Sub-Divisional Hospital only once a week, on a designated day.⁵⁰⁰ Our interviews revealed that the facility did not have any gynaecologist until recently. It is almost impossible for the gynaecologist, who only visits the facility once a week, to address the gynaecological health issues faced by all the women who

visit the Sub-Divisional Hospital.⁵⁰¹ Our finding in Chaibasa is in consonance with a 2019 report on the National Health Mission which states that there is a 75% shortage of gynaecologists and obstetricians at the Community Health Centre (“CHC”) level.⁵⁰²

As a consequence, second trimester abortion services are often not easily accessible. When women approach either a PHC or CHC, they are usually referred to the corresponding District Hospital.⁵⁰³ This entails travelling long distances to the relevant medical facility. It also means that abortion services cannot be obtained without families or communities becoming aware, since traveling to a distant facility would entail long absences from home. This is particularly daunting, given the stigma surrounding abortion. The costs and resources involved in travelling a long distance from their homes to seek an abortion are also intimidating and difficult to meet, if not outrightly prohibitive.⁵⁰⁴ Additionally, since the facilities at which abortion services are available are often tertiary care facilities, navigating the physical space of a large hospital premises and reaching the relevant personnel for each stage of the process can itself pose difficulty.⁵⁰⁵ Therefore, the logistical barriers presented by the legal requirement for two RMPs to authorise the abortion in the second trimester actively restrict access to safe and comprehensive abortion services.

While the requirement of the presence of two RMPs at every medical facility providing abortion services hinders the provision of second trimester abortions, more generally, the unmet need of training facilities for service providers also restricts access. For instance, in a block in Dharmapuri district, the nearest government facility where women can avail abortions in the first trimester is 20 kilometres away, whereas second trimester abortion services are available only at a distance of 50 kilometres. This is because the two medical practitioners who are employed at the block PHC, in the immediate vicinity, with the necessary infrastructure for providing abortion services in the first and second trimesters, are not RMPs, and hence, cannot provide abortion services.⁵⁰⁶

Training facilities for comprehensive abortion care (“CAC”) are usually situated in district or tertiary level government hospitals which may not be accessible to service providers (particularly, private service providers, who are not located within these facilities).⁵⁰⁷ Most training facilities are located in the public sector and only a handful in the private sector. These public sector facilities prioritise training to doctors in the public sector, and there is no clear policy on how a provider from the private sector can enrol and get trained in a public-sector facility.⁵⁰⁸ Further, norms laid down for providing training to medical practitioners in the public sector, and allocation of funds for such training limits the number of RMPs authorised to provide abortion services.⁵⁰⁹ For example, to be qualified to provide abortion services upto 12 weeks, a doctor should have assisted

in performing 25 abortions, of which 5 should have been performed independently, “in a hospital established or maintained or a training institute approved for this purpose by the government.”⁵¹⁰ Lack of such training facilities impedes the ability of doctors to meet the qualifications required for a RMP under the Act.⁵¹¹ Notably, in one of the districts we studied, a lack of female service providers in private clinics was identified as a factor impeding access to safe abortion services. A medical officer at a CHC⁵¹² told us that women in that area preferred approaching a female service provider for gynaecological issues. However, as all private clinics in the vicinity had male doctors, they availed the maternity and abortion services up to first trimester in the CHC and had to travel to a district hospital⁵¹³ in case of emergencies or second trimester abortions.⁵¹⁴ Consequently, government officials started providing training to more female doctors over male doctors.⁵¹⁵

Further, lack of infrastructural support (such as equipment and supplies) prevents trained RMPs from conducting abortions, particularly at the level of PHCs.⁵¹⁶ A government official in Jharkhand highlighted that “[d]octors are hesitant because of their training. They are not confident. Sometimes the equipment is not available, or they do not have enough time in training.”⁵¹⁷

II INFRASTRUCTURAL REQUIREMENTS OF HOSPITALS AS A BARRIER

Section 4 of the MTP Act authorises all hospitals established or maintained by the government to provide abortion services. Private facilities are subject to registration requirements and inspection by the Government or District Level Committees (“DLCs”).⁵¹⁸ The MTP Rules provide that a RMP can prescribe medication abortion drugs up to seven weeks of gestation at their clinic, on the condition that the RMP has access to an approved facility.⁵¹⁹ In order to obtain approval for providing abortion services up to 12 weeks of gestation, a facility must have “a gynaecological examination/labour table, resuscitation and sterilisation equipment, drugs and parenteral fluid, backup facilities for treatment of shock, and facilities for transportation.”⁵²⁰ Surgical support is necessary for providing second trimester abortions and therefore, a facility must have an operation table, surgical instruments for abdominal and gynaecological surgery, and anaesthetic equipment.⁵²¹ States and districts sometimes enhance the equipment and infrastructural requirements. For instance, Rajasthan added a requirement that the facility should have a designated and exclusive operation theatre for performing termination of pregnancies.⁵²²

While government hospitals do not require approval from a DLC,⁵²³ they may not be able to provide abortion services if they do not meet the other requirements - the requisite number

of RMPs, equipment/supplies, or both.⁵²⁴ As mentioned above, abortion services, including medication abortion, are rarely available at the level of PHCs.⁵²⁵ Even among CHCs and tertiary care institutions, the provision of abortion services remains insufficient.

A civil surgeon heading a DLC in Jharkhand told us that the presence of “qualified personnel” is the main requirement for the registration of a private medical facility as a “registered facility” under the MTP Act. Linking the grant of facility registration with the provider also limits access to abortion services by preventing a registered facility from availing the services of other RMPs, in addition to preventing RMPs from providing services at multiple registered facilities.⁵²⁶ Further, every time a RMP leaves a medical facility, the facility may need to make an amendment to the registration certificate of the facility. Failure to report change of the RMP or seeking the requisite amendment may constitute a violation of the MTP Act, especially in districts where an undertaking from the providers is essential for registration.⁵²⁷

While the unavailability of abortion services in public health facilities continues to restrict access to safe abortion services particularly in rural areas,⁵²⁸ onerous registration procedures and requirements may dissuade private health facilities from offering MTP services.⁵²⁹ Studies note that private facilities may avoid registration due to several reasons, such as the additional requirements prescribed by the state or district authorities for registration for providing MTP services,⁵³⁰ administrative delays and other bureaucratic hurdles, such as corruption, mismanagement, and cumbersome procedures.⁵³¹

In early 2000s, the Abortion Assessment Project India study recorded the additional requirements for private facilities in Maharashtra and Delhi, some of which may be still applicable.⁵³² For example, application for registration of a private facility may require a “certificate for blood supply from a bank situated within 5 km of proposed facility,” a “one-time certificate” from a microbiology department, confirming that the facility is sterile, an undertaking confirming the round-the-clock availability of an anaesthetist and a gynaecologist,⁵³³ details of space allocated for parking, floor area, and the structural design of the facility.⁵³⁴ It has been argued that some of the additional requirements may be “impractical”⁵³⁵ and “unnecessary,” particularly in cases of surgical abortions using manual vacuum aspiration method instead of dilation and curettage.⁵³⁶

In some states, private facilities are additionally required to fulfil criteria set for facilities that are meant to provide sterilisation services.⁵³⁷ For instance, in Tamil Nadu, a government official told us that registration was “not [given] for [an] individual MTP centre [but was given] along with

sterilisation services.”⁵³⁸ In some instances, the above additional requirements may mirror the rules for registration and regulation of clinical establishments or nursing homes⁵³⁹ operational in a particular state.⁵⁴⁰ Such additional requirements when tied with the registration requirements under the MTP Act apply uniformly to all clinical establishments or facilities⁵⁴¹ (clinics, nursing homes or hospitals), which may otherwise be subject to different minimum standards under the Clinical Establishment Registration Rules.⁵⁴²

A private service provider in Pune pointed out that while requirements for setting up a nursing home would cover the requirements under the MTP Rules, the additional requirements are often onerous and unaffordable for smaller clinics and establishments, and may deter them from obtaining registration for providing services under the MTP Act, further restricting access to abortion services.⁵⁴³ Private facilities also find it difficult to comply with the cumbersome reporting, documentation, and storage process for client records prescribed in the MTP Regulations.⁵⁴⁴ They are worried that they may be hauled up for technical/minor violations, especially in light of overzealous implementation of the PCPNDT Act.⁵⁴⁵ As we discuss later in this chapter, onerous compliances enforced by the PCPNDT Act and drug regulatory authorities, and the associated penal sanctions, coupled with the lack of economic gain from provision of these services, act as disincentives for service providers.⁵⁴⁶

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“You need to have a registration for the nursing home. You need to have 26 NOCs. That is required first and then you can get the MTP registration.”
- GD, government doctor in a tertiary care facility, Mumbai, Maharashtra

In 2011, Maharashtra constituted a committee to recommend measures for controlling “unauthorised MTPs” in the state (“**Oak Committee**”). Taking note of the unlicensed or unregulated centres providing abortion services, and having reviewed the registration requirements for private facilities, the Oak Committee recommended simplification of these requirements for increased availability of “legitimate centres” providing safe abortion services.⁵⁴⁷ It observed that the “excessive requirements” of equipment, infrastructure and staff, which are not essential for providing safe abortion services and not required for the registration of MTP Centres in the central rules and regulations “unnecessarily restrict access,” and should not be imposed on private facilities.⁵⁴⁸ No action was taken based on this recommendation and such requirements continue to exist in Maharashtra.⁵⁴⁹

Additionally, several private facilities may not register to provide services under the MTP Act, since they are unaware of this requirement under the Act and Rules.⁵⁵⁰ In one of the establishments we visited where abortion services were being provided, we were told that they had obtained registration under the Clinical Establishment Act, but stated that “there was no separate registration for MTP.”⁵⁵¹ The office of the civil surgeon in the district, who also heads the DLC,

was aware of “Form A” for the registration of facilities under the MTP Act, but could not provide information or trace documents for facilities registered under the MTP Act.⁵⁵²

Non-functional DLCs further compound the issue of registration under the MTP Act and Rules.⁵⁵³ In Jharkhand, one of the civil surgeons we interviewed, acknowledged that the MTP Committee was not “so active.”⁵⁵⁴ The civil surgeon in another district remarked, “I have not attended such committee. It might exist and there might be a signatory.”⁵⁵⁵

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“DLCs do exist for MTP. I head the Committee. It is not so active.”
- BQ, Civil Surgeon, Jharkhand.

Even where private facilities have the infrastructural and logistical requirements to provide second trimester abortions, they may still not provide second trimester abortions.⁵⁵⁶ Some providers cite health reasons, stating that second trimester abortions are riskier than those in the first trimester.⁵⁵⁷ However, evidence from the WHO indicates that abortions between the twelfth and the twentieth weeks of gestation are absolutely safe.⁵⁵⁸ This routine denial of abortions, or referral to higher-level facilities, once again entails hardship for those seeking abortion in terms of the time, costs and resources involved in reaching tertiary level facilities, or the costs associated with accessing abortion from the private sector in situations when public healthcare providers refuse to cooperate.⁵⁵⁹ This pushes abortion seekers to unsafe and illegal service providers, leading to immense health and legal risks.

III PCPNDT ACT, 1994

The PCPNDT Act was enacted in the context of a declining national sex ratio at birth and a perceived increase in gender-based sex selection - a consequence of the cultural and religious practice of son preference.⁵⁶⁰ It outlaws pre-conception and prenatal sex determination, i.e., no radiologist, gynaecologist etc. is permitted to communicate the sex of the foetus to the pregnant woman or her relatives by words, signs or any other method.⁵⁶¹

While the PCPNDT Act does not deal with abortion in general, the ban on sex determination gets conflated with the provision of abortion services. The massive and well-funded⁵⁶² governmental campaign to educate the public against sex determination has meant that there is greater awareness of the PCPNDT Act and the criminalisation of sex determination, as compared to the legality of abortion.⁵⁶³ Almost all medical facilities display clear signage in big font stating that sex determination is a crime and is not provided at the facility.⁵⁶⁴ Women themselves have also internalised this messaging:

“We know that it is a crime. There are boards in all hospitals saying that it is a crime and that one will be punished if one does it. At both the entrance of the hospital, and in the scan room, they have this board ... as soon as we enter the hospital, we find this out.”⁵⁶⁵

A senior government official in Chennai shared a PowerPoint presentation with us titled “Missing Angels,” which discussed the declining child sex ratio in Tamil Nadu while incorporating emotive images of female children. He also shared a poem titled “I love you, Mommy,” written from the perspective of a female foetus that had been terminated.⁵⁶⁶ Such messaging, and even the wording of the campaign, including usage of the word “foeticide,” clearly promotes an anti-abortion viewpoint.⁵⁶⁷ Messaging like this also causes misconception about the existence of foetal rights.⁵⁶⁸ It is clear from the IPC that life is considered to begin only once any part of the child’s body is delivered.⁵⁶⁹ Further, the fact that the foetus is not an independent rights-bearing entity has been recognised by courts.⁵⁷⁰

The widespread public knowledge about criminalisation of sex determination, combined with the stigma around abortion, has led to a prevailing social belief that abortion of any kind is a crime. This is particularly true in areas where the sex ratio is low. For example, in Dharmapuri, many women were of the view that all abortion is a crime, and “most abortions are sex-selective abortions.”⁵⁷¹ This was reinforced by a lawyer in Dharmapuri who said that sex-selective abortions constitute 95% of all abortions.⁵⁷² This is a myth.⁵⁷³ A member of Federation of Obstetric and Gynaecological Societies of India (“FOGSI”) pointed out that gender based sex selection constitutes around 15% of all second trimester abortions.⁵⁷⁴ There is therefore, a pervasive belief that because sex determination is illegal, and since most abortions are perceived to be sex selective abortions, abortion itself is illegal. This messaging restricts access to safe and legal abortion for all, pushing people to illegal service providers for unsafe abortions.

Experience of field-based workers and women’s groups is that people who seek sex determination despite its criminality, more often than not get a sex-selective abortion from the same medical facility that determines and reveals the sex of the foetus to them.⁵⁷⁵ It appears that the PCPNDT Act has not succeeded in its objective of preventing sex-determination and it merely pushes abortions underground. India’s sex ratio as per the 2011 census is 943 women for every 1000 men,⁵⁷⁶ compared to the 2001 census where the ratio was 933 women for every 1000 men,⁵⁷⁷ and the 1991 census when it was 927 women for every 1000 men.⁵⁷⁸ This indicates that the PCPNDT Act has not been entirely successful in preventing sex determination and sex selective abortions. Scholars have suggested that focusing on awareness raising incentives, such as changes in expectations from

educated and working daughters, are likely to lead to better results than criminalisation.⁵⁷⁹

The fear of being entangled with the PCPNDT Act plays a significant role in service providers' decisions to provide or withhold abortion services, particularly in the second trimester, or to even apply for a license to provide second trimester abortions. This is particularly the case in Maharashtra, where we were told the PCPNDT Act is strictly enforced.⁵⁸⁰ The Head of Department of Gynaecology at a leading government hospital said that most providers do not even apply for registration to perform abortions in the second trimester.⁵⁸¹ The bulk of service providers in Maharashtra do not perform second trimester abortions, out of fear of harassment,⁵⁸² even if they are compliant with the requirements of the MTP Act.

A private practitioner in Mumbai, who is also member of FOGSI, aptly summarised the problem:

“Maharashtra officials like to think of themselves as pioneers in this. They are always looking to implement newer and more restrictive ... regulations about the PCPNDT issue. Unfortunately, they seem to think cracking down on abortions will restrict [sex selective abortions] ... Abortion falls easy casualty to this, particularly second trimester abortions. So, doctors in fact are now wary about providing second trimester abortions ... [A] lot of them have stopped providing second trimester abortions.”⁵⁸³

As the only doctor who provides second trimester abortions in a few suburbs in Mumbai, he said that officials tasked with implementation of the PCPNDT Act carry out inspections of his facility every two weeks or so. He said that another gynaecologist he knows has been asked for a bribe of Rs. 30,000/- by PCPNDT officials under the garb of ensuring compliance with the PCPNDT Act.⁵⁸⁴

We came across the case of A, who approached a private provider in Pune for a second trimester abortion. Tests revealed that the foetus she was carrying had a high likelihood of having Down's Syndrome. However, she was denied the abortion due to the provider's fear of the PCPNDT Act.⁵⁸⁵ In such situations, patients are referred to government hospitals,⁵⁸⁶ which entails further problems for them, most of all in terms of privacy, since government hospitals are often at a considerable distance from their homes. They often feel compelled to disclose that they are undergoing an abortion to their families, to explain their long absence from home. A private provider in rural Pune mentioned that his is the only hospital in the two talukas nearby that has the facility to provide abortions in the second trimester. However, he does not provide second trimester abortions, except in cases of foetal anomalies, due to fear that it would involve legal entanglement and media reportage

due to the PCPNDT Act. He added that he is hardly ever approached for second trimester abortions - he had received only three or four cases in the previous seven months or so, in all these cases the pregnancies were carried to term, and the children born were given up for adoption.⁵⁸⁷

Other studies have also documented the reluctance of or outright refusal by service providers to provide second term abortions for fear of the PCPNDT process. One such study documents the ways in which service providers seek to protect themselves by creating additional barriers for women seeking abortion services.⁵⁸⁸ They found that apart from measures adopted by individual service providers, medical professional organisations have also been advising service providers to be cautious about providing second term abortions:

“In our Association we discussed various issues related to the PCPNDT Act and decided that, if any second trimester MTP cases come to our hospitals we would send them to the President of the association. Our President would look for the reasons for MTP, check their reports and then inform the respective medical officers about them. We ask the patients for a permission letter from the President to perform MTP.”⁵⁸⁹

Further, MTP facilities that conduct ultrasounds are required to maintain records under the PCPNDT Act.⁵⁹⁰ The PCPNDT Act prescribes the same punishment for sex determination as it does for other infractions, such as non-maintenance of proper records.⁵⁹¹ There is no gradation of punishments, as a result of which officials can misuse the PCPNDT Act by alleging that there is an issue with the service provider’s recordkeeping and harass service providers in that manner. A leading private service provider in Mumbai stated that the PCPNDT Act is a “draconian” legislation. He said that “compliance is tedious, painful and expensive, and one’s reputation can get tarnished.”⁵⁹² When authorities come to their facility for inspections, they therefore give the impression that it is better not to perform second trimester abortions at all.⁵⁹³

We were told that when women seeking an abortion report to a medical facility, they are usually asked how many children they already have, and how many of them are girls, ostensibly as part of the medical history-taking process. If a woman already has two or three daughters, several providers suspect, of their own accord, that the abortion is being sought for the purpose of sex-selection.⁵⁹⁴ Once the provider suspects that the abortion is being sought this reason, the woman is refused an abortion. Many service providers who otherwise do provide second trimester abortions, will refuse to provide an abortion in such cases due to a fear that this will invite questions at a later stage from officials tasked with the implementation of the PCPNDT Act.⁵⁹⁵

If a woman seeking an abortion already has two daughters, she is likely to be denied even a scan by a sonologist after 19 weeks of gestation.⁵⁹⁶ A service provider told us that she has an ultrasound machine in her private clinic. However, she does not do an ultrasound examination for women who are not within the first three or last three months of their pregnancies. She attributed this to her fear of harassment from officials responsible for implementation of the PCPNDT Act.⁵⁹⁷

Women's access to safe abortion may also be impacted by the plan of linking registration of medical facilities under the MTP Act with the PCPNDT Act. Government officials have been contemplating linking the functions of the MTP Committee and the PCPNDT Committee, in order to investigate violations of the PCPNDT Act by monitoring MTP facilities which may or may not be diagnostic centres, and tracking women undergoing second trimester abortions.⁵⁹⁸ This is based on the presumption that “most second trimester abortions [are] sex-selective.”⁵⁹⁹ An earlier study records that members of the DLC believe that “they were responsible for not letting [sex-selective] abortion[s] happen.”⁶⁰⁰ In Maharashtra, a senior member of the DLC stated that most applicants do not seek authorisation for second trimester abortion services “due to PCPNDT.”⁶⁰¹ This was corroborated by a service provider who stated that the “Civil Surgeon does not give [MTP certificate] for providing abortion between 12-20 weeks. They give [it] rarely. So, the facilities then cannot do second trimester abortion.”⁶⁰²

Such strict enforcement of the PCPNDT Act also impacts pharmacists.⁶⁰³ In all our interviews with pharmacists across Maharashtra, we found that not a single pharmacy stocked medication abortion (“MA”) pills.⁶⁰⁴ This is because of a past “scandal” where chemists and doctors were involved in sex determination and sex selective abortion, using MA drugs.⁶⁰⁵ We were told that only one pharmacy in the whole of Mumbai stocks MA drugs.⁶⁰⁶ Further, due to this fear of harassment from PCPNDT officials, women approaching pharmacists for MA drugs are unnecessarily asked for a prescription in triplicate,⁶⁰⁷ which is a requirement for Schedule X drugs, and not Schedule H drugs such as MA pills.⁶⁰⁸ Non-stocking of MA pills also adversely impacts access to first trimester abortions. This leads to women seeking unsafe abortions even in the first trimester. Another consequence of non-stocking is the emergence of a black market in MA pills. When researchers from the Pratigya campaign interviewed pharmacists on the availability of MA pills, they were told that the pharmacists do not stock MA pills. However, the same pharmacists provided the pill when a mystery client was sent to the shop.⁶⁰⁹

We were informed that government officials in charge of the implementation of the MTP and

PCPNDT Acts conduct regular awareness workshops to emphasise that strict implementation of the PCPNDT Act does not imply that abortion services should not be provided. The officials told us that they were aware that MTP is the legal right of a woman and that awareness on this issue and the distinction between PCPNDT and the MTP Acts is also spread through ASHA workers. However, various factors add to the fear about the PCPNDT Act. These include the strict implementation of the Act, the high conviction rate, monetary incentives for informants, use of decoys and sting operations.⁶¹⁰

The strict enforcement of the PCPNDT Act, coupled with the conflation of second trimester abortions with sex-selective abortions, and the general suspicion around late detection, means that women are routinely denied second trimester abortions by both government and private sector RMPs and/or are referred to other facilities. Women are thus, either compelled to carry their pregnancy to term or seek an abortion elsewhere. This pushes women to self-administer MA pills, or resort to illegal and unsafe abortions,⁶¹¹ which entail severe health consequences and legal risks.

As per a study conducted in six states in India, between 26% and 41% of pregnancies overall end in abortion, and a majority of unintended pregnancies are terminated (55-75%). Only between 11-32% of the abortions occurring annually in each state take place in registered health facilities. While a majority of abortions taking place in settings other than health facilities are medication abortions, which are safe and effective when administered properly, the quality of instructions and support to correctly administer medication abortions is often inadequate when provided outside health facilities. This is more so when it comes from “informal-sector providers.”⁶¹² The shortfall in access to second trimester abortion is a barrier that is most likely to be faced by the most vulnerable women – those who are unable to seek abortion earlier due to poverty, difficulty traveling to abortion facilities, or lack of agency – as well as women who develop health complications later in pregnancy. The documented lack of access to second trimester abortions⁶¹³ has the impact of pushing these women to quacks to get abortions services. A study in Tamil Nadu found that less than 50% of MTPs are reported.⁶¹⁴ Nearly 15,000-20,000 women die every year in India because of lack of access to safe abortion services,⁶¹⁵ constituting 8% of all maternal deaths.⁶¹⁶

Clearly, both the MTP and PCPNDT Acts are functioning to hinder, instead of facilitating access to safe abortion services.

NOTES FOR CHAPTER 5

- 494 Interview with Mr VS Chandrashekar, CEO, Foundation for Reproductive Health Services, India; See also Centre for Justice, Law & Society, JGLS, 'Medical Boards for Access to Abortion Untenable: Evidence from the Ground' (2021) 15-16 <https://jgu.s3.ap-south1.amazonaws.com/cjls/CJLS_Medical_Boards_Report_Final.pdf> accessed 10 July 2021 (demonstrating the lack of capacity in the public sector due to the shortfall of qualified service providers)."
- 495 See Response by the Minister of Health and Family Welfare, Government of India to Question in the Lok Sabha by Dr Kalanidhi Veeraswamy, Member of Parliament, 18 September 2020 <<http://164.100.24.220/loksabhaquestions/annex/174/AU1140.pdf>> accessed 10 July 2021.
- 496 Medical Termination of Pregnancy (Amendment) Act, 2002, Statement of Objects and Reasons.
- 497 Interview with Mr VS Chandrashekar, CEO, Foundation for Reproductive Health Services, India. Mr. Chandrashekar pointed out that in the 1970s, 'Dilation and Curettage' was the only method available for termination of pregnancy. This procedure required higher skills, and consequently, it made sense to provide requirements of the nature the MTP Act originally did. However, the law has not kept pace with changes in medical technology and amended the requirements accordingly.
- 498 MTP Act, s 3(2).
- 499 Interviews with ER (ANM) and ES (ASHA worker), at a health and wellness centre in West Singhbhum district, Jharkhand; interviews with HI, HJ, and HK, government doctors at a secondary health care facility in rural Pune, Maharashtra; group discussion HL, with nurses at a government secondary health care facility in rural Pune, Maharashtra.
- 500 Interview with EZ, health care worker in West Singhbhum, Jharkhand.
- 501 Group discussion DV, with seven youth leaders (who act as intermediaries) working with IPAS in Chakardharpur, West Singhbhum district, Jharkhand.
- 502 Snehal Shah, Ruchi Junnarkar and Avani Kapur, 'Budget Briefs, Volume 11(4), National Health Mission (NHM): GoI, 2019-20' (Centre for Policy Research and Accountability Initiative) 11 <<https://accountabilityindia.in/wp-content/uploads/2019/07/NHM-1-1.pdf>> accessed 10 July 2021.
- 503 Interviews with CP and CQ (ANMs), and CR (ASHA worker) at a primary health centre in Ranchi, Jharkhand; interview with CS, doctor at a primary health centre in Ranchi, Jharkhand; interview with CT, medical officer in-charge of a community health centre in a rural district in Jharkhand; interview with CU and CV, ANMs at a community health centre in Jharkhand; interview with CW and CX, sahiyas attached with a community health centre in Ranchi, Jharkhand; interview with CY, medical officer in-charge of a community health centre in Ranchi, Jharkhand; interview with CZ, nurse at a community health centre in Ranchi, Jharkhand; group discussion DA, with sahiyas attached with a government hospital in Ranchi, Jharkhand; interviews with DB, DE and DC, government doctors in a district hospital in, Jharkhand; group discussion DF, with ANMs at a government hospital in Ranchi, Jharkhand.. Note that all PHCs and CHCs provide child-birth services, which may be far riskier than an abortion.
- 504 Interview with GM, member of a civil society organization based in Pune, Maharashtra; interview with FG, academic and former associate at the Population Council based in Mumbai, Maharashtra; group discussion KT with ANMs at a primary health centre, Dharmapuri, Tamil Nadu; interview with KU, doctor at a primary health centre in Tamil Nadu. See Susheela Singh, 'Abortion and Unintended Pregnancy in Six Indian States' (n 70) 12.
- 505 Interview with AM, member of a civil society organisation working on health-related issues, and former head of department at a government tertiary care facility, Delhi.
- 506 Group discussion KT with ANMs at a primary health centre, Dharmapuri, Tamil Nadu; interview with KU, doctor at a primary health centre in Tamil Nadu.
- 507 Kirti Iyengar and Sharad D Iyengar, 'Elective Abortion as a Primary Health Service in Rural India: Experience With Manual Vacuum Aspiration' (2002) 10(19) Reproductive Health Matters 54 <[https://doi.org/10.1016/S0968-8080\(02\)00002-2](https://doi.org/10.1016/S0968-8080(02)00002-2)> accessed 10 July 2021.
- 508 Interview with Mr VS Chandrashekar, CEO, Foundation for Reproductive Health Services, India.
- 509 Singh S et al., Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs, New York: Guttmacher Institute, 2018; Siddhivinayak Hirve and Centre for Enquiry into Health and Allied Themes ("CEHAT"), 'Abortion Policy in India: Lacunae and Future Challenges' (2004, Abortion Assessment Project India) 33 <<http://www.cehat.org/go/uploads/AaplIndia/hirve.pdf>> accessed 10 July 2021; Ministry of Health and Family Welfare, Comprehensive Abortion Care: Training and Service Delivery Guidelines (2nd ed, 2018) ("CAC Guidelines").
- 510 MTP Rules, r 4(c).
- 511 Interview with Mr VS Chandrashekar, CEO, Foundation for Reproductive Health Services, India.
- 512 We were informed that this facility was previously a primary health centre and its status had been upgraded to that of a community health centre under the National Rural Health Mission. However, its status for the purpose of budget allocation by State Government was still the same as a PHC.
- 513 The nearest district hospital was 15 kms from the CHC. At the time of the study, there were no operational PHCs in that block.
- 514 Interviews with EW and EX, medical officers at a community health centre in Saraikela-Kharsawan district, Jharkhand.
- 515 Interview with BR and BW, government officials associated with the National Health Mission.
- 516 Susheela Singh, 'Abortion and Unintended Pregnancy in Six Indian States' (n 70) 12, 18.
- 517 Interview with CA, government official associated with the National Health Mission.
- 518 With the amendment in 2002, the power to approve the facilities was moved from the State to the District. This was intended to reduce time in approving the public health facilities. See TK Sundari Ravindran and Renu Khanna, 'Many a slip between the Cup and the Lip: Universal Access to Safe Abortion Services in India' (August 2012, CommonHealth and SAHAJ) 2 <<https://www.commonhealth.in/wp-content/uploads/2020/02/Monograph.-MANY-A-SLIP-BETWEEN-THE-CUP-AND-THE-LIP-Aug-2012.pdf>> accessed 10 July 2021.
- 519 MTP Rules, r 5, Explanation (The rules permit an RMP to provide medication abortion up to 7 weeks at their clinic. However, the DCGI has approved the drug for 9 weeks and the recent CAC guidelines (2019) clarify that this may be done up to 9 weeks. However, no amendment has been made to the Rules thus far).
- 520 MTP Rules, r 5(1).
- 521 *ibid*; Ministry of Health and Family Welfare, 'Comprehensive Abortion Care: Training and Service Delivery Guidelines' (2nd ed, 2018) <http://www.nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/CAC_Training_and_Service_Delivery_Guideline.pdf> accessed 10 July 2021.
- 522 Interview with Mr VS Chandrashekar, CEO, Foundation for Reproductive Health Services, India.
- 523 Siddhivinayak Hirve, 'Abortion Policy in India' (n 509) 19 (arguing for similar standards to apply in terms of approval and audit).
- 524 *ibid*; S. Singh et al., Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs, New York: Guttmacher Institute, 2018.
- 525 Interviews with ER (ANM) and ES (ASHA worker), at a health and wellness centre in West Singhbhum district, Jharkhand; interviews with HI, HJ, and HK, government doctors at a secondary health care facility in rural Pune, Maharashtra; group discussion HL, with nurses at a government secondary health care facility in rural Pune, Maharashtra.
- 526 See Siddhivinayak Hirve, 'Abortion Policy in India' (n 509) 39; See 'Checklist for MTP Centre under MTP Act, 1971' <https://www.pcmcindia.gov.in/admin/cms_upload/download_data/8616230831392797468.pdf> ("doctors performing MTP or abortions – name and qualification") (Pimpri, Maharashtra).
- 527 Siddhivinayak Hirve, 'Abortion Policy in India' (n 509); See 'List of documents to be attached with Form A' <https://www.pcmcindia.gov.in/admin/cms_upload/download_data/18177126741392797290.pdf> ("attested copies of degree, MMC Registration Certificate and its renewal with undertaking on own letter head of the gynae, anaesthetist attached to the hospital") (Pimpri, Maharashtra).

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- 528 Alagarajan M et al., 'Unintended Pregnancy, Abortion and Postabortion Care in Tamil Nadu—2015,' New York: Guttmacher Institute, 2018, <https://www.guttmacher.org/report/unintended-pregnancy-abortion-postabortion-care-tamil-nadu-india-2015>, <https://doi.org/10.1363/2018.30162> (49% of women in Tamil Nadu reside in rural areas with 5% of facilities. Only 20% of public facilities offer any abortion related care (71% public hospitals, 35% CHCs and only 6% PHCs)).
- 529 *ibid.*
- 530 Siddhivinayak S Hirve (2004) 'Abortion Law, Policy and Services in India: A Critical Review,' *Reproductive Health Matters*, 12:sup24, 114-121, DOI: 10.1016/S0968-8080(04)24017-4 ("Though states have adapted these rules and regulations, they differ in their interpretation and implementation. With the intent of ensuring safety and preventing unsafe abortions, some States have added layers of non-essential procedures and created administrative delays in the regulatory process and unnecessary control"). Note that Pune and Pimpri, both in Maharashtra, have differing requirements for registration of private clinics.
- 531 Nozer Sheriar, 'Manual Vacuum Aspiration: Decentralising Early Abortion Services' (2000), and Sunita VS Bandewar and Madhuri Sumant, 'Quality of Abortion Care: A Reality from the medical, legal and women's perspective' (2002, CEHAT) as cited in Siddhivinayak Hirve, 'Abortion Policy in India' (n 509) 25.
- 532 Siddhivinayak Hirve, 'Abortion Policy in India' (n 509) 22-6.
- 533 *ibid.*; See Pimpri Chinchwad Municipal Corporation, 'List of Documents to be attached with MTP Registration Form A and Form B' <https://www.pcmcindia.gov.in/admin/cms_upload/download_data/18177126741392797290.pdf> accessed 10 July 2021; Pimpri Chinchwad Municipal Corporation, Undertaking from Gynaecologist/Anaesthetist, <https://www.pcmcindia.gov.in/admin/cms_upload/download_data/10850233361392797594.pdf> accessed 10 July 2021 ("I will provide [...] consultations to OPD and IPD patients in [name of hospital and address]. I will also be available 24 hours for any kind of [...] related emergency and surgeries especially for MTP and tubectomy"); TK Sundari Ravindran, 'Many a slip between the Cup and the Lip' (n 518) 7.
- 534 Delhi Development Authority, 'Delhi Master Plan 2021 (Incorporating modifications up to 31st March 2017)' Table 13.2 <<http://52.172.182.107/BPAMSCClient/seConfigFiles/Downloads/MPD2021.pdf>> accessed 10 July 2021. The Clinical Establishment (Registration and Regulation) Act, 2010 also prescribes different minimum space requirement for different clinical establishments. See 'Minimum Standards' <<http://clinicalestablishments.gov.in/En/1070-draft-minimum-standards.aspx>> accessed 10 July 2021.
- 535 Siddhivinayak Hirve, 'Abortion Policy in India' (n 509) 24 (for instance, one time swab report to state that the OT is sterile; or blood bank within 5 kms).
- 536 Suchitra Dalvie, 'Second Trimester Abortions in India' (n 140) 39-40 ("[...] second trimester abortions require a more comprehensive set up, including an operation theatre with facilities for emergency surgery, blood transfusion, referral and transport if necessary. Given the average induction to abortion interval of 24-72 hours with older methods, round the clock staffing is also required. Hence, these procedures are most likely to be confined to doctors and within nursing homes. However greater utilisation of mifepristone-misoprostol and misoprostol [...] this is likely to change rapidly"); TK Sundari Ravindran, 'Many a slip between the Cup and the Lip' (n 518) 7 ("Much of these requirements are not necessary if abortion methods/techniques other than D&C are used").
- 537 Siddhivinayak Hirve, 'Abortion Policy in India' (n 509); Delhi Nursing Homes Act, 1953; Clinical Establishment (Registration and Regulation) Act, 2010; Delhi Masterplan (n 516).
- 538 Interview with IC, government official associated with the National Health Mission.
- 539 Allopathic Hospitals are classified into four types based on the nature of facilities and services provided (For instance, general medical services; specialist medical services; support systems for services such as pharmacy, laboratory, OT; and super specialty services and teaching hospital registered with Medical Council of India). Depending on the nature of the clinical establishment, it sets the minimum standards for scope of services, physical infrastructure, human resources, instruments and equipment, drugs, support services, legal and statutory requirements, record-keeping and reporting requirements, amongst others, See 'Operational Guidelines for Clinical Establishments Act' <<http://clinicalestablishments.gov.in/WriteReadData/2591.pdf>> accessed 10 July 2021.
- 540 Siddhivinayak Hirve, 'Abortion Policy in India' (n 509); Delhi Nursing Homes Act, 1953; Clinical Establishment (Registration and Regulation) Act, 2010; Delhi Masterplan (516).
- 541 Clinical Establishment (Registration and Regulation) Act, 2010.
- 542 Clinical Establishment (Registration and Regulation) Act, 2010 is a central legislation. As 'health' is a state subject, it is applicable only in states where it has been adopted by the state assemblies. Jharkhand state assembly has adopted the Act, and formulated state rules under Jharkhand State Clinical Establishments (Registration and Regulation) Rules 2013. Delhi, Maharashtra and Tamil Nadu have separate state legislations for regulating registration of clinical establishments. See eg, Tamil Nadu Clinical Establishments (Regulation) Act, 1997 and Rules (2018); Delhi Nursing Home Registration Act, 1953 and Rules (1953, 2011); Bombay Nursing Homes Registration Act, 1949 and Rules (1973); See 'Operational Guidelines for Clinical Establishments Act' (n 521) and 'Minimum Standards' (n 516).
- 543 Interview with GD, government doctor at a tertiary care facility in Mumbai, Maharashtra ("floor area requirements are a constraint in a place like Mumbai with high property prices").
- 544 *ibid.*
- 545 Interview with Mr VS Chandrashekar, CEO, Foundation for Reproductive Health Services, India.
- 546 For instance, running a nursing home without registration under the Clinical Establishment (Registration and Regulation) Act, 2010 results in monetary penalty, whereas MTP services in an unapproved facility is punishable with a minimum of two years of imprisonment, which can extend up to 7 years. See also interview with HD, doctor at a private hospital in Pune, Maharashtra. ("I have two legal advisors who audit us every month. I have 3 sonographers and 9 staff members who are working just on compliances for those sonographies. All your tablets and medicines are strictly monitored. The prescription needs to go in triplicate right up to the central government. You need to keep a tight log of those tablets and that's inspected. You need to keep a log of your cases and file monthly submissions...Many of the hospitals stay away from it because there is not much money in it. It is just a service in the umbrella of your services").
- 547 Dr Sanjay Oak and others, 'Recommendations for the Control of Unauthorised MTPs in the State of Maharashtra' (2011) 7-8 <<https://nrhm.maharashtra.gov.in/Oak%20Committee.pdf>> accessed 11 July 2021.
- 548 *ibid.*
- 549 See Pune Municipal Corporation ("PMC"), 'MTP Committee' (which states that "[F]or applying for approval [to the MTP Committee], the owner of the hospital should send an application addressed to Medical Officer of Health, PMC along with the following documents: Form A; Blood Bank Letter, Undertaking of arrangement of blood if blood is not available in the concerned blood bank, PMC Nursing Home Registration Certificate, Undertaking to not doing MTPs till hospital is not registered under the MTP Act, Undertaking of owner of the hospital paying availability of 24 hours for all MTP cases"); Pimpri, Maharashtra, 'List of documents to be attached with Form A' (n 509) (attested copies of degree, MMC Registration Certificate and its renewal with undertaking on own letter head of the gynaecologist attached to the hospital; letter from the nearest blood bank (mention the distance of the hospital from blood bank, swab report of the OT)).

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- 550 Siddhivinayak Hirve, 'Abortion Policy in India' (n 509) 25.
- 551 Interviews with EO and EP, doctors at a private nursing home in West Singhbhum district, Jharkhand; interview with EQ, manager of a private nursing home in West Singhbhum district, Jharkhand.
- 552 Interview with BQ, civil surgeon, Tamil Nadu.
- 553 K Brindaalakshmi, 'What does Indian law say about abortion? In conversation with Anubha Rastogi' (3 July 2017, Hidden Pockets) <<https://hidden-pockets.com/abortion-and-indian-law-anubha-rastogi/>> accessed 11 July 2021.
- 554 Interview with BQ, civil surgeon, Jharkhand.
- 555 Interview with EA, civil surgeon, Jharkhand.
- 556 For example, interview with HF, doctor at a private hospital in Pune, Maharashtra
- 557 For example, interview with GZ, in-charge of a health facility operated by a non-profit organisation providing sexual and reproductive healthcare services; interview with HA, doctor engaged with a non-profit organisation providing sexual and reproductive healthcare services.
- 558 See WHO, 'Medical Management of Abortion' (2018) <<https://www.who.int/reproductivehealth/publications/medical-management-abortion/en/>> accessed 11 July 2021 (providing guidance for medication abortion at different stages of pregnancy (induced abortion before and after 12 weeks of gestation)); WHO, 'Safe Abortion: Technical and Policy Guidance' (n 29) 20-21 ("When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure. In the USA, for example, [...] [I]ate second trimester legal abortion has a case-fatality rate [...] that is much lower than the lowest rate of unsafe abortion procedures").
- 559 Interviews with HE and HF, doctors at private hospitals in Pune, Maharashtra
- 560 Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002, Statement of Objects and Reasons.
- 561 Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 ("PCPNDT Act"), s 5(2).
- 562 Interviews with GL and GN, members of a civil society organisation working on women's rights, Pune, Maharashtra.
- 563 Group discussion HH, with two ASHA workers and a community worker in Pune, Maharashtra.
- 564 This is required by the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996 ("PCPNDT Rules"), r 17 which reads as follows: "Every Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic and Imaging Centre shall prominently display on its premises a notice in English and the local language or languages for information of the public, to the effect that disclosure of the sex of the foetus is prohibited under the law."
- 565 Group discussion LA, with married and unmarried adult women and members of a civil society organisation in Dharmapuri, Tamil Nadu.
- 566 Interview with IF, doctor and government official at the National Health Mission, Tamil Nadu.
- 567 Interviews with GL and GN, members of a civil society organisation working on women's rights, Pune, Maharashtra.
- 568 Interview with GC, doctor at a private hospital in Mumbai, Maharashtra.
- 569 IPC, s 299, Explanation.
- 570 High Court on Its Own Motion v State of Maharashtra 2017 Cri LJ 218 (Bom HC) paras 15, 22.
- 571 Group discussion LE, with adult women who manage self-help groups in different villages around Dharmapuri, Tamil Nadu.
- 572 Interview with JX, lawyer practicing at the district court in Dharmapuri, Tamil Nadu.
- 573 M Stillman and others, 'Abortion in India: A Literature Review' (2014, Guttmacher Institute) 16-18 <https://www.guttmacher.org/sites/default/files/report_pdf/abortion-india-lit-review.pdf> accessed 11 July 2021.
- 574 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 575 Group discussion HH, with two ASHA workers and a community worker in Pune, Maharashtra; Group discussion LE, with adult women who manage self-help groups in different villages around Dharmapuri, Tamil Nadu.
- 576 'Census Population Data, 2011: Sex Ratio 2011' <<https://www.census2011.co.in/sexratio.php>> accessed 11 July 2021.
- 577 'Sex Ratio' <https://censusindia.gov.in/census_data_2001/India_at_Glance/fsex.aspx> accessed 11 July 2021.
- 578 'Sex Composition of the Population' <https://censusindia.gov.in/Data_Products/Library/Provisional_Population_Total_link/PDF_Links/chapter6.pdf> accessed 11 July 2021.
- 579 Ravinder Kaur, 'Sex Ratio, Khaps and Marriage Reform' (2014) 49(31) Economic and Political Weekly 18-20 <<https://www.epw.in/journal/2014/31/commentary/sex-ratio-khaps-and-marriage-reform.html>> accessed 11 July 2021; 'Country Contexts: Abortion, Prenatal Testing and Disability' (2019) <<https://nairobiprinciples.creaworld.org/wp-content/uploads/2019/09/Country-contexts-report.pdf>> accessed 11 July 2021.
- 580 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 581 Interview with HM, government doctor at a tertiary care facility in Pune Maharashtra.
- 582 Interview with HE, doctor at a private hospital in Pune, Maharashtra.
- 583 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 584 ibid.
- 585 Interview with HG, doctor at a private hospital in Pune, Maharashtra.
- 586 ibid.
- 587 Interview with HF, doctor at a private hospital in Pune, Maharashtra
- 588 See Pritam Poddar, 'If a woman has even one daughter' (n 162).
- 589 ibid.
- 590 PCPNDT Act, s 4.
- 591 PCPNDT Act, s 23.
- 592 Interview with GC, doctor at a private hospital in Mumbai, Maharashtra.
- 593 Interview with GV, pharmacist at a private pharmacy in Hadaspur, Pune, Maharashtra.
- 594 Interview with AX, resident at a tertiary care government hospital, Delhi.
- 595 Interview with AU and AV, government doctors at a tertiary care hospital, Delhi; interview with HD, doctor at a private hospital in Pune, Maharashtra.
- 596 Interview with HG, doctor at a private hospital in Pune, Maharashtra.
- 597 Interview with HA, doctor engaged with a non-profit organisation providing sexual and reproductive healthcare services. See also Federation of Obstetrics and Gynaecological Societies of India (FOGSI) v Union of India (2019) 6 SCC 283 (where FOGSI contended that doctors are being penalised under the PCPNDT Act for committing clerical errors. The Supreme Court refused to "dilute the provisions" of the Act, holding that doing so would defeat the purpose for which the legislation was enacted).
- 598 Interviews with GO and GQ, government officials engaged in implementation of some of the laws under discussion, Pune, Maharashtra.
- 599 ibid.

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- 600 TK Sundari Ravindran, 'Many a slip between the Cup and the Lip' (n 518) 12.
- 601 Interview with HM, government doctor at a tertiary care facility in Pune Maharashtra.
- 602 Interview with HJ, medical officer at a secondary level government hospital in rural Pune, Maharashtra.
- 603 Interview with GA, member of a non-profit organisation providing sexual and reproductive healthcare services; interview with FV, lawyer practicing before the High Court of Bombay at Mumbai, Maharashtra.
- 604 Interviews with FW, FX and FY, pharmacists at pharmacies at Fort and Colaba Causeway, Mumbai, Maharashtra; interview with FZ, member of the Maharashtra Chemists and Druggists Association; interviews with GS, GT, GU, GV, GW, and GX, pharmacists at pharmacies in Hadaspur and CAMP area in Pune. Note however that unlike Tamil Nadu, emergency contraceptive pills are easily available.
- 605 Interview GV, pharmacist at a private pharmacy in Hadaspur, Pune, Maharashtra.
- 606 Interview with FL, ground-level worker with a civil society organisation for homeless women, Mumbai.
- 607 Interviews with FW, FX and FY, pharmacists at pharmacies at Fort and Colaba Causeway, Mumbai, Maharashtra; interview with FZ, member of the Maharashtra Chemists and Druggists Association; interviews with GS, GT, GU, GV, GW, and GX, pharmacists at pharmacies in Hadaspur and CAMP area in Pune; interviews with FO and FP, government officials at the Food and Drug Administration, Mumbai.
- 608 Schedules X and H, Drugs and Cosmetics Act 1940.
- 609 Interview with Mr VS Chandrashekar, CEO, Foundation for Reproductive Health Services, India.
- 610 Interview with GO, government official at the Family Welfare Bureau, Pune.
- 611 Mary Philip Sebastian, ME Khan and Daliya Sebastian, 'Unintended Pregnancy and Abortion in India with Focus on Bihar, Madhya Pradesh and Odisha' (2014, Population Council) <https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1267&context=departments_sbsr-rh> 11 July 2021.
- 612 Susheela Singh, 'The incidence of abortion and unintended pregnancy in India' (n 1) e115.
- 613 *ibid.*
- 614 TK Sundari Ravindran and Bhuvanewari Sunil. 'Access to Safe Abortion Services in Tamil Nadu: Intentions and Achievements' (August 2012, Sahaj and CommonHealth) 7 <<https://www.commonhealth.in/wp-content/uploads/2020/02/Monograph.-Access-to-Safe-Abortion-Services-in-Tamil-Nadu-August-2012.pdf>> accessed 11 July 2021.
- 615 CEHAT and CommonHealth (Coalition for Maternal-Neonatal Health and Safe Abortion), 'Report of the Dialogue on Gender, Sex-Selection and Safe Abortion' (27 February 2013) 8 <<http://www.cehat.org/uploads/files/Report%20of%20Safe%20Abortion.pdf>> accessed 11 July 2021.
- 616 Registrar General of India, 'Report on Medical Certification of Cause of Death 2014' <https://censusindia.gov.in/2011-Documents/mccd_Report1/mccd_report_2014.pdf> accessed 11 July 2021.

6 Medication Abortion

Medication abortion (also called “medical abortion”) refers to the termination of pregnancy using pharmacological drugs that usually include a combination of mifepristone and misoprostol (“**MA drugs**”), or misoprostol alone.⁶¹⁷ The dosage and combination of MA drugs varies with the age of gestation.⁶¹⁸

Medication abortion is regarded as an accessible, less invasive, and affordable alternative to surgical abortion. It has a high success rate of 95-99% for terminating early pregnancy,⁶¹⁹ and has significantly improved access to safe abortion.⁶²⁰ Owing to the lower “level of medicalisation” involved, medication abortion gives women the choice to avoid admission as an in-patient in a hospital, surgical intervention, and anaesthesia.⁶²¹ It is also cost-effective and reduces the time required to be spent at a medical facility.⁶²²

The WHO’s recent guidance on Medical Management of Abortion indicates that medication abortion (using MA drugs or misoprostol alone) can be administered throughout the pregnancy, subject to a person’s preference for treatment, clinical judgment, and preparedness of the health system for handling emergencies.⁶²³ Crucially, as per the WHO, MA drugs can be safely administered by the woman entirely at home up to 12 weeks of gestation.⁶²⁴ These findings on safe home-based administration of MA drugs are also supported by recommendations from the Royal College of Obstetricians and Gynaecologists in the United Kingdom.⁶²⁵ The WHO guidelines on medication abortion are also in tune with the International Federation of Gynaecology and Obstetrics’ updated guidelines on use of misoprostol-only regime for abortions.⁶²⁶

In India, from the viewpoint of access, medication abortion requires less technical support and infrastructure, making it feasible to access and provide even at the level of PHCs, which might often be much closer to women’s homes than other medical facilities, particularly in rural areas.⁶²⁷ The guidelines on ‘Comprehensive Abortion Care’ released by the Ministry of Health and Family Welfare (“**MoHFW**”) in 2019 also provide the RMP the discretion to prescribe home administration of misoprostol (following a dose of mifepristone in the medical facility) for termination of pregnancies up to 9 weeks, as long as the woman undergoing abortion has access to an ‘approved medical facility.’⁶²⁸ As such, medication abortion enhances women’s control in dealing with an unwanted pregnancy, and ensures their privacy and confidentiality. It is also more convenient, since it reduces the time required to be spent at the facility and causes minimal disturbance to their routine life, work, and responsibilities.⁶²⁹

A 2014 study in Rajasthan documented the experiences of women who had accessed early medication abortion at PHCs, had opted for subsequent home-administration of misoprostol, and had self-assessed the outcome and need for follow-up.⁶³⁰ Most women were able to confidently self-administer misoprostol and self-assess the outcomes of abortion, when equipped with the necessary information in an easily accessible form. Women preferred home-administration of misoprostol for many reasons, such as, less disruption to housework and child-care due to fewer clinical visits required; being able to avoid the inconvenience of travel to relatively far off hospitals for surgical abortion; and greater confidentiality, privacy and control over the procedure. Further, self-assessment of the completion of the abortion using home pregnancy tests, provided reassurance to women and alleviated their anxieties about successful termination.⁶³¹ This is illustrated by one woman's account documented in the study:

“It becomes difficult sometimes to go the hospital, so if there is something through which we can know the situation at home, then it is....better. One time visit is enough I think. It is definitely useful to women who live far away...for them coming again and again is not convenient.”⁶³²

More recently, acknowledging abortion as an essential and time-sensitive health service, many countries have allowed tele-consultation for medication abortion of early pregnancies (ranging between 9-12 weeks of gestation),⁶³³ and self-administration of MA drugs delivered to women at home in response to the COVID-19 pandemic.⁶³⁴ However, the Indian Telemedicine Guidelines, issued in March, 2020 in the wake of the COVID-19 related lockdown, are completely silent on the issue of providing abortion services through the telemedicine route.⁶³⁵

Notably, in India, 81% of the estimated 15.6 million abortions occurring in 2015 (around 12.7 million abortions) were medication abortions.⁶³⁶ Knowledge of the possibility of medication abortion is common, though women often do not have clarity on the precise modalities of accessing it. For example, in focus group discussions with mostly rural women across the country, we found that most women were aware of the possibility of medication abortion, generally through information passed on by way of whisper networks, and knew someone who had accessed it.⁶³⁷ In a focus group discussion with single women between the ages of 18 and 22 and a youth leader with IPAS, Chaibasa, Jharkhand we were told of the abortion experience of one of their peers:

“She was around 21-22 years old, unmarried. She was in a consensual relationship and became pregnant. It was 1-1.5 months later [into the pregnancy] when she had a doubt and she called me [youth leader] and said there is a problem. She wanted the abortion pills.

I [youth leader] told her to do the [pregnancy] test. I wrote her a parchhi [or] referral slip to be taken to a private clinic. [Referral slips by youth leaders working with the community] make it a bit easier [as] no one asks too many questions about whatever issue she is there for. Otherwise [in case of] unmarried girls they tend to ask more questions...

She took the pills [and abortion] was complete in 15 days. The doctor had told her how to check for expulsion [of the products of conception] so she checked and confirmed.”⁶³⁸

Similarly, in a focus group discussion with adult married women in Ranchi, a participant informed us:

“I have a friend, she told me to get this medicine for her. I told her I have not done this ever nor do I know anything about it. She told me that the [pharmacist] will take Rs. 500 for it.”⁶³⁹

However, women’s level of awareness or knowledge of accessing medication abortion varied and was often incorrect or inadequate. For example, in a focus group discussion at a village in Pune District, two women gave us competing accounts of how to access MA drugs:

A: [MA drugs] are not available in the medical store. It is available only with the doctor. We need doctor’s prescription.

B: Yes, it is available. I know someone who had got the medicine in Pune. I don’t know if they [pharmacist] insist on doctor’s prescription.”⁶⁴⁰

I LEGAL LIMITS OF MEDICATION ABORTION

Access to medication abortion is regulated by the MTP Act and the MTP Rules. Other laws, including the Drugs and Cosmetics Act, 1956 and Rules thereunder, and PCPNDT Act, which seeks to curb sex-determination, directly and indirectly determine the availability of medication abortions.

In addition to the legal barriers, women’s ability to access MA drugs remains contingent on several other factors affecting availability of MA drugs such as classification of MA drugs as essential medicines at “tertiary” level of health care facilities⁶⁴¹ as well as prevailing gender norms, which limit women’s ability to procure MA pills.⁶⁴² This section discusses the intersection of legal and social barriers that hinder access to medication abortion, and even emergency contraception. It

discusses how the punitive rules and regulations relating to the provision of medication abortion evoke a fear of legal liability among providers of abortion services and restrict the supply of MA drugs. This fear can be traced to criminalisation of abortion and over-regulation of MA drugs, which has resulted in disappearance of the MA drugs from many markets.⁶⁴³ The chapter explores the legal basis of such “over-regulation” and the link between over-regulation of MA drugs and enforcement of the PCPNDT Act to meet the objective of eliminating gender-biased sex-selection.

The WHO guidelines recommend self-administration of MA drugs (without the intervention or prescription of healthcare providers) up to 12 weeks of gestation where women have access to accurate information and access to health-care providers if needed,⁶⁴⁴ and the use of MA drugs under direct medical supervision throughout the pregnancy. Indian law, however, does not allow for self-administration of MA drugs at all; ‘clinical prescription of MA drugs’ by a RMP is allowed only up to 7 weeks,⁶⁴⁵ and the use of the combi-pack of MA drugs (one tablet of mifepristone 200 mg and four tablets of misoprostol of 200 mcg each) (“MA Kit”) up to 9 weeks gestation.⁶⁴⁶ These legal limits do not reflect the recent technological advancements or the globally accepted standards and clinical practices of medication abortion. Heightened regulation of retail sale of MA drugs with a view to curb gender biased sex-selection further restricts access to medication abortion.⁶⁴⁷

The Central Drugs Standards Control Organisation approved the use of mifepristone for termination of pregnancies up to 7 weeks of gestation in 2002, and additional strength of misoprostol for use with mifepristone in 2006.⁶⁴⁸ In 2008, the MA Kit was approved for termination of pregnancies up to 63 days or 9 weeks of gestation.⁶⁴⁹ MA drugs are classified under Schedule H of the Drugs and Cosmetics Rules, 1945, and accordingly, retail sale of these drugs can be made only on the basis of a prescription of an RMP.⁶⁵⁰

The place of administering medication abortion in early pregnancy is regulated by the MTP Rules.⁶⁵¹ Section 4 of the MTP Act, along with Rule 5 of the MTP Rules limit performing terminations to government hospitals and other “approved” facilities, that comply with these provisions. However, the explanation to Rule 5 of the MTP Rules states that a RMP can prescribe a combination of MA drugs at their “clinic” instead of an approved facility for termination of pregnancies up to 7 weeks of gestation.⁶⁵² Thus, the requirement of approval of place for MTP has been relaxed *provided* the RMP prescribing the MA drugs has access to an approved facility, and displays a certificate to that effect from the owner of the facility.⁶⁵³ Beyond 7 weeks, all terminations, medication or surgical, are required by law to be performed at government hospital or approved facility.⁶⁵⁴ There is no clarity on what constitutes termination in the context of medication abortion; taking the first pill, taking the second pill, the beginning or end of the process of expulsion of the products of conception etc.

The MTP Rules are also incongruent with the broader international consensus about medication abortion being safe. As discussed, an international consensus has emerged on the safety of self-administration of medication abortion at home up to 12 weeks of gestation.⁶⁵⁵ However, given the limitation under the MTP Rules, women can access medication abortion of pregnancies over 7 weeks only at an approved facility.⁶⁵⁶

Medication abortion conducted by any person other than a RMP, which would include a retail pharmacist dispensing MA drugs without prescription; or any abortion conducted at a place not approved under the MTP Act and the MTP Rules, is punishable with a minimum imprisonment of two years, which may extend up to seven years.⁶⁵⁷

Moreover, a woman accessing medication abortion in contravention of these provisions is deemed to have committed the offence of “causing miscarriage” under Section 312 of the IPC, which can result in a term of imprisonment of up to three years, or fine, or both. Estimates of incidence of abortion in 2015 indicate that 10.8-12.2 million abortions (accounting for 73% of all abortions) were carried out through medication abortion outside of facilities.⁶⁵⁸ Taken together, this law criminalises millions of women who choose to terminate their pregnancy.

II OVER-REGULATION OF MA DRUGS AND GENDER-BIASED SEX-SELECTION

A 2019 study by Pratigya Campaign on the availability of MA drugs in the market of four states in India reveals that a majority of retail pharmacists (69.4% overall; 90.4% in Maharashtra) refrain from stocking MA drugs due to the existence of “legal barriers.”⁶⁵⁹ The main reason for not stocking MA pills is that retail pharmacists perceive that MA drugs are “over-regulated” in comparison to other Schedule H drugs. They believe that dispensing MA drugs requires enhanced regulatory compliances such as collection of prescriptions (26.1%), maintenance of separate register (24.4%), and collection of personal information from clients (18.8%), along with frequent inspections by the drug authorities (11.8%).⁶⁶⁰ Other reasons for not stocking, include side effects of the drugs (31.1%) and low demand.⁶⁶¹ Classification as a Schedule H drug however only implies that MA pills can be dispensed only upon a prescription by a RMP. The additional restrictions that operate in practice such as collection of prescriptions and personal information, and the maintenance of registers etc., have been self-imposed by pharmacists to reduce their own exposure to legal liability.

The over-regulation (or perception of over-regulation) of MA drugs can be traced to the decline in child-sex ratio reported in the 2011 Census,⁶⁶² which led to increased restrictions on availability of abortion services in order to selectively eliminate female foetuses, following sex-determination.⁶⁶³ Acting together with the PCPNDT and MTP authorities, the drug authorities heightened the enforcement and regulation of abortion services, including monitoring of sale of MA drugs. A study conducted in 2012 notes that the availability of MA drugs sharply decreased with the “increased burden of documentation for dispensing these drugs and threats from drug inspectors or some authority against stocking them.”⁶⁶⁴ Our interviews with service providers confirm these findings. For example, FN, a private sector RMP in Mumbai, informed us that:

*“Chemists were raided with the assumption that MA pills which are being sold is what was impacting sex ratio [...] In fact, the chemist to whom I used to send prescriptions to said that [the MA drugs were] a hassle for him [as] he had to keep prescriptions in triplicate. Once a raid has happened there’s always a fear...”*⁶⁶⁵

Service providers opine that these efforts of health authorities are “misinformed” since ultrasonography based sex-determination, which is the most common, easily available, and affordable technology for sex-determination, is possible only in the second trimester of pregnancy.⁶⁶⁶

In Maharashtra, incidents of abortion of female foetuses which occurred in 2011 (“**Beed Incident**”) further created an environment of “terror” among the service providers and pharmacists.⁶⁶⁷ According to news reports, activists and local residents found a number of female foetuses disposed in different parts of the Beed district. As per the 2011 census, Beed district reported the lowest child sex ratio in Maharashtra.⁶⁶⁸ Pharmacists in Maharashtra referred to the routine raids by drug authorities following the Beed Incident, that led them to stop stocking MA drugs.⁶⁶⁹ Only 1.2% of the pharmacists in Maharashtra who participated in the 2019 Pratigya study stocked MA drugs in their pharmacies.⁶⁷⁰

To avoid legal liability, pharmacists have assumed the onus of confirming that the prescription was written by a RMP authorised under the MTP Act. Thus, pharmacists in Mumbai do not dispense MA drugs to people carrying prescriptions from RMPs or clinics not known to the pharmacist.⁶⁷¹ The pharmacists say that they do not stock MA drugs, and that a person interested in procuring the MA pills should instead approach the doctors.⁶⁷² Senior drug control officials recalled the events leading to this consequence:

“...Minister had raised the issue of sex determination along with MTP - female foeticide - and so there was a special drive. We are trying to reduce the free movement of these medicines [MA drugs]. But I cannot say whether [MA drugs] are being used for sex-selection. [...] There was an incident in Beed, around 2012-13. After that we started vigilance checks. Since then, we have increased the enforcement over time, and it has become a success in Maharashtra...

Nowadays the pills are not sold at medical shops. This is because the checking is harassment for shopkeepers.”⁶⁷³

Some service providers and pharmacists in rural and urban areas confirmed that MA drugs were available only at the government hospital or registered facilities.⁶⁷⁴ A private service provider stated that onerous regulatory compliances and fear of “legal repercussions,” coupled with the low profit margins linked with sale of MA drugs, do not make them an economically viable drug for pharmacists to stock. He further added:

“Yes, we are suffering with that. I have a pharmacy and the pharmacist says that it would be better for me to procure it and keep it with myself. So, I procure it directly from the supplier and disburse it to the patients myself. This is again dangerous [as it exposes me to] scrutiny [by drug authorities].”⁶⁷⁵

The fear of legal repercussions also grips the service providers directly dispensing the drugs to the patient. A service provider in Mumbai described the environment at a private nursing home as:

“The nurse will come in with a locked box and a register...[Last time] I [prescribed the drug], the nurse told me to call the woman and check if it was her real number...Environment of terror is being created. The nurse said no, this is what the management has said. This is because they are trying cover their backs [so that if] a raid happens tomorrow and it comes out that [a woman] has done sex-selection, at least we'll have her details.”⁶⁷⁶

In 2012, based on a suggestion put forth by Gujarat State Drug Advisory Board to address the problem of illegal abortions by unauthorised doctors, the Drugs Consultative Committee (“DCC”) recommended that retail sale of MA drugs should be disallowed and the drug should be sold only to the “medical practitioner who is eligible for MTP procedure.”⁶⁷⁷ The state drug authority’s suggestion was aimed at targeting “illegal abortions” by unauthorised doctors which had also resulted in creating an “imbalance in male-female child birth ratio.”⁶⁷⁸

More recently, in June 2019, the DCC again deliberated a suggestion to restrict the sale of MA Kits to facilities approved under the MTP Act and having services of RMPs.⁶⁷⁹ Subsequently, the Directorate General of Health Services (“DGHS”) issued an advisory calling for effective implementation of the following mandatory warning/label on the MA Kit:

*“Product is to be **used** only under the supervision of a service provider and **in** a medical facility as specified under MTP Act 2002 & MTP Rules 2003.”⁶⁸⁰*

As discussed above, the Explanation to Rule 5 of the MTP Rules makes room for “prescription” sale of MA drugs by retail pharmacists and the “use” or administration of these drugs at a place (can be a private clinic, or even home)⁶⁸¹ other than an approved facility, for termination of pregnancies up to 7 weeks of gestation. The Comprehensive Abortion Care Guidelines, 2019, issued by the MoHFW, Government of India also allow for home administration of misoprostol at the discretion of the RMP.⁶⁸² To the contrary, the recent Advisory appears to restrict access to medication abortion under the MTP Act and the MTP Rules for use in medical facilities alone.

Any sale by pharmacists in non-compliance with the Drugs and Cosmetics Act, 1940 or Rules made under it, will render them liable for imprisonment up to two years under Section 27 (d) of the Drugs and Cosmetics Act, 1940, in addition to penal consequences under Section 312 of the IPC. Thus, non-compliance with the advisory leaves women seeking abortion and service providers open to criminal consequences.



LEGAL BASIS OF OVER-REGULATION

While the Advisory by DGHS was issued in August 2019,⁶⁸³ a majority of service providers and pharmacists interviewed in Maharashtra and Tamil Nadu made references to “orders” by drug authorities placing a ban on stocking of MA drugs in retail pharmacies, or imposing additional regulations for sale of these drugs. However, there is little clarity on the nature of the orders over-regulating MA drugs, or their legal basis. A woman’s experience purchasing MA drugs in Mumbai, soon after the raids by the drug control officials in 2012 illustrates this:

“Initially when the FDA [Food & Drug Administration] raid happened, I approached a chemist with a prescription from my doctor. The chemist said that the abortion pill was not available. When I called my doctor, she spoke to the chemist who told her that FDA had asked them to not stock the pills.

The doctor asked for a photo of the circular issued by FDA. The chemist then said that “no actually, we are out of stock.”⁶⁸⁴

Pharmacists in Dharmapuri, Tamil Nadu also referred to similar verbal as well as written “orders” or directives.

“JY: No, it is just that the drug inspector has said that we must not stock it. So, we and a lot of other medical shops do not stock these medicines at all.”⁶⁸⁵

KC: The drug inspector has said that only if the prescription for that particular day is there, are we allowed to give the medicine. It’s a risk if we stock these drugs. The drug inspector is very strict and hence, we do not stock at all, to be safe.”⁶⁸⁶

KG: There was a circular issued by the drug authorities for the whole of TN. It was circulated on our [Pharmacists’] WhatsApp group a year back. It said that we cannot stock MA Kit and they can be made available only with a lady doctor. The drug inspector said that we cannot stock the MA kit in the pharmacies and so even with prescription you cannot get [them] outside.”⁶⁸⁷

On the other hand, the drug control authorities in both Maharashtra and Tamil Nadu denied having issued any such “orders” banning or regulating the retail sale of MA drugs, and emphasised that their role was limited to monitoring non-prescription sale of MA drugs.⁶⁸⁸

These contradictory responses indicate a strong perception of the existence of legal barriers among the service providers and pharmacists, which, together with the fear of legal processes, has severely restricted women’s access to medication abortion over the years.⁶⁸⁹ However, lack of documentary proof makes it impossible to challenge the “orders” or legal barriers due to which pharmacists either do not stock or dispense MA drugs to women. As a senior gynaecologist practising in Mumbai asked us, “Can you hold the chemist accountable for not keeping stock? Can you hold the public sector accountable for not indenting [that is placing an order or requisition for medicines]”?⁶⁹⁰

The increased burden of documentation and record-keeping resulting from over-regulation of MA drugs, in comparison to other Schedule H drugs, is a major reason why pharmacists tend to avoid stocking MA drugs.⁶⁹¹ As a result, in many states, women with a prescription would be hard-pressed to find a medical store maintaining a stock of these drugs.⁶⁹²

“A lot of records have to be maintained if you wish to sell these drugs. No one wants to do it. [...] Even if you come with a prescription, you will not find it in any of the medical stores.”⁶⁹³

A civil society worker in Mumbai shared the ordeal she faced in procuring MA drugs for termination of pregnancy of a homeless woman at a major government hospital in Mumbai:

“I was directly told that “take this paper and get the medicine.” Then I looked around all the medical stores around [redacted] hospital. Nobody told where the medicine was available. Finally, one medical store told me, “You won’t find this medicine anywhere. This medicine is only available at Victoria Terminus at a hospital.”

The medicines are not available even at government hospitals [...] I went back to the doctor late at night and told her that the medicine was unavailable, and that it required three “papers.” In the medical store, they ask for three copies of prescription of the same medicine. The doctor had not informed me this earlier. I went to VT at 1:30am in the night to get the MTP medicine. The pharmacist took two copies of the prescription and gave a copy to me. He put a stamp over it, then he put his signature, I put my signature, my name was written on it.”⁶⁹⁴

“I went to a pharmacy right next to a nursing home. I asked for an abortion kit. They said – ‘do you want an unwanted kit?’. I said, ‘Yes – just show me what you have’. They gave me the abortion kit. I purchased the abortion kit to see the details that they would record. They recorded my name and phone number. It was interesting because I [gave only my first name and initial], and the man at the counter said ‘[initial] stands for what’.”
- Mystery customer at pharmacy in Nolambur, Chennai, Tamil Nadu.

Service providers also confirmed the requirement of prescription in triplicate for purchasing MA drugs in Maharashtra.⁶⁹⁵ Notably, Rule 65 (9) of the Drugs and Cosmetic Rules, 1945 places a similar requirement of two copies of prescription only in case of sale of Schedule X drugs, and not for Schedule H drugs.⁶⁹⁶ In 2017, a panel constituted by the Maharashtra Government had recommended inclusion of MA drugs in Schedule X, while terming them as “poison” and a “weapon” used for gender-biased sex-selection.⁶⁹⁷ This has however, not come to pass, as yet.

In Chennai, some pharmacies ask those seeking to buy MA drugs to share identifying information, including their name and contact details.⁶⁹⁸ The objective of this practice is to monitor and track the sale and usage of MA drugs, to prevent gender-biased sex-selection. However, it comes at the cost of

grave injury to women's right to privacy and the guarantee of confidentiality under the MTP Act.⁶⁹⁹

Besides restricting access to a safe method of abortion, over-regulation may also negatively impact women's access to emergency contraception. In Tamil Nadu, for instance, interactions with multiple stakeholders, including women, confirmed the unavailability of emergency contraception in retail pharmacies.⁷⁰⁰ The pharmacists referred to “some kind of rule”⁷⁰¹ or “government order banning” sale of emergency contraception pill.⁷⁰² Many stakeholders opined that the underlying reason behind this “ban” was conflation of emergency contraception with abortion.⁷⁰³ However, the drug authorities denied existence of any order regulating sale of emergency contraception.⁷⁰⁴

These perceived ‘legal barriers’ to prescription sale of MA drugs and fear of the legal process and court system, due to which pharmacists do not stock MA drugs, force women to jump through hoops to buy these drugs. Stricter regulation of MA drugs has reduced access to medication abortion, putting those seeking it at the risk of carrying an unwanted pregnancy to term, forcing them to resort to unsafe methods of abortion, and increasing their vulnerability to exploitation and abuse.⁷⁰⁵ Moreover, the direct looming threat of prosecution for “causing miscarriage” (under Section 312 of IPC) over those undergoing medication abortion without approaching a RMP may further deter them from availing medical assistance in case they need post-abortion care.⁷⁰⁶

With adequate information, self-administration of MA drugs is safe up to 12 weeks of gestation.⁷⁰⁷ However, administration of drugs without adequate information regarding the drug(s), and the procedure involved, is a less safe method of self-administered abortion.⁷⁰⁸ Many service providers spoke of over-the-counter or non-prescription sale of MA drugs, and management of cases of incomplete abortion and excessive bleeding.⁷⁰⁹ However, as a senior health official in Tamil Nadu argued, the solution does not lie in restricting the sale of MA drugs as it affects the right to a safe abortion method, which provides greater privacy and confidentiality than other methods. Instead, this official suggested that abortions “should be a day-care service and must be anonymous and we must go through the extra-mile to ensure it” to protect the rights of the pregnant person.⁷¹⁰

Likewise, a study conducted in 2005 on the availability of medication abortion notes that the “safeguards do not lie in clamping down on chemists as this will only reduce access to prescription sales,” and will only expose those undergoing unprescribed medication abortions to further health risks.⁷¹¹ Another study by Marie Stopes International, published in 2009, found that many of the challenges arising out of over-the-counter sale of MA drugs could be addressed easily in other ways, such as enhancement of the knowledge and skills of pharmacists. The study concluded that

the “overarching lesson [was] that, in spite of these challenges, out-of-clinic provision of medical abortion has succeeded in making abortion more accessible.”⁷¹²

Over three systematic reviews of the evidence on medication abortion, WHO has confirmed its effectiveness, safety and acceptability even after 12 weeks of gestation.⁷¹³ In its recent guidance on “Medical Management of Abortion” released in 2019, WHO enlists provision of information as a guiding principle and necessary component of abortion care.⁷¹⁴ It recommends that women should be provided with easily accessible information to make an informed choice of the method of abortion as well as to recognise any potential complication and steps for its management (either by themselves or at the facility).⁷¹⁵ A routine follow-up is not necessarily required after “an uncomplicated surgical or medical abortion using mifepristone and misoprostol.”⁷¹⁶

Till 2018, WHO had included MA drugs in its essential list of medicines with the rider that its administration “requires close medical supervision.”⁷¹⁷ After review, this rider was dropped in 2019,⁷¹⁸ based on:

“Evidence from WHO guidelines, systematic reviews, hundreds of randomised controlled trials and comparative clinical trials since 2005, [which] support the safety of medical abortion provision at all levels of the health care system. Specifically, this means that the continuum of abortion care (pre-abortion care, provision of abortion and follow-up) can be provided in an outpatient setting by various cadres of health workers and is not restricted to specialist doctors. This includes auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians and non-specialist doctors.”⁷¹⁹

Evidence from India backs up these claims. A study by Population Council published in 2012 found that with adequate training, allopathic physicians (who were not RMPs), ayurvedic physicians, and nurses, could provide comparable medication abortion care as RMPs in relation to determining eligibility for medication abortion, as well as completeness of abortion. This suggests that expanding the provider base for medication abortion can significantly expand access without endangering health outcomes for women from medication abortion.

WHO has also outlined the role that different non-specialist health workers can play in provision of safe abortion care and recommended that sub-tasks such as management of common side-effects as well as assessment of completion of abortion and necessity of any follow-up could be safely and effectively performed by pharmacists (or lay health workers) who are often the “first

point of care” in access to medication abortion.⁷²⁰ Further research is underway on the safety and efficacy of medication abortion provided through pharmacies in comparison to service provision in clinical settings.⁷²¹ In India, however, efforts to expand the service provider base for abortion services has not borne fruit, and the RMP remains the sole legally recognised provider of abortion services.⁷²²

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- 617 Referred to as “medical abortion”, “medical methods of abortion”, “non-surgical abortion”. See WHO, ‘Safe Abortion: Technical and Policy Guidance’ (n 29) iv and ch 2.2; WHO, ‘Clinical Practice Handbook for Safe Abortion’ (2014) 3, 29-31 <http://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1> accessed 11 July 2021 (Although misoprostol alone is less effective and carries a higher risk of side-effects compared to the combined dosage of mifepristone and misoprostol).
- 618 WHO, ‘Medical Management of Abortion’ (2018) 27-29 <<https://www.who.int/reproductivehealth/publications/medical-management-abortion/en/>> accessed 11 July 2021; WHO, ‘Safe Abortion: Technical and Policy Guidance’ (n 29) 3-5; WHO, ‘Clinical Practice Handbook’ (n 617) 29-31.
- 619 Minister of Health and Family Welfare, ‘Comprehensive Abortion Care Guidelines’ (n 509) 45.
- 620 M Stillman, ‘Abortion in India’ (n 573) 24; See also National Institute for Health and Care Excellence and Royal College of Obstetricians and Gynaecologists (“RCOG”), ‘Abortion Care NICE Guideline [NG140]’ (25 September 2019) <<https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#choice-of-procedure-for-abortion>> accessed 11 July 2020.
- 621 M Stillman, ‘Abortion in India’ (n 573) 24.
- 622 *ibid.*
- 623 WHO, ‘Medical Management of Abortion’ (n 598) 27-29 (This guidance updates the recommendations for medication abortion in WHO’s ‘Safe Abortion: Technical and Policy Guidance’ issued in 2012).
- 624 *ibid.*, paras 3.4.4-3.4.5 (“[...] abortion process can be self-managed with pregnancies less than 12 weeks of gestation without direct supervision of a health care provider (evidence is limited for pregnancies greater than 10 weeks) [...] studies are needed on the efficacy, safety and acceptability of medical abortion [...] in the outpatient setting for pregnancies 9-12 weeks of gestation”). In September 2019, UK’s National Institute for Health and Care Excellence, in consultation with RCOG, recommended that women should be offered a choice between medication and surgical abortion up to 24 weeks of gestation. The recommending committee noted the lack of evidence indicating any “clinically important difference” in completion of abortion between 13-24 weeks of gestation using surgical or medication methods, or the risks involved (such as haemorrhage necessitating blood transfusion, infections or uterine injuries) between the two methods. However, it opined that medication abortion carries an “extremely low” risk of cervical injury, see ‘Abortion Care NICE Guideline’ (n 620). These recommendations for medical abortion are also in tune with the International Federation of Gynaecology and Obstetrics (“FIGO”) updated guidelines on use of misoprostol-only regime for abortions. Jessica L Morris and others, ‘FIGO’s Updated Recommendations for Misoprostol used alone in Gynaecology and Obstetrics’ (2017) 138(3) *International Journal of Gynaecology and Obstetrics* 363, 366 <<https://doi.org/10.1002/ijgo.12181>> accessed 11 July 2021.
- 625 See ‘Abortion Care NICE Guideline’ (n 620); RCOG, FSRH and BSACP, ‘Clinical Guidelines for Early Medical Abortion at Home – England’ (2019) 2 <<https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf>> accessed 11 July 2021 (“There is no medical justification for drugs to be taken in a hospital or clinic setting”).
- 626 *ibid.*
- 627 See Kirti Iyengar, ‘Elective Abortion as a Primary Health Service’ (n 507); Shireen Jejeebhoy and others, ‘Feasibility of Expanding the Medical Abortion Provider Base in India to Include Ayurvedic Physicians and Nurses’ (2012) 38(3) *International Perspectives on Sexual and Reproductive Health* 133 <https://www.guttmacher.org/sites/default/files/article_files/3813312.pdf> accessed 11 July 2021.
- 628 Minister of Health and Family Welfare, ‘Comprehensive Abortion Care Guidelines’ (n 509) 48 (Approved medical facilities are defined in Section 4 of the MTP Act, and Rule 5 of the MTP Rules).
- 629 M Stillman, ‘Abortion in India’ (n 573) 24.
- 630 Kirti Iyengar and others, “‘Who Wants to Go Repeatedly to the Hospital?’ Perceptions and Experiences of Simplified Medical Abortion in Rajasthan, India’ (2016) 3(1-13) *Global Qualitative Nursing Research* 1 <<https://doi.org/10.1177/2333393616683073>> accessed 11 July 2021.
- 631 *ibid.*
- 632 *ibid.*, 9.
- 633 See Katherine Gambir, ‘Self-administered versus Provider-administered Medical Abortion’ (2020) 3(3) *Cochrane Database System Review* <10.1002/14651858.CD013181.pub2> accessed 11 July 2021 (A recent review finding no “statistically significant differences” between self-administered medical abortion and provider administered medical abortion in any clinical setting).
- 634 RCOG, ‘Covid-19 Infection and Abortion Care Version 3.1’ (31 July 2021) 12-13 <<https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf>>; Chief Medical Officer Directorate, Scottish Government, ‘Abortion- COVID-19-Approval for Mifepristone to be taken at Home and Other Contingency Measures’ (31 March 2020) <[https://www.sehd.scot.nhs.uk/cmo/CMO\(2020\)09.pdf](https://www.sehd.scot.nhs.uk/cmo/CMO(2020)09.pdf)> accessed 11 July 2021 (allowing up to 12 weeks of gestation). See also Hazal Atay, ‘Countries’ Covid-19 Responses Could De-bunk Some Myths Around the “Abortion Pill” (17 April 2020, The Conversation) <<https://theconversation.com/countries-covid-19-responses-could-debunk-some-myths-around-the-abortion-pill-136088>> accessed 11 July 2021.
- 635 ‘Telemedicine Practice Guidelines, Appendix 5, Indian Medical Council (Professional Conduct, Etiquette and Ethics Regulation, 2002’ March 25, 2020) <<https://www.mohfw.gov.in/pdf/Telemedicine.pdf>> accessed 11 July 2021.
- 636 See Susheela Singh, ‘The Incidence of Abortion and Unintended pregnancy in India’ (n 1).
- 637 Interview with LG and LH, representatives of an online platform disseminating information on providing sexual and reproductive health counselling to young persons; interview with HT, gender and sexuality rights activist who has assisted women in accessing abortion services in Chennai, Tamil Nadu.
- 638 Group discussion FE, with unmarried women in the age group of 18-22 years and a youth leader working with IPAS in Chaibasa, West Singhbhum district, Jharkhand.
- 639 Group discussion DL, with adult married women in a Rugdighadha informal settlement area, Ranchi, Jharkhand.
- 640 Group Discussion HN, with married adult women in Parinchay village in Pune, Maharashtra.
- 641 Ministry of Health and Family Welfare, ‘National List of Essential Medicines 2015’ 63 <<https://main.mohfw.gov.in/sites/default/files/NLEM%2C%202015.pdf>> accessed 11 July 2021; See also Souvik Pyne and TK Sundari Ravindran, ‘Availability, Utilisation and Health Providers’ Attitudes Towards Safe Abortion Services in Public Health Facilities of a District in West Bengal, India’ (2020) 1(1) *Women Health Reports* 80, 81 <<https://www.liebertpub.com/doi/full/10.1089/whr.2019.0007>> accessed 11 July 2021 (noting that such classification of MA drugs makes their availability at lower-level public health facilities uncertain); See also Neetu Chandra Sharma, ‘Abortion Pills Make Essential Drugs List, Unsafe Techniques to be Phased Out’, (13 December 2017, LiveMint) <<https://www.livemint.com/Science/sAhsOCUkd176IgdzQalsJN/Abortion-pills-make-essential-drugs-list-unsafe-techniques.html>> accessed 11 July 2021 (reporting a proposal by the Ministry of Health and Family Welfare to include the drugs as essential medicines at all levels of public health facilities, which provide safe abortion services).
- 642 For example, HR, an independent researcher based in Tamil Nadu who works on right to safe and comprehensive abortion care, told us that, “[m]any women are denied medical abortion pills. They get the prescription and ask the husband to buy the pills. This is due to gender roles.”
- 643 PratiGYa Campaign for Gender Equality and Safe Abortion, ‘Availability of Medical Abortion Drugs in the Markets of Four Indian States, 2018’ (2019) 27-28 <<https://pratiGYacampaign.org/wp-content/uploads/2019/09/availability-of-medical-abortion-drugs-in-the-markets-of-four-indian-states-2018.pdf>> accessed

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- 11 July 2021.
- 644 WHO, 'Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception' (2015) 41-42 <http://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1> accessed 11 July 2021; WHO, 'Medical Management of Abortion' (n 598) 29, 40 ("[...] the abortion process can be self-managed with pregnancies <12 weeks of gestation without the direct supervision of a health-care provider (evidence is limited for pregnancies >10 weeks)").
- 645 MTP Rules, r 5.
- 646 See Central Drugs Standard Control Organisation, 'Approval of Mifepristone + Misoprostol Combipack (1 tablet of mifepristone 200mg and 4 tablets of misoprostol 200 mcg)' (16 December 2008) <<https://cdscoonline.gov.in/CDSCO/Drugs>> accessed 11 July 2021 (See Item 1782, "For medical termination of intrauterine pregnancy (MTP) up to 63 days of gestation on the first day of the last menstrual period").
- 647 Pratigya Campaign, 'Availability of Medical Abortion Drugs' (n 643) 31-2, 35.
- 648 Central Drugs Standards Control Organisation, 'Approval of Misoprostol tablet 25 mcg/50 mcg/ 200 mcg (additional strength indication) for first trimester abortion with mifepristone' (8 December 2006) <<https://cdscoonline.gov.in/CDSCO/Drugs>> accessed 11 July 2021 (see item 869).
- 649 Central Drugs Standard Control Organisation, 'Approval of Mifepristone + Misoprostol Combipack (1 tablet of mifepristone 200mg and 4 tablets of misoprostol 200 mcg)' (16 December 2008) <<https://cdscoonline.gov.in/CDSCO/Drugs>> accessed 11 July 2021 (See Item 1782).
- 650 Drugs and Cosmetics Rules 1945, r 65(9)(a).
- 651 "Medical methods of abortion", "medical abortion", "non-surgical abortion".
- 652 MTP Act, s 4; MTP Rules, r 5.
- 653 MTP Rules, r 5, Explanation.
- 654 MTP Act, s 4; MTP Rules, r 5.
- 655 WHO, 'Medical Management of Abortion' (n 598) 29, 40; See also 'Abortion Care NICE Guideline' (n 620) (providing the option for home expulsion up to 10 weeks of gestation); RCOG, FSRH and BSACP, 'Clinical Guidelines for Early Medical Abortion at Home – England' (n 625) 2 ("There is no medical justification for drugs to be taken in a hospital or clinic setting").
- 656 Minister of Health and Family Welfare, 'Comprehensive Abortion Care Guidelines' (n 509) 46 (laying down the procedure for medical methods of abortion up to 9 weeks of gestation).
- 657 MTP Act, ss 5 (2), (3) and (4).
- 658 See Susheela Singh, 'The Incidence of Abortion and Unintended Pregnancy in India' (n 1).
- 659 Pratigya Campaign, 'Availability of Medical Abortion Drugs' (n 643) 11 (The study was conducted in 5 cities each in the states of Bihar, Maharashtra, Rajasthan and Uttar Pradesh. The samples consisted of 1008 chemists, out of which 252 were from Maharashtra).
- 660 *ibid*, 31 ("[S]ome chemists [...] reported that they have been informally told by drug regulatory authorities to not sell MA drugs [...] Chemists report that they are asked to keep copies of prescriptions, maintain registers with name of clients to whom they have sold MA drugs [...] over 91% [respondents] in Maharashtra and 68% in Rajasthan reported that MA drugs are overregulated, compared to other schedule H drugs).
- 661 *ibid*, 16.
- 662 IPAS, 'Disappearing Medical Abortion Drugs: Facts and Reasons' (2013) <<https://www.ipasdevelopmentfoundation.org/resourceFiles/56201909053601.pdf>> accessed 11 July 2021; see 'Sex Ratio in India' <<https://www.census2011.co.in/sexratio.php>> accessed 11 July 2021.
- 663 M Stillman, 'Abortion in India' (n 573) 28; 'Shortage of Drugs Hits Abortion Services Nationwide: Study' (9 September 2013, The Hindu) <<https://www.thehindu.com/sci-tech/health/policy-and-issues/shortage-of-drugs-hits-abortion-services-nationwide-study/article5107755.ece>> accessed 11 July 2021 (reporting a significant decline in access to MA drugs following the 2011 census). We were also informed of this in an interview with FN, doctor at a private hospital in Mumbai, Maharashtra.
- 664 IPAS, 'Disappearing Medical Abortion Drugs: Facts and Reasons' (n 662).
- 665 Interview with FN, doctor at a private hospital in Mumbai, Maharashtra; See Pritam Poddar, 'If a woman has even one daughter' (n 162); Malathy Iyer, 'State Driving Abortion Pills out of Market' (25 April 2013, The Times of India) <<https://timesofindia.indiatimes.com/city/mumbai/state-driving-abortion-pills-out-of-market/articleshow/19718182.cms>> accessed 11 July 2021.
- 666 Interview with FN, doctor at a private hospital in Mumbai, Maharashtra; See also Pratigya Campaign, 'Availability of Medical Abortion Drugs' (n 643) 35.
- 667 Interview with FN, doctor at a private hospital in Mumbai, Maharashtra.
- 668 Bhagyashree Kulthe, 'Shocking Female Foeticide Racket Unearthed in Maharashtra's Beed District' (26 June 2011, DNA) <<https://www.dnaindia.com/mumbai/report-shocking-female-foeticide-racket-unearthed-in-maharashtra-s-beed-district-1559284>> accessed 11 July 2021; 'Doctor Couple Fed Dogs Aborted Female Foetuses' (23 May 2012, The New Indian Express) <<https://www.newindianexpress.com/nation/2012/may/23/doctor-couple-fed-dogs-aborted-female-foetuses-370735.html>> accessed 11 July 2021 (News reports indicate that activists and local residents found a number of female foetuses disposed of in different parts of the Beed district. As per the 2011 Census, Beed district reported the lowest child sex ratio in Maharashtra).
- 669 Interview with GS, pharmacist in a pharmacy in Saswad, Pune District.
- 670 Pratigya Campaign, 'Availability of Medical Abortion Drugs' (n 643) 11.
- 671 Malathy Iyer, 'State Driving Abortion Pills out of Market' (n 665).
- 672 Interview with FO and FP, government officials at the Food and Drug Administration, Mumbai.
- 673 *ibid*.
- 674 Interview with GS, pharmacist in Saswad, Pune District; Interview with HD, doctor at a private hospital in Pune, Maharashtra; interview with FN, doctor at a private hospital in Mumbai, Maharashtra.
- 675 Interview with HD, doctor at a private hospital in Pune, Maharashtra.
- 676 Interview with FN, doctor at a private hospital in Mumbai, Maharashtra.
- 677 Drugs Consultative Committee, 'Report of the 44th Meeting of the Drugs Consultative Committee Held on 20 July 2012' 43 <<https://cdsco.gov.in/opencms/resources/UploadCDSCOWeb/2018/UploadCommitteeFiles/44dcc.pdf>> accessed 11 July 2021.
- 678 *ibid*.
- 679 Drugs Consultative Committee, 'Minutes of the 56th Meeting of Drugs Consultative Committee Held on 1 June 2019' 2 <https://cdsco.gov.in/opencms/opencms/system/modules/CDSCO.WEB/elements/common_download.jsp?num_id_pk=OTyZ> accessed 2 May 2020 (A proposal was forwarded by the State of Haryana for "sale of MTP kits containing Misoprostol and Mifepristone by Wholesalers only to the approved MTP centres having required facilities and services of duly qualified and experienced RMP under the MTP Act").
- 680 Directorate General of Health Services, CDSCO (DTAB-DCC Division), 'Advisory on Labelling Requirements for Combi Kit of Misoprostol and Mifepristone Tablets for MTP' F No 15-35/2019-DC (9 August 2019). <https://cdsco.gov.in/opencms/resources/UploadCDSCOWeb/2018/UploadGazette_NotificationsFiles/Advisoryletter.pdf> accessed 11 July 2021; see Drugs Consultative Committee, 'Minutes of the 56th Meeting' (n 679).
- 681 MTP Rules, r 5, Explanation.

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- 682 See Minister of Health and Family Welfare, 'Comprehensive Abortion Care Guidelines' (n 509) 46.
- 683 Directorate General of Health Services, CDSCO (DTAB-DCC Division), 'Advisory on Labelling Requirements for Combi Kit of Misoprostol and Mifepristone Tablets for MTP' F No 15-35/2019-DC (9 August 2019).
- 684 A client's experience narrated by FN, a senior gynaecologist practicing in Mumbai; See also Malathy Iyer, 'State Driving Abortion Pills out of Market' (n 645) (discussing the difficulties faced by women in purchasing MA drugs in Mumbai and disappearance of the drugs from the markets following the crackdown by the Food and Drug Administration in mid-2012s).
- 685 Interview with JY, pharmacist in Dharmapuri, Tamil Nadu.
- 686 Interview with KC and KD, pharmacists in Dharmapuri, Tamil Nadu.
- 687 Interview with KG and KH, pharmacists in Dharmapuri, Tamil Nadu.
- 688 Interviews with FO and FP, government officials at the Food and Drug Administration, Mumbai; interview with IH, government official in the Tamil Nadu Drug Control Department, Chennai, Tamil Nadu.
- 689 See Pratigya Campaign, 'Availability of Medical Abortion Drugs' (n 643).
- 690 Interview with FN, doctor at a private hospital in Mumbai, Maharashtra.
- 691 Interview with EI, pharmacist in Sadar Bazar, Chaibasa, West Singhbhum, Jharkhand; Pratigya Campaign, 'Availability of Medical Abortion Drugs' (n 643) 27.
- 692 Interview with EI, pharmacist in Chaibasa, West Singhbhum, Jharkhand; interview with GS, pharmacist in Saswad, Pune district, Maharashtra. See also Pratigya Campaign, 'Availability of Medical Abortion Drugs' (n 643) (As per the study, only 1.2% of the chemists in Maharashtra, 66% in Uttar Pradesh and 37.8% in Bihar reported that they maintained the stock of MA drugs. Notably, none of the chemists from Rajasthan who participated in the study reported stocking of these drugs. Of the chemists who were not selling MA drugs, 69.4% cited "legal barriers" whereas 26.1% cited "requirement of collecting prescriptions" as the reason for not stocking the MA drugs. In the State of Uttar Pradesh, 58.1% of the chemists not selling MA drugs, cited frequent visits by drug authorities to "enquire" about the sale of MA drugs as the reason for not stocking).
- 693 Interview with GS, pharmacist in Saswad, Pune district, Maharashtra (stating that pharmacies do not stock MA drugs).
- 694 Interview with HK, government doctor at a secondary health care facility in rural Pune, Maharashtra (stating that public hospitals were unable to provide medication abortion to women despite several requests, as the MTP Kit was not available).
- 695 Interview with HD, doctor at a private hospital in Pune, Maharashtra.
- 696 Drugs and Cosmetics Rules, 1945, r 65(9)(a) ("[...] in the case of substances specified in Schedule X, the prescriptions shall be in duplicate, one copy of which shall be retained by the licensee for a period of two years"); see also Anita Jain, 'Sex-selection and Abortion in India: Efforts to Curb Sex-Selection Must not Retard Progressive Safe Abortion Policies' (2013) 346 (7902) *British Medical Journal* <<https://doi.org/10.1136/bmj.f1957>> accessed 11 July 2021 (noting a proposal under consideration by the Maharashtra Government to ban retail sale of MA drugs or place them under Schedule X, which requires recording details of the purchaser and two copies of prescription for sale of these drugs. The purpose was to monitor and track the movement and usage of MA drugs by women and curtail gender-biased sex-selection); Sayli Mankikar, 'State wants to ban sale of abortion pills' (31 October 2011, *Hindustan Times*) <<https://www.hindustantimes.com/mumbai/state-wants-to-ban-sale-of-abortion-pills/story-4D7xfQ9zFbG3Y0Enn0vtXl.html>> accessed 11 July 2021.
- 697 Priyanka Vora, 'A Maharashtra Committee Wants to Restrict Access to All Abortions – Even Legal Ones' (17 July 2017, *Scroll.in*) <<https://scroll.in/pulse/844023/a-maharashtra-committee-wants-to-restrict-access-to-even-all-abortions-even-legal-ones>> accessed 11 July 2021; See also Suchitra Dalvie, 'Right to Safe Abortion' (2017) 52(32) *Economic and Political Weekly* <<https://www.epw.in/journal/2017/32/web-exclusives/right-safe-abortion.html>> accessed 11 July 2021.
- 698 Mystery Customer purchase at IT, pharmacy in Nolambur, Chennai, Tamil Nadu.
- 699 MTP Regulations, regs 5 and 6.
- 700 Personal experiences shared by HU, a sustainability and sexual rights consultant based in Chennai, Tamil Nadu; HV, a disability rights activist and lawyer based in Chennai, Tamil Nadu; HT, a gender and sexual rights activist based in Chennai, Tamil Nadu; and CLPGs' observation at IL and IS, pharmacies in Teynampet, Chennai, Tamil Nadu. See also Vaishnavi Sundar, 'The Nightmare of Trying to Find an i-pill in Chennai' (26 September 2016, *Scroll.in*) <<https://scroll.in/pulse/817420/the-nightmare-of-trying-to-find-an-i-pill-in-chennai>> accessed 11 July 2021; Shweta Tripathi, 'Abortion Meds Sold in Place of "Banned" Morning After Pills in Chennai' (24 August 2019, *DTNEXT*) <<https://www.dtnext.in/News/TamilNadu/2019/08/24040901/1173230/Abortion-meds-sold-in-place-of-banned-morningafter-vpf>> accessed 11 July 2021 (noting that a majority of the pharmacists do not stock the "morning after pill" pursuant to directions issued by the Drugs Control Authority disallowing sale of emergency contraceptives on "moral grounds").
- 701 Interview with IP and IQ, pharmacists at V.R. Road and Eldams Road, Teynampet, Chennai, Tamil Nadu.
- 702 Interview with IR, pharmacist in Teynampet, Chennai, Tamil Nadu.
- 703 Interview with HX, LGBTQA rights activist based in Chennai, Tamil Nadu; Interview with HU, a sustainability and sexual rights consultant based in Chennai, Tamil Nadu.
- 704 Interview with IH, government official in the Tamil Nadu Drug Control Department, Chennai, Tamil Nadu.
- 705 See Bela Ganatra and others, 'Global, Regional and Sub-Regional Classification of Abortions by Safety, 2010-14; estimates from a Bayesian Hierarchical Model' (2017) 390(1010) *The Lancet* 2372 <[https://www.thelancet.com/journals/lancet/article/PIIS0104-6736\(17\)31794-4/fulltext?elsca=t1pr](https://www.thelancet.com/journals/lancet/article/PIIS0104-6736(17)31794-4/fulltext?elsca=t1pr)> accessed 11 July 2021 (a study by WHO and Guttmacher Institute using a three-tiered categorisation of abortion – as safe, less safe and least safe, to represent all situations along the spectrum of unsafe abortion); See also Soumya Gupta and Isha Trivedi, 'Abortion comes at a steep price in India' (10 Nov 2017, *LiveMint*) <<https://www.livemint.com/Science/a5QMsT48DwglFGzglZlQ6H/Abortion-comes-at-a-steep-price-in-India.html>> accessed 11 July 2021; Soumya Gupta and Isha Trivedi, 'Attitudes to Abortion Putting Women at Risk of Exploitation' (17 November 2017, *LiveMint*) <<https://www.livemint.com/Science/Ug7l9ukXqIYZwgWcvhpTQJ/Attitudes-to-abortion-putting-women-at-risk-of-exploitation.html>> accessed 11 July 2020; Tania Boler and others, 'Medical Abortion in India: A Model for the Rest of the World' (2009, *Marie Stopes International*) 8 <<https://www.mschoices.org/media/2131/medical-abortion-in-india.pdf>> accessed 11 July 2021 ("[w]omen using "backstreet" clinical settings are open to exploitation, for example, in terms of the price charged and forced sterilisation as a determinant for surgery").
- 706 Interview with HM, government doctor at a tertiary care facility in Pune Maharashtra.
- 707 WHO, 'Medical Management of Abortion' (n 598) 29, 40 ("[...] abortion process can be self-managed with pregnancies less than 12 weeks of gestation without direct supervision of a health care provider (evidence is limited for pregnancies greater than 10 weeks) [...] studies are needed on the efficacy, safety and acceptability of medical abortion [...] in the outpatient setting for pregnancies 9-12 weeks of gestation"); In September 2019, UK's National Institute for Health and Care Excellence, in consultation with Royal College of Obstetricians and Gynaecologists, recommended that women should be offered a choice between medication and surgical abortion up to 24 weeks of gestation. The recommending committee noted the lack of evidence indicating any "clinically important difference" in completion of abortion between 13-24 weeks of gestation using surgical or medication methods, or the risks involved (such as haemorrhage necessitating blood transfusion, infections or uterine injuries) between the two methods. However, it opined that medication abortion carries an "extremely low" risk of cervical injury, see 'Abortion Care NICE Guideline' (n 620). These recommendations for medical

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- abortion are also in tune with the International Federation of Gynaecology and Obstetrics' ("FIGO") updated guidelines on use of misoprostol-only regime for abortions, see Jessica L Morris, 'FIGO's Updated Recommendations for Misoprostol used alone in Gynaecology and Obstetrics' (n 624).
- 708 Bela Ganatra 'Global, Regional and Sub-Regional Classification of Abortions by Safety' (n 705) 2378-2379; Bela Ganatra and others, 'Availability of Medical Abortion Pills and the Role of Chemists: A Study from Bihar and Jharkhand' (2005) 13(26) *Reproductive Health Matters* 65 <[https://doi.org/10.1016/S0968-8080\(05\)26215-8](https://doi.org/10.1016/S0968-8080(05)26215-8)> 73 accessed 11 July 2021; See Anuya A. Pawde and others, 'A Study of Incomplete Abortion Following Medical Method of Abortion (MMA)' (2016) 66(4) *Journal of Obstetrics and Gynaecology India* 239 <[10.1007/s13224-015-0673-1](https://doi.org/10.1007/s13224-015-0673-1)> accessed 11 July 2021 (Of the 100 women with first trimester incomplete abortion, who participated in the study, 32 had medication abortion. Only 15.6% had obtained the prescription from an MBBS doctor (who may or may not have been a registered medical practitioner under the MTP Act). 63.3% of the women who had medication abortion required blood transfusion, however this was associated with use of MA drugs "at higher gestational age (mean gestational age 11 weeks), use of single drug rather than [recommended combination], and late presentation]" at the hospital").
- 709 See for instance, interview with AW, government doctor at a tertiary care facility in Delhi; interview with JG, government doctor at a tertiary care facility in Chennai, Tamil Nadu; interview with IW, doctor at private hospital in Chennai, Tamil Nadu; interview with FD, government doctor in a district hospital in Jharkhand; interview with GG, government doctor in a tertiary health care facility, Mumbai, Maharashtra; interview with HM, government doctor at a tertiary care facility in Pune Maharashtra; interview with FO and FP, government officials at the Food and Drug Administration, Mumbai, Maharashtra; But see also WHO, 'Health Worker Roles in Providing Safe Abortion Care' (n 644) (Annexure 8: MA 3 (pages 70-75) provides evidence of the effectiveness and safety of self-administered medication abortion. It notes that "there may be little or no difference in the rate of serious adverse events (hospitalisation, blood transfusion or death) when women themselves manage medication for medical abortion"); Ingrida Platais and others, 'Prospective Study of Home Use of Mifepristone and Misoprostol for Medical Abortion upto 10 weeks of Pregnancy in Kazakhstan' (2016) 134 (3) *International Journal of Gynaecology and Obstetrics* 268-71 <[10.1016/j.ijgo.2016.02.018](https://doi.org/10.1016/j.ijgo.2016.02.018)> accessed 11 July 2021 as cited in WHO, 'Medical Management of Abortion' (n 598) (In this study on efficacy of medical abortion self-administered at home, only 1% of the women participants (3 out of 289) required surgical intervention for incomplete abortion).
- 710 Interview with IA, government official associated with the National Health Mission, Chennai, Tamil Nadu.
- 711 Bela Ganatra, 'Availability of Medical Abortion Pills' (n 708) 73.
- 712 Tania Boler and others, 'Medical Abortion in India' (n 705) 8.
- 713 WHO, 'Medical Management of Abortion' (n 598) para 3.4.3.
- 714 *ibid*, para 3.1.1 (At a minimum, following information should be provided – "the available options for abortion methods and pain management; what will be done before, during and after the procedure, including any tests that may be performed; what they are likely to experience (e.g. pain and bleeding) and how long procedure and the recovery are likely to take (vaginal bleeding for two weeks is normal after medical abortion – such bleeding can last up to 45 days in rare cases); how to recognise potential complications, and how and where to seek help, if required (individuals should return to the hospital or clinic if they experience increased intensity of cramping or abdominal pain, heavy vaginal bleeding and / or fever); when normal activities can be resumed, including sexual intercourse (the return of fertility can occur within two weeks following abortion); where and how to access additional services and follow-up care").
- 715 See also WHO, *Frequently Asked Clinical Questions about Medical Abortion: Conclusions of an International Consensus Conference on Medical Abortion in Early First Trimester*, Bellagio: Italy (2006) 3-13 (on pre-abortion care).
- 716 WHO, 'Medical Management of Abortion' (n 598) para 3.1.4.
- 717 WHO, 'Model List of Essential Medicines, 20th List' (March 2017) 46 <<https://www.who.int/publications/i/item/eml-20>> accessed 11 July 2021.
- 718 WHO, 'Model List of Essential Medicines, 21st List' (2019) 47 <<https://apps.who.int/iris/bitstream/handle/10665/325771/WHO-MVP-EMP-IAU-2019.06-eng.pdf>> accessed 11 July 2021.
- 719 See WHO, Department of Reproductive Health and Research, 'Essential Medicines List Application Mifepristone–Misoprostol for Medical Abortion' 2 <https://www.who.int/selection_medicines/committees/expert/22/applications/s22.1_mifepristone-misoprostol.pdf> accessed 11 July 2021 (citing WHO, 'Health Worker Roles in Providing Safe Abortion Care' (n 644) and Bela Ganatra, 'Health Worker Roles in Safe Abortion Care and Post-Abortion Contraception' (2015) 3(9) *The Lancet Global Health* 512 <[https://doi.org/10.1016/S2214-109X\(15\)00145-X](https://doi.org/10.1016/S2214-109X(15)00145-X)> accessed 11 July 2021).
- 720 Aradhana Srivastava and others, 'Pathways to Seeking Medication Abortion Care: A Qualitative Research in Uttar Pradesh India' (2019) 14(5) *PLoS ONE* e0216738 <<https://doi.org/10.1371/journal.pone.0216738>> accessed 11 July 2021 ("[...] users first sought MA kits at pharmacies out of convenience, low cost and customer anonymity...as pharmacists are often the first point of care and the main source of abortion medication and guidance, they should be trained to inform customers adequately to ensure clients know what to expect when taking MA"); See also, Bela Ganatra, 'Availability of Medical Abortion Pills' (n 708) 73 ("providing chemists with educational material on abortion and abortifacient drugs that they can provide to customers at the time of drug sales may also be useful [...] Keeping in mind the low literacy level in these two states, material that rely on pictorial messaging may be needed"); Tania Boler and others, 'Medical Abortion in India' (n 705) 8.
- 721 See Maria Rodriguez and others, 'Medical Abortion Offered in Pharmacy versus Clinic Based Settings' (2020) 3 (CD1013566) *Cochrane Database of Systematic Review* 2 <<https://doi.org/10.1002/14651858.CD013566>> accessed 11 July 2021 (In this article proposing a review of the safety and efficacy of medical abortion administered through pharmacies, the authors argue that pharmacies could play an important role in provision of safe abortion services through "formal or informal distribution of information or medications", which may aid in management and reduction of complications as well as morbidity linked to unsafe abortion).
- 722 Draft Medical Termination of Pregnancy (Amendment) Bill, 2014, cl 3 (substituting the definition of 'registered medical practitioner' under s 2(d) of the MTP Act with that of 'registered health care provider'. A registered health care provider includes practitioners of Ayurveda, Unani, Siddha and Homoeopathy medicine as well as nurses or auxiliary nurse midwives); But see MTP Amendment Act, 2021 (where a registered medical practitioner is required to perform abortions).

7 Mandatory Reporting Requirement under the POCSO Act

The CrPC does not require anyone to report the commission of an offence to the police, except for a limited set of offences listed in Section 39 of the Code. Sexual offences, punishable under the IPC are not in this list of offences that require to be reported.⁷²³ However, POCSO Act requires a person who has knowledge that an offence under the Act has been committed or is likely to be committed, to report the same to the police.⁷²⁴ Failure to report is punishable and can lead to imprisonment for a maximum period of six months.⁷²⁵ This mandatory requirement to report under the POCSO Act is meant to further India's obligation under the Convention on the Rights of the Child to protect children from "any form of abuse, exploitation and neglect."⁷²⁶ As stated in the Model Guidelines under the POCSO Act, the mandatory reporting requirement aims to identify children who are at risk of sexual abuse and protect them from further harm.⁷²⁷ The Act recognises that the child may not want to report the sexual abuse for a variety of reasons, and therefore places the burden of such reporting on the adults surrounding the child who may find out about the abuse in a personal or professional capacity (doctors, parents, teachers, counsellors, NGO workers etc.). It is not necessary for such adults to disclose the duty to report to the child or the child's guardian.⁷²⁸ In this way, the requirement seeks to target under-reporting of child sexual abuse by bringing forward the abuse and preventing further harm by the offender.⁷²⁹

This chapter demonstrates that the mandatory reporting requirement under the POCSO Act hinders access to safe abortion services for minors. Since the POCSO Act requires doctors to mandatorily report to the police if they come across a case where an offence under the Act has been committed or is likely to be committed, it forces minor girls to make one of three choices; first, obtaining an abortion from a health facility, which would lead to their partner (and possibly them) being prosecuted under the POCSO Act; second, not getting an abortion at all and carrying the pregnancy to term without accessing ante-natal care; or third, obtaining an abortion from an unsafe and/or illegal facility. The mandatory reporting requirement also poses a dilemma for service providers, who must choose between their statutory obligation to report to the police, and their ethical duty of confidentiality as medical professionals, especially where the patient expressly wishes not to involve the legal system. There is also a lot of confusion around the form and timing of the mandatory reporting requirement, which further deters providers. Finally, not only does this reporting requirement adversely impact access to safe abortion, it also prevents/prohibits access to contraceptive service, advice and information.⁷³⁰



LEGAL FRAMEWORK UNDER THE POCSO ACT

The POCSO Act was enacted in order to provide a comprehensive legal framework for addressing child sexual abuse. Section 2(1)(d) of the POCSO Act defines a “child” as a person below the age of 18 years.⁷³¹ Section 3 criminalises penetrative sexual assault (inserting the penis, any body part or object into an orifice of the child, or making a child do this with another person/child). Note that the Act is gender neutral with respect to both the survivor and the perpetrator, i.e., both can be of any gender. Therefore, any sexual activity with anyone below the age of 18 years is an offence. Consent is immaterial. Significantly, the POCSO Act does not consider closeness in age as a circumstance to not hold the person/s criminally liable. Hence, for instance, it treats consensual sexual activity between a 17-year-old and a 19-year-old similarly as forced sexual activity between a 17-year-old and a 30-year-old.

Before the POCSO Act came into force, the age of consent for sexual intercourse under Section 375 of the IPC was 16 years. Section 375 was subsequently amended in 2013, and the age of consent for sexual activity was increased to 18. In fact, the Justice Verma Committee, which was set up in December 2012 to suggest changes to Indian rape law, had taken note that the POCSO Act had in June 2012 raised the age of consent from 16 to 18 years, and recommended that the age of consent in the IPC (which was 16 years at that time) not be changed.⁷³² It also recommended that the definition of “child” in the POCSO Act be amended to mean a child under the age of 16, and not 18.⁷³³ This recommendation was not accepted, and the age for sexual consent in the IPC too was increased to 18 years. The IPC made a distinction between married and unmarried girls, and extended the marital rape exemption in the IPC to married girls above the age of 15.⁷³⁴ This was challenged before the Supreme Court, which struck down the exemption.⁷³⁵ Consequently, the age for sexual consent is now 18 years, irrespective of whether the couple is married or not.

Section 19(1) of the POCSO Act mandates that any person, including any child, who has knowledge of the *commission* of an offence punishable under the POCSO Act, or an *apprehension* that such an offence may be committed, is required to provide such information to the special juvenile police unit or local police. Failure to report, as required by Section 19, is punishable with imprisonment of up to six months or fine or both.⁷³⁶ Children, however, have been exempted from liability by Section 21(3) of the Act. This reporting requirement therefore extends to all sexual activity before the age of 18 since under the law consent is immaterial. Therefore, anyone having knowledge or apprehension of any adolescent sexual activity must report it or be subject to punishment. In this context, it is worth noting that prior to the enactment of the POCSO Act, the Government held consultations

with multiple stakeholders and experts regarding various aspects of the Act, including the mandatory reporting provision.⁷³⁷ According to a person who was part of these consultations, most experts consulted were not in favour of introducing a mandatory reporting provision. It was felt that there had not been enough research exploring the consequences of mandatory reporting, especially as an obligation imposed on all. Some opined that the obligation to mandatorily report should be confined to a few situations.⁷³⁸ However, these recommendations were not accepted, and a blanket mandatory reporting provision was introduced in the Act.

II **IMPACT OF THE MANDATORY REPORTING PROVISION ON PREGNANT GIRLS**

A **SEEKING CLANDESTINE/UNSAFE ABORTIONS**

Since consent is irrelevant in cases under the POCSO Act, the Act brings within its ambit girls whose pregnancy may be a result of consensual sexual intercourse with a partner. Further, sexual activity resulting in pregnancy is an aggravated offence under Section 5(j)(ii) of the POCSO Act, which carries a minimum punishment of imprisonment for 20 years, and a maximum punishment of death.⁷³⁹ Consequently, although they may want to seek abortion services, girls risk their partners being prosecuted and punished if the case is reported to the police. They may be especially wary of the legal system if the activity was consensual,⁷⁴⁰ or the person responsible for the pregnancy is a family member.⁷⁴¹ Often parents do not want to report, preferring termination of the pregnancy in anonymity.⁷⁴² Further, generally girls and their parents may be wary of getting involved with the legal system. In such circumstances, mandatory reporting leads to denial or delay in accessing safe abortion, as girls are forced to seek services from quacks or illegal abortion centres, with dangerous consequences.⁷⁴³

We came across two cases in Tamil Nadu with contrasting situations, but with the same reproductive health consequence for the victim. The first case involved a 13-year-old girl who reported to a government health centre with abdominal pain. She was found to be five months pregnant, but seemed unaware of how she had become pregnant. When the doctor questioned her privately, she revealed that she had been raped by her father. However, she did not want to report the crime, and hence was not provided abortion services. She decided to go to another facility where she could get the abortion done secretly.⁷⁴⁴ The second case involved a 16-year-old girl who had become pregnant after a consensual sexual act with her partner. She (and her mother) wanted to terminate the pregnancy in privacy, since they could not stay in their neighbourhood due to the stigma of the pregnancy. However, when they realised that accessing abortion services

would mean that the police would be informed and criminal prosecution would be initiated against the boy, the girl decided not to seek the abortion. The mother later reported that the daughter had had a “natural” abortion in the first trimester using “herbs” given by someone.⁷⁴⁵ These cases provide a contrasting picture of why underage girls do not want to report to the police, and the failure of the existing legal framework to differentiate between and provide appropriate remedies for child sexual abuse and adolescent sexual activity. The first case falls within a classic definition of child sexual abuse, whereas the second one is an attempt to use criminal sanction to proscribe adolescent sexual behaviour. The mandatory reporting requirement seeks to identify cases of sexual abuse, which, as the two cases demonstrate, it does not succeed in doing – it potentially results in dangerous health consequences for the girl, who effectively is re-victimised. Mandatory reporting to the police makes interface with the criminal justice system a pre-condition for accessing abortion services, and leaves girls vulnerable both to continuing exploitation as well as to worsening health outcomes from unmet sexual and reproductive health needs.

Such cases of clandestine abortions were reported in other states as well. According to the Additional Public Prosecutor in Chaibasa, Jharkhand, if parents get to know about their daughter’s pregnancy, and if the pregnancy is within the first one or two months, they get an abortion done secretly.⁷⁴⁶ This problem appears to be particularly acute in rural areas across the country. Recognising this, service providers at the Dharmapuri government hospital in Tamil Nadu told us that they prefer to provide abortion first, and report the case to the police thereafter.⁷⁴⁷

In contrast, girls who approach a non-governmental medical facility in Pune have to wait for the facility to report the case to the police, and for the police to come there and register a case, before they are provided abortion services. This leads to situations where the girl decides not to avail abortion services at the facility. We came across a case of a married couple (the girl being a minor), who wanted an abortion and approached the facility.⁷⁴⁸ The facility, as per its standard practice, reported the case to the police. The policewoman who arrived at the facility in response to the report, told the husband that he would be prosecuted, and his wife would be sent to a shelter home. However, she also told them that they could discard all the papers and get an abortion done from a remote place. Clearly, the policewoman was sympathetic towards the couple, possibly since they were already married, and hence, advised them on how to avoid criminal prosecution. The clinic reached out to private practitioners, all of whom refused to provide the service. Eventually, the couple left the facility and did not return. Similarly, when an unmarried minor girl, who had become pregnant as a result of consensual intercourse approached the same clinic, she was also told that the police would be informed. However, her family was concerned that reporting would

lead to their reputation being tarnished and wanted the matter to remain entirely private. The family proposed that the couple get married. When the clinic objected to this on the ground that the boy and girl were too young to be married, the family said they would “manage” the issue themselves and did not return. They were in fact unhappy with the person who had referred them to the clinic in the first place.⁷⁴⁹ In this context, it is important to recognise the continued prevalence of child marriage in India,⁷⁵⁰ and the impracticality in this context, of asking married couples not to engage in sexual activity until they turn eighteen.⁷⁵¹

Cases have been reported by the Centre for Enquiry into Health and Allied Themes (CEHAT),⁷⁵² where underage girls have preferred to go to unregistered hospitals to access abortion services rather than report the matter to the police.⁷⁵³ Doctors have also expressed concern that mandatory reporting will result in girls approaching quacks or resorting to other dangerous methods of abortion.⁷⁵⁴ Similarly, WHO has noted that, that the fear that confidentiality will not be maintained, deters many women – particularly adolescents and unmarried women – from seeking safe, legal abortion services, and may drive them to clandestine, unsafe abortion providers.⁷⁵⁵ It has recommended that rape survivors not be required to press charges or to identify the man alleged to have committed rape on them in order to obtain an abortion.⁷⁵⁶

Lack of access to safe and legal abortions often causes many young girls to lie about their actual age in order to seek termination of pregnancy in some form or another.⁷⁵⁷ In the context of consensual sexual relationships between underage couples/adolescents, the state instead of using education as a tool to make them aware of the risks of early pregnancy, and taking measures to reduce maternal morbidity rates caused by early pregnancy and unsafe abortion practices, has focused on using criminal law, particularly against the girl’s partner.⁷⁵⁸ Research has indicated that the risk of death from an abortion related complication in India is highest in the case of underage girls (aged 15-19).⁷⁵⁹ Hence, unsafe abortions in underage girls is a major concern, and a public health issue that warrants attention.

B ENTERING INTO COMPROMISES

In several communities, the law does not play a role at all when it comes to underage sexual activity (either consensual or non-consensual). Instead of reporting the case to the police, and taking the legal route, a social method (often termed as ‘compromise’) is resorted to. This may be due to fear of social stigma in case the incident were to become public,⁷⁶⁰ or a general reluctance to get involved with the legal process.⁷⁶¹ The girl is married off either to her partner (in cases where intercourse was consensual) or the man who raped her,⁷⁶² or to a third person. Such marriage is

viewed as a satisfactory resolution of the matter. Abortion does not enter the picture at all, since the stigma of being an unwed mother no longer applies. These situations illustrate the disconnect between the law and social realities. The “stigma” of a pregnancy outside marriage overrides any desire to seek legal recourse, even where the act is non-consensual. The lack of access to safe and confidential abortion can therefore push young girls into early marriage against their will.

In Chennai, a 17-year-old girl delivered a child in the bathroom of an examination centre, where she had gone to appear in an examination. The pregnancy was a result of a consensual relationship between her and her cousin. Since they were not married, the young girl felt helpless and in a desperate situation. She abandoned the child in a field nearby. Instead of reporting the case to the police as required under the POCSO Act, it was suggested to the parents of the couple that the two be married to each other. The parents were also warned that if the boy did not marry the girl, legal action would be initiated, and he risked imprisonment. The two ultimately got married. The authorities justified their actions by saying that had this marriage not taken place, no one would have married the girl and the boy would have gone to prison. Hence, they viewed the marriage as a “just” outcome.⁷⁶³

In fact, in most cases of pregnancy arising out of underage sexual intercourse, due to the stigma and shame associated with sexual activity, most girls do not reveal the fact of their pregnancy until they absolutely have to, or it becomes overtly evident due to physical changes in their bodies.⁷⁶⁴ By this point, they often cannot access safe abortion as most service providers are wary of providing abortion, citing so-called health risks. In such situations, marriage is sometimes seen as a convenient solution that allows them to carry the pregnancy to term without social shame. Other times, they obtain the abortion through unsafe and/or illegal methods. For instance, we came across a case in Mumbai, where a girl who was in a consensual relationship got pregnant at the age of 16. Thereafter, her partner stopped taking her calls. The pregnancy was around twenty-four weeks and she could not gain admission in any of the hospitals in Mumbai because she was deemed too young for an abortion. Her parents took her to Kolhapur, where she obtained an abortion.⁷⁶⁵

In Chaibasa, in West Singhbhum district of Jharkhand, the mandatory reporting requirement poses a problem due to cultural norms relating to sex and marriage in which domestic and intimate partnerships are prevalent among unmarried adolescents and are not socially frowned upon. We were told that this is also the case in certain other areas of the country, such as Wayanad and Idukki in Kerala.⁷⁶⁶ We came across a case where an underage couple, who no longer wanted to be together, approached the District Hospital for an abortion. They were advised to “resolve the

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“Like it happens in the village, the relationship happens but there is no ‘tag’ of them being married...It is like live-in relationship. But then now, things were not working out between them and they were saying we will separate and don’t want to have the child. Their age was also very less. The girl was below 18. They wanted to get the abortion. We told them that abortion was very difficult as the girl was very young.

We told them to resolve / compromise (*rajamandi kar lijiye*) as there could be danger to her life due to the abortion. Then they went to the doctor. They were insisting to get it done (*zid kar rahe the – karayenge karayenge*). We told them to resolve the matter internally and get married only. We told them there was a risk that she could have excess bleeding, it could endanger her life or she may not become mother again. Then I don’t know what happened. Those people did not come back again.”
- FA, family planning counsellor at a district hospital, Jharkhand.



IMPACT ON SERVICE PROVIDERS

matter” by getting married to each other. They were told that if an abortion were to be performed, there were various risks involved, including danger to the girl’s life, the possibility of excessive bleeding, and secondary infertility. They left the hospital, never to return.⁷⁶⁷ Generally, cases like these do not get reported, and the government mechanisms working in this sphere do not interfere too much with the munda-manki (village heads) system.⁷⁶⁸ Under this system, the heads of the village intervene to “resolve” the issue, rather than report the matter to the police, as required by the POCSO Act. Consequently, in Chaibasa, multiple cases have been filed against the heads of the village, who have subsequently been convicted under Section 21 of the POCSO Act.⁷⁶⁹ The Additional Public Prosecutor in Chaibasa told us about a couple of cases where the munda (village head) tried to prevent the family from going to the police station and filing a case under the POCSO Act. In these cases, the munda was convicted for an offence under Section 21. In one of these cases, two other parties who supported the munda (including a sahiya or front-line health worker) were also convicted.⁷⁷⁰

Service providers face a dual dilemma. First, underage girls do not want any interface with the legal system, but want to seek sexual and reproductive health services. Second, service providers are also not clear on what the reporting requirement means and how it is to be fulfilled. Often, in cases involving underage girls, service providers believe that they have to seek additional permissions before conducting an abortion.⁷⁷¹ This, along with service providers hearing anecdotal reports of doctors being arrested for commission of an offence under Section 21 of the POCSO Act, makes them wary of providing abortions to underage girls.

Service providers are also faced with an ethical dilemma between their legal mandate to report under the POCSO Act and their patient’s preference to neither have her parents nor the legal system involved. As discussed earlier, when informed of the reporting requirement, most girls do not seek reproductive health services and do not even return to the facility again.⁷⁷² A government practitioner near the Dharavi slum area in Mumbai told us that 40% of his patients are minors, and he notifies the police in all cases which in his opinion involve underage sexual activity. He added that most of these cases are consensual, and consequently, sometimes the girls lie about their age. He was apprehensive that in such cases the police may proceed against the doctor for providing abortion services to a minor, without reporting first. Hence, he believed that it is always better to first report to the police, or let the police take in writing from the girls that they do not want to report.⁷⁷³ Private practitioners in Mumbai reported anecdotes of police officers⁷⁷⁴ and other legal

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“The [POCSO] Act is to stop sexual abuse of children. But we know of so many young people, 16 or 17yr olds, and their hormones are pushing them into sexual activity. Then they have consensual sex, they do land up in problems and we do inform police in such cases but the outcome is really pathetic. Police charges boy with rape, and the boy will be ruined for his life. Girl will sometimes stand by him and say it was consensual, but most easy way out is to say it was nonconsensual. What police has to do – law does not say. It just says you inform police, but what the police has to do – the law does not say. Police usually extracts money from every party possible. That happens.”
- HG, doctor at a private hospital in Pune, Maharashtra.

“We have to follow age-wise. More than 18: self-consent is fine. Less than 18: they have to get court report or order and then only abortion services are provided... They have to communicate to local police from where they are coming. Police takes the case to court.”
- JD, government doctor in tertiary care facility, Chennai, Tamil Nadu
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functionaries demanding bribes from service providers, for not being proceeded against for their failure to report.⁷⁷⁵ They also complained of regular inspections of their facility under the garb of checking compliance with the POCSO Act.⁷⁷⁶ We were told of a case where a 16-year-old girl approached a doctor for post-abortion care after having had an illegal abortion elsewhere. The doctor treated the girl. However, the police found out, came to his clinic, and asked him to shut his clinic down, as he had not reported the case to them. Note that POCSO Act does not provide the police the power to shut down an establishment for non-reporting. Ultimately, the doctor apparently paid a bribe, so that no action was taken against him.⁷⁷⁷ In many cases, therefore, when underage girls approach providers for abortion services, they are either refused, or leave without obtaining the abortion.

In some situations, women are advised by providers themselves that the abortion should be sought elsewhere. We were told of a case where a married couple from Assam (who were both 15 years old) travelled to Chennai and approached a private practitioner there for an abortion. The doctor advised them not to get an abortion done in Chennai where most doctors comply with the reporting requirement. The doctor suggested to them that they return to Assam and get the abortion there, since he believed that doctors in Assam might not be as strict about complying with the mandatory reporting requirement.⁷⁷⁸ Doctors may also charge extra for providing reproductive health services to minor girls without reporting to the police. We were told of a case in Pune, Maharashtra, where a married underage girl approached a private practitioner for delivering her child. The doctor delivered the child but charged her four times the regular cost. He also advised her to remain inside the house, so that prosecution under the POCSO Act was not initiated against her husband.⁷⁷⁹

Further, as noted earlier, there is little clarity for providers on what the reporting requirement actually means. They are not clear at what point they need to report and in the absence of a template/proforma, the manner/form in which a case has to be reported.⁷⁸⁰ As a result, some providers insist on an order from a court (which is contrary to Rule 6(3) of the POCSO Rules,⁷⁸¹ and is not mandated by any other law) before they provide abortion services for underage girls, irrespective of gestational age. At a leading government hospital in Chennai, if a girl under 18 years of age seeks abortion services, she is asked to get a “court report” or court order before abortion services are provided.⁷⁸² There is a police facility within the hospital, and the girl seeking abortion is sent there. The police then register a case and approach the court. A senior government official in Chennai identified the lack of continuing education as a reason for doctors not being aware of their obligations under the POCSO Act. He was of the opinion that doctors need to be trained about

their roles and responsibilities under the Act.⁷⁸³

In order to provide sexual and reproductive health services to underage girls, without reporting to the police, many providers try to find loopholes in the law, using which they attempt to escape from the rigours of the laws.⁷⁸⁴ On the other hand, we found that many hospitals in Maharashtra are under the impression that they must immediately report to the police, when an underage girl seeks an abortion. They do not provide the service until they complete the reporting requirement.⁷⁸⁵ In one case in Mumbai, the girl was told she could not obtain an abortion until after the police had filed a FIR, because the police insisted on giving the service provider a DNA kit to preserve the products of conception before the procedure could be performed.⁷⁸⁶

IV **CONFUSION REGARDING INTERFACE OF POCSO ACT WITH OTHER LAWS**

Service providers are also confused about the interface of the MTP Act and the POCSO Act with the JJ Act, and therefore the involvement of CWCs. Given that under the POCSO Act, all instances of sexual activity before the age of 18 are deemed to be non-consensual, many authorities are under the impression that one or both parties involved are children “in need of care and protection” under the JJ Act.⁷⁸⁷ This leads to permission/authorisation being sought from CWCs before service providers can terminate the pregnancy. There have been several news reports of service providers being investigated for providing an abortion without prior permission from the CWC,⁷⁸⁸ or the CWC denying permission to doctors to conduct abortions.⁷⁸⁹

In Tamil Nadu in particular, it appears that when underage girls approach doctors seeking termination of their pregnancies, doctors prefer to seek and get judicial authorisation (although the law does not require it) out of fear that if there is any complication, the doctor will be held liable.⁷⁹⁰ In spite of the fact that in their training the Tamil Nadu police, as well as members of the CWCs are told that authorisation from a court is not required in order to provide abortion services to an underage girl, medical facilities seek authorisation either from a court or from the CWC. When a pregnant underage girl approaches the medical facility seeking an abortion there is confusion as to the next steps. Doctors/hospitals are confused as to whether parental consent is sufficient, or whether they require authorisation from the CWC or a court, or whether all of them are required in order to perform an abortion.⁷⁹¹ We were told that this approach of doctors/hospitals is particularly problematic since a new set of people have been appointed to CWCs in Tamil Nadu recently, and are not certain of their role with regard to abortion.⁷⁹² There have been reports of the

CWC approaching court to authorise abortions even if the pregnancy is under 20 weeks.⁷⁹³

A complex case from Mumbai reflected the interplay of the MTP Act, the PCPNDT Act and the POCSO Act, and indicated various issues that underage girls face when they seek abortion services.

A woman approached a doctor in a government hospital with her 17-year-old daughter requesting an abortion. The pregnancy was a result of a consensual sexual act. The girl did not want to carry the pregnancy to term but did not want legal action against her partner, since she was in love with him. The doctor who was sympathetic to her, wanted to provide the abortion, but told them that since it was a government hospital, he would have to create a medico-legal record. So, he asked them to come to his private clinic instead. At the clinic, in an effort to help them, he recorded the mother's name as the patient's name and performed the abortion. Thereafter, he handed over the products of conception to the woman and asked her to dispose of it - apparently a common practice. When the mother and daughter were disposing of the products of conception, they were apprehended by the police. Since the foetus was female, questions as to whether it was a gender biased sex-selection also arose. During their investigation, the police found that the abortion had been performed on the girl, and not on the mother. However, as mentioned earlier, in his record in the clinic, the doctor had recorded the mother as the patient. We were told that the doctor was ultimately convicted under the POCSO Act.⁷⁹⁴

V IMPACT ON CONTRACEPTION AND CONTRACEPTIVE ADVICE

There is also concern around the wording of Section 19 of the POCSO Act being broad enough to hinder minors' access to contraceptive information and services.⁷⁹⁵ Further, there is confusion with respect to the POCSO Act's complete criminalisation of any sexual activity before the age of 18, and the conflicting guidelines under the Adolescent Reproductive and Sexual Health (ARSH) programme under the National Health Mission, as well as the Rashtriya Kishor Swasthya Karyakram (RKSK).⁷⁹⁶ Both these schemes recognise consensual sexual activity among adolescents. At a Community Health Centre ("CHC") where we conducted interviews for this study, a 15-year-old unmarried woman was administered an Intra Uterine Contraceptive Device. The medical officer in-charge objected, on the ground that the girl was unmarried. However, the treating doctor responded that as per ARSH guidelines unmarried women were allowed to obtain contraception.⁷⁹⁷

Some providers, including a member of the Obstetric and Gynaecological Society of Southern India, are of the opinion that contraception and contraceptive advice do not fall within the mandatory reporting requirement, and therefore, they provide contraceptive advice, without reporting to the police.⁷⁹⁸ A private practitioner in Pune contended that reporting is not required as contraceptives can also be used for therapeutic purposes.⁷⁹⁹ A study conducted in 2018 found that the number of minors in Tamil Nadu contracting sexually transmitted infections (“STIs”) was on the rise, but when the minors and their families were recommended by doctors to report to the police, they simply did not return to the medical facility for treatment of the STI.⁸⁰⁰ Therefore, the mandatory reporting requirement is also causing routine denial of care even for STIs.

VI CONCLUSION

The POCSO Act’s blanket criminalisation of all underage sexual activity irrespective of consent, as well as its reporting requirement, inhibit underage girls from approaching health service providers and accessing safe and comprehensive abortion services. It pushes girls to unsafe and illegal providers in order to access abortion services. The Act also presents myriad issues for service providers, such as the conflict between the reporting requirement and their duty of confidentiality under medical ethics as well as their patients’ reluctance to report. Providers, because of their lack of clarity and knowledge about the Act also take steps, such as seeking authorisation from courts or CWCs when they encounter an underage girl. This further impacts the sexual and reproductive health rights of girls and restrict their access to safe abortion services. Finally, not only does the POCSO Act affect abortion-seeking as well as abortion-providing behaviour, but it also may affect minors’ access to contraceptive information and services, due to the possibility of the mandatory reporting requirement covering such services as well.

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- 723 CrPC, s 357C, which was added to the Code in 2013, mandates hospitals to provide first aid or medical treatment free of cost to victims of rape. It also requires the hospital to “immediately inform the police of such incident.” Failure to follow the mandate of the section is punishable with imprisonment for a maximum of one year (IPC, s 166B). We did not come across any case relating to Sections 357C or 166B in our study, nor are there any cases that have reached appellate courts on this issue. Hence, in this chapter, we do not discuss Section 357C.
- 724 POCSO Act, s 19.
- 725 POCSO Act, s 20.
- 726 Centre for Child and Law, National Law School of India University, ‘An Analysis of Mandatory Reporting under the POCSO Act and its Implications on the Rights of Children’ (15 June 2018) 7-9 <<https://feministlawarchives.pldindia.org/wp-content/uploads/Mandatory-Reporting-Paper-CCL-NLSIU-1.pdf?>> accessed 11 July 2021.
- 727 Ministry of Women and Child Development, ‘Model Guidelines under Section 39 of the Protection of Children from Sexual Offences Act, 2012’ (September 2013) 73 <<http://wcd.nic.in/sites/default/files/POCSO-ModelGuidelines.pdf>> accessed 11 July 2021.
- 728 *ibid.*, 74.
- 729 Centre for Child and Law, ‘An Analysis of Mandatory Reporting under the POCSO Act’ (n 706) 3-4.
- 730 CrPC, s 357C also requires doctors to mandatorily report to the police if they come across a woman who has been raped. In our study, we did not come across cases of this nature, and hence, this chapter is confined to the POCSO Act.
- 731 Note that in this chapter, the term “underage girls” will be used to refer to girls under the age of 18. Most of the cases discussed are generally of the age group of 15-18 years.
- 732 Justice JS Verma and others, ‘Report of the Committee on Amendments to Criminal Law’ (January 23, 2013) 443-444 <<https://www.prsindia.org/uploads/media/Justice%20verma%20committee/js%20verma%20committe%20report.pdf>> accessed 11 July 2021.
- 733 *ibid.*
- 734 IPC, s 375, Exception 2.
- 735 *Independent Thought v Union of India & Anr* (2017) 10 SCC 800.
- 736 POCSO Act, s 21(1).
- 737 Interview with LN, lawyer practicing before the High Court of Madras at Chennai, Tamil Nadu.
- 738 Interview with LN, lawyer practicing before the High Court of Madras at Chennai, Tamil Nadu; Interview with HZ, head of a civil society organisation working on child rights, Chennai, Tamil Nadu.
- 739 POCSO Act, s 6(1).
- 740 Interview with IK, lawyer engaged with a civil society organisation in Chennai, Tamil Nadu.
- 741 Interview with IG, public health consultant and former government doctor, National Health Mission, Tamil Nadu.
- 742 Interview with IW, doctor at private hospital in Chennai, Tamil Nadu.
- 743 Interview with HQ, academician and researcher based in Chennai, Tamil Nadu; Family Planning Association of India, ‘Providing Essential Sexual and Reproductive Health Care to Adolescents in India in the Context of POCSO: Challenges and Recommendations, A Position Paper’ 5.
- 744 Interview with IC, government official at the Tamil Nadu National Health Mission.
- 745 Interview with LN, lawyer practicing before the High Court of Madras at Chennai, Tamil Nadu.
- 746 Interview with EH, Additional Public Prosecutor at Chaibasa District Court, West Singhbhum, Jharkhand.
- 747 Interview with KX, government doctor at a tertiary care centre, Tamil Nadu.
- 748 Interview with GZ, in-charge of a health facility operated by a non-profit organisation providing sexual and reproductive healthcare services
- 749 *ibid.*
- 750 See Madhu Mehra and Amrita Nandy, ‘Why Girls Run Away to Marry: Adolescent Realities and Socio-Legal Responses in India’ (2019, Partners for Law in Development) 1-3 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3560854> accessed 11 July 2021.
- 751 Interview with FR, lawyer practicing before the High Court of Bombay at Mumbai, Maharashtra.
- 752 CEHAT is a research centre involved in research, training, service and advocacy on health and allied themes.
- 753 Lawyers’ Collective and CEHAT, ‘Joint Submissions on the MoWCD National Child Protection Policy, 2019’ <<https://lawyerscollective.org/wp-content/uploads/2017/07/Joint-Submission-to-MoWCD.pdf>> accessed 11 July 2021.
- 754 ‘Maharashtra State Consultation to Review the Protection of Children from Sexual Offences Act, 2012’ (8-9 August 2014) 11 <<http://esocialsciences.org/Download/Download.aspx?qs=sO61F/Ryd+YqfWs04so3Md7C167rWaW5pINQ5IJXErDs1rLJND5icKvEAnX2oubR6CQnpIqWl1pwLrG1JLJLJlBlg3F9QbbmPnMxNx4hUMd7cDYnjK1Cz+cbjBe0IgL6ZQDhf1UriEKOnedp5hQ==>>> accessed 11 July 2021.
- 755 WHO, ‘Safe Abortion: Technical and Policy Guidance’ (n 29) 68-9.
- 756 *ibid.*
- 757 *ibid.*, 22.
- 758 *ibid.*, 17-19, 22.
- 759 See Ryo Yokeo and others, ‘Unsafe abortion and abortion-related death among 1.8 million women in India’ (2019) 4(3) *BMJ Global Health* 7 <<https://gh.bmj.com/content/bmjgh/4/3/e001491.full.pdf>> accessed 11 July 2021.
- 760 Mrinal Satish, *Discretion, Discrimination, and the Rule of Law: Reforming Rape Sentencing in India* (2016) 198.
- 761 See generally Pratiksha Baxi, ‘Justice is a Secret: Compromise in Rape Trials’ (2012) 44(3) *Contributions to India Sociology* 207 <<https://doi.org/10.1177/006996671004400301>> accessed 11 July 2021.
- 762 See eg Chandan Kumar, ‘Time running out for 14-year-old rape survivor seeking abortion’ (19 August 2016, *Hindustan Times*) <<https://www.hindustantimes.com/india-news/people-and-fate-betrayed-my-family-father/story-rKCXgBfovUrGYcvUB4rPgO.html>> accessed 11 July 2021.
- 763 Interview with IF, doctor and government official at the National Health Mission, Tamil Nadu.
- 764 Group discussion BE, with members of seventeen civil society organizations in Ranchi, Jharkhand.
- 765 Group discussion GI, with women in conditions of destitution, Mumbai, Maharashtra.
- 766 Interview with HZ, head of a civil society organisation working on child rights, Chennai, Tamil Nadu.
- 767 Interview with FA, family planning counsellor at a district hospital, Jharkhand.
- 768 Interview DR, a civil society organization based in West Singhbhum district, Jharkhand.
- 769 See for instance *State v Gurucharan Bari & Ors Spl POCSO Case No. 41/2018* (Order dated 19 March 2019) (Court of Additional Sessions Judge – I West Singhbhum at Chaibasa).
- 770 Interview with EH, Additional Public Prosecutors at Chaibasa District Court; *State v Gurucharan Bari & Ors Spl POCSO Case No. 41/2018* (Order dated

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- 19 March 2019) (Court of Additional Sessions Judge – I West Singhbhum at Chaibasa) (where the Munda, the Sahiya and another were convicted by the court).
- 771 See Chapter 4 for a discussion on the issue.
- 772 Interview with JH, government doctor at a tertiary care centre in Chennai, Tamil Nadu and member of FOGSI.
- 773 The law does not provide for this option. This may reflect an opinion of the service provider of the action taken by the police.
- 774 Interview with HG, doctor at a private hospital in Pune, Maharashtra.
- 775 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 776 *ibid.*
- 777 *ibid.*
- 778 Interview with IX, doctor at a private hospital in Chennai, Tamil Nadu.
- 779 Interview with GY, head of a health facility operated by a non-profit organisation providing sexual and reproductive healthcare services.
- 780 Interview with GA, member of a non-profit organisation providing sexual and reproductive healthcare services.
- 781 POCSO Rules, r 6(3) state as follows: “No medical practitioner, hospital or other medical facility center rendering emergency medical care to a child shall demand any legal or magisterial requisition or other documentation as a pre-requisite to rendering such care.”
- 782 Interview with JD, government doctor in tertiary care facility, Chennai, Tamil Nadu.
- 783 Interview with IE, doctor and government official, National Health Mission, Tamil Nadu.
- 784 Interview with AM, member of a civil society organisation working on health-related issues, and former head of department at a government tertiary care facility, Delhi; interview with AN, doctor engaged with a non-profit organisation providing sexual and reproductive healthcare services; interview with AP, doctor at a private hospital and former government doctor in a tertiary health care facility, Delhi.
- 785 Interview with HQ, academician and researcher based in Chennai, Tamil Nadu; interview with FS, lawyer practicing before the High Court of Bombay at Mumbai, Maharashtra.
- 786 Interview with FT, lawyer practicing before High Court of Bombay at Mumbai, Maharashtra.
- 787 Juvenile Justice (Care and Protection of Children) Act, 2015 (“JJ Act”), s 2(14).
- 788 Chetna Choudhry, ‘Abortion without CWC nod, doctors face probe’ (3 June 2018, Times of India) <<https://timesofindia.indiatimes.com/city/gurgaon/abortion-without-cwc-nod-docs-face-probe/articleshow/64432729.cms>> accessed 12 July 2021; Shruti Tomar, ‘Minor rape victims become mothers in MP’ (24 June 2016, Hindustan Times) <<https://www.hindustantimes.com/bhopal/minor-rape-victims-become-mothers-in-mp/story-OdFexxYUW5dxARoQtydv7H.html>> accessed 12 July 2021.
- 789 *Minor G v State & Anr*, WP (CrI) 344/2020, order dated 6 February 2020, Delhi High Court.
- 790 Interview with LN, lawyer practicing before the High Court of Madras at Chennai, Tamil Nadu.
- 791 Interview with HQ, academician and researcher based in Chennai, Tamil Nadu.
- 792 Interview with HZ, head of a civil society organisation working on child rights, Chennai, Tamil Nadu.
- 793 ‘Doctors terminate pregnancy of minor rape victim’ (20 September 2017, The Hindu) <<https://www.thehindu.com/news/national/tamil-nadu/doctors-terminate-pregnancy-of-minor-rape-victim/article19717346.ece>> accessed 12 July 2021.
- 794 Interview with HZ, head of a civil society organisation working on child rights, Chennai, Tamil Nadu; interview with FH, member of a civil society organization based in Mumbai, Maharashtra; interview with FV, lawyer practicing before the High Court of Bombay at Mumbai Maharashtra.
- 795 Interview with GB, doctor at a private hospital in Mumbai, Maharashtra.
- 796 Interviews with GJ and GK, members of a civil society organisation based in Pune, Maharashtra; Family Planning Association of India, Providing Essential Sexual and Reproductive Health Care to Adolescents in India in the Context of POCSO: Challenges and Recommendations, A Position Paper.
- 797 Interview with EW and EX, medical officers at a community health centre in Saraikela-Kharsawan district in Jharkhand; interview with EV, ANM and ARSH counsellor at a community health centre in Saraikela-Kharsawan district in Jharkhand.
- 798 Interview with JF, doctor formerly at a government tertiary care centre in Chennai, Tamil Nadu and member of OGSSI.
- 799 Interview with HD, doctor at a private hospital in Pune, Maharashtra.
- 800 Ekatha Ann John, ‘Child sex abuse: More TN kids queue up in clinics to treat sexually transmitted infections’ (19 April 2018, Times of India) <<https://timesofindia.indiatimes.com/city/chennai/why-hushed-cases-of-sti-among-tn-kids-could-indicate-child-sex-abuse/articleshow/63776402.cms>> accessed 12 July 2021.

8 Conclusion

This report demonstrates that the Indian Penal Code, 1860 (“**IPC**”) and the Medical Termination of Pregnancy Act, 1971 (“**MTP Act**”) along with a range of other laws create various legal barriers in accessing safe and comprehensive abortion care. These laws deny pregnant persons their rights to reproductive and sexual autonomy, bodily integrity, equality, health, privacy, and dignity. They enable a system of social and medical surveillance and control over women’s sexual and reproductive behaviour. At the same time, restrictive abortion laws do not reduce the incidence of unsafe abortions.⁸⁰¹ To the contrary, they actively push pregnant persons to such unsafe methods by denying them access to safe abortion services.⁸⁰²

While this study was conducted before the enactment of the Medical Termination of Pregnancy (Amendment) Act, 2021 (“**MTP Amendment Act, 2021**”), we discuss below how many of the concerns that we have highlighted in this report remain unaddressed despite the recent amendments. In this concluding chapter, we first summarise our findings. Next, we examine the MTP Amendment Act, 2021 and conclude that it does not address the barriers that we have identified. Finally, we provide our recommendations for law reform based on this study.

I KEY FINDINGS

The MTP Act is not a rights-based legislation. Abortion is and remains a crime under the IPC,⁸⁰³ and the MTP Act carves out an exception for “a registered medical practitioner [who] shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.”⁸⁰⁴ Thus, the MTP Act is a provider protection law. In direct contravention of the right to reproductive autonomy guaranteed by the Constitution,⁸⁰⁵ the MTP Act shifts decision-making regarding termination of a pregnancy from the person seeking such termination to the Registered Medical Practitioner (“**RMP**”). The law goes so far as to assume that the RMP,⁸⁰⁶ rather than the pregnant person, is the appropriate judge of the “actual and reasonably foreseeable circumstances” of the pregnant person in deciding whether to provide abortion or not.⁸⁰⁷

Our report demonstrates that RMPs’ decisions on whether to provide or withhold abortion services are influenced by a range of factors external to the health and autonomy interests of the person seeking abortion. These factors include a fear of getting embroiled in the legal process, general stigma around abortion, and patriarchal and ableist understandings of women’s appropriate role and behaviour in society.⁸⁰⁸

This report documents how the fear of the legal process, including the criminalisation of abortion under the IPC, the conflation of abortion and gender-biased sex-selection in the enforcement of the Preconception and Prenatal Diagnostic Techniques, 1994, (“PCPNDT Act”), mandatory reporting requirement under the Protection of Children from Sexual Offences Act, 2012 (“POCSO Act”), as well as hesitation regarding involvement in potential divorce or other civil proceedings, heavily influence service providers in deciding whether to provide abortion, and under what conditions. We note that service providers, be they RMPs, or pharmacists, or other service providers, face no consequences for denial of service. However, they open themselves up to potential legal implications for providing abortion services. In such a scenario, denial of service is often a safer option rather than providing the service.

This report documents the chilling effect of these laws on service providers’ willingness to provide abortion services, including through an outright denial of services, particularly in the second term, or through creating extra-legal barriers for pregnant persons to access abortion in order to safeguard service providers’ own interests. In particular, this report shows the kinds of extra-legal consent and documentation requirements that operate in practice, in order to protect service providers from potential legal liability. The report highlights how such extra-legal barriers often end up denying access to safe and legal abortion, especially for those in vulnerable socio-economic circumstances, undocumented persons, and those in precarious family situations.⁸⁰⁹ In the context of India, these circumstances generally overlap with caste, class, minority religion, disability, and gender non-conformity-based marginalisation.

Overall, the legal framework within which the MTP Act operates puts the RMP’s own interests in avoiding legal liability at odds with the best interests of the patient.

The report also documents how RMPs’ decisions about providing or withholding abortion services is often influenced by general abortion stigma. Often, service providers operate under the belief that all abortions are illegal, or that the MTP Act is “too liberal.”⁸¹⁰ Denial of abortion because of abortion stigma is often couched as “health” reasons, such as refusing abortion for first pregnancy on the ground that it may lead to infertility. There is little scientific evidence to back up these claims.⁸¹¹

RMPs and other service providers are also not immune from the general heteropatriarchal and ableist societal norms regarding woman’s role in society. These norms also shape service providers’ willingness to provide or deny abortion services. The report finds, unsurprisingly, that access

to abortion is easiest for married women, who have engaged in heterosexual, procreative sex, within marriage, and who seek abortion on grounds of foetal impairment, for spacing reasons, or because their family is complete. In such cases, the woman seeking abortion is viewed as desirous of performing her social role as a mother, but is either hindered by circumstances beyond her control, or her ability to mother her existing children is likely to be compromised by the current pregnancy. Never married women's access to abortion, on the other hand, is mediated by concerns about her marriageability versus fears of promoting "promiscuity" in women if abortion becomes easily accessible. The frequent use of terms like "illegal sex" and "illegal pregnancies" to refer to sex outside the confine of marriage demonstrates that denying abortion services is often a way to exercise social control over a woman's sexual and reproductive choices.⁸¹² The report highlights, through a brief examination of select medical textbooks, that medical education plays an important role in furthering these heteropatriarchal attitudes in RMPs.⁸¹³

Overall, the report concludes that in shifting the decision-making power over abortion from pregnant persons to RMPs, the law puts the former's constitutional, statutory, and human rights at the mercy of a chance encounter with a willing service provider. The law empowers and legitimises RMPs to act as gatekeepers to accessing abortion care, and creates a conflict between the RMP's own interests and the best interests of their patients.

Another legal barrier created by the MTP Act is that it permits abortions post- 20 weeks only when it is "immediately necessary to save the life of the pregnant woman."⁸¹⁴ Courts have created an elaborate system of third-party authorisations to determine when abortions can take place post-20 weeks. Building on an earlier analysis of post 20 weeks jurisprudence by the Centre for Reproductive Rights, in this report, we have extensively documented the problems that arise with mandating court authorisations for post-20 week abortions, as well as concerns with the procedures put in place by courts to determine when to permit abortions in such cases. In particular, we have examined problems with the setting up and functioning of medical boards to determine whether the termination should be authorised. We have noted the delays that take place because of this process, the multiple rounds of examinations that the pregnant person is subjected to by medical boards, and the lack of precise terms of reference to medical boards, which often results in a lack of clarity on what the boards are supposed to focus on. We note for example, that though the Supreme Court has held that the predominant concern in determining whether abortion should be authorised post-20 weeks is the health of the pregnant woman,⁸¹⁵ medical boards often focus predominantly on questions of foetal viability. The mental health impact on the pregnant person from carrying an unwanted pregnancy to term is often negated.⁸¹⁶

The report also concludes that the MTP Act framework is out of touch with advances in medical technology and the current state of abortion practice in India and around the world. In particular, the MTP Act was legislated at a time when surgical abortion was the safest method for termination of pregnancies. Today, the bulk of abortions take place through medications.⁸¹⁷ However, many of the requirements of this law, for example the requirement that abortions be conducted in approved facilities post 7 weeks,⁸¹⁸ and the kind of equipment etc., that these facilities are required to have, is out of touch with the needs of medication-based abortion practice. The registration and inspection requirements for facilities also pose an additional regulatory hurdle for service providers and operate as a disincentive to provide abortion services. We also note that these regulatory requirements are over and above those required for other clinical and medical establishments which may perform more complex procedures. This is again an indication that the regulatory framework for abortion is geared towards restricting access to safe abortion instead of protecting the reproductive autonomy and health needs of pregnant persons.⁸¹⁹

The conflation between the MTP Act and the PCPNDT Act serves to create additional barriers to accessing safe abortion services. While the PCPNDT Act criminalises sex determination and does not address gender biased sex selection, we document how in practice, PCPNDT is enforced through regulating access to abortion services. This conflation between the MTP Act and the PCPNDT Act in practice, has had significant adverse impact on access to abortion services since the fear of falling foul of the PCPNDT Act creates a strong disincentive for service providers to provide abortion services, especially in the second term. We find that many otherwise qualified establishments refuse to register themselves for second term abortions since they do not want to deal with the PCPNDT enforcement machinery. A significant cause for fearing the PCPNDT system is the fact that this law creates a range of documentation, reporting and other regulatory requirements apart from prohibiting sex-determination. However, the punishment for all contraventions of the law is the same.⁸²⁰ Thus, failure to stamp documents properly can lead to the same consequences as revealing the sex of the foetus. Since RMPs and their establishments are more likely to come under scrutiny of the PCPNDT Act authorities if they provide second term abortions, service providers are strongly deterred from providing such services.⁸²¹

Another area where the law operates as a barrier to safe abortion is in the restricted access to drugs required for medication abortion (“**MA drugs**”). The World Health Organisation (“**WHO**”) guidelines recommend self-administration of MA drugs up to 12 weeks of gestation, where the pregnant person has adequate information and access to medical care, should the need arise.⁸²² Contrary to these guidelines, Indian law authorises medication abortion (even under the

supervision of RMPs) only up to 9 weeks.⁸²³ All other use of medication abortion takes place “off-label.”⁸²⁴ While in practice, medication abortion is the most common method of abortion, and the bulk of such abortions are carried out outside facilities,⁸²⁵ the MTP Rules permit prescription of MA drugs outside approved facilities only up to 7 weeks.⁸²⁶ MA drugs are also over-regulated since access to MA drugs is conflated with seeking gender biased sex selective abortion. Therefore, drug controllers as well as authorities under the PCPNDT Act have been increasingly seeking to restrict access to these drugs. Because of this, we explore how pharmacists are increasingly wary of stocking MA drugs, or how they create extra-legal barriers for people to access these drugs, even when they have authorisation from RMPs. Overall, the reduced access to MA drugs in conjunction with the other ways in which the law creates barriers or enables extra-legal barriers to be created, significantly impedes access to safe abortion services.⁸²⁷

Finally, we document how the mandatory reporting requirement under the POCSO Act is creating a major obstacle to accessing safe abortion services for minors. The POCSO Act places a universal reporting requirement on anyone who has knowledge or apprehension that an offence under the Act has taken place or is likely to take place.⁸²⁸ Such a person must report the same to the local police on pain of criminal liability.⁸²⁹ The age of sexual consent under the POCSO Act and the IPC is 18 years, and any sexual activity under that age is an offence regardless of consent. This implies that all pregnancies under the age of 18 are deemed to be the result of an offence under the POCSO Act, and all such cases have to be reported to the police. However, for a variety of reasons, minors and/or their guardians may not want to engage with the criminal justice process. They may also prefer to seek abortion services in privacy. Thus, access to abortion services for minors has become contingent on reporting to the police and getting involved in the criminal justice process. We document how this reporting requirement drives abortion services to minors underground and opens them up to exploitation as well as adverse health outcomes.⁸³⁰

Overall, the report documents the various ways in which the legal framework governing abortions in India erects or exacerbates substantial barriers to accessing safe abortion services.

II THE MTP AMENDMENT ACT, 2021

In 2021, after 50 years of its enactment, the MTP Act underwent significant amendments. However, as we discuss below, these amendments have not addressed most of the barriers documented in this report.

The Statement of Objects and Reasons appended to the MTP Amendment Bill, 2021 states that:

“With the passage of time and advancement of medical technology for safe abortion, there is a scope for increasing upper gestational limit for terminating pregnancies especially for vulnerable women and for pregnancies with substantial foetal anomalies detected late in pregnancy. Further, there is also a need for increasing access of women to legal and safe abortion service in order to reduce maternal mortality and morbidity caused by unsafe abortion and its complications. Considering the need and demand for increased gestational limit under certain specified conditions and to ensure safety and well-being of women, it is proposed to amend the said Act.

The proposed Bill is a step towards safety and well-being of women and will enlarge the ambit and access of women to safe and legal abortion without compromising on safety and quality of care. The proposal will also ensure dignity, autonomy, confidentiality and justice for women who need to terminate pregnancy.”

Though this statement locates the 2021 amendments within the framework of “dignity, autonomy, confidentiality and justice” for pregnant women, as well as their “safety and well-being”, the amended Act fails to secure access to safe and comprehensive abortion care for the following reasons:

1 Fails to decriminalise abortion and recognise access to abortion as a health care right:

The MTP Amendment Act, 2021 leaves the basic framework of the laws intact. That is, abortion remains a crime, including for the woman seeking abortion, unless the termination is in consonance with the MTP Act. This implies that the woman seeking abortion, as well as the service provider are liable under the IPC, unless abortion is for the reasons mentioned in the MTP Act and is performed as per the requirements of the Act. Women do not have a right to an abortion if they choose to not carry a pregnancy to term. This leaves the core issue of treating abortion as a crime rather than as a healthcare measure intact and brings with it the range of concerns about the intersection of criminal law and healthcare services that we have documented in this report. These include the chilling effect of criminalisation on seeking and providing safe abortion services, as well as concerns regarding the extra-legal barriers erected by service providers to avoid legal liability. The RMP continues to perform a gatekeeping function for accessing abortion, and concerns about the extra-legal factors that influence RMPs decisions, are not resolved by these amendments. Thus,

the safety and well-being of pregnant persons, as well as their autonomy and dignity, will continue to be at the mercy of willing RMPs, whose own interests in avoiding legal liability can be in conflict with the best interests of the pregnant person.

2 Fails to move towards global standards on self-managed abortions and expanded provider base:

The MTP Act was enacted at a time when surgical abortion was the norm for providing safe abortion care, and the requirements under the Act were calibrated accordingly. The Statement of Objects and Reasons to the 2021 Amendment Act recognises that medical advances are one of the reasons behind the amendment. One of the most significant medical advances in the field of termination of pregnancies has been the shift from surgical to medication abortion for the bulk of pregnancies. The MTP Amendment Act, 2021 recognises this by defining terminations to include both medication and surgical abortions.⁸³¹ The WHO has moved towards self-management of abortions using MA drugs up to 12 weeks of pregnancy when accompanied by adequate information and access to medical facilities, should the need arise.⁸³² However, the MTP Amendment Act, 2021 still requires all abortions to be performed under the care of RMPs and for abortions to take place in facilities.⁸³³ While the Act leaves it to the Rules to define who counts as a RMP for purposes of the Act, it is clear that at the very least the RMP will have to be a duly qualified doctor, having some training in obstetrics and gynaecology.⁸³⁴ Earlier attempts under the MTP Amendment Bill, 2014⁸³⁵ to expand the provider base have been jettisoned.

3 Facility-focused approach as a barrier to access:

In the same vein, Section 4 retains the focus on facilities, instead of recognising the advances in medical sciences that enable home based provisioning of abortion care.⁸³⁶ While the exact nature of facilities that will be approved for providing abortion services, and the process of seeking such approval will be known only after the Rules under the Act are promulgated, the requirement for private facilities to seek specific approval under the MTP Act itself brings in an added layer of regulation beyond those that are required for other clinical establishments. Given that other, more complex, medical procedures can be carried out in other clinical establishments without the need for additional approvals, these requirements in the case of abortion services, when abortion is otherwise a relatively safe process, indicates that the motivation behind these extra regulations is to curb abortions rather than to advance women's access to healthcare.

4**Medical boards institutionalise prohibitive third-party authorisation requirements:**

Section 3 (2-D) of the now amended Act has provided statutory recognition to medical boards. The many problems with such boards, as documented in this report, will not be resolved through this amendment. While specific aspects of the functioning of these Boards will be determined through yet-to-be promulgated Rules, some concerns are evident on the face of the Act. First, it is unclear whether women can directly approach the Boards or whether there is need for prior court referral for this purpose. Second, Section 3(2C) of the amended Act states that each State and Union Territory shall constitute “a Board”, implying that a single Board shall be constituted for the entire state. In such a case, it is quite likely that the Board shall be constituted in the capital city of each State/Union Territory. This will create a range of access issues especially for persons from marginalised communities, as we have discussed in this report. Third, the law does not prescribe specific terms of reference for medical boards, or provide a framework for decision-making by such boards. Unless the Rules fill these gaps, the existing problems with the functioning of these boards, especially their disparate approaches to decision-making and their focus on foetal viability instead of the health of the pregnant person, will likely continue. The institutionalisation of such third-party authorisations for abortion also infringe pregnant persons’ rights to reproductive autonomy under the Constitution and under international human rights norms.⁸³⁷

5**Exacerbates false tensions between reproductive autonomy and disability rights through a continued exceptions framework:**

The MTP Act continues to operate within an exceptions regime, whereby women have to fall within a particular exception in order to legally seek abortion. This exceptions framework creates a hierarchy of justified and un-justified reasons for abortion. Rather than letting the pregnant person determine, in the context of their own material, social and other circumstances, whether they are able to carry the pregnancy to term, the law creates a list of justified reasons where they can seek abortion. This is particularly problematic in the context of the amended Act which now permits abortion at any gestational stage only when a medical board finds “substantial foetal anomalies.”⁸³⁸ The law will in effect determine which foetuses, with what types of anomalies, can be justifiably aborted.

As the 2018 Joint Statement by the CEDAW and CRPD Committees recognised, a human rights-based approach to sexual and reproductive health places the autonomy of the woman at the centre of policy and law-making related to sexual and reproductive health services, including abortion care. The statement also noted that gender equality and disability rights are *mutually reinforcing concepts*.⁸³⁹ Viewed in this light, the MTP Amendment Act creates a false tension between the

pregnant person's right to reproductive autonomy and bodily integrity on the one hand, and rights of persons with disabilities on the other.

6 Leaves consent requirements unchanged, impacting access to safe abortion for persons with disabilities:

The MTP Amendment Act, 2021 leaves the consent requirements under the Act unchanged. As this report has discussed,⁸⁴⁰ the requirement for consent of a guardian for persons with mental illness is in conflict with the requirements of the Rights of Persons with Disabilities Act, 2016 ("RPWD Act").

III RECOMMENDATIONS

In light of the continuing concerns with the MTP Act as well as the other legal barriers to accessing safe abortion as documented in this report, we conclude with recommendations for reforming India's abortion laws and practice in a manner that facilitates women's access to safe and comprehensive abortion care. We recommend as follows:

1 Decriminalise and reframe abortion within a rights-based healthcare framework:

There is an urgent need to fully decriminalise abortion to ensure access to safe abortion services. This will take abortion out of the criminal law framework and no person, including the pregnant person, service providers, or other accompanying or attending persons shall be criminally liable for participating in a voluntary abortion process.⁸⁴¹

However, decriminalisation of abortion is necessary but not sufficient in securing access to abortion care. As this report has documented, apart from criminal law, other laws, such as divorce laws continue to create obstacles in women's ability to access abortion care. At the same time, abortion stigma and socialisation in heteropatriarchal normative structures influences service providers' decisions to provide or withhold abortion services. In such a situation, even if abortion is decriminalised, service providers may continue to deny abortion services.

The experience of other laws, such as the RPWD Act and the Mental Healthcare Act, 2017, shows that laws can and have been enacted to overcome and redress deep-seated societal prejudices, including within the healthcare community,⁸⁴² through putting in place a rights-oriented framework, and the use of inclusive language to address prejudice and catalyse change. These laws also incorporate positive state obligations to secure conditions in which the constitutional and statutory rights of persons with disabilities and mental illness can be freely and meaningfully

exercised.⁸⁴³ While there are issues with the approach and implementation of these laws in the context of reproductive rights of persons with disabilities, these laws do mark an attempt to address structural and societal biases, especially in healthcare settings.⁸⁴⁴ Similarly, we recommend the enactment of a rights-based legislation that entitles persons to abortion as part of their right to life with dignity, right to health, reproductive autonomy, privacy, and equality.⁸⁴⁵

The contours of the legislation, its interactions with other laws, and the entitlements of persons seeking abortion care should be determined within the framework of abortion as healthcare, and of these other rights. If a pregnant person is entitled to seek abortion, then it follows that no legal liability can attach to their decision to seek an abortion. Likewise, no liability can attach to another person who is duly authorised to provide such services. This should also allay the concerns of service providers about legal liability arising from providing abortion services. Such a rights-based legislation should have an intersectional approach to abortion access for all, including of trans-persons and of persons with disabilities.

2 Facilitate accessible, affordable, acceptable and quality abortion within the public health system:

Locating abortion within the framework of right to health will entail an entitlement to accessible, affordable, acceptable, and quality abortion information and services.⁸⁴⁶ In the context of India, this implies an obligation on the state to ensure accessible abortion care within the public health system.

Annually, millions of persons undergo abortion. Without access to affordable and accessible abortion care, many of them are pushed to unsafe abortion processes. Around 10% of all maternal deaths in India occur due to unsafe abortion.⁸⁴⁷ Unsafe abortion also leads to significant maternal morbidity.⁸⁴⁸ In such a scenario, timely access to affordable abortion care requires focusing on the availability of abortion services within the public healthcare system.

The public health infrastructure of the country as a whole requires auditing from the perspective of providing access to abortion as close to the ground as possible, consistent with the relative safety of abortion services. This would also entail expanding the provider base for medication abortion in line with the internationally recognised standards for safe abortion care. Further, access to abortion as an element of public health would imply that legal and extra-legal barriers to access such as consent, documentation, and monitoring requirements will have to be re-examined from the perspective of ensuring equality and non-discrimination, respect for pregnant persons’

reproductive autonomy and right to privacy, as well as the confidentiality of such processes.

3 Review and reform access to abortion services on the basis of current scientific knowledge:

As this report has documented, the current abortion laws in India are not in sync with current scientific knowledge about the relative safety of abortion as a medical procedure. For example, the over-regulation of MA drugs, the facilities-based approach, and the doctor-centric law, all place additional barriers in accessing abortion services, even though such restrictions are not placed on other medical procedures involving greater complexity.

The regulation of abortion services should be based on current scientific knowledge, rooted in an understanding that abortion is a healthcare procedure. This implies auditing of relevant laws to remove barriers and proactively advance the healthcare needs of pregnant persons in a manner that is consistent with current scientific knowledge and other medically comparable procedure. For example, the facilities-centred approach to medication abortion in the first trimester should be reformed in light of WHO's recommendations on self-management of medication abortion in early pregnancy.⁸⁴⁹

4 Audit medical education, government guidelines, and educate officials to address biases and abortion stigma:

Medical education, and especially medical textbooks, require an audit to remove biases and prejudices that come into the medical profession by way of their basic learning and training. To unlearn these prejudices, the Ministry of Health and Family Welfare in its Comprehensive Abortion Care Guidelines should focus on express negation of problematic tropes found in medical textbooks.

Likewise, educating public health officials, drug controllers as well as authorities under the PCPNDT Act about access to safe abortion care as a public health right, would be instrumental. These requirements should be built into the rights-based law.

5 Remove requirement under POCSO Act to mandatorily report underage sexual activity to the police:

This report has documented the stigmatisation and exclusion from abortion services that results from mandatory reporting of underage sexual activity to the police. To overcome this barrier, we recommend a re-examination of the mandatory reporting requirement under the POCSO

Act. Other models of securing accountability for child sexual abuse, such as reporting to support services rather than to the police, and/or allowing for informed refusal to report, may also be examined.

NOTES FOR CHAPTER 8

- 801 The WHO has recognised that restrictive laws are a leading cause of unsafe abortions worldwide, since they push pregnant persons to seeking unsafe abortion, see WHO, 'Preventing Unsafe Abortion' (n 4).
- 802 Apart from our own findings documented in this report, data shows that globally restrictive abortion laws do not reduce the incidence of abortion, see Jonathan Baerak and others, 'Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019' (2020) 8(9) *Lancet Global Health* <[https://doi.org/10.1016/S2214-109X\(20\)30315-6](https://doi.org/10.1016/S2214-109X(20)30315-6)> accessed 12 July 2021; At the same time, restrictive laws are a leading cause of unsafe abortions, see WHO, 'Preventing Unsafe Abortion' (n 4).
- 803 IPC, s 312.
- 804 MTP Act, s 3.
- 805 *Suchita Srivastava v Chandigarh Administration* (2009) 9 SCC 1; *Justice K.S. Puttaswamy (Retd.) and Anr. v. Union of India and Ors* (2017) 10 SCC 1.
- 806 MTP Act, s 3.
- 807 MTP Act, s 3(3).
- 808 See Chapter 1: Introduction.
- 809 See Chapter 4: Consent and Documentation.
- 810 See Chapter 2: Legal Factors Mediating Women's Access to Safe Abortion.
- 811 *ibid.*
- 812 *ibid.*
- 813 See Chapter 4: Consent and Documentation.
- 814 MTP Act, s 5.
- 815 Aparna Chandra et al, *Securing Reproductive Justice in India* (n 18) 112-114.
- 816 See: Chapter 3: Post 20-week abortions. See also, *Ensuring Reproductive Rights* (n 17) p. 14-15.
- 817 Susheela Singh, 'The incidence of abortion and unintended pregnancy in India' (n 1).
- 818 MTP Rules, r 5.
- 819 See Chapter 4: Infrastructural Requirements.
- 820 PCPNDT Act, s 23.
- 821 See: Chapter 5: Infrastructural Requirements.
- 822 WHO, 'Self-management of medical abortion: WHO recommendations on self-care interventions' (25 June 2020) <<https://www.who.int/publications/i/item/WHO-SRH-20.11>> accessed 12 July 2021.
- 823 MTP Rules, r 5(1); Minister of Health and Family Welfare, 'Comprehensive Abortion Care Guidelines' (n 509) 48.
- 824 Drugs Consultative Committee, 'Minutes of the 56th Meeting (n 679) (for labelling requirements of MA drugs).
- 825 Susheela Singh, 'The incidence of abortion and unintended pregnancy in India' (n 1).
- 826 MTP Rules, r 5.
- 827 See Chapter 5: Medication Abortion.
- 828 POCSO Act, s 19.
- 829 POCSO Act, s 21.
- 830 See Chapter 6: POCSO and Mandatory Reporting.
- 831 MTP Act, s 2(e).
- 832 WHO, 'Medical Management of Abortion' (n 598) 29, 40 ("the abortion process can be self-managed with pregnancies <12 weeks of gestation without the direct supervision of a health-care provider (evidence is limited for pregnancies >10 weeks)").
- 833 MTP Act, ss 3-4. The yet to be promulgated Rules will determine the nature of facilities required for providing abortion services at various stages.
- 834 MTP Act, ss 3-4.
- 835 MTP Act, ss 3-4. The yet to be promulgated Rules will determine the nature of facilities required for providing abortion services at various stages. Under the MTP Amendment Bill, 2014, Section 2(d) was proposed to be re-drafted to include allopathic as well as non-allopathic healthcare service providers, as well as duly qualified nurses and Auxiliary Nurse Midwives (ANMs) as abortion service providers.
- 836 WHO, 'Medical Management of Abortion' (n 598) 29, 40 ("the abortion process can be self-managed with pregnancies <12 weeks of gestation without the direct supervision of a health-care provider (evidence is limited for pregnancies >10 weeks)").
- 837 See Chapter 1: "Normative Framework".
- 838 MTP Act, s 3(2B).
- 839 "Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities," Joint statement by the Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of All Forms of Discrimination against Women, adopted the 29 August 2018, (2018), https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_STA_8744_E.docx.
- 840 See Chapter 4: Consent and Documentation.
- 841 See generally, Alka Barua and Payal Shah, 'Technical Guidance: Decriminalisation of Abortion' Safe Abortion Advocacy Initiative (2021) (calling this approach the "full decriminalisation" approach).
- 842 See discussion in Chapter 4.
- 843 See eg, Chapter VIII: Rights of Persons with Disabilities Act, 2016.
- 844 On concerns with these laws in the context of reproductive rights, see Chapter 4.
- 845 On the international human rights and constitutional rights implicated in a rights-based abortion law, see Chapter 1.
- 846 On the international human rights based right to health framework and its application to sexual and reproductive health rights, both under international law, and in Indian law, see Aparna Chandra et al, *Securing Reproductive Justice in India* (n 18) Introduction.
- 847 Ann Montgomery, 'Maternal Mortality in India' (n 5); As per the last available official figures (from 2003) unsafe abortions accounted for 8% of maternal mortalities, see, 'Maternal Mortality in India: 1997 – 2003' (n 5) 15.
- 858 WHO, 'Preventing Unsafe Abortion' (n 4).
- 849 WHO, 'Medical Management of Abortion' (n 598) 29, 40.

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