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ABOUT THE CONTRIBUTORS

1. The Centre for Justice, Law and Society (CJLS) is a multidisciplinary research centre that critically engages with contemporary issues at the intersection of law, justice, society and marginalisation in South Asia.[i] We have been a thought leader in the domain of Reproductive Justice in India. We have led academic and advocacy efforts towards increasing access to abortions, contributed towards legal reforms, and addressed literature gaps through our scholarship on issues of sexual and reproductive health and rights.
2. CommonHealth is a rights-based, multi-state coalition of organisations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalised communities. Within sexual and reproductive health and rights, CommonHealth concentrates its efforts largely on maternal health and safe abortion. The coalition draws its membership from diverse disciplines, thematic areas and geographies within the country.
3. Hidden Pockets Collective is an India based charity Trust running projects in Karnataka, Bihar and Kerala. Hidden Pockets Collective believes in advancing a Sexual & Reproductive Justice Framework and approaches activism within this framework.

GAPS IN INDIA'S 2017 UPR ON THE SUBJECT OF ABORTION

4. During India's third cycle review, it was noted that despite more importance given to reproductive health under health missions adopted by the government, there were close to 46,500 maternal deaths each year, 8% of which were attributed to unsafe abortions.[ii]

5. Another shadow report noted that most women were unaware that abortion is legal – although abortion under certain circumstances is permitted under the Medical Termination of Pregnancy Act, 1971 (**MTP Act**), the chilling effects of the ban on gender-biased selection under the **Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994** (**PCPNDT**) and the criminalisation of abortion under the **India Penal Code, 1860** (**IPC**) cannot be understated. Further, there are barriers in terms of availability of, and access to contraceptives as well as a lack of comprehensive education on the different forms of contraception.[iii] In light of the criminalisation of abortion, barriers to contraceptives result in a high incidence of female sterilisation – 37% of women in India within the age range of 15-49 are sterilised. It is also noteworthy that these sterilisations are often performed under extremely hazardous conditions and constitute a gross violation of human rights.[iv]

6. In its final report, the Working Group on the Universal Periodic Review for India specifically recommended: (i) the allocation of resources to reduce maternal mortality[v] and prohibit forced sterilisations,[vi] (ii) the provision of comprehensive sexuality education to ensure access to a range of affordable and quality contraception methods in a voluntary and safe manner,[vii] and (iii) implementation of urgent measures to end gender-biased termination of pregnancies. However, the final report did not include any recommendations or submissions on the chilling effect of the criminalisation of abortion. As a result, this submission seeks to highlight the inadequacies of the legal framework that governs abortions in India.

7. The continued criminalisation of abortion in India acts as a barrier to safe abortion services for pregnant persons. The present legal framework is not rooted in a rights-based framework and creates a very restrictive landscape for pregnant persons to terminate pregnancies, thus denying them their reproductive autonomy. This continued criminalisation also acts as a major barrier to safe abortion services for pregnant persons. In the light of the conflation with other laws that regulate the gender determination of pregnancies and the carceral framework for addressing sexual offences against minors, the implementation of the present law is inadequate and inefficient. The effect of these broad issues is that access to legal and safe abortion services is restricted, resulting in high mortality rates and a gross infringement of the reproductive autonomy of pregnant persons in the country.

INTRODUCTION: ABORTION LAWS IN INDIA

8. Abortion is criminalised under Section 312 of the IPC, under which any person (including the woman herself) who causes a child to miscarry will be punishable by imprisonment up to 3 years or imposition of fine or both. The only exception in the IPC is for an act done in good faith to save the life of the woman. The MTP Act was enacted as an exception to the criminalisation under the IPC with the aim of enabling access to safe and legal abortions. The MTP Act allows access to abortion services for pregnant women up to a certain gestational age and is contingent upon the satisfaction of certain conditions laid down under the Act, which is further determined by a medical practitioner. The Act was recently amended in 2021 to expand upon the conditions and categories of women eligible to terminate their pregnancies. Notably, the use of the word ‘women’ makes the Act exclusive to primarily cis- gender women and hinders access to safe and legal abortion services for other pregnant persons.

9. Over the last few years, the government has implemented various schemes and programmes, such as ***Surakshit Matritva Ashwasan*** 2019, ***Pradhan Mantri Matru Vandana Yojana*** 2017, ***Pradhan Mantri Surakshit Matritva Abhiyan*** 2016 and the **National Family Planning Programme**, to improve maternal health. However, despite these initiatives and policies to provide greater access to healthcare for pregnant persons: (i) women, girls and pregnant persons continue to face significant barriers in accessing safe abortion and maternal care services, (ii) the Maternal Mortality Ratio in India, at 113 per 100,000 live births, remains to be one of the highest in the world,[viii] and (iii) there is a lack of access to contraceptive measures and education pertaining to reproductive and sexual health.

SRHR JURISPRUDENCE AND LEGAL REFORMS

10. An analysis of the legal landscape around abortion and, more broadly, issues of sexual and reproductive rights begins with an overview of relevant jurisprudence of the Supreme Court. Jurisprudence around sexual health and reproductive rights in India has been increasingly progressive, especially in recent years. For instance, in 2017, the Supreme Court held in the case of ***Retd. Justice K.S. Puttaswamy v. Union of India***[ix] that reproductive autonomy, bodily integrity, and dignity are essential ingredients of personal liberty under Article 21 of the Constitution of India, 1950. Further, in ***Navtej Singh Johar* v *Union of India***[x], the Supreme Court highlighted the importance of sexual autonomy in "the idea of a free individual" and in ***Joseph Shine* v *Union of India***[xi] the Supreme Court stated that the right to sexual autonomy and privacy are protected under the Constitution. Indian Courts have recognised the fundamental rights to privacy, dignity, and bodily and sexual autonomy in various cases, thereby including reproductive rights within the ambit of fundamental rights.

11. Despite the progressive jurisprudence of the Supreme Court and High Courts, the provisions of the MTP Act remain restrictive. The MTP Act was amended in 2021 allegedly to expand access to safe and legal abortion services but continues to pose significant barriers to abortion access. Section 3 of the amended MTP Act allows medical practitioners to terminate pregnancies if they are of the opinion that the continuance of the pregnancy would involve a risk to the life of the pregnant person or cause grave injury to their physical or mental health, or when there is a high risk of the child being born with serious physical or mental disabilities. Grave injury to mental health is extended to pregnancies caused due to failure of the contraceptive method used by the pregnant person or their partner and includes pregnancies resulting from rape. The opinion of one medical practitioner is required to terminate a pregnancy where the gestation period is less than 20 weeks and the opinion of two medical practitioners is required if the pregnancy has

exceeded 20 weeks but not 24 weeks.

12. Pursuant to the recent amendment, the MTP Act provides that in cases of “foetal abnormalities” diagnosed by a Medical Board, there will be no upper gestational limit on termination. The MTP Amendment Act also mandates the setting up of a Medical Board in every State and Union Territory. Each Board will consist of a gynaecologist, pediatrician, radiologist or sonologist and any other number of members proposed by that State or Union Territory. The Medical Board will be responsible for the diagnosis of substantial foetal “abnormalities” that necessitate the termination of the pregnancy.

EFFECTS OF LEGAL REFORMS

13. The legal reforms to the MTP Act, through the amendment in 2021, fail to incorporate a gender justice approach to the abortion law, in turn failing to uphold the fundamental rights of reproductive and sexual autonomy of pregnant persons.

14. The amendment to the Act that exempts cases of “foetal abnormalities” from an upper gestational limit has three main problems. First, it advances eugenic goals, which furthers ableist rationales that depict certain foetuses as “unwanted” or “undesirable”. This is evidenced by the Press Information Bureau, which has stated that the MTP Bill intended to expand access to “safe and legal abortion services on therapeutic, eugenic, humanitarian or social grounds.”[xii] Second, the provision only allows for abortion on grounds of “abnormalities” and therefore excludes other circumstances where persons may require an abortion after 24 weeks, which in turn can constrain vulnerable persons’ access to abortion (for example, survivors of rape). Finally, the provision is highly doctor-centric, as the decision to carry a pregnancy to full term or to abort, whether or not there is an “abnormality”, should be at the sole discretion of the pregnant person, in consultation with their medical practitioner – without the intervention of State machinery.

15. The provisions that govern the constitution of Medical Boards under the amended MTP Act are highly problematic – by undermining the autonomy of pregnant persons and placing decision making power squarely in the hands of medical practitioners. Until the amendment in 2021, medical boards have been entirely outside the scope of the MTP Act and were the product of judicial inventions. A requirement for third-party authorisation, which has now been concretised under the MTP Act, has resulted in (and continues to cause) severe delays in granting abortions, often foreclosing the option for persons with advanced gestational ages. Additionally, Medical Board opinions hinge on varied factors unspecified in the law, which can often go against the

wishes of the pregnant person. The massive shortage of medical professionals across India, especially in rural and tribal areas, calls into question the feasibility of setting up Medical Boards in every district, with potentially devastating consequences for pregnant persons desirous of obtaining abortions. As per the findings of a study conducted by CJLS titled ***Medical Boards for Access to Abortions Untenable: Evidence from the Ground,*** [xiii] additional authorisation requirements create obstacles to pregnant persons exercising their reproductive autonomy, who are then forced to carry unwanted pregnancies to term against their will with detrimental effects to their physical and mental health. Further there is an 80% shortage in the availability of specialists. In some states such as Tamil Nadu, Arunachal Pradesh and Gujarat, there was a complete absence in the availability of certain specialists.

CHILLING EFFECT OF CRIMINALISATION OF ABORTION

16. In the background of the jurisprudence around reproductive rights, as well as the eugenic and autonomy-stripping provisions of the law around abortion, the legal provisions that criminalise abortion have a significant effect on access to abortions by pregnant persons throughout the country. The current criminalised status of abortion, along with the interaction of the MTP with the POCSO and the PCPNDT, creates a "chilling effect" on medical professionals. The fear of criminal prosecution in turn affects ease of access to abortions, especially for marginalised and oppressed groups. [xiv] This section will explore these interactions.

Maternal Mortality Rate and Unsafe abortion

17. The World Health Organisation (WHO) has noted that the criminalisation of abortion does not lead to an increase in birth rates or a decrease in abortion rates.[xv] There is also a discernible and direct link between restrictive abortion laws and morbidity and mortality associated with unsafe abortions. In the Indian context, a study that examined the incidence of abortion and unintended pregnancies showed that 73% of abortions were done outside of health facilities in 2015, and many abortions occurred without prescriptions.[xvi] 5% of all abortions were unsafe, took place outside health facilities and were not medical abortions.[xvii] Abortion complications are amongst the leading causes of maternal deaths in India.[xvii]

18. The criminalisation of abortion under the IPC has not proven to be an effective deterrent for those seeking an abortion. Instead, it only serves as a barrier for access to safe abortion.[xix] The relationship between restrictive abortion laws, morbidity and mortality associated with unsafe abortion, is an indicator of the deleterious effects of criminalisation, resulting in situations where

pregnant persons are constrained to obtain abortions in unsafe facilities. The health risks associated with such methods of abortion are catalyst events for maternal morbidity and mortality, whose levels are revealingly high in the country of the lack of access to safe and affordable abortions.

Criminalisation of medical practitioners

19. The MTP Act, by itself, contains provisions that are disempowering to pregnant persons, but its interaction with certain other laws creates a "chilling effect" on medical practitioners that prevents them from performing abortions for fear of criminal prosecution. The MTP Act interacts with the IPC, the **Protection of Children from Sexual Offences Act 2012** (**POSCO**) and the PCPNDT to have this effect in varied circumstances.

Intersection with IPC

20. In India, if a pregnant person wishes to terminate their pregnancy, they require the opinion of one or more registered medical practitioners or the medical board, depending on the gestational period. The MTP Act contains provisions that outline the circumstances where abortions are legally permissible, but the criminalisation of abortion under the IPC gives rise to the misunderstanding that any step relating to abortion is illegal and will attract criminal sanctions on those who participate, including both pregnant persons and medical practitioners. Even though Section 5 of the MTP Act provides protection to medical practitioners acting in good faith, practitioners are still reluctant to terminate pregnancies and provide abortion services where the pregnancy exceeds 20 weeks of gestation.[xx] The fear of legal proceedings for medical practitioners results in the denial of abortion services to pregnant persons, with the ill-effects of such denial being disproportionately high for marginalised groups and individuals.

21. In certain instances, medical practitioners insist on other arbitrary formalities and ad hoc measures which are not mandated by the law to prevent criminal charges, including seeking enhanced consent, documentation, and third-party authorisations.[xxi] For instance, a government hospital in Mumbai would file an Emergency Police Report ("EPR") if any unmarried person sought abortion as they believed that any sexual intercourse outside marriage was unlawful, to pre-empt criminal prosecution.[xxii] The justification provided by medical officers was that EPR was meant to keep a record of termination of pregnancy, when in reality, an EPR only applies if the person seeking abortion is under the age of 18.[xxiii] The criminalisation under IPC therefore results in doctors that are reluctant to provide abortion services, and hinders access to abortions

for pregnant persons.

Intersection with POSCO Act

22. The interaction of the MTP Act with the POCSO Act occurs on two primary levels: firstly, with respect to the notion of 'consent' to both sexual acts and abortions, as well as the protection of privacy of a pregnant person undergoing an abortion. The MTP Act expressly recognises the provision of abortion services to minors with the consent of their guardian. A guardian "means a person having the care of the person of a minor or a mentally ill person." Minors are recognised as a vulnerable group under the special categories of women who may seek termination of pregnancies under Rule 3B of the Medical Termination of Pregnancy Rules, 2021 (MTP Rules) (as amended in 2021). However, there is no clarity on the course of action when the minor does not consent to the termination of pregnancy, but the legal guardian does. Further, Section 5A of the MTP Act bars any medical practitioner from revealing "the name and other particulars of a woman whose pregnancy has been terminated (...) except to a person authorised by any law for the time being in force."

23. Jurisprudence on abortions for minors has reinforced the requirement of consent of the guardian, thereby often disregarding the wishes of the pregnant minor. For instance, in the case of ***Sundarlal v. State of MP and Ors.***[xxiv], the High Court of Madhya Pradesh held that only the consent of the guardian of the minor woman was necessary, and once consent was obtained, the willingness of the minor was not needed. The Court went on to direct the constitution of a committee of medical practitioners to form an opinion on the termination.[xxv] Notably, jurisprudence is inconsistent, as in another case of ***Ram Avatar v. State of Chhattisgarh and Ors***.[xxvi], the Chhattisgarh High Court considered the minor as someone who was mature enough to decide whether she wished to terminate her pregnancy. Since the pregnancy was at 27 weeks, the court did not grant leave for termination of pregnancy and also noted the unwillingness of the minor to terminate the pregnancy.[xxvii]

24. The requirement of consent of a pregnant minor's guardian creates complications for access to abortion for adolescents, which is compounded by the mandatory reporting provision in Section 19 of the POCSO Act. This provision requires anyone with knowledge or apprehension of an offence under the Act, including the adolescent, to report it either to the Special Juvenile Police Unit or to the local police. Anyone who fails or refrains from reporting is liable to imprisonment of up to 6 months or fine or both.

25. Therefore, there is a clear conflict between the POCSO Act, which requires any sexual acts involving persons below the age of 18 to be reported and the MTP Act which mandates confidentiality of the pregnant person. All sexual encounters including consensual and non-exploitative acts involving adolescents of proximate ages amount to statutory rape.[xxviii]

26. Additionally, the mandatory reporting requirement also acts as a barrier in accessing safe and legal abortions or causes an unnecessary delay in termination of unwanted pregnancies. Doctors and hospitals often feel threatened due to the POCSO Act which compels them to report adolescents. To avoid encounters with state machinery and imposition of legal sanctions, they often refrain from providing abortion services.[xxix]

Intersection with PCPNDT

27. The MTP Act's interaction with the PCPNDT, much like with the POCSO Act, creates a "chilling effect" on medical practitioners, leading to the denial of abortions and consequent lack of access to abortion services by pregnant persons. Originally, the PCPNDT was enacted to prohibit gender- biased selection by regulating diagnostic techniques for prenatal gender determination, providing strict documentation requirements and penalties against offences. Its text and objectives are completely different from the MTP Act, but practical implementation of the statute by law enforcement has targeted medical professionals performing abortions, on suspicion of performing gender-biased abortions. Despite the differential purposes of the PCPNDT and the MTP Act, they are often confused and conflated in practice which is compounded by the lack of awareness amongst stakeholders regarding the differences between the Acts. [xxx]

28. A study has shown that the conflation of the PCNPDT with the MTP Act has been the cause of harassment of medical professionals by law enforcement who threaten them with criminal prosecution and consequently create a hostile medico-legal environment that dissuades practitioners from performing abortion services on the basis that they may face prosecution for sex selection.[xxxi] Interviews with gynaecologists in the study also showed that practitioners had refused abortions to pregnant persons who already had one daughter, thereby disregarding their reproductive autonomy on absolutely arbitrary grounds not supported by the law.[xxxii] Another study found that banning prenatal sex determination has been used by state governments to target abortion providers, which does not reduce sex-selective abortions, but instead causes

providers to deny second trimester abortions, which in turn leads to pregnant persons resorting to unsafe options.[xxxiii]

29. Apart from the conflation of the laws, the PCPNDT provides for strict and exhaustive documentation requirements that medical practitioners are often forced to share with government authorities, in contravention to Section 5A of the MTP Act that upholds the privacy of pregnant persons. The cumulative effect of the conflation of the PCPNDT and MTP Act, along with the disregard for the privacy and confidentiality requirements outlined in the MTP Act, results in a situation where again, a "chilling effect" is observed amongst medical practitioners licensed to perform abortions, and pregnant persons are ultimately denied access to safe and timely abortion services.

BARRIERS TO SAFE ABORTION AND IMPACT ON MARGINALISED PERSONS

Legal and Procedural Barriers

30. Access to safe abortion is fundamental to pregnant person's realisation of their right to reproductive autonomy. The barriers to access abortion are exacerbated by a person's caste identity, socio-economic background, religious identity, gender identity and geographical location amongst other such factors.

31. As seen above, the recent reforms to the MTP Act require the government to set up medical boards in every state and union territory, and the boards are tasked with the diagnosis of fetal abnormalities that require termination post the 24-week period. Such third-party authorisations not only cause delays in abortions, but also highlight the sheer lack of specialised medical practitioners at the district level, particularly in rural and tribal areas. A recent study found that there is a shocking 69.7% shortfall of obstetricians and gynaecologists in the majority of states and Union Territories in India.[xxxiv] This shortage will delay the very constitution of these district- level Medical Boards, and promises to have grave implications for access to abortions in rural and remote areas and for persons who are unable to afford private healthcare services and need to rely on government facilities. [xxxv]

32. Marginalised and oppressed groups face extra barriers in accessing abortions, directly affecting health outcomes of persons from Scheduled Castes, Scheduled Tribes and oppressed caste and class persons in remote areas. The high cost of accessing abortions is a significant barrier for the access of abortion services for Dalit, Adivasi, De-notified Tribes, Migrants and other

socioeconomically and historically oppressed groups.In a study conducted in 2014 in Madhya Pradesh to understand the socio-economic background of women accessing abortion, 74% of the women participating self-identified as part of a Scheduled Tribe/ Caste or Other Backward Class (OBC) and the majority of those grouped as "poor" under the study came from rural areas and caste oppressed backgrounds.[xxxvi] At public health care facilities in rural areas, these women had to bear an indirect cost (associated with travel, medicines and clinical tests) of INR 67, which became INR 239 for women accessing abortion in urban areas.[xxxvii] Further, it was found that poor women spent more on average in indirect costs than their middle and rich counterparts, and that they were the predominant users of post-abortion care facilities, confirming their limited access to formal abortion services.[xxxviii]

33. A study in Tamil Nadu also found that options to terminate pregnancies were more complex when pregnant persons were from marginalised groups.[xxxix] They had to visit providers 2-5 times before they could undergo an abortion successfully.[xl] Another study conducted in Madhya Pradesh indicated that access to abortion differed among urban and rural women. While 60% of urban women said that access to abortion was easy, only 18% of rural women indicated the same. [xli]

34. The legal and procedural barriers faced by women from marginalised backgrounds in accessing abortions can be illustrated through the case of ***Amita Kujur v State of Chhattisgarh***.[xlii] The petitioner, an Adivasi rape survivor, wished to terminate her pregnancy at twelve weeks, which is well within the legal gestational limit. The district hospital referred her to the Chhattisgarh Institute of Medical Sciences (CIMS), where she was subsequently asked to produce a copy of the FIR registering the rape, medico-legal documents, as well as a reference letter from the District Hospital. She was unable to get these documents and approached the High Court, seeking permission to terminate the pregnancy. Far from immediately granting permission for the abortion, the Court constituted a two-doctor team to examine the petitioner, who found that the pregnancy had progressed in this time to twenty-one weeks, therefore placing it outside the ambit of the Act. Ultimately, however, the Court granted an order for the termination of the pregnancy. The case highlights the obstacles faced by marginalised persons in accessing abortions, given their inability to repeatedly approach courts and heavy reliance on the public healthcare system. They also have limited access to post-abortion care, thus increasing the risk of complications when abortion services outside the legal machinery are availed.

Access to Contraceptive Services and Informed Choice

35. Access to contraception is necessary for realising the sexual and reproductive rights of women. In India, studies show the high incidence of unintended pregnancies, with an estimated 2 million adolescent women in India having an unmet need for contraception.[xliii] Statistics reveal that if all adolescent women in India with the desire to avoid a pregnancy had access to contraception and appropriate information there would be 732,000 fewer unintended pregnancies and 482,000 fewer unsafe abortions.[xliv]

36. The National Health and Family Survey-5 (NHFS-5) states that the use of family planning methods has increased from 53.5% in 2015-2016 to 66.7% in 2019-2020. However, the burden of using contraception continues to rest on women – 99% of sterilisation processes were female operations, while only 1% were male sterilisation operations as noted by the National Health Mission in 2019-20.[xlv] In NHFS-5, female sterilisation has gone up from 36% in NHFS-4 to 37.9% and continues to be the most common type of contraception used.[xlvi]

37. Again, pregnant persons from marginalised groups are often forced into sterilisation. In Tamil Nadu, when pregnant persons approached providers for abortion, a portion of study participants belonging to marginalised groups and communities were permitted to access abortion services only if they agreed to undergo sterilisation after the abortion to prevent any more unintended pregnancies.[xlvii]

38. At the grassroots level, Accredited Social Health Workers (ASHA) are responsible for distributing condoms, IUDs etc. and counselling couples on Family Planning methods.[xlviii] They are paid on an incentive basis, where distribution of temporary contraceptive methods invoke a much lower incentive than convincing people to undergo sterilisation procedures.[xlix] A fact-finding study conducted in Delhi showed that these incentive-based payments are geared towards encouraging female sterilisation procedures over spacing methods.[l] ASHAs are routinely overburdened and over-worked, therefore prioritising those duties which had higher monetary benefits. It was observed that many women in the study had not consented to such sterilisation procedures or did not have enough knowledge of the procedure while consenting to it.

39. There is a need for contraception to reduce maternal mortality and temporally distribute births so that pregnant persons do not suffer from pregnancy related complications. Access to and information about temporary methods of contraception is necessary since many individuals are forced to turn to permanent options like sterilisation. Additionally, in the absence of the availability of contraception or contraceptive failure, pregnant persons must have the option to

terminate unintended pregnancies. The lack of contraception, as well as the dearth of affordable, timely and easily obtainable abortions by pregnant persons from rural and marginalised communities forces pregnant persons to carry unwanted pregnancies to term, or to undertake unsafe back-alley abortions that could result in serious complications and even death.

DECRIMINALISATION: UPHOLDING DECISIONAL AUTONOMY & IMPROVING ACCESS TO SAFE ABORTION

40. The legal framework governing abortion in India is highly doctor-centric in nature, ignoring the sexual and reproductive autonomy of pregnant persons, which have been upheld by various Courts in the past as inalienable fundamental rights. The intersections between the MTP Act, the IPC, POCSO and PCPNDT serve to create an environment where abortions are *prima facie* deemed to be illegal, dissuading medical practitioners from performing them and affecting access to such services by pregnant persons. The criminalisation of abortions by the law also compounds the stigma and taboo surrounding abortion, despite the so-called confidentiality provision in the MTP Act[li], thereby driving pregnant persons towards unsafe back-alley providers for fear of discovery by others[lii]. This can have a disproportionate impact on adolescents, who are also navigating the stigma of premarital sex, and who may not be in a position to disclose their pregnancies to their guardians, as mandated by law. Therefore, in India, the role of criminalisation in exacerbating stigma can have a higher impact on deterring adolescents from accessing safe abortion, who already face a significant barrier through the mandatory reporting in the POCSO Act.

41. Apart from exacerbating stigma against abortions, the framework of criminalisation in Indian law forces those who fall outside the strict conditions laid out by the MTP Act to seek judicial authorisation for abortions. Such a requirement for judicial authorisation imposes additional financial costs and delays on pregnant persons, thereby forcing those who cannot afford to do so to seek other methods. Furthermore, those who can afford the high financial costs associated with legal procedures are confronted with uncertainties, due to the uneven and inconsistent jurisprudence when it comes to the granting of terminations by the judiciary. The third-party authorisation requirement contained in the recently amended MTP Act, whereby Medical Boards must provide permission for abortions in certain cases, also adds to the bureaucracy, arbitrariness and inaccessibility surrounding abortions, especially for vulnerable groups living in remote areas.

42. The criminalisation of abortion disproportionately affects women, gender non-conforming and transgender persons,[liii] thereby making it discriminatory and violating Articles 14 and 15 of the Constitution – the right to equality and non-discrimination respectively[liv] Despite Indian jurisprudence having framed reproductive rights as falling within Article 21, criminalisation continues to violate such a recognition.[lv] Further, the openly eugenic rationale employed by the MTP Act, especially in light of recent legal reforms removing the gestational limit in cases of "foetal abnormalities", is highly ableist in nature, devaluing so-called "abnormal" foetuses and adding to already discriminatory societal attitudes against persons with disabilities.

43. The criminalisation of abortion ultimately affects access to not just abortions, but to temporary contraceptive methods and post-abortion care by marginalised groups, who may live in remote areas and rely entirely on underfunded and understaffed public health facilities to meet their sexual and reproductive healthcare needs. The agenda of female sterilisation employed by State authorities under the garb of family planning, in lieu of other methods of contraception, demonstrates the systemic violation of women's sexual and reproductive autonomy, especially since a large number of marginalised persons forced to undergo sterilisation are often unaware of the implications of such procedures.

44. The solution to the convoluted legal framework around abortions and its deleterious impacts on pregnant persons is decriminalisation. The decriminalising of abortion will allay the fear of persecution that besets persons seeking abortions as well as medical providers – thereby reducing the risk of persons seeking abortions through informal and unsafe providers. It will reduce social stigma and taboo around abortion, making it easier for pregnant persons to seek these procedures without fear of societal repercussions, Further, it will also eliminate the conflicts between the PCPNDT and the POCSO, creating a more permissive atmosphere for providers to perform abortions freely, as well as for pregnant persons to approach registered providers without the fear of their privacy being breached. As criminalisation is seen to act as a barrier to access of safe abortion in a myriad of ways[lvi], decriminalisation is an imperative first step towards dismantling the Indian architecture of unsafe abortion.[lvii]

[i] https://jgu.edu.in/cjls/about-us/

[ii] United Nations Universal Periodic Review India – Third Cycle, Published on February 23rd, 2017 available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/044/56/PDF/G1704456.pdf?OpenElement

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[v] Report of the Working Group on the Universal Period Review: India, 1-29 September 2017, Paragraph 161.187.

[vi] Report of the Working Group on the Universal Period Review: India, 1-29 September 2017, Paragraph 161.102

[vii] Report of the Working Group on the Universal Period Review: India, 1-29 September 2017, Paragraph 161. 179

[viii] https://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR%20Bulletin%202016-18.pdf

[ix] *Retd. Justice K.S. Puttaswamy v. Union of India*, (2017) 10 SCC 1

[x] *Navtej Singh Johar v Union of India* (2018) 10 SCC 1.

[xi] *Joseph Shine v Union of India* (2019) 3 SCC 39.

[xii] See Press Information Bureau, Government of India, *Cabinet approves The Medical Termination of Pregnancy (Amendment) Bill, 2020*, Jan. 24, 2020, https://pib.gov.in/PressReleseDetail.aspx?PRID=1600916#:~:text=Press%20Information%20Bureau,-Government%20of%20India&text=The%20Union%20Cabinet%2C%20chaired%20by,the%20ensuing%20session%20of%20theParliament.

[xiii] Medical Boards for Access to Abortions Untenable: Evidence from the Ground, A report Published by Centre for Justice Law & Society available at: https://jgu.edu.in/cjls/centre-reports/medical-boards-for-access-to-abortion-untenable-evidence-from-the-ground/

[xiv] Dipika Jain, *Time to Rethink Criminalisation of Abortion? Towards a Gender Justice Approach*, 12 NUJS L. Rev. 2 (2019), pg 29-34, http://nujslawreview.org/2019/10/26/time-to-rethink-criminalisation-of-abortion-towards-a-gender-justice-approach/.

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