Advocacy Manual
on

LEGAL REGULATION OF ABORTION IN INDIA: COMPLEXITIES AND CHALLENGES

Jindal Global Law School
India's First Global Law School

CJLS
CENTRE FOR JUSTICE, LAW AND SOCIETY

CENTER for REPRODUCTIVE RIGHTS

CommonHealth

RISING FLAME

FRONT COVER DESIGN BY HAMSINI MARADA, ASSISTANT PROFESSOR, JINDAL GLOBAL LAW SCHOOL

The Law and Marginalization Clinic, CJLS

The Law and Marginalization Clinic is an advocacy-community outreach initiative by the Centre for Justice, Law, and Society (CJLS) at Jindal Global Law School. The Clinic brings together activists, movements, scholars and community members to tackle issues of systemic harms, challenge power structures and develop intersectional anti-oppression discourses that comprehensively address marginalization along the axes of gender, caste, indigeneity disability, and sexuality through classroom teaching and field projects.

The Clinic is a collaborative endeavour, and its engagements involve policy interventions, research, and advocacy to advance interdisciplinary and critical approaches towards using the law as a tool for social change. It foregrounds community-centric and anti-carceral models of justice as well as intersectional anti-oppression discourses that comprehensively address the structural hierarchies that have aided in the historical marginalization of individuals and groups. One of the key objectives of the Clinic has been to take knowledge and learning beyond the confines of the classroom. Our pedagogical tools engage students directly, while also shifting the focus away from pure doctrinal questions, shedding light on the lived experiences of marginalized persons and developing tools for facilitating systemic change in the domain of sexual and reproductive health and rights (SRHR). At the Clinic, we see ourselves facilitating conversations and legal and policy interventions, as well as collaborating with social movements. We do not claim to speak for any movements. Over the years we have continued to reflect on and learn from our activist and scholar friends on the various projects we have worked on.

Common Health

Constituted in 2006, CommonHealth is a rights-based, multi-state coalition of organizations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized 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.

Center for Reproductive Rights

The Center for Reproductive Rights is a global human rights organization of lawyers and advocates who ensure reproductive rights are protected in law as fundamental human rights for the dignity, equality, health, and well-being of every person.

Since its founding in 1992, the Center's game-changing litigation, legal policy, and advocacy work—combined with unparalleled expertise in constitutional, international, and comparative human rights law—has transformed how reproductive rights are understood by courts, governments, and human rights bodies. Through its work across five continents, the Center has played a critical role in securing legal victories before national courts, United Nations Committees, and regional human rights bodies on reproductive rights issues. The Center's Asia program has built and strengthened partnerships, networks, and collaborated with diverse stakeholders to improve access to safe abortion and post-abortion care, all forms of contraception, adolescents' sexual and reproductive health and rights, and maternal health services.

Rising Flame

Rising Flame is a National Award winning nonprofit organisation based in India, working for recognition, protection, and promotion of human rights of persons with disabilities, particularly women and youth with disabilities. Rising Flame's vision is to build an inclusive world in which diverse bodies, minds, and voices thrive with dignity; live free of discrimination, abuse, and violence; and enjoy equal opportunities and access. Since our establishment in 2017, we aim to enable persons with disabilities standing at multiple intersections to have a voice, have a space, be heard and lead from the front. As a self-led organisation, we are committed to upholding disability justice values and feminist principles.

ACKNOWLEDGEMENTS

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Faculty Supervisors: Professor Dipika Jain, Natasha Aggarwal, Joshika Saraf and Disha Chaudhari, Law and Marginalization Clinic, Jindal Global Law School

Brototi Dutta and Prabina Bajracharya, Center for Reproductive Rights (Asia)

Dr. Alka Barua, CommonHealth

Rupsa Malik, Independent Consultant, SRHR

Students: Abhinaya Raj, Anvita Datla, Ishan Puri, Ishika Garg, Mahima Sharma, Mansi Upadhyay, Maria Jovita, Muskan Singla, Pragati Thapa, Rashi Kumar, Reet Singh, Shivani Milimody, Shivank Singh, Shriram Rishi, Upmanyu Mehrotra, Vrishti Shami

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INTRODUCTION

The Indian government introduced the first five-year plan in 1952, under which it allocated funds for "family planning" with the aim of stabilizing the population at the level consistent with the requirements of a national economy. In the 1960s and 1970s, family planning occupied more of the State's development agenda. Historically, advocates of family planning programs positioned their advocacy for contraception as being beneficial for women but also as being "beneficial to the nation, which could meet its economic development by curbing population growth." Family planning was posited as necessary for economic and social development, and women were called upon to curtail reproduction as their "duty" to the State. Scholars argue that instead of targeting and rectifying structural causes of inequality (such as unequal land distribution, caste-based injustices, and patriarchal norms) "family planning" and "population control" were marketed as the magic cure to inequality. In practice, policies took on increasingly coercive and violent measures, especially impacting historically marginalized communities and individuals including Dalit, Bahujan, Adivasi and Muslim persons. Given the reliance of marginalized persons on the public healthcare system, they were frequent targets of birth control measures. Further, cash incentives offered at mass vasectomy camps were effectively coercive, as the targets were landless and land-poor men (and therefore more likely to have belonged to marginalized communities). Family planning programs have thus "left hierarchies of class, caste, and gender almost entirely unchallenged."

In 1964, the Ministry of Health & Family Welfare appointed a committee under Dr. Shantilal Shah to consider the legalization of abortion. The recommendations submitted by this committee in 1966 served as a basis for the Medical Termination of Pregnancy Bill, thus framing abortion as a means to lower the birth rate. The Medical Termination of Pregnancy Act, 1971 (first amended in 2002 and then in 2021) (the **MTP Act**) was therefore enacted as an exception to the criminalization of abortion under the Indian Penal Code, 1860 (the **IPC**), which was introduced during the British colonial era and criminalized non-heteronormative identities and abortions. This framework transformed reproduction into a political and economic question and reformers thereby began focusing on curbing the population growth and improving its health and eugenic "quality."

Under Sections 312-316 of the IPC, abortion is a criminal act with a criminal liability for an abortion service provider as well as a pregnant person,* except if the abortion is provided to save the life of the pregnant person.

In September 2022, the Supreme Court in *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi* recognized that the criminalization of abortion acts as a barrier to abortion access. Despite the good-faith exception in the MTP Act, the strict requirements under the Act, as well as the continued criminalization of abortion under the IPC create a fear of prosecution among medical practitioners, who then refuse to provide abortions. Additionally, the criminalization of abortion impacts safe access to abortion and also exacerbates the barriers to access for marginalized persons. It is, therefore, imperative to re-examine the approach to abortion access, particularly in light of the historical link between reproduction and national, economic and eugenic objectives.

The MTP Act was also recently amended in 2021 to, *inter alia*, increase the gestational limits for termination of pregnancies, permit unmarried women to obtain abortions pursuant to contraceptive failure, and institutionalize the requirement to obtain approval of a medical board to terminate a pregnancy that is above 24 weeks of gestation.

However, the MTP Act does not center bodily autonomy of pregnant persons. For example, the MTP Act specifies a strict standard for registered medical professionals (**RMPs**) who may provide abortion services and mandates that abortion facilities need to be approved by state-level authorities. Also, the provision of an abortion is entirely dependent upon medical opinion and, as a result, the autonomy and will of a pregnant person are subservient to the opinion of an RMP (i.e., abortions are not provided on-request). Thus, far from recognizing the rights of pregnant persons, the MTP Act simply enables state control over how and when abortions take place. Within such a framework, all policy measures will fail to truly establish a rights-based framework.

*The MTP Act uses the word "women" throughout. However, access to abortion services is critical not only for cis-gender women, but also for transgender, intersex and gender-variant persons (as noted by the Supreme Court in *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi).* This manual uses the phrase pregnant persons to ensure that the law is taking note of all individuals in need of access to safe abortions, except when making direct references to the MTP Act.

Reproductive rights have been recognised as statutory rights under the Medical Termination of Pregnancy Act, 1971 and fundamental rights by the Supreme Court.

In September 2022 in *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi*, the Supreme Court held:

"The ambit of reproductive rights is not restricted to the right of women to have or not have children. It also includes the constellation of freedoms and entitlements that enable a woman to decide freely on all matters relating to her sexual and reproductive health. Reproductive rights include the right to access education and information about contraception and sexual health, the right to decide whether and what type of contraceptives to use, the right to choose whether and when to have children, the right to choose the number of children, the right to access safe and legal abortions, and the right to reproductive healthcare. Women must also have the autonomy to make decisions concerning these rights, free from coercion or violence."

In 2017, a nine-judge bench of the Supreme Court in *Justice K.S. Puttaswamy v. Union of India* noted that reproductive rights were part of the fundamental right to life under Article 21 and that the right to make reproductive decisions is a facet of the pregnant woman's decisional autonomy.

In 2009, the Supreme Court in *Suchitra Srivastava v. Chandigarh Administration* held that the right to make reproductive decisions, which is a facet of personal liberty under Article 21 of the Constitution of India, includes the right to procreate as well as the right to abstain from procreating.

Abortion Laws in India

Although the MTP Act is the primary legislation that governs abortions in India, a comprehensive analysis reveals the impact of several other legislations including the Protection of Children from Sexual Offences Act, 2012 (the **POCSO Act**), the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 (the **PCPNDT Act**), and the Rights of Persons with Disabilities Act, 2016 (the **RPWD Act**). The combined on-ground impact of these legislations has resulted in major barriers to accessing abortion services, particularly for marginalized individuals, including adolescents, persons with disabilities, Dalit, Bahujan & Adivasi persons, and transgender and gender-variant persons.

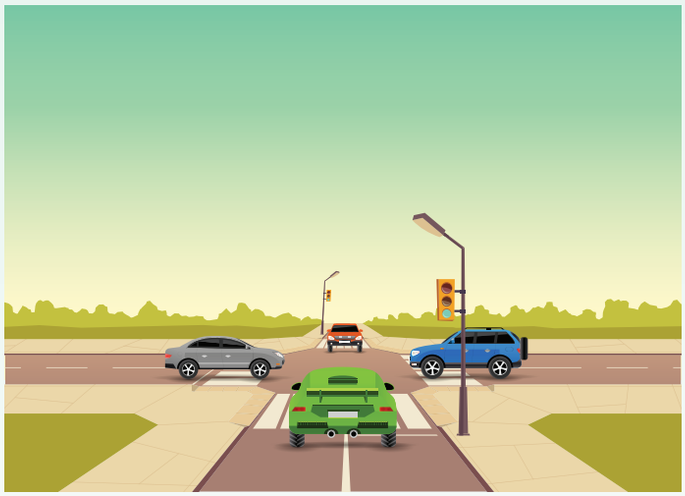
An analysis of the MTP Act from a disability rights perspective reveals its eugenic framework. By permitting abortions after a gestational period of 24 weeks only in cases of foetal anomalies, the MTP Act furthers the prejudice that persons with disabilities are unwanted or undesirable. If it is safe and legal to terminate pregnancies after 24 weeks, why single out a foetus with an anomaly? Termination after 24 weeks should be extended to all persons who are pregnant. Further, while Section 92 of the RPWD Act imposes penalties in relation to the provision of an abortion to a woman with a disability without their express consent, it also creates an exception for the provision of abortions to women with "severe cases of disability" as long as the abortion is authorized by an RMP and consented to by the guardian of the woman. This discriminatory nature of the provision and the legal ambiguity in the definition of "severe disabilities" presents a significant barrier to accessing abortion services by pregnant persons with disabilities.

The POCSO Act was introduced to criminalize sexual assault, sexual harassment, and pornography against all persons below the age of 18. Section 19 of the POCSO Act mandates the reporting of sexual encounters, including consensual sex, involving adolescents. Even if an adolescent approaches an RMP to terminate a pregnancy that is the result of consensual sex, the RMP is required by Section 19 of the POCSO Act to report such activity, thereby introducing a chilling effect on the ability of an adolescent to seek safe and legal abortion services. Although this reporting requirement is intended to prosecute sexual abuse, it effectively acts as an impediment to adolescents seeking safe and legal abortions pursuant to consensual sexual relationships. Recently, the Supreme Court of India took note of this and held that this requirement of mandatory reporting under Section 19 of the POCSO Act was likely to leave minors with the options of either approaching an RMP and facing the possibility of criminal proceedings under the POCSO ACT, or seeking clandestine abortion services from an unqualified doctor.

Moreover, the unintended on-ground impact pursuant to the confusion between, and lack of legal awareness regarding, the PCPNDT Act and the MTP Act also demonstrates several barriers to abortion access in India, as pregnant persons are often denied termination of pregnancies by medical practitioners due to fear of prosecution for gender-based termination under the PCPNDT Act.

An Intersectional Approach to Understanding Legal Barriers to Abortion Access

In 1989, Kimberlé Crenshaw critiqued the single axis framework that is often employed by the law and its conflict with the multidimensionality of Black women's experiences. Crenshaw coined the term "intersectionality" to illustrate the unique positionality of Black women whose experiences were defined by an overlapping and interdependent system of discrimination and disadvantage.



Crenshaw uses the example of a traffic intersection to explain multidimensional oppressions and identities. Discrimination, like traffic, comes from multiple directions. A person standing at this intersection may be injured by one, some, or all four cars – likewise, a Black woman at the intersection of several identities may be oppressed due to gender as well as race.

The simultaneous operation of caste, class, religion, disability, and gender identity warrants the use of an intersectional lens in India. The application of an intersectional lens in the Indian context shows us how multiple facets of marginalization are at play. Particularly, we must recognize that groups are not homogenous and persons who are marginalized on the basis of their caste, class, gender identity, or disability may be privileged in some ways and may be oppressed in other ways.

For example, a Dalit trans man may be oppressed on the basis of his caste as well as his gender identity, while an upper-caste woman may be oppressed on the basis of her gender identity but is privileged by virtue of her caste. There is an urgent need to recognize the heterogeneity of marginalized individuals. Feminist legal discourse and advocacy, including on abortion, must account for the varying experiences of individuals based on multiple axes of oppression.

Despite this, the amendments to the MTP Act in 2021 failed to recognize that trans persons may get pregnant and need an abortion and referred only to women in the legislative framework.

However, in September 2022, the Supreme Court in *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi* recognized that persons other than cis-gender women require abortion services, and therefore interpreted "woman" to include all persons who may require access to safe abortion services.

Intersectionality in Indian Jurisprudence

The continued application of the single-axis framework is evident in judicial decisions such as *Vishakha & Ors. v State of Rajasthan & Ors.*, which laid down guidelines to prevent sexual harassment of women at workplace. Although the impetus for the case was an incident involving a woman belonging to an oppressed caste who was gang-raped by a group of upper-caste men when she was trying to intervene as a social worker, the Court failed to address the oppression arising from casteism.

In April 2021, Justice Chandrachud in *Patan Jamal Vali v State of Andhra Pradesh* noted Crenshaw's framework of intersectionality and stated:

"While the model of intersectionality was initially developed to highlight the experiences of African-American women, there is a growing recognition that an intersectional lens is useful for addressing the specific set of lived experiences of those individuals who have faced violence and discrimination on multiple grounds…intersectional analysis requires us to consider the distinct experience of a sub-set of women who exist at an intersection of varied identities. This is not to say that these women do not share any commonalities with other women who may be more privileged, but to equate the two experiences would be to play down the effects of specific socio-economic vulnerabilities certain women suffer….Intersectional analysis requires an exposition of reality that corresponds more accurately with how social inequalities are experienced."

This case involved what Justice Chandachud referred to as "twin tales of societal oppression", i.e., caste and disability, and the conviction of a man who raped a woman with a visual disability from a Scheduled Caste. Noting the necessity of an intersectional analysis:

"When the identity of a woman intersects with, inter alia, her caste, class, religion, disability and sexual orientation, she may face violence and discrimination due to two or more grounds. Transwomen may face violence on account of their heterodox gender identity. In such a situation, it becomes imperative to use an intersectional lens to evaluate how multiple sources of oppression operate cumulatively to produce a specific experience of subordination for a blind Scheduled Caste woman.

As the facts of this case make painfully clear, women with disabilities, who inhabit a world designed for the able-bodied, are often perceived as "soft targets" and "easy victims" for the commission of sexual violence. It is for this reason that our legal response to such violence, in the instant case as well as at a systemic level, must exhibit attentiveness to this salient fact."

Despite this recognition of intersectional oppression, the Supreme Court continued to apply a single-axis framework and relied solely on the survivor's gender, and not their caste, held that the provisions of the Scheduled Caste and Scheduled Tribe (Prevention of Atrocities) Act, 1989 were inapplicable. Adopting homogenous views of individuals in regulating and advocating for SRHR leads to further exclusion and oppression of marginalized individuals and groups. Further, experiences of casteism, sexism and ableism that are prevalent in healthcare settings create fragmented care and information pathways for individuals from historically marginalized caste or indigenous groups. There is an urgent need for the legal framework to reflect an intersectional analysis of marginalization.

Methodology and Objective

In 2021-22, the Law and Marginalization Clinic, Centre for Justice, Law and Society at Jindal Global Law School, Center for Reproductive Rights, and CommonHealth offered a year-long clinical course titled "Reproductive Justice and the Law Clinic." This collaborative clinical course sought to engage students with critical scholarship on the origins and evolution of norms and politics on sexual and reproductive health rights, feminism, reproductive justice, clinical legal pedagogy, and the legal framework on abortion and reproductive health in India. Students also engaged in reflective exercises including journal entries and classroom activities on intersectionality.

The primary outcome of the Reproductive Justice and the Law Clinic was the conceptualization and publication of this advocacy manual in consultation with key stakeholders and activists. The manual presents a holistic understanding of the current legal framework governing abortion services by highlighting unintended legal conflicts and the lacunae in implementation of legal frameworks. This manual has been envisioned as a resource guide that seeks to catalyse further discourse and advance a rights-based intersectional framework for sexual and reproductive health and rights.

Keeping the above in mind, the manual:

01
Analyzes the impact of certain legislations that affect access to abortion services, i.e., the MTP Act, the RPWD Act, the POCSO Act, and the PCPNDT Act;

02
Critiques the current legal framework on its failure to protect decisional and reproductive autonomy and provide accessible services and information to pregnant persons, especially marginalized individuals;

03
Highlights how the barriers to abortion access are amplified for marginalized groups and persons by illustrating the on-ground barriers to access to abortion; and

04
Proposes recommendations to the current legal framework.

01

At age 20, Paras Dogra began advocating for the rights of trans men, like himself, who were assigned female at birth, raised as girls and ostracized by their families. Recently, Paras started facing health issues. When they approach a doctor, …… Dogra states, “We are made to feel as if we do not deserve medical care.”

Indian trans activists and allies are pushing for legislation towards a more inclusive abortion law, which includes trans men, and their right to health, privacy, and bodily autonomy: “I am just as much a human as you are,” says Dogra.

Source: Dorjee Wangmo, India’s abortion law progressive but excludes us, say trans men, The Indian Express (July 30, 2022) (https://indianexpress.com/article/lifestyle/indias-abortion-law-progressive-but-excludes-trans-men-transgender-rights-queer-lgbtqai-8056577/)

02

Nishu Yadav, 21, is a trans man living in Uttar Pradesh’s Hathras district. When he came out as trans to his parents, they took him to a local doctor, fearing there was something medically wrong with him. The doctor said “aisa kuch nahi hota” (there’s nothing like that). Yadav states, “[t]he doctors here are also very unaware. So in such a situation, the question of giving abortion rights to trans men does not even arise.”

There are many barriers to receiving medical care for transgender persons in India. Yadav recalls traumatic past experiences of being misgendered in hospitals, as well as invasive treatment that is different from that experienced by cisgender people: “If a trans person is a victim of sexual assault and goes to the doctor to get an abortion, the doctor will ask ‘sau sawaal’ (hundred questions) about unnecessary details regarding the case. They might get personal ‘faltu mein’ (unnecessarily),” says Yadav. “Even though I don’t think I can get pregnant now with my hormones, I’d still like to have the choice about my body to myself.”

Source: Dorjee Wangmo, India’s abortion law progressive but excludes us, say trans men, The Indian Express (July 30, 2022) (https://indianexpress.com/article/lifestyle/indias-abortion-law-progressive-but-excludes-trans-men-transgender-rights-queer-lgbtqai-8056577/)

03

Babita Valmiki, a Dalit woman, earns approximately 250 rupees a month gathering human excrement by hand from dry latrines in Uttar Pradesh. She works as a manual scavenger, an occupation outlawed 10 years ago but continuing nationwide. Of the 1.2 million manual scavengers in India, 95% to 98% are Dalit women.

The MTP Act, although allows for access to services for all, overlooks the reality of many women in the Dalit community. Surgical abortions in government hospitals typically cost 15,000 rupees and medical abortions typically cost approximately 1,500 rupees, but these are expensive services particularly as a majority of Dalit women earn less than 90 rupees per week. Babita was unpaid throughout her three pregnancies and was repeatedly denied reproductive care by government hospitals for 11 years due to her caste. “Who will treat an untouchable?” she says. Babita was forced to borrow 40,000 rupees (i.e., 133 times her monthly income) for an abortion in a private hospital.

Oppressed by both their gender and their caste, Dalit women suffer extremely adverse health outcomes due to structural, institutional, socio-cultural and legal barriers.

Source: Shreeja Rao, Feminists in India applaud their abortion rights- but they don’t extend to Dalit women, The Guardian (August 3, 2022) (https://www.theguardian.com/global-development/2022/aug/03/india-abortion-rights-dalit-women)

04

A woman named Kamala and her husband Ravi (names changed) are both from the Gond Adivasi community in Chhattisgarh. When Kamala, who is in her early 30s, got pregnant for the fourth time, she and Ravi, who is 35, decided to terminate the pregnancy. Instead of going to Benoor primary health centre (PHC), she went to a local clinic where the unqualified provider gave her five pills to take over the course of three days and charged her Rs 500. No information was provided about the pills. When she began to bleed a couple hours after, the provider sent her to Benoor PHC, the best equipped and serviced PHC in the district. However, Kamala had no knowledge of its existence, and did not benefit from this readily available pre- or post-natal care during her previous pregnancies: “We didn’t know you could get such things done here.”

Like Kamala, the community in rural Chhattisgarh experience a disconnect from the public healthcare system. “For nearly 90 per cent of the population of Narayanpur that lives in rural areas, with poor or no road connectivity, access to reproductive healthcare remains low.” This forces Kamala and many other Adivasi women to rely on dubious and unqualified medical practitioners.

Source:Priti David, ‘They are Just Given a Pill and Sent Away, PARI: People’s Archive of Rural India (March 11, 2020) (https://ruralindiaonline.org/en/articles/they-are-just-given-a-pill-and-sent-away/)

05

Arpita, a 22-year old person with a hearing disability was forced by her parents into an arranged marriage with Alok (name changed), who is also a person with hearing disability. After Arpita missed her period, she visited a gynaecologist who confirmed her pregnancy. However, after her check-up, she was asked to wait outside so that the doctor could speak with her mother-in-law. Her mother-in-law then gave her a few pills which, within a few days, caused Arpita to bleed heavily. She then discovered that she was given abortion pills against her wishes and without her consent by her mother-in-law and the doctor.

Due to infrastructural inaccessibility, lack of informational access, lack of reasonable accommodations, and lack of supported decision making models embedded in structural and legal frameworks, conversations surrounding their health and courses of action, treatment, and recovery, including relating to sexual and reproductive health, are often exclusionary and violative of the bodily and decisional autonomy and right to privacy of persons with disabilities.

Source:Shreya Raman, India’s Laws Fail To Uphold Abortion Rights Of Women With Disabilities, BehanBox (November 11, 2021) (https://behanbox.com/indias-laws-fail-to-uphold-abortion-rights-of-women-with-disabilities/)

06

Nisha (name changed), a Dalit woman and a person living with disability, wanted to visit the gynecologist because she thought that she might be pregnant. As a person with a visual disability, she struggled to navigate the hospital as the receptionist, without carefully looking through Nisha's paperwork, misdirected her to the wrong office. In fact, the receptionist assumed that Nisha, as someone with a visual disability, needed to see the ophthalmologist.

Once Nisha reached the gynecologist's office, the doctor confirmed that Nisha was pregnant, but also looked at Nisha awkwardly and held an uncomfortable silence. Nisha had expected the gynecologist to congratulate her, just as she had seen in films, instead she had to break the silence to ask the doctor what she needed to do next. The gynecologist, in turn, asked her if she wanted to continue with the pregnancy.

Since Nisha living with a disability, the gynecologist assumed that she would like to terminate her pregnancy, thereby reinforcing the prejudice that persons with disabilities are incapable mothers or parents.

Source:Shreya Raman, India's Laws Fail To Uphold Abortion Rights Of Women With Disabilities, BehanBox (November 11, 2021) (https://behanbox.com/indias-laws-fail-to-uphold-abortion-rights-of-women-with-disabilities/)

07

Shabana (name changed), 18, moved to Delhi to help support her impoverished family in a village in Uttar Pradesh. She did not anticipate that the man who promised her employment would sell her into sex work. When she went into a clinic seeking an abortion, the provider denied her services after learning her profession. She was not a minor but he asked for her parents' consent. Although she eventually was given an abortion when a local community leader intervened, the way she was treated alerted her to the difficulty she and other sex workers would face when accessing reproductive healthcare.

Women in sex work face exclusion and abuse from their families and partners. They are often unable to negotiate with clients who refuse to wear condoms in exchange for more money. They may need access to HIV testing, contraception, maternal care, prevention of parent to child transmission, and safe abortion. In practice however, they encounter social stigma and policy barriers when attempting to access SRH services. Evidence from ongoing projects in India indicates that the uptake of HIV services increases by addressing gender-based violence and the immediate SRH needs of sex workers, including access to contraception, abortion, and post-abortion care are fulfilled.

Source:Sonal Mehta and Shamnu Rao, Ensure sex workers in India have access to sexual and reproductive health services, Hindustan Times (https://www.hindustantimes.com/opinion/ensure-sex-workers-in-india-have-access-to-sexual-reproductive-health-services/story-RVTvzu1CealCKvwi8j3WxH.html)

THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

Section 3 of the MTP Act specifies the conditions subject to which pregnancies can be terminated.

Gestational period of less than 20 weeks

- Consent of the pregnant woman or, in case of a minor or "mentally ill" woman, the consent of their guardian; and
- Opinion of one RMP

Gestational period of 20 – 24 weeks

- Consent of the pregnant woman or, in case of a minor or "mentally ill" woman, the consent of their guardian; and
- Opinion of two RMPs

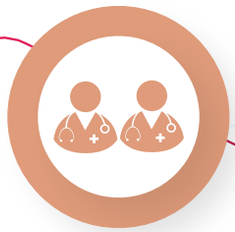
Gestational period of more than 24 weeks

- Consent of the pregnant woman or, in case of a minor or "mentally ill" woman, the consent of their guardian; and
- Diagnosis of "foetal abnormalities" by a Medical Board

The number of RMPs that need to provide their opinion on whether the reason for abortion meets the requirements of the MTP Act **depends solely on the gestational period.** It is not dependent upon the reason given for the termination of pregnancy.

If the gestational period is **within twenty weeks,** then only the **opinion of an RMP** is required.

- A pregnancy within 20 weeks of gestation may be terminated under certain conditions laid down under section 3 of the MTP Act; where there is (1) risk to the life of the pregnant woman; (2)risk of grave injury to her physical or mental health (taking into account her actual and foreseeable environment); or (3) in case of risk of serious foetal anomalies.
- Explanation 1 to Section 3 states that the anguish of a pregnancy which is the result of rape constitutes a grave injury to mental health.
- Explanation 2 to Section 3 provides that a woman can be granted an abortion if there is a failure of the contraceptive method used.



On the other hand, if the **gestational period has exceeded twenty weeks but is less than twenty-four weeks, then the opinion of two RMPs** is necessary.

- However, only certain categories of women, as notified by the Medical Termination of Pregnancy Rules, 2021, are allowed to undergo an abortion beyond twenty weeks.

In the case of gestational period **exceeding twenty four weeks**, the pregnant person must approach a medical board.

- In case of a foetal **anomaly, the reports will be reviewed by a Medical Board** constituted by the State Government or Union Territory Administration and can be aborted without regard to the gestation age or opinion of medical practitioners.

Categories Of Women Eligible For Termination Up To 24 Weeks

The categories of women eligible for termination of pregnancy up to twenty-four weeks under Section 3(2)(b) of the MTP Act and Rule 3B of the MTP Rules are:

*In *X v. Principal Secretary, Health and Family Welfare, Govt. of NCT Delhi*, the Supreme Court provided an expansive interpretation of Rule 3B of the MTP Rules, stating that:

"A change in material circumstance may also result when a woman is abandoned by her family or her partner. When a woman separates from or divorces her partner, it may be that she is in a different (and possibly less advantageous) position financially. She may no longer have the financial resources to raise a child. This is of special concern to women who have opted to be a homemaker thereby forgoing an income of their own. Moreover, a woman in this situation may not be prepared to raise a child as a single parent or by coparenting with her former partner. Similar consequences may follow when a woman's partner dies. Women may undergo a sea change in their lives for reasons other than a separation with their partner...They may find themselves in the same position (socially, mentally, financially, or even physically) as the other categories of women enumerated in Rule 3B but for other reasons. For instance, it is not unheard of for a woman to realise that she is pregnant only after the passage of twenty weeks. Other examples are if a woman loses her job and is no longer financially secure, or if domestic violence is perpetrated against her, or if she suddenly has dependents to support. Moreover, a woman may suddenly be diagnosed with an acute or chronic or life-threatening disease, which impacts her decision on whether to carry the pregnancy to term. If Rule 3B(c) was to be interpreted such that its benefits extended only to married women, it would perpetuate the stereotype and socially held notion that only married women indulge in sexual intercourse, and that consequently, the benefits in law ought to extend only to them. This artificial distinction between married and single women is not constitutionally sustainable. The benefits in law extend equally to both single and married women."

Who can terminate?

(a) Until 9 weeks of gestation by medical abortion

- A medical practitioner who was registered in a State Medical Register immediately before the commencement of the MTP Act should have at least three years of experience in gynaecology and obstetrics; or
- A medical practitioner who was registered in a State Medical Register should have:

  (i) Completed six months of house surgency in gynaecology and obstetrics; or

  (ii) At least one year of experience in the practice of obstetrics and gynaecology at any hospital; or
- A medical practitioner who has assisted another RMP in the performance of 25 cases of medical termination of pregnancy, at least five of which should have been conducted independently, at a hospital or training institute approved for this purpose by the Government.
- A medical practitioner should have:

  (i) At least three months of experience in the practice of obstetrics and gynaecology at any hospital, or

  (ii) Independently performed 10 cases of medical termination of pregnancy by medical methods of abortion under the supervision of another RMP at a hospital or training institute approved for this purpose by the Government.
- A medical practitioner who is registered in a State Medical Register should have a post-graduate degree or diploma in gynaecology and obstetrics.

(b) Until 12 weeks of gestation by surgical abortion

- A medical practitioner who was registered in a State Medical Register immediately before the commencement of the MTP Act should have at least three years of experience in gynaecology and obstetrics; or
- A medical practitioner who was registered in a State Medical Register should have:

  (i) completed six months of house surgency in gynaecology and obstetrics; or

  (ii) at least one year of experience in the practice of obstetrics and gynaecology at any hospital; or
- A medical practitioner who has assisted another RMP in the performance of 25 cases of medical termination of pregnancy, at least five of which should have been conducted independently, at a hospital or training institute approved for this purpose by the Government.
- A medical practitioner who is registered in a State Medical Register should have a post-graduate degree or diploma in gynaecology and obstetrics.

(c) Between 12 to 20 weeks of gestation

- A medical practitioner who was registered in a State Medical Register immediately before the commencement of the MTP Act should have at least three years of experience in gynaecology and obstetrics; or
- A medical practitioner who was registered in a State Medical Register should have:

  (i) completed six months of house surgency in gynaecology and obstetrics; or

  (ii) at least one year of experience in the practice of obstetrics and gynaecology at any hospital; or
- A medical practitioner who is registered in a State Medical Register should have a post-graduate degree or diploma in gynaecology and obstetrics.

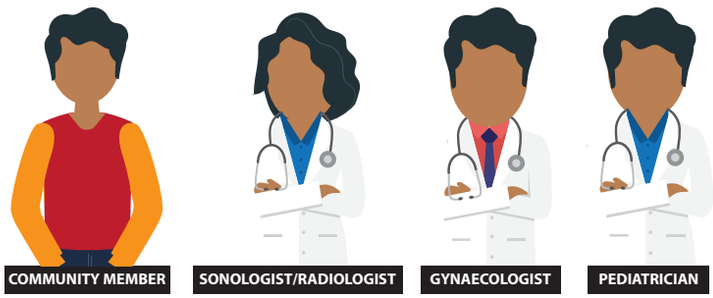
(d) Between 20 to 24 weeks of gestation

- A medical practitioner who was registered in a State Medical Register immediately before the commencement of the MTP Act should have at least three years of experience in gynaecology and obstetrics; or
- A medical practitioner who was registered in a State Medical Register should have:

  (i) completed six months of house surgency in gynaecology and obstetrics; or

  (ii) at least one year of experience in the practice of obstetrics and gynaecology at any hospital; or
- A medical practitioner who is registered in a State Medical Register should have a post-graduate degree or diploma in gynaecology and obstetrics.

(e) Medical Board:



The Medical Termination of Pregnancy (Amendment) Act, 2021 (the **MTP Amendment Act**) introduced key amendments to the MTP Act. For example, pursuant to the MTP Amendment Act, the gestational period up to which a woman is permitted to get an abortion has been increased (from 20 weeks to 24 weeks in limited circumstances and subject to approval of a medical board). However, the MTP Amendment Act continues to reflect eugenic rationales, with abortion only being permissible in the case of pregnancies beyond 24 weeks when there is a foetal "abnormality" as diagnosed by a medical board. By limiting the right to medical termination of pregnancy after 24 weeks to cases of foetal anomalies, the legislature has created an exceptionalizing framework that: (i) furthers the prejudice that persons with disabilities are unwanted, and (ii) begs the question: if termination of pregnancy is medically safe after 24 weeks in cases of foetal anomalies, why is termination not permitted without exceptions?

Moreover, the use of the term "mentally ill" further stigmatizes persons with disabilities and continues to violate their autonomy.

The MTP Amendment Act also fails to recognize that access to abortions is an issue that concerns persons other than cis-gender women and the use of the word "woman" in the Act operates to the exclusion of transgender and gender-variant persons who may also need access to abortion services in addition to other sexual and reproductive healthcare. This issue was addressed by the Supreme Court of India in September 2022, in the case of *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi* where the Court recognized that persons other than cis-gender women require abortion services, and therefore interpreted "woman" in that judgment to include all persons who may require safe access to abortion services.

While the MTP Act, particularly pursuant to the MTP Amendment Act, is perceived as a progressive legislation, the legislative framework of the law:

a. Remains doctor-centric and does not centre the rights of pregnant persons, particularly pregnant persons from marginalized groups;

b. Continues to abide by the archaic rationale of population control instead of strengthening the rights of the sexual and reproductive autonomy, as well as dignity of pregnant persons; and

c. Fails to adopt a rights-based framework.

For example, the MTP Act continues to ignore the dichotomy between the exercise of decisional and bodily autonomy and the requirement to obtain third-party authorizations for abortions, thereby hindering access to safe and legal abortions. Section 3(4)(b) of the MTP Act states that, except in limited circumstances, a pregnancy cannot be terminated without the consent of the pregnant woman. In *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi*, the Supreme Court stated that:

"Reproductive autonomy requires that every pregnant woman has the intrinsic right to choose to undergo or not to undergo abortion without any consent or authorization from a third party."

"[T]he decision to carry the pregnancy to its full term or terminate it is firmly rooted in the right to bodily autonomy and decisional autonomy of the pregnant woman."

However, in all cases of termination, the consent of the pregnant person is not enough for an abortion as the approval of an RMP is always required. Currently, pregnant person's autonomy is always subservient to medical opinion, which may be based on several other factors, including a fear of criminal prosecution under the IPC. In *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi*, the Supreme Court noted *"it is a common yet lamentable practice for RMPs to insist on compliance with extra-legal conditions such as consent from the woman's family, documentary proofs, or judicial authorization. This compels pregnant persons to approach their parents, guardians or spouses (even though spousal consent is not required for an abortion), courts (even though the MTP Act does not mandate judicial authorization), medical boards, etc. in order to access safe and legal abortion services."*

Prior to the MTP Amendment Act, medical boards were typically set up by courts during proceedings for permission for termination of pregnancies. Medical boards have been institutionalized by the MTP Amendment Act. The MTP Act now requires a medical board to diagnose foetal "abnormalities" for termination of pregnancies exceeding 24 weeks of gestation. However, the setting up and smooth functioning of these medical boards is untenable: not only does institutionalization of third-party authorizations hinder the exercise of decisional and bodily autonomy by pregnant persons, there is also an abysmal shortage of specialized doctors in India. States and Union Territories have recorded a shortfall of 80% in obstetricians and gynaecologists and some states, such as Arunachal Pradesh, Meghalaya, Mizoram and Sikkim, recorded a shocking 100% shortfall of paediatricians, thereby rendering the state-wise setting up of medical boards impossible.

Additionally, the refusal by an RMP and the subsequent requirement to approach courts can be daunting for pregnant persons, particularly pregnant persons from marginalized groups for whom judicial authorities or medical boards are complicated, expensive, and inaccessible.

In *Amita Kujur v State of Chhattisgarh & Ors*., the petitioner, an Adivasi rape survivor, wished to terminate her pregnancy at 12 weeks, which is well within the legal gestational limit for termination. The District Hospital in Jashpur was not able to terminate her pregnancy due to the unavailability of trained doctors and referred her to the Chhattisgarh Institute of Medical Sciences (CIMS). At CIMS, she was asked to produce a copy of the First Information Report (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 21 weeks, therefore placing it outside the ambit of the unamended MTP Act. Ultimately, however, the Court granted an order for the termination of the pregnancy. The case highlights the obstacles faced by marginalized persons in accessing abortions, given their inability to repeatedly approach courts and heavy reliance on the public healthcare system which is lacking in infrastructure.

The barriers that are inherent in the legislative framework are compounded by the on-ground barriers to accessing abortions, which are exacerbated for marginalized groups and individuals, such as Dalit, Bahujan, Adivasi persons, transgender and gender-variant persons and persons with disabilities. The examples below seek to highlight:

01

How barriers to accessing sexual and reproductive healthcare, including abortion, are heightened on the basis of gender, caste, class, religion, disability, etc.

02

The importance of incorporating an intersectional framework in examining, understanding, and removing barriers to accessing sexual and reproductive healthcare, including abortion.

01 Shehnaz and her family belong to the Bakarwal pastoralist tribal community and live in makeshift tents in remote areas for large parts of the year. Shehnaz is currently pregnant - she thinks about 15-20 weeks pregnant - and is experiencing heavy bleeding and severe pain in the abdomen.

- Shehnaz is worried about reaching a healthcare facility. There are no doctors, public health centres or ambulance services in her vicinity. The only available option is for Shehnaz's family to carry her on a makeshift stretcher to the nearest medical facility, which is 67 kilometres away.
- In the past, when she tried to access medical services after walking on hilly terrain for hours, she was faced with arbitrary closure timings – the persons who were running the PHC were simultaneously engaged in other forms of work to sustain their livelihoods in light of high poverty levels and rising inflation.
- Shehnaz is afraid of discrimination and the resultant inadequate medical treatment. From her past experiences at medical facilities, Shehnaz remembers that Bakarwals are treated with disgust and negligence by hospital staff and are not provided complete information about their condition.

02 Shriji is a sex worker in Kolkata. Many of her clients refuse to use contraception and, as a result, Shriji needs to frequently get tested for sexually transmitted diseases.

- Shriji is nervous about visiting nearby health camps and the breach of her rights to privacy and confidentiality. Due to the cultural and social stigma, Shriji does not want members of her community to know that she is a sex worker and at risk for HIV/AIDS. Therefore, Shriji would like to visit a private healthcare facility. However, she has not had stable income since the beginning of the pandemic and lockdowns in March 2020, and cannot afford tests in a private facility.
- Shriji is afraid of harassment, including sexual harassment, at healthcare facilities. Often, sex workers are subjected to harassment, including sexual harassment. Medical professionals also cast moral judgments on persons who engage in sex work or in sexual activity with multiple partners.
- Given her past experience with miscarriages, she is apprehensive about the lack of adequate and accessible reproductive healthcare.

03 Tenu is a Dalit trans man and lives with his partner and family in Maitha, Uttar Pradesh. Tenu is currently pregnant and wants to undergo an abortion, but is unaware of the procedural and medical requirements.

- Tenu is nervous that he will not receive comprehensive healthcare services, as the staff at nearby government hospitals do not have the knowledge or skills to treat and care for transgender patients like him.
- Tenu is apprehensive that he will be denied abortion services due to his identity as a trans man. The legal regulation and the provision of healthcare, including sexual and reproductive healthcare, are constructed around the male-female gender binary and do not account for the rights, experiences, or needs of the transgender and gender-variant communities.
- Tenu is afraid that doctors will refuse to treat him. Untouchability and casteism continue to be a reality, including in healthcare facilities and for the provision of abortion services.

INTERNATIONAL FRAMEWORK

In March 2022, the World Health Organization (WHO) issued the "Abortion Care Guideline" to present "recommendations and best practice statements relating to abortion." The guideline:

- Recommends that abortion be centred within primary health care, which should in turn be fully integrated within the healthcare system and refer cases to higher-level care as and when required.
- Emphasizes that the strengthened systems of primary care will be a *"safe and effective strategy to advance equitable access to, and provide an enabling environment for, abortion"*
- Recommends that states ensure *"the provision of comprehensive, non-discriminatory, scientifically accurate and age-appropriate education on sexuality and reproduction, including information on abortion, both in and out of schools"*
- Recommends that states ensure *"that comprehensive sexuality education (CSE) is available to minors without the consent of their parents or guardians"*
- Reiterates the recommendation from 2012 that: *"abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution"*
- Recommends that *"[r]egardless of whether third-party authorization requirements apply, informed consent of the person availing of abortion is a prerequisite for the provision of abortion"*
- Recommends that the authorization or consent of parents should not be required before the provision of abortion care to adolescents
- Recommends that states ensure that informed consent is, *inter alia:*

  a. "safeguarded through legislative, political and administrative means as a fundamental aspect of a range of human rights (i.e. the rights to health, information, freedom from discrimination, and security and dignity of the person);

  b. based on provision of complete information about the associated benefits, risks and alternatives;

  c. based on information that is of high quality, accurate and accessible (including ensuring it is available in a range of formats and languages, and in forms that make it accessible to people with reduced capacity), and presented in a manner acceptable to the person consenting."

General Recommendation 24 of the Convention on Elimination of All Forms of Discrimination against Women Committee recognized that the authorization of husbands, partners, parents, or health authorities is a significant barrier to access to abortion.

The 2006 United Nations Convention on the Rights of Persons with Disabilities (CRPD) states that *"consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:*

a) The diagnostic assessment;

b) The purpose, method, likely duration and expected benefit of the proposed treatment;

c) Alternative modes of treatment, including those less intrusive, and

d) Possible pain or discomfort, risks and side effects of the proposed treatment."

The CRPD also requires the State to ensure that health professionals provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, *inter alia*, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.

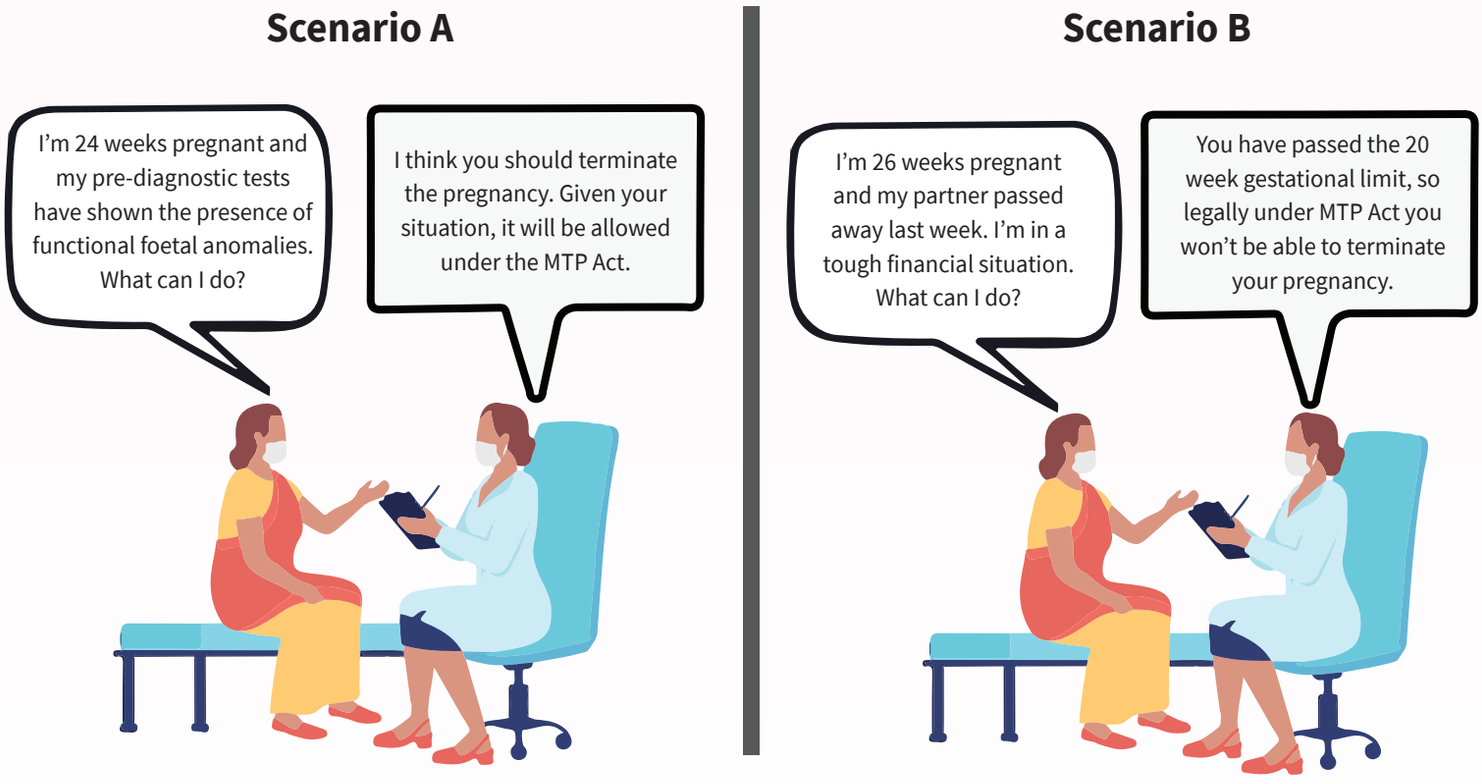
In General Comment 1 the CRPD Committee also stated: *"Supported decision-making is distinct from substituted decision-making in that it does not replace the decision of the individual receiving support and prioritizes that individual's values, will, and preferences."*

BARRIERS TO ABORTION ACCESS FOR PERSONS WITH DISABILITIES

Persons with disabilities encounter several barriers including structural, institutional, infrastructural, socio-cultural, and legal barriers in accessing sexual and reproductive healthcare services in India. Access forms a key part of engagement with the ecosystem for a person with disability. For instance, if a person with a visual disability wants to take a pregnancy test, they might need to seek the support of a sighted individual who would provide them with the information on the home pregnancy test. Similarly, a person with an auditory disability faces barriers in accessing information about their healthcare from a doctor and there is often a need for a hearing family member or another hearing person to be present to translate the doctor's explanation. These access barriers create concerns of independence, violations of privacy or increase in misinformation and impact overall decision-making.

An analysis of the MTP Act and the RPWD Act from a disability rights perspective reveals their eugenic framework.

- **The only circumstance in which medical termination of pregnancy is permitted after 24 weeks of gestation is in case of a "foetal abnormality" as diagnosed by a medical board. By permitting abortions after 24 weeks in this limited circumstance, the law furthers the prejudice that disability is an adverse exceptional situation. The legislative framework also fails to recognize other circumstances in which persons may require abortions after 24 weeks of gestation. If it is safe and legal to terminate pregnancies after 24 weeks, why single out a foetus with an anomaly?**



In *Priyanka Shukla v Union of India*, the Delhi High Court allowed a 25-week pregnant woman's plea to terminate her pregnancy since the foetus had enlarged kidneys and was not expected to survive.

A bench of Chief Justice D N Patel and Justice Hari Shankar said the section of the Medical Termination of Pregnancy Act which prohibits abortion after 20 weeks of pregnancy even if the foetus is "abnormal", and the provision which relaxes this restraint if there is an immediate threat to the life of the mother, have to be considered cumulatively and not in isolation.

- The legal framework fails to account for the decisional autonomy of persons with disabilities.
  - Section 3(4) of the MTP Act requires the consent of a guardian for terminating the pregnancy of a person with a disability, thereby assuming that all persons with disabilities are incapable of providing free and informed consent. This provision perpetuates the harmful prejudice that all disabilities, particularly psychosocial and intellectual disabilities, necessarily lead to the incapacity to exercise decisional autonomy.
  - Section 92 of the RPWD Act imposes penalties in relation to the provision of an abortion to a woman with a disability without their express consent, but also creates an exception for the provision of abortions to women with "severe cases of disability" as long as the abortion is authorized by an RMP and consented to by the guardian of the woman. Therefore, Section 92 of the RPWD Act permits abortions to be provided without consent of the pregnant woman in cases of "severe disabilities". However, the RPWD Act does not define "severe cases of disability", thus leaving room for interpretation and further violation of the rights of persons with disabilities.
- These provisions permit guardians to override the exercise of bodily and reproductive autonomy by pregnant persons with disabilities and, therefore, a pregnant person with disability may be prevented from accessing abortion services or may be forced to undergo an abortion. This entire framework does not give any weightage to the wishes of the person with a disability or envisage a supported-decision making model.

Set forth below is a hypothetical situation highlighting barriers to accessing sexual and reproductive healthcare, including abortion, for persons with disabilities. This situation seeks to highlight the importance of incorporating an intersectional framework in examining, understanding, and removing barriers to accessing sexual and reproductive healthcare, including abortion.

Sabah is a 22 year old unmarried Muslim woman who lives in Nagpur with her family. Sabah also uses a wheelchair. Recently, Sabah has been experiencing extreme pain and discomfort during her periods and has had to take multiple sick leaves from her office. Despite being formally educated, Sabah has not received any information about her reproductive health and does not know what to do about her pain.

- Sabah is afraid to ask her family or friends for advice. There is a lot of taboo and shame associated with sexual and reproductive health – is she allowed to ask questions and seek help?
- Sabah is worried that no clinic or hospital will be safe and accessible for her. Often, healthcare facilities do not have wheelchair ramps, elevator access, clear navigation / signage, sign language interpreters and other infrastructural measures to ensure access for persons with disabilities. Additionally, healthcare facilities often insist that a person with a disability is accompanied by a guardian and are not sensitized towards communicating with persons with disabilities.
- Sabah is afraid that she will be asked to remove her hijab. She has heard that healthcare facilities frequently accuse Muslim women of stealing babies, and therefore force them to remove their hijabs and burqas. This will be humiliating for Sabah.

In *Suchita Srivastava v. Chandigarh Administration,* the Supreme Court drew a distinction between persons that are "mentally ill" and those that are "mentally retarded." The Court held that the consent of the person living with disability, and not the guardian, is still required in cases where the person is living with mild disability. Only in cases of severe disability (that is, where the person is placed in an institutionalized environment) can the consent of the guardian substitute that of the pregnant person. This case is pertinent to take note of given the court's ruling and its attempt to facilitate a model of supported decision making. However, the lack of clarity as to what would constitute a "severe disability" leaves room for legal ambiguity and can result in denial of the rights of autonomy and dignity of pregnant persons with disabilities.

BARRIERS TO ABORTION ACCESS FOR ADOLESCENTS

This chapter highlights the barriers to abortion access faced by adolescents, which increase the likelihood that adolescents will seek unsafe and illegal abortions.

The WHO defines adolescents as individuals from ages 10 to 19. According to NFHS-4 (2015-16), 39% women reported that they had sexual intercourse before the age of 18. There is a widely held notion that increasing awareness and access to contraception will lead to promiscuity among adolescents, especially women. Social and cultural conventions strive to "safeguard" young women's "purity" by controlling their sexuality and bodies. Such conventions also hinder the ability of doctors to inquire about sexual histories or have open discussions about sexual health, resulting in incomplete medical information that may impact quality of care. Due to internalized stigma and a lack of awareness on adolescent sexuality, doctors also often impose moral checks on adolescents, sometimes at the cost of providing quality sexual and reproductive healthcare. Based on a 2020 report by the Guttmacher Institute, 2 million adolescent women in India have an unmet need for contraception. Adolescents are also less likely to approach registered healthcare providers to seek safe and legal abortions.

Additionally, due to the lack of accessible and comprehensive sexuality education, adolescents have been restrained in exercising decision-making power with respect to their sexualities and bodies. It has been reported that only 25% of girls between the ages of 15 - 24 years have reported to have received some form of sex education. The clear absence of comprehensive sexuality education has also been recognized by the Supreme Court in *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi*: *"The absence of sexual health education in the country means that most adolescents are unaware of how the reproductive system functions as well as how contraceptive devices and methods may be deployed to prevent pregnancies."* The Supreme Court further noted that reproductive rights include the right to access education and information about contraception and sexual health.

The autonomy of adolescents is also curtailed by a legal framework that does not typically give any weightage to their wishes or recognize their capacity to consent:

1. Section 3(4) of the MTP Act requires the consent of a guardian for the medical termination of a minor's pregnancy. Section 2(c) of the MTP Act defines "minor" as "someone who has not attained the age of majority, as given under the provisions of Indian Majority Act, 1875" (i.e., someone under the age of 18). However, the requirement to obtain guardian consent may also act as a deterrent against approaching RMPs, particularly in light of the taboo surrounding adolescent sexuality, thereby increasing the likelihood of adolescents resorting to unsafe and illegal abortions.

2. The POCSO Act was introduced to criminalize sexual assault, sexual harassment, and pornography against all persons below the age of 18. As noted by the Supreme Court in September 2022, the POCSO Act does not account for consensual sexual relationships, and consent is therefore deemed irrelevant in determining liability. Sex with a person below the age of 18 years is statutory rape under the POCSO Act and, therefore, consensual relationships between adolescents are criminalized.

In *Ajithkumar v The State,* the Madras High Court adjudicated a case involving two adolescents who were in a consensual relationship and ran away together to get married. The girl filed a petition to quash the criminal proceedings against her partner, who was being prosecuted under the POCSO Act. The Madras High Court stated:

> *"When the girl below 18 years is involved in a relationship with the teen age boy or little over the teen age, it is always a question mark as to how such relationship could be defined, though such relationship would be the result of mutual innocence and biological attraction. Such relationship cannot be construed as an unnatural one or alien to between relationship of opposite sexes. But in such cases where the age of the girl is below 18 years, even though she was capable of giving consent for relationship, being mentally matured, unfortunately, the provisions of the POCSO Act get attracted if such relationship transcends beyond platonic limits, attracting strong arm of law sanctioned by the provisions of POCSO Act, catching up with the so called offender of sexual assault, warranting a severe imprisonment of 7/10 years.*
>
> *Therefore, on a profound consideration of the ground realities, the definition of 'Child' under Section 2(d) of the POCSO Act can be redefined as 16 instead of 18…The Act can be amended to the effect that the age of the offender ought not to be more than five years or so than the consensual victim girl of 16 years or more. So that the impressionable age of the victim girl cannot be taken advantage of by a person who is much older and crossed the age of presumable infatuation or innocence.*
>
> *It is now well evidenced that adolescent romance is an important developmental marker for adolescents' self-identity, functioning and capacity for intimacy. Developmental-contextual theories of adolescent romantic stages also provide a framework for how romantic relationships assist young adults with addressing their identity and intimacy needs. Therefore, the age of adolescence as can be seen evidently, is one associated with an amassing change in the neurological, cognitive and psychological systems of a person and one of the most important aspect is that the individual tries to establish their identity, develops emotional and biological needs during this period as a result of which the individual tends to look for new relationships, bonding and partnership. It is also important to acknowledge in addition to this, the vast exposure that is available to adolescents and youth in the form of digital content that play a major role in influencing their growth and identity."*

The Court also noted another adverse impact of the provisions under the POCSO Act:

> *"As a consequence of such a FIR being registered, invariably the boy gets arrested and thereafter, his youthful life comes to a grinding halt. The provisions of the POCSO Act, as it stands today, will surely make the acts of the boy an offence due to its stringent nature. An adolescent boy caught in a situation like this will surely have no defense if the criminal case is taken to its logical end. Punishing an adolescent boy who enters into a relationship with a minor girl by treating him as an offender, was never the objective of the POCSO Act."*

In AK v State Govt of NCT of Delhi and Anr. the parents of a 17-year old married woman filed an FIR against her partner. The Delhi High Court in October 2022 noted that the woman was not forced into the marriage and stated:

> *"In my opinion the intention of POCSO was to protect children below the age of 18 years from sexual exploitation. It was never meant to criminalize consensual romantic relationships between young adults."*

In quashing another case under the POCSO Act, the Meghalaya High Court in *Shri Silvestar Khonglah & Anr. v State of Meghalaya & Anr* in November 2022 noted that:

> *"[I]n a case where there is mutual love and affection between a child and a person which might even lead to a physical relationship, though the consent of the child under the law is immaterial as far as prosecution for an alleged offence of sexual assault is concerned, but considering the peculiar facts and circumstances of a particular case, such as in a case of a boyfriend and girlfriend particularly, if both of them are still very young, the term 'sexual assault' as could be understood under the POCSO Act cannot be attributed to an act where, there is, as pointed above, mutual love and affection between them."*

Section 19 of the POCSO Act mandates reporting of sexual encounters, including consensual sex, involving adolescents. Failure to report may result in six months of imprisonment and/or the imposition of a fine. If an adolescent approaches an RMP to terminate a pregnancy that is the result of consensual sex, the RMP is required by Section 19 of the POCSO Act to report such sexual activity to the special juvenile police unit or the local police. Although this reporting requirement is intended to prosecute sexual abuse, it effectively acts as a barrier to the rights of adolescents to seek safe and legal abortion. Often, adolescents will be fearful of attracting consequences under the POCSO Act (i.e., criminal action against their partner) and will therefore resort to unsafe and/or unlawful means of abortion to avoid triggering any reporting requirements.

This reporting requirement introduces a chilling effect on the ability of an adolescent to seek safe and legal abortion services.

Set forth below are hypothetical situations highlighting barriers to accessing abortion for adolescents. These situations also seek to highlight the importance of incorporating an intersectional framework in examining, understanding, and removing barriers to accessing sexual and reproductive healthcare, including abortion.

Sukana is a 16 year old Dalit girl who lives with her family in Khimsar, Rajasthan and studies in a private school. Sukana is in a consensual relationship with her classmate. Sukana realises that she is pregnant through a home pregnancy test.

- As an adolescent, Sukana cannot access sexual and reproductive healthcare without her parents' accompaniment. The stigmatization of sexuality and high value on adolescent abstinence, particularly by girls, makes Sukana fearful of talking to her parents and decides to approach a doctor in a public hospital.
- The doctor confirms that she is 8 weeks pregnant. The doctor requests the nurse to administer medical abortion pills. The nurse refuses to administer the pill given her caste status. Sukana faces discrimination and is unable to avail the medical service.
- A few minutes later, police arrives to arrest her partner because the doctor reported this case to the police. Due to the reporting requirement under the POCSO Act, Sukana's doctor was required to contact authorities regarding their sexual relationship.

Jeeva, a 13 year old who lives in Arvi in the Wardha district of Maharashtra has been in a consensual sexual relationship with her 17 year old partner who lives in the same village.

- Jeeva discovers that she is pregnant and she and her partner approach a medical practitioner to terminate the pregnancy.
- A complaint is subsequently filed by Jeeva's parents against the adolescent male partner under the POCSO Act and an arrest is made by the police as the POCSO Act criminalizes all sexual activity that involves a person under the age of 18. Jeeva's partner is then sent to a Juvenile Home.
- Meanwhile, the police also arrest the medical practitioner and nurses who facilitated the termination of pregnancy on the basis of the provisions of the IPC that criminalize abortions.
- Given the manner in which adolescent sexuality is policed and the lack of access to abortions for adolescents in particular, adolescents are reluctant to approach medical practitioners. The criminalization of doctors under the IPC further acts as an additional barrier since it creates a chilling effect that deters doctors from providing abortion services, especially in the case of adolescents in view of the POCSO Act.

In an effort to safeguard the confidentiality of adolescents seeking abortions, the Supreme Court in *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi* held that:

> *"To ensure that the benefit of Rule 3B(b) is extended to all women under 18 years of age who engage in consensual sexual activity, it is necessary to harmoniously read both the POCSO Act and the MTP Act. For the limited purposes of providing medical termination of pregnancy in terms of the MTP Act, we clarify that the RMP, only on request of the minor and the guardian of the minor, need not disclose the identity and other personal details of the minor in the information provided under Section 19(1) of the POCSO Act. The RMP who has provided information under Section 19(1) of the POCSO Act (in reference to a minor seeking medical termination of a pregnancy under the MTP Act) is also exempt from disclosing the minor's identity in any criminal proceedings which may follow from the RMP's report under Section 19(1) of the POCSO Act. Such an interpretation would prevent any conflict between the statutory obligation of the RMP to mandatorily report the offence under the POCSO Act and the rights of privacy and reproductive autonomy of the minor under Article 21 of the Constitution. It could not possibly be the legislature's intent to deprive minors of safe abortions."*

The framing of sexual relationships by the POCSO Act eliminates the possibility of a consensual relationship and fails to recognize the evolving sexual capacity of adolescents. Both mandatory reporting as well as criminalization of sexual activity among adolescents need to be critically examined.

THE MTP ACT AND THE PCPNDT ACT

The PCPNDT Act regulates the use of pre-conception and pre-natal diagnostic techniques and aims to prohibit pre-natal gender determination. The PCPNDT Act does not regulate abortion. In fact, the term "medical termination of pregnancy" is not used a single time in the entire statute. The term "abortion" is used only once to indicate that pre-natal diagnostic techniques are permitted in the instance that a pregnant woman has undergone two or more spontaneous abortions.

However, healthcare service providers often refuse to provide abortions due to a fear of prosecution under the PCPNDT Act. In February 2015, the Ministry noted that:

> *"At times, an instant reaction based on a flawed understanding leads to imposing restrictions on access to abortion services and most significantly, second trimester abortions, seen as an easy solution to fix the problem of sex selection. Anecdotal evidence from various States highlight the challenges faced by women seeking safe abortion services on legal grounds due to restrictions imposed in efforts to address sex selection. It is, therefore, important to ensure that the implementation of each Act is done judiciously without impinging on the objectives of the other."*

The text and objective of the PCPNDT Act are not related to abortions in any manner. A study by the Samyak revealed the lack of awareness on the purposes of the MTP Act and the PCPNDT Act – one medical practitioner mistakenly believed that "the MTP Act had been 'converted into the PCPNDT Act in 1994.'"

There is no conflict between the MTP Act and the PCPNDT Act, because the legislative intent behind the PCPNDT Act is strictly related to diagnostics and does not in any way deal directly with abortions. Yet, medical practitioners are often fearful of prosecution under the IPC or the PCPNDT and therefore deny abortion services, particularly after the first trimester.

The Samyak study revealed that 17 out of 19 medical practitioners avoid providing abortion services in the second trimester of a pregnancy due to the "probability" of pre-natal gender determination. Revealing the impact on abortion access, medical practitioners stated:

- "Generally we never do MTPs for referral cases because there might be a chance of sex selective abortions. Also if the patient has one or two daughters then we refuse the abortion."
- "Though I am authorized to do MTP up to 20 weeks in our hospital, still we are not doing abortions after 10 weeks. We make sure that women do not abort at our hospital in the second trimester. Because we don't know if it is sex selective abortion or not, so it is better to keep ourselves away from it."
- "Recently, government have announced that we should not use indication of contraception failure for the second trimester abortions as they can be sex selective abortions. It is a protective step taken by the government. So we do not provide abortion service in the second trimester, even if there is any anomaly in the baby."
- "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."
- "Government people troubled us for various reasons. They even said 'You are lying; you must be doing sex selection.' This is very disturbing for us. That's why I stopped doing MTPs in the second trimester."
- "Pregnancy in unmarried girls may be due to certain illegal things. It can create problems for that girl and her family. My opinion is that we should inform the police while dealing with these types of cases because there are chances of medico-legal problems after MTP. So it is better to inform police. I generally do not do MTPs of unmarried girls in my hospital. I advise them I will do it in the institute (privately) because it is easy to deal with these types of cases there."

Notably, healthcare service providers will not face any consequences under the PCPNDT Act for terminating a pregnancy in consonance with the MTP Act. However, it should be noted that gender determination is not a criterion for legal termination of pregnancy.

In addition, doctors have pointed to the record-keeping requirements under the PCPNDT Act and the intrusion by Government authorities in relation to such records:

- "When government people come to us, they ask us about the records of women who have two or more girls. That's it. They don't want anything else."
- "This record keeping is a very time-consuming process. I have to spend my time on that. It impacts my practice. I can't give sufficient time to patients. Also since the last one year I have stopped doing second trimester MTPs because of this record-keeping."

Set forth below is a hypothetical situation highlighting barriers to accessing abortion services due to lack of awareness around the MTP Act and the PCPNDT Act.

Sama is a 40-year old person who works as a domestic worker and has two daughters. Although Sama and her husband used contraception, Sama discovers that she is pregnant. Given their financial situation, Sama seeks to terminate her pregnancy.

- By the time that Sama saves enough money for termination of pregnancy and reaches the nearest Government hospital, she is at 20 weeks of gestation.
- The doctor refuses to provide an abortion. Since Sama is in her second trimester and has two daughters, the doctor is fearful that Sama has undergone pre-natal gender determination.
- However, under the MTP Act, termination of a pregnancy between 20 to 24 weeks of gestation is permitted in case of contraceptive failure with the consent of the pregnant person and opinion of two RMPs.

A lack of legal clarity and awareness, particularly around the distinct purposes and provisions of the MTP Act and the PCPNDT Act, thereby hinders the ability to pregnant persons to seek safe and legal abortions.

RECOMMENDATIONS TO ENSURE ABORTION ACCESS

Legal Recommendations

The Indian Penal Code

- Sections 312-318 of the IPC which currently criminalizes abortion should be deleted to allow for complete decriminalization of abortion.

The Medical Termination of Pregnancy Act should:

- Ensure that the legal framework permits the exercise of decisional, bodily, and reproductive autonomy of pregnant persons by enabling a rights-based framework for the MTP Act.
- Amend the word “woman” to “person” to recognize the right of every pregnant person (including trans men, non-binary individuals, gender-variant individuals as well as cis-gender women) to access abortion services.
- Permit the provision of abortion services on-request without any conditions.
- Remove the requirement to obtain the opinions of two RMPs for termination of pregnancies between 20 to 24 weeks and permit termination of pregnancy with the opinion of one medical practitioner.
- Remove all third-party authorization requirements (including medical boards) from the abortion law framework.
- Permit the provision of abortion services to all persons without any restriction as to gestational period – termination of pregnancy after 24 weeks of gestation should be permitted in all cases and not just in cases of foetal anomalies.
- Remove stigmatizing and discriminatory language such as “abnormality” instead use “anomaly”.

The Rights of Persons with Disabilities Act should:

- Implement a supported-decision making model for persons with disabilities in the provisions surrounding consent.
- Amend Section 92 of the RPWD Act pursuant to consultations with persons with disabilities.

The Protection of Children from Sexual Offences Act should:

- Recognize the evolving sexual capacity of adolescents.
- Remove mandatory reporting to account for consensual sexual relationships and ensure access to SRHR services.
- The mandatory reporting requirement under POCSO should be removed only to the extent to account for consensual sexual relationships involving adolescents and ensure access to SRHR.
- Decriminalize consensual sex for adolescents recognising evolving capacity and reduce the age of consent after consultation with stakeholders.

As opposed to blanket criminalization, legal recognition of evolving sexual capacity of adolescents would better speak to our realities. The conversation on recognition of evolving sexual capacity is notably complex. For example, can there be a blanket age of consent that is applicable to all persons? Should the State be involved in regulated adolescent sexuality? How do we balance the legitimate concerns surrounding sexual abuse?

While these questions elicit complex answers, they are necessary conversations since the implicit criminalization of adolescent sexual activity takes away the sexual and reproductive autonomy of adolescents. Human rights bodies have recognized the "evolving capacities" of adolescents and the need to increase their recognized assumption of responsibility for their wellbeing and safety as they get older. The CRC has explicitly called on states to "avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity."

Table 1. Current legal provisions on underage consensual sex

Partner A age, years	Partner B age, years	Current legal provisions on underage consensual sex
12 - 15	12 - 15	Not an offence
12	16 or 17	Offence; age gap > 2 years
13	16 or 17	Offence; age gap > 2 years
14	16	Not an offence
14	17	Offence; age gap > 2 years
15	16 or 17	Not an offence

Recognition of adolescent sexuality in South Africa

Source: Unpacking the 2-year age-gap provision in relation to the decriminalization of underage consensual sex in South Africa

The movement towards recognizing adolescent sexuality in South Africa has led towards the recognition of consensual sex among adolescents between the ages of 12 years and 15 years as well as between a person who is 12 – 15 years old and a person who is 16 – 17 years old, as long as they are no more than two years apart in age.

Another noteworthy example is the decriminalization of consensual sexual activity between adolescents in Peru, thereby enabling persons from the ages of 14 to 18 to access sexual and reproductive healthcare, including HIV testing and abortion services, without attracting criminal liability. This recent recognition by way of an amendment in 2015 demonstrates the possibility of departing from a model of blanket criminalization of adolescent sexual activity.

The legal recognition of adolescent sexuality will permit access to safe and legal sexual and reproductive healthcare, such as abortion and testing for sexually transmitted diseases. In addition, such recognition will steer away from a carceral approach and cater to the realities of adolescents and facilitate their growth.

Other Recommendations

- **Increase legal awareness on the prohibitions under the PCPNDT Act versus the rights of pregnant persons under the MTP Act.**
- **Sensitize doctors and other healthcare professionals on the rights of pregnant persons and the obligations of registered medical practitioners. "Access to Safe and Legal Abortion: A Handbook on Abortion Laws for Healthcare Service Providers in India" is a helpful resource for sensitization of healthcare professionals (available here).**
- **Sensitize lawyers and judges on the legal framework for abortion access in India.**
- **Introduce modules on sexual and reproductive health and rights in the curriculum for law schools.**
- **Introduce modules on sexual and reproductive healthcare within a rights-based framework in the curriculum for medical schools.**
- **Introduce compulsory comprehensive sexuality education in schools.**
- **Prohibit discrimination on the basis of disability, caste, class, gender, sexual orientation, religion, age, marital status, nature of work/employment, etc. at healthcare facilities.**
- **Recognize and address intersectional discrimination faced by pregnant persons in accessing abortion services.**

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