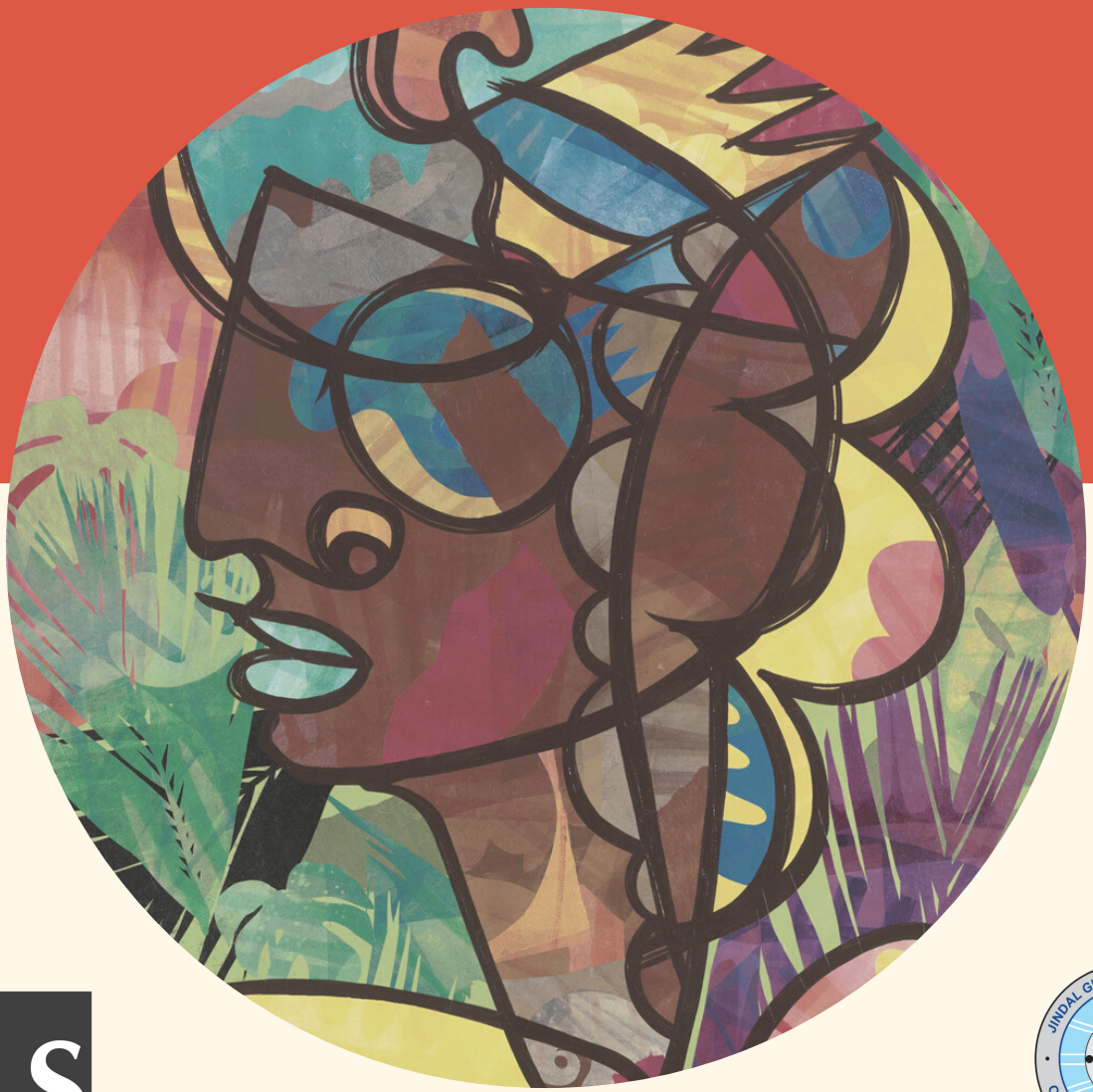
LEGAL BARRIERS TO ABORTION ACCESS DURING THE COVID-19 PANDEMIC IN INDIA

ONE YEAR AT A GLANCE



CJLS
CENTRE FOR JUSTICE, LAW AND SOCIETY

Jindal Global Law School
India's First Global Law School

LEGAL BARRIERS TO ABORTION ACCESS DURING THE COVID-19 PANDEMIC IN INDIA:

ONE YEAR AT A GLANCE (MARCH 2020-21)

Centre for Justice, Law and Society (CJLS)
Jindal Global Law School

MARCH 2021

DIPIKA JAIN, ANMOL DIWAN, KAVYA KARTIK, JOSHIKA SARAF

Designed by:
Kavya Kartik

EXECUTIVE SUMMARY

India confirmed its first case of COVID-19 on 30th January 2020, on the same day that the World Health Organisation (WHO) declared it a public health emergency of international concern. According to the most recent data, there are currently a total number of 11.5 million cases in India, with over 159,000 deaths. In an attempt to combat the pandemic, the Government of India announced a nation-wide lockdown in an attempt to curb the impact of COVID-19 after a period of almost two months from the first case, *i.e.* starting on 25th March 2020. This lockdown was implemented without providing adequate time and resources for citizens to prepare for it, thereby rendering them vulnerable.

Since the outbreak of the virus, India's healthcare system has been severely dependent on immediate personal prevention. This has led to an adverse impact on the sexual and reproductive health (SRH) services in the country. The lockdown had an unprecedented impact on person's ability to access safe abortion services due to suspension of transport and lack of adequate services for non-COVID related healthcare issues amongst others. In this background, the objectives of this report are: to highlight instances of disadvantage faced by marginalised persons during and after the COVID-19 pandemic and to critically engage with the legal barriers on access to safe abortions.

India has no comprehensive legislation to deal with pandemic or other health related crisis/disasters. The lack of a legal framework to deal with pandemics, epidemics and public health emergencies in general has far-reaching implications for challenges associated with such events, including restrictions on mobility and travel, employment status, provision of essential commodities and many others. The application of broad and general legislations during the pandemic, including the Epidemic Diseases Act, 1897 and the Disaster Management Act, 2005, and Section 144 of the Indian Penal Code, 1860, awarded the governments a wide range of powers, with limited legislative or judicial check upon their exercise.

In this background, the situation of abortion services during the pandemic became chaotic and arbitrary, with lockdowns and the fear of COVID-19 have intensifying existing shortfalls in the public health system and exacerbating structural factors that impede access of marginalised groups to SRH services. There exist multiple challenges to access safe abortion services, including both surgical and non-surgical methods, such as disruption in the supply chain for drugs and commodities, redeployment of facilities and staff for COVID-19 care, closure of private facilities, lack of transport, lack of access to legal remedies, and restricted mobility.

The legal barriers are highlighted with a review of litigation on abortion in the past year, given numerous news reports and court orders pertaining to petitions filed by pregnant persons seeking permission for medical termination of pregnancy before and during the COVID-19 pandemic and during the ensuing lockdown. Further, the lack of access to abortion facilities and denial of reproductive services on grounds of discrimination, casteism and communalism were severely exacerbated, resulting in several deaths to both pregnant persons. Litigation and reports of cases across various High Courts show the uneven jurisprudence and court orders, as well as the reliance on medical board opinions, which meant a denial of access to abortions for many petitioners. Several cases were documented, where pregnant women were unable to access healthcare facilities in a timely manner, due to lockdown restrictions. Such restrictions affect marginalised groups the most, who already face barriers in access to SRH services due to structural barriers.

This report contains an analysis of the various barriers to SRH services, including the overburdened and insufficient health infrastructure in India, the restrictive guidelines around telemedicine, the lack of specialised laws to tackle issues arising from the pandemic and, finally, the **failure of the Central and State Government to identify and protect the most marginalised groups who are likely to be the worst affected in a health crisis**. The report highlights select instances of legal barriers to safe abortion services including legal reforms introduced during the pandemic as well as the litigation.

ACKNOWLEDGMENTS

CJLS would like to recognise the contribution of many people, without whom this report would not have been possible.

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Credit for the artwork used in this report and on the cover belongs to Favianna Rodriguez.

We have learnt a lot from activists in the past few years on the importance of cross-movement solidarity, intersectionality in our activism, and how to selectively advocate for those who are most marginalised. Our interactions with people's movements, collectives, advocates, healthcare providers and activists working on the ground to ensure access to safe abortion services have been immensely beneficial and have opened us up to new and nuanced perspectives. We are especially grateful to Dr. Aqsa Shaikh, Kiruba Munusamy, Nidhi Goyal, Nikita Sonavane, Shampa Sengupta, Vqueeram, Dr. Alka Barua, Anubha Rastogi, Dr. Kalpana Apte, Manisha Gupte, Dr. Manisha Malhotra, Rupsa Mallik, Sangeeta Rege, Dr. Suchitra Dalvie, V.S. Chandrashekar, V. Deepa, and Vinoj Manning for their unwavering support with all of our efforts.

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CENTRE FOR JUSTICE, LAW AND SOCIETY

The Centre for Justice, Law and Society (CJLS) is a multidisciplinary research centre at Jindal Global Law School that critically engages with contemporary issues at the intersection of law, justice, society and marginalisation in South Asia. CJLS is a collaborative endeavour of a group of scholars, activists and students who are engaged in high quality empirical and theoretical research. CJLS foregrounds the question of justice, especially intersectional justice, in law and society studies, to respond to the changing relationship between law and society in South Asia today. CJLS inaugurates a distinct terrain of research that is not mimetic of Western mainstream paradigms of law and society studies or those studies that do not focus on justice as a central theme.

CJLS recognises that there is an urgent need for legal studies to engage with social sciences and humanities. Our position allows us to enhance critical conversations between the Global South and perhaps globally by building transnational academic, activist and civil society conversations. We are committed to ethical engagements in the process of our initiatives, including with students who are integral to all our undertakings and contribute to projects in meaningful ways. Although it is primarily a research centre, CJLS is unique because it combines research with activism and advocacy and recognises the importance of interdisciplinary engagement with the law. CJLS takes everyday forms of social suffering seriously by ensuring that all policy and legal interventions are informed, not only by high quality research, but also by closely working with and learning from marginalised persons.

At CJLS, we see ourselves facilitating conversations, legal and policy interventions and collaborating with social movements. We do not claim to speak for any movements and 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.

INTRODUCTION

INTRODUCTION

The COVID-19 pandemic, caused by the severe acute respiratory syndrome coronavirus 2 (SARS - CoV2) was first identified in Wuhan, China in December 2019 before spreading across the globe as a worldwide pandemic. As of 18th March 2021, more than 2.67 million deaths have been attributed to COVID-19 across the globe, with people at the greatest risk having underlying conditions, such as being immunocompromised, or having heart or lung problems.

The challenges associated with the pandemic have been far-reaching across the world. There have been consequences on pharmaceutical supply chains, food systems, education, cities and sustainable infrastructure; security, protracted conflict, refugee crises, and forced displacement; environmental resilience; and global health. The consequences have been exacerbated due to structural discrimination as a result of the caste system, race, gender, religion, disability, age, and regional/geographical disparities.

India confirmed its first case of COVID-19 on 30th January 2020. On 24th March 2020, the Government of India announced a nation-wide lockdown (beginning on 25th March) in an attempt to curb the impact of COVID-19. However, this lockdown was implemented without providing adequate time and resources for citizens to prepare for it, thereby rendering them vulnerable, especially those relying on the informal economy such as migrant workers, manual scavengers, domestic workers, and transgender, intersex and gender variant persons among others.

The 2011 census places the internal migrant worker population at about 45 million, or 37% of the total population. When lockdown was announced, millions of workers were left to fend for themselves, having lost their jobs and thus their ability to pay rent and to buy essential items such as food and medical supplies. While some state governments announced relief measures such as shelters and feeding centres for migrants, these measures were temporary and unsustainable for an extended lockdown period.

Since the outbreak of the virus, India's healthcare system has been severely dependent on immediate personal prevention. Consequently, this has led to an adverse impact on the sexual and reproductive health (SRH) services in the country.

Although the Government of India, on April 14, 2020, declared abortion as an essential health service in their *Guidance Note on Enabling Delivery of Essential Health Services during the COVID-19 Outbreak*, the lockdown had an unprecedented impact on people's ability to access safe abortion services due to suspension of transport and lack of adequate services for non-COVID related healthcare issues amongst others. This was also due to a shift in focus and resources of the entire healthcare system to COVID-19 related services, and the non-availability of skilled health care providers to provide such services in many parts of the country.

Access to medically managed abortion services (through abortion pills) up to seven weeks of pregnancy has been extremely challenging, especially for pregnant persons from marginalised groups who constantly face systemic discrimination due to caste, class, religion and gender. Since their livelihoods and access to quality healthcare services are already impacted due to their vulnerable status in society, the lockdown has created additional barriers to accessing safe and legal abortion services.

During the COVID-19 pandemic, the Indian Government was not only caught ill-prepared but also unaware of many of the barriers faced in access to SRH services which existed even prior to the pandemic. At the beginning of the India's struggle against the pandemic, many doctors had pointed out the gaps in India's healthcare system making the country extremely vulnerable in a pandemic like situation.

1:
10,926

DOCTOR:
PATIENT RATIO
IN RURAL INDIA

1.3

PERCENTAGE
OF GDP
SPENT ON
HEALTHCARE
IN 2020

0.53

NUMBER OF
HOSPITAL
BEDS
AVAILABLE
PER 1000
PEOPLE

A shortage of healthcare staff, medical equipment and medicines has been detrimental to the life and health of many individuals. As per data from 2020, India only spends 1.3% of its GDP on the health sector, as opposed to 7.5% by Brazil, 3.6% by Bhutan and 2.2% by Bangladesh. Further, the doctor-patient ratio in rural areas is 1:10,926 as opposed to the recommended figure of 1:1000 by WHO.

These figures show the dire gaps in availability and accessibility for patient care. With only **0.53 beds available for 1000 people**, India has one of the lowest figures in the world with respect to health facilities. With the diminishing role of government run hospitals, patient-care cost has been increasing exorbitantly at the hands of private entities. It has been observed that "**in terms of affordability, healthcare is a calamity that throws an afflicted family into the jaws of poverty. About 55 million Indians were dragged into poverty in a single year due to patient-care costs**", according to a study by the Public Health Foundation of India (PHFI).

Over the years, India's approach to healthcare has been slow and arduous. Marginalised persons view government run facilities as unapproachable and the private facilities as expensive. They are either forced to resort to other means for accessing health services including SRH or must refrain from accessing medical care, which may endanger their health and life.

The Report will focus on situations where pregnant persons were left with very few choices such as continuation of pregnancy even though it may be unplanned or unintended; attempting an unsafe abortion during the lockdown with the help of backstreet providers or via other dangerous practices; or waiting until the relaxation of the lockdown restrictions to undergo a second-trimester abortion in a health facility. The report draws on research and statistics carried out by several studies conducted in the last one year, as well as newspaper reports, to show the extent of disruption of these essential reproductive facilities and services and to substantiate the inadequacy of the health infrastructure in the country in the light of the COVID-19 pandemic.

The main objectives of this report are:

- To highlight instances of disadvantages faced by marginalised persons during and after the COVID-19 pandemic
- To critically engage with the legal barriers on access to safe abortions

The first part of the report critically examines the legal status of abortion prior to and during the pandemic. There exists no comprehensive Indian legislation which is equipped to deal with pandemic or other health related crisis/disasters. India also does not have a central health legislation to govern the broader aspects of health and related infrastructure. Part 1 highlights these concerns.

The second part of the report briefly examines the situation of abortion services during the pandemic. The national and regional lockdowns and the fear of COVID-19 have intensified existing shortfalls in the public health system. There exist multiple challenges to access safe abortion services, including both surgical and non-surgical methods, such as disruption in the supply chain for drugs and commodities, redeployment of facilities and staff for COVID-19 care, closure of private facilities, lack of transport, and restricted mobility. Additionally, marginalisation due to systemic issues such as caste discrimination drastically impacts accessibility of SRH services.

The third part of the report focuses selectively on litigation on abortion in the past year, looking at the numerous news reports and court orders of pregnant women approaching courts for medical termination of pregnancy before and during the COVID-19 pandemic and ensuing lockdown. Litigation and reports of cases across various High Courts show the uneven jurisprudence resulting in lack of access to abortions for unwanted pregnancies, as well as the reliance on medical board opinions to grant or reject permission for abortions. Several cases were documented where pregnant women were unable to access healthcare facilities in a timely manner, due to lockdown restrictions. Such restrictions affect marginalised communities the most, who already face barriers in access to SRH services due to their vulnerable positions.

With movement restricted due to the lockdown, a fear of contracting COVID-19, or other reasons, access to surgical abortion and medically managed abortion has been severely affected during the focus period, adding to the existing barriers. The general categories of barriers, as identified by our research include those related to punitive laws, policies, and practices; inadequate structural and legal framework; gender inequality and gender-based discrimination; poverty, economic and social inequality; caste-based discrimination; lack of health infrastructure; and artificial and natural disruption in supply of drugs and commodities.

This report largely explores the barriers faced by marginalised persons in accessing abortion and other SRH-related services due to gaps in law, strategies and policies. The main aim of the report is to **highlight the difficulties faced by pregnant persons in accessing safe abortion services due to state and judicial complicities.**

PART 1

LEGAL STATUS OF ABORTION IN INDIA: BEFORE AND DURING THE PANDEMIC

1.1 BEFORE THE PANDEMIC

Abortion in India is governed by the Medical Termination of Pregnancy (MTP) Act, 1971. This law was enacted as an exception to the criminalization of abortion under the Indian Penal Code (IPC), 1860, which penalises both the person causing "miscarriage" (even with the consent of the pregnant woman) and the person undergoing a consensual abortion.

On 26th March, 2021, the Centre notified the MTP Amedment Bill 2020 which was passed by the Parliament on 16th March, despite calls by civil society and Members of Parliament to send the Bill to a Select Committee for stakeholder consultation. This Bill makes a few significant changes to the Act, but still falls short of creating a rights-based framework for access to abortion services.

Prior to the passing of the MTP Amendment Bill, abortions within 12 weeks of pregnancy required one doctor's approval, while abortions within 12-20 weeks required the approval of two doctors. Any abortion that is not carried out in India in accordance with the provisions of the MTP Act, 1971 is a criminal offence punishable under the IPC.

312. Causing miscarriage.—Whoever *voluntarily causes a woman with child to miscarry*, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be *punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both*; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.
Explanation.—A woman who causes herself to miscarry, is within the meaning of this section.

SECTION 312, IPC

Abortion is a qualified right in India. The actual purpose of the MTP Act was to protect the doctors from criminal liability rather than to recognise abortion as an absolute right. The Act laid out certain conditions, at least one of which needed to be fulfilled before an abortion could be performed.

1. **The pregnancy was a result of rape or incest**
2. **The foetus was diagnosed with severe 'abnormalities'**
3. **The pregnancy would cause grave injury to the physical or mental health of the pregnant woman**
4. **The pregnancy would involve a risk to the life of the pregnant woman**
5. **The pregnancy was a result of the failure of any contraceptive method used by a married woman and her husband**

As many activists and scholars have pointed out, the MTP Act was set in a paternalistic doctor-centric framework where the decision to abort vested with the doctor and not the pregnant person.

The process of medically managed abortion (MMA) was introduced by the Medical Termination of Pregnancy Rules, 2003, which included provisions for abortions to be conducted through medical abortion (MA) pills. Explanation to Rule 5 of the MTP Rules states that medical abortions can only be performed within 7 weeks of the gestational age of the foetus, although the WHO recommends that pills can be taken up to 12 weeks.

The Handbook on Medical Methods of Abortion to Expand Access to New Technologies for Safe Abortion, 2016 ('MMA Handbook') released by the Ministry of Health and Family Welfare refers to the December 2008 order of the Central Drugs Standards Control Organization ('CDSCO') to allow for MMA after 9 weeks/63 days of the gestation period to terminate pregnancies. Other than the MTP Act and Rules, abortion is India is governed by guidelines such as the *Comprehensive Abortion Care - Providers Manual*, 2014.

1.2 PANDEMIC RELATED LEGAL AND POLICY STRUCTURES

On 25th March 2020, the Centre invoked the Disaster Management Act (DMA), 2005, in order to tackle the COVID-19 pandemic and impose a nation-wide 21-day lockdown, which would be the first of many. This law was originally enacted in the wake of a natural disaster (the Indian Ocean Tsunami of 2004) and was not intended to deal with public health emergencies such as pandemics.

The Epidemic Diseases Act 1897 ('EDA') gives extensive powers to both the State and Union government to take special measures and pass regulations for the management of the dangerous epidemic disease. This archaic colonial legislation, which was passed in times of the Bubonic plague at the end of the 19th century, suffers from multiple drawbacks.

Section 3 of the Act provides penalties for violating the regulations passed under the Act and states that such person shall be deemed to have committed an offence under Section 188 of the IPC (Disobedience to order duly promulgated by a public servant). The Epidemic Diseases (Amendment) Ordinance 2020 was promulgated on 22nd April, 2020 for the protection of healthcare workers and to expand the powers of the Union government to inspect and detain travellers. However, it failed to address the glaring gaps in the healthcare system of the country or introduce any provisions for the most vulnerable groups.

During the pandemic, it was observed that states and the central government were scrambling to quickly release guidelines and executive orders, due to reports of barriers in accessing healthcare services. The guidelines were only released after a few weeks of the lockdown announcement and resulted in grave delays in delivery of care. Moreover, despite abortion, ante-natal and neo-natal care, immunisation and other related services being considered essential services, governments failed to take action to ensure that persons were adequately able to access hospitals and doctors.

There have been multiple incidents where pregnant persons have suffered adversely due to denial of pregnancy-related health services. One of the most shocking cases that came to light was that of a 22-year old woman, who was forced to give birth while standing in a queue for a COVID-19 test, as the hospital refused to admit her without clearing the test.

The strict lockdown was imposed with little consideration for access to healthcare services, especially for marginalised persons. Although the Ministry of Health and Family Welfare (MoHFW) released certain guidelines for enabling delivery of essential health services during the COVID-19 outbreak, including reproductive, maternal, newborn and child health, these were not sufficient to enable access to safe abortion and other SRH services for all persons.

During the pandemic, the Centre brought in the following policies were to ensure delivery of abortion and other SRH services:

- Guidance Note on Enabling Delivery of Essential Health Services during the COVID-19 Outbreak
- Guidance Note on Provision of "Reproductive, Maternal, New-born, Child, Adolescent Health Plus Nutrition (RMNCAH+N) services during & post COVID-19 pandemic
- Indian Council for Medical Research: Guidance for Management of Pregnant Women during the COVID-19 Pandemic

The *Guidance Note on Enabling Delivery of Essential Health Services* mandated that appropriate health facilities should ensure that they provide both medical and surgical abortion services, with infection prevention measures, counselling for post-abortion care and provision of contraceptives as well.

However, the restrictions on movement of persons coupled repurposing of many health centres into COVID-19 facilities meant that many pregnant persons could not access abortions.

With the announcement of the lockdown, the Centre also released the Telemedicine Practice Guidelines which enabled doctors to consult with patients over the phone or through the internet, and prescribe medications.

The Combipack of Mifepristone and Misoprostol, used for medical abortions, is a Schedule H drug under the Drugs and Cosmetics Rules 1945, meaning that it can only be sold with a prescription. While the Telemedicine Guidelines list many classes of drugs such as over-the-counter (OTC) medicine, ointments, ear drops, eye drops, refill medicines for diseases such as hypertension, diabetes and asthma, and add-on medicines for the existing conditions, they fail to provide for MA pills, but also do not explicitly prohibit it.

This has led to an ambiguity in the law regarding use of telemedicine services for medical abortions. On 14th April 2020, the Centre declared abortion an essential health service in their *Guidance Note on Enabling Delivery of Essential Health Services*. Additionally, the National Human Rights Commission (NHRC) issued an *Advisory on Rights of Women* in October 2020 and highlighted the importance of providing abortion services:

> *"The lockdown has had an unprecedented impact on women's ability to access safe abortion services. Such a situation has left pregnant women with very few choices such as, continuation of pregnancy even though it may be unplanned or unintended; attempting an unsafe abortion; or waiting until the relaxation of the lockdown restrictions to probably undergo a second-trimester abortion in a health facility."*

Furthermore, serious concerns have been raised on the non-accessibility of internet and phone services for persons living in rural and semi-urban areas. This disparity of access is borne disproportionately by marginalised groups such as persons with disabilities, Dalit and Adivasi persons, and gender variant persons. A prerequisite for digital health is basic infrastructure, but the disparate nature of urban and rural planning, and quality of healthcare infrastructure, resources and personnel substantially hinders the ability of all persons to access and enjoy digital health services.

> Just 4.4 rural households have a computer, against 14.4 per cent in urban areas, with just 14.9 per cent rural households having access to the internet against 42 per cent households in urban areas...only 13 per cent people of over five years of age in rural areas have the ability to use the internet against 37 per cent in urban areas

National Sample Survey 2017-18

Despite having the second largest number of internet users in the world, Indian citizens are still far behind in accessing internet services. There still exist barriers such as poor network coverage, lack of digital literacy, language barriers or simply lack of access to the internet.

Digital solutions for increasing access to healthcare services do not address the root causes of the failing healthcare system in India. These include systemic discrimination based on caste, class, religion, gender, disability, and age among other factors. Further, given the unreliable supply of electricity in many parts of the country, and poor internet connectivity, telemedicine remains a largely urban-centric solution.

> Girls and women who live with their families may have no privacy even for a phone or video call, let alone to go through an abortion at home, alone or with a companion...In fact, the feasibility of telemedicine for women living in conditions of poverty and with limited literacy, especially in remote, rural and low-resource settings with few healthcare providers, requires far more attention in order to develop appropriate support systems.

Marge Berer

> Telemedicine predominantly helps only the middle class, restricted by 36% internet penetration in India... telemedicine is a mere band-aid on the ailing outpatient consultation system in India. It complements but cannot replace face-to-face clinical care in a pandemic or beyond.

Dr. Saif Razvi

> There is limited data on performance and outcomes although one review of the Indian Space Research Organisation (ISRO)'s telemedicine facilities in Madhya Pradesh described the overall condition as poor, with only 2 out of 10 patient nodes being classified as "functional".

Surya Bali, Arti Gupta, Asif Khan, Abhijit Pakhare

Apart from these laws and policies, the Protection of Children from Sexual Offences Act (POCSO), 2012 also impacts abortion access. The POCSO Act was enacted to protect children from sexual assault, sexual harassment and pornography, and defines a 'child' as any person below the age of 18 years. The Act characterises all sexual contact with minors as sexual offences, and, most importantly, contains a mandatory reporting provision where all sexual offences under POCSO involving a child must be reported to law enforcement.

If POCSO is applied, adolescent girls seeking abortions would be presumed to be survivors of rape or penetrative sexual assault, even if the sexual intercourse was consensual, and the medical practitioner would be bound to report the same to the police. This is very problematic, given that the MTP Regulations contain strict confidentiality requirements that medical practitioners must maintain when carrying out abortions.

Failure to report a sexual offence against a 'child' entails punishment with imprisonment for up to six months or one year, and/or a fine. Even though the rationale behind the mandatory reporting provision is to ensure that no one is immune from prosecution for POCSO offences, operationally it may result in discouraging people from reporting abuse. Adolescent girls seeking reproductive health services, contraceptives or abortions are likely to not want to visit registered medical practitioners out of fear of their sexual partners being reported and may resort to unsafe or unhygienic options.

1.3 LEGAL REFORMS DURING THE PANDEMIC: A CRITIQUE

One week before the lockdown, the MTP Amendment Bill was introduced and passed in the Lok Sabha. The Bill was drafted without any stakeholder consultation and has several critical gaps. While the Bill was presented as a women's rights legislation, it is far from that as abortion continues to be at discretion of doctors as opposed to request of women. It fails to incorporate the perspective of pregnant persons from marginalised groups due to the lack of an effective consultative process during the drafting of the law.

The Bill proposed the following changes to the Act:

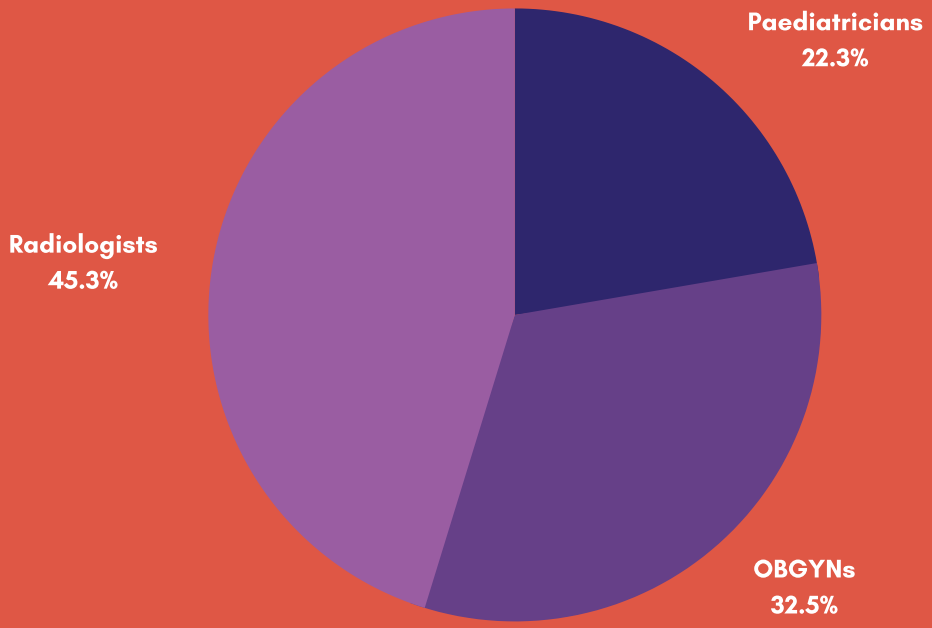
1. Extension of the upper-limit on abortions from 20 to 24 weeks for 'certain categories' of women
2. Removal of the upper-limit for foetuses diagnosed with 'abnormalities' but only upon diagnosis by a Medical Board
3. Mandatory constitution of Medical Boards in every State and Union Territory
4. Provision of abortions to *any woman* in case of contraceptive failure
5. Introduction of a privacy clause

While some of these amendments may sound progressive, they are re inadequate and continue to reflect the hetero-patriarchal, population-control and eugenic rationale of the state. The Bill was not drafted keeping in mind a rights-based framework. Abortion is still not a right for the pregnant person, but is instead at the discretion of the doctor.

The removal of an upper gestational limit along with the setting up of Medical Boards for diagnosis of foetal anomalies reinforces the view that certain foetuses are unwanted, advancing an ableist rationale. The singling out of disability as a ground for abortion at any stage perpetuates the idea that persons with disabilities have less value than persons without disabilities.

Moreover, a recent report by CJLS titled *Medical Boards for Access to Abortion Untenable: Evidence from the Ground* highlights some of the drawbacks in constituting Medical Boards. The report finds that there are sweeping shortages of healthcare professionals and specialists across India, poor public health infrastructure and healthcare funding exacerbated by unsound privatisation policies, and significant data gaps for doctor availability.

Most Indian states and UTs record a dire shortfall (nearly **80% on average**) of obstetricians and gynaecologists, paediatricians, and radiologists, thus making the proposal of constituting functional state or district-wise Medical Boards with all three specialists practically impossible.



Percentage availability of specialist doctors at Community Health Centres from 2015 to 2019

Medical Boards were never envisaged in the MTP Act, and the law makes no mention of judicial or any other third-party authorisation for abortion. The addition of this layer to an already hetero-patriarchal, discriminatory, and exclusionary framework will spell greater, rather than fewer unsafe abortions. Medical Boards and other third-party authorisation requirements have also been recognized as major barriers to accessing safe abortion services under international law and policy. The human rights violations caused due to denial of accessible healthcare services and structural discrimination in reproductive health spaces will be exacerbated by the invasive, traumatic, and prolonged authorisation processes of such Boards.

Between March 2020 to March 2021, numerous civil society organisations, grassroots activists, feminist groups, disability rights groups, Dalit and Adivasi persons, Trans-led movements, child rights groups, lawyers and academics, and other groups came together to deliberate on the Bill and its shortfalls. However, despite concerted efforts to bring these issues, the Bill was tabled in the Rajya Sabha and passed on 16th March, 2021, despite much opposition and with little debate in the Parliament.

The lack of consultative exercises for lawmaking has been a key issue in the Indian legislative drafting processes, and other law reform efforts.

For example, the Committee on Criminal Law Reforms was also set up during the pandemic, amidst much opposition, and deliberated on decriminalization of abortion under Section 312 of the IPC (among many other provisions). Various concerns regarding the process of the legal reform framework proposed by the Committee were raised. Some of these concerns related to the transparency in the functioning of the Committee, as well as the fact that the Committee did not include any full-time members.

The composition of this Committee was entirely male and upper-caste. Furthermore, this reform exercise was carried out during a serious public health crisis due to the COVID-19 pandemic. The six-month timeline proposed for 'consultation' with experts, and that too only in English and through online medium, did not indicate a bonafide approach to criminal law reform.

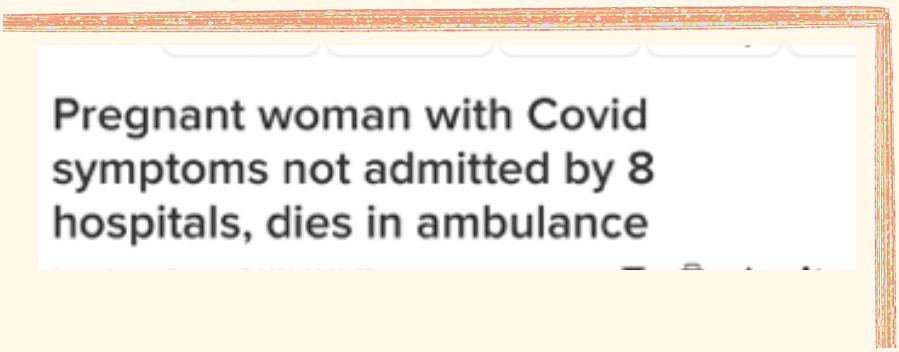
Legal reform processes cannot be effectively carried out while the country is struggling to deal with a pandemic. The laws that this Committee sought to change, and laws such as the MTP Amendment Bill that were introduced and passed during a pandemic, fundamentally affect our civil and political liberties. Therefore, legal reform efforts must necessarily involve wide stakeholder consultation with representation from all communities. Specifically, women, Dalits, Adivasis, religious minorities, LGBTQI persons and persons with disabilities must be involved in the process.

PART 2

ABORTION SERVICES DURING THE PANDEMIC

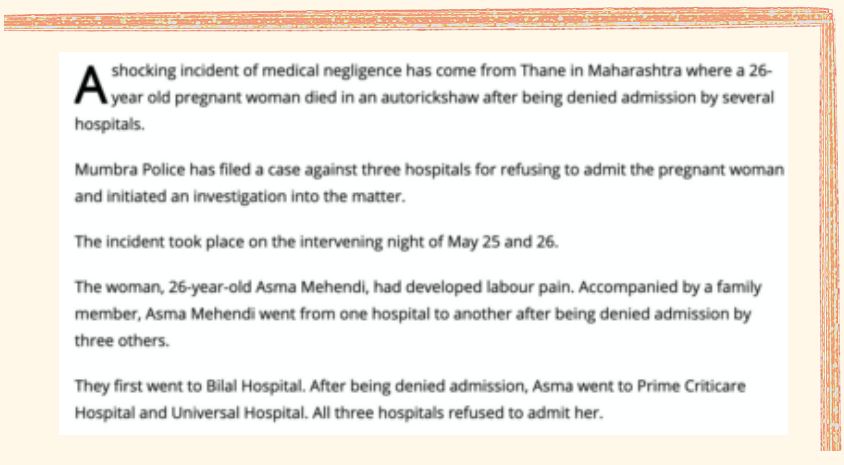
2.1 IMPACT ON ABORTION AND SRH SERVICES

The Global Financing Facility (GFF) brief highlighted how large service disruptions in India have the potential to leave more than 4 million women without access to facility-based deliveries. Media reports citing data from various states (Uttar Pradesh, Bihar, West Bengal, Jharkhand, Odisha and Chhattisgarh) in the country indicate that the number of institutional deliveries may have fallen as much as 40 percent during the lockdown. Furthermore, the inaccessibility of abortion and SRH services generally has been disproportionately felt by marginalised persons.


Pregnant woman with Covid symptoms not admitted by 8 hospitals, dies in ambulance


Jharkhand: Family Takes Pregnant Woman To Hospital On Motorcycle After Being Denied Ambulance

After travelling over 10 kilometres from her village, she was referred to the Latehar Sardar Hospital where she was once again ferried on the motorcycle.


A shocking incident of medical negligence has come from Thane in Maharashtra where a 26-year old pregnant woman died in an autorickshaw after being denied admission by several hospitals.

Mumbra Police has filed a case against three hospitals for refusing to admit the pregnant woman and initiated an investigation into the matter.

The incident took place on the intervening night of May 25 and 26.

The woman, 26-year-old Asma Mehendi, had developed labour pain. Accompanied by a family member, Asma Mehendi went from one hospital to another after being denied admission by three others.

They first went to Bilal Hospital. After being denied admission, Asma went to Prime Criticare Hospital and Universal Hospital. All three hospitals refused to admit her.

Undoubtedly, the national and regional lockdowns, and the overall fear of COVID-19 intensified the existing shortfalls in our public health system imposing newer challenges due to suspension of transport, lack of adequate services for non-COVID related healthcare issues etc. According to a study conducted by the Ipas Development Foundation (IDF), COVID-19 and the State's response thereto has severely compromised access to safe abortion in public and private sector facilities as well as chemist outlets.

2.95 MILLION UNINTENDED PREGNANCIES ESTIMATED

ACCESS TO 1.85 MILLION ABORTIONS COMPROMISED

In assessing the impact of the pandemic in the three months following the commencement of a nationwide lockdown (25th March 2020 - 24th June 2020), the study concluded that of the 3.9 million abortions that would have taken place in three months, access to around 1.85 million was compromised due to COVID-19 restrictions. It is pertinent to note that lack of access to contraception is likely to result in higher unintended pregnancies (around 2.95 million), unsafe abortions, maternal deaths and maternal morbidity. The Study further found that between March 25th and May 3rd 2020, when the 1st and 2nd lockdowns were in place, **59% of pregnant persons failed to access abortions**.

ESTIMATED UNSAFE ABORTIONS DUE TO LOCKDOWNS

834,042

80%

PREGNANT PERSONS UNABLE ABORTION DUE TO NON-ACCESSIBILITY OF MA PILLS

DECLINE IN ABORTION RATES AT MAJOR HOSPITALS

60%

According to FRHS India's analysis in June 2020, the lockdown and the pandemic in India is likely to result in an additional 2.38 million unintended pregnancies, 679,864 childbirths, 1.45 million abortions (including 834,042 unsafe abortions) and 1,743 maternal deaths. This was predicted till September 2020 and, for places where clinical family planning services operate at full capacity by September 2020 and sales of over-the-counter contraceptives resume in a phased manner by the third week of May, they estimated that 25.6 million couples would not have been able to access contraception during the lockdown and the weeks leading up to 'complete normalcy' (September 2020). In this scenario, there would be a loss of 6.9 lac sterilisation services, 9.7 lac intra-uterine contraceptive devices (IUCDs), 5.8 lac doses of ICs, 23.08 million cycles of oral contraceptive pills, 9.2 lac emergency contraceptive pills and 405.96 million condoms.

Across India, access to MA Pills has always been difficult. As per the Study by Ipas Development Foundation Data during the initial months of the COVID-19 pandemic, **almost 80% of pregnant persons were unable to terminate pregnancies due to the inability in accessing MA Pills**; 16% couldn't access private hospitals; major hospitals across the country reported 60% decline in abortion rate, while the number was found to be 24% for community hospitals and 17% for PHCs.

Additionally, due to the ambiguity created by the sudden lockdown, intra and inter-State travel for supplies were disrupted. Restrictions on mobility and inability to contact a pharmaceutical provider or local chemist also affected access to MA pills. News reports highlighted the grave shortage of the combipack of Mifepristone and Misoprostol, which are generally used to carry out MMA without active care of a healthcare worker. Reports indicated shortage in almost all states, including in Madhya Pradesh, Punjab, Haryana and Delhi. In Punjab and Haryana, a meagre 1% and 2% of pharmacies had stock of the pills. This shortage has the potential to cause an unprecedented increase in second and third trimester abortions.

SRH services were also affected due to ASHAs Accredited Social Health Activists) being redeployed for COVID-19 management, despite their primary mandate being reproductive and maternal health. While ASHAs were at the frontline of COVID management, they continued to suffer from the State's apathy towards their well-being and unwillingness to recognise them as 'workers'.

ASHAs often work for long hours, sometimes all seven days a week, but do not receive salaries in line with minimum wage requirements, and are not eligible for any statutory benefits. The performance-based incentives paid to ASHAs are also insufficient, and often handed out with several months' delay. Moreover, many ASHAs reported that they had not been given adequate PPE and were reusing masks, thus compromising their health.

> *Corona kal mein toh hum logo ki duty lag gai thi March se hi. Subah 8 Baje jate the; logo ke ghar jana, survey karna.. Kabhi kabar 3 baj jata tha.. Iske ilawa kabhi raat ko (maternal) case ki delivery ke vakt jana hota hai* (We had our duty since March, leaving home at 8am and coming back as late as 3pm. We had no time to attend to our cases during the day so, had to rush late night for deliveries of high-risk pregnancies)

Sarwari, ASHA worker in Lucknow

> Since the beginning of the pandemic, all the government has given us is one N95 mask and one set of gloves. I also need to stay safe and take care of myself as I have a family, therefore I bought my own set of masks, gloves and sanitisers.

Rekha Balhara, ASHA worker in Delhi

Although there is no concrete data yet on increase in numbers of unsafe abortions during COVID-19 yet, the limited availability of services may have prompted people to resort to unsafe abortion methods. This may be detrimental for their health since it could cause several complications such as haemorrhaging, infections or uterine perforation.

1-2

AVERAGE PERCENTAGE OF PHARMACIES STOCKING MA PILLS

2.2 MARGINALISATION AND ACCESS TO ABORTION

A survey conducted by CommonHealth in 2019 found that many Dalit persons were denied access to medical abortion facilities unless their guardian or husband accompanied them. Between deprivation of their agency and bodily autonomy at the behest of government hospital officials and unaffordable private healthcare providers, marginalised persons fall through the cracks of the public healthcare system. The survey stated that of 2500 abortions conducted in Bihar, 78% were done via private healthcare providers.

Marginalised persons often face serious monetary constraints and are thus deterred by the cost of abortions. The cost of an abortion at a private hospital is 7.5 times higher than that at a government hospital. However, many pregnant persons prefer to go to a private health care provider in order to to maintain secrecy and avoid bureaucratic delays.

There are several marginalised groups across India who faced added disadvantages during the pandemic. These include persons living with disability (PWDs), Dalits, Adivasis, prisoners, people living in rural and scheduled areas, sex workers, transgender and gender variant persons persons living with HIV, religious minorities and migrant workers. These persons are, more often than not, unable to access SRH services due to structural discrimination. For pregnant persons from marginalised groups, for whom systemic discrimination due to caste, class, religion and gender already impacts access to quality healthcare service, the lockdown created additional barriers to accessing safe and legal abortion services.

Structural barriers such as caste, class, religion, disability, and marital status intersect with and significantly impact access to healthcare generally, and particularly access to abortion/SRH services. A law that restricts abortion access infringes on pregnant persons' privacy, dignity, decisional autonomy and equality, thereby affecting the availability, accessibility, affordability, acceptability and quality of SRH services.

April 2020

In Rajasthan, a pregnant woman was turned away from a hospital due to her Muslim faith. She ended up delivering a stillborn child in the ambulance.

May 2020

A 22-year-old pregnant woman from Bihar lost her child despite visiting the nearest primary care centre. It is alleged that an auxiliary nurse midwife (ANM) initially attended to her but subsequently denied service after realizing that she was Muslim.

July 2020

A 22-year-old woman was forced to give birth while standing in line for a COVID-19 test at one of the biggest government hospitals in Lucknow, Uttar Pradesh.

August 2020

A 20-year-old pregnant woman was denied service by 5 hospitals in Manipur before she lost her life. Despite having a COVID-19 negative test result, some hospitals cited non-availability of doctors while others plainly refused urgent care.

The Constitution of India, under Articles 14 and 15 guarantees the right to equality and non-discrimination. Religion and place of birth are among the prohibited grounds of discrimination in Article 15.

In 1996, the Supreme Court made the right to health "independently justiciable" in the case of *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, in which the State was directed to pay compensation to a petitioner who had been denied emergency care admission at seven different hospitals. Emergency care was included as a core element of the fundamental right to health and the Court concluded that the "[p]rimary duty of government in a welfare state is to secure the welfare of people, especially by providing medical facilities."

In 1997, in *State of Punjab v. Mohinder Singh Chawla*, the Supreme Court explicitly recognized the right to health, holding that the government, under Article 21 and Directives 39, 41, and 43, was constitutionally obligated to provide medical facilities to government workers. In this decision, the Court noted it was settled law that the "[r]ight to health is integral to the right to life."

> Primary duty of government in a welfare state is to secure the welfare of people, especially by providing medical facilities.

> Women from Particularly Vulnerable Tribal Groups cannot get abortions done in hospital because their population is dwindling, and they may be refused an abortion. These women had to give birth to children during the pandemic even if they did not want to.

Rajim Ketwas, founder Dalit Adivasi Manch

The "double disaster" that marginalised persons face includes socio-cultural and economical barriers which do not cease to exist in the light of the disaster. Moreover, the non-recoverable loss to health, including lack of access to time sensitive services, places them in a precarious situation.

Due to gaps in emergency and urgent care, pregnant persons have been severely and disproportionately affected. Instances of non-availability of doctors, discrimination, and an unreasonable requirement for a COVID-19 negative test, amongst others, have resulted in deaths, unintended pregnancies carried to term, and people being forced to resort to unsafe methods of abortion.

> Lessons from the Ebola and Zika virus disease outbreaks show that during such outbreaks access to sexual and reproductive health (SRH) services can be severely disrupted, disempowering individuals – particularly women and girls – and exposing them to preventable health risks.

WHO interim guidance for maintaining essential health services

PART 3

LITIGATION ON ABORTION: A YEAR IN REVIEW

LITIGATION ON ABORTION

With the announcement of a complete lockdown in India, the Indian judiciary decided to partially close its doors. Soon after, the Supreme Court of India and some other courts announced their intention to start entertaining urgent matters through a virtual court system.

In light of the heightened vulnerability of marginalised persons in need of SRH services during a crisis and situations of lockdown, it is clear that an absence of any provision enabling their access to the judicial system is a monumental failure in ensuring access to justice.

Just before the lockdown, a petitioner approached the **Madhya Pradesh High Court** in March 2020, at 24 weeks of gestation, seeking permission for abortion. She argued that her pregnancy was affecting her mental health and if forced to carry it to term, the child would "suffer the mental torture" throughout its life. The court denied permission, concurring with the argument of the state that her pregnancy was "the outcome of a voluntary act" and that she was "very much aware of the consequence". The court additionally stated that "while there was always the possibility that the pregnant woman and her partner could resume their relationship, termination would be absolute".

There have been numerous reports of pregnant women approaching courts for medical termination of pregnancy before and during the COVID-19 pandemic and the ensuing lockdown.

According to reports by the Pratigya Campaign, 243 women approached courts between May 2019 and 15 August 2020, with as many as 112 cases coming up after the imposition of the lockdown in March 2020. The majority of cases went before the Bombay High Court (53.1%), followed by the Madhya Pradesh High Court (14.8%) and the Gujarat High Court (6.6%), with 50% of the pregnant women approaching courts at gestation between 21 and 24 weeks.

53.1%

BOMBAY HIGH COURT

MADHYA PRADESH HIGH COURT

14.8%

6.6%

GUJARAT HIGH COURT

3.1 STATE'S OBLIGATION TO ENSURE ACCESS TO HEALTHCARE

In April 2020, one of first cases post announcement of the lockdown dealing with pregnant persons was a Public Interest Litigation (PIL) filed before the **Delhi High Court** in April 2020, seeking directions to ensure adequate medical facilities for non-COVID-19 related patients, especially pregnant persons.

Yash Aggarwal v. Union Of India, Delhi High Court

"Medical care is also assured to pregnant women, both during pregnancy and at the time of delivery. We are satisfied that requisite measures are being taken by the respondents to the best of their capacity, despite the enormous pressures which are already existing on the hospital staff and other agencies."

"We also find that besides issuing Guidelines and Guiding Notes for enabling essential medical services during the outbreak to the citizens, the Central Government has also taken steps to ensure their effective implementation and letters have been addressed to the various State Governments to take steps in that direction. A Committee has been constituted to oversee the implementation of the Guidelines on ground and a special WhatsApp number has been created to register the grievances/complaints of any patient or his or her family member, in case of any difficulty in getting medical treatment. A citizen friendly web-based tele-consultation has also been launched, where patients can have a safe and structured video-based clinical consultation with the doctor while remaining in the confines of his or her home."

Observing the practice by hospitals of asking patients to show COVID-19 negative tests as a precondition for treatment, the Delhi government submitted before the **Delhi High Court** on July 15th, 2020 that a pregnant person will be assumed to be COVID negative and will be admitted and provided with services such as surgeries, delivery and other interventions.

Similarly, in the **Telangana High Court**, a petition was filed that sought to address the failure of the state government to protect and safeguard meaningful access to essential health services to pregnant women and for neonatal care during COVID-19 lockdown. It sought to initiate a dedicated helpline services for the women during lockdown, to allow private vehicles carrying pregnant women to move freely without restrictions, and to cap the price/fees charged for medical services rendered by private hospitals, relating to maternity, childbirth and abortion during the pandemic and lockdown. The court directed the state to ensure that ambulances are available on national and state highways as migrant workers, including pregnant women, are using the same to reach destinations.

In April 2020, a 19-year old survivor of rape found out about her pregnancy right at the dawn of the announcement of lockdown. Abortion services could only be availed with the help of Centre for Enquiry into Health and Allied Themes (CEHAT) where they picked them up in their ambulance and approached the health facility. Similarly, in May 2020, a Delhi-based college student found out about their pregnancy and decided to consume the MA Pill with a clear intent to abort. The pill failed, causing them to look for in-person appointment for surgical abortion but to no-avail due to the overburdened health facilities. Several private facilities were also contacted but and some quoted very high rates for the procedure.

The Supreme Court has also previously recognised reproductive rights as an important part of the right to health and an aspect of personal liberty under Article 21 of the Constitution and defined such rights to include the right to "**access a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behaviour**."

Barriers to access include an insufficient number of facilities offering abortion care, shortage of staff and equipment, failures to ensure privacy and confidential care, and stigma surrounding seeking abortion-related care, and the complicated nature of the legal framework itself.

Access to quality medical care is a right for all persons. The State has an obligation to facilitate the complete realization of this right despite the pandemic. In the present scenario, abortion was only termed as an 'essential service' 20 days after announcement of the lockdown and despite that, no concrete steps were taken to improve the provision of abortion and other SRH servies.

RIGHT TO PERSONAL AND REPRODUCTIVE AUTONOMY WITH HAS BEEN RECOGNIZED BY THE SUPREME COURT IN THE CASE OF *SUCHITA SRIVASTAVA V. CHANDIGARH ADMINISTRATION*

3.2 FUNDAMENTAL RIGHT TO ABORTION

Courts in India have expounded significantly on the issue of the right to life, as well as the various rights falling within its expansive scope. In *Devika Biswas v Union of India*, the Court stated that Article 21 included "the reproductive rights of a person". In *Suchita Srivastava v. Chandigarh Administration*, the Supreme Court held that a woman's right to make reproductive choices is a dimension of the guarantee of personal liberty under Article 21 of the Constitution of India .

Three recent landmark judgements by the Indian Supreme Court have read reproductive rights as fundamental rights in India, inextricable from the Fundamental Right to Life (Article 21), Equality, and Non-discrimination (Articles 14 and 15).

In *Justice K.S. Puttaswamy (Retd) & Anr. v. Union of India & Ors.* , the Supreme Court recognized the right to privacy as a fundamental right under the Indian Constitution, which included within its scope the rights to bodily integrity, reproductive choice and decisional autonomy. Decisional autonomy would in turn encompass the right of reproductive choice, including a person's right to decide whether to stay pregnant.

In 2017, a nine-judge bench considered whether privacy was a fundamental right in India in *Justice K.S. Puttaswamy (Retd.) v. Union of India*. While answering this question in the affirmative, the court also noted that reproductive choices were part of the fundamental right to life and liberty under Article 21 of the Constitution.

Puttaswamy v. UOI, 2017

In 2018, in *Navtej Johar v. Union of India*, the Court read down Section 377 of the IPC, which criminalised conensual sodomy. By acknowledging that the state could not create or uphold penalties for sexual acts, nor restrict sex to the confines of "rigid, marital procreational sex", the judgement raises questions about the criminalization of abortion as a denial of the right to privacy, autonomy, and dignity for pregnant persons.

Navtej Johar v. UOI, 2018

Again in 2018, in *Joseph Shine v. Union of India*, the Court struck down Section 497 of the IPC and decriminalized adultery. The court held the section unconstitutional and violative of the fundamental right to sexual privacy and sexual autonomy. The judgment specifically highlighted the archaic gender stereotypes concerning sexual autonomy that underlie this provision.

Joseph Shine v. UOI, 2018

3.3 CASES RELATED TO THE MTP ACT, 1971

In spite of landmark Supreme Court Jurisprudence affirming reproductive rights within the ambit of the right to life, health, personal liberty and dignity, as well as the right to decisional autonomy, Courts in India have been quite inconsistent in deciding cases relating to grant of medical termination of pregnancy. The Supreme Court, while hearing the cases on abortion, has not relied on the medical opinions of the doctors consulted by the petitioners, but has chosen instead to direct the setup of separate medical boards to provide a fresh opinion on the facts and circumstances of each case.

The Supreme Court's approach in the last decade or so has created public opinion that the termination of any pregnancy over 20 weeks in gestation would require the court's permission. Ironically, the MTP Act never envisaged judicial authorisation. This, in turn, has resulted in many petitions being filed for MTP, when in fact, the procedure could have been conducted legally with the opinion of two registered medical practitioners. The court has not yet settled this legal ambiguity, but has only decided individual cases based on the opinions of the medical board. There was a surge in these cases even during the pandemic, as this section shows.

In June 2020, the **Bombay High Court** allowed an unmarried pregnant woman at 23 weeks' gestation to undergo an abortion. She had approached the court for permission mainly because she had been unable to consult a doctor within the legally prescribed 20-week time limit due to the COVID-19 lockdown. The court noted that giving birth to a child 'out of wedlock' would cause immense mental anguish, granting permission thereafter.

Similarly, in July 2020, a 38-year old woman approached the **Bombay High Court** seeking an abortion, stating that she had not been able to obtain the procedure, nor had she been able to approach the court earlier on account of the lockdown. The petitioner claimed to be mentally unprepared for the pregnancy, cited financial hardship, and stated that since she was of an 'advanced age', she should be permitted to terminate her pregnancy. However, the court stated that none of the petitioner's arguments formed valid grounds for termination of pregnancy under the MTP Act and denied permission for abortion.

In April 2020, the **Rajasthan High Court**, in *Muskan v. State of Rajasthan* allowed a sex worker (who, by her own account before the court, appears to have been trafficked) to terminate her pregnancy, on grounds that abortions can be allowed for the purpose of protecting the victim from the trauma of rape and that "abortion is imperative, so that petitioner can settled in life and the baby does not emerge as a snag in her possible peaceful life".

In 2020 and 2021, the **Supreme Court**, **Punjab and Haryana High Court**, **Kerala High Court**, **Madhya Pradesh High Court** and the **Delhi High Court** heard several petitions seeking abortion on grounds of 'foetal abnormality', with petitioners being at varying stages of gestation, granting abortion in all cases.

In January 2021, the **Delhi High Court** heard a petition for abortion made by a petitioner at 28 weeks' gestation, allowing the same as it was on grounds of foetal 'abnormality', namely a condition called anencephaly. In this case, the court referred the petitioner to a medical board constituted by AIIMS, who advised that abortion take place due to the anencephaly, wherein the foetus' skull bone had not properly formed, being "incompatible with life". Relying on the report by the medical board, the court granted abortion even at such an advanced gestational stage.

Then, in March 2021, the **Punjab and Haryana High Court** allowed a petition filed for abortion on grounds that the foetus had medical conditions including Tetralogy of Fallot, Ventricular Septal Defect and a hole in the heart. The court allowed the abortion subject to the advice of the specialised medical professionals conducting the abortion.

However, High Courts do not uniformly grant requests for abortion on account of foetal 'abnormality'. For example, the **Kerala High Court**, in February 2021, refused to grant permission for abortion as the gestation period for the pregnancy had already crossed 30 weeks. The court referred to the medical board's opinion, which stated that even though the foetus was diagnosed with congenital heart disease, it was treatable. The court opined that since there is a chance of a 'baby born alive' that needs extra neonatal care and there are no maternity risks for continuation of pregnancy, abortion would not be permitted.

> "Abortion is imperative, so that petitioner can settled in life and the baby does not emerge as a snag in her possible peaceful life"

Muskan v. State of Rajasthan (2020)

3.4 CASES RELATED TO THE POCSO ACT, 2012

As stated earlier in this report, the POCSO Act complicates access to abortion for adolescents due to its mandatory reporting requirements. While courts have largely been willing to grant permission for abortions, the criminalisation of adolescent sexuality itself has led to major barriers to safe abortion access.

In June 2020, the **Bombay High Court** heard a petition for medical termination of pregnancy by a minor rape survivor, who was then at 25 weeks' gestation. The court directed the petitioner to appear before a medical board in KEM Hospital in Mumbai and took into account their report advising against the abortion. However, in an atypical order, the court noted that the pregnancy was caused by rape and stated that there was "no doubt that the continuance of this pregnancy is causing a grave injury to the mental health of the petitioner". Therefore, the court granted permission for abortion.

There were similar cases in May 2020 and September 2020, where the **Bombay High Court** allowed 16-year-old rape survivors to terminate their 23-week-old pregnancies after the constitution of Medical Boards. In July 2020, the Court permitted a 17 year old rape victim to terminate her 25-week pregnancy. This was despite the medical report of the hospital advising against it, keeping in mind the social and psychological effects on the minor since it was a case of rape. The Court also allowed a 23-week pregnant minor to undergo abortion since the pregnancy would cause physical and mental stress to her.

The **Kerala High Court**, in January 2021, allowed abortion for a 14-year old minor rape survivor, directing the medical board to preserve DNA for the purposes of a criminal trial for rape. Between the period of July 2020 and January 2021, the Kerala High Court allowed 7 adolscents to undergo abortion as per the MTP Act, 1971.

In February 2021, a minor aged 14 years approached the **Madras High Court** to terminate their 7-week pregnancy. The court, again, constituted a Medical Board to determine if the termination would cause any detrimental effects to the health of the person and granted permission for termination based upon their report.

On January 7, 2021, a 15-year-old rape survivor died of pregnancy related complications at a district hospital in Uttar Pradesh. When her family discovered that she was six months pregnant in December 2020, they immediately approached the police. Reportedly, they also approached a magistrate seeking approval for termination of the pregnancy as doctors had refused to perform an abortion given that the rape investigation was underway. Since the pregnancy had advanced beyond the 20-week time limit set out in the Medical Termination of Pregnancy Act, 1971 (MTP Act), approval was not granted. The adolescent girl was eventually admitted to the hospital and died a few days later.

The refusal to acknowledge that adolescents can consciously choose to engage in sexual activity and be and in consensual relationships without such behaviour being viewed as non-normative, makes the POCSO Act as it stands extremely problematic.

CONCLUSION

CONCLUSION

The COVID-19 pandemic has had far reaching effects for the people of India, with disproportionately grave outcomes for marginalised groups who face structural discrimination on a daily basis, now compounded with additional barriers to accessing basic facilities. The characterisation of reproductive services as 'essential' by the Central Government prior to the 2020 lockdown belied the situation on the ground, where pregnant persons experienced major barriers to accessing testing, medical, pharmaceutical and abortion facilities.

Data shows that structural discrimination, especially on grounds of caste and religion, affected access to SRH for pregnant persons. High Courts, due to the lack of coherent, uniform jurisprudence on abortion, experienced a surge in cases between 2020 and 2021, where pregnant persons at various stages of gestation came to seek permission for medical termination of pregnancy. Further, the reliance on medical boards to provide their opinions resulted in long delays in more than one case and compounded the non-uniformity in judicial decision-making.

In current times, when the COVID-19 crisis has already gravely affected access to healthcare and SRH, exacerbating injustices faced by marginalised persons, the inclusion of medical boards into the abortion framework is just a ground for further delays, arbitrariness, the denial of rights and the perpetuation of stigma against pregnant persons.

The numerous legal reforms attempted during the pandemic indicate the State's apathy towards those whom these laws most affect. Disparity in access to abortion and other SRH services is borne disproportionately by marginalised communities such as Dalits and Adivasis, religious minorities, gender minorities, persons with disabilities and adolescents.

It is, thus, imperative to have a reflective and consultative lawmaking process that not only comprehends structural challenges in India's healthcare system but also responds effectively to the needs of marginalised persons and enables access to justice for all. It is high time that policymakers engage with these issues meaningfully and bring all stakeholders together to consider nuanced perspectives.

> **Global evidence has shown that gender-based discrimination and violence are often reinforced, perpetuated and exacerbated by disasters and crises. Thus, the integration of a gender equality and social inclusion (GESI) approach in all stages of the COVID-19 response and recovery process, including preparedness, is critical. In particular, the effort should ensure equitable access to, and benefit from, relief, services and information. Women and girls, especially those from marginalised and vulnerable groups who are disproportionately impacted and in need of targeted support, should receive sufficient attention and support.**

UN Women

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