



May 13, 2019

Human Rights Committee
Human Rights Treaties Division, OHCHR
Palais Wilson
52, rue des Paquis
CH-1201 Geneva Switzerland

Re: Supplementary information for the adoption of the list of issues on India in the absence of a state report and for the consideration of the Committee in its 126th session on 1-26 July 2019

Honorable Committee Members,

The Center for Reproductive Rights (the Center), the Centre for Constitutional Law, Policy and Governance at National Law University, Delhi (CCLPG), and Ipas Development Foundation (India) (IDF)¹ have prepared this letter to assist the Human Rights Committee (the Committee) in the formulation of its list of issues for its review of the Government of India (state party) and to provide information on the state party's efforts to promote women's and girls' reproductive rights as guaranteed under the International Covenant on Civil and Political Rights (ICCPR).² This submission discusses the following: (1) barriers to accessing abortion services due to poor availability of medical services and restrictive abortion laws; (2) violations of the rights of adolescents to access reproductive health services; and (3) violations of women's and girls' rights resulting from unsafe and coerced sterilizations. The Center, the CCLPG, and IDF also respectfully suggest questions to pose to the state party by the Committee in its list of issues, found on page 14.

I. LEGAL AND PRACTICAL BARRIERS TO ACCESSING ABORTION SERVICES (Articles 3, 6(1), 7, 17(1))

In India, millions of women and girls who seek abortion services continue to face several legal and practical barriers which constitute a range of violations of their human rights. Despite the fact that India's Medical Termination of Pregnancy Act, 1971 (MTP Act) permits abortion on several grounds, gaps and weaknesses in the legal framework as well as practical barriers mean that approximately half of all abortions in India are considered unsafe.³ Unsafe abortion is estimated to account for 9 to 20% of all maternal deaths in the country.⁴

Based on a study conducted in 2015, the Guttmacher Institute reported that 15.6 million abortions took place in India.⁵ An estimated 3.4 million abortions (22%) took place in health facilities, 11.5 (81%) million were performed with medication obtained either from a health facility or another source, and 0.8 million (5%) were

done outside health facilities.⁶ Currently, slightly fewer than one in four abortions are provided in health facilities. The public sector – which is the main source of health care for rural and poor women – accounts for only one-quarter of facility-based abortion provision, in part because many public facilities do not offer abortion services.⁷ The majority of facilities that provide induced abortions are in the private sector. In a survey of 6 states in India it was reported by 33-56% of private health facilities that they only provide post abortion care and not abortion care.⁸ Because many public health facilities do not provide abortion, poorer women, especially those from rural areas, are forced to resort to unsafe or less safe methods of abortion from unskilled providers or unregistered facilities that may be more affordable.⁹

Further, women and girls also face delays in accessing abortion early in pregnancy due to **lack of awareness about their legal rights**, misunderstandings about the law, and **societal stigma** surrounding abortion.¹⁰ In some areas such as Bihar, up to 75% of women are unaware that abortion is legal.¹¹ Providers also entertain **misconceptions about the law**, such as the requirement of spousal consent when in fact no such requirement exists.¹² As discussed below, **gaps, weaknesses, and ambiguity in the legal framework on abortion** compound these practical barriers to accessing abortion services.

Legal and practical barriers to safe abortion services violate a range of human rights guaranteed under the ICCPR, including the rights to life, privacy, equality, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.¹³ The Committee in particular has highlighted the importance of ensuring access to abortion services to respect and protect women's and girls' right to life. In its recent General Comment 36, the Committee called on states to amend their abortion laws to ensure that women and girls are not forced to resort to unsafe abortions, including by not penalizing women and girls undergoing abortions and the medical service providers who assist them, and providing them with the protection against the mental and physical harm resulting from unsafe abortions.¹⁴ In individual communications, the Committee has also found that legal and practical barriers to accessing abortion services violates several rights including the rights to privacy, equality before the law, and to be free from ill-treatment.¹⁵ The Committee has noted that denial of access to abortion leads to physical and mental suffering that could constitute cruel, inhuman or degrading treatment.¹⁶

Several treaty monitoring bodies including the Committee have also called on states parties to ensure that legal abortion services must be available, accessible, affordable, acceptable and of good quality.¹⁷ They have recognized that abortion services must be economically accessible and recommended that states parties lower the costs of abortion or otherwise provide financial support when needed.¹⁸ States parties must also guarantee that women and girls are not denied access to legal abortions due to restrictive interpretation of laws, imposition by providers of extra-legal requirements such as spousal consent, or discrimination against vulnerable subgroups such as rape victims or adolescents.¹⁹

A. Overview of the gaps, weaknesses, and ambiguities in the state party's current legal framework on abortion

There is an urgent need for the state party to reform the MTP Act and decriminalize abortion to ensure women's and girls' rights under the ICCPR. Under the MTP Act, a registered medical provider is authorized to provide an abortion to a woman whose pregnancy does not exceed 12 weeks based on "a good faith opinion" that the continuation of the pregnancy would involve a risk to the woman's life or mental or physical health (which is defined to include rape or contraceptive failure for married women), or if there is a substantial risk that the child would be born with "physical or mental abnormalities as to be seriously handicapped."²⁰ When the woman's pregnancy exceeds 12 weeks and is less than 20 weeks, at least two providers are needed to form this opinion.²¹ When the pregnancy exceeds 20 weeks, abortion may be performed only when the provider has formed a "good faith" opinion that an abortion is "immediately necessary" to save the life of the pregnant woman.²² The MTP Act exempts the provider from damages if he or she has provided an abortion based on a "good faith" belief that it falls within the purview of the law.²³ Abortion remains criminalized under the Indian Penal Code (IPC) unless the exceptions set forth in the MTP Act are met.

The MTP Act contains several gaps and weaknesses which create significant barriers to abortion. First, the MTP Act does not permit abortion on the request of the woman in the absence of approval from a registered medical provider at any stage during the pregnancy. This means that women are dependent on the discretion of registered medical providers for abortion. However, the MTP Act permits abortion to be carried out only by a limited cadre of health care professionals; according to the law, abortion can be legally provided only by registered medical providers in a hospital established or maintained by the state party or in a facility approved for this purpose by the state party or a district level authority.²⁴ The lack of sufficient number of trained, legally registered health care providers and the necessary facilities contribute to the delays and denials of safe, quality, and legal abortions in the country.²⁵ According to a survey of six Indian states conducted in 2015, the primary reasons for the absence of abortion services in primary health centers is the shortage of trained staff and inadequate supplies.²⁶

Other limitations in the law include the discriminatory exclusion of unmarried women and girls from the provision of contraceptive failure as a ground for abortion, which is only permitted for married women. The law also imposes parental/guardian consent requirements for everyone under the age of 18,²⁷ which creates barriers for adolescent girls in seeking abortion services as will be discussed in more detail below.

The law also severely restricts access to abortion after 20 weeks of pregnancy. At this stage, abortion is permitted only if the provider considers it to be "immediately necessary" to save the life of the pregnant woman. There have been an increasing number of cases brought to courts by women and girls seeking termination after 20 weeks, including in cases of diagnosis of fetal impairment after 20 weeks or late detection of pregnancy after rape for minor girls.²⁸ As will be discussed below, while courts have permitted MTPs in some of these cases, there continues to be ambiguity about the scope of the life and health exceptions after 20 weeks and the government has failed to clarify the law. As more cases are referred to the courts, the judiciary has

responded by establishing a **system of third-party authorization** by the courts and medical boards.

In October 2014, the Ministry of Health and Family Welfare (MoHFW) proposed draft amendments to the MTP Act that would address some of these gaps and weaknesses.²⁹ These proposed amendments sought to reduce barriers for abortion services by expanding the cadre of health care providers who can provide abortion, allowing women to access abortion by a registered health care provider on request until 12 weeks of pregnancy, and extending gestational limits for women and girls who were beyond 20 weeks of pregnancy. The amendments proposed to increase the gestational limit for abortion from 20 to 24 weeks where there is a risk of grave injury to a pregnant woman's physical or mental health (including pregnancies resulting from rape or contraceptive failure for all women) and to maintain an exception throughout pregnancy for life-threatening cases and cases of "substantial foetal abnormalities." The amendments also removed the requirement of marriage for women and girls to access abortion on the grounds of contraceptive failure. However, the proposed amendments have been stalled for over four years. In June 2017, the draft amendments were returned to the MoHFW by the Prime Minister's Office, and still have not been tabled in Parliament.³⁰

Until the gaps in the law are resolved, women and girls will continue to face barriers to accessing safe abortion, including by remaining **vulnerable to criminal penalties** under the IPC and being forced to seek **third-party authorization from courts and medical boards**. The subsections below discuss these issues in more depth.

1. *Women remain subject to criminal penalties for self-managed abortion*

Under the IPC and the MTP Act, women can face criminal penalties for self-managed abortion; even the 2014 draft amendments only permit abortion without penalty where women go to registered health care providers. Recent studies indicate that a majority of abortions in India today are outside health facilities,³¹ reflecting the barriers to registered providers, as discussed above, as well as abortion stigma. A study of abortion in six states (Tamil Nadu, Uttar Pradesh, Madhya Pradesh, Gujarat, Assam and Bihar) revealed that a majority of abortions use medical methods and do not take place within health facilities.³² Seventy-eight percent of the 15.6 million abortions in 2015 in India occurred outside of health facilities.³³ Seventy-three percent of these were medical abortions done outside of health facilities (with or without medical supervision). In some states (Bihar, Gujarat and Uttar Pradesh), non-facility medical abortions account for 4 out of 5 abortions.³⁴ This means that millions of women seeking abortion in India are often seen as criminals, and compounds stigma and barriers in access to care. Evidence suggests that the majority of medical abortion users purchase medicines from chemists with limited or inaccurate information and little or no counseling.³⁵

The significant gap in the legal framework in India fails to account for the rapidly rising trend of medical abortion, exposing women and girls to the risks of unsafe abortions as well as criminal penalties. Medical abortion was approved by the Drug Controller General of India in 2002 as a Schedule H drug, meaning it is not an over-the-counter medication.³⁶ For women and girls, however, the practical barriers to safe abortion and registered providers means that self-managed abortion is the next safest

option— but the law criminalizes women for taking this route. The prohibition is inconsistent with recent guidelines from the World Health Organization (WHO) which state that medical abortion for pregnancies less than 9 weeks may take place at the home and be controlled by women,³⁷ provided that women have the required information as well as a trained healthcare provider and health facility as a back-up.³⁸ In a recent Lancet article, experts from WHO and others have urged for a more nuanced understanding of abortion law to include safe, less safe, and least safe—reflecting that medical abortion even without trained providers is safer than other methods typically employed when women cannot access health facilities.³⁹ Experts providing abortion services in India have noted that “complications following self-use of MA [medical abortion] are far less and less severe than those encountered during the earlier decades. This is shown in the drop in maternal deaths and injuries due to unsafe abortions, and primarily by the virtual disappearance of women presenting themselves with peritonitis, septicaemia, septic shock, damaged intestines hanging through a perforated uterus — severe complications that require major abdominal surgeries and even removal of the uterus.”⁴⁰

Criminalizing women for utilizing the safest method available in practice runs contrary to the recommendations by the Committee in its General Comment 36 which calls on states parties to ensure that the regulations on abortion do not conflict with their duty to protect women and girls from unsafe abortions.⁴¹ The Working Group on Discrimination Against Women in Law and Practice has also called for allowing women to terminate pregnancy on request on the first trimester.⁴² Instead of criminalizing women, the State party should improve access to safe abortion including by expanding the base of legal providers to broaden access to services; provide counseling to women who self-manage abortion on proper use and how to identify complications; permit registration of providers trained only on medical abortion; and eliminate restrictions on chemists that lead to barriers to medical abortion.⁴³

2. *De facto judicial and medical board authorization requirements for abortion beyond 20 weeks.*

Although the MTP Act only allows abortion in cases of risk to the life of a pregnant woman after 20 weeks, the courts have received dozens of petitions from women and girls seeking abortion. Courts have responded by establishing a system of judicial and medical board authorization. As the Center for Reproductive Rights has [documented](#) in *Ensuring Reproductive Rights: Reform to Address Women’s and Girls’ Need for Abortion after 20 Weeks in India* (annexed herein),⁴⁴ the majority of legal petitions are from women or girls—often facing health risks from pregnancies—who were denied abortion at health facilities because they are beyond 20 weeks of pregnancy. The judiciary has permitted abortion in some cases of health risks after 20 weeks. However, they have not issued any guidance clarifying when abortion is allowed after this point, and instead largely deferred to the opinion of court-appointed medical boards that typically do not include the woman’s own physician.⁴⁵ The courts in turn have generally deferred to these boards’ medical findings when approving or denying an abortion.

Z'S STORY

In May 2017, the Supreme Court of India denied a medical termination of pregnancy to Z, a 35 year old woman from Patna, Bihar living with HIV who became pregnant as a result of rape. Z was homeless and discovered that she was 17 weeks pregnant and HIV positive when she was admitted into a government shelter. Z's request for an abortion was denied by a government hospital which improperly demanded spousal and parental consent, despite the fact that the law requires neither for adult women. The hospital's refusal led Z to file for permission from the High Court of Judicature at Patna, which denied her permission on reasoning that the Supreme Court on appeal stated was "completely erroneous."⁴⁶ Although the Supreme Court recognized that Z's rights had been violated as the result of improper requirements imposed on her, she was ultimately denied an abortion because she was nearly 26 weeks pregnant by the time she was able to file the appeal.⁴⁷

Since 2016, at least 80 cases of women and girls seeking permission from the courts to access abortion have been filed.⁴⁸ The outcomes in such cases have been inconsistent, creating ambiguity about when abortion is permitted after 20 weeks of gestation. The Center's study analyzed 35 decisions from Indian courts and found that once in court, women and girls seeking abortion face delays, public scrutiny, stigma, and repeated invasive exams by unfamiliar doctors on judicially-established medical boards. Because of limited guidance to these boards on factors to consider in authorizing an abortion, many fail to adequately examine the harmful impact of forcing continuation of pregnancy on women and girls. Further, women and girls without financial and legal resources to seek judicial authorization have no recourse but to continue an unwanted pregnancy or risk their lives through unsafe abortion.

In August 2017, in response to a Supreme Court order, the MoHFW issued a circular directing each state to establish permanent medical boards to respond to judicial requests to prepare medical reports in authorization cases for abortion. While an important recognition of the procedural challenges facing women, the circular does not mention whether medical boards could receive appeals without judicial involvement. Rather, the circular and a subsequent guidance note to medical boards⁴⁹ appear to reinforce the position that women must seek judicial and medical board authorization for all abortions after 20 weeks⁵⁰ except within a narrow interpretation of the life exception under the MTP Act.⁵¹ Recently, in the April 2019 case of XYZ v. Union of India, the Bombay High Court has taken a progressive reading of the life exception to include health grounds, but then very problematically reiterated that judicial and medical board authorization is required where women and girls seek to avail of MTP on health grounds.⁵²

R'S STORY

In 2016, R was abducted while staying at a friend's house. After her parents found her, they attempted to report her rape to the local authorities. R was 21 weeks pregnant by the time her pregnancy was finally detected. She was denied an abortion by her doctors due to their fear of prosecution. R filed a petition to the High Court of Punjab and Haryana for authorization to terminate her pregnancy just one week over the MTP gestational limit. The High Court recognized that the government hospital's failure to conduct a pregnancy test during her initial exam led to her crossing the 20-week limit before requesting the MTP. Although her case came up for hearing just days after she filed the petition, the High Court waited two weeks before passing an order stating that R was at liberty to appear for medical examination by a medical board. When R was examined by a medical board, she was 22 weeks pregnant. She underwent two days of exams by a medical board. Without stating why, the medical board stated that termination would be harmful to R's life and that an MTP could not be provided. The High Court asked the medical board to reassess given R's state of mind, but the medical board reiterated that it could not provide an abortion because R was by now 25 weeks pregnant.⁵³ The High Court criticized the unwillingness of the doctors to provide the MTP due to "fear of prosecution" but ultimately stated that it could not allow the MTP given lack of favorable medical board opinion.⁵⁴

There is an urgent need for the State party to end third party authorization by clarifying that the health exception extends throughout pregnancy; this can be done by the judiciary expansively reading the health exception or the legislature passing amendments to extend the gestational limits for MTP. The Committee has urged state parties to repeal third-party authorization requirements, such as those required from judges or health authorities, classifying these requirements as barriers to accessing healthcare.⁵⁵

The WHO has also called for an end to a third-party authorization, observing that "negotiating authorization procedures disproportionately burdens poor women, adolescents, those with little education and those subjected to, or at risk of, domestic conflict and violence, creating inequality in access."⁵⁶ Requiring judicial or medical board authorizations in all cases contravenes the state's constitutional and human rights obligations to create a legal and procedural framework that respects reproductive autonomy.

3. Chilling effect on abortion from fear of penalties for providers under other laws

Like women, providers also face risks arising from the continued criminalization of abortion along with additional penalties under other laws. Barriers to abortion are compounded by providers' concerns of investigation, harassment, and prosecution related to performing abortion under the Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT Act) and the Protection of Children from Sexual Offenses Act of 2012 (POCSO Act).⁵⁷ Interviews with providers have repeatedly documented that providers' fear of prosecution under these laws lead to denials of abortion or requests for judicial authorization.⁵⁸ By exposing providers to criminal penalties for abortion, these laws create the stigma and chilling effect of laws directly criminalizing

abortion. In their current form, the PCPNDT and POCSO Acts are effectively leading to restrictions on access to abortion and these laws should not be enforced so as to create risks of criminal prosecution for providers and women and girls seeking MTP. By creating obstacles to abortion, these measures are in contravention of the Committees' recommendations in General Comment No. 36 which has provided that "States parties should not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion."⁵⁹

a. Conflation of the PCPNDT Act and MTP Act

The PCPNDT Act of 1994, which prohibits sex determination but intentionally does not regulate abortion on any grounds, has been improperly implemented to target MTP providers in government "crackdowns" on sex-selection.⁶⁰ Although the PCPNDT and the MTP Acts deal with two distinct acts – the former with sex determination and the second with abortion – enforcement authorities tend to conflate the two.⁶¹ This has led to the denial of abortion requested during the second trimester, despite studies showing that only a small proportion of these abortions are sex-selective.⁶² A 2015 study of the attitudes and practices of 19 gynecologists in the state of Maharashtra found that medical practitioners regularly refuse to provide abortions to women for fear of prosecution under the PCPNDT Act.⁶³ All but two of the gynecologists interviewed for the study shared that while they perform abortion in the first trimester, they avoid providing abortion services beyond it because the women may have had the sex of the fetus already determined.⁶⁴ All the respondents had negative experiences with the PCPNDT Act and complained about harassment from enforcement authorities and highly cumbersome bureaucratic requirements.⁶⁵ Further, misconceptions about the timeframe for the determination of the fetus' sex have contributed to further restrictions on women's access to medical abortion.⁶⁶ The effectiveness of the PCPNDT Act towards limiting sex selection is also questionable. Despite the law and the crackdown on health facilities, the national sex ratio at birth (number of girls per 1000 boys) has changed little in the past decade (901 girls per 1000 boys in 2005-07 as compared to 906 girls per 1000 boys in 2012-14).⁶⁷

Efforts to address the low status of women and girls and resulting gender-biased sex selection must not create barriers in access to reproductive rights. This only further limits women's and girls' ability to equally exercise their rights and leads to discrimination in the enjoyment of their rights to life, freedom from torture and ill-treatment, and privacy. Rather, measures to address the sex ratio must focus on root causes.

b. Mandatory reporting requirements under the POCSO Act

Providers also fear backlash or investigation arising from a provision in POCSO Act that calls for mandatory reporting by providers of sexual assault of a minor.⁶⁸ The law recognizes any sexual activity involving a minor as rape, without exception, leading providers to interpret it as requiring mandatory reporting of any pregnant adolescent patient, even where she is seeking an abortion.⁶⁹ Providers also report a heightened fear of providing abortions to unmarried adolescent girls, due in part to concerns of backlash from girls' families.⁷⁰ As discussed in more detail below, the mandatory reporting requirement also undermine adolescents' access to sexual and reproductive health services and information.

II. VIOLATIONS OF ADOLESCENTS' RIGHTS TO ACCESS REPRODUCTIVE HEALTH SERVICES (Articles 3, 6(1), 7, 17(1) and 24)

In India, the median age at first sexual intercourse is 19 years for women age 25-49 with 10.6% of women age 25-49 having their first sexual intercourse before the age 15, and 38.7% before the age of 18.⁷¹ An estimated 7.9% of women aged 15-19 have already begun childbearing with rural women (9.2%) and those without schooling (20.2%) more likely to have experienced live birth or are pregnant with their first child than urban women (5%) and those who have completed at least 12 years of schooling (4.4%).⁷² However, despite the early age of first sexual encounter and early childbearing, among currently married women, only 10% of those between the ages of 15-19 and 23.5% of those between 20-24 are currently using modern methods of contraception.⁷³ Among sexually active unmarried women, only 16.4% of those between the ages of 15-19 and 20.9% of those between 20-24 are currently using modern methods.⁷⁴ Of those who were pregnant during the last five years preceding the NFHS, 2.7% resulted in abortion for those between the ages 15-19.⁷⁵

Adolescents are particularly vulnerable to the risk of maternal mortality and morbidity to barriers to access maternal healthcare. This is recognized in the 2018 commissioned study by the state party's National Human Rights Commission (2018 NHRC report) which noted that early pregnancies and childbirth compromise the health of young girls.⁷⁶ The WHO has noted that young mothers or those between ages 10 to 19 are exposed to increased risk of suffering from eclampsia, puerperal endometritis, and systemic infections than women aged 20 to 24 years.⁷⁷ Complications during pregnancy and childbirth remains the leading cause of death among adolescent girls globally.⁷⁸

The obligation to ensure reproductive rights is heightened for vulnerable subgroups of women including adolescent girls. International human rights law and standards require states parties to ensure adolescents' sexual and reproductive health and rights, including through recognition of the evolving capacity of adolescents to make independent, informed decisions about their sexual and reproductive health while respecting the principle of best interest of the child.⁷⁹ The Committee has previously called on states parties to improve access to sexual and reproductive health information and services for adolescents.⁸⁰ In General Comment 36, the Committee called on states parties to ensure girls' access to "quality and evidence-based information and education about sexual and reproductive health [including a] wide range of affordable contraceptive method...and [to] prevent the stigmatization of [those] seeking abortion."⁸¹ However, as will be discussed in this section, there are several laws and policies that prevent adolescents in India to freely access the full range of reproductive health services.

A. Guardian or parental consent requirement to access abortion services

The MTP Act requires minors to obtain guardian or parental consent for abortion.⁸² This requirement prevents many adolescents from obtaining abortions without informing their parents or guardians. In contexts where there are strong taboos against adolescent sexual activity as well as stigma around reporting pregnancy resulting from sexual violence within the family, imposing such guardian and parental consent

requirement can pose a significant deterrent. As noted in the 2018 NHRC report, third-party consent “poses a huge barrier for girls seeking safe and abortion services as many times the guardians could be abusers themselves and seeking their consent would be more torturous [causing] many girls to seek services that maybe unsafe, leading to morbidities and even mortality.”⁸³

Treaty monitoring bodies have consistently found that requirements that make women and girls obtain third-party authorizations before accessing abortion services constitute as barriers and violations of reproductive rights.⁸⁴ As noted above, the Committee, in its General Comment 36, recommended that states parties should remove existing barriers that deny effective access by women and girls to safe and legal abortion.⁸⁵ Further, the Committee on the Elimination of All Forms of Discrimination against Women specifically called on states parties to “abolish rules and practices that require parental or spousal authorization for access to services such as ... health, including sexual and reproductive health.”⁸⁶

B. Sweeping criminalization of adolescent sexual relations and mandatory reporting requirements among providers

To protect children from sexual abuse and exploitation, the POCSO Act has increased the age of legal consent to sexual activity from 16 to 18 years, effectively criminalizing a wide spectrum of consensual sexual acts from mere touching, penetrative sexual intercourse, to any physical contact with sexual intent involving all minors (below 18 years of age) without regard to their evolving capacities. However, as noted in the 2018 NHRC report, the increase has “render[ed] them vulnerable to retribution and punishment for any degree of consensual sexual contact, from touching to penetrative sex.”⁸⁷ Coupled with the continued stigma on adolescent sexual activity, the criminalization of consensual adolescent sexual relations, including between two adolescents, has intensified the chilling effect on adolescents’ ability and willingness to seek sexual and reproductive health services.

Adolescents’ access to reproductive health services is further compromised by the introduction of the mandatory reporting requirements in the POCSO Act which treats all pregnant minors as rape survivors by requiring a person who has knowledge, or has an apprehension, that an offence punishable under the Act has been committed or is likely to be committed, to report the same to the police.⁸⁸ Specific to the provision of abortion services, these mandatory reporting requirements go against the MTP Act which obliges providers to preserve the confidentiality of all abortion cases.⁸⁹ This effectively prevents providers and other health professionals from performing their duty to provide confidential counselling and services to adolescents even in cases where sexual relations between them is consensual.⁹⁰ As recommended in the 2018 NHRC report, the repeal of mandatory reporting requirements “is especially important for adolescents whose sexuality and sexual health needs should be handled with empathy and dignity, not shunned punitively.”⁹¹

Treaty monitoring bodies have recognized the rights of adolescents to access sexual and reproductive health services without risk of criminal penalties or violation of their confidentiality. The Committee on the Rights of the Child has recommended that states parties recognize the evolving capacities of adolescents to make their own

health care decisions and consider establishing a legal presumption stating that adolescents are competent to seek and have access to sexual and reproductive health commodities and services, including abortion.⁹² The Committee on the Rights of the Child has also called on states to “avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity.”⁹³ It also called on providers to maintain confidentiality about medical information, which can only be disclosed with the consent of the adolescent or in the same situations that apply to the violation of an adult’s confidentiality.⁹⁴

III. UNSAFE AND COERCED STERILIZATION (Articles 3, 6(1), 7 and 17(1))

Despite the state party’s National Population Policy (“NPP”), which commits the Government to ensure a “voluntary and informed choice” and a “target free approach” in providing family planning services,⁹⁵ state implementation policies continue to focus disproportionately on female sterilization at the expense of all other methods.⁹⁶ This has resulted in violations of the state party’s obligation to ensure women do not bear a disproportionate burden in family planning and have access to a full range of contraceptive methods. Women and girls, including married girls who face risks of early pregnancy, lack access to non-surgical or non-permanent methods that would allow them to time and space pregnancies.⁹⁷

The focus on permanent methods and the burden of family planning on women is reflected in the latest NFHS which shows that among currently married women aged 15-49 the most common method of family planning remains to be female sterilization (35.7%) followed by male condoms (6%) and pills (4%).⁹⁸ Data from 2017-18 also showed that of the total 14,73,418 sterilization procedures in the country, only 6.8% were on men and over 93% were performed on women.⁹⁹ The NFHS also reported that only 42% of women who were sterilized were informed about the possible side effects and issues of such procedure with a larger proportion among rural women (40.3%) compared to those living in urban areas (46.4%).¹⁰⁰

In India, sterilization camps have been routinely established in accordance with state-level family planning programs that promote a one-child norm and set targets for sterilization, IUD insertion and contraceptive use.¹⁰¹ These camps primarily focus on women’s sterilization and offer incentives for individuals who undergo sterilization procedures to cover lost wages and transportation costs.¹⁰² Doctors have reported that the state governments pressure local governmental officials and doctors to meet certain sterilization “quotas.”¹⁰³ Further, in certain states, there have been reports of penalties being imposed on women and their families, such as denial of government subsidies including food rations, unless they consent to sterilization.¹⁰⁴ These pressures lead to violations of national guidelines on sterilization that require informed consent, counseling as to the full range of contraceptive methods, and quality and safe sterilization procedures.¹⁰⁵ Marginalized women tend to be the most impacted due to their lack of access to other forms of contraceptives and the fact sterilization is the only contraceptive method for which compensation for costs incurred is provided.¹⁰⁶

Female sterilization camps are routinely conducted in India under state policies and programs that set targets for female sterilizations and are funded through the country’s national health program. Alarming, women face serious harm as a result

of unsafe and potentially fatal sterilization procedures in such camps. For example, during a “mass sterilization drive” in Chhattisgarh state in November 2014, more than eighty women were paid 1,400 rupees (roughly \$23) to undergo sterilization procedures in camps that were unequipped to sufficiently sanitize the facilities, perform quality operations, and provide adequate post-operative care.¹⁰⁷ Thirteen women died.¹⁰⁸ The judicial commission charged with investigating the incident attributed the deaths to “serious negligence,” poor operating conditions and poisonous post-operation medication.¹⁰⁹

This highly publicized event is indicative of a broader pattern of abuse and human rights violations faced by women in mass-sterilization drives across India. In January 2015 in Varanasi state, seventy-three women were sterilized within four hours by one doctor in a “bid to set [a] record.”¹¹⁰ Later that month in a government facility in Jharkhand state, forty women were sterilized without pre-operative screenings, and doctors operated by flashlight.¹¹¹ Continued reports of coerced and unsafe sterilizations throughout the country illustrate a lack of political will to stop the abuses.

Treaty monitoring bodies have recognized that women are denied reproductive autonomy when they are subjected to violence or coercion such as forced or coerced sterilization which violate women’s rights to health-related decision-making and informed consent.¹¹² In certain situations particularly those involving women from marginalized groups, treaty monitoring bodies have found that such practices violate their right to be free from torture or ill-treatment.¹¹³ They have called on states parties to ensure access to information as a means of ensuring informed consent for contraceptive services, particularly sterilization.¹¹⁴ The Committee has further called on states parties to ensure access to reparation as well as sterilization reversal where possible.¹¹⁵ Further, the CEDAW Committee has identified forced sterilization as a form of gender-based violence, and has called for complaints about forced sterilization to be duly investigated and for the provision of remedies and redress that are “adequate, effective, promptly granted, holistic and proportionate to the gravity of the harm suffered.”¹¹⁶

A. Court rulings to address unsafe and coerced sterilizations

State policies and programs leading to sterilization abuse have been recognized by the Supreme Court of India as violating women’s rights as protected under the Indian Constitution. Supreme Court rulings concerning unsafe and coerced sterilization have mandated extensive guidelines for sterilizations with an emphasis on counseling and informed consent. In 2005, the Supreme Court issued directives known as the *Ramakant Rai* principles, pursuant to which the Government of India adopted national sterilization guidelines and standards in 2006 and 2008.¹¹⁷

Despite these measures, reports of substandard care, abuse, and discrimination in sterilization camps remain widespread and persist primarily because of the absence of proper monitoring mechanisms.¹¹⁸ In a commendable step, in September 2016, the Supreme Court of India issued a decision in the case of *Devika Biswas v. Union of India & Ors.* calling on the Government to “reconsider the impact that policies such as the setting of informal targets and provision of incentives by the Government can have on the reproductive freedom of the most vulnerable groups of society whose

economic and social conditions leave them with no meaningful choice . . . [and] render them the easiest targets of coercion.”¹¹⁹ The Supreme Court ordered the Government to stop conducting sterilization camps within three years and to ensure informed consent for sterilization including through implementation of the *Ramakant Rai* orders.¹²⁰ Further, the case calls for the Government to specifically take action in Chhattisgarh following the 2014 sterilization deaths—particularly pass a national health policy promoting gender equity, establish a system of annual reporting for more effective oversight of states in implementing family planning policies, introduce audits for every sterilization-related death, and improve compensation for sterilization deaths.¹²¹

Importantly, the Supreme Court stated that it was “pained to note the extremely casual manner in which some... [s]tates have responded” to the petition and criticized the lack of “any acceptable response to the allegations.”¹²² As a result, it ordered the chief justices in these states to initiate *suo moto* petitions in high courts of certain priority states to follow up on the decision.¹²³ However, despite the failure of states to take these rights violations seriously, the Supreme Court failed to clearly mandate that states need to eliminate targets in contraceptive and population policies, and instead stated that it “leave[s] it to the good sense of . . . each State Government or Union Territory to ensure that such targets are not fixed so that health workers and others do not compel persons to undergo what would amount to forced or non-consensual sterilization merely to achieve the target.”¹²⁴ It remains to be seen if the State party will meet the target set by the Supreme Court to end camps by 2019.

Several UN Special Rapporteurs, including those on torture and other cruel, inhuman or degrading treatment or punishment, and on violence against women, expressed “grave concern” over these procedures in a spring 2015 communication.¹²⁵ In this communication, the Rapporteurs expressed concern regarding the sterilization practices across India, with monthly reported averages of 14 deaths, 20 complications, and 541 failed surgeries occurring across the country from 2010-2013.¹²⁶ The state party did not respond to this communication, so the Rapporteurs followed up in late 2015, again noting concern with the procedures in government-sponsored camps, as well as the lack of accountability for these practices and the lack of remedy for victims.¹²⁷

B. Current status of compliance with court directives

A recent review of the State Health Department websites indicate that no state has filed complete reports or fully complied with the directives set out by the Supreme Court.¹²⁸ A brief survey of the States demonstrates inconsistent application of the directives. The Central Government also appears to be relying primarily on the States to provide data as they see fit, rather than ensuring compliance through a national plan. For example, the Union of India has not set any uniform format for providing data, which leads to inconsistencies in the reported data, and makes it difficult to compare sets of data across states. The 2017-18 Annual Report of the Ministry of Health and Family Welfare does not provide any plan for the phasing out of sterilization camps.¹²⁹ Nor does it provide information regarding the compliance of states with Supreme Court directives. It is evident that full compliance of the Supreme Court’s directives has not been achieved and reproductive rights violations are continuing. Stories of medical negligence in sterilization camps continue to be

reported: in January of 2019, a woman complained that a doctor in a sterilization camp broke an incision blade and left it in her abdomen.¹³⁰ In its 2017 review of India, the Human Rights Council's Working Group on the Universal Periodic Review recommended that India take concrete steps to end unsafe, coerced and abusive sterilization.¹³¹

Instead of promoting sterilization, which leads to the abuses described above, the State Party should ensure access to a full range of quality contraceptive services. Treaty monitoring bodies have found that sexual and reproductive health information and contraception must be accessible, acceptable, available, and of good quality. For contraceptives in particular, they have noted that women should have access to information about contraceptives, including through comprehensive sexuality education and awareness programs about the importance of contraceptives.¹³² States parties must also ensure access to information as a means of ensuring informed consent for contraceptive services, particularly sterilization.¹³³ The Committee in particular has severally called on states parties to ensure full access to sexual and reproductive health services and that contraception are available, affordable, and accessible with efforts undertaken to increase awareness on their use.¹³⁴

PROPOSED LIST OF ISSUES

The Center, the Centre for Constitutional Law and Governance, and IDF respectfully request that this Committee raise the following issues with the delegation representing India:

1. What measures are being taken to reform the legal framework on abortion to ensure the right of women and girls to safe abortion services and strengthen access to medical abortion and other safe abortion services in health facilities? Specifically:
 - What measures are being taken to pass amendments to the MTP Act providing for the legal termination of pregnancy at any gestational stage when the pregnant woman's life or physical or mental health is at risk, including when the pregnancy is the result of rape or involves fetal impairment?
 - What measures are being taken to pass amendments to the MTP Act as proposed by the Ministry of Health and Family Welfare that would allow for abortion on request before 12 weeks; abortion with just one provider's opinion throughout pregnancy; increase the number of providers who can legally perform abortions?
 - What measures are being taken to clarify that judicial and medical board authorizations are not required for an abortion, even beyond 20 weeks?
 - What measures are being taken to provide women with accurate information on self-use of medication abortion?
2. What measures are being taken to resolve the lack of clarity in laws other than the MTP Act that creates a chilling effect on access to safe abortion services due fear of prosecution amongst providers as well as stigma and risk of criminalization for women and girls? Specifically:

- In light of the measures are being taken to amend the POSCO Act to ensure that adolescents are able to access abortion without facing the risks caused by mandatory reporting requirements?
 - What measures are being taken to ensure that implementation of legislation intended to address gender-based sex selection does not result harassment or “crackdowns” on providers of abortion, which lead to barriers to access abortion?
 - What measures are being taking to amend the Indian Penal Code to decriminalize abortion with the goal of ensuring that women do not face criminal penalties for self-managed abortion?
2. What steps are being taken to implement orders of the Supreme Court of India and put an end to unsafe and coerced sterilization by 2019? How many sterilization camps are still ongoing and to what extent are Quality Assurance Committees monitoring the quality of services offered at existing sterilization camps?

If you have any questions on the information submitted herein, please contact Payal Shah, Acting Regional Director for Asia, Center for Reproductive Rights, at pshah@reprorights.org. Thank you for your consideration.

Respectfully submitted,
 Center for Reproductive Rights
 Ipas Development Foundation
 Centre for Constitutional Law, Policy, and Governance, National Law University,
 Delhi

¹ The Center for Reproductive Rights is a global legal advocacy organization with offices in Nepal, Colombia, Kenya, Switzerland and the United States using the power of law to advance reproductive rights as fundamental rights around the world. The Center has been working with partners in India since 2003 to advance women’s and girl’s reproductive rights in the country. The Centre for Constitutional Law Policy and Governance at National Law University, Delhi focuses on foregrounding rights, rightslessness and other vulnerabilities in understanding, critiquing and reforming laws, legal institutions and modes of governance, so that they reflect the constitutional ideal of justice. Ipas Development Foundation (IDF) is a not-for-profit and the local partner organization in India for [Ipas](#). IDF is dedicated to preventing and managing unwanted pregnancies, and ending deaths and disabilities from unsafe abortion. Through local, national, and global partnerships, IDF works to ensure that women can obtain safe, respectful, and comprehensive abortion and contraceptive care to prevent future unintended pregnancies.

² International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR].

³ Suchanta K. Banerjee et al., *An exploration of the socio-economic profile of women and costs of receiving abortion services at public health facilities of Madhya Pradesh, India*, 223 BMC HEALTH SERVICES RESEARCH, 2 (2017), *available at* <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2159-6>.

⁴ MARY PHILIP SEBASTIAN ET AL., POPULATION COUNCIL, UNINTENDED PREGNANCY AND ABORTION IN INDIA: COUNTRY PROFILE REPORT 54, (2014) [hereinafter *Unintended Pregnancy and Abortion in India*].

-
- ⁵ Susheela Singh et al., *The Incidence of Abortion and Unintended Pregnancy in India*, 6 THE LANCET GLOBAL HEALTH e111, e116 (2018), available at [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30453-9/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30453-9/fulltext) [hereinafter *The Incidence of Abortion and Unintended Pregnancy in India*].
- ⁶ *Id.* See also Partners for Law in Development and SAMA Resource Group for Women and Health, *Status of Human Rights in the Context of Sexual Health and Reproductive Health Rights: Country assessment undertaken for National Human Rights Commission*, 102-103 (2018) [hereinafter *2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights*].
- ⁷ *The Incidence of Abortion and Unintended Pregnancy in India*, supra note 5 at e116; See also Susheela Singh et al., *Abortion and Unintended Pregnancy in Six Indian States* 11 GUTTMACHER INSTITUTE (2018) [hereinafter *Abortion in Six Indian States*].
- ⁸ *Id.*, at 12.
- ⁹ 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, supra note 6 at 107-108.
- ¹⁰ See e.g., Unintended Pregnancy and Abortion in India, supra note 4.
- ¹¹ *Id.*, at 57.
- ¹² See e.g., *Ms. Z v. The State of Bihar and Others*, CA 10463 of 2017 at 19. See also *Abortion in Six Indian States*, supra note 7, p. 12.
- ¹³ See e.g., *K.L. v. Peru*, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005) [hereinafter *K.L. v. Peru*]; *L.C. v. Peru*, Committee on the Elimination of Discrimination against Women (CEDAW), Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011) [hereinafter *L.C. v. Peru*]. See also Human Rights Committee, *General Comment No. 36 on article 6 of the International Covenant on Civil and Political Rights*, (124th Sess., 2018), para. 8, U.N. Doc. CCPR/C/GC/36 (2018) [hereinafter Human Rights Committee, *Gen. Comment No. 36*].
- ¹⁴ Human Rights Committee, *General Comment No. 36*, supra note 13, para. 8.
- ¹⁵ *K.L. v. Peru*, supra note 13; *Mellet v. Ireland*, Human Rights Committee, Commc'n No. 2324/2013, paras. 7.6, 7.7, 7.8, U.N. Doc. CCPR/C/116/2324/2013 (2016) [hereinafter *Mellet v. Ireland*].
- ¹⁶ *Mellet v. Ireland*, supra note 15, paras. 7.6, 7.7, 7.8.
- ¹⁷ See, e.g., Committee on Economic, Social, and Cultural Rights (ESCR), *General Comment No. 14: The right to the highest attainable standard of health (Art.12 of the International Covenant on Economic, Social and Cultural Rights)*, (22nd Sess., 2000), para. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter *ESCR Committee, Gen. Comment No. 14*]; *K.L. v. Peru*, supra note 13; *L.M.R. v. Argentina*, Human Rights Committee, Commc'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); *L.C. v. Peru*, supra note 13.
- ¹⁸ See *ESCR Committee, Concluding Observations: Slovakia*, para. 24, U.N. Doc. E/C.12/SVK/CO/2 (2012); *CEDAW Committee, Concluding Observations: Austria*, paras. 38, 39, U.N. Doc. CEDAW/C/AUT/CO/7-8 (2013); *Mellet v. Ireland*, supra note 16, para. 7.11.
- ¹⁹ *ESCR Committee, General Comment No. 22: On the Right to Sexual and Reproductive Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights)*, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter *ESCR Committee, Gen. Comment No. 22*].
- ²⁰ S.3, India's Medical Termination of Pregnancy Act, 1971.
- ²¹ *Id.*
- ²² *Id.* S.5(1).
- ²³ *Id.* S.3(1).
- ²⁴ *Id.*, S.4.
- ²⁵ 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, supra note 6 at 102.
- ²⁶ *The Incidence of Abortion and Unintended Pregnancy in India*, supra note 5 at e118.
- ²⁷ S.3 India's Medical Termination of Pregnancy Act, 1971.
- ²⁸ See CENTER FOR REPRODUCTIVE RIGHTS, ENSURING REPRODUCTIVE RIGHTS: REFORM TO ADDRESS WOMEN'S AND GIRLS' NEED FOR ABORTION AFTER 20 WEEKS IN INDIA, 12-14 (2018) [hereinafter *CENTER FOR REPRODUCTIVE RIGHTS*].
- ²⁹ India's Medical Termination of Pregnancy Act Amendment Bill, 2014.
- ³⁰ Abantika Ghosh, *Abortion Law Amendments On Hold*, Indian Express, June 8, 2017.
- ³¹ *Abortion in Six Indian States*, supra note 7, pp. 8-9.
- ³² *Id.*
- ³³ *The Incidence of Abortion and Unintended Pregnancy in India*, supra note 5, p. 120.

-
- ³⁴ *Abortion in Six Indian States*, *supra* note 7, pp. 8-9.
- ³⁵ *Id.*
- ³⁶ Visaria et. al. *Medical Abortion in India: Role of Chemists and Providers*, Vol. 43 No. 36 Economic and Political Weekly 35 (2008).
- ³⁷ WORLD HEALTH ORGANIZATION, CLINICAL PRACTICE HANDBOOK FOR SAFE ABORTION 28 (2014) *available at* https://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf;jsessionid=CD1BE35CDEA3423565A52AEC2F3B047E?sequence=1
- ³⁸ *Id.*, at 28-30.
- ³⁹ Bela Ganatra et. al., *Global, regional, and sub-regional classification of abortions by safety, 2010-14*, 390 *The Lancet* 2372-81, 2373-2375 (2017) *available at* [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(17\)31794-4.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)31794-4.pdf).
- ⁴⁰ Vinoy Manning, *Self-managing abortions safely*, *The Hindu*, October 08, 2017 *available at* <https://www.thehindu.com/sci-tech/health/self-managing-abortions-safely/article19820640.ece>.
- ⁴¹ Human Rights Committee, *General Comment No. 36*, *supra* note 13, para. 8. "States parties may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and they should revise their abortion laws accordingly."
- ⁴² Working Group on the Issue of Discrimination Against Women in Law and Practice, *Women's Equality, Autonomy and Reproductive Health in International Human Rights: Between Recognition, Backlash and Regressive Trends*, Oct. 2017 *available at* <https://www.ohchr.org/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf>
- ⁴³ Vinoy Manning, *Self-managing abortions safely*, *The Hindu*, October 08, 2017 *available at* <https://www.thehindu.com/sci-tech/health/self-managing-abortions-safely/article19820640.ece>.
- ⁴⁴ A copy of this report is also available on our website at <https://www.reproductiverights.org/document/ensuring-reproductive-rights-reform-to-address-womens-and-girls-need-for-abortion-after-20->.
- ⁴⁵ See CENTER FOR REPRODUCTIVE RIGHTS, *supra* note 28, p. 19.
- ⁴⁶ Ms. Z v. The State of Bihar and Others, C.A. 10463 of 2017, S.C.C. 17 Aug. 2017.
- ⁴⁷ *Id.*
- ⁴⁸ CENTER FOR REPRODUCTIVE RIGHTS, IT'S TIME TO END JUDICIAL AUTHORIZATION FOR ABORTION IN INDIA (2019) *available at* <https://www.reproductiverights.org/feature/time-to-end-judicial-authorization-for-abortion-in-india>.
- ⁴⁹ The MoHFW Guidance Note is available on file with the Center for Reproductive Rights.
- ⁵⁰ Government of India, Ministry of Health and Family Welfare, Circular for Establishment of Permanent Medical Board, D.O. No. M12015/58/201-MCH (2017).
- ⁵¹ Government of India, Ministry of Health and Family Welfare, Circular for Establishment of Permanent Medical Board, D.O. No. M12015/58/201-MCH (2017).
- ⁵² XYZ v. Union of India, W.P. No. 10835 of 2018, 3 April 2019.
- ⁵³ R v. State of Haryana, W.P. (C) 6733 of 2016, H.C. P&H., 74, 30 May 2016.
- ⁵⁴ *Id.*
- ⁵⁵ Human Rights Committee, *Concluding Observations: Bolivia*, para 9(b) U.N. Doc. CCPR/C/BOL/CO/3 (2013).
- ⁵⁶ WORLD HEALTH ORGANIZATION, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 95 (2012) *available at* https://www.ncbi.nlm.nih.gov/books/NBK138196/pdf/Bookshelf_NBK138196.pdf
- ⁵⁷ India's Pre-Conception and Pre-Natal Diagnostic Techniques, 1994; India's Protection of Children from Sexual Offences Act, No. 32, 2012.
- ⁵⁸ Lalita Panicker, *Hindustan Times*, *The MTP Act 2014 Makes Safe Abortion Easier, It Should Be Passed* (2017) [hereinafter *The MTP Act 2014 Makes Safe Abortion Easier, It Should Be Passed*]; See also Roli Srivastava, *Reuters*, *'Not a Woman's Choice': India's Abortion Limit Puts Women at Risk, Say Campaigners* (2017); 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, *supra* note 6, 109-110.
- ⁵⁹ Human Rights Committee, *Gen. Comment No. 36*, *supra* note 13, para. 8.
- ⁶⁰ Susanne Sjoström et. al., *Medical students are afraid to include abortion in their future practices: in-depth interviews in Maharashtra, India*, 16 *BIOMED CENTRAL MEDICAL EDUCATION* 8, 3-4 (2016) [hereinafter Sjoström et. al., *In-depth interviews in Maharashtra, India*]; Pritam Potdar et. al., "If a

woman has even one daughter, I refuse to perform the abortion," *Sex determination and safe abortion in India*, 23 REPRODUCTIVE HEALTH MATTERS 45, 119-122 (2015) [hereinafter Potdar et. al., *Sex determination and safe abortion in India*].

⁶¹ See e.g. Sjostrom et. al., *In-depth interviews in Maharashtra, India*, *supra* note 60; Potdar et. al., *Sex determination and safe abortion in India*, *supra* note 60, at 115.

⁶² See e.g. Sjostrom et. al., *In-depth interviews in Maharashtra, India*, *supra* note 60; Potdar et. al., *Sex determination and safe abortion in India* *supra* note 60.

⁶³ Potdar et. al., *Sex determination and safe abortion in India*, *supra* note 60, at 121-122.

⁶⁴ *Id.*, at 118.

⁶⁵ *Id.* at 119-122.

⁶⁶ Asia Safe Abortion Partnership et. al., *Talking about abortion: A guide for journalists and advocates* 22 (2018) available at http://www.pratigyacampaign.org/wp-content/uploads/2018/11/Talking_About_ABORTION_MediaToolkit.pdf.

⁶⁷ OFFICE OF THE REGISTRAR AND CENSUS COMMISSIONER, SAMPLE REGISTRATION SYSTEM STATISTICAL REPORT 2014 (2016); OFFICE OF THE REGISTRAR AND CENSUS COMMISSIONER, SAMPLE REGISTRATION SYSTEM STATISTICAL REPORT 2007 (2008).

⁶⁸ S.19, India Protection of Children from Sexual Offences Act, No. 32, 2012.

⁶⁹ Potdar et. al., *Sex determination and safe abortion in India*, *supra* note 60, at 118. See also Indian Penal Code, 1860; India's Protection of Children From Sexual Offences Act, No. 32, 2012; *The MTP Act 2014 Makes Safe Abortion Easier, It Should Be Passed*, *supra* note 58.

⁷⁰ See e.g. Suchitra Dalvie, *Second Trimester Abortions in India*, 16 REPRODUCTIVE HEALTH MATTERS 37 (2008).

⁷¹ International Institute for Population Sciences (IIPS) and ICF. 2017. *National Family Health Survey (NFHS-4)*, 171, 2015-16: India. Mumbai: IIPS [hereinafter 2015-16 NFHS].

⁷² 2015-16 NFHS, *supra* note 71, at 99.

⁷³ 2015-16 NFHS, *supra* note 71, at 132.

⁷⁴ 2015-16 NFHS, *supra* note 71, at 133.

⁷⁵ 2015-16 NFHS, *supra* note 71, at 181.

⁷⁶ 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, *supra* note 6, 116.

⁷⁷ WORLD HEALTH ORGANIZATION, *Adolescent Pregnancy* (2018) available at <https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>. See also WORLD HEALTH ORGANIZATION, *Adolescents: Health Risks and Solutions* (2018) available at <https://www.who.int/en/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions>.

⁷⁸ WORLD HEALTH ORGANIZATION, *Maternal Mortality Factsheet* (2018) available at <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>

⁷⁹ See e.g. CRC Committee, *General Comment No. 20: On the implementation of the rights of the child during adolescence*, paras. 13, 39, 59, U.N. Doc. CRC/C/GC/20 (2016) [hereinafter CRC Committee, *Gen. Comment No. 20*]; CRC Committee, *General Comment No. 15: On the right of the child to the enjoyment of the highest attainable standard of health*, (2013), para. 56, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee, *Gen. Comment No. 15*]; CRC Committee, *Concluding Observations: India*, para. 66(b), U.N. Doc. CRC/C/IND/CO/3-4 (2014).

⁸⁰ See, e.g., Human Rights Committee, *Concluding Observations: Pakistan*, paras. 15-16, U.N. Doc. CCPR/C/PAK/CO/1 (2017); *Concluding Observations: Honduras*, para. 17, U.N. Doc. CCPR/C/HND/CO/2 (2017); *Concluding Observations: Jamaica*, paras. 25-26, U.N. Doc. CCPR/C/JAM/CO/4 (2016).

⁸¹ Human Rights Committee, *Gen. Comment No. 36*, *supra* note 13, para. 8.

⁸² S.3(4), India's Medical Termination of Pregnancy Act, 1971.

⁸³ 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, *supra* note 6, at 111.

⁸⁴ See, e.g., CRC Committee, *Gen. Comment No. 15*, *supra* note 79 para. 31; CRC Committee, *Gen. Comment No. 20*, *supra* note 79, para. 60; See also CEDAW Committee, *Concluding Observations: Timor-Leste*, para. 31(a), U.N. Doc. CEDAW/C/TLS/CO/2-3 (2015); CRC Committee, *Concluding Observations: India*, para. 66(b), U.N. Doc. CRC/C/IND/CO/3-4 (2014); CEDAW Committee, *Concluding Observations: Kuwait*, para. 43(b), U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).

⁸⁵ Human Rights Committee, *Gen. Comment No. 36*, *supra* note 13, para. 8.

⁸⁶ CEDAW Committee, *General Recommendation No. 33: On women's access to justice*, para. 25(c), U.N. Doc. CEDAW/C/GC/33 (2015) [hereinafter CEDAW Committee, *Gen. Recommendation No. 33*].

- ⁸⁷ 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, *supra* note 6, at 41.
- ⁸⁸ S.19(1), 21, India's Protection of Children from Sexual Offences Act, No. 32, 2012.
- ⁸⁹ S.7(1)(c), India's Medical Termination of Pregnancy Act, 1971.
- ⁹⁰ 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, *supra* note 6, at 35.
- ⁹¹ 2018 NHRC Country Assessment of Sexual Health and Reproductive Health Rights, *supra* note 6, at 42.
- ⁹² CRC Committee, *Gen. Comment No. 20*, *supra* note 79, paras. 39-40.
- ⁹³ CRC Committee, *Gen. Comment No. 20*, *supra* note 79, para. 40.
- ⁹⁴ CRC Committee, *Gen. Comment No. 20*, *supra* note 79, paras. 39, 46, 60.
- ⁹⁵ India National Commission on Population, National Population Policy 2 (2000), available at <https://india.unfpa.org/sites/default/files/pub-pdf/NationalPopulation-Policy2000.pdf>; International Institute for Population Sciences (IIPS) and ICF. 2017. *National Family Health Survey (NFHS-4)*, 171, 2015-16: India. Mumbai: IIPS [hereinafter 2015-16 NFHS].
- ⁹⁶ See 2015-16 NFHS *supra* note 71 at 111 (stating that female sterilization is the most commonly used contraceptive method among women aged 15-49).
- ⁹⁷ See 2015-16 NFHS, *supra* note 71, at 112.
- ⁹⁸ 2015-16 NFHS *supra* note 71 at 112.
- ⁹⁹ 11th COMMON REVIEW MISSION 3, 54 (2017), available at http://nhsrcindia.org/sites/default/files/11th%20CRM_Report_Web.pdf.
- ¹⁰⁰ 2015-16 NFHS, *supra* note 71, at 141.
- ¹⁰¹ Center for Reproductive Rights and Human Rights Law Network, Re: *Supplementary Information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its 58th Session (July 2014)* (Shadow Report), 19 June 2014. Online: <http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/INT_CEDAW_NGO_Ind_17_511_E.pdf>. See also: Vidya Krishnan, "Doctor freed in Bilaspur sterilisation case", *The Hindu* 21 February 2017, online: <<http://www.thehindu.com/news/national/other-states/sterilisation-deaths-in-chhattisgarh-doctor-freed/article17336215.ece>>.
- ¹⁰² Dipika Jain and Natassia Rozario, *Voices From The Field: Barriers To Contraceptive Information And Services In The State Of Haryana* (2013).
- ¹⁰³ Annie Gowen, *Indian investigators suspect tainted drugs involved in botched sterilizations*, WASHINGTON POST, Nov. 14, 2014; Maneeza Naqvi, *Doctor arrested after India sterilization deaths*, USA TODAY, Nov. 13, 2014; *Botched sterilizations kill 12 in India*, ALJAZEERA AMERICA, Nov. 12, 2014.
- ¹⁰⁴ Milind Ghatwai, *No sterilisation, no ration: MP Sarpanch's new order*, THE INDIAN EXPRESS, Mar. 8, 2012.
- ¹⁰⁵ Jason Burke, *Indian women die after state-run mass sterilisation campaign goes wrong*, THE GUARDIAN, Feb. 7, 2016.
- ¹⁰⁶ *Id.*
- ¹⁰⁷ Sugam Pokharel and Sumnima Udas, *India: 11 women die, 62 more hospitalized after being paid to be sterilized*, CNN, Nov. 12, 2014.
- ¹⁰⁸ Raksha Kumar, *India's lethal contraception culture*, ALJAZEERA AMERICA, Feb. 4, 2016.
- ¹⁰⁹ *Chhattisgarh: Negligence, sub-standard drugs led to sterilisation camp deaths*, INDIA TODAY, Dec. 24, 2015.
- ¹¹⁰ Kirite Jiturekha Chauhan, *'Patriarchal' India is pushing women into sterilisation since 44 years*, IAMIN, Feb. 5, 2015.
- ¹¹¹ Deepu Sebastian Edmond, *Jharkhand: Sterilisation procedures not under flashlight, but other violations found*, INDIAN EXPRESS, Jan. 10, 2015.
- ¹¹² CEDAW Committee, *General Recommendation No. 24: On women and health*, para. 22, U.N. Doc. A/54/38/Rev.1, chap. I (1999) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; CRPD Committee, *General Recommendation No. 1: On equal recognition before the law*, para. 35, U.N. Doc. CRPD/C/GC/1 (2014) [hereinafter CRPD Committee, *Gen. Recommendation No. 1*].
- ¹¹³ CRPD Committee, *General Comment No. 3: On women and girls with disabilities*, para. 32, U.N. Doc. CRPD/C/GC/3 (2016) [hereinafter CRPD Committee, *Gen. Comment No. 3*]; CAT Committee, *Concluding Observations: Peru*, para. 19, U.N. Doc. CAT/C/PER/CO/5-6, (2012); CAT Committee, *Concluding Observations: Czech Republic*, para. 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012); CEDAW

Committee, *General Recommendation No. 35: On gender-based violence against women*, para. 18, U.N. Doc. CEDAW/C/GC/35 (2017) [hereinafter CEDAW Committee, *Gen. Recommendation No. 35*].

¹¹⁴ A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, para. 11.2, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

¹¹⁵ Human Rights Committee, *Concluding Observations: Namibia*, para. 12(b), U.N. Doc. CCPR/C/NAM/CO/2 (2016).

¹¹⁶ CEDAW Committee, *Gen. Recommendation No. 35*, *supra* note 112, para. 18; CEDAW Committee, *Concluding Observations: Slovakia*, para. 33(d), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CEDAW Committee, *Gen. Recommendation No. 33*, *supra* note 85, para. 19(d); CEDAW Committee, *Concluding Observations: Barbados*, paras. 41-42 U.N. Doc. CEDAW/C/BRB/CO/5-8 (2017).

¹¹⁷ MINISTRY OF HEALTH AND FAMILY WELFARE (hereinafter MOHFW), STANDARDS FOR FEMALE AND MALE STERILIZATION SERVICES (2006), MOHFW, QUALITY ASSURANCE MANUAL FOR STERILIZATION SERVICES (2006), MOHFW, STANDARD OPERATING PROCEDURES FOR STERILIZATION SERVICES IN CAMPS (2008), MOHFW, OPERATIONAL GUIDELINES ON FIXED DAY STATIC APPROACH FOR STERILIZATION SERVICES UNDER THE FAMILY PLANNING PROGRAMME (2008).

¹¹⁸ HUMAN RIGHTS LAW NETWORK, FACT-FINDING REPORT ON STERILIZATION, ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES, AND WOMEN'S HEALTH IN BILASPUR DISTRICT, CHHATTISGARH, at 16-17 (2014).

¹¹⁹ Devika Biswas v. Union of India & Others (2016) 10 SCC 726, para. 112.

¹²⁰ *Id.* para. 133.

¹²¹ *Id.* paras. 113-113.15.

¹²² *Id.* para. 13.

¹²³ *Id.*

¹²⁴ *Id.* para.10.

¹²⁵ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, and the Special Rapporteur on violence against women, its causes and consequences, AL IND. 3/2015 (Mar. 11, 2015).

¹²⁶ *Id.*

¹²⁷ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, and the Special Rapporteur on violence against women, its causes and consequences, AL IND. 14/2015 (Nov. 17, 2015).

¹²⁸ MOHFW, *Implementation of directions of Hon'ble Supreme Court available at* <http://www.nhm.gov.in/nrhmc-components/rmnc-h-a/family-planning/family-planing.html>.

¹²⁹ MOHFW, ANNUAL REPORT (2017-18).

¹³⁰ P Srinivasan, *Incision blade breaks, gets stuck in Rajasthan woman's abdomen in sterilization camp*, Hindustan Times, Jan. 17 2019 available at <https://www.hindustantimes.com/india-news/incision-blade-breaks-gets-stuck-in-rajasthan-woman-s-abdomen-in-sterilization-camp/story-xWLq6yVvsOyM8g3V23aPMI.html>

¹³¹ Human Rights Council, Report of the Human Rights Council on its Thirty-Sixth Session, U.N. Doc. A/HRC/36/10, (Sep. 11-29, 2017).

¹³² CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 112, para. 28; Human Rights Committee, *Concluding Observations: Paraguay*, para. 13 U.N. Doc. CCPR/C/PRY/CO/3 (2013); CRC Committee, *General Recommendation No. 15*, para. 69.

¹³³ A.S. v. Hungary, CEDAW Committee, Commc'n No. 4/2004, para. 11.2, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

¹³⁴ See Human Rights Committee, *Concluding Observations: Paraguay*, para. 13 U.N. Doc. CCPR/C/PRY/CO/3 (2013); see also Human Rights Committee, *Concluding Observations: Paraguay*, para. 13, U.N. Doc. CCPR/C/PRY/CO/3 (2013).