June 3, 2024

Human Rights Committee
Office of the High Commissioner for Human Rights (OHCHR)
Palais Wilson
52, rue des Paquis
CH-1201 Geneva – Switzerland

Re: Supplementary Information on India, Scheduled for Review by the Human Rights Committee during its 141st Session on 1-23 July 2024

Honorable Committee Members,

The Centre for Justice, Law and Society (CJLS) at Jindal Global Law School and CommonHealth respectfully submit this letter to assist the Human Rights Committee in its review of India's compliance with the International Covenant on Civil and Political Rights (ICCPR) for consideration in the Concluding Observations for India.

About the Contributors

1. The Centre for Justice, Law and Society (CJLS), Jindal Global Law School is a multidisciplinary research centre that critically engages with contemporary issues at the intersection of law, justice, society and marginalization in South Asia. CJLS has been a thought leader in the domain of Reproductive Justice and Trans Justice in India, leading academic and advocacy efforts towards increasing access to abortions, contributing towards legal reforms, and addressing literature gaps through our scholarship on issues of sexual and reproductive health and rights.

2. CommonHealth is a rights-based, multi-state coalition of organizations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities. CommonHealth concentrates its efforts mainly on maternal health and safe abortion. The coalition draws its membership from diverse disciplines, thematic areas and geographies within the country.

I. BARRIERS TO SAFE, LEGAL AND AFFORDABLE ACCESS TO ABORTION SERVICES (Article 3, 6 (1) and 17(1))

The criminalization of abortion and conflicting laws in India instill widespread fear of prosecution among both abortion seekers and service providers. This fear often results in life-threatening situations for pregnant persons, who are either compelled to resort to unsafe abortions or endure unwanted pregnancies for extended periods. The Human Rights Committee's General Comment No. 36 on Article 6 of the ICCPR marks a significant step toward securing the rights to equality and non-discrimination and ensuring the right to life for women and girls [1] and includes preventing foreseeable threats and life-threatening conditions that may not immediately result in loss of life but still pose significant risks[2]. Safe, legal and effective access to abortion is a human right protected under the ICCPR, with the right to life beginning at birth. States are obligated to ensure this access, especially when pregnancy endangers health or causes significant pain or suffering.[3] They must eliminate any abortion restrictions that threaten lives, cause suffering, discriminate, or violate privacy and must remove barriers that deny access, including those from healthcare providers' conscientious objections.[4] States must not introduce new barriers or regulate pregnancy and abortion in ways that force unsafe abortions, such as third-party authorization and criminalizing those who seek or provide abortions. Revision of abortion laws to align with these obligations is essential in protecting the decisional autonomy, health and rights of women and girls globally.

Nevertheless, the continued imposition of criminal penalties for abortion in India impedes access to safe abortion services. Sections 312 -318 of the Indian Penal Code (IPC) criminalize access to abortion services in manifold ways. Section 312 criminalizes anyone who causes a 'miscarriage,' including the pregnant woman herself, unless the procedure is done in good faith to save the woman's life.[5] Notably, these provisions have been replicated in the recently enacted reforms to the criminal laws in India. Sections 86-92 of the revised Bhartiya Nyaya Sanhita 2023 retain the criminal framework of the IPC. The Medical Termination of Pregnancy Act (MTPA), 1971, was introduced as an exception to section 312 of the IPC, permitting registered medical practitioners (RMPs) to provide abortion services up to 20 weeks' gestation, only under circumstances including a risk to the woman's life, serious physical or mental health risks, instances of rape or incest, significant fetal anomalies and failure of contraception. There have been significant changes in the abortion law framework due to amendments to the MTPA in the years 2002 and 2021. These amendments have created a more permissive framework by extending the law's benefits to pregnant persons irrespective of their marital status, though some limitations remain. The most recent changes to the law were in 2021, and these increased the gestational age limit for terminating a pregnancy, permitting abortions up to 20 weeks (previously permissible only up to 12 weeks)[6] with the approval of one RMP and between 20-24 weeks with the approval of two RMPs.[7]

The law now allows specific 'special categories of women', such as those experiencing a change in marital status, unmarried women, emergency or humanitarian settings and survivors of rape or incest, to seek abortion services between 20-24 weeks.[8] Abortion services can be provided for pregnancies exceeding 24 weeks in instances of 'substantial fetal abnormalities' confirmed by a Medical Board (including a gynecologist, a pediatrician, a sonologist or radiologist and any other members as notified by the state)[9] to be established in each district.[10] However, terminations in the later stages of pregnancy due to other conditions are prohibited, regardless of the health and safety of the pregnant person, thus creating a form of "disability exceptionalism."[11] Arguably, if termination poses no risk, it should be allowed for all late-term pregnancies.

Under Sections 3 and 5 of the MTPA, the medical practitioner's opinion is paramount, undermining the pregnant person's agency in deciding about their pregnancy. The requirement for approval from an RMP often leads to the denial of services, forcing pregnant persons to seek abortions outside medical facilities in unsafe conditions. Studies show that medical practitioners have asked pregnant persons to obtain judicial permission even for pregnancies under 20 weeks, which can be lawfully terminated as per the scheme of the MTPA.[12] Therefore, the law regulating access to abortions in India adopts a provider-centric framework that grants medical practitioners arbitrary discretion in deciding who can access safe abortion services.[13] This has led to a continued reliance on the judiciary to authorize termination requests, and the judicial position is largely inconsistent.

In addition to the IPC, the Protection of Children from Sexual Offences Act, 2012 (POCSO) and the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 (PCPNDT) further restrict access to abortion services. POCSO classifies all sexual contact with minors as sexual offenses and imposes a mandatory reporting (Section 19) requirement for all unlawful sexual activity under this Act.[14] This provision mandates that any sexual offense involving a 'child' (defined as a person below 18 years) under POCSO must be reported to law enforcement.[15] While the Act does offer protection to children and adolescents who are survivors of rape, sexual assault, or sexual harassment, it also broadly criminalizes adolescent sexuality. This criminalization hampers sexual and reproductive health education for adolescents, as the law assumes their abstinence. It also complicates access to necessary medical care for sexual and reproductive healthcare (SRHR) services resulting from consensual sex.

Further, POCSO deters adolescents from seeking medical assistance for post-abortion complications. It increases the prevalence of illegal abortions and risks criminalizing healthcare providers who offer abortion services to adolescents without reporting these incidents as sexual assaults, as required by the law. For example, in 2022, a gynecologist was arrested for terminating the pregnancy of a 13-year-old girl in Maharashtra. Despite the circumstances indicating consensual involvement with a 17-year-old boy, the incident fell under the purview of the POCSO. The RMP faced charges of unlawful abortion, among other offenses, under IPC.[16] In many Indian states, mandatory reporting under POCSO has obstructed safe abortion access for adolescent girls who are often hesitant to engage with the legal system, especially given the criminal consequences that follow for their partners who will be charged with statutory rape.[17]

Further, the text and objectives of the PCPNDT are entirely distinct from the MTPA. PCPNDT does not regulate abortion access and only prohibits pre-conception and pre-natal diagnostic screenings. PCPNDT’s stringent penal provisions and stringent implementation have negatively impacted pregnant persons' right to access abortion. This Act targets RMPs providing abortion services, often under suspicion of engaging in gender-biased sex selection.[18] This has created a hostile medico-legal environment for accessing abortion services.[19] Denial of abortion services forces pregnant persons to either continue with unwanted pregnancies or resort to clandestine abortions, which may increase the risk of post-abortion complications and add to their physical and mental trauma. This situation is further complicated by existing structural barriers, including inadequate public healthcare facilities and the prohibitive costs of private healthcare, which make safe abortion services increasingly inaccessible, with a disproportionate impact on marginalized persons.[20]

Despite robust constitutional jurisprudence on reproductive rights, decisional autonomy of pregnant persons, and the constitutional rights to healthcare, privacy, dignity, and life and liberty of persons as enumerated in several cases, the most recent being *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi*[21], the right to access safe abortions remains largely aspirational for most pregnant persons in India. Restrictive and punitive laws, such as the IPC and the MTPA, coupled with POCSO and PCPNDT, criminalize induced abortion services and impose stringent conditions for accessing legal abortion services. The law suffers from ambiguity, resulting in a "chilling effect" on RMPs and pregnant persons.

Therefore, significant barriers obstruct pregnant persons' access to safe and legal abortion services. Lack of access (SRHR) services for pregnant persons contravenes the right to equal enjoyment of all civil and political rights under Article 3 of the ICCPR. Article 6 of the ICCPR notes that State parties must ensure that no one is arbitrarily deprived of their right to life.[22] The widespread fear of persecution resulting from the criminalization of abortion forces pregnant persons to seek unsafe abortions or delay timely abortions, thereby exposing them to life-threatening situations contrary to the Right to Life. Article 6 of the Covenant notes that State parties must ensure that no one is arbitrarily deprived of their right to life.[23]

General Comment No. 36 further notes that State Parties must ensure that existing restrictions on women's or girls' ability to seek abortions do not endanger their lives or subject them to physical or mental pain or suffering, in violation of Article 7.[24] The law on abortion in India is provider-centric and adopts a carceral framework. The institutionalization of Medical Boards and increased reliance on judicial authorization for abortions further complicate the contours of access by stripping pregnant persons of reproductive rights and decisional autonomy and granting medical professionals and State authorities the power to interfere with their reproductive decisional autonomy arbitrarily. The right to retain and exercise individual autonomy over one's body and mind and the decision to bear a child is protected by the right to privacy,[25] which is enumerated under Article 17 of the Covenant. The interference of third parties in deciding whether a pregnant person is allowed to terminate their pregnancy also defeats this right.

A. **Access to Abortion Services by Adolescents**

In India, any sexual activity involving a person below the age of 18 is a criminal offense, as per POCSO. POCSO mandates that any person with knowledge of a sexual offense against a minor must report this information and failure can lead to imprisonment for up to six months, a fine, or both.[26] This provision often provokes reluctance by medical professionals to provide abortions to adolescents. For example, in 2021, a medical practitioner in Meghalaya was arrested under POCSO for attempting to provide abortion services to an adolescent who had only sought the abortion to prevent her partner from being charged with rape.[27]

This mandatory reporting provision conflicts with the MTPA's confidentiality provision and impedes adolescent girls' access to reproductive healthcare services.[28] Analyzing cases under POCSO and MTPA from 2020 to 2022 revealed that when adolescents became pregnant from consensual sexual relationships but wanted abortions, the adolescent's consent was deemed

irrelevant since it did not constitute 'legal consent.'[29] Instead, the decisions highlighted the victimhood of the pregnant "child" and the circumstances of the "unborn child." [30] A Court ruling also underscored the inherent nature of motherhood, citing Hindu religious scriptures to describe abortion as a sin.[31] A study found that mandatory reporting led to delays or denial in accessing safe reproductive health services and prompted adolescent girls to seek unsafe abortion services.[32] In one instance, an adolescent girl who had been raped by her father did not want to report the incident. An RMP denied her abortion services, insisting she first file criminal charges to access them, which compelled her to seek a clandestine abortion.[33] These examples highlight how the interplay between POCSO and MTPA can result in the criminalization of people in different scenarios and hinder access to safe and legal abortion services.

According to the National Family Health Survey (2019–21), 10% and 39% of women (aged 25-49 years) had sexual intercourse before the ages of 15 and 18 respectively.[34] A 2016 study of adolescent behavior in Bihar found that 41% of boys and 17% of girls engaged in premarital sex.[35] Furthermore, a study by the Guttmacher Institute revealed that of the two million pregnancies that occur among adolescents in India each year, 53% of them end in abortion, resulting in 930,000 abortions annually.[36] Despite these compelling statistics, POCSO's criminalization of adolescent sexual activity disproportionately limits adolescents' reproductive autonomy and healthcare choices. This requirement overlooks the evolving sexual capacities of adolescents, fails to distinguish cases of child sexual abuse and instead obstructs abortion access for adolescents, regardless of whether the pregnancy is a result of consensual activity or abuse.[37]

B. **Surveillance, Harassment, Intimidation, and Fear of Prosecution**

The regulation of abortion access through criminal laws serves as a mode of surveillance, harassment and fear resulting in discrimination against pregnant persons and service providers. These perpetuate gender stereotypes, punish personal decisions about one's body and life choices, and create a picture of appropriate forms of sex. Criminalization of abortion does not decrease the number of abortions that take place but instead increases unsafe abortions that risk harming a person's health and life. Such criminal laws have also been found to violate the right to health, non-discrimination, privacy and bodily autonomy.[38]

In *X v. The Principal Secretary,* [39] the Supreme Court recognized that the current framework of criminal laws creates a fear of prosecution, which has a chilling effect on RMPs who offer abortion services, thus affecting access to safe and legal abortions. [40] The threat of prosecution leads to requiring extra-legal documentary proofs and familial consent that are not mandated by law, and non-production of these leads to denial of abortion services, prompting pregnant persons to seek recourse from courts, which inevitably leads to delays in accessing SRH services.[41]

Service providers are also often brought within the ambit of family disputes, where the abortion service is seen as a means to aid one of the parties in the dispute. In a case before the Delhi High Court concerning a divorce proceeding, the prosecutrix had filed a police complaint against her husband and two RMPs under section 315 of the IPC for an "act done with intent to prevent a child being born alive or to cause it to die after birth."[42] According to the prosecutrix, the husband had, in a fit of frustration, told his wife that he had asked the accused RMP lie to the prosecutrix that she had suffered a miscarriage when in reality, he had convinced them to terminate the pregnancy.

Evidence revealed that the complainant had visited another RMP before the termination, who found no fetal heartbeat. Based on this finding, the accused RMP was referred to confirm the diagnosis and perform a dilatation and evacuation (D&E) procedure with the prosecutrix's consent. The Court noted that the D&E procedure was conducted to save the life of the prosecutrix and set aside the summoning order against the accused doctor.[43] This decision, however, came 4 years after the summoning order was issued resulting in substantial harassment of the RMP.

In an anticipatory bail matter before the Bombay High Court, a medical practitioner who had terminated the pregnancy of an adolescent was charged under sections 312 and 315 of the IPC.[44] The adolescent's father had falsely informed the service provider that his daughter was 18 years old. The Court noted that the service provider had adhered to the provisions of MTPA by seeking the opinion of a second RMP before abortion, with consent from the parents and the adolescent. The Court determined that section 313 was not applicable, and section 312 of the IPC was bailable. In this case, despite bail being granted eventually, it is evident that there was unwarranted arrest, imprisonment, and trial of an innocent RMP, likely instilling fear within the entire community.[45]

In a similar instance, a medical practitioner was accused of committing an offense under section 313 of the IPC for terminating the pregnancy of a 17-year-old minor who was in a relationship with a minor boy.[46] The police had registered offenses under POCSO and IPC against the minor boy. The adolescent and her mother had represented the adolescent as a married woman of age, and the abortion had been conducted at their behest. The Court granted anticipatory bail to the accused practitioner and observed that if the RMP was not protected by anticipatory bail, other persons awaiting services from the provider would be jeopardized.[47]

A study[48] highlighted that "The MTP and PCPNDT Acts are distinct in content, addressing two completely different types of facilities with no cross-referencing. Despite this, at the implementation level, most authorities tend to conflate the two and speak of 'preventing sex-selective abortions."[49] 17 of the 19 medical providers interviewed avoided providing second-trimester abortions due to the probability of pre-natal gender determination. One of the respondents in the study claimed, "It does not make any difference to my practice if I say no to providing an abortion, but it makes a great difference to my practice if I do an abortion and it turns out to be a female fetus."[50] A second respondent echoed these sentiments, "Though I am authorized to do MTP up to 20 weeks in our hospital, still we are not doing abortions after ten weeks. We make sure that women do not abort at our hospital in the second trimester. Because we don't know if it is sex-selective abortion or not, so it is better to keep ourselves away from it."[51]

Many medical practitioners are fearful of the strict surveillance, harassment, penalties and repercussions under PCPNDT and thus refuse to provide abortions. While there are limited successful prosecutions under the PCPNDT, especially regarding complaints of gender-biased sex selection, the law has been utilized to harass RMPs.[52] The interpretation of these laws, together and separately, invites a broad range of legal offenses associated with abortion services, which can potentially hold RMPs, consensual partners (adolescents), family members and most significantly, the pregnant persons criminally liable.[53]

C. **Institutionalization of Third-Party Authorization**

The 2021 Amendment to the MTPA institutionalized medical boards in every Union Territory and State to diagnose fetal anomalies in pregnancies where termination was sought after 24 weeks of gestation. A 2022 study by Centre for Justice, Law and Society found that forming medical boards was impractical or impossible in the country due to limited medical personnel. Most Indian states face a shortfall of over 80% in the availability of gynecologists and obstetricians in public healthcare institutions.[54] In rural North India, there is an 84% shortfall in obstetricians and gynecologists, 68.76% in pediatricians, and 74.5% in radiologists. Similarly, rural South India faces a 57.2% shortfall in gynecologists and obstetricians, 61.4% in pediatricians, and 68% in radiologists. States such as Arunachal Pradesh, Meghalaya, Mizoram, and Sikkim have recorded a near 100% shortfall in the availability of specialists, especially in rural areas.[55] Additionally, a 2020 study in a district in West Bengal showed that 30 out of 42 health facilities did not provide abortions. Of the remaining 12, only three secondary-level facilities in urban areas provided MTP services in the second trimester, and only two had female service providers. Only 11 of the 42 facilities had trained doctors.[56]

The shortage of medical professionals makes the process of constituting and conducting board proceedings delay legal decisions,[57] adversely impacting pregnant individuals. For example, in *Ms. Z v. State of Bihar*, delays by the Patna High Court caused the petitioner to endure an unwanted pregnancy for 36 weeks.[58] When the petitioner sought relief from the Supreme Court, the Court found the pregnancy too advanced for termination but ordered the State to pay INR 10 Lakhs as compensation, citing negligence by the State and the High Court.

Third-party authorizations can be burdensome and result in delays (given that these cases are time sensitive) in granting abortions. This is particularly true in the case of late-term abortions with judicial authorizations. In *X v Union of India*,[59] a married woman with post-partum psychosis and suicidal tendencies approached the Supreme Court seeking permission to terminate her 25-week-long pregnancy, given her mental health. The Court declined the petitioner's request after the Medical Board found that there was a viable fetus and no substantial anomalies. A two-judge Bench initially approved the termination, which was revoked after the presiding doctor of the Medical Board raised concerns about the termination due to fetal viability. Subsequently, a three-judge bench refused the termination despite demonstrated risk to the petitioner's life, compelling her to carry the pregnancy to term and surrender the child for adoption to the State. Proceedings before the medical board resulted in significant delays, and by the time the decision was made, gestation was almost 28 weeks. The medical board's report refused to perform 'feticide' and sought permission from the Court to proceed with the procedure. However, the Court declined to make the decision, ultimately leading to denial of abortion.[60]

Feticide is widely and safely practiced worldwide and is endorsed by the Ministry of Health and Family Welfare guidelines for late-stage abortions after 24 weeks. A study reported a 95.1% success rate in terminating pregnancies using this method.[61] In 2021, an obstetrician-gynecologist was seen to have performed feticides for authorized pregnancies beyond 24 weeks, suggesting that this could become a standard practice.[62]

Denial of termination to a person with mental health concerns aggravated by unwanted pregnancy constitutes cruel, inhuman, and degrading treatment resulting in violation of Article 7 of the

Covenant. The Human Rights Committee's General Comment No. 36 records that State Parties are obligated to ensure that any existing restrictions on women's or girls' access to abortions do not put their lives at risk or expose them to physical or mental anguish, which would contravene Article 7 of the Covenant.[63] In the case of *Mellet v. Ireland*, the Committee observed that a legislative framework causing intense physical and mental suffering to pregnant individuals by denying them adequate healthcare and safe abortion constitutes cruel, inhuman and degrading treatment under Article 7 of the ICCPR.[64]

The CEDAW Committee, in its General Recommendation No. 35, acknowledged that denying or delaying safe abortion services and coercing the continuation of pregnancy constitute forms of gender-based violence that could potentially amount to torture or cruel, inhuman or degrading treatment, as prohibited under the ICCPR. The Committee further observed that the prohibition of gender-based violence against women has evolved into a principle of customary international law.[65]

In India, the combined effect of various legislative farmwork has created a draconian carceral legal framework, creating a "chilling effect" on abortion service providers.[66] This has led to MRPs' reluctance to provide abortion services pushing abortion seekers to seek permission from the judiciary or causing significant delays in accessing these services, violating the rights enshrined under Articles 2 and 26 of the ICCPR.

In another case, *H v Union of India & Another*,[67] the High Court of Delhi denied the request for termination of a 27-week pregnancy by a 20-year-old unmarried student, relying on the Medical Board report that noted no substantial fetal anomalies nor any risk to the life of the petitioner if she were to carry the pregnancy to term. The Court accordingly denied the request, and this decision was also upheld in an appeal to the Supreme Court despite the pregnant person requesting termination to avoid grave injury to her physical and mental well-being.[68] These cases highlight the arbitrary decision-making power and detrimental impact of medical boards on the mental and physical health of pregnant persons.

Denial of reproductive healthcare, either because of refusal to initiate criminal proceedings or inaccessibility due to fear of prosecution of the male partner, reflects a failure on the part of the State in its responsibility to protect the right to life under Article 6(1)[69] and the right to not be subjected to arbitrary interference under Article 17 of ICCPR.[70] Third-party authorization amounts to an undue invasion of the pregnant person's privacy and bodily autonomy and leads to delays in seeking abortion services. The State fails in its obligation to fulfill the rights under the ICCPR by not providing adequate healthcare infrastructure at all levels of the public healthcare system and in remote and rural settings. These factors cumulatively create cascading barriers to accessing abortions and instead redirect people to seek unsafe abortions that carry grave risks to their lives.

II. REPRODUCTIVE AUTONOMY, THE RIGHT TO SUBSTANTIVE EQUALITY AND NON-DISCRIMINATION AND FREE FROM INHUMAN AND CRUEL TREATMENT (Article 2, 7, 17, 26)

The lack of safe and affordable access to abortion services infringes on reproductive health rights and decisional autonomy, often forcing individuals to carry unwanted pregnancies to term. Laws and policies that restrict sexual and reproductive freedom, ignoring the physical and mental well-being of pregnant individuals, deepen social inequalities and hinder marginalized groups' access to sexual and reproductive health (SRH) services, violating the right to life, equality and non-discrimination under Articles 2 and 26 of the ICCPR. Article 7 of the ICCPR forbids subjecting individuals to torture or cruel, inhuman, or degrading treatment or punishment. Moreover, the Indian law's provider-centric framework places pregnant individuals at the mercy of third parties like Medical Boards and Judiciary, leading to arbitrary and unwarranted intrusions into their decision-making processes, thus violating the right to privacy under Article 17.

A. Equal treatment and Non-discrimination

In General Comment No. 28, the Human Rights Committee noted that State Parties are required to take measures to help women prevent unwanted pregnancies and to ensure that they do not have to undergo life-threatening clandestine abortions.[71] In General Comment No. 22 on SRH, the Committee on Economic, Social, and Cultural Rights has observed that the right to SRH is intimately linked to civil and political rights underpinning the physical and mental integrity of individuals and their autonomy, such as the rights to life; liberty and security of person; freedom from torture and other cruel, inhuman or degrading treatment; privacy and respect for family life; and non-discrimination and equality.[72] In India, the lack of safe and affordable access to abortion for all pregnant individuals infringes upon the right to reproductive health, safeguarded under the right to life, freedom from cruel, inhuman, or degrading treatment, right to privacy, and right to equality as per the Covenant. The Supreme Court of India has already acknowledged the right to health, encompassing women's entitlement to survive pregnancy and childbirth and avail reproductive healthcare, as part of the State's constitutional obligation in cases such as *Laxmi Mandal v. Deen Dayal Harinagar Hospital* and *Jaitun v. Maternity Home*.[73]

Article 2 and 26 of ICCPR provide for equal treatment of all persons. There are systematic forms of discrimination rooted in gender, race, social class, and disability, which hinder individuals' access to information, education, and services related to SRH. These entrenched obstacles also deprive individuals, particularly those capable of pregnancy, of the ability to independently and meaningfully determine their reproductive choices, bodily autonomy and overall life trajectory. An analysis grounded in principles of equality is crucial, as it enables the court to examine the stereotypes and societal expectations that underlie laws governing reproductive health.[74] Moreover, it considers the financial and opportunity costs borne by women, particularly those from marginalized communities, due to laws, policies and practices that restrict access to reproductive healthcare and decision-making.[75]

B. Right to Privacy

The Human Rights Committee has emphasized that unreasonable and arbitrary interference with privacy violates State Parties' obligations under the Covenant to protect the right to privacy of all individuals.[76] The UN Working Group on Discrimination against Women and Girls has noted that

a woman's or girl's right to make autonomous decisions about her own body and reproductive functions is central to her fundamental rights to equality and privacy.[77] The Special Rapporteur on the Right to Health has argued that laws criminalizing abortion infringe on women's dignity and autonomy by severely restricting their decision-making regarding SRH[78] Based on its decision in *Mellet*, in *Whelan v. Ireland*, the Human Rights Committee noted that laws causing intrusive interference in a pregnant person's decision on how best to cope with their pregnancy could violate Article 17 of the Covenant.[79]

The Supreme Court of India has extensively addressed the rights to life and privacy in various cases. 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.[80]The Court noted that the right to privacy and decisional autonomy includes the right of reproductive choice, encompassing a person's right to decide whether to continue a pregnancy. In *X v. Principal Secretary*, the Court also discussed the jurisprudence on the right to privacy. Reiterating *Puttaswamy*, the Court noted that reproductive autonomy falls within the realm of privacy.

Case studies also document how third-party authorization strips away a pregnant person's right to privacy. For example, in a case where the pregnant person approached a private service provider for a second-trimester abortion due to a fetal anomaly, she was denied this service as the provider did not want to attract PCPNDT's provisions. In such cases, patients are referred to government hospitals, often located away from their homes, and this poses issues in explaining long absences to family members.[81] In another instance, an adult pregnant person who had run away from home and was at four weeks gestation sought to terminate her pregnancy. When she approached a hospital in Mumbai, she was denied services as she had no form of identifying documentation with her nor any family member to sign off on her forms. The civil society organization that was assisting the pregnant person found that such outcomes, where health providers deny abortion services on the grounds of unnecessary documentation and familial consent, occurred several times.[82]

Thus, in practice, a pregnant person lacks decisional autonomy despite the Supreme Court's articulation of reproductive autonomy. The pregnant individual is subjected to multiple medical examinations and third-party authorizations, violating their right to privacy since it is provided in the legislative framework. The increased instances of judicial authorization or denial of requests for terminations are indicative of a systemic issue of arbitrary State interference in determining the outcome of a pregnancy. As noted in *L.M.R v. Argentina*, the decision to terminate or carry a pregnancy, when taken by the judiciary, is an unlawful interference and violation of the right to privacy.[83]

C. Access to Abortion Services and Reproductive Justice

Global consensus on the imminent need for SRH concerns to be addressed in a rights-based framework emerged after the International Conference on Population and Development (ICPD) held in Cairo in 1994. The framework of reproductive justice builds on this SRHR framework. It is situated in the promise of fundamental human rights guarantees, such as the rights to life, health, privacy, information, freedom of expression, freedom from violence and discrimination, and

freedom from torture, cruel, inhuman and degrading treatment.[84] The framework of justice moves beyond the individualistic rights-based access to SRH to advocate for removing structural and systemic barriers impeding one's ability to enjoy sexual and reproductive freedom and centering the experiences of marginalized persons in developing laws and policies.[85] In 2023, the 8 March Principles were published by the International Commission for Jurists and these aim to address the detrimental impact of criminal laws on SRH, among other things, highlighting the disproportionate impact on marginalized groups.[86]

Although the MTPA permits abortions under certain conditions, unsafe abortions remain the third leading cause of maternal mortality in India, with nearly eight women dying every day due to complications from unsafe abortions. A survey by Arrow revealed that in states like Bihar, 78% of all abortions were performed clandestinely by private providers.[87] These figures indicate a significant lack of trust in the state and a fear of persecution. Heavy regulation of abortion services and prevalent 'anti-abortion' sentiment severely limit access to abortion services, particularly for marginalized individuals. Dalit, Indigenous and Adivasi persons, persons with disabilities, and transgender and gender-diverse persons are most adversely affected by these limitations. These groups often view the healthcare system as elitist, expensive and unapproachable and are 26% more likely to undergo unsafe abortions.[88] They also believe that seeking abortions through public health officials threatens their privacy and social status. Consequently, marginalized pregnant persons often prefer clandestine abortions over those provided in public hospitals despite the subsidized prices.

1. **Structural Barriers for Dalit, Indigenous and Adivasi Persons**

The current framework for accessing abortion services systematically excludes Dalit, Indigenous and Adivasi pregnant persons from exercising their bodily autonomy and accessing safe medical terminations of their pregnancies. For instance, Dalit women in Tamil Nadu reported having to visit public healthcare facilities three to five times to receive abortion services. While 60% of urban women reported that abortions were accessible, only 18% of rural women shared this belief, highlighting the disparity in healthcare access between rural and urban areas.[89] This gap further accentuates the barriers to abortion in rural settings, where there is only one medical practitioner for every 10,926 residents and 0.53 hospital beds per 1,000 people, placing India's public health system among the lowest in the world.[90]

Dalit and Adivasi women face "triple discrimination" based on their gender, class, and caste or Adivasi status, reflecting the deep-seated inequalities in public health services.[91] The case of Amita Kujur, an Adivasi girl and rape survivor, exemplifies these barriers. In 2016, Amita sought to terminate her twelve-week pregnancy at the District Hospital in Jashpur, Chhattisgarh, and later at the Chhattisgarh Institute of Medical Sciences. Despite being well within the twenty-week gestational limit stipulated by the MTP Act, she was required to obtain unnecessary documents, such as a reference letter and a copy of the first information report (FIR), to proceed with the termination. By the time she petitioned the Court, she was twenty-one weeks pregnant. Although the Court ultimately granted her request, citing her status as a rape survivor, the delay caused by unnecessary bureaucratic hurdles highlighted the systemic issues faced by Adivasi women.[92]

Shanti Devi's case highlights the structural barriers Dalit women face in accessing healthcare facilities. Shanti Devi was a Dalit landless migrant from Bihar. In 2008, she suffered a fall while she was pregnant and was initially taken to a local hospital. Later, she was moved to a hospital in Delhi that was fifty-five kilometers away. She was discharged after back and forth despite her weak physical condition. Although the Court intervened and demanded that Shanti be readmitted, she received no medical assistance or follow-up counseling. Eventually, Shanti became pregnant again and died soon after delivery.[93]

Kujur's case vividly highlights the challenges Adivasi women encounter when seeking abortion services, including the lack of availability in hospitals and the insistence on unnecessary formalities by medical professionals. These obstacles often result in delays in obtaining timely and affordable abortions. Research indicates that women from Adivasi communities in Chhattisgarh and Jharkhand frequently turn to private healthcare providers due to the inadequate accessibility and quality of public health facilities.[94] This situation contravenes Article 3 of the ICCPR, which requires State Parties to take steps to prevent unwanted pregnancies and ensure individuals do not resort to dangerous clandestine abortion services.[95] Such obligations stem from principles of equal rights and non-discrimination outlined in Article 26, guaranteeing equal legal protection and prohibiting discrimination on any basis, including race. Governments must uphold the principles of equality enshrined in Articles 2 and 26 by ensuring equitable legal protection and prohibiting discrimination based on factors such as race, caste, or ethnicity.

2. **Access to safe and legal abortion services for Persons with Disability**

In its submission on the SRHR Of Girls and Young Women With Disabilities to the General Assembly, the Special Rapporteur on the Rights of Persons with Disabilities noted that Women with disabilities account for almost one-fifth of the world's female population.[96] The Rapporteur also observed that women with disabilities will be unable to realize their rights until their SRH needs are met.[97] The Rapporteur, most significantly, noted that states are obligated to respect, protect and fulfil the SRHR of girls and women with disabilities under the ICCPR, CEDAW, Convention Against Torture, and CRPD. Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD) requires, that "States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination based on disability."[98] It specifically calls on State Parties to require that all healthcare professionals provide quality care to persons with disabilities based on their free and informed consent. There is a lack of awareness among persons with disabilities on the basic knowledge and support to protect themselves from sexual abuse, unwanted pregnancy and sexually transmitted infections.[99]

While the Act stipulates an upper gestational limit of 24 weeks for pregnancy termination, this limit does not apply in cases of substantial fetal anomalies. This omission results in disability-exceptionalism, promoting a eugenic narrative by implying that individuals with disabilities and fetuses with anomalies are 'less than whole.' The Act's ableist language devalues persons with disabilities and reinforces discriminatory social attitudes, portraying disabled individuals as unequal citizens.[100] For example, in the 2020 Supreme Court case *of Komal Hiwale v State of Maharashtra,* the Court granted the 25-week pregnant petitioner's request for a fetal reduction for one of her two fetuses since the fetus was diagnosed with Down Syndrome.[101] The Court held that

the fetus diagnosed with Down Syndrome may affect the other fetus and thus granted the plea. In *Dhanya Hari v Union of India*, the Kerala High Court granted allowed medical termination of pregnancy between 24 to 26 weeks due to fetal anomalies in the heart.[102] The courts have recognized the rights of pregnant individuals to seek medical termination when faced with fetal abnormalities, irrespective of the gestation period, even before the amendments in 2021, but have not allowed termination in cases based on marital status, socio economic conditions or mental health despite the wish of the pregnant person.

Section 92(f) of the Rights of Persons with Disabilities Act 2016 further promotes the ableist narrative since it stipulates that anyone who conducts a medical procedure on a woman with a disability, which leads to termination of the pregnancy, without her express consent, shall be liable to punishment with imprisonment for a term of at least six months, but which may extend to five years and an accompanying fine.[103] However, in cases of 'severe disability,' (this is not defined in law) the procedure can be conducted with the consent of the pregnant person's guardian. This provision raises concerns as it essentially disempowers persons with disabilities, stripping them of their agency. Moreover, criminalization in such scenarios can significantly hinder their access to SRHR, perpetuating inequality and marginalization.[104] For instance, Arpita, a 22-year-old person with a hearing disability, was forced to marry Alok, who also had a hearing disability. When Arpita missed her period, she visited a gynecologist who confirmed her pregnancy. However, after her checkup, she was asked to wait outside while her mother-in-law spoke with the doctor. Her mother-in-law then gave her a few pills, and within a few days, Arpita bled heavily. She then discovered that she was given abortion pills against her wishes and without her consent by her mother-in-law and the doctor.[105]

The infrastructural inaccessibility, lack of informational access, reasonable accommodations and supported decision-making models often make conversations on SRH exclusionary and violative of the bodily and decisional autonomy and right to privacy of persons with disabilities.[106] A 2015 paper highlights that persons with disabilities face significant physical and informational barriers to healthcare.[107] 36% of women with disabilities reported physical barriers in accessing the facility. This included no ramps or transportation and inappropriate examination tables. 22% cited long waiting hours, and 20% stated inaccessible toilets as impediments. 8% said that the attitude of healthcare providers was a barrier, and 6% of the women reported that assistance would have helped them better access the facility.[108] Additionally, most public healthcare facilities lack the resources to effectively communicate information on reproductive health and family planning to persons with disability.[109] These structural barriers often force them to be accompanied by a support person, reducing their privacy and preventing them from confidentially seeking abortion services.[110]

Perceptions about pregnant persons with disabilities as incapable parents or sexual actors prevent them from accessing crucial information on SRHR. For instance, Rohini, a partially visually impaired person, visited a gynecologist when she suspected she may be pregnant. The gynecologist confirmed her pregnancy but asked whether Rohini would like to continue the pregnancy.[111] Since Rohini was living with a disability, the gynecologist assumed that she would like to terminate her pregnancy, thereby reinforcing the prejudice that persons with disabilities are incapable parents.[112] This violates Article 2 and 26 of the ICCPR, which prohibits discrimination on any grounds and

guarantees equal protection under the law for all individuals. Additionally, Article 17 of the ICCPR forbids subjecting individuals to torture or cruel, inhuman, or degrading treatment or punishment.

3. **Access to safe and legal services for Transgender and Gender Diverse Persons**

Article 26 of ICCPR mandates non-discrimination and protection of all persons before the law. Several Committees, including General Comment No. 22 of the Committee on Economic, Social and Cultural Rights on the right to SRH has recognized that legal, procedural, social and other barriers to services restrict access and enjoyment of these services. This access is further restricted for individuals and groups, such as transgender and gender-diverse persons, who experience multiple and intersectional forms of discrimination that further heighten barriers to access.[113] This General Comment further recognizes that encompassed within the right of non-discrimination of SRHR are the rights of transgender, gender diverse and intersex persons who should be respected for their identities. Therefore, the Comment notes that equality and non-discrimination require not only formal equality but substantive quality that addresses the unique sexual and reproductive needs of different groups. [114]

The World Health Organisation's Abortion Care Guideline recognizes that transgender, non-binary, gender diverse, and intersex persons with the capability of becoming pregnant also need safe and legal abortion services. In recognition of this need, the guideline uses terminology such as 'individuals,' 'persons,' and 'abortion seekers.'.[115]

Abortions sought by transgender persons are conspicuously absent from the public health discourse. The MTPA refers only to women as pregnant persons, neglecting the fact that trans men can also become pregnant and may require abortions. However, the landmark judgment *X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi* recognized every pregnant person, including transgender and gender-diverse individuals, has a right to reproductive autonomy.[116]

Transgender and gender-diverse persons often encounter significant discrimination when seeking abortion services. Stereotypes linked to their identities heavily influence healthcare providers' perceptions and decisions, creating obstacles to accessing vital medical care. For example, Paras Dogra, who began advocating for trans men's rights at age 20, has faced discrimination while seeking medical attention for health issues.[117] Dogra has expressed feeling undeserving of medical care due to their transgender identity. Similarly, Nishu Yadav, a 21-year-old trans man from Hathras, Uttar Pradesh, encountered ignorance from local doctors upon coming out to his parents. Doctors dismissed the existence of transgender people, failing to acknowledge Yadav's healthcare needs, including potential abortion rights.[118] Yadav also recounts experiences of being misgendered and treated with bias by doctors, illustrating a violation of Article 26 of the ICCPR, which ensures the right to equality and non-discrimination for all individuals. Additionally, Article 7 of the ICCPR prohibits individuals from being subjected to torture or cruel, inhuman, or degrading treatment or punishment, including medical or scientific experimentation, without their free consent. Article 7 of ICCPR prohibits individuals from being subjected to torture or cruel, inhuman, or degrading treatment or punishment. In the context of the experiences described, the violation of Article 7 is evident in the mistreatment and bias that transgender and gender-diverse individuals like Nishu Yadav face when seeking medical care. Article 2 also stands contravened

since there is a substantial denial of necessary medical care and subjected to mistreatment by healthcare providers due to their transgender identity, which constitutes a clear violation of Article 2. By failing to provide equal access to healthcare services and allowing discriminatory practices to persist, States fail to uphold their obligation to ensure the rights enshrined in the Covenant without distinction.

D. Stereotypes

The *Mellet* case highlighted how the criminalization of abortion by the State subjected the complainant to a gender-based stereotype, viewing women primarily as mothers and reducing them to mere reproductive instruments, thereby subjecting them to discrimination. The Covenant Committee recognized that such stereotypes violate equality under Articles 2 and 26, hindering the non-discriminatory implementation of the Covenant.[119] The Special Rapporteur on Violence Against Women noted that laws requiring institutional authority consent for accessing reproductive health services often stem from harmful gender stereotypes, contributing to violence and mistreatment of women in reproductive health services.[120]

In *L.C. v. Peru*, L.C., a 13-year-old girl became pregnant following a rape and attempted suicide as a consequence.[121] The suicide attempt resulted in a severe spinal injury, but L.C. was denied emergency surgery needed to prevent permanent damage to her spine because she was pregnant. When she sought an abortion, the Medical Board denied the same, rendering her quadriplegic. The Committee held that the decision of L.C.'s doctors to postpone her surgery due to her pregnancy was influenced by the gender stereotype that views a woman's reproductive capacity as a duty rather than a right, affected by the stereotype. This case underscores how harmful gender stereotypes can lead to the denial of essential health services to women and girls, resulting in severe consequences for their health and well-being.[122] In *Navtej Singh Johar v. Union of India*, [123] the Supreme Court of India emphasized the need to dismantle discriminatory laws and practices grounded in harmful stereotypes to uphold constitutional rights, echoing the principles of non-discrimination and equality enshrined in Articles 26 of the ICCPR

In a study that undertook an audit of 54 abortion facilities across seven states in India, the Y.P. Foundation visited these abortion facilities and found that service providers in 38 facilities, 16 public facilities and 22 private facilities, were insistent on inquiring about the marital status of the abortion seeker.[124] Five private facilities in Punjab and one tertiary-level government facility in Assam denied abortion services to unmarried persons. Doctors at three private hospitals in Punjab informed that ultrasound scans are illegal for unmarried abortion seekers. An abortion seeker who had visited a facility in Assam recounted their experience, noting that marital status also determined the cost of service.[125]

An intersectional equality-based approach ensures marginalized women's reproductive autonomy by recognizing the complex interplay of factors like race, class, caste, and disability, thereby addressing their unique challenges and striving for their full reproductive rights. These laws and practices enforce gendered stereotypes and restrict women's decisional autonomy over their bodies, thereby violating both Article 2 and Article 26 of the ICCPR. By denying women equal protection under the law and subjecting them to discrimination based on their reproductive

decisional autonomy, these practices undermine the principles of equality and non-discrimination enshrined in the Covenant.

III. Recommendations

CJLS and CommonHealth humbly request that this Committee consider incorporating the following recommendations in its Concluding Observations to the Government of India.

1. It is urgent to transition from a punitive, criminal law approach to a rights-based perspective centered on reproductive justice and access to affordable, safe and legal abortion services. Currently, medical practitioners providing abortion services face fears of criminalization, harassment and punishment. Extra-legal factors influence the criminalization of abortion and perpetuate systemic inequalities based on caste, class, race, gender, religion, age and disability. Decriminalizing abortion under IPC is crucial to eliminating structural barriers, including third-party authorization and centering the pregnant person's decisional autonomy.

2. Laws regulating adolescent sexuality and access to reproductive health services, especially abortion, need reassessment. There is an pressing need tomove away from blanket criminalization of consensual sexuality for those under 18 and acknowledge adolescents' evolving sexual capacity. There is also an urgent need to do away with mandatory reporting provisions that hinder access to SRHR and abortion services by adolescents.

3. Conflicting laws exacerbate barriers to safe and legal abortion services. These laws create legal ambiguities and uncertainties, leading medical providers to refuse abortion services, even where legally permissible, due to fear of harsh penalties and lack of awareness. The State should harmonize laws affecting SRHR access.

4. The laws need to be reframed within a rights-based framework that prioritizes the well-being and autonomy of pregnant persons. Abortion must be allowed at the will/request of the pregnant person without additional regulatory barriers, such as gestational limits, eugenic rationale and third-party authorization. Abortion should be permitted as long as it is safe, regardless of the gestational period. Additionally, laws should address the structural barriers faced by marginalized persons including economic barriers.

5. The State should repeal laws and policies conflicting with international obligations and adopt guidelines aligning with global standards, particularly concerning late-term and medical abortions, as recommended by the World Health Organization and The International Federation of Gynaecology and Obstetrics.

6. There is a glaring gap between the number of RMPs and the need for safe and legal abortion services. The State should expand the provider base beyond RMPs to include trained nurses, midwives, and auxiliary nurses, especially for medical abortion services.

We hope this information is helpful to the Committee as it prepares to review the Indian government's compliance with the provisions of the Convention. If you have any questions or require further information, please do not hesitate to contact us at cjls@jgu.edu.in.

Thank you for your consideration.

Sincerely,

Centre for Justice, Law, and Society, Jindal Global Law School and CommonHealth India

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