

TIME TO RETHINK CRIMINALISATION OF ABORTION? TOWARDS A GENDER JUSTICE APPROACH

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Safe abortion ought to be considered a non-criminal healthcare procedure, accessible to everyone and decided upon between a patient and their physician. The current legal framework jeopardises the complete wellbeing of women and girls, leaving them confused, scared and unable to attain medically safe and affordable health services. In this paper, I argue that there is an urgent need for decriminalising abortions in order to allow women to have full power over the decisions regarding their health. Criminalisation has a chilling effect on the provision of sexual and reproductive health services. Further, I argue that abortion ought to be removed from the criminal domain and be considered an issue of equal access to healthcare within a gender justice framework.. Not only do barriers to abortion access lead to unsafe abortions and high maternal mortality rates, they also place an extraordinary burden of childrearing on women. The right to bodily autonomy and integrity is a fundamental right, and includes the right to reproductive and decisional autonomy. Additionally, if women are forced to carry unwanted pregnancies to term, their right to equality and non-discrimination is also violated due their inability to exercise other basic rights. Decriminalisation of abortion would mean that women, girls and gender diverse people are unable to exercise all their rights freely and would specifically ensure that their right to health is fulfilled as well.

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I. INTRODUCTION

At approximately 7:00 pm on November 19, 2012, a young woman named Halima set her live-in partner on fire while he was asleep in their rented home in Azad Nagar, Indore.¹ Halima was married with three children at the approximate age of nineteen or twenty. During the investigation, it came to light that in order to cohabit, the couple had disassociated from their respective spouses a few months ago. Halima alleged later that her partner had forced her into ‘prostitution’ and had connived a deal to sell her. Upon her conviction of murder under §302 of the Indian Penal Code, 1860,² (‘IPC’) she was sentenced to life imprisonment.

While in custody, Halima made a request to terminate a current pregnancy, alleging that the conception was an outcome of rape. She submitted the termination application to jail authorities, but due to the absence of any available procedural guidelines, the matter was forwarded to the Chief Judicial Magistrate who rejected her application.³ Later that year, when she was 11 weeks pregnant, she filed a petition in the Madhya Pradesh High Court,⁴ praying that the Court allow her to medically terminate her pregnancy. According to the Medical Termination of Pregnancy Act, 1971⁵ (‘MTP Act’) the anguish caused by any pregnancy due to rape is presumed to constitute a grave injury to a woman’s mental health and thus, meets the abortion authorisation requirements. While the Court held in favour of Halima and permitted her to terminate the pregnancy,⁶ it is imperative to note that the MTP Act did not and never has required judicial authorisation in order for a person to receive abortion services.

Recently, the Madras High Court expressed concern over women approaching the Court for judicial authorisation to terminate their pregnancy.⁷ The Court noted that rape survivors have often been compelled to approach the judiciary to obtain permission for abortion. The Court emphasised that where the gestational period does not exceed twenty weeks, it is within the power of medical practitioners to terminate the pregnancy in accordance with the conditions in the Act.

The palpable concern that arises is the subsisting trend wherein women and girls continue to seek judicial authorisation from the Court for abortion procedures. In this article, I examine the reasons behind this erroneous practice of women unnecessarily seeking judicial assent, as well as the imperative need to decriminalise abortions at will. Further, I argue that abortion services should be considered a non-criminal public health issue reflecting unequal access to care and should be available to all women and girls and gender diverse persons, irrespective of their marital status. Decriminalising abortion would allow women to freely exercise their right to decisional autonomy within a gender justice framework.

¹ Hindustan Times, *Undertrial Prison Jail Inmate Attempts Suicide*, December 19, 2012, available at <https://www.hindustantimes.com/bhopal/undertrial-pregnant-jail-inmate-attempts-suicide/story-cBd5GhrWIGn2KmW6tTVLpN.html> (Last visited on October 17, 2019).

² The Indian Penal Code, 1860, §302.

³ *Hallo Bi @ Halima w/o Aamin v. State of Madhya Pradesh*, W. P. 408 of 2013, ¶2.

⁴ *Id.*

⁵ The Medical Termination of Pregnancy Act, 1971, §3.

⁶ *Hallo Bi @ Halima w/o Aamin v. State of Madhya Pradesh*, W. P. 408 of 2013, ¶23.

⁷ *X v. The State*, Crl.O.P.No.14506 of 2019 and Crl.M.P.No.7043 of 2019.

This article first maps out the legal framework on abortion in India, primarily the criminal provisions and the MTP Act which regulates abortions. It then examines the two major barriers of access to safe abortion services: (1) third-party authorisation requirements, and (2) the law against sex-determination of foetuses. The article analyses how these barriers cause delays in accessing abortions as well as a chilling effect on medical practitioners, leading to denial of services especially for the marginalised people. This issue is compounded due to criminalisation, and marginalised women and girls are disproportionately impacted by restrictions on abortion access. The article also draws from national and international jurisprudence on reproductive rights to argue for a recognition of women's right to safe and affordable reproductive healthcare, including abortion services. The article argues that decriminalisation is necessary in order to ensure that women and girls can exercise their fundamental right to autonomy. Finally, the article concludes that any conversation – on legal reforms – on this issue must include wide, meaningful consultation with multiple stakeholder perspectives, and that the issue of access to abortion is not limited to women and girls only.

II. ABORTION LAW IN INDIA

Under the Indian Penal Code, abortion is a crime for both the woman and the doctor, except to save the woman's life.⁸ §312 criminalises abortion,⁹ making any person liable for causing the miscarriage of a woman with an unborn foetus (including the pregnant woman herself), except in circumstances in which the procedure is done in good faith order to save the woman's life. Such provisions in criminal law may be required to address situations where a woman's pregnancy is terminated due to intentional bodily harm or medical negligence. However, by failing to make a distinction between the termination of wanted and unwanted pregnancies, the law makes it extremely challenging for women to access safe abortion services at will.

The MTP Act was created to legislatively govern the exception to the criminalisation of abortion under §312 of the IPC, in order to enable medical practitioners to terminate pregnancies under certain conditions. As Nivedita Menon highlights, the MTP Act was passed “quite independently of the women's movement”¹⁰ and its real objective was family planning. Menon argues that the ‘right to abortion’ was never at the centre of the debate, as the dominant ideology has been – and continues to be – population control through, often coercive, family planning measures.¹¹ Thus, the MTP Act is doctor-centric and does not frame abortion

⁸ Siddhivinayak S. Hirve, *Abortion Law, Policy and Services in India: A Critical Review*, 12 REPRODUCTIVE HEALTH MATTERS 24, 114-124 (2004).

⁹ Indian Penal Code, 1860, §312 reads thus:

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

¹⁰ Nivedita Menon, *The Impossibility of 'Justice': Female Foeticide and Feminist Discourse on Abortion*, 29 CONTRIBUTIONS TO INDIAN SOCIOLOGY, 369–392 (1995).

¹¹ *Id.*

within a gender justice framework; it is the doctor who has the final say on whether a woman can get an abortion, as the doctor's opinion is decisive under the grounds and restrictions laid down in §3 and §5 of the Act. Arguably, any termination of pregnancy that does not fall within the rigorous confines of the MTP Act is deemed to be a criminal offence under §312 of the IPC, even when it is done with the woman's consent. While the MTP Act has been touted as a progressive legislation for women's rights yet gaps remain as the Act (and other legislations) continue to control and limit women's and girls' rights to abortion services. The MTP Act allows registered medical practitioners to perform abortions up to twenty weeks' gestation but only under certain conditions, laid down in §3. Medical practitioners, at certified medical facilities, are permitted to terminate a pregnancy if there is: (1) risk to the life of the woman, (2) risk of grave injury to her physical or mental health (taking into account her actual or foreseeable environment), or (3) serious foetal abnormalities. Explanation 1 to this section states that the anguish of a pregnancy caused by rape constitutes grave injury to mental health. Explanation 2 provides that a *married* woman can be granted an abortion if a contraceptive method used by her or her husband has failed.¹² By carving out a provision only for married women, the Act deliberately excludes unmarried women from accessing abortion services.

As a result of this criminalisation of abortion, medical practitioners are less likely to perform even legal abortions out of a fear of prosecution. Medical practitioners receive little personal benefit relative to the harsh criminal penalties that may result if an abortion does not fall within the bounds of legally permissible circumstances. Thus, laws that criminalise or restrict abortions dissuade service providers from performing the remaining legal types of abortion.¹³ Furthermore, since abortion is only permitted with the approval of a registered practitioner, denial of services compels women to undergo abortions outside medical facilities in potentially unsafe conditions.

These limited grounds for abortion keep it within the criminal law domain, and fail to address it as an issue of public health and access to reproductive healthcare services.

III. BARRIERS TO ABORTION ACCESS

Access to abortion remains a major challenge for women and girls all over the country. The MTP Act and its subsequent amendments have been heralded as progressive, and judgments have, in some cases, moved away from the rigorous confines of §312 of the IPC. However, hurdles to accessing voluntary abortions remain. In this section, the article will discuss first, third party authorisation, and second, the law on sex selective abortion to examine how they act as barriers to abortion access.

A. THIRD-PARTY AUTHORISATION

In addition to the barriers created by the restrictive grounds under the MTP Act, several other directly and indirectly related laws pose significant hurdles to abortion access in

¹² Melissa Stillman, et al., *Abortion in India: A Literature Review*, (2014), available at https://www.guttmacher.org/sites/default/files/report_pdf/abortion-india-lit-review.pdf (Last visited on October 23, 2019).

¹³ Brandice Canes-Wrone & Michael Dorf, *Measuring the Chilling Effect*, NYU LAW REVIEW 90, 1095-1114 (2015).

India. For example, §3 of the MTP Act specifies that in order to terminate a pregnancy where the gestation period has not exceeded twelve weeks, an opinion of one registered medical practitioner given in good faith and stating that the conditions under the Act have been met is required. For pregnancies between twelve to twenty weeks, two medical practitioners must give their opinion. §5 states that the twenty-week limit will not apply if the medical practitioner considers, in good faith, that termination is immediately necessary to save the life of the woman. The Act does not allow for abortions post twenty weeks under any other circumstances.

This has led to women constantly approaching the courts seeking permission for termination of unwanted pregnancies. Doctors often advise pregnant women to obtain a court order giving them permission to terminate the pregnancy. Such denial of services has forced women to approach the Court for permission to abort. In addition, doctors have at times compelled women to approach the judiciary even for pregnancies under twenty weeks;¹⁴ this push is apparently driven by a fear of prosecution due to the harsh penalties laid out in the IPC, as well as the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994¹⁵ ('PCPNDT Act') which aims to curb sex-selective abortions. Medical practitioners also fear investigations due to the implementation of the Protection of Children from Sexual Offences Act, 2012¹⁶ ('POCSO Act') and often refuse to provide services to pregnant adolescent girls without a court order.¹⁷

An analysis of Supreme Court and High Court decisions from 2016 to 2019 on termination of post-twenty-week pregnancies shows that the judiciary has been inconsistent in how it enforces the MTP Act. The study undertaken by the Pratigya Campaign highlights how different courts have relied on differing standards to permit or decline termination of pregnancy. For example, in some cases, the viability of the foetus has been a factor in the decision-making process, which marks a departure from the original standard that took into account the impact of a pregnancy on a woman's mental or physical health.¹⁸ Even in cases where rape survivors have requested abortions, the courts have relied on the opinion of medical boards, which have offered advice based on inconsistent sets of parameters.¹⁹ The prospect of having to obtain authorisation from the court is daunting and this deters some women from pursuing the option entirely, forcing them to resort to unsafe abortion methods.

The double layer of authorisation, from the court and then the medical board, is unnecessary especially given that reliance is ultimately placed on the opinion of registered medical practitioners to determine whether termination can be carried out. In the case of *Murugan Nayakkar v. UOI*,²⁰ the Supreme Court allowed a 13-year-old rape survivor to terminate her pregnancy on account of the trauma she had suffered. The Court relied solely on the opinion of the Medical Board which recommended that the pregnancy be terminated. High

¹⁴ Pratigya Campaign, *Assessing the Judiciary's Role in Access to Safe Abortion*, available at <https://pratigyacampaign.org/wp-content/uploads/2019/09/assessing-the-judiciarys-role-in-access-to-safe-abortion.pdf> (Last visited on October 23, 2019).

¹⁵ The Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994.

¹⁶ The Protection of Children from Sexual Offences Act, 2012.

¹⁷ Pratigya Campaign, *supra* note 14, 6; Dipika Jain & Brian Tronic, *Conflicting abortion laws in India: Unintended barriers to safe abortion for adolescent girls*, INDIAN JOURNAL OF MEDICAL ETHICS (2019).

¹⁸ Pratigya Campaign, *supra* note 14, 15.

¹⁹ Pratigya Campaign, *supra* note 14, 17.

²⁰ *Murugan Nayakkar v. Union of India*, (2017) SCC Online SC 1902.

Courts have also allowed for termination beyond twenty weeks, such as in *Bhavikaben v. State of Gujarat*,²¹ and *Shaikh Ayesha Khatoon v. UOI*.²² In *R v. State of Haryana*,²³ the Punjab and Haryana High Court observed that the pregnant woman had been referred to multiple medical boards which returned differing opinions; this ultimately delayed the matter to a point where the pregnancy had advanced beyond twenty-four weeks and could no longer be terminated. The Court clarified that when doctors act in good faith and terminate a pregnancy in order to save the life of a woman, or prevent injury to her mental or physical health, they will not be unnecessarily prosecuted. Thus, it is clear that the courts have noted that these additional layers of authorisation create barriers to women's exercise of reproductive autonomy. Unwanted pregnancy is a risk factor for poor maternal mental health,²⁴ and may have negative consequences for any existing children²⁵. Studies have also suggested a strong correlation between unwanted pregnancy and poorer later-life mental health outcomes.²⁶ The forced continuation of an unwanted pregnancy due to time lost in the litigation process is detrimental to women's physical and mental health. Unwanted pregnancies are a major public health concern²⁷ and, hence, third-party authorisation barriers to abortion access result in detriments to the health of women as well as children. It should be noted that neither §3 nor §5 of the MTP Act provide that termination of pregnancy be authorised either by the judiciary or a medical board. The requirement of third-party authorisation, then, is entirely outside the scope of the Act.

At the international stage, the UN Human Rights Committee in *LMR v. Argentina* stated that the decision on termination of a pregnancy should remain between a pregnant woman/girl and her physician, and that the involvement of the court in this decision would amount to a violation of the right to privacy.²⁸ In its General Comment No. 22, the Committee on Economic, Social, and Cultural Rights mandates States to "remove and refrain from enacting laws that create barriers in access to sexual and reproductive health services," including third-party authorisations for accessing abortion services.²⁹ The World Health Organization has also acknowledged that third-party authorisation requirements undermine women's autonomous decision-making.³⁰

²¹ *Bhavikaben v. State of Gujarat*, (2016) SCC Online Guj 9142 (Gujarat High Court held that the petitioner could terminate her 24-week pregnancy as it was adversely affecting her mental status. It further noted that her 'poverty-stricken condition' had caused delays in approaching the court).

²² *Shaikh Ayesha Khatoon v. Union of India*, (2018) 3 Mh. LJ (Bombay High Court held that the petitioner could terminate her pregnancy in the 27th week due to foetal abnormalities).

²³ *R v. State of Haryana*, (2016) SCC Online P&H 18369.

²⁴ Jinwook Bahk et al., *Impact of unintended pregnancy on maternal mental health: a causal analysis using follow up data of the Panel Study on Korean Children (PSKC)*, 15 BMC PREGNANCY AND CHILDBIRTH 85 (2015).

²⁵ Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 THE JOURNAL OF PEDIATRICS (2019).

²⁶ Pamela Herd et al., *The Implications of Unintended Pregnancies for Mental Health in Later Life*, 106 AJPH PERSPECTIVES 3 (2016).

²⁷ Mili Dutta, Chander Shekhar & Lokender Prashad, *Level, Trend and Correlates of Mistimed and Unwanted Pregnancies among Currently Pregnant Ever Married Women in India*, PLoS ONE (2015).

²⁸ *LMR v. Argentina*, Human Rights Committee, Comm'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

²⁹ Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the Right to sexual and reproductive health E/C.12/GC/22, available at: <https://www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health> (Last visited on October 23, 2019).

³⁰ WORLD HEALTH ORGANIZATION ('WHO'), *Safe abortion: technical and policy guidance for health systems* (2012), available at

The unwritten tradition of coercing pregnant women into requesting judicial authorisation for abortion services causes unwanted anxiety and harassment. The fear is further compounded by the confusion over the law on sex selective abortion.

B. LAW ON SEX SELECTIVE ABORTION

The fear of wrongful prosecution continues to affect healthcare service providers' decision to offer legal abortions in India. This is further complicated by the PCPNDT Act which regulates the use of diagnostic techniques in order to prohibit sex-selection procedures before and after conception.³¹ Many service providers fear prosecution under the Act while conducting abortions because of the looming assumption that an abortion may have been carried out by a doctor for the purposes of sex-selection.³² As most doctors have no legal training, the interplay between the MTP and PCPNDT Acts may be difficult for them to comprehend, and the harsh penalties for performing or facilitating sex-selective abortions are a major deterrent to provision of abortion services. However, it is crucial to note that the Act is very clear: if a doctor's intention, while performing any procedure, is *not* to increase the probability that an embryo will be of a particular sex, then the procedure will not amount to sex-selection.

While the actual number of successful prosecutions under the PCPNDT Act – especially with respect to complaints of sex-selection – is limited, the law has been used as a tool for the harassment of doctors.³³ Monitoring authorities tend to pick up on trivial errors, such as the wrong size or colour of the font in required forms, in order to intimidate medical professionals.³⁴ Additionally, sting operations and surprise visits are used by the authorities to monitor compliance with the Act. While in certain cases these operations have revealed a violation of the Act,³⁵ providers note that they have often been used to unduly harass them.³⁶ In fact, the Bombay High Court recently addressed the increasing harassment of abortion service providers and ruled that minor procedural errors or inadvertent omissions in maintaining records cannot be regarded as punishable violations.³⁷

https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=7D7261384A06937FFF02CB773EEB6FBE?sequence=1 (Last visited on October 23, 2019).

³¹ The PCPNDT Act does not discuss abortion. It only prohibits sex-selection procedures.

³² Pratigya Campaign, *supra* note 14; Dipika Jain, *supra* note 17.

³³ Center for Reproductive Rights, *Reform to address women's and girl's needs for abortions after 20 weeks in India*, available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Post-20-Week-Access-to-Abortion-India-0218.pdf> (Last visited October 23, 2019).

³⁴ Pritam Podtar 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 (2015); The Tribune, *Can PCPNDT alone improve sex ratio*, May 25, 2019, available at <https://www.tribuneindia.com/news/comment/can-pndt-act-alone-improve-sex-ratio/84766.html> (Last visited on October 23, 2019).

³⁵ Shalini P. Joshi, *Compilation and Analysis of case laws on Pre-conception and pre-natal diagnostic techniques (prevention of sex selection) Act, 1994*, available at https://www.wbhealth.gov.in/uploaded_files/PNDT/Compilation and Analysis.pdf (Last visited on October 23, 2019).

³⁶ Shireen J Jejeebhoy et al., *Gender Biased Sex-selection in India: A Review of the situation and intervention to counter the practice* (2015), available at https://assets.publishing.service.gov.uk/media/57a0897eed915d3cfd000284/61192_India_Lit_Review_Sex_Selectio n.pdf (Last visited on October 23, 2019).

³⁷ Dr. Sai w/o Santosh Shiradhkar v. State of Maharashtra, W.P. (Cr) 1381 of 2015.

Nevertheless, service providers are afraid of jeopardising their practice and often simply refuse to perform abortions during the second trimester.³⁸ Some providers, alternatively, increase their charges for conducting a sonography, as compensation for the harassment they face.³⁹ These practices hinder women's access to abortion, even if they meet the conditions laid down under the MTP Act. Resultantly, women seeking abortion inevitably approach the Court to seek permission for the termination of their pregnancy.

IV. THE NEED FOR DECRIMINALISATION: PROTECTING THE HEALTH AND DECISIONAL AUTONOMY OF PREGNANT WOMEN

Criminal law has been used around the globe to limit not only sexual conduct perceived as violent but also consensual sexual relations between consenting adults. Research shows that criminalisation of consensual behaviour is a direct impediment for access to sexual health care and services.⁴⁰ Regimes of criminalisation also impose disproportionate penalties on women, thus compounding the discrimination they face.⁴¹ In this section, the article will discuss, first, the impact that criminalisation of abortion has on women and, second, the national and international jurisprudence which supports the contention that reproductive rights must include a right to abortion. The article argues that there is a need for decriminalisation as well as a need to include multiple and diverse stakeholder perspectives in the conversation surrounding decriminalisation.

A. THE IMPACT OF CRIMINALISATION

Criminalisation of abortion harms women, girls and gender diverse people in several ways. First, it is a major legal barrier to safe abortion access. It has been well documented that banning or restricting abortion does not eliminate demand – it only eliminates access to safe abortions.⁴² Furthermore, and quite importantly, criminalising abortion forces women and girls underground, to access illegal procedures in less than optimal circumstances. These procedures are offered without oversight and often with lower standards of care,

³⁸ Podtar, *supra* note 34; Center for Reproductive Rights, *Breaking Ground: Treating Monitoring Bodies on Reproductive Rights*, (2018), available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Breaking-Ground-2018.pdf> (Last visited on October 23, 2019).

³⁹ Podtar, *supra* note 34.

⁴⁰ Alice Miller, Mindy J. Roseman & Corey Friedman, *Sexual Health and Human Rights: United States and Canada* (WHO Working Paper 2010) available at <http://hrp.law.harvard.edu/wp-content/uploads/2013/03/sexual-health-and-human-rights-united-states-and-canada.pdf> (Last visited on October 23, 2019).

⁴¹ *Id.*

⁴² Michelle Oberman, *The Consequences of El Salvador's Abortion Ban*, January 11, 2018, available at <https://www.guernicamag.com/consequences-el-salvador/> (Last visited on October 23, 2019); Michelle Williams, *Anti-abortion laws have dire public health consequences*, May 17, 2019, available at <https://www.bostonglobe.com/opinion/2019/05/17/opinion-michelle-williams-anti-abortion-laws-have-dire-public-health-consequences/O3fLh6tQSeSofoQNC1qAhL/story.html> (Last visited on October 23, 2019); Human Rights Watch, *It's Your Decision, It's Your Life – The Total Criminalization of Abortion in the Dominican Republic*, 2018, available at <https://www.hrw.org/report/2018/11/19/its-your-decision-its-your-life/total-criminalization-abortion-dominican-republic> (Last visited on October 23, 2019).

increasing the chances of medical harm.⁴³ In fact, unsafe abortion remains one of the major causes of maternal mortality globally.⁴⁴ In India, for instance, around two-thirds of abortions are unsafe.⁴⁵ Thus, one of the main impetuses for criminalising the behaviour⁴⁶ – to eradicate the use of abortions from society – fails, as women continue to receive abortions by non-legal means. In addition, criminalisation allows stigma to run rampant as the medical procedure continues to be cloaked under an air of secrecy and criminality. The taboos surrounding abortion have a grave impact on women’s health, and play a significant role in their decisions on whether to have a safe or unsafe abortion, and whether to disclose the abortion to others.⁴⁷ Combined, this produces a chilling effect on the exercise of reproductive autonomy.

This is also the case for other types of laws purportedly passed to prevent the occurrence of socially undesirable behaviour. For example, the criminalisation of sex work leads to increased stigmatisation of sex workers and prevents their ability to access the legal system, making them less likely to report violence.⁴⁸ Similarly, prior to being struck down by India’s Supreme Court,⁴⁹ the criminalisation of same-sex relations under §377 of the IPC hindered HIV prevention efforts, by creating barriers to access for necessary services for those who were most at risk for contracting HIV.⁵⁰ Further, anti-abortion laws have a disproportionate effect on those already marginalised.⁵¹ Studies have noted that the cost of an abortion in the private sector is a major barrier to abortion access for Dalit and Adivasi groups.⁵² Women in these groups experience poorer maternal health outcomes as a result of the barriers in accessing healthcare services⁵³, due to excessive bureaucracy and caste-based discrimination. This is illustrated well by the case of *Amita Kujur v. State of Chhattisgarh* where the petitioner, an Adivasi girl and rape survivor, wanted to terminate a pregnancy at twelve weeks.⁵⁴ The District Hospital referred her

⁴³ Sally Sheldon, *The Decriminalisation of Abortion: An Argument for Modernisation*, 36 OXFORD JOURNAL OF LEGAL STUDIES 2, 334-365 (2016).

⁴⁴ WHO, *Worldwide, an estimated 25 million unsafe abortions occur each year*, September 28, 2017, available at <https://www.who.int/en/news-room/detail/28-09-2017-worldwide-an-estimated-25-million-unsafe-abortions-occur-each-year> (Last visited on October 23, 2019).

⁴⁵ EPW Editorial, *Right to Safe Abortion Care*, 53 ECONOMIC AND POLITICAL WEEKLY 9 (2017).

⁴⁶ Frankie Herrmann, *Building a Fair and Just New York: Decriminalise Transactional Sex*, 15 HASTINGS RACE AND POVERTY LAW JOURNAL 1, 65-129 (2018).

⁴⁷ Ayodeji Oginni et al., *Correlates of individual-level abortion stigma among women seeking elective abortion in Nigeria*, 10 INTERNATIONAL JOURNAL OF WOMEN’S HEALTH, 361-366 (2018).

⁴⁸ Erin Albright & Kate D’Adamo, *Decreasing Human Trafficking through Sex Work Decriminalisation*, 19 AMA JOURNAL OF ETHICS 1, 122-126 (2017).

⁴⁹ See *Navtej Singh Johar v. Union of India*, (2018) 10 SCC 1.

⁵⁰ Dipika Jain & Kimberly Rhoten, *The Heteronormative State and the Right to Health in India*, 4 NUJS LAW REVIEW, 627-638 (2013); Danish Sheikh, *The Road to Decriminalisation: Litigating India’s Anti-Sodomy Law*, 16 YALE HUMAN RIGHTS AND DEVELOPMENT LAW JOURNAL 1 (2013).

⁵¹ The ‘effects test’ was used in the *Navtej Johar* §377 decision to address the indirectly discriminatory nature of §377 and its impact on LGBT individuals. Justice Chandrachud’s opinion notes that although the provision is facially neutral, its effect is primarily and disproportionately on LGBT persons. Similarly, although abortion laws do not specifically target marginalized groups, the restrictions placed on abortion access have a disproportionate impact on people based on caste and socioeconomic status.

⁵² Ravi Duggal & Vimala Ramachandran, *The Abortion Assessment Project—India: Key Findings and Recommendations*, 12 REPRODUCTIVE HEALTH MATTERS 24, 122-129 (2004).

⁵³ Linda Sanneving et al., *Inequity in India: the case of maternal and reproductive health*, GLOBAL HEALTH ACTION (2013).

⁵⁴ *Amita Kujur v. State of Chhattisgarh & Ors.*, WP (C) 976/2016.

to the Chhattisgarh Institute of Medical Sciences (CIMS), where she was asked to produce a copy of the FIR, medico-legal documents, and a reference letter from the District Hospital.⁵⁵ She was unable to obtain these documents, allegedly due to the callous attitude of the *Thana* in charge.⁵⁶ She then approached the court seeking permission to terminate the unwanted pregnancy. The court directed CIMS to constitute a team of two doctors to examine the petitioner, who determined that her pregnancy was at twenty-one weeks, thus putting her outside the confines of the MTP Act. Fortunately, the court granted an order for termination of pregnancy, in the interest of the petitioner.⁵⁷ However, this case demonstrates the range of social and legal issues that impede access to healthcare services for marginalised persons.

Access to healthcare is asymmetric between rural and urban India,⁵⁸ and caste-based discrimination is embedded in public health services.⁵⁹ Human Rights Watch has noted that access to maternal health services is challenging for Dalit and Adivasi communities.⁶⁰ They face ‘triple discrimination’ due to their gender, caste and socioeconomic status.⁶¹ A study in Meenkera, Karnataka found that caste “operates through both formal and informal structures and networks” and that all significant positions in local public health facilities are occupied by dominant castes.⁶² Another study conducted in Ballabgarh, Haryana, found that caste is one of the major determinants for induced abortions; declining socioeconomic status and caste location are directly correlated with lower odds of an induced abortion.⁶³ An analysis of data from the 1998-1999 National Family Health Survey also revealed that those who are in a more favourable position in the caste system have elevated odds of abortion, as compared to women in rural areas or Dalit and Adivasi women.⁶⁴ Inequity in access to healthcare is further exacerbated by the fact that state governments often leave large portions of the health budget unspent, which results in failing healthcare infrastructure especially in rural areas.⁶⁵ Consequently, women without familial support and/or those who live in poverty disproportionately experience barriers to abortion services, without the resources to access legal and non-legal abortions. This demonstrates how reproductive justice is in fact a social justice issue. One cannot disregard “the different economic, political and environmental contexts in which women live their reproductive

⁵⁵ SAMA – RESOURCE GROUP FOR WOMEN AND HEALTH, *From the Margins to the Centre: A study on the health inequities among the tribal communities in selected districts of Chhattisgarh, Jharkhand and Odisha*, available at <http://nhrc.nic.in/sites/default/files/SAMA%20Final%20Report.pdf> (Last visited on October 23, 2019).

⁵⁶ *Id.*, 146.

⁵⁷ *Id.*, 147.

⁵⁸ Debasis Barik & Amit Thorat, *Issues of Unequal Access to Public Health in India*, FRONTIERS IN PUBLIC HEALTH (2015).

⁵⁹ Sobin George, *Reconciliations of Caste and Medical Power in Rural Public Health Services*, 54 ECONOMIC AND POLITICAL WEEKLY 40 (2019).

⁶⁰ HUMAN RIGHTS WATCH, *Unaccountable: Addressing Reproductive Health Care Gaps* (2010), available at <https://www.hrw.org/report/2010/05/27/unaccountable/addressing-reproductive-health-care-gaps> (Last visited on October 23, 2019).

⁶¹ Parisa Patel, Mahua Das & Utpal Das, *The perceptions, health-seeking behaviours and access of Scheduled Caste women to maternal health services in Bihar, India*, 26 REPRODUCTIVE HEALTH MATTERS 54, 114-125 (2018).

⁶² George, *supra* note 61.

⁶³ Shashi Kant et al., *Induced abortion in villages of Ballabgarh HDSS: rates, trends, causes and determinants*, 12 REPRODUCTIVE HEALTH 51 (2015).

⁶⁴ Saseendran Pallikadavath & R. William Stones, *Maternal and Social Factors Associated with Abortion In India: A Population-Based Study*, 32 INTERNATIONAL FAMILY PLANNING PERSPECTIVES 3 (2006).

⁶⁵ Human Rights Watch, *supra* note 56.

lives”.⁶⁶ The compounded identities produce unique experiences of discrimination in which marginalised women struggle to acquire proper resources and institutional power to make healthy decisions for themselves.

Denial of healthcare services is a violation of the fundamental right to life and liberty under Article 21 of the Constitution. Jurisprudence from the Supreme Court of India has established that access to emergency care is a fundamental right,⁶⁷ and that a duty of care is the foremost obligation of the medical profession.⁶⁸ As Edward Pinto notes, repeatedly “running to the courts is not an option for the poor, since they do not have adequate financial resources, political clout and influence over the judiciary”.⁶⁹ Hence, access to timely and affordable health services is critical for marginalised persons. For women and girls who rely on the public healthcare system and have limited access to post-abortion care, the risk of serious complications or even death is higher when clandestine abortion services are the only available option.⁷⁰ The threat of unsafe abortions is magnified when women are forced outside the legal machinery of safe abortions, unless they wish to be caught up in litigation while asking the Courts for permission when denied doctors’ consent.⁷¹

Criminalising abortions is unsupported by the major tenets of human rights,⁷² and this has been recognised both nationally and internationally. Indian Courts have established through a series of case laws that the right to abortion is a fundamental right of a woman and includes the right to bodily autonomy, health, dignity and choice as discussed in the next section. Similarly, jurisprudence from countries such as Nepal and Canada highlights the importance of ensuring that women are able to exercise their reproductive autonomy.

B. JURISPRUDENCE ON REPRODUCTIVE RIGHTS

In recent years, there have been several Supreme Court and High Court decisions in India that have made significant strides in recognising the fundamental rights to privacy, dignity, and bodily and sexual autonomy. Through these decisions, the Indian judiciary has also made it clear that reproductive rights is a fundamental right in India.

In a landmark nine-judge bench of the Supreme Court of India in *KS Puttaswamy v. Union of India*⁷³ (‘Puttaswamy’) categorically held that the exercise of reproductive choices is rooted within the a constitutionally protected right to life and personal liberty under Article 21 of the Constitution. In the plurality opinion, Justice Chandrachud noted that the statutory right of a

⁶⁶ LORETTA ROSS & RICKIE SOLINGER, *REPRODUCTIVE JUSTICE: AN INTRODUCTION*, UNIVERSITY OF CALIFORNIA PRESS 47 (2017).

⁶⁷ Pt. Parmanand Katara v. Union of India and Ors., 1989 SCR (3) 997.

⁶⁸ Edward P. Pinto, *The jurisprudence of emergency medical care in India: an ethics perspective*, 2 INDIAN JOURNAL OF MEDICAL ETHICS 4 (2017).

⁶⁹ *Id.*

⁷⁰ Jocelyn E. Getgen, *Reproductive Injustice: An Analysis of Nicaragua’s Complete Abortion Ban*, 41 CORNELL INTERNATIONAL LAW JOURNAL 1 143-175 (2008).

⁷¹ Alka Barua, Hemant Apte, & Suchitra Dalvie, *Safe Abortion as a Women’s Right: Perceptions of Law Enforcement Professionals*, 50 ECONOMIC AND POLITICAL WEEKLY 33 (2015).

⁷² Center for Reproductive Rights, *supra* note 38.

⁷³ K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1.

woman, under the MTP Act, to decide whether or not to consent to a termination of pregnancy “[...] is relatable to the constitutional right to make reproductive choices which has been held to be an ingredient of personal liberty under Article 21”.⁷⁴ He noted that this right has been deduced from a woman’s fundamental right to privacy, dignity and bodily integrity. Justice Chandrachud went on to discuss the concept of decisional autonomy – inextricably linked to the rights to privacy and self-determination – and held that the “family, marriage, procreation and sexual orientation are all integral to the dignity of the individual. Above all, the privacy of the individual recognises an inviolable right to determine how freedom shall be exercised”.⁷⁵ Finally, he observed that decisional autonomy comprehends such intimate personal choices as those governing reproduction and the ability to make decisions regarding one’s sexual or procreative nature. Similarly, Justice Chelameshwar in his opinion unequivocally stated that a “woman’s freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy”.⁷⁶

The Court in *Puttaswamy* referred to the landmark *Suchita Srivastava v. Chandigarh Administration*⁷⁷ (‘Suchita’) judgment of 2009 as well as the 2016 judgment in *Devika Biswas v. Union of India*,⁷⁸ (‘Devika Biswas’) both of which have been crucial in advancing reproductive justice in the country. In *Suchita*, the Court held that the right to make reproductive choices is a dimension of ‘personal liberty’ guaranteed by Article 21 and further, that “reproductive choices can be exercised to procreate as well as to abstain from procreating”. The Court expressly stated that there should be no restrictions on the exercise of reproductive choices and that a woman’s right to privacy, bodily integrity and dignity should be respected. In *Devika Biswas*, the Court again held that the right to life and personal liberty under Article 21 encompasses reproductive rights. It emphasised that this includes the right to “access a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behaviour.”⁷⁹

In 2018 the Supreme Court delivered two very important judgments that upheld the rights to sexual and decisional autonomy. In *Navtej Johar v. Union of India*,⁸⁰ the Court highlighted the role that sexual autonomy plays “in the idea of a free individual”⁸¹ and stated that sexuality could not be reduced to its function as a means of recreation. Similarly, in *Joseph Shine v. Union of India*,⁸² the Court stated that the right to sexual autonomy and privacy has the stature of a constitutional right. It is clear from these decisions that the Supreme Court has located the rights to life, personal liberty, privacy, dignity, bodily integrity and autonomy as intertwined with reproductive rights, within the framework of gender justice.

The Bombay High Court in the case of *High Court on its own Motion v. State of Maharashtra*, (‘Suo Moto PIL’) a significant judgment through a *suo moto* PIL employed similar

⁷⁴ *Id.*, ¶83.

⁷⁵ *Id.*, ¶298.

⁷⁶ *Id.*, ¶373.

⁷⁷ *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1.

⁷⁸ *Devika Biswas v. Union of India*, (2016) 10 SCC 726.

⁷⁹ *Id.*, ¶ 110.

⁸⁰ *Navtej Singh Johar v. Union of India*, (2018) 10 SCC 1.

⁸¹ *Id.*, ¶478.

⁸² *Joseph Shine v. Union of India*, (2019) 3 SCC 39.

reasoning to guarantee access to abortion services for incarcerated women.⁸³ In *Suo Moto PIL*, the Court dealt with a situation where pregnant women prisoners were being referred to a Committee which would give them permission to terminate pregnancies. Holding that such a reference to a Committee is unnecessary, the Court observed that the burden of an unwanted pregnancy falls on the woman and questioned why only the woman should suffer. The Court further noted that an unborn foetus is not an entity with human rights; it is vested with rights only at birth.⁸⁴ On the contrary, the pregnant woman undoubtedly has basic rights, especially the right to life and liberty which are severely impacted if she is forced to carry an ‘unwanted’ pregnancy. The High Court therefore concluded that women alone have a say in how they want to deal with pregnancies and recognised their “right to autonomy and to decide what to do with their own bodies”.⁸⁵ This right extends to all women whether they are homemakers, working women, or prisoners. The Court explicitly held that women have absolutely rights over their bodies and their well-being should take precedence over that of a foetus. The mental anguish that a woman suffers due to the forced continuation of an unwanted pregnancy must outweigh any considerations of potential foetal rights. In doing so, the Court further recognised the unique harm that only women and girls are made to suffer under the present construction of the law. The *Suo Moto PIL* was one of the first cases to recognize restrictions on access to abortion as an issue of discrimination and address the gender injustice that results from carrying unwanted pregnancies to term.

Reproductive rights must be situated within a gender justice framework in order to ensure that they are robust. Restrictions on access to abortion disproportionately impact women due to biological factors as well as societal perceptions of women as ‘natural’ childrearsers. Women face systemic discrimination that prevents them from exercising their basic rights. In this context, a demand for individual rights that focus solely on private citizens cannot deliver reproductive justice. The rights must be tied to larger issues of social justice and access to healthcare, thereby addressing “questions of inequality, justice and systemic oppression within which reproductive rights are denied or rendered in effective”⁸⁶.

International jurisprudence also supports the contention that reproductive rights, including the right to abortion, are basic human rights. In 2009, the Supreme Court of Nepal issued a landmark verdict in *Lakshmi Dhikta v. Nepal*,⁸⁷ holding that a woman could not be forced to continue with a pregnancy and that there should be legal recognition of a woman’s right to abortion. The Court recognised the consequences of compelling women to continue with unwanted pregnancies and highlighted the burden of childcare that disproportionately falls on women. The Court further stated that a woman is “the master of her own body and whether or not to have sexual relations, to give birth to a child or not to give birth, and how to use her body are matters in which a woman has the final say”. In Canada, abortion was decriminalised (under limited grounds) in 1969. In 1988, the Supreme Court held in *R v. Morgentaler*⁸⁸ that forcing a woman to carry a foetus to term is an interference with her right to life, liberty as well as the

⁸³ High Court on its own Motion v. State of Maharashtra, (2016) SCC OnLine Bom 8426.

⁸⁴ *Id.*, ¶15.

⁸⁵ *Id.*

⁸⁶ Sumi Madhok et al., *On reproductive justice: ‘domestic violence’, rights and the law in India*, 16(10) CULTURE, HEALTH & SEXUALITY: AN INTERNATIONAL JOURNAL FOR RESEARCH, INTERVENTION AND CARE (2014) at 1239.

⁸⁷ *Lakshmi Dhikta v. Nepal*, Writ Petition No. WO-0757, 2063 BS (2009).

⁸⁸ *R v. Morgentaler*, (1988) 1 SCR 30.

security of her person guaranteed under §7 of the Canadian Charter of Rights and Freedoms. Abortion in Canada is placed within a healthcare framework and the decision is for a woman and her physician to make; the State need not interfere unless it is to ensure that all persons have access to safe and affordable reproductive healthcare services.

Thus, in the face of an increasing progressive rights jurisprudence on abortion, to have a provision that criminalises abortion *at will* is an anathema. As explained above, there is an urgent need to decriminalise abortions. Angela Davis, in her seminal book *Are Prisons Obsolete?* challenges the readers to explore ‘new terrains of justice’ that no longer have prison as a major anchor. In the context of abortion, this leads to larger questions on how we conceptualise ‘crime’ and how we can confront the State’s increasing control over women’s lives and bodies. The criminalisation of abortion is gendered and has a disproportionate impact on women who must carry the burden of pregnancy and childrearing. Joanna Erdman argues that the decision to gestate and birth a child “carries serious consequences for a person in their self-worth, stability and security, and in the ways they think about themselves and how they relate to others and to society”.⁸⁹ However, matters of pregnancy and abortion have not been treated as aspects of personal liberty, bodily integrity or privacy. If motherhood is understood as a hegemonic ideology,⁹⁰ reinforced by certain core beliefs such as the need to regulate and control mothers who put their own interests before those of their children, it becomes clear why pregnant women who violate these beliefs are subject to criminal sanction.⁹¹ Pregnant women are expected to be completely self-sacrificing, to the extent of giving up their lives for their foetuses;⁹² those who engage in any behaviour that harms their foetuses are, thus, deemed ‘bad mothers’ who must be punished. The criminalisation of abortion, even self-induced abortions, has resulted in increased maternal mortality due to women resorting to unsafe back-alley abortions and consequently hesitating to seek medical help for fear that doctors or hospitals will report them to the police. Restrictive abortion laws treat pregnant women as *mothers* first, and subject them to gender norms that invisibilise the needs of the woman in favour of the needs of the foetus.

Criminalising abortions, except under restrictive grounds and only within certain gestational limits, is a major barrier to women’s exercise of reproductive autonomy. However, it should be noted that abortions against a pregnant person’s consent can occur, particularly in cases of domestic violence and medical malpractice.⁹³ Pregnant women who lose their pregnancy as a result of a third-party unwanted, non-consensual intervention, should have the right to seek legal redressal. The question is whether such legal recourse must remain within the criminal law framework or if we can envision alternative modes of justice.

If abortion were to be fully decriminalised in India, there would be no need for the MTP Act, which currently serves as an exemption to criminal liability for registered medical practitioners who terminate pregnancies. In lieu of a specific legislation regulating the termination of pregnancy, abortion could be treated as a healthcare issue, allowing for a woman

⁸⁹ Joanna N. Erdman, *The gender injustice of abortion laws*, 27 *SEXUAL AND REPRODUCTIVE HEALTH MATTERS* 1 2 (2019).

⁹⁰ April L. Cherry, *Shifting our Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses*, 28 *JOURNAL OF LAW AND HEALTH* 6 41 (2015).

⁹¹ *Id.*, 42.

⁹² *Id.*, 45.

⁹³ *Dr. Meeru Bhatia Prasad v. State*, (2002) CriLJ 1674.

to make the final decision in consultation with her doctor. Since the *Morgentaler* decision in Canada, abortion care has been decided between a pregnant woman and her doctor, with no third-party intervention. There is no criminal law or other legal provision that regulates abortion; decisions are made “in the same way as those about vasectomy or treatment for a ruptured appendix or an ectopic pregnancy”.⁹⁴ Abortion is, therefore, treated like any other medical procedure with the same oversight and standards of care. Recently, the Australian state of New South Wales also decriminalised abortion, overturning an archaic 119-year-old law.⁹⁵

If there is need for legislation, however, it should be one that recognises, unconditionally, the right to abortion and reproductive healthcare services. In Vietnam, for example, abortion has been available on request since the 1960s⁹⁶ and the Law on Protection of Public Health, 1989, recognises women’s right to abortion and does not set any upper gestational limit.⁹⁷ In Singapore, the Termination of Pregnancy Act, 1974, provides for abortion on request up to twenty-four weeks.⁹⁸ Similarly, in Victoria, Australia, abortion is available on request up to twenty-four weeks and beyond that, two medical practitioners must determine that “the abortion is appropriate” in order to proceed with termination.⁹⁹ It should be noted here that the Indian Medical Association issued guidelines on foetal viability in 2017, where it stated that twenty eight weeks has been set as the stage of viability.¹⁰⁰ The chance of survival for a foetus under twenty eight weeks is low. Thus, any legislation on abortion should that sets the gestational limit at twenty is extremely restrictive and in contradiction to medical opinion. The legislation should merely provide for a woman to consult with one registered medical practitioner who will determine whether it is safe for her to undergo termination. There should be no court or medical board intervention in this decision. Women must have a right to abortion *at will*, and not qualified rights that situate abortion within a patriarchal framework.

The argument that women must have the absolute right to ‘choose’ an abortion is not without its limitations. Robin West argues that establishing an individual right to terminate pregnancies could have the effect of “legitimizing the profoundly inadequate social welfare net and hence the excessive economic burdens placed on poor women and men who decide to parent”.¹⁰¹ In other words, if parenting is considered a ‘choice’, the State is no longer obligated to provide or subsidise support services such as education, healthcare etc. As West states, by offering abortion as an opt-out from parenting, “[the woman’s] consent legitimates the parental

⁹⁴ W. V. Norman & J. Downie, *Abortion care in Canada is decided between a woman and her doctor, without recourse to criminal law*, THE BMJ (2017).

⁹⁵ BBC News, *Australia abortion laws: Terminations now legal in New South Wales*, September 26, 2019, available at <https://www.bbc.com/news/world-australia-49834734> (Last visited on: October 24, 2019).

⁹⁶ WHO, *Abortion in Vietnam : An Assessment of Policy, Programme and Research Issues* (1999) available at https://apps.who.int/iris/bitstream/handle/10665/66158/WHO_RHR_HRP_ITT_99.2.pdf?sequence=1&isAllowed=y (Last visited on October 24, 2019).

⁹⁷ Centre for Reproductive Rights, *Vietnam’s Abortion Provisions*, available at <https://reproductiverights.org/world-abortion-laws/vietnams-abortion-provisions> (Last visited on October 24, 2019).

⁹⁸ The Termination of Pregnancy Act, 1974 (Singapore).

⁹⁹ Abortion Law Reform Act, 2008 (Australia).

¹⁰⁰ Press Trust of India, *After Max Hospital Death, IMA Issues Guidelines on Foetal Viability*, December 15, 2017, available at <https://www.hindustantimes.com/india-news/after-max-hospital-death-ima-issues-guidelines-on-fetal-viability/story-lssbGQN0IHQD3VGNxLW4O.html> (Last visited on October 24, 2019).

¹⁰¹ Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 THE YALE LAW JOURNAL 7 1394-1432 (2009).

burden to which she has consented”.¹⁰² The consequences of this will be felt disproportionately by women from marginalised groups who are not economically well-off; their choice, then, is between parenting in poverty or forgoing children altogether.¹⁰³ In India, marginalisation on the basis of caste and/or indigenous identity compounds the disproportionate impact of any ‘choice’ made regarding abortion or carrying a pregnancy to term. Arguments based on choice should, therefore, take into account the structural conditions within which the choice is made.¹⁰⁴ Menon similarly points out that “the right to ‘choose’ makes little sense in the context of economic and cultural constraints which limit women’s possibilities of choice”.¹⁰⁵ Nevertheless, the response to these critiques must involve strengthening the social welfare system and working towards a reproductive justice movement that considers multiple stakeholder perspectives. Restricting abortion access is not a feasible solution.

While the legal, social and medical discourse only focuses on women’s right to abortion, it should be noted that access to reproductive healthcare is crucial for all persons, including transgender, intersex and gender-diverse persons. The reproductive justice movement, pioneered by Black American women, specifically notes the need for intersectionality in feminist activism around reproductive rights issues.¹⁰⁶ Furthermore, this framework recognises that reproductive oppression is experienced not only by biologically defined women, but also by transmen, trans women and gender non-conforming individuals.¹⁰⁷ Recent years have also seen calls to “queer abortion rights advocacy”,¹⁰⁸ given that queer theory has questioned the very construction of the gender binary and, therefore, categories of ‘woman’ and ‘man’ are no longer stable.¹⁰⁹ Centring the conversation solely around ‘women’s’ access to abortion or reproductive healthcare excludes persons whose identities are beyond the confines of the gender binary. The *National Legal Services Authority v. Union of India* decision by the Supreme Court of India declared that trans persons have the right to self-determination and legal recognition of their gender identity,¹¹⁰ and should have enjoyment of all other fundamental rights. The right to health has also been recognised as a fundamental right under Article 21 (right to life) of the Constitution, and the Delhi High Court has also read within this the right to reproductive healthcare.¹¹¹ Any conversation on decriminalisation of abortion, right to reproductive healthcare services, and abortion at will must necessarily involve a consultative process with all the stakeholders, including gender diverse persons. The ‘National Campaign for the Right to Legal, Safe and Free Abortion’ in Argentina shows us that it is possible to imagine an abortion rights and reproductive justice movement that is inclusive of all those who might be pregnant, regardless of their gender or sexual identity.¹¹²

¹⁰² *Id.*, 1411.

¹⁰³ *Id.*, 1412.

¹⁰⁴ Rashmi Luthra, *Toward a Reconceptualization of "Choice": Challenges by Women at the Margins*, FEMINIST ISSUES (1993).

¹⁰⁵ Menon, *supra* note 10.

¹⁰⁶ Loretta J. Ross, *Reproductive Justice as Intersectional Feminist Activism*, 19 SOULS 3 (2017).

¹⁰⁷ *Id.*, 291.

¹⁰⁸ Barbara Sutton & Elizabeth Borland, *Queering Abortion Rights: Notes from Argentina*, CULTURE, HEALTH & SEXUALITY (2018).

¹⁰⁹ *Id.*, 1; See generally JUDITH BUTLER, *GENDER TROUBLE*, (1990).

¹¹⁰ *National Legal Services Authority v. Union of India*, AIR 2014 SC 1863.

¹¹¹ *Laxmi Mandal v. Deen Dayal Harinagar Hospital*, (2010) 172 DLT 9.

¹¹² Sutton & Borland, *supra* note 108, 11.

Finally, while considering legal reforms around decriminalisation of abortion, it is imperative to be cognisant of the fact that legal reforms are likely to be meaningful and have the greatest impact when they are brought about through consensus and a fair process.¹¹³ The voices of all stakeholders including the disability rights movement, anti-caste movement, indigenous people's movements, and trans, gender-diverse and intersex persons' movements must be consulted. All persons and Groups from diverse socioeconomic backgrounds, must be heard and given due consideration.¹¹⁴ It is only possible to understand the nuances and complexities of this issue when we hear from marginalised persons on their experiences of barriers to accessing abortion and reproductive healthcare. The impact of legal reforms depends on public participation in the decision-making process; not allowing them to voice their concerns casts a shadow of doubt over the legitimacy of democratic institutions.¹¹⁵ Thus, this article concludes that wide consultation – including multiple perspectives – and deliberation is the key to successfully reimagining a gender justice approach to abortion rights.

V. CONCLUSION

Decriminalising consensual as well as self-induced abortions would ensure that women have better access to safe abortion services. The legal framework in India is clear on the circumstances in which abortions can be performed. However, the inappropriate linking of the MTP and PCPNDT Acts¹¹⁶ results in denial of services due to fears of prosecution and, consequently, results in barriers to abortion access. This combinatory effect pushes women to seek judicial authorisation in order to receive abortion services. Pregnant women and girls who, due to stigma or lack of resources, do not wish to jump through such judicial hoops, are left with limited options: either to not get an abortion, or to acquire an unlicensed procedure. Unlicensed procedures may have higher rates of risk; providers have less supervision and, thus, women who are harmed may be unlikely to report for fear that they too will fall under criminal liability.

The end result is a convoluted web of barriers preventing access to medically safe, accessible, and affordable abortion services in India. This produces a chilling effect on access to safe abortions. Entirely decriminalising abortion services – by not requiring that women and girls meet restrictive grounds for abortion access – would alleviate these barriers and is in keeping with the constitutional tenets of human dignity as well as the right to bodily autonomy. Finally, without the right to choose whether or not to carry a foetus to term, women and girls face an impossible decision: to have a potentially unsafe, unlicensed abortion or to lose decision-making control over their own bodies; the State's interests taking primacy over women right to decisional autonomy. It is high time we had a gender justice framework for abortion, only *at will*.

¹¹³ Dipika Jain, *Law-Making by and for the People: A Case for Pre-legislative Processes in India*, 20 STATUTE LAW REVIEW 20 (2019).

¹¹⁴ See Dipika Jain & Kimberly Rhoten, *Sex Work and the Law in India: Perspectives, Voices and Narratives from the Margins*, 40 HARVARD JOURNAL OF LAW AND GENDER 2 (2017).

¹¹⁵ Jain, *supra* note 114.

¹¹⁶ Hirve, *supra* note 8.