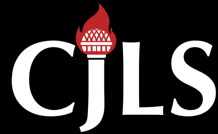

MEDICAL BOARDS FOR ACCESS TO ABORTION UNTENABLE:

EVIDENCE FROM THE GROUND

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

The Medical Termination of Pregnancy Act, 1971 ('MTP Act') was passed as an exception to the criminalisation of abortion under the Indian Penal Code, 1860 ('IPC). Although the IPC penalises both the abortion seeker and the one who performs the abortion, the MTP Act exempts registered medical practitioners ('RMP') from criminal liability if abortions are performed under the conditions laid down in the Act. The Act allows for abortions if (i) the pregnancy is a result of rape or incest; (ii) the foetus has been diagnosed with severe 'abnormalities'; (iii) the pregnancy would result in a risk to the life of the pregnant woman or result in a risk of grave injury to her mental/physical health; or (iv) a contraceptive method used by a married woman and her husband fails. Abortions up to 12 weeks' gestation require the approval of one RMP while abortions of pregnancies between 12-20 weeks require the approval of two RMPs. Beyond 20 weeks, abortions may only be performed to save the life of the pregnant woman.

In March 2020, the Medical Termination of Pregnancy (Amendment) Bill, 2020 ('MTP Amendment Bill') was introduced in the Lok Sabha by the Ministry of Health and Family Welfare. The Bill proposes certain reforms to the current law, such as extension of the 20-week limit to 24 weeks – but only for certain categories of women – and the mandatory constitution of Medical Boards to decide on termination of pregnancy after 24 weeks, provided the foetus is diagnosed with 'abnormalities'. The Bill seeks to set up Medical Boards in every state and union territory (UT). Each board is to have one gynaecologist, one radiologist or sonologist, one paediatrician, and other members prescribed by the state/UT government, and will have the power to grant permission for abortions beyond 24 weeks of gestation in case of 'substantial foetal abnormalities'.[5]

We, at the Centre for Justice, Law and Society (CJLS) undertook a study to closely analyse the district-wise availability and accessibility of specialist doctors across all Indian states, and the ramifications of the paucity of such doctors across rural, urban, and scheduled regions. The report focuses on access to abortion services in the country and specifically explores the feasibility of setting up Medical Boards for abortion. The report finds that there are sweeping shortages of healthcare professionals and specialists across India, poor public health infrastructure and healthcare funding exacerbated by unsound privatisation policies, and significant data gaps for doctor availability. Given these findings, requiring specialist doctors to sign off on a procedure as common as abortion is impossible – and will result in pregnant persons accessing unsafe abortions.

Persistently dismal investment in healthcare (at 1.3% of GDP in 2015-16 and 1.6% of GDP as of 2019-20, which is among the lowest in the world) and chronic disregard for medical capacity-building in India have resulted in severe shortages of specialist doctors as well as dysfunctional and/or poor health infrastructure across the country. Healthcare access is tremendously disparate between rural, urban, and scheduled areas. The research finds that the availability of specialists is extremely low in all states, and particularly so in rural and scheduled regions. Urban data on specialist availability is notably absent for most states, except for statistics on allopaths and radiographers, indicating poor record-keeping by relevant state departments. Sikkim, Meghalaya, Mizoram and the UTs also demonstrated an absence or near absence of specialist data.

Most Indian states and UTs record a dire shortfall (of 80% or more) of obstetricians and gynecologists, rendering the proposal of constituting functional state or district-wise Medical Boards practically impossible. In some states, at-home abortions were twice as many as public sector abortions. The private sector is the leading provider of abortions in many states and UTs, while unsafe at-home abortions compete numerically with those in the public sector. In the states of Himachal Pradesh, Uttarakhand, Chhattisgarh, Jharkhand and Odisha, homes are the most common venues of abortion.

The research revealed, first, that there is an absence of data for Primary Health Centres (PHCs) due to which our analysis had to be limited to Secondary Health Centres (SHCs). The research also showed that women completely lack control over their reproductive choices and bodily autonomy. The stigma associated with abortion and the inaccessibility of safe abortion services have led to a large number of unsafe abortions, which have resulted in serious complications – including death –for pregnant persons. Unsafe abortion is the third leading (and completely preventable) cause of maternal deaths in India, and close to 8 women die every day in the country because of unsafe abortions.[6] A study from 2019 in the British Medical Journal found that two-thirds of abortions in India are unsafe.[7] The study analysed a sample of 1.8 million women from 9 Indian states, which house 50% of India's population. Although there are variations across the states, the study revealed that there is a disproportionately higher risk of unsafe abortion among vulnerable and marginalised communities in India. It found that socioeconomic vulnerability in the forms of poverty, living in rural areas, caste and indigenous status, Muslim identity, education, and age are key determinants of unsafe abortions.[8]

On a reflection of the findings from the empirical research undertaken by CJLS, we find that instituting Medical Boards for abortion approval is practically unfeasible in many regions and impossible in others. It will exacerbate the structural inequalities

that characterise marginalised peoples' experiences in seeking reproductive health services and will serve to further bureaucratise a system that already remains inaccessible to many communities, including Dalit, Adivasi, Muslim, transgender, gender-variant, and intersex persons, as well as those residing in rural and scheduled regions of India.

Medical Boards were never envisaged in the MTP Act in 1971, and the law makes no mention of third-party authorisation for abortion. The addition of this layer to an already hetero-patriarchal, discriminatory and exclusionary framework will spell greater, rather than fewer unsafe abortions and consequently, increased post-abortion complications and even deaths of abortion seekers. Medical Boards and other third-party authorisation requirements have been recognized as major barriers to accessing safe abortion services under international law and policy. For example, The World Health Organisation (WHO) has urged states to remove such requirements from law and policy and has noted that 'negotiating authorisation procedures disproportionally burdens poor women, adolescents, those with little education and those subjected to, or at risk of, domestic conflict and violence, creating inequality in access'. Instead of instituting such Medical Boards, the Executive needs to work to better fund healthcare and make it easily accessible. The legal framework needs to reorient itself to give primacy to abortion upon request of patients, and specialist doctors need to be incentivised for service in public sector health facilities, especially in rural and remote reaches of the country.

This report has been structured to reflect on various changes in healthcare access from 2015-2019 to see the propensity for improvement and accommodation of Medical Boards as per the intent of the MTP Bill, across the country. Section I introduces the MTP Act, the MTP Amendment Bill and the main contentions against instituting Medical Boards to approve abortions. Section II looks at healthcare investment in India over the years, as well as public financing of health, stating that it is one of the lowest in the world, unable to even cover basic facilities for all persons. High levels of out-of-pocket expenditure in India lead to a phenomenon called 'distress financing' amongst the poor and marginalised, resulting in and sustaining medical poverty. This section also examines the trend of privatisation of healthcare since 2017 in India, which further impedes already tenuous access to healthcare facilities by raising costs, as well as foreclosing accountability of public authorities in covering the healthcare of persons who would normally have to rely on public facilities. The failure of the Central Government to ensure public health availability is mirrored in most states, which fare extremely poorly in financing public healthcare, as well as providing requisite specialists and services. Section III examines state statistics from across the country, pertaining to the availability of specialists in urban, rural, and scheduled regions of states; finding that obstetricians and gynaecologists are in short supply, with shortfalls of over 80% in most Indian states and UTs.

The research shows that there are serious shortfalls in the availability of specialist doctors in all the states and UTs of India, and that, with the exception of Scheduled Areas I (see Section II Part 4) where internal conflicts and increased military/police presence are major barriers to development of health infrastructure and accessibility of healthcare services, all other regions have similar causes for the shortfalls. The research highlights the inadequacy of healthcare availability, both in terms of infrastructure and requisite specialists to provide reproductive health services. With the onset of the COVID-19 pandemic and subsequent lockdown, access to healthcare has become even more difficult across India.

The report proceeds to make various national and state-level analyses in Section IV, which shows that constituting Medical Boards at any level is completely impractical in nature on a prima facie level when it comes to fulfilling the statutorily prescribed composition of such Boards.

Many states such as Tamil Nadu, Arunachal Pradesh and Gujarat have recorded a near complete absence in the availability of certain specialists (gynaecologists and obstetricians, paediatricians, radiologists), especially in rural areas. In rural North India, there is on average a 84.2% shortfall in obstetricians and gynaecologists a 68.76% shortfall in paediatricians, and a 74.5% shortfall in radiologists. Rural South India fares similarly, with a 57.2% shortfall in gynaecologists and obstetricians, a 61.4% shortfall in paediatricians and a 68% shortfall in radiologists. In East and North-east India, the research revealed a 100% shortfall of paediatricians in Arunachal Pradesh, Meghalaya, Mizoram and Sikkim and a near complete absence of other specialists as well. In the Scheduled Areas as well, there is an abysmal shortfall of specialists with Himachal Pradesh recording a 98% shortfall in obstetricians and gynaecologists.

Since the MTP Amendment Bill requires these three specialist doctors to be part of the Board, along with other members that the State/UT may appoint, it would be nearly impossible to constitute such Boards in most regions of the country. Such bureaucratic processes would inevitably delay the abortion until the pregnancy is at an advanced stage. Additionally, the costs incurred by the pregnant person in travelling to present themselves before the Board can be a serious financial setback. The human rights violations caused due to denial of accessible healthcare services and structural discrimination in reproductive health spaces will be exacerbated by the invasive, traumatic and prolonged authorisation processes of Medical Boards.

Given the sweeping shortages of healthcare professionals and specialists across the regions of India, along with poor public health infrastructure and healthcare funding, unsound privatisation trends and significant data gaps, we argue that it will be catastrophic to the rights of pregnant persons to institute Medical Boards to sign off on abortions. It is imperative that the Government sends the current Bill to the Standing Committee for further deliberation and retracts this and many other laws that directly or indirectly impact access to abortion in India.

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THE CENTRE FOR JUSTICE, LAW AND SOCIETY

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

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

We began as a research centre (Centre for Health Law, Ethics and Technology, CHLET) in 2009, the first-of-its-kind with a focus on health law and policy. In the last 11 years, our journey has seen us work on issues of judicial diversity, critical pedagogy, critical legal theory, gender, sexuality, constitutional law, legal education and public health law, caste and indigeneity, and social movements and the law. Our efforts have included facilitation of national consultations for transgender, intersex and gender-diverse persons, exciting symposiums and conferences in collaboration with national and international organisations and civil society movements, policy interventions and advocacy with parliamentarians on abortion law and the transgender law, rigorous work with law students from across the country through the Law and Marginalisation Clinic, our Internship Programme and Research Fellowships, pro bono legal representation, filing UPR submissions, filing RTIs, organising collaborative queer film festivals, and hosting academics, activists and lawyers from across India and the world for public lectures, seminars, conversations, courses and discussions.

At CJLS, we see ourselves facilitating conversations, legal and policy interventions and collaborating with social movements. We do not claim to speak for any movements and over the years we have continued to reflect on and learn from our activist and scholar friends on the various projects we have worked on.

ACKNOWLEDGMENTS

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

We would like to acknowledge the contribution of all the research assistants for their commitment, passion, and tireless research for the study and the cause including Ahana Bag, Ayush Shukla, Devangana Kuthari, Mansi Upadhyay, Pragya Choudhary, Priya Agrawal, Rebecca Cardoso, Shreeya Sud, Vinnakota Ambika Madhavi Sneha, and Vishal Vinod.

Gratitude to Dr. Suchitra Dalvie for her valuable comments on the draft of this report. We would also like to thank Dolashree Mysoor for proofreading the report, and Joshika Saraf for her invaluable assistance.

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

Further, we would like to recognize the support of the faculty and administration at O.P. Jindal Global University (JGU) and Jindal Global Law School (JGLS) including the Registrar, Prof. Dabiru Sridhar Patnaik, Prof. (Dr.) S.G. Sreejith, and Prof. Arjya B. Majumdar. We are grateful to and sincerely appreciate the work of the communications and graphic design teams of JGU, especially Yatendra Singh, Pratiksha Rana, and Mr. Manoj GD, as well as student designer Chaitanya Kishore Sunkara.

Finally, we thank the Vice Chancellor, O.P Jindal Global University, Prof. Dr. C. Raj Kumar, for his constant support, encouragement, and guidance.

GLOSSARY

Ableism: Ableism can be defined as a set of discriminatory, oppressive, abusive beliefs or practices that devalue and discriminate against people with physical, intellectual, or psychiatric disabilities and often rests on the assumption that disabled people need to be 'fixed' in one form or the other. Ableism refers to prejudice, stereotyping, or "institutional discrimination" against disabled persons. It is intertwined in our culture, due to many limiting beliefs about what disability does or does not mean, how able-bodied people learn to treat people with disabilities and how people with disabilities are often not included at the table for key decisions.

Abortion: Abortion is the termination of a pregnancy. Induced abortions are those initiated by deliberate action taken with the intention of terminating pregnancy; all other abortions are considered spontaneous. Spontaneous abortions are synonymous with miscarriages.

Distress financing: Distress financing is defined as borrowing money or selling assets to meet out of pocket health expenditure. Distress financing tends to push persons and households into poverty.[1]

Gestational Limits: Gestational limits prescribe the point within pregnancy when a termination is permissible. Such limits often vary depending on the legal framework, including the circumstances under which abortion is allowed.

Miscarriage: The spontaneous loss of a pregnancy.

Out-of-pocket expenditure: Healthcare expenses borne by patients themselves, as opposed to services financed by governments, health insurance companies, etc.

Reproductive Autonomy: Autonomy in this context means the right of a person to make decisions concerning their fertility and sexuality, free of coercion and violence. The right to autonomy in making health decisions in general, and sexual and reproductive decisions in particular, derives from the fundamental human right to liberty.

Reproductive Health: A state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce should they so choose, and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of all persons to be informed, have access to safe, effective, affordable and acceptable methods of contraception, abortion, and family planning, including methods for regulation of fertility which are not against the law; and the right of access to appropriate health care services to pregnant persons to either terminate or carry their pregnancy to term.

Reproductive Rights: These embrace certain human rights that are already recognised in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of persons to decide freely and responsibly whether they wish to reproduce and the number, spacing and timing of their children, and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

Safe abortion: According to the World Health Organization (WHO), abortions are safe when they are carried out with a method that is recommended by WHO that is appropriate to the pregnancy duration, and when the person carrying out the abortion has the necessary skills. Such abortions can be done using tablets (medical abortion) or a simple outpatient procedure.[2]

Self-induced abortion: Abortions performed by the pregnant person themselves are called 'self-induced abortions'. Such procedures can be highly perilous. Although medical abortion pills can be consumed safely to induce an abortion, done without access to post-abortion care in case of complications leaves pregnant persons susceptible to health hazards.

Third-party authorisation: Third-party authorisation requirements compel individuals to obtain consent from a party beyond their healthcare provider, such as a parent, spouse, judge, or medical committee, before they can access legal abortion services. Such requirements may be written into laws or policies or imposed in practice. Third-party authorisation requirements can delay women and girls' access to abortion services while they seek the necessary approvals or can result in denials of access altogether, such as when women and girls are unable to obtain the necessary approvals or fear violence or reprisal for seeking consent of a third-party. In such circumstances, women and girls may be forced to seek out unsafe, clandestine abortion services as a result.[3]

Unsafe abortion: Unsafe abortion is defined by the World Health Organization (WHO) as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.[4]

SECTION - I

Introduction

The law on abortion in India is primarily governed by the Indian Penal Code (IPC) and the provisions of The Medical Termination of Pregnancy Act, 1971 (MTP Act). Sections 312-314 of the IPC refer to abortion as 'causing a miscarriage' and Section 315 refers to it as an '[a]ct done with intent to prevent child being born alive'. IPC provisions criminalise both the person undergoing the abortion, as well as the medical practitioner facilitating the abortion.[9] Abortion is, therefore, a crime in India unless carried out in accordance with the provisions of the MTP Act.

Indian activists have been calling for reform of abortion laws for over a decade, through strategic litigation as well as parliamentary actions.[10] Activists have argued that the MTP Act is a doctor-centric law, which does not provide for abortion according to the choice of the pregnant person, granting discretion to medical professionals to make such decisions.[11] In March 2020, the Ministry of Health and Family Welfare introduced an amendment to the MTP Act in the Indian Parliament, namely the MTP Amendment Bill of 2020. The Statement of Objects and Reasons of the MTP Amendment Bill clearly articulates that the MTP Act intended to provide legal, affordable, and safe access to abortion. However, the proposed amendments continue to reflect population control, family planning, eugenics-based, heteropatriarchal ideals of the state.[12] Neither the MTP Act nor the Amendment Bill are set in a rights-based framework to enable pregnant persons to freely exercise their reproductive autonomy.

The MTP Amendment Bill has increased the overall upper gestational limit for termination of pregnancies from 20 to 24 weeks for certain categories of women, which have not been defined in the Bill. However, this amendment still requires the approval of one registered medical practitioner for abortions within the gestational period up to 20 weeks and the approval of two medical practitioners for abortions between 20-24 weeks' gestation. Thus, it is not based on request or at will of the pregnant person, but on a doctor's opinion.[13] The importance of obtaining access to abortion at will is critical, since medical professionals are often hesitant to provide services due to fear of prosecution under the IPC.[14] The reluctance of medical professionals to perform abortions is compounded by confusion and misconceptions arising out of two laws: The Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 ('PCPNDT Act') and the Protection of Children from Sexual Offences Act, 2012 ('POCSO Act').[15]

The PCPNDT Act, which prohibits sex determination of foetuses, has been implemented harshly and in an arbitrary manner that has led to many doctors refusing to provide abortion services after 12 weeks of gestation, out of fear that legal authorities will assume that the abortion was carried out pursuant to sex selection.[16] It is important to understand that there are two different legislations with different legislative intent and purpose. Further, the POCSO Act characterises all sexual contact with minors as sexual offences and more importantly, contains a mandatory reporting

provision where all sexual offences under POCSO involving a minor must be reported to law enforcement. The criminalisation of adolescent sexuality under this law has meant that pregnant adolescents hesitate to seek abortion services out of fear that their partners will face criminal charges.[17] The conflict between laws serves to create ethical dilemmas and has a 'chilling effect' on medical practitioners' willingness to perform abortions.[18]

The MTP Amendment Bill provides that in cases of "foetal abnormalities" diagnosed by a Medical Board, there will be no upper gestational limit on termination. There are three main problems with this provision. First, it continues to advance eugenic goals. This is evident from the press release issued by the State's Press Information Bureau, which categorically states that the Bill intends to expand access to "safe and legal abortion services on therapeutic, eugenic, humanitarian or social grounds."[19] Eugenic goals reinforce the view that certain foetuses are per se unwanted and undesirable, advancing ableist rationales. Second, "abnormality" should not be the sole ground on which terminations are permitted at all stages of the pregnancy. There are several other reasons why a person may need an abortion after 24 weeks, including a sudden change in circumstances that could be caused by situations like domestic violence, separation from or death of a partner, or a change in financial situation. The proposed amendment limits access to abortion of certain 'vulnerable' categories, including survivors of rape and pregnant persons from marginalised communities. The law is arbitrary in that it allows for one category of persons to undergo abortions based on medical opinion but excludes other persons who may seek abortions for other reasons. Third, the decision to carry a pregnancy to full term or to abort, even if the foetus has a potential disability, should be at the sole discretion of the pregnant person, in consultation with their medical practitioner. The State should not be involved in making this decision.

Finally, the MTP Amendment Bill, 2020 mandates the setting up of a Medical Board in every State and Union Territory. Each Board will consist of a gynaecologist, paediatrician, radiologist or sonologist and any other number of members proposed by that State or Union Territory. The Medical Board will be responsible for the diagnosis of substantial foetal "abnormalities" that necessitate termination. Medical Boards have thus far been entirely outside the scope of the MTP Act, 1971, which bore no mention of them. Yet, they have been constituted and relied upon by the Supreme Court of India and High Courts to provide medical expertise on abortions. Thus, they are judicial interventions that will be reified into law with the MTP Amendment Bill, 2020. In abortion cases before the Supreme Court pertaining to such foetal "abnormalities", when Medical Boards believed that foetuses were likely to survive after birth, the Court took into account the viability of the foetus, rather than the original legal standard of measuring the impact of the pregnancy and its termination on the mental and physical health of the pregnant person (woman).[20] In three cases before the Supreme Court, specifically, the Court rejected the MTP of pregnant persons whose foetuses were between 26 and 28 weeks on the ground that the Medical Boards in those cases opined that the foetuses were viable in nature.[21] In High Courts, there have been at least ten cases of rejection of MTP requests on grounds of foetal "abnormalities"; court decisions were based on Medical Board opinions, which, amongst others, stated that the "abnormalities" in question were either "not significant" or "could be rectified after one or more surgeries".[22]

A review of Supreme Court and High Court MTP cases between 2016 and 2019 shows that rather than consulting the medical professionals chosen by the pregnant persons themselves, courts task Medical Boards to give definitive medical opinions on

regulating abortions after 24 weeks.[23] This third-party authorisation can be burdensome and has previously resulted in severe delays in granting abortions, which are highly time-sensitive in nature, thereby foreclosing the option of aborting.[24] The serious issue of delay and its adverse consequences to pregnant persons are illustrated in cases before the Supreme Court. In the case of Ms. Z v State of Bihar[25] the Court rejected medical termination of pregnancy, after delays by the Patna High Court caused the pregnant person to endure the unwanted pregnancy for 36 weeks, until she was able to approach the Supreme Court for relief. The Court found that it was then too late to allow MTP, but ordered that the State pay the petitioner compensation of INR 10 lakhs, noting the negligence of the State and the respective High Court in not providing MTP to the petitioner earlier.[26] In the case of R v. State of Haryana[27], the Punjab and Haryana High Court observed that the pregnant person had been referred to multiple Medical Boards earlier, which returned different opinions on MTP, causing delays to the point where the pregnancy was too advanced to be terminated.

Further, Medical Boards' opinions have been inconsistent and have considered factors extraneous to the MTP Act, against the interests of pregnant persons. The study undertaken by the Pratigya Campaign analysing MTP cases before the Supreme Court and High Courts between 2016 and 2019 shows that overall, courts rely heavily on Medical Board opinions, which take into account factors not prescribed as conditions in the MTP Act.[28] In High Courts, such factors could include consideration of the "significance" of foetal "abnormalities" and whether such "abnormalities" could be "corrected" through surgeries.[29] Due to reliance on Medical Board opinions that could be highly varied in nature, High Courts were seen to pass orders based on inconsistent criteria[30], resulting in fragmented and varying jurisprudence on grant or rejection of MTP. With diverse composition of such Boards as well as a lack of uniform judicial precedent on abortions, quick decisions by Courts are often rendered practically impossible, resulting in pregnancies reaching advanced stages before termination is permitted, if at all.

Indian courts have noted that additional layers of authorisation have created barriers to women exercising their reproductive autonomy and it is clear that if pregnant persons are forced to continue with unwanted pregnancies pending third-party authorisation (by courts or Medical Boards), it is detrimental to their physical and mental health. The problems inherent in third-party authorisation have also been highlighted at the international level. The UN Human Rights Special Procedures Working Group on the Issue of Discrimination against Women in Law and in Practice released a statement in 2017 asserting that any legislative requirements for abortion should not cause delays that would prevent the carrying out of termination before the pregnancy becomes too advanced.[31] Similarly, the Committee on the Elimination of Discrimination against Women (CEDAW) has raised concerns about third-party authorisation requirements[32], and the World Health Organization (WHO) has acknowledged that third-party authorisation requirements undermine women's autonomous decision-making.[33]

The multiple layers of authorisation required for MTP as per India's current legal and healthcare distribution frameworks act as major impediments to marginalised persons being able to access safe abortion services. The obstacles to accessing timely abortions are also well illustrated through the case of Amita Kujur v. State of Chhattisgarh[34] wherein the petitioner, an Adivasi girl and rape survivor, wanted to terminate her pregnancy at twelve weeks. She was referred to the Chhattisgarh Institute of Medical Sciences (CIMS), which required documentation including a copy of the FIR recording rape, medico-legal documents, and a reference letter from the

District Hospital, which she was unable to obtain.[35] The petitioner approached the Chhattisgarh High Court seeking permission for MTP, and the Court directed the constitution of a Medical Board comprising of two doctors to examine her. They determined that her pregnancy was at twenty-one weeks, outside the confines of the MTP Act. However, the Court proceeded to grant MTP in the interest of the petitioner, albeit with a significant delay caused by the convoluted authorisation framework.

Amita Kujur's case shows that access to abortion is not just impeded by delays due to judicial authorisation, but also due to the lack of abortion services available in rural and scheduled areas.[36] The delays experienced by her were caused by the non-availability of services for abortion at the hospitals that she went to, as well as allegedly callous attitudes demonstrated by the police station in charge.[37] Further delays were caused as hospital authorities denied an abortion in the absence of a FIR provided by the petitioner, in contravention to existing medico-legal protocols for survivors of sexual violence that clearly state, "if a person has come directly to the hospital without the police requisition, the hospital is bound to provide treatment and conduct a medical examination with consent of the survivor/parent/guardian (depending on age). A police requisition is not required for this".[38]

The Ministry of Health and Family Welfare guidelines on medico-legal care for survivors of sexual violence additionally mandate the provision of "immediate access to health care services"[39] for survivors of sexual violence, including "access to safe abortion services". Since the petitioner had already filed an FIR before the jurisdictional police station, the hospital and police station should have recorded the same and coordinated with each other to receive the requisite documents, instead of issuing a blanket refusal to conduct the MTP procedure.[40] This further points to unnecessary delays leading to extension of the period of gestation beyond the statutorily permitted time period of 20 weeks, to the detriment of the pregnant person's physical and psychological health.[41]

Methodology

Research has shown that there is a disproportionately higher risk of unsafe abortion among vulnerable and marginalised communities in India, not just on account of the nature of the legal framework, but also due to unequal and disparate distribution of healthcare infrastructure across the country. Pre-existing research demonstrates that rural areas in states like Chhattisgarh, Jharkhand, and Odisha show highly inadequate access to safe abortion services.

We undertook quantitative empirical research to comprehend the availability of specialists in Community Health Centres, and the state-wise distribution of abortions between public facilities, private facilities, and at-home abortions. We used national as well as state-wise statistics from various governmental agency surveys and non-governmental studies conducted between 2015 and 2019. Since the Primary Health Centres (PHCs) data is not available, we relied on secondary literature for the PHCs.

We relied primarily on the Rural Health Surveys (RHS) and the National Family Health Surveys (NFHS) from 2015 to 2019 for Community Health Centres (CHC), of which the latter contained data for both rural and urban regions. Data included statistics pertaining to national health policy, availability of specialists in Community Health Centres, and the state-wise distribution of abortions between public facilities, private facilities, and at-home abortions. The data gathered from RHS was analysed to identify, state- and year-wise the total number of positions available for specialist doctors and the number of positions filled. We then calculated the shortfall in each year as well as an average over the five-year period. The NFHS data was analysed to determine the number of abortions taking place in the public sector as compared to private and at-home abortions. This data is presented for urban and rural regions.

SECTION - II

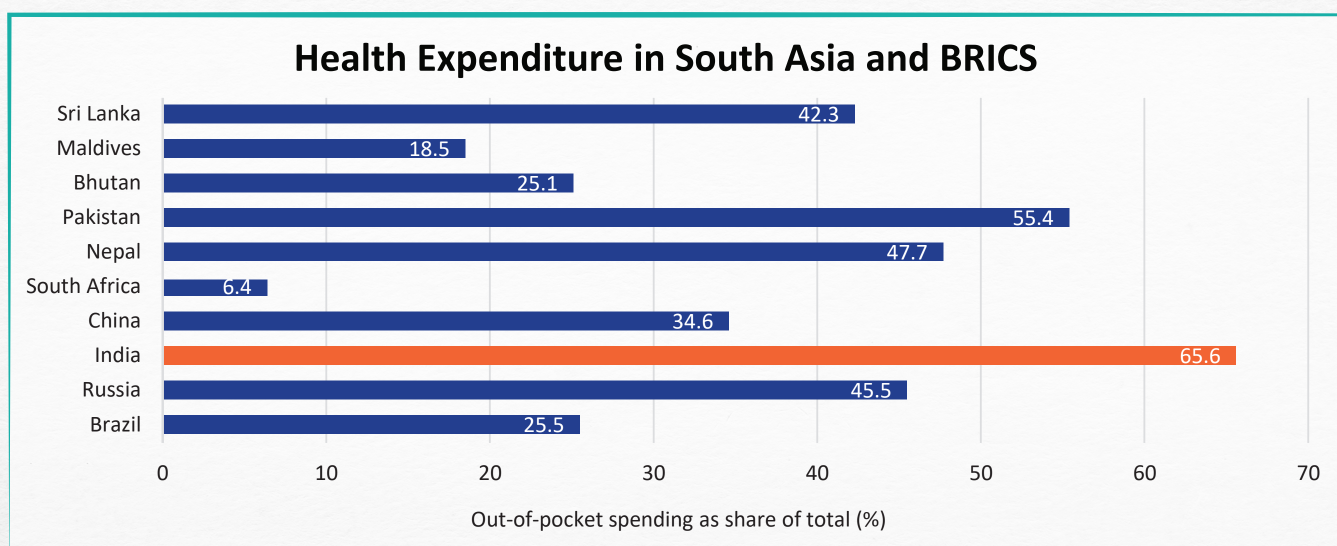
Observations at the National Level

This section of the report provides observations pertaining to healthcare access at the national level, examining pre-existing trends of investment in health by India, statistics relating to out-of-pocket expenditure by Indian patients, trends towards privatisation of healthcare, as well as various government-enacted schemes affecting the sources of provision of healthcare, impacting overall access.

The Indian legal framework – due to ambiguities between laws, prescribing bureaucratic processes entailing high levels of medical and judicial discretion and incorporating lengthy authorisation processes in granting abortions – has adversely impacted overall access to abortions by pregnant persons, especially those who are already marginalised in the country. This section takes the research one step further, analysing national trends, patterns and inclinations, to determine the practical feasibility of setting up Medical Boards on the back of a healthcare system that struggles with various existing shortfalls and impediments to accessing basic reproductive services. This research aims to set the context for analysis as to whether it is practically feasible to set up, staff, and maintain Medical Boards in accordance with the legal stipulations of the MTP Amendment Bill.

1. Health Policy

The current level of public financing of health in India is one of the lowest in the world, and is far from covering basic facilities for all.[44] For over 15 years, India has spent close to 1% of its GDP on healthcare; a shockingly low expenditure.[45] In 2019, India's public expenditure on health was at 1.28% of the GDP, which is one of the lowest globally.[46] While the target for spending is 2.5% by 2025, the country is lagging far behind this goal. In comparison, India's neighbours such as Sri Lanka and Nepal spend far more on public health.[47]



(Graph - 01)

The failure of public health has meant that most health expenditure in the country is out of pocket (OOP) i.e., borne by patients themselves. Out of pocket expenditure was 58.7% as per the National Health Accounts in 2016-17.[48] A study by the Lancet found that out of 184 countries, Indians are the 6th biggest OOP spenders for healthcare.[49] India fared the worst in the BRICS group (Brazil, Russia, India, China and South Africa) in OOP health expense.

OOP expenditure abandons the poor to 'distress financing' of medical care by selling off personal or ancestral assets like land and livestock, borrowing from predatory moneylenders, etc. and is a major cause of impoverishment in India, affecting those in rural and conflict zones the most.[50] For instance, about 17.4% of the women from the lowest quintile in Mumbai slums financed their maternal care expenditure by borrowing money.[51] Every year, 3.5 to 6.2% of the population of India is pushed into poverty due to high OOP expenditure.[52]

The Central Government since 2017 has been pushing for the privatisation of healthcare, turning hospitals into an 'industry' and the state into a 'strategic purchaser' of healthcare as a consumer good. The cost of supporting private players is socialised, while their gains are privatised. In 2017, NITI Aayog and the Ministry of Health prepared a 140-page document in consultation with the World Bank for the 'radical privatisation' of medicine.[53] NITI Aayog and the Ministry of Health encouraged all states to privatise urban health for non-communicable diseases, allowing private entities to take over hospital beds and patients approaching district hospitals, and compelling public hospitals to share resources like blood banks, ambulances, and other infrastructure.[54] NITI Aayog argued that India does not have the capacity to improve its public health. However, there has been strong opposition to this move from civil society as well as by state governments, such as those of Chhattisgarh and Madhya Pradesh.

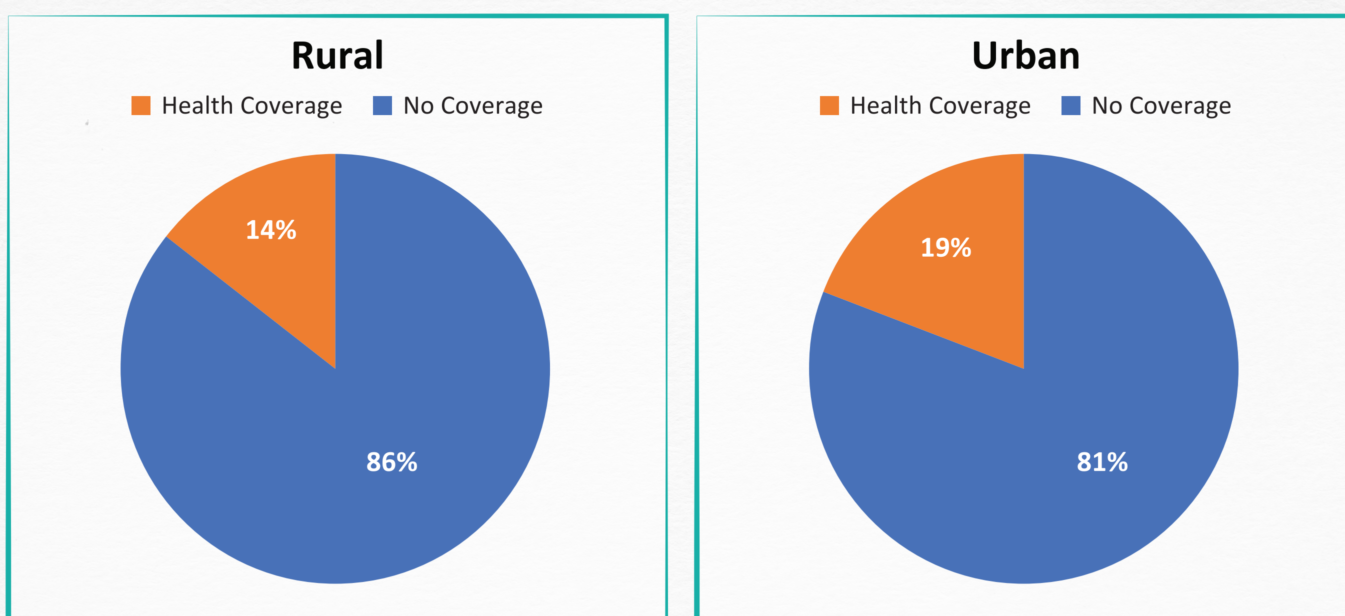
This policy will further compromise quality and access to healthcare, mainly for poor patients. Our public healthcare facilities, built over decades, need investment. It's like handing over an unpolished jewel to someone else saying we don't have resources to polish it.
It's a ridiculous argument since our healthcare spending is one of the lowest in the world.

Dr. Abhay Shukla,
National co-convenor, Jan Swasthya Abhiyan

Dalits, Adivasis, labourers, the last person in society, all depend on these hospitals. How can we give it in private hands?

Tulsi Silawat,
Madhya Pradesh Health Minister

Despite this, the Central Government has preferred to incentivise private players to set up or offer services, instead of building infrastructural and professional capacity. Privatisation drives up costs of care and the handing over of public facilities to the private sector is a fatal, catastrophic decision. Private institutions prioritise profit over health and have no reason to cater to the vulnerable or marginalised. Nor are they accountable to stay affordable or transparent (for instance, through Right to Information enquiries), or to uphold Fundamental Rights like non-discrimination in treatment or employment, or even the Fundamental Right to Health. The Centre has chosen to provide insurance schemes for private care instead of investing in widely available, subsidised public healthcare, draining public resources and making health access further depend on the will of private providers, as well as bureaucratic barriers of insurance documentation. Simply put, the schemes do not cover all people but only those who qualify under them. The National Sample Survey Organization (NSSO)'s 75th report shows that less than 20% of the population is covered by health insurance in India.[55]



(Figure - 01)

These findings all demonstrate the failure of governments to ensure public health availability, and strongly warn against instituting Medical Boards for abortion approval, which will leave pregnant persons stuck without approval for abortion – a highly time-sensitive decision.

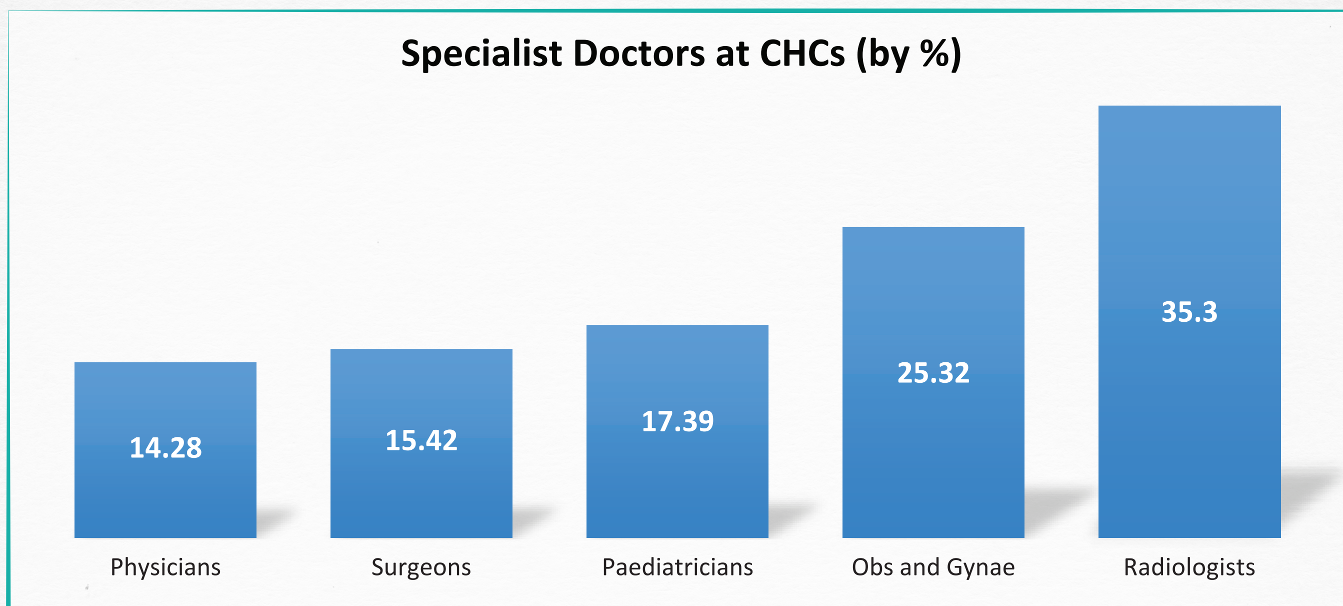
2. Findings on Availability of Healthcare

According to the National Health Profile 2017, India has a mere 1 million qualified doctors for a population of 1.3 billion people. There is one doctor for roughly 10,200 people in the public sector.[56]

The table below shows the availability of specialist doctors in all Indian states:

Indian States	2019		2018		2017		2016		2015	
	Required	In Position	Required	In Position	Required	In Position	Required	In Position	Required	In Position
Andhra Pradesh	560	237	772	384	772	348	772	159	716	159
Arunachal Pradesh	252	4	252	4	252	4	252	4	208	1
Assam	708	136	688	158	638	139	604	131	604	121
Bihar	600	82	600	82	600	82	592	40	280	63
Chhattisgarh	680	61	676	57	676	59	620	61	620	78
Goa	20	5	16	10	16	4	16	5	16	4
Gujarat	1448	118	1452	118	1452	92	1288	148	1280	74
Haryana	460	15	452	17	448	16	440	30	436	30
Himachal Pradesh	348	5	364	4	356	12	316	7	312	7
Jammu and Kashmir	336	242	336	256	336	191	336	190	336	167
Jharkhand	684	66	684	92	752	75	752	122	752	128
Karnataka	792	465	824	498	824	498	824	498	824	502
Kerala	908	35	908	40	928	40	900	40	888	39
Madhya Pradesh	1236	104	1236	248	1236	180	1336	289	1336	263
Maharashtra	1456	485	1444	485	1440	508	1440	505	1440	578
Manipur	92	3	92	3	68	3	68	3	68	3
Meghalaya	112	4	112	9	108	13	108	12	108	3
Mizoram	36	0	36	0	36	0	36	0	36	0
Nagaland	84	8	84	8	84	8	84	8	84	4
Odisha	1508	236	1508	253	1480	318	1508	354	1508	356
Punjab	356	93	604	105	593	390	600	196	600	173
Rajasthan	2284	455	2352	565	1593	1096	2284	497	2272	526
Sikkim	8	0	8	0	8	1	8	1	8	0
Tamil Nadu	1540	179	1540	210	1540	78	1540	76	1540	0
Telangana	340	258	364	112	456	125	456	147	456	116
Tripura	72	2	88	2	-	-	-	-	-	-
Uttar Pradesh	2716	484	3288	192	3099	1615	3092	484	3092	484
Uttarakhand	268	27	268	29	200	159	236	41	236	49
West Bengal	1392	71	1392	125	1396	117	1396	125	1388	114
TOTAL:	**21296**	**3880**	**22440**	**4066**	**21387**	**6171**	**21904**	**4173**	**21444**	**4042**
Vacancy	17416		18374		15216		17731		17402	
Shortfall	81.80%		81.90%		71.10%		80.90%		81.20%	

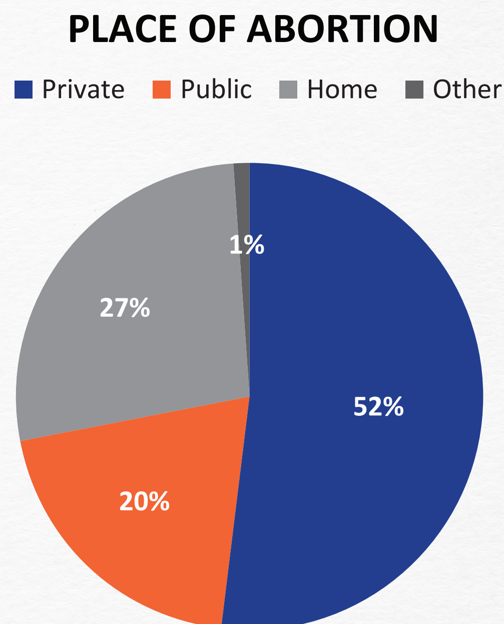
Although there has been a 68% increase in the number of functioning CHCs – which are supposed to be equipped to perform abortions – from 2015 to 2019, there is a severe shortage of specialist doctors at the centres.



(Graph - 02)

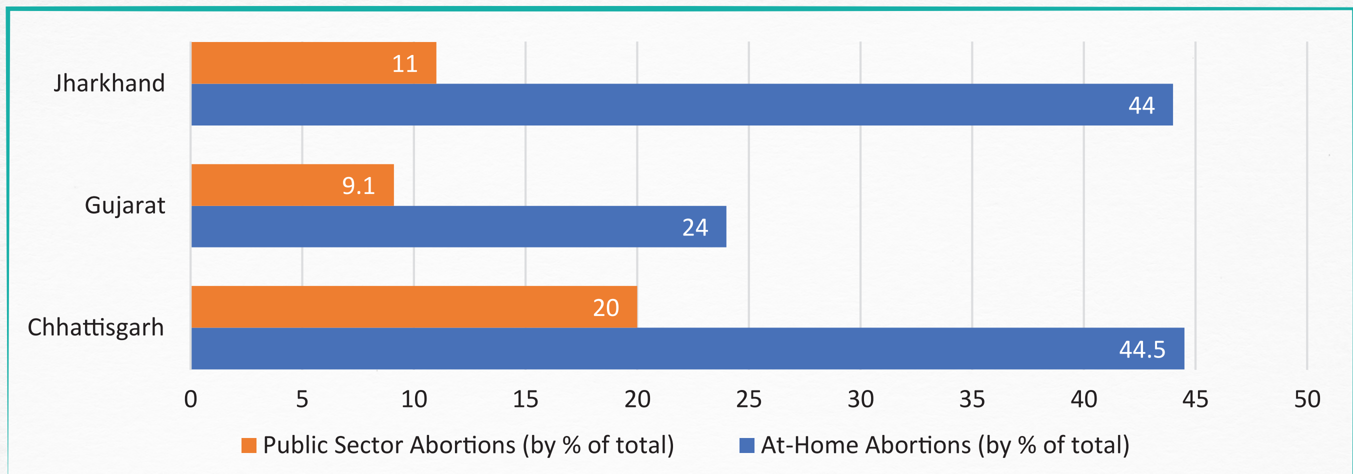
Overall, there is a dire shortage of nearly 80% specialist doctors at these centres. Specialist doctors are shockingly few, making the institution of Medical Boards inviable. In contrast, AYUSH practitioners are abundant, exceeding their requirement in several regions, and dominating states like Karnataka. However, the MTP Act does not allow them to perform abortions.

Most states fare poorly in financing public healthcare. Even when states spend well and are able to construct more PHCs and CHCs (such as in Kerala and Goa), the centres severely lack specialists and doctors. Poor public health infrastructure and absence of specialists in PHCs and CHCs across the country have meant that most abortions do not happen in the public sector, but at private centres or at home. This in turn leads pregnant persons to resort to costly and inaccessible private abortions, or potentially dangerous methods of self-administered abortions. Barriers in access to abortion for pregnant persons can also lead to dangerous repercussions such as infections, incomplete abortions or deaths.[57]

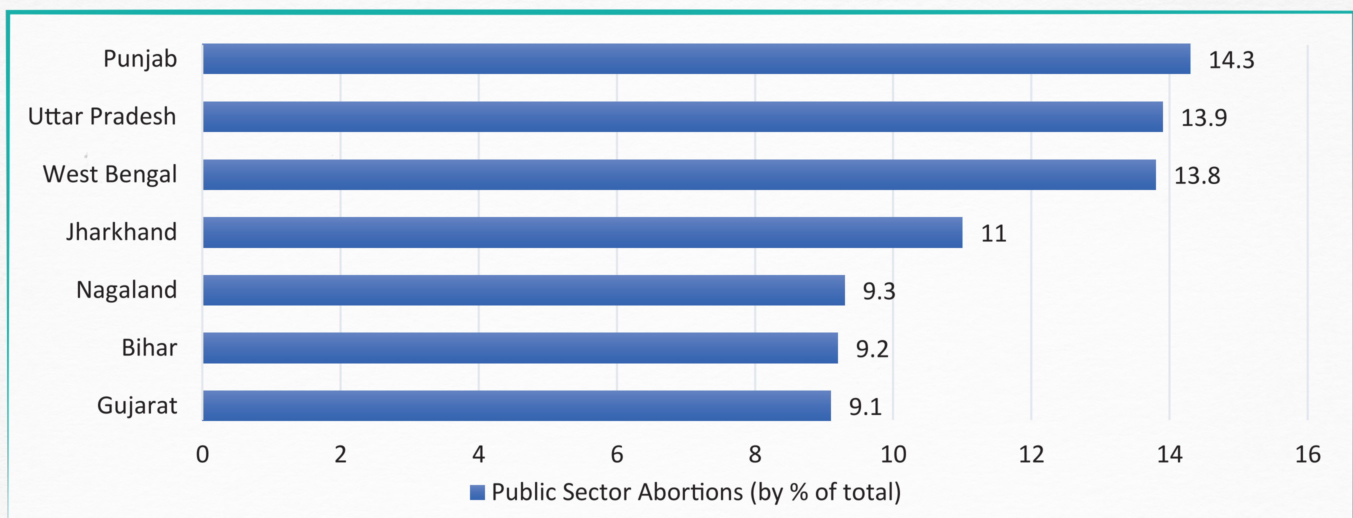


(Figure - 02)

Regional findings show similar trends, with most Indian states and UTs having a shortfall of over 80% in the availability of obstetricians and gynaecologists. The private sector is the leading provider of abortions in nearly all states. In some states, at-home abortions were four times as many as public sector abortions. In many states, public sector abortions were less than 15% of all abortions conducted.



(Graph - 03)



(Graph - 04)

All states for which data was available saw women treated for complications in abortions. Notable among these was Assam, with 51,000 women seeking treatment for complications arising from unsafe abortions. In Madhya Pradesh, 36 women died in 2018 and 56 women died in 2019 from unsafe abortions.[58] These findings clearly demonstrate the need for increasing the capacity of public hospitals across the country to provide abortions. In light of the severe shortfall in specialist doctors, constituting Medical Boards will prove to be a major barrier to safe abortion access, compelling pregnant persons to seek riskier methods.

The following section presents data from each region of the country, which demonstrates the practical impossibility of constituting Medical Boards. Data from states (where such data was available) shows dire shortfalls in numbers of specialists, particularly in rural and scheduled regions, with serious gaps in data from urban areas across the country. Union Territories and some of the North-Eastern states also show a near or total absence of specialist data, indicating that any major changes to healthcare policy, including the setting up of Medical Boards, would be carried out without any knowledge of infrastructure and human resource availability in those areas. Further, state data indicates that access to reproductive services is already dismal in nature, with high prevalence of maternal deaths, lack of control over birth rate and high proportions of unsafe, at home abortions. The data clearly shows the impracticality in seeking to set up Medical Boards to decide requests for medical termination of pregnancy.

SECTION - III

Observations at the State Level

This section of the report provides observations relating to healthcare access at the state level, collating and analysing data from states as well as union territories in various regions of the country. This section, like the preceding section, takes into consideration the availability of specialists at CHCs, including surgeons, obstetricians, gynaecologists, physicians, and paediatricians in rural, urban, and scheduled areas, the shortfall of experts in every state, place of abortion and comparisons of the number of abortions carried out in the public sector with those performed in the private sector or at home. Further, this section examines rates of abortion complications, as well as trends in all the data, wherever available, from 2015 to 2019.

The research shows that specialist availability is dire in all states, and particularly so in rural and scheduled regions. Urban data on specialist availability was absent for most states, except for allopaths and radiographers. The union territories (UTs), Sikkim, Meghalaya and Mizoram, had an absence or near absence of specialist data. Most Indian states and UTs demonstrated a shortfall of over 80% in the availability of obstetricians and gynaecologists, making the proposal of state or district-wise Medical Boards unfeasible. There is also a significant dearth of primary health centres (PHCs) and community health centres (CHCs) throughout India.

1. North India *(Bihar, UP, Uttarakhand, Rajasthan, Punjab and Haryana)*

1.1. Availability of Specialists at Community Health Centres

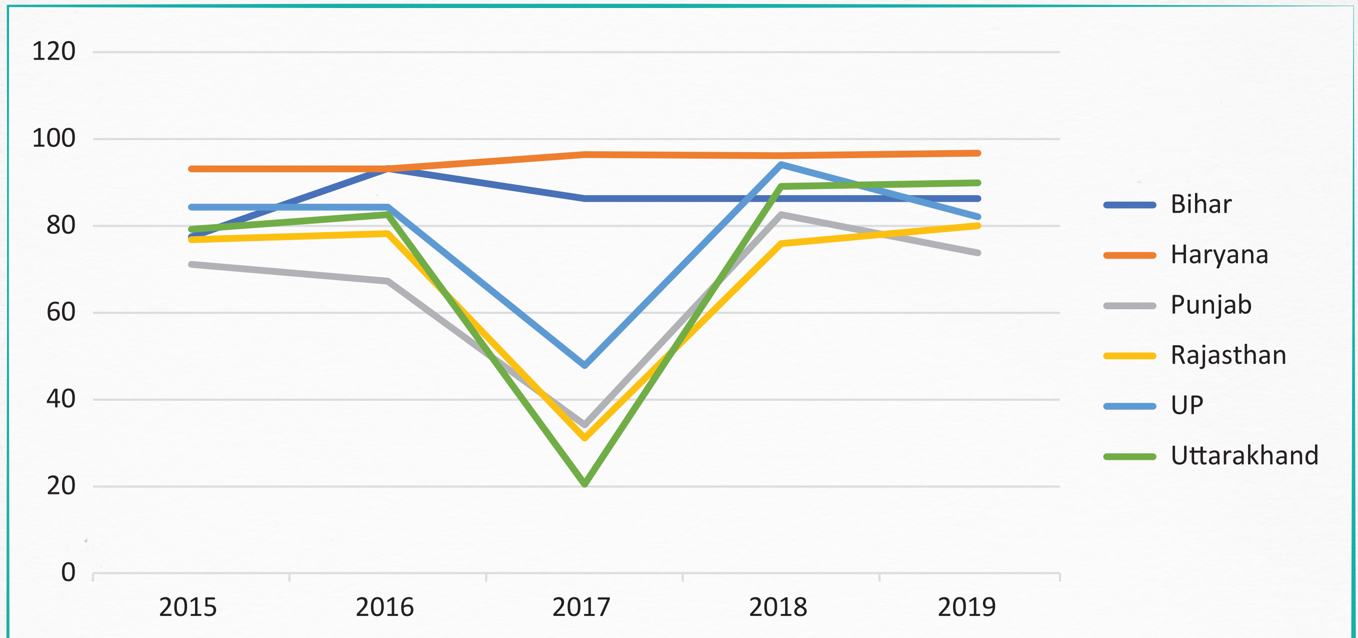
This sub-section presents data from six North Indian states. Due to the unavailability of data from urban areas, the focus is on CHCs in rural areas.

The table below shows the availability of specialists (surgeons, OBGYNs, physicians and paediatricians) at CHCs in rural areas, as of 31 March each year from 2015 to 2019. The data presented is from the annual Rural Health Survey.

North Indian States	2019		2018		2017		2016		2015	
	Required	In Position	Required	In Position	Required	In Position	Required	In Position	Required	In Position
Bihar	600	82	600	82	600	82	592	40	280	63
Haryana	460	15	452	17	448	16	440	30	436	30
Punjab	356	93	604	105	593	390	600	196	600	173
Rajasthan	2284	455	2352	565	1593	1096	2284	497	2272	526
Uttar Pradesh	2716	484	3288	192	3099	1615	3092	484	3092	484
Uttarakhand	268	27	268	29	200	159	236	41	236	49

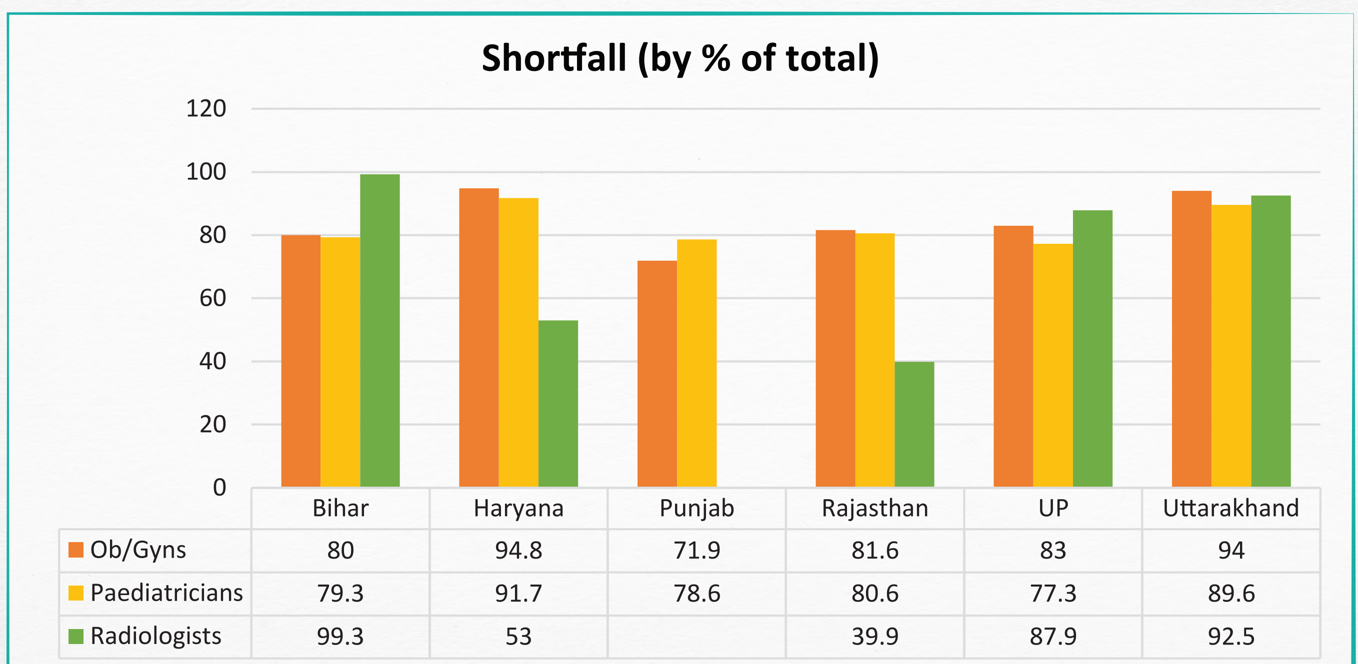
(Table - 1.1)

The graph below depicts the shortfall in each state over the five-year period. Except for a dip (corresponding to an increase in the number of positions filled) in 2017, the shortfall in each state has remained largely the same. For example, Haryana has had 90% vacancy from 2015 to 2019.



(Graph - 05)

For a more detailed examination, we considered data on the shortfall of each specialist in the states. The data revealed an abysmal shortfall of gynaecologists and obstetricians, paediatricians, and radiologists – all of whom the MTP Amendment Bill requires for the constitution of Medical Boards. Bihar, Haryana, Punjab and Uttar Pradesh present statistics of specialist availability in rural areas (through the Rural Health Statistics Reports), but not for urban or scheduled areas. The only urban statistics available for these states are for allopaths and radiographers. Hence, the chart below depicts the shortfall in each category of specialist only for rural areas in these six states.



	Bihar	Haryana	Punjab	Rajasthan	UP	Uttarakhand
Ob/Gyns	80	94.8	71.9	81.6	83	94
Paediatricians	79.3	91.7	78.6	80.6	77.3	89.6
Radiologists	99.3	53		39.9	87.9	92.5

(Graph - 06)

On average, rural North India recorded an 84.2% shortfall in obstetricians and gynaecologists, and 68.76% shortfall in paediatricians. Except Punjab, which had a surplus of radiologists, the other states recorded an average 74.5% shortfall. Significantly, Bihar only had one (1) radiologist in a region that needed at least 150.

SHORTFALL IN NORTH INDIA

Obstetricians and Gynaecologists	84.2%
Paediatricians	68.7%

1.2. Place of Abortion

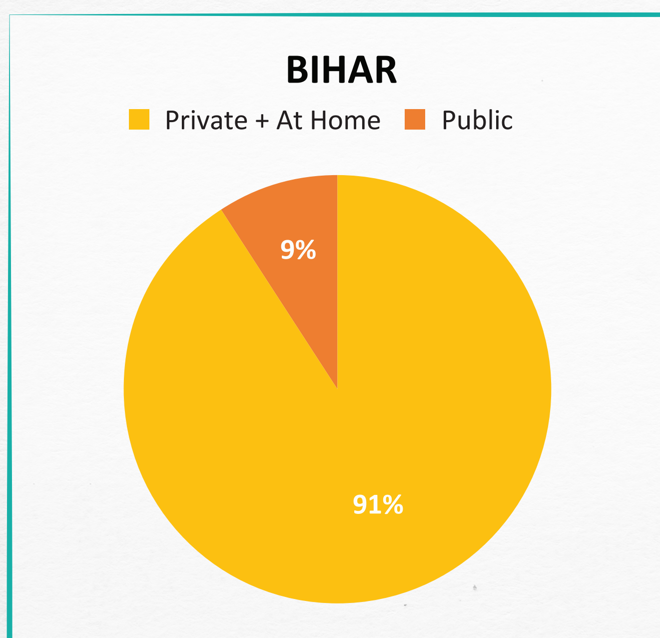
The MTP Act allows for abortions to be performed only in registered places. All public health facilities are approved MTP sites. However, our research reveals that the majority of abortions are performed either at home or in the private sector.

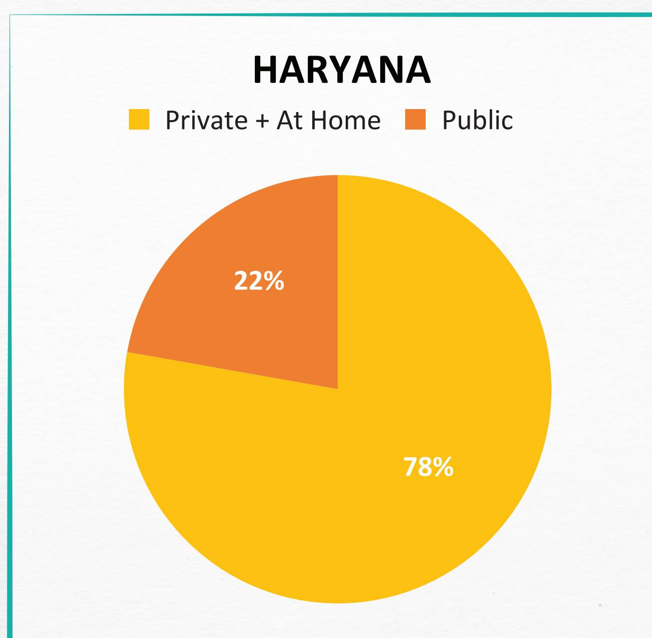
This table shows where most abortions are conducted in each state with data taken from the National Family Health Survey-4 for 2015-16.

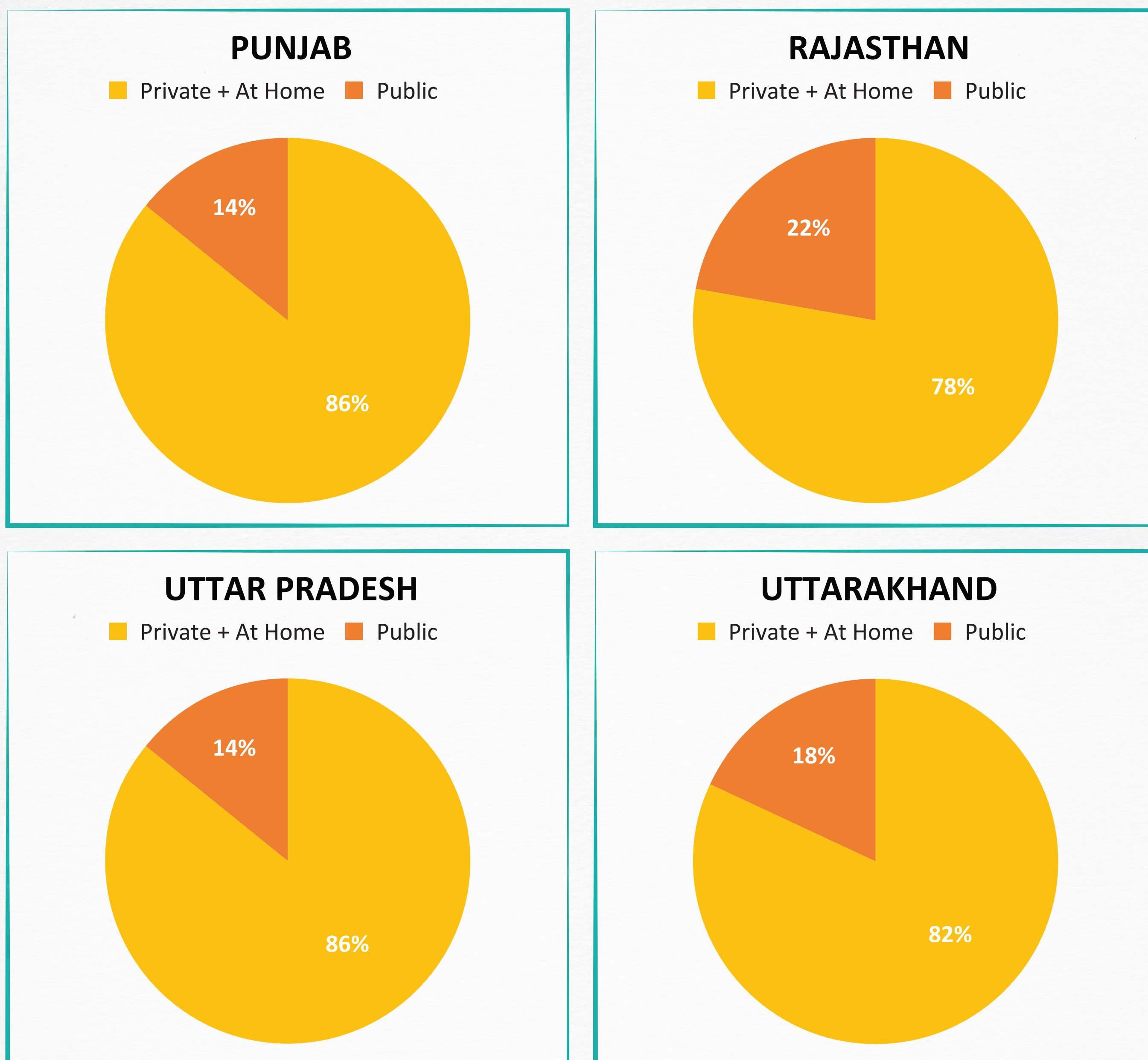
North Indian States	URBAN				RURAL			
	Public	Private	At Home	Other	Public	Private	At Home	Other
Bihar	4.9	77	18.1	0	10	66.2	23.2	0.6
Haryana	24.1	53.1	22.9	0	20	59.9	20.2	0
Punjab	3.9	82.8	13.3	0	23.5	63.7	12.8	0
Rajasthan	18.4	62.3	19.3	0	23.3	57.7	18.3	0.8
Uttar Pradesh	10	51.1	38.3	0.6	15.6	41.3	42.4	0.7
Uttarakhand	15.4	42.6	42.1	0	19.4	35.8	42.6	2.2

(Table - 1.2)

The charts below depict the total number of abortions performed in the public sector compared with the number of abortions performed in the private sector or at home, as an aggregate of the rural and urban data collected.



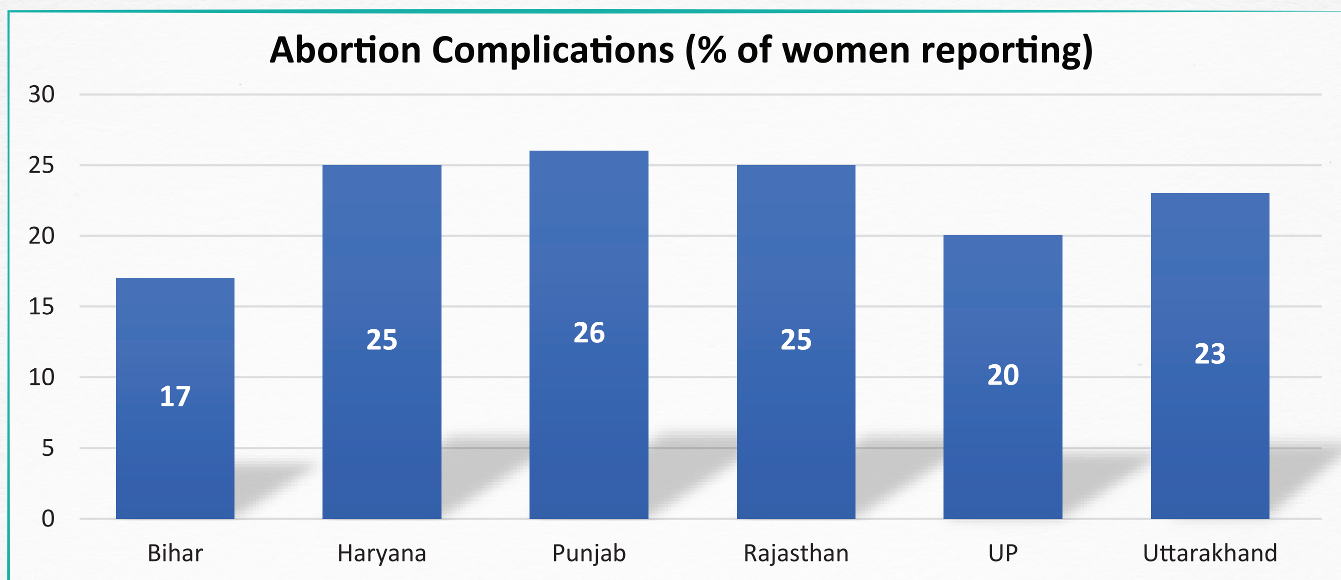




(Figure - 02)

In North India, the bulk of abortions are performed in the private sector or at home.[59] Only a small minority (9-22%) of procedures take place in the public health sector. Abortions performed at home have the potential to be extremely risky and threaten the life of pregnant persons, whereas the ones in the private sector are unaffordable for many. This increases the OOP expenditure, as explained above, and pushes marginalised persons deeper into poverty.

The inaccessibility of abortion services in the public sector has resulted in pregnant persons resorting to unsafe and unhygienic methods of abortion, often leading to complications. Reporting of abortion complications are provided in the graph below, showing that in the North Indian states, at least 17% of women reported complications in abortions. Punjab, Haryana and Rajasthan showed the highest rates of abortion complications, with a quarter or more of pregnant women reporting the same. Since the data only contains reported abortion complications, it is likely that the percentages are conservative, as various structural barriers could impede the ability of pregnant persons to report complications. A study from 2015 found that about 3,00,000 women in Bihar, and over a million women in Uttar Pradesh received treatment for complications from abortions in that year.[60]



(Graph - 07)

2. South India* *(Goa, Kerala, Karnataka, Tamil Nadu and Telangana)*

2.1. Availability of Specialists at CHCs

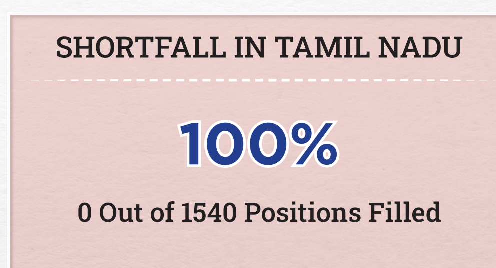
This sub-section presents data from five South Indian states. Due to the unavailability of data from urban areas, the focus is on CHCs in rural areas.

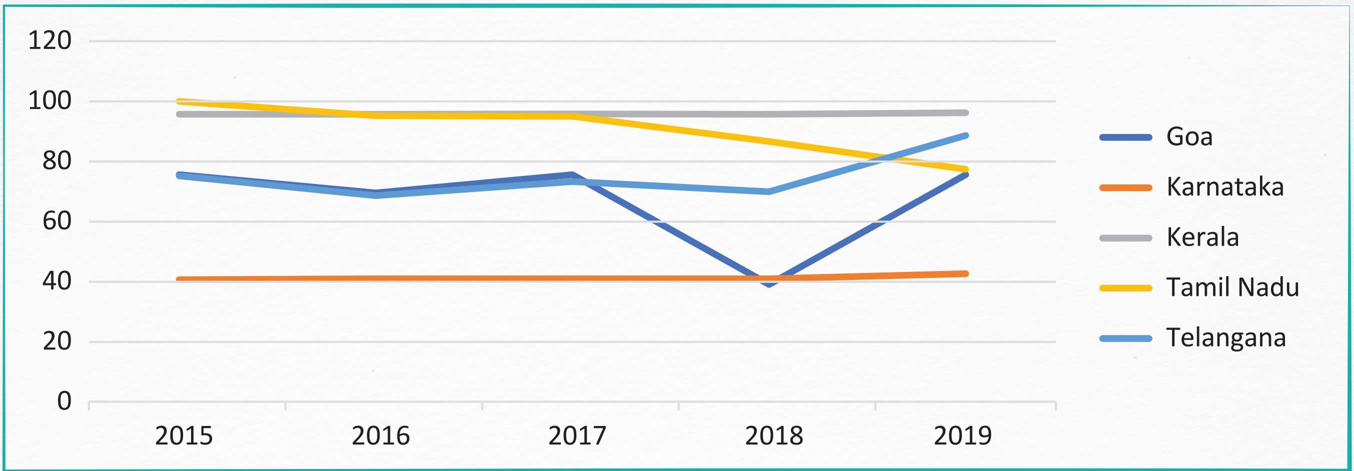
The table below shows the availability of specialists (surgeons, OBGYNs, physicians and paediatricians) at CHCs in rural areas, as of 31 March each year from 2015 to 2019. The data presented is from the annual Rural Health Survey.

South Indian States	2019		2018		2017		2016		2015	
	Required	In Position	Required	In Position	Required	In Position	Required	In Position	Required	In Position
Goa	20	5	16	10	16	4	16	5	16	4
Karnataka	792	465	824	498	824	498	824	498	824	502
Kerala	908	35	908	40	928	40	900	40	888	39
Tamil Nadu	1540	179	1540	210	1540	78	1540	76	1540	0
Telangana	340	258	364	112	456	125	456	147	456	116

(Table - 2.1)

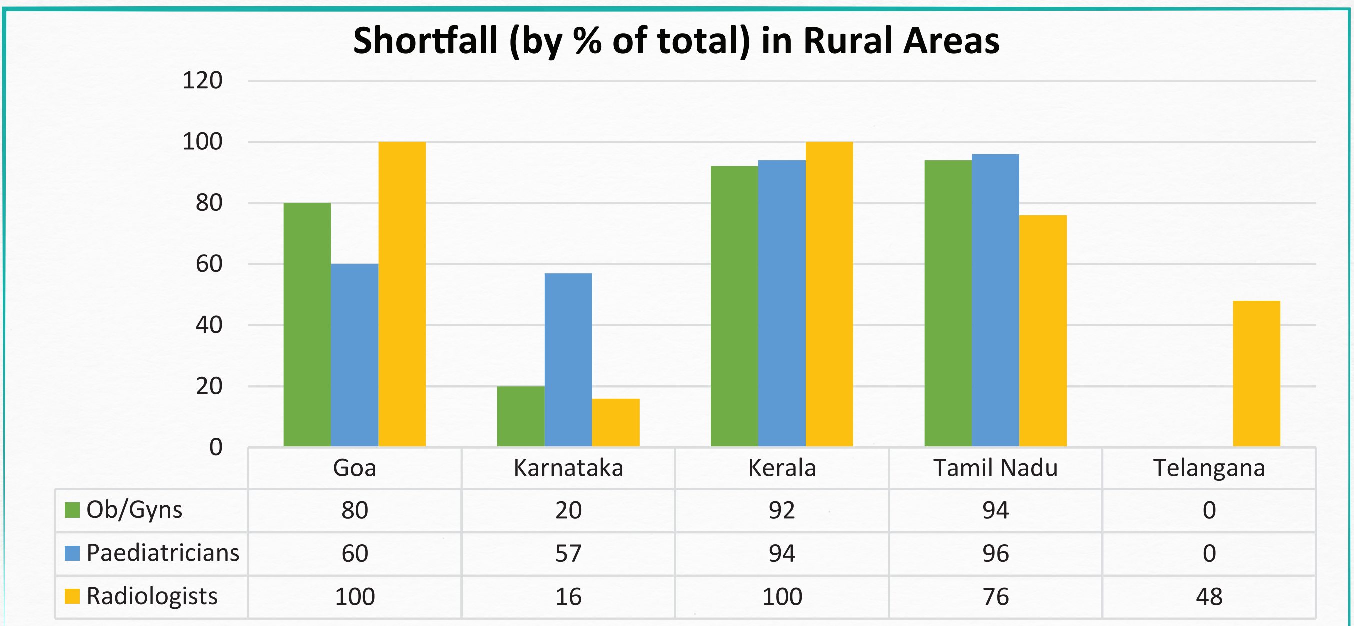
The graph below depicts the shortfall in each state over the five-year period. These numbers paint a very bleak picture. Karnataka fares the best in this region, with a steady vacancy of approximately 40% in the five-year period, while Tamil Nadu and Kerala fare the worst. Tamil Nadu had a 100% shortfall in 2015, with none of 1540 required positions filled.





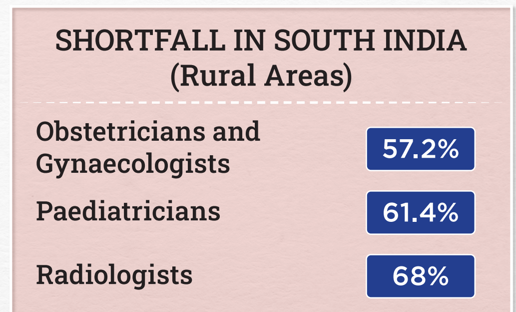
(Graph - 08)

As for the availability of specialists, the data again reveals an abysmal shortfall of gynaecologists and obstetricians, paediatricians and radiologists. Data from urban areas was missing for the Southern regions, except for allopaths and radiographers. However, data from regions classified as scheduled areas was available. The charts below depict the shortfall in each specialist doctor for rural as well as scheduled areas in the five states.

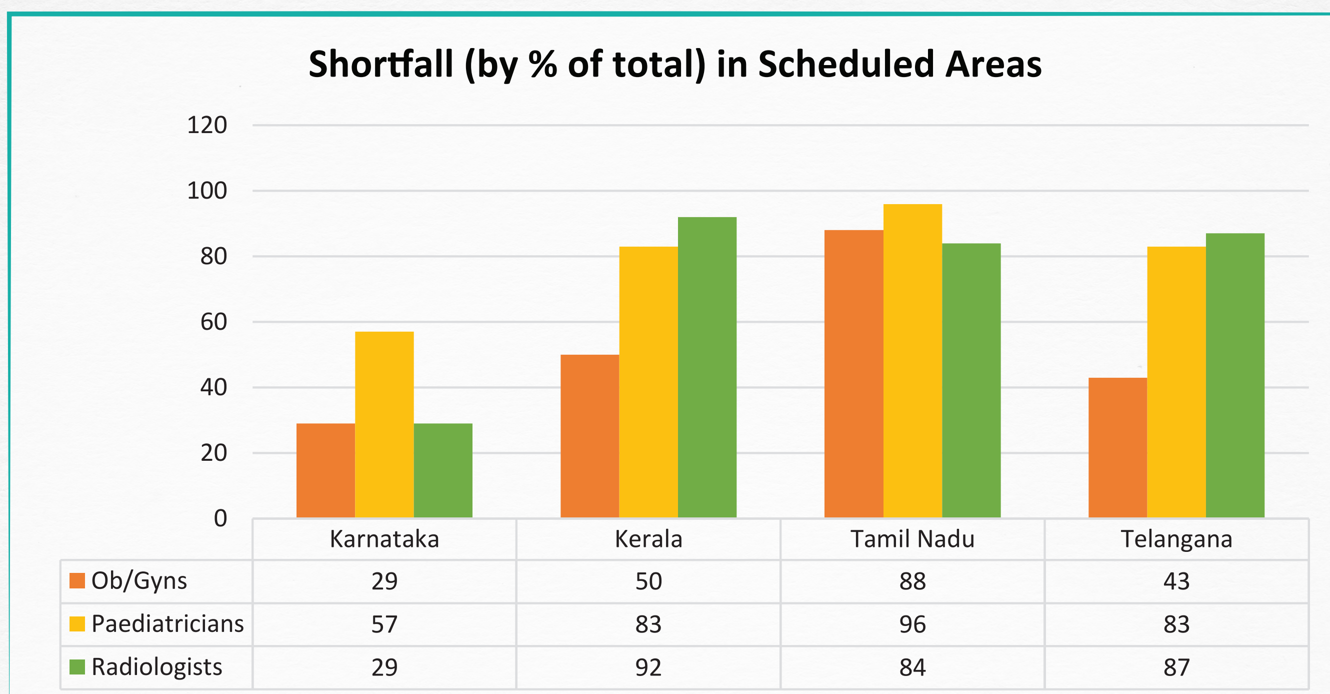


	Goa	Karnataka	Kerala	Tamil Nadu	Telangana
Ob/Gyns	80	20	92	94	0
Paediatricians	60	57	94	96	0
Radiologists	100	16	100	76	48

(Graph - 09)



As the data reveals, there is a shocking dearth of specialists, both in rural as well as scheduled areas of the Southern states. Goa and Kerala, for instance, had no radiologists in the rural areas. Even in the urban areas, Karnataka and Tamil Nadu had no radiologists. Although Telangana fared best in availability of obstetricians and gynaecologists, as well as paediatricians in rural areas, its scheduled areas continue to face shortages in specialists. On average, rural areas of South India recorded a 57.2% shortfall in gynaecologists and obstetricians, a 61.4% shortfall in paediatricians and a 68% shortfall in radiologists.



(Graph - 10)

All Southern states demonstrated a consistent increase in shortfall percentages of specialist medical practitioners with no significant improvements from 2015 to 2019. While the AYUSH registered practitioners are well-staffed and even dominate medicine to an extent, in comparison, the number of doctors at CHCs, or other specialists such as radiologists are lacking and centres are understaffed. There is notable disparity between rural and urban areas for doctor availability, as doctors do not find the costs of lower pay and remote living compensated by service.

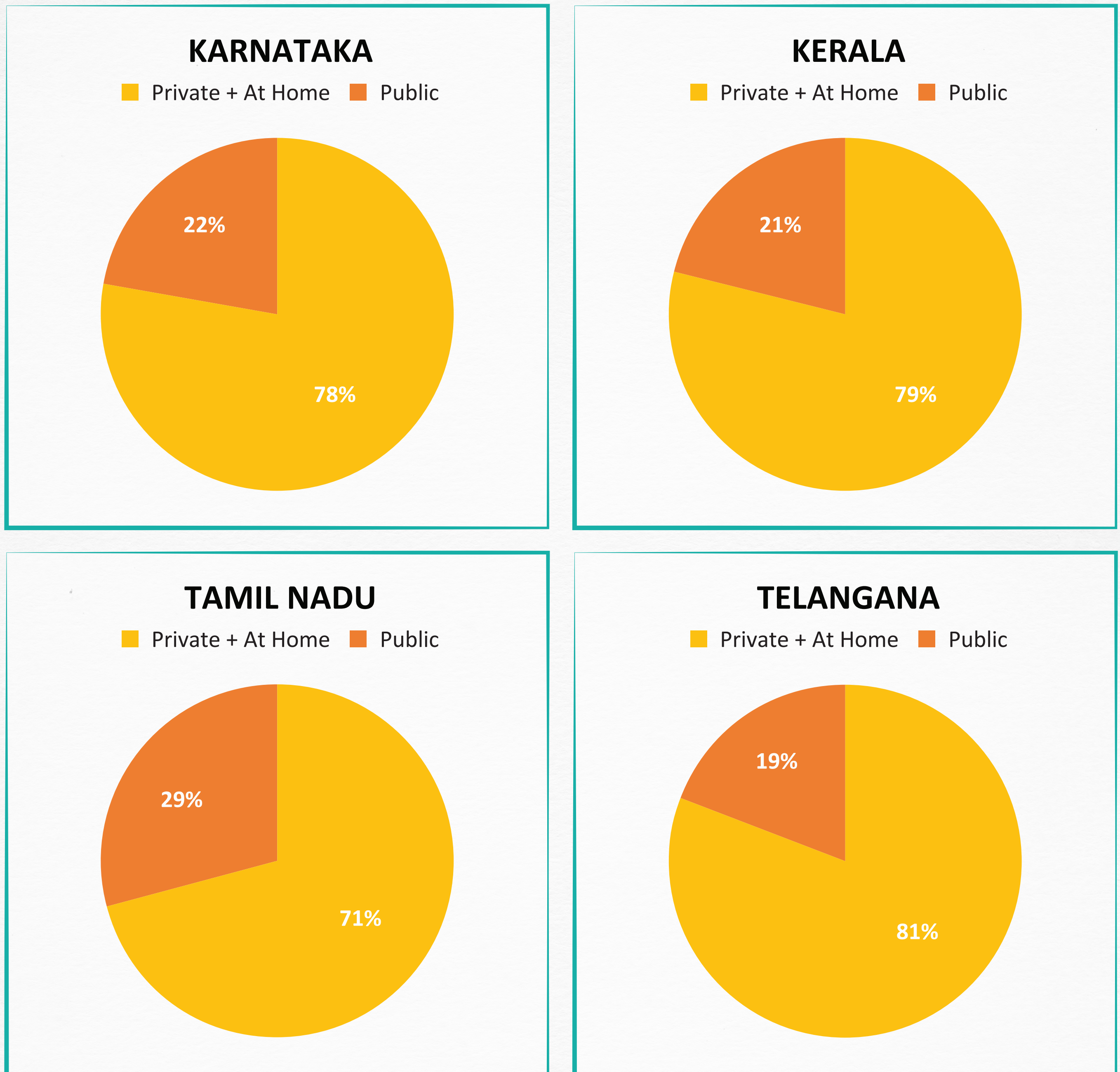
2.2. Place of Abortion

This table shows where most abortions are conducted in each state, with data taken from the NFHS-4 survey for 2015-16. There was no data available for Goa and it is been omitted from the table below.

South Indian States	URBAN			RURAL		
	Public	Private	At Home	Public	Private	At Home
Karnataka	14	72.4	13.6	29.8	57.8	12.4
Kerala	12.3	85.5	2.2	31.4	68.6	0
Tamil Nadu	28.6	64	7.4	30	63.9	6.1
Telangana	21.6	71.1	7.3	15	66.3	18.7

(Table - 2.2)

The charts below depict the total number of abortions performed in the public sector compared with the number of abortions performed in the private sector or at home, as an aggregate of the rural and urban data collected.



(Figure - 03)

As with the Northern states, South India also sees the majority of abortions performed in the private sector or at home. Tamil Nadu records the highest number of abortions in the public sector at a mere 29%. Incentives to work in rural areas and in public service could alleviate the observed paucity. Unplanned pregnancies are fairly common in South India as well.

The number of women reporting complications from abortions is at par with Northern states. In Karnataka, nearly one-fourth (23%) of women reporting an abortion reported having complications from the abortion.[61] In Kerala, one-sixth of women reported having complications from the abortion.[62] In Tamil Nadu, one-eighth of women reporting an abortion reported having complications from the abortion.[63] In Tamil Nadu, over 1,43,000 women received treatment for abortion complications in 2015 alone.[64]

3. East and North-East India *(Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura and West Bengal)*

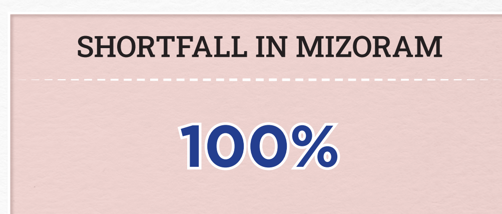
3.1. Availability of Specialists at CHCs

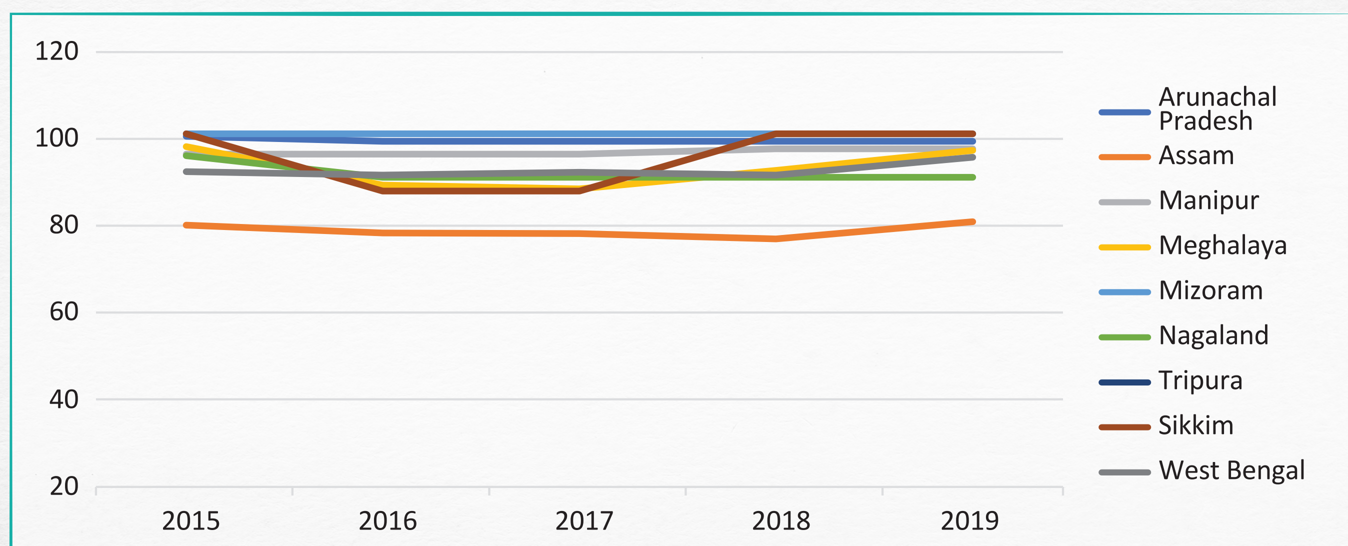
The table below shows the availability of specialists (surgeons, OBGYNs, physicians, and paediatricians) at CHCs in rural areas, as of 31 March each year, from 2015 to 2019. The data presented is from the annual Rural Health Survey.

East and North-East Indian States	2019		2018		2017		2016		2015	
	Required	In Position	Required	In Position	Required	In Position	Required	In Position	Required	In Position
Arunachal Pradesh	252	4	252	4	252	4	252	4	208	1
Assam	708	136	688	158	638	139	604	131	604	121
Manipur	92	3	92	3	68	3	68	3	68	3
Meghalaya	112	4	112	9	108	13	108	12	108	3
Mizoram	36	0	36	0	36	0	36	0	36	0
Nagaland	84	8	84	8	84	8	84	8	84	4
Tripura	72	2	88	2						
Sikkim	8	0	8	0	8	1	8	1	8	0
West Bengal	1392	71	1392	125	1396	117	1396	125	1388	114

(Table - 3.1)

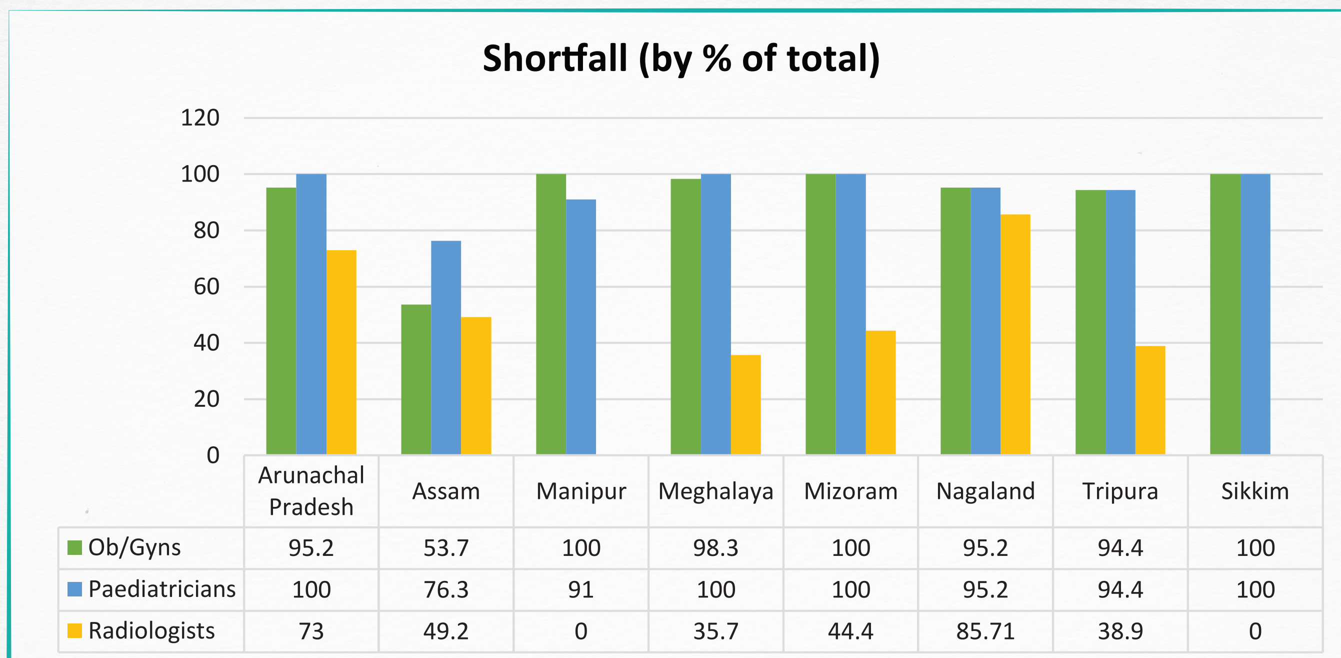
The graph below depicts the shortfall of specialists in each state in the five-year period. Mizoram has had a shocking 100% shortfall in the availability of specialists at CHCs from 2015 to 2019. Most other states also record over a 90% shortfall, with little improvement seen over five years.





(Graph - 11)

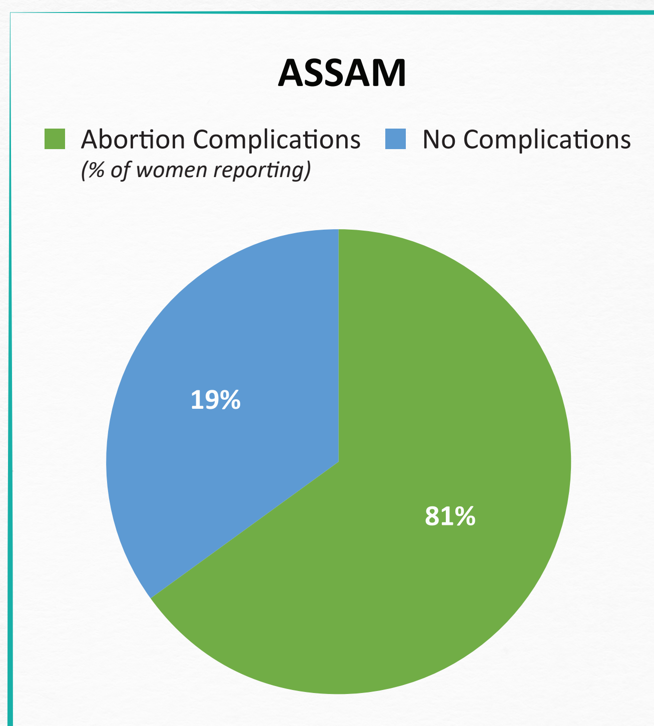
As for the availability of specialists, here too the data reveals a severe shortfall of gynaecologists and obstetricians, paediatricians and radiologists. Data for rural and scheduled areas was not available separately for many states. Hence, the charts below depict the shortfall in each specialist doctor across both areas in all states. West Bengal is covered below separately.



	Arunachal Pradesh	Assam	Manipur	Meghalaya	Mizoram	Nagaland	Tripura	Sikkim
Ob/Gyns	95.2	53.7	100	98.3	100	95.2	94.4	100
Paediatricians	100	76.3	91	100	100	95.2	94.4	100
Radiologists	73	49.2	0	35.7	44.4	85.71	38.9	0

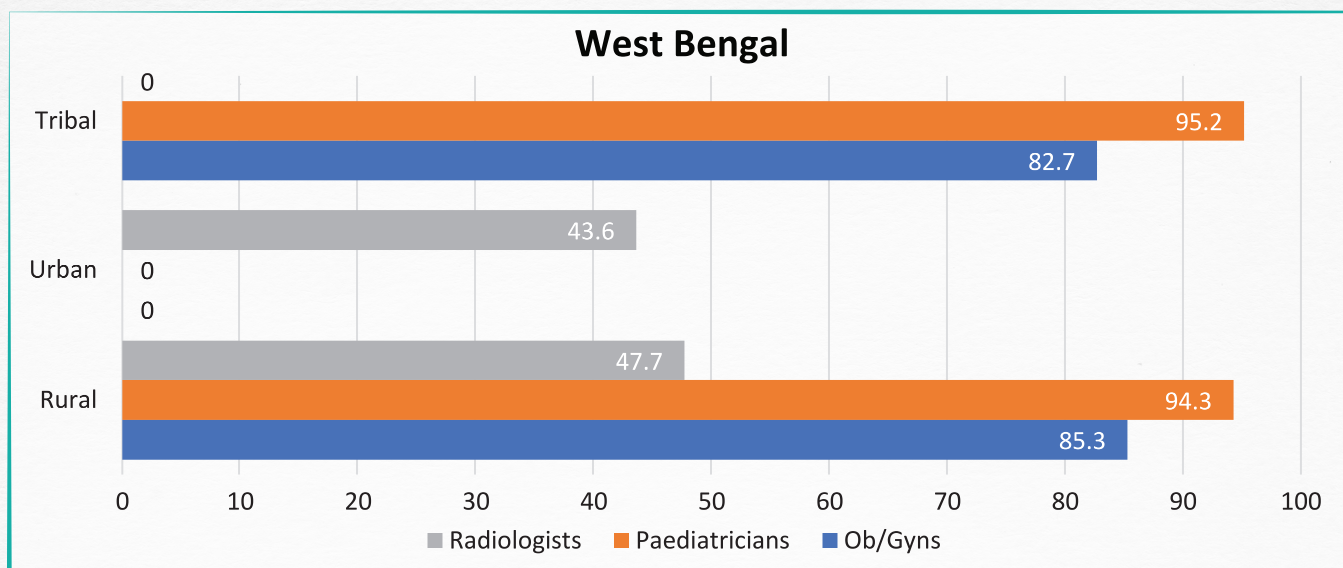
(Graph - 12)

As the data shows, Sikkim and Mizoram had a complete absence of gynaecologists /obstetricians and paediatricians, while rural Manipur had a total absence of obstetricians and gynaecologists and a near total absence of paediatricians. It would, therefore, be impossible to constitute Medical Boards in these regions. Assam is the only state that does not have an extreme dearth of specialist doctors, but even Assam records a 76% shortfall in paediatricians and has only half the required radiologists. Moreover, despite 49% of abortions being conducted in the public sector, the high number of abortions outside public health facilities has resulted in numerous post-abortion complications. A study found that the number of women treated for induced abortion complications in Assam was about 51,000 in 2015.[65]



(Figure - 4)

West Bengal records data for rural and urban areas as well as areas that are predominantly Adivasi (indigenous). Overall, the state shows an upward trend in the percentage shortfall of specialists from 91% in 2018 to 95% in 2019.[66]



(Graph - 13)

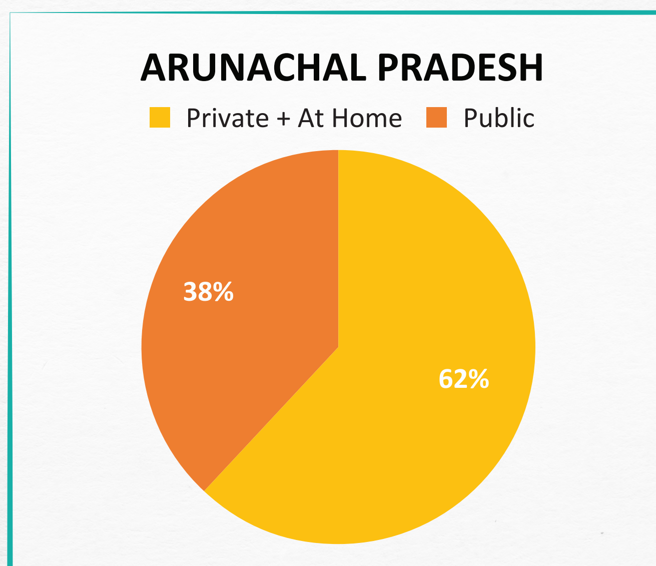
3.2. Place of Abortion

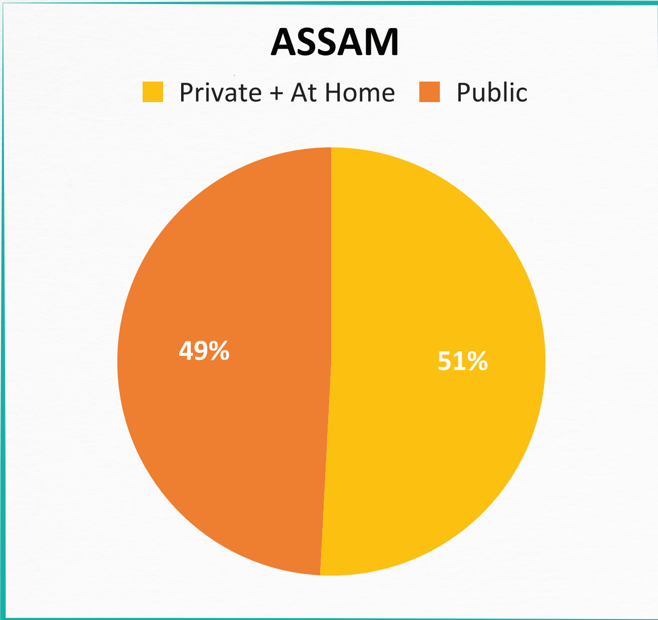
This table shows where most abortions are conducted in each state with data taken from the NFHS-4 survey for 2015-16. Data for Meghalaya, Mizoram, Sikkim and urban Tripura was unavailable.

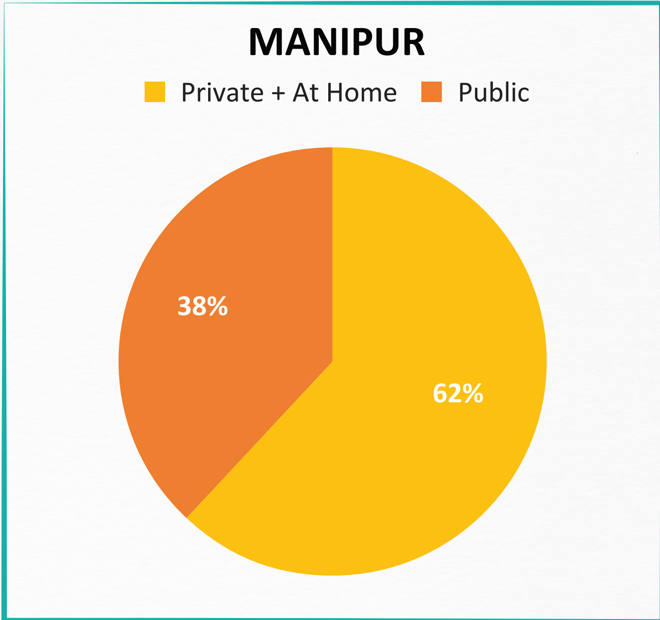
East and North-East Indian States	URBAN			RURAL		
	Public	Private	At Home	Public	Private	At Home
Arunachal Pradesh	49.1	38.3	12.6	34.1	29.3	36.6
Assam	35.1	29.1	35.8	51.7	18.6	29.8
Manipur	32.3	55	10.9	42.6	45.7	10.0
Nagaland	18.3	53.1	28.7	9.3	56.9	31.7
Tripura	NA	NA	NA	67.7	7.8	24.5
West Bengal	10.5	47.7	41.8	16.3	51.7	32.1

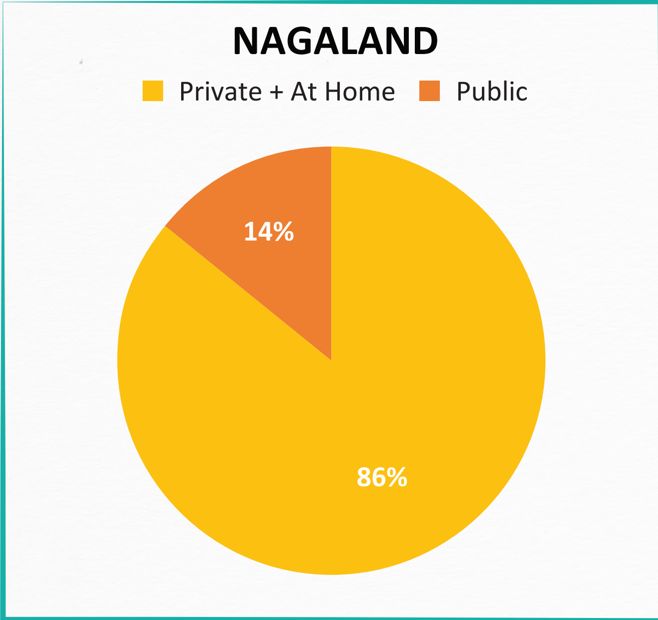
(Table - 3.2)

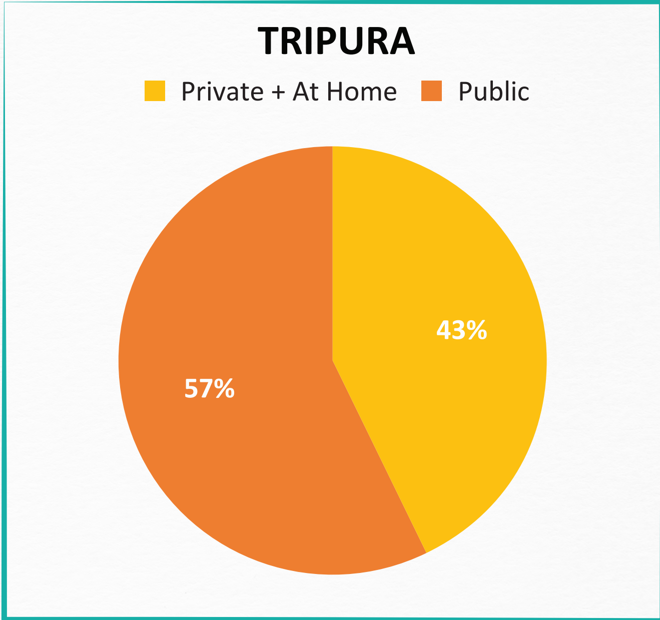
The charts below depict the total number of abortions performed in the public sector compared with the number of abortions performed in the private sector or at home, as an aggregate of the rural and urban data collected.

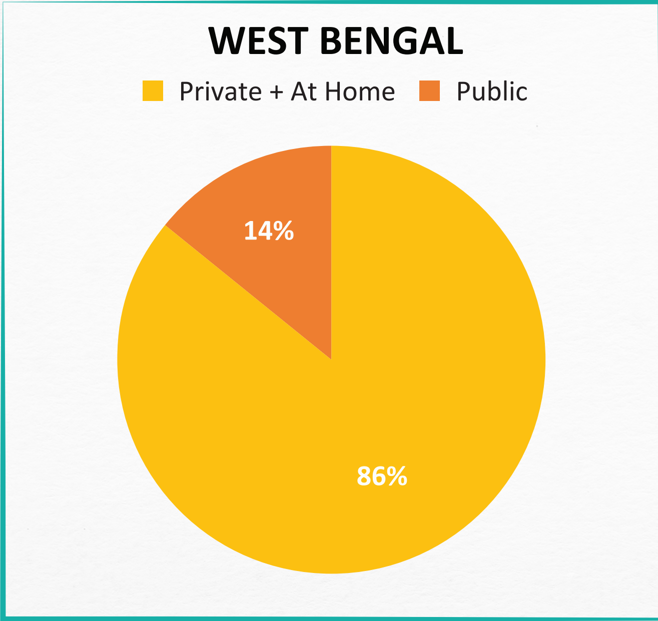












(Figure - 5)

Some North-Eastern states fare much better than their Northern or Southern counterparts. Tripura, for instance, records that 43% of abortions are conducted in the public sector, while Assam records 49%, which is nearly half of all abortions. However, most abortions in East and North-East states continue to be conducted at home or in the private sector.

4. Scheduled Areas - I *(Jammu and Kashmir, Chhattisgarh, Jharkhand, Gujarat and Himachal Pradesh)*

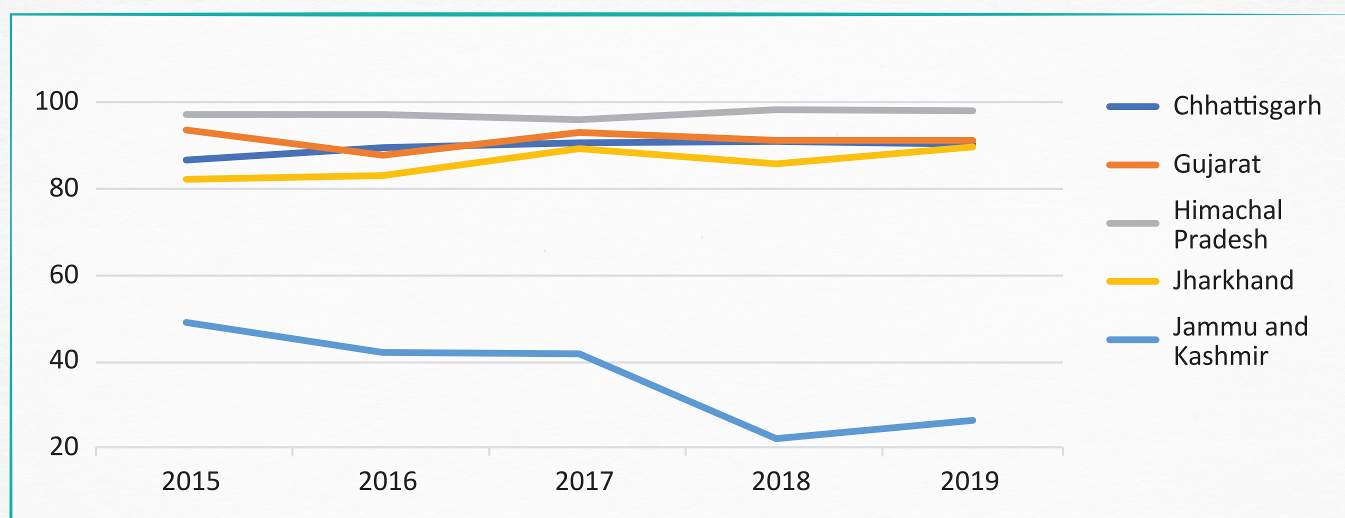
4.1. Availability of Specialists at CHCs

The table below shows the availability of specialists (surgeons, OBGYNs, physicians and paediatricians) at CHCs in rural areas, as of 31 March each year, from 2015 to 2019. The data presented is from the annual Rural Health Survey.

Scheduled Areas - I	2019		2018		2017		2016		2015	
	Required	In Position	Required	In Position	Required	In Position	Required	In Position	Required	In Position
Chhattisgarh	680	61	676	57	676	59	620	61	620	78
Gujarat	1448	118	1452	118	1452	92	1288	148	1280	74
Himachal Pradesh	348	5	364	4	356	12	316	7	312	7
Jharkhand	684	66	684	92	752	75	752	122	752	128
Jammu and Kashmir	336	242	336	256	336	191	336	190	336	168

(Table - 4.1)

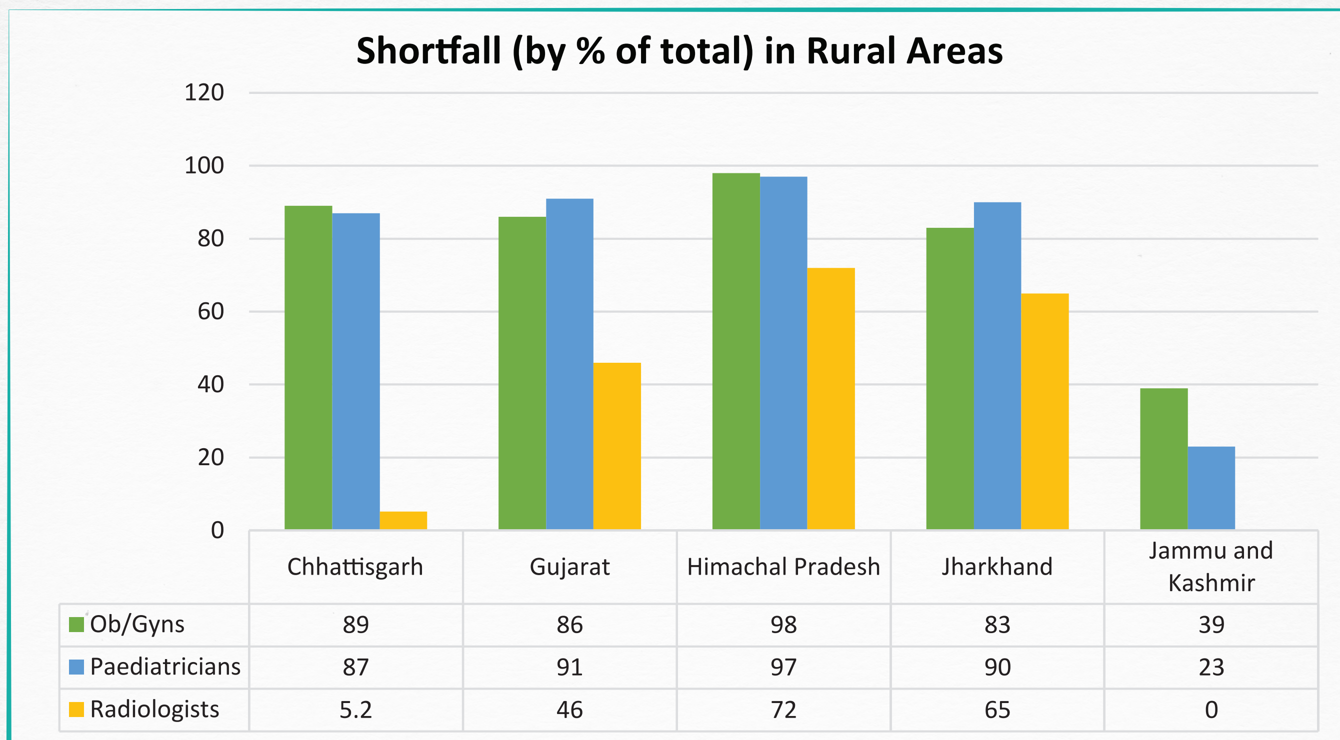
The graph below depicts the shortfall in each state in the five-year period. Jammu and Kashmir fares significantly better than the other states, with only a 28% shortfall as of 2019. Compared to shortfalls between 80-100% in the other states in this section, Himachal Pradesh has had over 96% shortfall over the five-year period.



(Graph - 14)

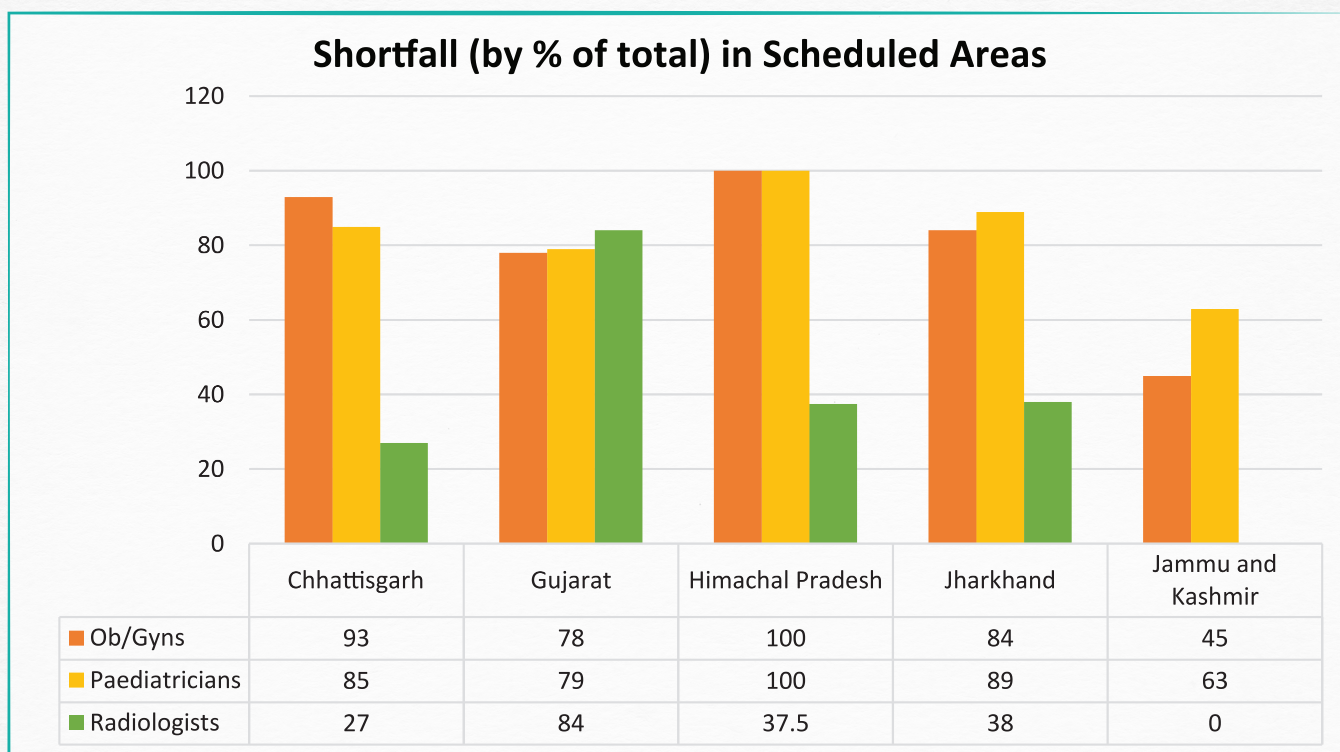
As for the availability of specialists, the data once again reveals an abysmal shortfall of gynaecologists and obstetricians, paediatricians and radiologists. Every state except Jammu and Kashmir records average shortfalls of nearly 80% for gynaecologists and obstetricians, with occasional surpluses in allopathic practitioners. There is, however, a data gap in the number of radiographers, pharmacists, lab technicians, nursing staff, physicians, and other specialist positions for these states.

The charts below depict the shortfall of each kind of specialist doctor in rural areas and scheduled areas in the five states.



	Chhattisgarh	Gujarat	Himachal Pradesh	Jharkhand	Jammu and Kashmir
Ob/Gyns	89	86	98	83	39
Paediatricians	87	91	97	90	23
Radiologists	5.2	46	72	65	0

(Graph - 15)



	Chhattisgarh	Gujarat	Himachal Pradesh	Jharkhand	Jammu and Kashmir
Ob/Gyns	93	78	100	84	45
Paediatricians	85	79	100	89	63
Radiologists	27	84	37.5	38	0

(Graph - 16)

The data reveals that the combined rural areas of Gujarat, Himachal Pradesh, Chhattisgarh and Jharkhand see an average shortfall of 88% in gynaecologists and obstetricians, who form an essential requirement for the constitution of Medical Boards. Jammu and Kashmir fares better than the other states, especially in scheduled areas, but even there, there are significant shortfalls in the number of gynaecologists and obstetricians as well as paediatricians.

The shortfall of specialists in scheduled areas reflects extremely poorly, with Himachal Pradesh having a complete absence of both gynaecologists and obstetricians as well as paediatricians in the region. Chhattisgarh and Jharkhand, which are states containing a large number of Adivasi communities, also have a nearly 90% shortfall. These findings are significant, especially given that marginalised persons face systemic barriers to accessing healthcare. Adding another layer of bureaucratisation in the form of Medical Boards to a healthcare system that is already failing would completely forsake pregnant persons' Right to Health.

> **"Himachal Pradesh has a complete absence of both gynaecologists and obstetricians as well as paediatricians. Chhattisgarh and Jharkhand, which are states containing a large number of Adivasi communities, also have a nearly 90% average shortfall."**

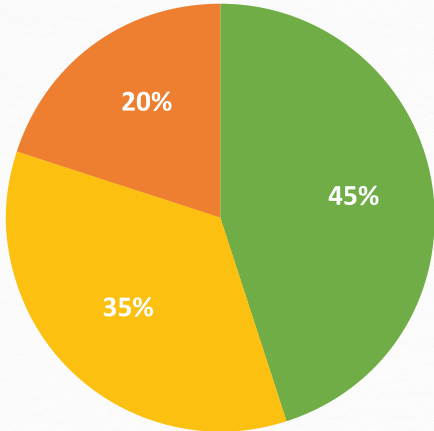
4.2. Place of Abortion

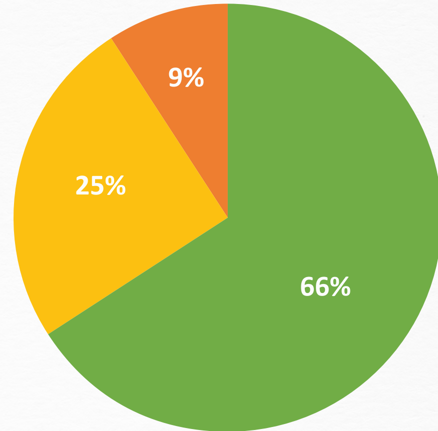
The table below shows the availability of specialists (surgeons, OBGYNs, physicians and paediatricians) at CHCs in rural areas, as of 31 March each year, from 2015 to 2019. The data presented is from the annual Rural Health Survey.

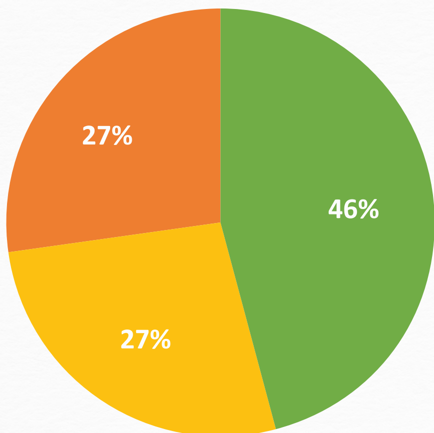
Scheduled Areas - I	Public	Private	At Home
Chhattisgarh	20	35.4	44.5
Gujarat	9.1	24.1	65.3
Himachal Pradesh	26.8	27	46.3
Jharkhand	11	47.7	40.1
Jammu and Kashmir	54.3	38.3	7.3

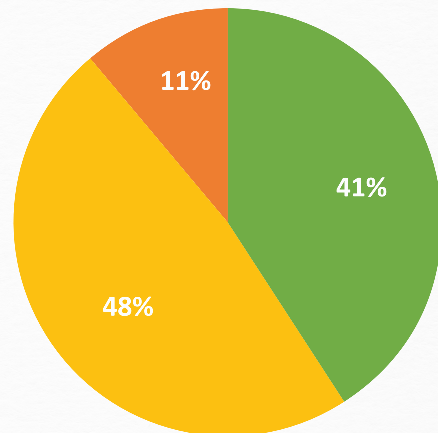
(Table - 4.2)

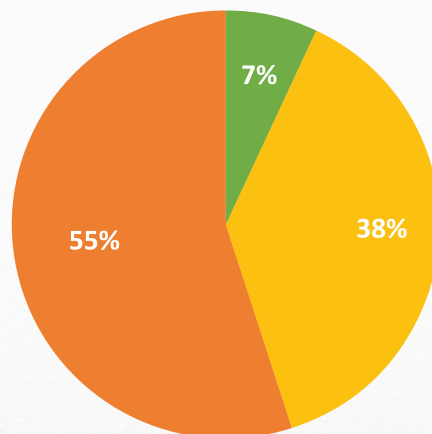
Evidently, home-based, risky abortions are the leading form of abortions in Himachal Pradesh, Chhattisgarh and Jharkhand. The charts below depict the total number of abortions performed in the public sector compared with the number of abortions performed in the private sector and abortions at home. Over 67,000 women in Gujarat received treatment for complications from abortions in 2015.[67]











(Figure - 06)

5. Scheduled Areas - II *(Andhra Pradesh, Madhya Pradesh, Maharashtra and Odisha)*

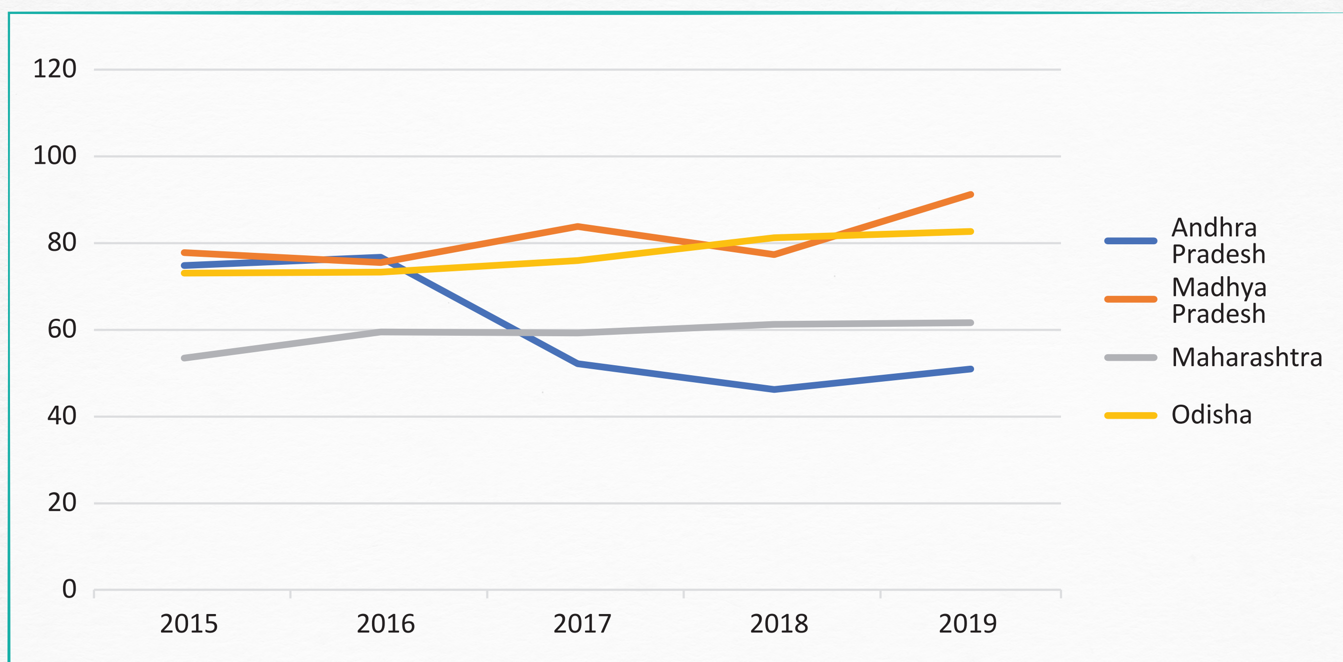
5.1. Availability of Specialists at CHCs

The table below shows the availability of specialists (surgeons, OBGYNs, physicians and paediatricians) at CHCs in rural areas, as of 31 March each year from 2015 to 2019. The data presented is from the annual Rural Health Survey.

Scheduled Areas - II	2019		2018		2017		2016		2015	
	Required	In Position	Required	In Position	Required	In Position	Required	In Position	Required	In Position
Andhra Pradesh	560	237	772	384	772	348	772	159	716	159
Madhya Pradesh	1236	104	1236	248	1236	180	1336	289	1336	263
Maharashtra	1456	485	1444	485	1440	508	1440	505	1440	578
Odisha	1508	236	1508	253	1480	318	1508	354	1508	356

(Table - 5.1)

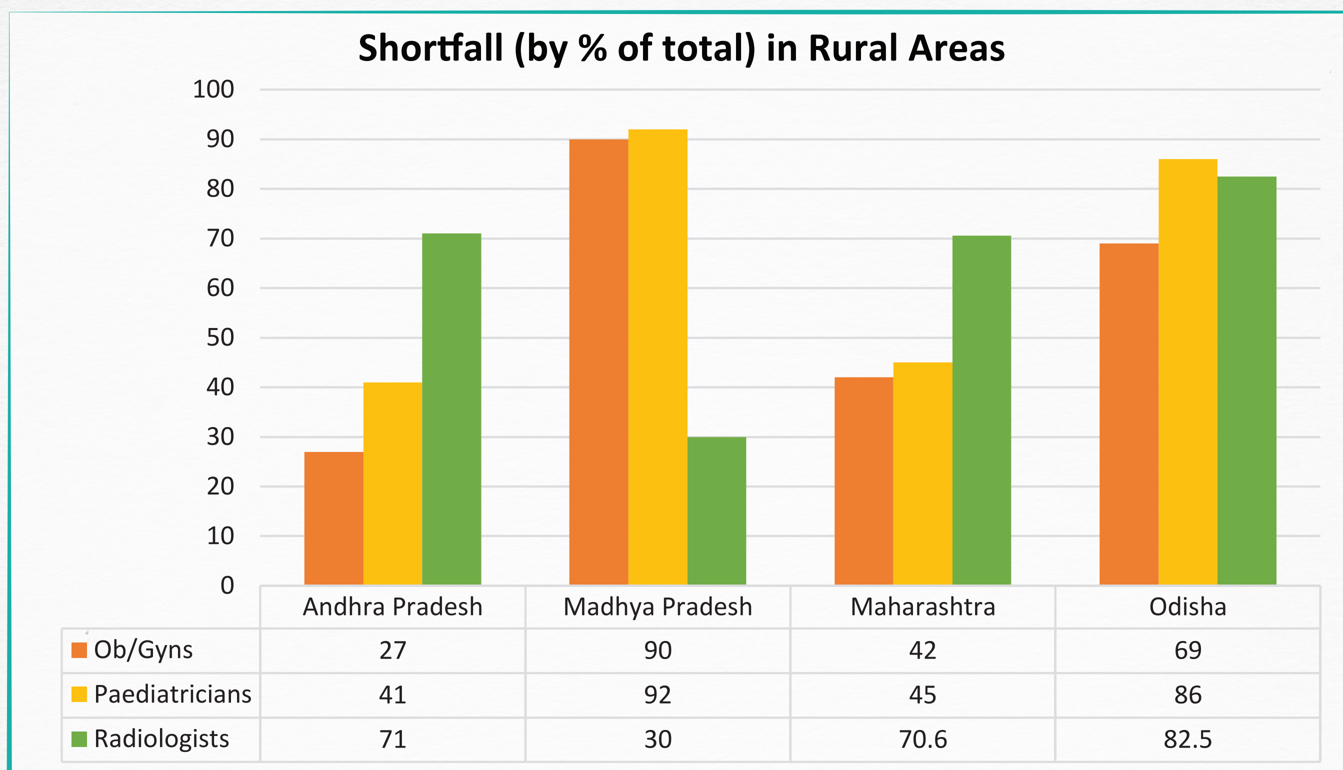
The graph below depicts the shortfall in each state over the five-year period. In all states except Andhra Pradesh, there has been an increase in the shortfall of specialists in rural CHCs since 2015.



(Graph - 17)

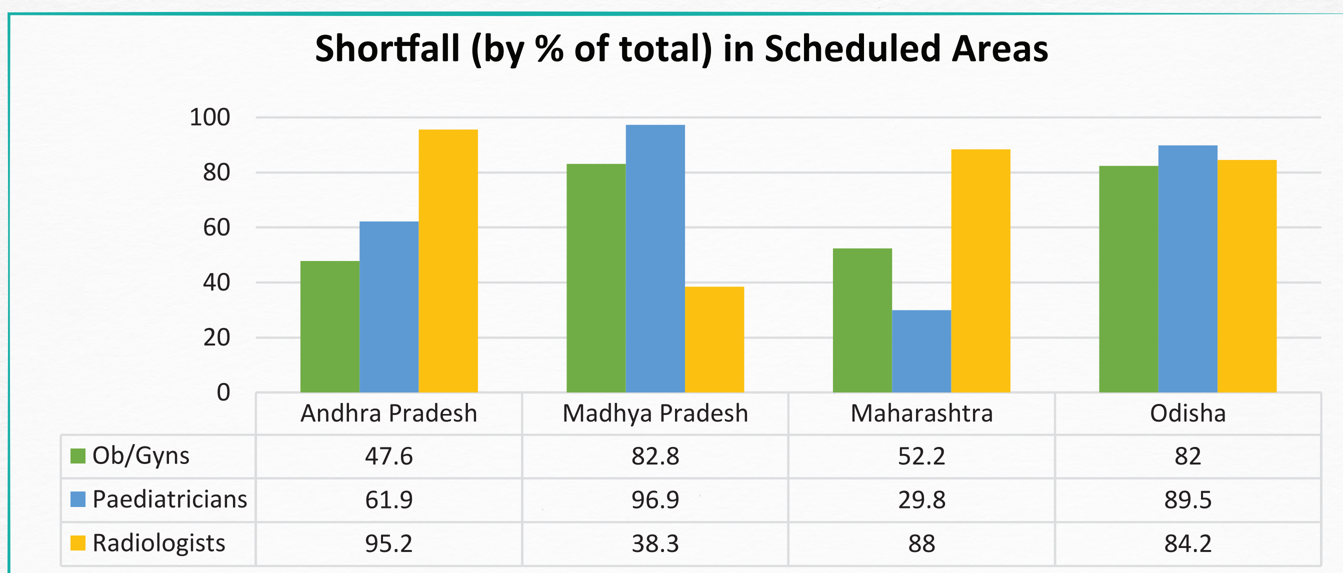
As with the other regions, Andhra Pradesh, Madhya Pradesh, Maharashtra and Odisha also demonstrate a consistent shortfall of medical practitioners (obstetricians, gynaecologists, paediatricians, and radiographers), which has not significantly improved between 2015 and 2019.

The charts below depict the shortfall in each specialist category for rural and scheduled areas in these four states.



	Andhra Pradesh	Madhya Pradesh	Maharashtra	Odisha
Ob/Gyns	27	90	42	69
Paediatricians	41	92	45	86
Radiologists	71	30	70.6	82.5

(Graph - 18)



	Andhra Pradesh	Madhya Pradesh	Maharashtra	Odisha
Ob/Gyns	47.6	82.8	52.2	82
Paediatricians	61.9	96.9	29.8	89.5
Radiologists	95.2	38.3	88	84.2

(Graph - 19)

While these states appear to be doing slightly better than other regions, there is still a glaring dearth of specialists in all four states. Rural Madhya Pradesh has a 90% shortfall of obstetricians and gynaecologists, as well as paediatricians, and a shocking 97% shortfall of paediatricians in scheduled areas. In 2015, nearly 5,19,000 women from Madhya Pradesh received treatment for complications from abortions.[68] On average, scheduled areas fared much worse than rural ones with all states showing significant shortfalls in all specialist categories.

ABORTION COMPLICATIONS

5,19,000

Women in Madhya Pradesh received treatment in 2015

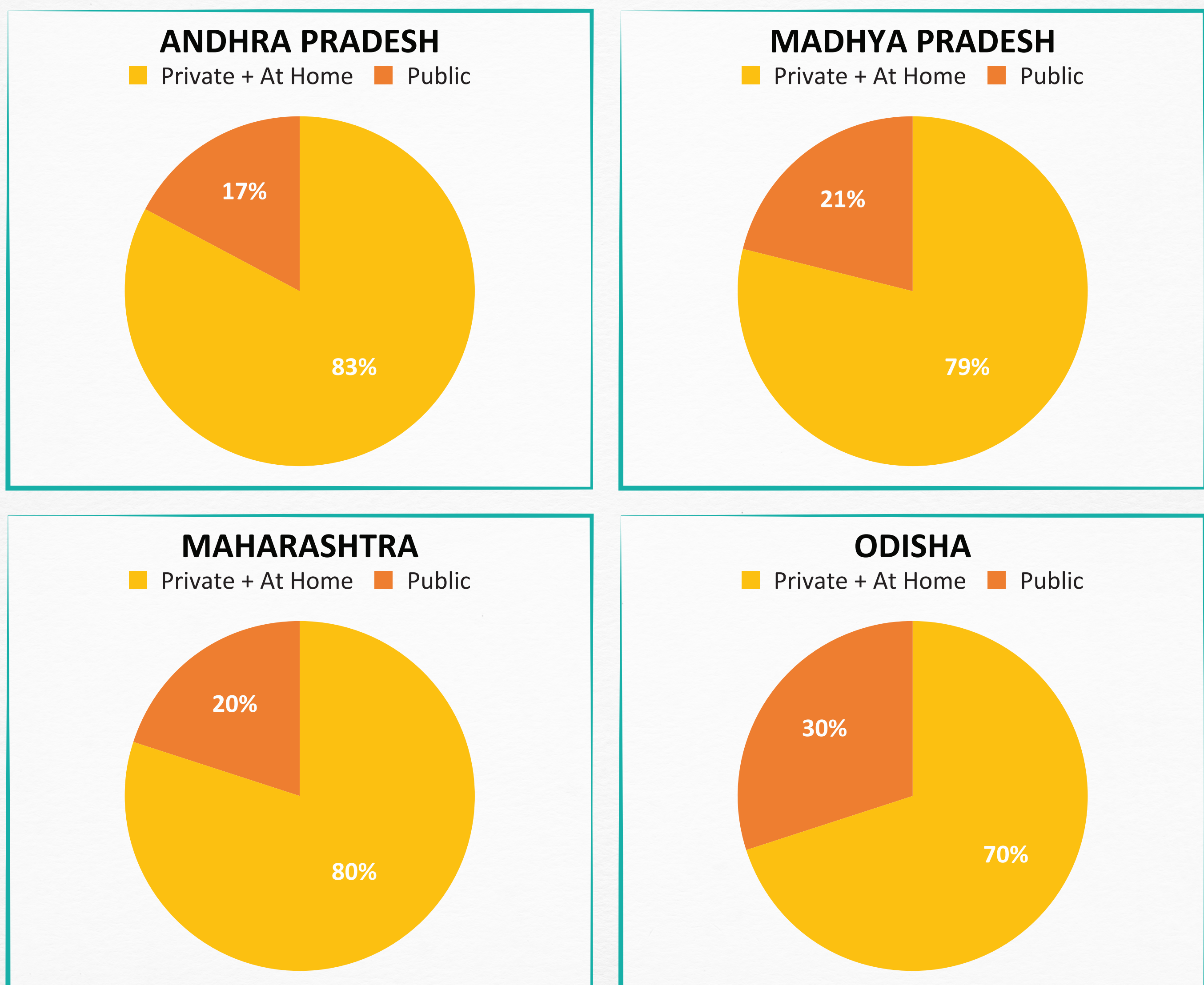
5.2. Place of Abortion

This table shows where most abortions are conducted in each state with data taken from the NFHS-4 survey for 2015-16.

Scheduled Areas - II	URBAN			RURAL		
	Public	Private	At Home	Public	Private	At Home
Andhra Pradesh	NA	NA	NA	21	72.9	6.1
Madhya Pradesh	20.6	53.5	25.1	21.6	44.9	33.1
Maharashtra	17.3	79.4	3.2	23.9	68.4	7.7
Odisha	24	31.1	44.9	31.5	19.9	47.5

(Table - 5.2)

The charts below depict the total number of abortions performed in the public sector compared with the number of abortions performed in the private sector or at home, as an aggregate of the rural and urban data collected.



(Figure - 07)

As with the other regions, the majority of abortions are conducted either in the private sector or at home. Odisha records the highest number of public sector abortions at 30%.

6. Union Territories *(Andaman and Nicobar Islands, Daman and Diu, NCT of Delhi, Lakshadweep and Puducherry)*

There is, at present, an immense lack of healthcare data on Union Territories. Due to the limited data, it will suffice to present compendious information on each UT.

The table below shows the availability of specialists (surgeons, OBGYNs, physicians and paediatricians) at CHCs in rural areas in 2005 and in 2019.

Union Territories	2019		2005	
	Required	In Position	Required	In Position
Andaman and Nicobar Islands	16	0	16	0
Daman and Diu	NA	NA	4	0
Lakshadweep	12	0	12	0
Puducherry	8	1	16	0

(Table - 6)

As is evident, three of the four UTs for which data was available had a 100% shortfall in the specialists required.

SHORTFALL IN SPECIALISTS

3 out of 4 UTs had a

100%

Shortfall

There were also no AYUSH - registered practitioners. Furthermore, the number of doctors at PHCs decreased from 36 in 2015 to 34 in 2016 and there are zero doctors at CHCs as recorded by the National Health Profile, 2019 in rural areas.[69] There also exists no recorded data for percent distribution by place of abortion or percent distribution of the person who performed the abortion[70] for UTs.

SECTION - IV

Analysis

Indian and international jurisprudence has, in the past, located the right to decisional autonomy, bodily integrity, and the exercise of certain liberties (located within the domain of the right to privacy) as being permissible only within certain private spaces.[71] However, the 'right to choose' of every pregnant person cannot be disconnected from its location within a larger framework of reproductive justice. The concept of reproductive justice is rooted in "the belief that systemic inequality has always shaped people's decision-making around childbearing and parenting, particularly for vulnerable women."[72] Reproductive justice activists like Loretta Ross and Dorothy Roberts have asserted that in realising reproductive justice, focusing solely on individual rights, such as a right to abortion located within a right to privacy, will do little to adequately address oppression experienced by such individuals, on multiple grounds.[73]

Focusing on concepts of privacy and decisional autonomy can "result in a fractured framework in which decisions around abortion, pregnancy, and women's sexuality are seen distinctly, rather than as part of a broader context in which women's and girls' gender-based differences are disregarded and minimized".[74] According to Justice Ruth Bader Ginsburg, there is a pressing need to look at reproductive rights, particularly around abortion, as not just about individual autonomy but substantive equality as well.[75] Dorothy Roberts has additionally argued that focusing solely on individual autonomy advances gender essentialist notions that in turn force women of colour to "fragment their experiences in order to make cognizable legal claims", rather than being able to fully express the intersectional discrimination experienced by them.[76]

As a long-term strategy, scholars have seen that liberal, private rights claims treat groups as homogenous in nature, assuming, in the context of reproductive justice, that all women across classes and cultures are the same, with homogenous experiences, oppressions, and demands.[77] Recognising liberal, private rights does little to address real structural inequalities acting as impediments to individuals in exercising their rights.[78] As stated by Chandra Mohanty, "material and ideological specificities that constitute a particular group of women as 'powerless' in a particular context are left unquestioned",[79] which renders an "individualized absolute right to abortion" meaningless without dismantling the structural barriers preventing pregnant persons from accessing abortion and impeding access to other reproductive health services.[80]

Narratives around "choice", spearheaded by the liberal feminist movement, especially in the United States, advocate the "right to control the biological body and its reproductive resources."[81] However, arguments that solely focus on decisional autonomy, without discussing the roles of poverty, the inability to access healthcare facilities, and other structural forms of discrimination that impede the right to choose, have been strongly criticised by scholars.[82] The liberal celebration of "choice" fails to consider structural issues that impede "free" choices and does not account for the experiences of persons who may seek abortions due to structural issues that adversely impact their ability to raise children.[83] A study conducted in four villages of Tamil Nadu found that factors including domestic violence, superstitions surrounding the month of conception, and the threat of losing employment influenced women's decision to terminate their pregnancies. Abortions allowed these women to "negotiate the harsh realities of work and the increasing control over their sexuality in the workplace and at home."[84]

Challenging only restrictive abortion laws does not encompass the struggles and demands of marginalised women, who are concerned with challenging coercive measures, such as sterilisation, which impede their ability to make free and informed reproductive choices.[85] The legal recognition of reproductive rights is insufficient without the creation of dedicated state and social structures equipped to provide persons with the ability to access these rights and exercise corresponding freedoms.[86] The ability to make informed and free reproductive choices cannot be looked at from a limited perspective of liberal rights, laws and policies, without a discussion of the broader social and economic oppressions and experiences that can constrain decisional autonomy.[87]

Scholars have seen that the "full exercise of autonomy" requires the making of "meaningful choices" that are "limited by discrimination or lack of opportunities".[88] Understanding the exact nature of compounded discrimination from various

structures of oppression is essential to prevent violations arising from structural and legal restrictions that disproportionately impact marginalised women and girls.[89] In India and globally, disparate impacts of exclusionary approaches to reproductive rights have led the reproductive justice movement to garner momentum, reflecting that "those most marginalised must be central in the analysis of autonomy" in human rights law.[90]

Scholars like Joanna Erdman have argued that perceptions of restrictive abortion laws should be shifted, to account for their origins in gender discrimination and "control" of women, and to take reproductive rights beyond the discourse of substantive equality, into the domain of gender justice.[91] If gender "as a ground of discrimination is not tied to any identity characteristic or group category" being considered as the intersecting effect of prevalent social norms,[92] then discrimination analysis takes on a "structural understanding of gender discrimination", which can account for inequalities among different classes of women as well as gender-diverse persons in circumstances restricting access to abortion.[93] This "structural understanding of discrimination" would also allow for a more inclusive reproductive rights movement, including transgender, intersex and gender-diverse persons.[94] As recognised by the reproductive justice movement in the United States, "reproductive oppression is experienced not only by biologically defined women"[95] and focusing reproductive rights arguments and movements solely around 'women' would create an exclusionary situation for individuals falling beyond the gender binary.[96] An equality-based, inclusive approach that treats gender as a social norm would make it possible to challenge abortion laws that create discriminatory distinctions between any groups of persons, not restricted to women and men.[97]

The data from this research clearly substantiates the disproportionate impact of unequal healthcare distribution on marginalised persons, especially those living in rural and scheduled areas. Abortions in most states were concentrated in the private sector or were conducted at home, despite private sector abortions being unaffordable for most women, betraying the lack of confidence in and accessibility of public sector facilities. Although there is evidence that shows that medical abortion (MA) is a safe method of abortion and can be self-administered by the pregnant person in their home, the inaccessibility of healthcare services in case of any post-abortion complication increases the risk of this procedure.

As illustrated by scholars in the past, structural inequalities and impediments, including social and economic marginalisation, can seriously affect access of pregnant persons to reproductive healthcare services that are highly concentrated in the private sector, often entailing exorbitant costs.[98] The serious shortfalls in the availability of specialist doctors in all the states and union territories of India, as seen in this research, as well as internal conflicts and increased military/police presence in Scheduled Areas I (see Section II) act as major barriers to setting up and accessing healthcare services and ultimately, the exercise of reproductive choice for marginalised persons.

1. Regional Analysis

A lack of funding is one of the main reasons for the severe shortfalls in healthcare availability in each state and UT. Additionally, other determinants such as low pay for doctors and security risks (e.g.: attacks at the workplace) have a role to play.

1.1. North India

In 2020, the Government released no funds to Bihar under the Ayushman Bharat-PM Jan Arogya Yojana (AB-PMJAY) scheme.[99] Even prior to this, only 4.4 million individual e-cards had been issued to families in Bihar to allow them to use the scheme, which means four-fifths of the state's population currently remains out of the ambit of AB-PMJAY.

In Haryana, there are no computers, digital connectivity or software to identify the beneficiaries of schemes and keep record of the patients. The government is also yet to appoint other staff, such as sweepers, in several clinics.[100] Most vacancies for doctors, nurses, technicians and medical officers have not been filled. In Karnal, for example, there is not a single doctor in 11 Primary Health Centres (PHCs), while 10 PHCs are functioning with only one doctor.[101]

NO doctor in 11 PHCs

only ONE doctor in 10 PHCs

KARNAL (HARYANA)

In Uttarakhand, one major barrier to health care services stems from the unique geographical layout of the state: 86% of the region is mountainous and 65% is covered by forest and hilly areas. Thus, the availability of general physicians, doctors, surgeons, and various health specialists, especially in the rural and far-flung hill areas is an important determinant of the health and longevity of the people living there.

1.2 South India

Unlike the Northern states, the state-wise analysis here shows that most Southern states spend well on healthcare. However, there are other factors that determine the severe shortfalls in healthcare availability in each state.

Goa spends Rs 2,439/- per capita on healthcare, almost four times the national average. Yet, the state faces an acute shortage of specialists, making the idea of Medical Boards unfeasible.[102] One of the reasons is the low pay for public sector medical service.

> There is less salary in the government sector as private sectors are more lucrative and there is also a 15-year residence criteria which could serve as an inhibition for medical practitioners.

Francis D'Souza,
Former Goa Health Minister

In 2016-17, only 60.7 per cent of the funds for family planning were spent in Karnataka.[103] This is indicative of the need for the Government to appropriately allocate funds to public healthcare to break down the barriers that people face when availing public health care facilities, notably the access to abortion services. On the other hand, Kerala has ensured sufficient allocation of funds towards healthcare and the state also has one of the lowest vacancies for PHCs in the country.[104] Despite this, the availability of doctors and specialists in the public sector is extremely low, as they prefer to work in the private sector.

In Tamil Nadu, the distribution of doctors within the state is highly unequal and rural districts are particularly worse-off.[105] While urban districts such as Chennai have more than 18 doctors per 10,000 people, smaller/rural areas like Tiruvarur have just two.[106] Telangana similarly has a particularly high percentage of seats vacant for specialists such as surgeons, paediatricians, obstetricians, gynaecologists and physicians.

With the onset of the COVID-19 pandemic and subsequent lockdown, access to healthcare has become even more difficult. In Goa, for instance, to combat the shortage of beds, "the government has prepared another battleground to combat the virus. "Operations of Hospicio hospital would be entirely shifted to the New South Goa District Hospital and the old hospital will be used as a COVID hospital for Pre-Natal and Ante-Natal activities" said Goa's current Health Minister, Vishwajit Rane.[107] However, these measures might still not be adequate in facilitating abortion services while combating rising coronavirus cases. Similarly, Karnataka has also been overwhelmed due to the rise of COVID-19 cases.[108] The State is struggling with inadequate healthcare infrastructure, which has left several hospitals in North Karnataka in dire conditions as they are unable to treat critical cases and thus patients are being referred to nearby governmental healthcare institutions.[109] Doctors are also reluctant to join public healthcare because of low pay, or to serve in rural areas as the isolation is not compensated for in pay.[110]

1.3 East and North-East India

The healthcare infrastructure in the North East is ruptured and lacks the capacity to cater to health needs of pregnant persons considering the paucity of health care units and low number of specialists at such units. The healthcare units are understaffed in terms of doctors, health care workers and specialists, making the constitution of Medical Boards impractical and unfeasible. Some of the scheduled and rural areas of these states present a 100% shortfall in the number of required specialists. The state-wise analysis shows that the hilly geographical terrain of many areas in the North East is a barrier to healthcare access. Arunachal Pradesh has difficult, hilly terrain[111] and is a conflict point with China[112] due to multiple cases of aggression at the border. However, this is not the only reason for the shortfalls in healthcare availability and accessibility in the region.

The allocation of funds for healthcare infrastructure is another major barrier, with many states spending low amounts on health. For example, the per capita expenditure on healthcare in West Bengal has fallen from 16% in 2015-16 to 0.4% in 2018-19.[113] The hospitals are understaffed and in dire need of infrastructure; long waiting lines and poor service increase the pressure on the patients seeking medical care at public sector facilities, especially in rural areas. Secondary and tertiary services such as diagnostics, ambulances and catering have been outsourced to private partners who have been accused of charging higher prices for these essential services. Doctors also face a lack of security: a massive strike was held in the month of June 2019, with hundreds of senior doctors tendering their resignations after a junior doctor was brutally injured by the patient party in a government hospital, following the death of an elderly man.[114]

Of all the states in this region, Assam is the only one where greater access to abortion is provided by public health centres than private ones. Although this appears to be encouraging, barriers to access in 'facility based abortions' continue to exist and hinder greater penetration of such services to rural and remote areas, on account of a 'paucity of equipment and supplies, social or religious concerns and lack of registration/authorisation to provide abortion'.[115]

The Assam results prove that women do seek abortion care at public sector facilities when services are made available closer to their communities. While no woman wants to turn to an unsafe provider, there are many factors that can lead a woman to seek an abortion outside of the formal health sector. Increasing the provision of abortion services in the public sector is critical to meeting demand for abortion services for rural and lower-income women. Important steps to achieving this goal include expanding categories of approved abortion providers, including midlevel providers, and ensuring that trained staff and needed supplies are available up to the last mile.

Dr. Nozer Sheriar,
Board Member, Guttmacher Institute, New York, and former Secretary General,
Federation of Obstetrics & Gynaecological Societies of India (FOGSI)

1.4 Scheduled Areas - I

(Jammu and Kashmir, Chhattisgarh, Jharkhand, Gujarat and Himachal Pradesh)

In this region, as with the others, lack of proper budgetary allocation towards healthcare is a key factor causing severe shortfalls in availability of specialists and low numbers of abortions performed in the public sector. There is also a greater reliance on the private sector due to poor health infrastructure. Additionally, many of the states covered in this region are “conflict zones”. Doctors are hesitant to work in these areas due to fear of attacks.

In Chhattisgarh, adequate safety and security was provided in only one CHC. Staff in remote scheduled areas reported that they felt insecure to work in sub-centres, owing to the lack of watchmen and the proximity of nearby arrack shops and “goondas”.[116] Similarly in Jharkhand, security in the workplace is a leading factor that prevents doctors from practicing in the state. In June of 2019, the state saw protests over security concerns, reports of violence and assaults on doctors at Ranchi Trust Hospital, and the introduction of the Medical Protection Act[117].

In Gujarat and Himachal Pradesh, while security risks are not a major concern, the shortfall in specialist doctors can be attributed to a low return on investment for many students – especially from rural areas – who spend a lot of money on their medical education.[118] Additionally, doctors are often not provided proper residential accommodations and health centers are poorly equipped.[119]

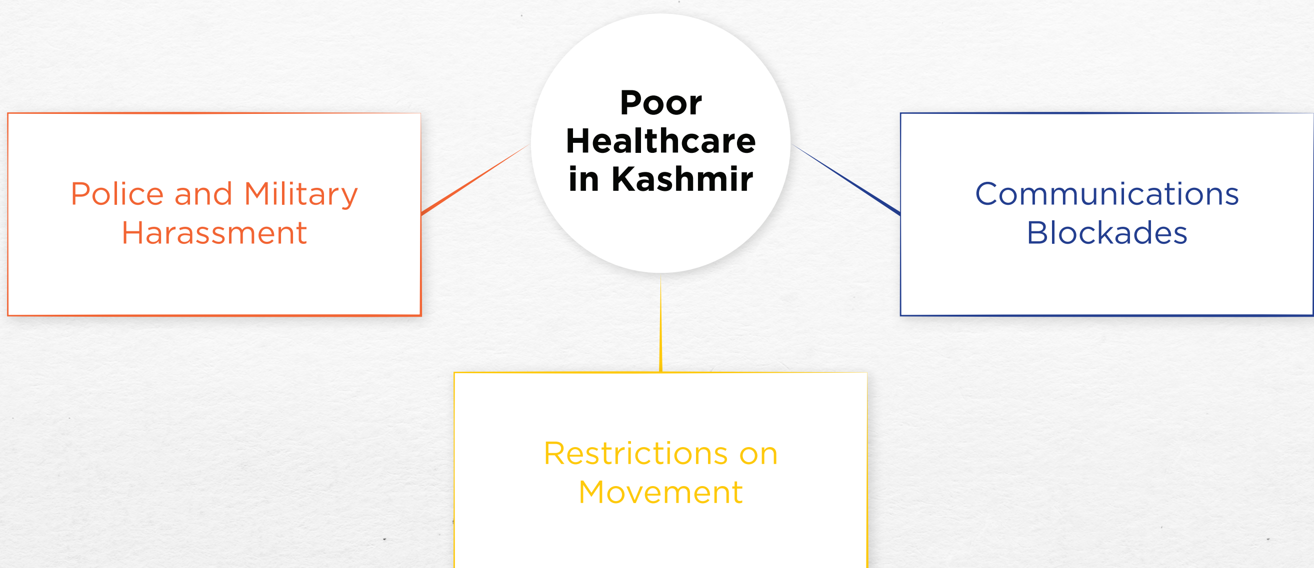
In Kashmir, constant lockdowns and communications blackouts have been extremely detrimental to the accessibility of healthcare services. The digital blockade prevents doctors from accessing the Ayushman Bharat data base and dispensing medication accordingly. Doctors have also been arrested for revealing such information. On August 16, 2019, 19 doctors from across India wrote to the Indian government, in a letter in the British Medical Journal (BMJ),[120] asking them to ease restrictions on communication and movement as they hindered patients and staff from reaching hospitals.

> A blatant denial of the right to health care and the right to life.
>
> **Statement by doctors,**
> British Medical Journal

On August 26, 2019, Dr Omar Salim Akhtar had spoken to BBC Urdu, stating that restrictions on driving and communications (imposed after Kashmir's statehood and special status were revoked by Parliament) would impede access to healthcare for many. For fear of state censure, he even wore a placard around his neck saying 'This is not a protest. This is a request.' Even so, he was promptly arrested by police on camera after making his statement.[121]

> A journalist from Kashmir wrote about his sister who suffered a miscarriage:
> "The doctors at the hospital regret that the ban on communication prevented them from real time communication to the senior gynaecologist that could have saved the baby."

On August 9, a stillborn baby was born to parents who, with the suspension of transport, had to walk to a district hospital after developing complications. Human Rights Watch reported in August 2019 that "...patients are struggling to access lifesaving treatment on time. Poorer patients are unable to receive free medical care under a government insurance scheme because that requires phone or digital connectivity to access records."[122] As recently as May 2020, Doctors Association Kashmir (DAK) announced a black-band protest across Kashmir, following recent incidents in which doctors were allegedly manhandled, harassed and not allowed to reach hospitals by the police[123].



1.5 Scheduled Areas - II

(Andhra Pradesh, Madhya Pradesh, Maharashtra and Odisha)

In this region as well, a lack of funding is a key reason for poor healthcare infrastructure and accessibility.

In Andhra Pradesh, public hospitals have poor medical facilities, outdated equipment and inadequate infrastructure.[124] Welfare schemes (Ayushman Bharat Yojana implemented under the name of YSR Aarogyasri Scheme by the YSR Congress Party Government)[125] have not been successful in boosting access to public welfare.[126] Moreover, in Madhya Pradesh, low salary is one of the reasons fewer doctors opt for public service.

In Maharashtra, public hospitals are understaffed and lack necessary infrastructure, thus leading to people seeking out alternatives such as informal providers, semi-skilled or unskilled providers.[127] The State has also had a rough past with access to safe abortion and has reacted in a counter-productive manner. In March 2017, after 19 female foetuses were found dumped in a stream in Sangli[128], the government committee investigating the crime recommended steps that would curtail access to legal abortions. The Dean of the Government Medical College in Sangli compared abortion pills to poison and weaponry, suggesting the categorisation of the same under Schedule X of medicines under the Drugs and Cosmetics Rules. This new categorisation would require pharmacies to store copies of prescriptions for these pills as proof and record of legitimate sale.[129] Preventing access to legal medication and safe abortion is, of course, never the solution to sex-selective abortion practices. However, these views are not just propagated by highly trained individuals but are further being ratified by committees without consultations with persons who can or have been pregnant.

1.6 Union Territories

There is a substantial data gap for the four UTs analysed. Nevertheless, the data available shows a large dearth in healthcare availability.

The Andaman and Nicobar Islands have been vulnerable to isolation and connectivity issues, coupled with a fragile ecosystem.[130] Moreover, there are not enough medical colleges that can produce local medical practitioners. Mr. Kuldeep Sharma, Member of Parliament from the islands, noted the low salary given to doctors as a reason for the medical absenteeism.[131]

Delhi's performance in the health sector is radically better than all the other union territories. The number of subcentres and PHCs increased in Delhi in 2018-2019, while the same decreased in all other union territories or remained the same[132]. The national capital could thus be a positive outlier in health performance. However, the lack of data on specialist availability hinders any possible analysis. Lakshadweep similarly has a large data gap, as does Puducherry.

Puducherry's public health system has faced a steep fall over the last few years. A reflection of this was recently recorded in the union territory's oldest government hospital, Indira Gandhi Government General Hospital. The report blamed acute shortage of manpower and a cash crunch as the factors responsible for the hospital's dire state, with ongoing struggles to keep afloat and tackle ever-increasing inflows of patients.[133]

2. Feasibility of Constituting Medical Boards

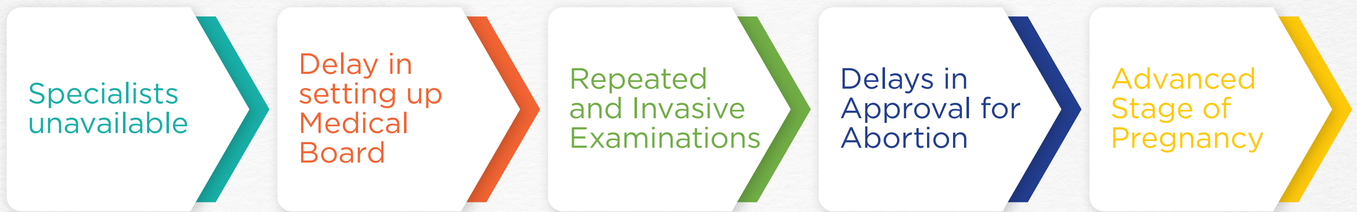
The constitution of Medical Boards at any level is completely impractical. Many states such as Arunachal Pradesh, Meghalaya, Mizoram and Sikkim have recorded a near 100% shortfall in the availability of specialists (gynaecologists and obstetricians, paediatricians, radiologists) especially in rural areas. The MTP Amendment Bill requires these three specialist doctors to be part of the Board, along with other members that the State/UT may appoint. As demonstrated above, it would be nearly impossible to constitute such Boards in most regions of the country, and the process would inevitably delay abortions until pregnancies reached their advanced stages.

The non-feasibility of setting up Medical Boards has been supported by statements made by scholars and practitioners, with V.S. Chandrashekar, CEO of the Foundation for Reproductive Health Services stating that in 2019, there were only approximately 60,000 to 70,000 legal abortion providers in the country, mostly in urban areas, which he termed as "woefully inadequate" for India, which is estimated to have about 15.6 million abortions every year.[134] Such shortages, mirrored in this research, indicate an urgent requirement to expand the base of medical service providers who are equipped and trained to carry on abortions, even without the consideration of Medical Board membership.

> In 2019, there were only 60,000 to 70,000 legal abortion providers in the country, mostly in urban areas, which is **woefully inadequate** for India.
>
> **V.S. Chandrashekar,**
> Foundation for Reproductive Health Services India

The Ministry of Health and Family Welfare, in an implicit acknowledgment of the shortage of medical professionals in the country, had proposed certain amendments to the MTP Act in 2014, seeking the decentralisation and expansion of accessible abortion services by substituting "registered medical practitioners" mentioned in the Act with "registered health care providers", who could include persons with certifications in alternative medicine, nurses or auxiliary staff who would be trained to provide abortions.[135] Further, the WHO Guidelines issued in 2015 also state that a critical barrier to accessing abortion services is the lack of trained providers, recommending "task shifting" of certain abortion-related tasks and smaller sub-tasks be carried out by non-physician healthcare professionals, including nurses and alternative medicine practitioners.[136] However, the amendments were not adopted, rendering only "registered medical practitioners" eligible to perform abortions.

Fundamentally, the MTP Act did not envisage any third party authorisation including the role of Medical Boards and Courts in termination of pregnancy. The law allows for abortion under certain restrictive conditions, with the approval of 1-2 doctors. The MTP Act allows for abortions after the 20-week limit to 'save the life of the pregnant woman' (Section 5). However, hundreds of cases have come up in recent years where pregnant persons have approached the courts seeking termination of pregnancy after 20 weeks. The courts have not clearly laid down the law on this issue yet, instead choosing to appoint ad-hoc Medical Boards in each case to deliver 'expert assessments' on: (a) the health risk the abortion would pose to the pregnant person, and (b) whether the foetus would have anomalies.[137]



The formal health system in India eludes those seeking abortion by inserting bureaucratic and judicial mediators that fail to appreciate a person's reproductive choices. The constitution of Medical Boards at the state level compounds these barriers multifold, enmeshing abortion in a rigid medico-judicial framework as opposed to a reproductive justice framework. The immediate threat that Medical Boards pose to access to abortion is that they require several specialists to sign off on a procedure, in a country where finding a single gynaecologist in a district can be difficult. The delays that pregnant persons have been put through by the judicial system alone have jeopardized access and often taken away the option to abort.

2.1. Medical Boards Cause Delays

In the past few years, several Supreme Court and High Courts have relied on the decisions of Medical Boards to decide cases on abortions. Such ad-hoc boards have been functioning without clear mandates or guidelines; their decisions have thus been inconsistent and often in breach of the MTP Act. For instance, in five cases heard in the past five years by the Supreme Court, Medical Boards opined that the foetuses were 'viable' and likely to survive after birth – a factor that is alien to the Act's considerations of the physical and mental health of the pregnant person and foetal anomalies. The court used the Boards' opinions to reject the abortion pleas. Importantly, the courts consulted the Medical Boards instead of the doctors chosen by the pregnant persons themselves.[138]

Reviews of existing jurisprudence on MTP cases before High Courts and the Supreme Court show the delay in systemic responses to abortion requests before Courts.[139] In High Courts, the average time to decide MTP cases ranged from 23 days before the Madras High Court to seven (7) days before the Karnataka High Court, which showed the quickest average resolution period.[140] However, these periods only consider the time from filing writ petitions to final orders being passed, when in reality, pregnant persons seeking abortions first approach medical practitioners who reject their abortion requests, and sometimes file cases in district courts before approaching respective High Courts.[141] The cumulative delays add additional barriers to abortions for such pregnant persons, as in many cases, Medical Boards that are appointed by High Courts deem such advanced-stage abortions to be unsafe in nature, forcing pregnant persons to carry their unwanted pregnancies to term.[142]

The adverse effects of such delays can be seen in cases like Ms. Z v State of Bihar[143], which was an appeal filed in the Supreme Court by a minor survivor of rape who had become pregnant. She had initially approached authorities at 13 weeks' gestation, but owing to systemic delays, the pregnancy reached 20 weeks of gestation, forcing her to approach the High Court.[144] The High Court heard the case and rejected the request for MTP, after which she filed an appeal before the Supreme Court.[145] At this point, her pregnancy had reached 36 weeks of gestation, rendering the Supreme Court unable to grant the request for abortion, as the procedure would entail a risk to the life of the petitioner.[146]

In Ms. Z, although the Supreme Court was forced to reject the abortion request, the Court recognised the serious delays caused by the State and High Court, granting the petitioner compensation of INR 10 lakhs.[147] The Court additionally stated that the manner in which the petitioner's case had been handled by the relevant authorities amounted to a violation of her fundamental rights. This is not an isolated case where the judiciary has acknowledged serious systemic delays hampering pregnant persons' access to timely abortions. In July 2017, a ten-year old rape survivor approached the Supreme Court to end her pregnancy.[148] The Court, relying on the Medical Board's assessment that abortion would endanger her life, denied the application. In this case, delay by the Medical Boards and courts was significant to the denial of abortion. The survivor was 26 weeks pregnant when her family first realised that she was pregnant. They approached the District Court, which set up a Medical Board. The District Court denied abortion, at which point the family approached the Supreme Court. By the time the Supreme Court-appointed Medical Board could examine her, the pregnancy had progressed to 32 weeks, and an abortion became too dangerous to perform[149]. In another case, R v. State of Haryana, the Punjab and Haryana High Court observed that being shuttled between multiple Medical Boards with differing opinions caused the completely avoidable delay beyond 24 weeks, foreclosing the right to abort.[150] The Court went on to clarify that when doctors act in good faith and carry out abortions to save the life of pregnant women or prevent injury to their physical and mental health, they will not be unnecessarily prosecuted – showing judicial recognition of the barriers of access created by additional steps for granting permission for abortions.[151]

Jurisprudence from the Supreme Court and High Courts shows that the constitution of Medical Boards to decide the medico-legal aspect of granting or rejecting abortion requests is wholly unnecessary. For instance, in Meera Santosh Pal v Union of India[152], the Supreme Court heard a case for MTP with a gestation period of 24 weeks, prayed for on ground of foetal abnormality. The Court had constituted a Medical Board, which opined that the foetus was not viable and would not survive.[153] However, the Court specifically stated that it would not consider medico-legal aspects pertaining to the foetus, choosing instead to adjudicate the case based on the rights of the petitioner.[154] The Court upheld the right of the petitioner to "protect and preserve her life by making an informed decision"[155] and stated that women's rights to make reproductive choices formed a dimension of their personal liberty, protected under the Constitution. This judgment has acted as a precedent for other cases before the Supreme Court and High Courts where the rights of the petitioner have been given primacy over Medical Board opinions.[156]

In Sundar Lal v State[157], the Madhya Pradesh High Court heard a request for MTP filed on behalf of a pregnant rape survivor, who had not been examined by registered medical practitioners as per the MTP Act. The Court constituted a committee, but notably did not take the medical report into account, legally permitting abortion by reference to the MTP Act as well as existing jurisprudence.[158] Additionally, the Bombay High Court in Rajashri Nitesh Chadar v Union of India[159] noted that an abortion would pose a significant risk to the health of the pregnant woman, based upon the Medical Board opinion, but still granted the MTP on the basis of the petitioner's wishes and her willingness to accommodate the risks associated with the procedure.[160] This shows that courts do not have to base their decisions on Medical Board opinions, but are at liberty to pass orders and judgments based on the informed consent and choice of the pregnant person.[161]

Further, of late, judicial discourse has started to point out the issues with Medical Boards and third-party authorisation of abortions in general, in a more critical manner.

For instance, the Bombay High Court in High Court on its own Motion v State of Maharashtra[162] was adjudicating a PIL pertaining to abortion services for incarcerated women, who had to be referred to a committee that would grant or deny permission for abortions. The specific request for abortion had come from an undertrial prisoner, whose MTP request before the committee had been pending for over a month with no response.[163] The Court, in this case, commented on the unnecessary nature of the Committee as an authorising body, stating that the MTP Act does not mandate an additional obstacle of a committee to a pregnant woman.[164]

The Court went on to state that pregnant women alone are the decision-makers of their pregnancies, recognising that their well-being should take precedence over that of a foetus.[165] The Court recognised that restrictions on abortion access take the form of gender-based discrimination, pointing out that reference to external committees would often result in burdens of unwanted pregnancies being borne solely by the pregnant women, which would severely impact their basic rights, including their right to life and liberty.[166] By way of resolution in this case, the Court stated that every request for abortion by an incarcerated pregnant person in the state should be directly referred to a government hospital to undertake procedures under the MTP Act, issuing appropriate directions for women's prisons in Maharashtra.[167]

In the case of Surjhibhai v State[168], the Gujarat High Court heard an MTP request filed on behalf of a minor rape survivor, which was at a gestational age of 26 weeks.[169] The Medical Board opined that the foetus would be viable, stating that the risks to the pregnant minor would be the same, whether from abortion or from delivery. The High Court reluctantly rejected the abortion request but observed in its judgment that doctors providing medical opinions "thought more about the foetus" than about the pregnant person.[170] It is also noteworthy that although the petitioner approached the court at 26 weeks of pregnancy, by the time the medical opinion was obtained and the case decided, the pregnancy stood at 31 weeks' gestation.[171]

The Madras High Court also addressed the issues of unnecessary court as well as Medical Board authorisations and consequent delays in X v the State[172], where the Court noted that rape survivors were often constrained to obtain judicial orders as permission for MTP. The Court expressed concern over women repeatedly having to approach the judiciary for authorisation, stating that if the length of pregnancy is not more than 20 weeks, a single medical practitioner can carry out the abortion legally.[173]

In Raisi Bi v. State of Madhya Pradesh, where the Madhya Pradesh High Court constituted a Medical Board to examine a 13-year-old rape survivor, her lawyers pleaded for a child psychologist to be on the board. Not a single child psychologist could be found in the entire metropolitan city of Bhopal, so the family settled for a psychiatrist.[174] The data gathered by CJLS on shortfall of specialist doctors in all Indian states and UTs is consistent with these experiences. The chances of having specialists in rural areas are far too low to design abortion laws and policies that require specialists to be on Boards.

2.2. Medical Boards Violate Constitutional and Human Rights

The MTP Act does not contemplate any judicial or third-party authorisation for the termination of pregnancy by itself. The MTP Amendment Bill, in seeking the mandatory constitution of Medical Boards, is in effect, denying access to healthcare services for pregnant people, especially from marginalised backgrounds. In India, the

denial of healthcare services amounts to a violation of the fundamental right to life and liberty under Article 21 of the Constitution, with Supreme Court jurisprudence stating that access to emergency care is a fundamental right[175] and emphasising that the "foremost obligation" of medical professionals is the duty of care borne by them to their patients.[176] Access to affordable, non-judgmental and prompt abortion services is highly critical. Complicated and inaccessible systems of authorisation magnify the threat of unsafe abortions.[177]

The effect that Medical Boards will have on healthcare access will serve to exacerbate existing disparities in access to reproductive services and abortions. It is established that access to abortion is asymmetric between rural and urban India and caste-based discrimination is embedded in public health services. Dalit and Adivasi persons already face 'triple discrimination' due to their gender, caste, and socioeconomic status, which impedes their access to maternal and reproductive health services.[178] Studies conducted in Meenkera, Karnataka[179] and Ballabgarh, Haryana[180] have respectively found that significant positions in local public health facilities are occupied by dominant castes and that caste is a major determinant for access to abortions. There is additionally a direct correlation between "declining socioeconomic status and caste location", with lower chances of having access to an induced abortion.[181] The rates of abortion in rural areas, or amongst Dalit and Adivasi women, as compared to people from more favourable positions in the caste system are much lower[182], showing that pregnant people who are from marginalised castes or living in poverty have much lower access to legal abortions. The inequity in health services based on socioeconomic hierarchies and caste structures shows that reproductive justice is a social justice issue at its core.[183]

The framework of Medical Boards, notwithstanding their practice or feasibility, thoroughly bureaucratises abortion services, turning what should be the decision of a pregnant person in consult with their doctor into an invasive, technocratic screening with state interests. The judiciary and Medical Boards constitute what the United Nations Committee on Economic, Social and Cultural Rights (CESR) calls 'third-party authorisations'. These have widely been regarded in international human rights law as restrictive, discriminatory and violative of civil, political, social and economic rights. They delay access to abortion or deny it altogether. Third-party requirements ignore that most "Indian women and girls lack financial and legal resources to seek judicial authorisation and will be forced to carry an unwanted pregnancy to term or risk their lives through unsafe abortion".[184] Whereas the demand from activists and stakeholders has been abortion at will[185] through fewer restrictions for the extremely time-sensitive decision, state-level Medical Boards jeopardise pregnant persons' safety, well-being and bodily autonomy, by unnecessarily delaying permission to abort. The formal medico-legal system, in failing to appreciate a pregnant person's reproductive choices, pushes them to unsafe, back-alley abortions.

The reliance on multiple Medical Boards for a simple procedure is invasive and deters pregnant persons from taking the formal health care route. The very functioning of Medical Boards, through their appropriation of decision-making without giving primacy to the pregnant person's choice, the bureaucratic setup for deciding abortion requests and discriminatory treatment within healthcare services towards marginalised persons serve to violate pregnant persons' rights to decisional autonomy, privacy and equality. The Supreme Court acknowledged that the right to reproductive autonomy falls within the Right to Liberty under Article 21 in Mrs. X v Union of India.[186] Similarly, in Suchita Srivastava[187], the court noted that "There is no

doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity, and bodily integrity should be respected".[188]

The Puttaswamy[189] judgment passed by the Supreme Court explicitly held that reproductive autonomy, bodily integrity and dignity, are essential ingredients of personal liberty under Article 21. The judgment has generated discussions in India about whether it might act as a basis for the clear recognition by Indian courts of abortion as an absolute right for women and girls.[190] In Navtej Singh Johar v Union of India[191], the Supreme Court emphasised the role of sexual autonomy in "the idea of a free individual" and in Joseph Shine v Union of India[192] the Court clearly declared the right to sexual autonomy and privacy as a right protected by the Constitution of India. The Supreme Court as well as High Courts, in taking significant steps to recognise the fundamental rights to privacy, dignity and bodily and sexual autonomy, have made it clear that reproductive rights are to be considered as fundamental rights in India.[193] The location of the fundamental right to life, personal liberty, dignity, privacy, bodily integrity and autonomy has been framed by Indian courts to be "intertwined with reproductive rights, within the framework of gender justice".[194]

In these decisions, the Supreme Court elucidated how the right to privacy, equality and non-discrimination based on sex and gender together create obligations on states to "eliminate laws that serve as barriers to healthcare and reflect discriminatory gender stereotypes".[195] In both cases, the court elucidated a framework to understand the modes of intersection of the rights to privacy, equality, and non-discrimination on the basis of sex and gender, giving rise to state obligations to eliminate laws that serve to reinforce discriminatory gender stereotypes, including those pertaining to sexuality.[196] It has been stated that qualifications or restrictions on the right of a pregnant person to have an abortion marginalise women by controlling their right to bodily autonomy and denying them privacy and equality.[197] In this background, such jurisprudence of the Supreme Court demonstrates that potentially successful arguments for reproductive rights can be based on considerations of equal citizenship.[198]

Similar discourse around laws on abortion and reproductive rights have taken place in other parts of the world, with scholars like Sally Sheldon stating that control over one's fertility is a "fundamental prerequisite" for full participation of women in the public sphere, conferring obligations upon states to promote the health (and reproductive health) of their citizens.[199] Further, international jurisprudence supports the contention that reproductive rights, including the right to abortion, are basic human rights.[200] In 1988, the Supreme Court of Canada, in R v. Morgentaler[201] declared the provision for abortion in Canada's Criminal Code unconstitutional, as it violated §7 of the Canadian Charter of Rights and Freedoms that provides for the right to life, liberty and security of persons.[202] The Court declared that forcing a woman to carry a foetus to term is an interference to her right to life and liberty, as well as the security of her person.[203]

Nepal decriminalised abortion on broad grounds in 2002. In 2009, the Supreme Court of Nepal issued a landmark verdict in Lakshmi Dhikta v. Nepal[204] where the petitioner, Lakshmi Dhikta, could not pay the fees for her abortion at a public hospital, being from a very poor background.[205] The Court stated that the right of abortion could be realised only if it was accessible and affordable, noting that the state had the primary

obligation to ensure the same.[206] The Court held that women could not be forced to continue unwanted pregnancies and that there should be legal recognition of the right to abortion.[207] The Court 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".[208]

The case of Lakshmi Dhikta frames denials of women's reproductive rights within the context of equality and discrimination, particularly due to gender stereotypes placing the primary burden of childcare on women.[209] The case relies on disproportionate burdens placed on women during pregnancy that places them in a unique position of vulnerability, as well as social and legal stereotypes of women as "child bearers" and "caregivers", legally and practically reinforcing their subordination and violating their right to equality.[210] Cases from CEDAW[211] and the Inter-American Court of Human Rights[212] reiterate that negative gender stereotyping additionally contributes to discrimination against women, acting as a major barrier to accessing reproductive health services.[213]

The Center for Reproductive Rights, New York (CRR), has highlighted the fact that the practice of requiring women to petition a court for termination of pregnancy has resulted in additional barriers and delays in access to abortion services. The procedure of courts appointing Medical Boards and then relying on their opinions to grant permission or decline termination can cause not only severe procedural delays for women who need urgent care, but also lead to invasive examinations. Additionally, the CRR report found that in many cases, Medical Boards return opinions that "neglect entirely to discuss the health risks of continuing a pregnancy for a woman or girl, or improperly prioritize the foetus' survival over a woman or girl's well-being" (p 25). There is a need to clarify that the decision to terminate a pregnancy should be taken by a woman in consultation with her doctor only, and no third-party, including the judiciary, should be called upon for authorisation of termination.

The Working Group on the issue of discrimination against women in law and in practice, as part of the UN Human Rights Special Procedures released a statement in 2017 addressing the issues around termination of pregnancy and women's autonomy. Articles 3 and 17 of the International Covenant on Civil and Political Rights (ICCPR) provide that the "right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, concerning intimate matters of physical and psychological integrity". The decision on whether to continue with a pregnancy is fundamentally a woman's decision, as pregnancy and childrearing have a "crucial impact on women's enjoyment of other human rights". Further, legal and practical barriers adversely affecting access of persons to safe abortion services violate various human rights guaranteed under the ICCPR, including the right to life, privacy, equality, freedom from gender discrimination or gender stereotyping and freedom from ill-treatment.[214] In General Comment 36, the Human Rights Committee called on states to amend their abortion laws to prevent women and girls being constrained to resort to unsafe abortions.[215] The Committee has also observed that the denial of access to abortion leads to suffering that could constitute cruel, inhuman or degrading treatment.[216]

The UN Human Rights Committee in the case of LMR v. Argentina[217] has recognised that the requirement of judicial authorisation for abortion services is a human rights violation. The Committee determined that the decision for termination of 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.[218] The Committee has also urged state parties to remove third-party authorisation requirements, whether judicial or medical, classifying these requirements as barriers to accessing healthcare.[219]

Similarly, the Committee on Economic, Social and Cultural Rights has stated in its General Comment No. 22 that States should remove restrictive laws that create barriers in access to sexual and reproductive health services, including third-party authorisations for abortions. The Committee on the Elimination of Discrimination against Women has also raised concerns about third-party authorisation requirements. Further, the World Health Organization has also acknowledged that third-party authorisation requirements undermine women's autonomous decision-making, stating that "negotiating authorisation procedures disproportionally burdens poor women, adolescents, those with little education and those subjected to, or at risk of, domestic conflict and violence, creating inequality in access."[220]

SECTION - V

Conclusion

The MTP Amendment Bill, 2020 has sought to make third-party authorisation of abortions a statutory requirement, by constituting Medical Boards in every state, comprising of specialists including a gynaecologist, paediatrician, radiologist or sonologist and other members as may be proposed, to regulate medical terminations of pregnancy beyond the statutorily prescribed 24-week gestational period. Supreme Court and High Court jurisprudence over the past 5 years has shown that the requirement of third-party authorisation by Medical Boards can be burdensome and has previously resulted in severe delays in granting abortions. Courts have been seen to largely rely on Medical Board opinions, which take into account a variety of factors not necessarily prescribed as conditions in the MTP Act. The reliance on highly variant Medical Board opinions resulted in court orders based on inconsistent criteria and an abject lack of uniform jurisprudence on grant and rejection of MTP in the country.

Indian courts and international narratives have noted that multi-layered authorisation requirements for abortions have created barriers to women exercising their reproductive autonomy. The multiple layers of authorisation as provided by India's current legal and healthcare distribution frameworks act as major impediments to marginalised persons being able to access safe abortion services. Research has shown that there is a disproportionately higher risk of unsafe abortion among vulnerable and marginalised communities in India, not just on account of the nature of the legal framework, but also due to unequal and disparate distribution of healthcare infrastructure across the country.

The research carried out by CJLS utilised national as well as state-wise statistics from various governmental agency surveys and non-governmental studies conducted between 2015 and 2019 to determine the feasibility of implementation of this statutory provision, which is likely to completely alter access to reproductive healthcare and timely abortions by a significant population of pregnant women and persons across the country. This research sought to assess the practicality of this venture by the Central Government by looking at the district-wise availability and accessibility of specialist doctors across all Indian states, especially for paediatricians, obstetricians and gynaecologists, and radiologists. The data covered considerations including the number of vacancies and the extent of paucity of specialists at CHCs across rural, urban and scheduled regions of different States and Union Territories in India. Most Indian states and UTs demonstrated a dire shortfall of over 80% in the availability of obstetricians and gynaecologists, making the proposal of state or district-wise Medical Boards impossible, given the lack of specialists who are actually qualified to perform abortions.

The overwhelming vacancies for specialised medical professionals, especially in rural and scheduled areas, coupled with the prevalence of unsafe home births, abortion-related complications, maternal death rates and lack of public sector facilities already form a dire situation for pregnant women across the country. The failure of the Central Government to ensure public health availability is mirrored in most states, which fare extremely poorly in financing public healthcare. In this background, with Medical Boards carrying out third-party authorisations of abortions, the paucity of specialists and safe equipped public facilities (or affordable, accessible private facilities) is likely to exacerbate the lack of access of pregnant persons (especially from rural, scheduled or otherwise marginalised and isolated communities) to reproductive healthcare.

Until recently, the framing of reproductive rights discourses within liberal rights narratives focused on decisional autonomy of pregnant persons, largely failing to consider structural issues that impede “free” choices as well as the experiences of persons who may seek abortions due to structural issues that adversely impact their ability to raise children. However, scholars have argued for equality-based, inclusive approaches which would make it possible to challenge abortion laws that create discriminatory distinctions between any groups of persons, not restricted to women and men – and would create spaces for gender-diverse, transgender and intersex persons within reproductive rights movements. The current Indian legal framework that only contemplates pregnant “women” already manifests in exclusionary, inaccessible and bureaucratic experiences for a significant proportion of marginalised pregnant persons in the country. Adding Medical Boards to this structurally unequal framework will only exacerbate experiences of oppression and discrimination amongst people seeking reproductive health services.

Statistics from the state-wise reports of the National Family Health Survey 4 have shown that uniformly across India, women exhibit a sweeping lack of control over their bodily autonomy and reproductive choices. This is seen through data where women claimed that if they had only the number of children they wanted, they would definitely have fewer children, bringing the average number of children down in almost every jurisdiction covered in this research, where data was available.[221] This lack of freedom of “choice” of pregnant persons will only be exacerbated by creating yet another decision-making authority (the Medical Boards), which are highly medicalised in nature and far from the ‘abortion at will’ legal framework that grants primacy to the wishes of a pregnant person.

The constituting of Medical Boards across the country will not only impede access to safe and timely abortions by pregnant persons but will serve to act as yet another bureaucratic hurdle, source of intimidation and deterrent to pregnant persons exercising their reproductive rights. Medical boards will add another layer of bureaucracy, requiring pregnant persons to navigate red-tapeism, tedious and time-consuming processes, as well as the potential biases of 'specialists'. As Nayanika Mathur writes in her work Paper Tiger, there are various challenges in how laws operate on the ground due to the "elite disconnection from the labours of real implementation".[222] The impact of setting up Medical Boards will be that large swathes of pregnant persons will be excluded from the ambit of medical care. Those who rely on state facilities for healthcare, especially, will be left in the lurch. As healthcare, including reproductive healthcare, is the condition precedent to the Right to Life in a democratic society, the injustice engineered by instituting Medical Boards will chip away at pregnant persons' citizenship itself.

With overwhelming shortfalls in specialist availability, especially in rural and scheduled areas, it would be impossible to constitute Boards with requisite specialist representation as contemplated under the MTP Amendment Bill. Further, the perilous delays caused by third-party authorisation, as evidenced in Indian and international jurisprudence and discourse, as well as violations of basic human rights through the bureaucratisation of abortion services turns what should be the decision of a pregnant person in consultation with their doctor into prolonged, traumatic and invasive ordeals. The very functioning of Medical Boards, through their appropriation of decision-making without giving primacy to the pregnant person's choice, their bureaucratic setup for deciding abortion requests, and their perpetuation of discriminatory treatment within healthcare services towards marginalised persons, serve to violate pregnant persons' rights to decisional autonomy, privacy and equality. In doing so, those who are most marginalised due to their caste, religious identity, gender and disability will carry the heaviest burden, setting the movement for reproductive justice back irrevocably.

The MTP Amendment Bill, in seeking to reform a 50-year-old law, has proposed changes that strip the pregnant person of decisional autonomy. The human rights violations of third-party authorisation mechanisms such as Medical Boards have been recognised internationally, and Indian Supreme Court jurisprudence has also emphasised reproductive autonomy as an integral component of the fundamental right to life and liberty, privacy, and dignity. If abortion is not accessible to pregnant persons at will, they will be compelled to undergo risky and unsafe procedures which may lead to severe health complications as well as deaths. Furthermore, the singling out of disability (through the setting up of Boards only for diagnosis of foetal anomalies) advances a eugenics-based rationale for abortion and must be revisited. It is imperative that the Bill be referred to a Standing Committee, and extensive consultations with all stakeholders must take place in order to understand the complexities of this issue.

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