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Access to Safe and Legal Abortion Services in Asia: Challenges and Opportunities

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ABOUT US

ASIAN PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN

The Asian Pacific Resource & Research Centre for Women (ARROW) is a regional non-profit women's organisation based in Kuala Lumpur, Malaysia, that has consultative status with the Economic and Social Council of the United Nations (ECOSOC). It was established in 1993 with the originating vision to create a resource centre that would 'enable women to better define and control their lives'. ARROW strives to enable women, non-binary people and young people to be equal citizens in all aspects of their lives by ensuring that their sexual and reproductive health and rights are achieved.

CENTRE FOR JUSTICE, LAW AND SOCIETY, JINDAL GLOBAL LAW SCHOOL.

The Centre for Justice, Law and Society (CJLS) is a queer intersectional feminist research centre in Jindal Global Law School (JGLS) that critically engages with contemporary issues at the intersection of law, justice, society and marginalisation in South Asia. It is a collaborative endeavour of scholars, activists and students 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 and inaugurates a distinct terrain of research that is not mimetic of Western mainstream paradigms of law and society studies or studies that do not focus on justice as a central theme. Its approach combines research and education with activism and advocacy and recognises the importance of interdisciplinary critical engagement with the law. CJLS has created spaces through pedagogical and community led interventions, including doctrinal courses, clinical courses, workshops, and collaborative deliberations, that facilitate critical dialogue and reflections to develop an inclusive and intersectional framework for advocacy and research. CJLS has also crafted judicial, legislative and policy interventions and facilitated consultations with grassroots social movements designed to address punitive laws, regressive policies that de-centre those most affected, and access to justice for marginalised groups. CJLS has been a thought leader on reproductive justice and trans-justice in India.

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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwives
ASAP	Asia Safe Abortion Partnership
BPOM	Indonesian Drug & Food Authority
CAC	Comprehensive Abortion Care
CEDAW	United Nations Convention for Elimination of All Forms of Discrimination Against Women
CMRA	Child Marriage Restraint Act
CRC	Convention on the Rights of Child
CSE	Comprehensive Sexuality Education
DCC	Drug Control Committee
FDA	Food and Drug Administration
FIR	First Information Report
FMOH	Federal Ministry of Health
FWLD	Forum for Women, Law & Development
GBV	Gender-Based Violence
HCD	High Court Division of the Supreme Court of Bangladesh
IACHR	Inter-American Commission on Human Rights

ICC	Indonesian Criminal Code
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICPD	International Conference on Population and Development Programme of Action
IPC	Indian Penal Code
IUD	Intrauterine Device
KUPI	Komgres Ulama Perenpuan Indonesia
LGBTQIA+	Lesbian Gay Bisexual Transgender Queer Intersex Asexual Plus
LMP	Last Menstrual Period
MA	Medical Abortion
MMR	Maternal Mortality Rate
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medicine
MRTSP	Menstrual Regulation Training and Services Programme
MTP ACT	Medical Termination of Pregnancy Act
MUI	Majelis Ulama Indonesia
MVA	Manual Vacuum Aspiration

NGO	Non-Government Organisation
OB-GYN	Obstetrics and Gynaecology
PAC	Post-Abortion Care
PAPAC	Pakistan Alliance for Postabortion Care
PCPNDT ACT	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PHP	Phillippine Pesos
PINSAN	Philippine Safe Abortion Advocacy Network
PMAC	National Policy on Prevention and Management of Abortion Complications
POCSO ACT	The Protection of Children from Sexual Offences Act
PPC	Pakistan Penal Code
RPC	Revised Penal Code
RPD ACT	The Rights of Persons with Disabilities Act
RSMRHR ACT	Right to Safe Motherhood and Reproductive Health Rights Act
SAAF	Safe Abortion Action Fund
SC	Supreme Court
SCMRA	Sindh Child Marriage Restraint Act
SPC	Spanish Penal Code

SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TGA	Therapeutic Goods Administration
TOP	Termination of Pregnancy
UCS	Universal Coverage Scheme
UDHR	Universal Declaration of Human Rights
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNHRC	The United Nations Human Rights Council
UNICEF	United Nations Children's Fund
USA	United States of America
USD	United States Dollar
VCAT	Values Clarification and Attitude Transformation Training
WHO	World Health Organisation

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CHAPTER II

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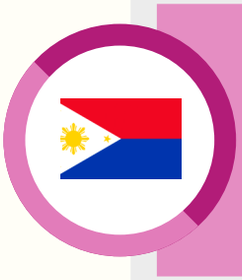

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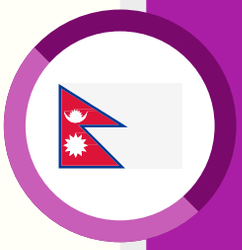

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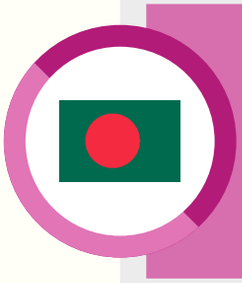

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EXECUTIVE SUMMARY

Abortion has and continues to be a contentious issue in the Global North as well as the Global South. While abortion has been historically criminalised in most countries, recent legal reforms have led to liberalisation of abortion laws in many parts of the world. However, there remains a dearth of postcolonial analysis on abortion laws and legal developments, particularly in South Asia and Southeast Asia. Therefore, it is crucial to map the legal status of abortion laws within this region. Accordingly, this study seeks to identify and critically examine the abortion laws and their impact on access to safe abortion services in ten countries in South Asia and Southeast Asia. These ten countries are: Bangladesh, India, Indonesia, Malaysia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand and Vietnam.

The key questions this study seeks to answer are:

- What is the legal status of abortion in each country?
- How does a criminal legal framework contribute to hindrances in accessing safe abortion services?
- How does criminalisation of abortion impact access to abortion services?

The study followed a qualitative research approach with semi-structured interviews as the primary method of data collection.

The study begins with a country-wise analysis of abortion laws, mapping legislative and judicial developments which have affected the evolution of legal frameworks around abortion services. It thereafter outlines the findings of the interviews while contextualising them within a larger discussion on the impact of legal regulation of abortion services primarily through restrictive and penal laws. Thereafter, it provides broad recommendations and offers concluding observations.

Abortion laws in South Asian and Southeast Asian countries are restrictive. The stigma and cultural unacceptability of abortion, although a social phenomenon, has its roots in the widespread systematic need to control women's sexuality and body, perpetuated by unequal power structures. Interviews from the Philippines, Indonesia, Pakistan, Sri Lanka and Bangladesh reinforce the relationship between stigma, abortion and the legal framework. This perpetuation of stigma in countries like Thailand and Nepal, despite the presence of progressive laws, is telling of religious opposition and cultural influences.

This study highlights the Respondents' insights on the unwillingness of healthcare professionals as a significant barrier to accessing abortion services, both medical and surgical. Religious morality and conservative political environments have resulted in restrictive laws and policies in some countries. Further, while the history and impact of the criminalisation of abortion varies by country, criminalisation policies universally make safe abortion services less accessible for pregnant persons.** Criminalisation of abortion forces pregnant persons to access illegal abortion procedures in medically unsafe circumstances. Unsafe abortion remains one of the major causes of maternal mortality on a global level. The criminalisation of abortion also has significant impact on marginalised persons,*** including adolescents in need of medical termination of pregnancy, as well as those who require essential information and education on sexual and reproductive health. Most importantly, the study highlights prosecution, harassment and intimidation of healthcare providers and abortion seekers, establishing an urgent need for legal reforms within a reproductive justice framework.

NOTES

* This study uses the term LGBTQIA+ to denote persons of diverse sexual orientations and gender identities including, lesbian, gay, bisexual, transgender, queer, intersex, asexual persons and all those individuals who do not identify themselves within the gender binary, or are of sexual orientations not restricted to heterosexual, monogamous interactions. The term LGBTQIA+ has been used as an inclusive umbrella term, however this does not work to the exclusion of terms like sexual and gender minorities that are used colloquially in contexts like India.

**Access to abortions is a critical issue that affects not only cis-gender women, but also concerns transgender, gender-diverse, non binary, gender queer and intersex persons. This study uses the phrase pregnant persons to ensure that it is inclusive of the experiences of all persons with capacity for pregnancies who may need to access abortion services. The use of the phrase pregnant woman in this study is limited to instances where the study quotes directly from a primary source or legislation.

*** For the purpose of the study, we define "marginalised individuals/groups" to include individuals or groups who require special protections due to their social, cultural, economic and/or political status, historical, traditional and/or present exclusion from political power, representation and/or resources or physiological or mental health conditions, including but not limited to women, infants, children, adolescents, elderly individuals, individuals with disabilities, individuals with stigmatised communicable diseases, individuals who use drugs, Dalit individuals (including but not limited to individuals from Scheduled Castes), Adivasi (including but not limited to individuals from Scheduled Tribes, wherever such categories exist de-notified tribes and nomadic tribes) and other indigenous persons, individuals who have been discriminated based on their race, gender identity, gender expression, disability, sexual orientation or sex characteristics, trafficked individuals, sex workers, inter-state, intra-state and international migrants, individuals in conflict situations, refugees, individuals fleeing abusive households, homeless individuals, individuals with rare diseases among others.

CHAPTER I

INTRODUCTION

INTRODUCTION

A university student from Jakarta, Indonesia recalled her traumatic experience of seeking an abortion from an unauthorised clinic. After she got pregnant, she was clear that "keeping it was never an option." Her experience was distressing because of the lack of compassion of the service providers. "It was traumatic,"[1] she recalled. For a year after the procedure, she faced many complications but did not visit a doctor. Abortion is legally restricted in Indonesia.

In the Philippines, scholars argue that abortion was permitted before Spanish colonial rule and the imposition of Catholicism in the late nineteenth century. Abortion was criminalised with the enactment of the Spanish Penal Code of 1870 (SPC), which remained in practice from 1887 – 1931. After the United States of America (USA) took control of the Philippines, the legal prohibition on abortion was retained in the Revised Penal Code (RPC) enacted in 1932. Articles 256-259 of the RPC prohibit and criminalise abortion. This framework of criminalisation makes the Philippines the country with one of the most restrictive abortion laws in Southeast Asia, with a disproportionate impact of criminalisation on marginalised persons.

In an incident documented in a study in the Philippines, a young woman from Manila faced discrimination, pressure and abuse by her healthcare providers. Her experience has been quoted below:

"Terrified and haemorrhaging after taking an unregistered drug to induce an abortion, Kaye, a young woman from Manila, sought medical treatment at a government hospital. Instead of prompt and compassionate care, she was verbally abused by the staff and had to wait for almost 24 hours before receiving life-saving treatment for her complications. Hospital workers refused to provide treatment until Kaye admitted that she had self-induced an abortion. After the forced confession, she was immediately reported to the police by hospital staff. Police officers came to the hospital and brought Kaye to jail, where she was charged and detained for illegally inducing abortion."[2]

In 2009, Lakshmi Dhikta, a woman from a socioeconomically weak background residing in the far-western region of Nepal, was forced to give birth for the sixth time because she could not afford an abortion from a government hospital. The cost of obtaining an abortion was 1130 Nepalese rupees (approximately USD 8.46). Abortion services in Nepal were not provided free of charge. However, a subsequent development in 2017 led to the provision of free abortion services in public sector hospitals.

Her strenuous financial situation was worsened by the need to provide for a sixth child. In *Lakshmi Dhikta v. Government of Nepal* (2009), the Supreme Court of Nepal found that Lakshmi's reproductive rights were violated due to the structural barriers in accessing abortion services resulting from her socioeconomic status. The Court held that anything that prevents a person from exercising the right to abortion and forces them to continue their pregnancy is a violation of the rights guaranteed by the Nepalese Constitution and other laws. However, despite this progressive jurisprudence, a recent 2023 study found that women who were:

"Young, non-married, less educated, less wealthy, and from the Dalit caste were more likely to present later for abortion beyond 10 weeks. Some logistical factors also increased the chance participants presented at or beyond 10 weeks, such as traveling more than 3 hours to get to the clinic, discovering pregnancy after six weeks gestation, and having previously attempted to terminate the pregnancy elsewhere."[3]

In the Indian State of Tamil Nadu, as with much of the rest of India, poor and marginalised women overwhelmingly seek reproductive healthcare, including abortion services at public health facilities. The anecdote quoted below details the experiences of a woman from Tamil Nadu who sought abortion services:

"I pleaded to the doctor to do an abortion. I cried, pleaded and begged. My husband had left me knowing I am pregnant ... to get married to another woman ... I do not have anyone else. Will you please do an abortion? I can't raise the children alone, and I am just a casual labourer, and there is no one else to support me. The doctor said that I have to stay there for ten days for observation. It [my pregnancy] was only 48 days then. They kept tablets in my vagina, and it did not come out. Then they gave oral pills every alternate day; it still did not happen. Each tablet cost Rs. 500 [US$ 6.02]. One day the senior lady doctor came for rounds and began to comment in a very rude manner, you would go and lie down to evannukko (some man), and is it our job to do abortion for you?"[4]

The above quote is from a participant in a 2022 study by Bhuvaneswari Sunil, which offers insight into the on-ground reality of the abortion landscape in India. It reveals that health facilities, government-run health facilities in particular, are hostile towards persons seeking abortion services. This hostility is attributable to stigma and cultural vilification of abortion, even though abortion is conditionally legal under the Medical Termination of Pregnancy Act, 1971 (MTP Act).

The criminalisation of abortion and the legal restrictions placed on access to sexual and reproductive healthcare services significantly impact the health and rights of persons with capacities for pregnancies and other reproductive health needs. Restrictive abortion laws, coupled with the sociocultural norms that further a stigmatised discourse on abortion, are significant points of contestation for abortion rights advocates in the ten countries that inform this study. The stories above highlight the fact that legal restrictions on abortion impede access to abortion on the ground. They also reveal that there is a significant difference between the legal permissibility of abortion services and the realities in terms of on-ground accessibility of the service, especially for marginalised persons.

Strict laws surrounding abortion, like those in the Philippines, make it significantly more difficult to access safe abortion while also creating a culture of fear and stigma around abortion and post-abortion care. Notably, significant barriers to abortion access are also prevalent in countries where abortion is legalised under certain conditions. Vietnam, Indonesia, Malaysia, Nepal and India all have laws that allow pregnant persons to avail abortion services with varying degrees of the extent of permissibility in each country. However, as demonstrated in the cases and instances quoted above, pregnant persons who wish to access abortion services still face hostility and discrimination due to cultural stigma. This is also reflected in the continued criminalisation of abortion under the respective Penal Codes of these countries and the legalisation of abortion only in specific circumstances.

Historically, most countries have criminalised abortion, although recent legal reforms have led to liberalisation of laws in many parts of the world. In 1920, Russia became the first country to legalise abortion during the first trimester, though abortion was subsequently regulated and criminalised by the Stalin regime in 1936. However, abortion remains decriminalised in Russia since 1955.

Marge Berer,[5] tracing the history of abortion laws around the world, notes that abortion was legally restricted in almost every country by the end of the 19th century. The most important sources of such laws were the legal systems of imperial European countries like Britain, France, Portugal, Spain and Italy, since these colonial regimes imposed their domestic laws forbidding abortion in their colonies. Further, Berer argues that the reasons for restrictions on abortion are threefold:

1. **It was believed that abortion was dangerous and that healthcare professionals were 'killing' women. The rationale behind abortion laws then was to protect women - who nevertheless sought abortion and risked their lives in doing so (as they still sometimes need to do today).**

2. **Abortion was considered a sin or a form of transgression of morality, and the laws were intended to deter and punish.**

3. **It was restricted to protect 'foetal life' in some or all circumstances.**

Bela Ganatra[6] argues that in South Asia and Southeast Asia, abortion activism is largely centred on the issues of services and accessibility, rather than the legal barriers. However, it is imperative to unpack the legal barriers to enable a more holistic understanding of challenges to accessing safe abortion services.

> Abortion laws in most South Asian and Southeast Asian countries are situated within a paradigm of criminalisation. The challenges that stem from such criminalisation are compounded by the social stigma and cultural unacceptability of abortion, which although a social phenomenon, has its roots in the widespread and systemic need to control women's sexuality and bodies, perpetuated by unequal power structures and cis-heteronormative gender norms.

Significantly, in many countries in the Global South, abortion is permitted under the law, with a few exceptions due to political, economic and social contexts. For instance, in Vietnam, there are very few legal restrictions on abortion services. In 1954, Vietnam, newly liberated from French colonial rule, underwent significant reforms in their sexual and reproductive health policy, beginning with the law on marriage and family, which was adopted in 1960 and guaranteed the protection of the rights of women and children. The trajectory continued with the implementation of Vietnam's first Population Policy in 1963. To reduce the rate of population growth, this policy required each family to have fewer children spaced out over 5 or 6 years, promoted the use of intrauterine devices (IUDs) and condoms free of charge, and made abortion services available at some health facilities. In 1977, Vietnam's family law aimed to promote women's rights by creating a favourable climate for contraception use. Such policies continued in post-independence Vietnam, whose liberation from colonial rule was marked by policies that recognised women's decisional autonomy. The country now has one of the most liberal abortion laws in Southeast Asia with 'illegal abortion' being criminalised under the amendment to the Criminal Code, recently in 2015 (came into effect in 2018). Vietnam also has a rights-based legislation allowing for abortion services.

However, in other countries, abortion laws are more restrictive – such as in the Philippines, where the Catholic Church exercises immense power and extensively influences the politics to push for an anti-abortion agenda. There is a consequent fear of seeking post-abortion care due to the strict criminalisation of abortion and threat of being reported. The next section gives a bird's eye view on legal regulation of abortion in each of these countries, which is then elaborated upon in Chapter II.

Criminalisation of Abortion in South Asia and Southeast Asia: An Overview

It is imperative to understand the colonial and postcolonial history of abortion to comprehend the legal framework of abortion in a few countries in Asia. This study focuses on ten countries, of which eight (i.e.,

the Philippines, Vietnam, Sri Lanka, Pakistan, Bangladesh, Malaysia, Indonesia, and India) have a colonial history and the colonial legal orders have significantly framed the current abortion laws. The other two countries, Nepal and Thailand, do not have a colonial history but mirror the framework of criminalisation to some extent. In South Asia, restrictive abortion laws in India, Pakistan, Sri Lanka and Bangladesh are rooted in British colonial laws.

In Southeast Asian countries such as the Philippines, access to abortion continues to be very restricted owing to the criminalisation of abortion, first under the Spanish Penal Code (SPC) of 1870 and then under the RPC, which was adopted after the United States of America (USA) took control of the country. Articles 256-259 of the RPC criminalise abortion under all circumstances and do not make any exceptions for permitting termination of a pregnancy. This criminal framework has remained in operation in the Philippines even after the formal recognition of its status as an independent country in 1946. Such criminalisation of abortion can also be observed in Indonesia, a former colony of the Netherlands, whose legal system was wholly adopted from the Dutch system. Law No. 32 of 2009 on Health allows for the provision of abortion services up to six weeks of gestation under conditions of medical emergency at early stages of pregnancy that threaten the life of the pregnant woman or the 'foetus'; in the case of 'foetal' anomalies which affect its life expectancy inside the 'womb'; and if the pregnancy is the result of rape and may cause psychological trauma to the pregnant woman. The most recent amendments, which include the revised Criminal Code of 2023, Health Law 17 of 2023 and the Sexual Violence Law of 2022, have resulted in the expansion of the permissible limit for abortions to 14 weeks, legalising terminations in case of pregnancies resulting from sexual violence. Pertinently, sexual violence has also been redefined to widen the contours of the term and include nine distinct forms of violence. Additionally, under Shariah Law, abortion is allowed within the initial 40 days, but exclusively for pregnancies where there is a threat to the life of the 'mother'; where the pregnant woman has been affected by a lethal disease; in cases of foetal anomalies; and for pregnancies resulting from rape. It is important to note that Shariah Law applies solely to the province of Aceh.

Vietnam was a French colony, and when France saw a decline in fertility rates in the early 20th century, they passed more stringent measures to end the practice. To this effect, in addition to the criminal status awarded to abortion, French Law of July 31, 1920 penalised acts that could 'incite abortion' or act as propaganda for contraception, which was changed to a civil liability in 1923. Legal reforms, with the establishment of the *Code de la Famille* [Family Code] in July 1939 placed further sanctions on abortion. First, the prohibition of attempted abortion was confirmed; next, the punishment for 'professional abortionists' was increased, and finally, the term 'pregnant woman' was broadened to "whosoever procured an abortion or attempted to procure an abortion on a pregnant woman or a woman who is presumed to be pregnant."[7] This meant that any woman who tried to seek an abortion could be charged, whether or not they succeeded, or were even actually pregnant. Further, self-induced abortion

was also penalised, albeit with lesser punishment and finally, formal authorisation was given to "therapeutic abortions" to save the life of a woman who could be in danger.

In Malaysia, the legal landscape surrounding abortion stands as a testament to the relatively permissive framework governing this contentious issue. The Malaysian Penal Code governs and regulates abortion. It was amended in 1989, allowing for terminations when abortion is provided where there is injury to the mental or physical health of the pregnant woman. Malaysia is a secular State with Islamic law being applicable to Muslims. The Syariah rulings (Fatwas), issued by the National Fatwa Committee are only applicable to Muslims in each state, further extend the permissible window for abortion, including the first 120 days of gestation. This dual-layered legal approach underscores Malaysia's commitment to safeguarding women's health and well-being by providing them with options within the boundaries of civil and religious law. While Malaysia's legal framework is progressive, the practical implementation of abortion rights can vary due to cultural and healthcare challenges including public awareness, the availability of healthcare infrastructure and deeply entrenched societal attitudes. Nevertheless, the Malaysian legal system's flexibility in recognising a woman's right to choose, particularly in cases concerning her health and well-being, underscores a nuanced and harmonious blend of civil and religious considerations.

The Indian legal landscape surrounding abortion is marked by the coexistence of the Indian Penal Code (IPC), a colonial-era law, and the MTP Act. Enacted in 1971, with amendments to the law in 2002 and 2021, the MTP Act significantly liberalised abortion laws in India, allowing abortion in a wide range of circumstances up to 20 weeks of gestation. Pertinently, the revisions to the law in 2002 and 2021 expanded the scope of the MTP Act, allowing for access to abortion services for unmarried women, medical abortion (MA) using MA pills up to nine weeks and arguably there is no gestation period for termination in case of "substantial foetal abnormalities." However, the IPC, a colonial-era law, still criminalises abortion services when not provided as per the provisions of the MTP Act. This dual legal framework raises concerns about the need for comprehensive reform and a more coherent approach to abortion regulation. The existing legal structure can be confusing and may result in criminal charges for pregnant persons seeking abortions outside the MTP Act's scope, highlighting the importance of further legal clarity and reforms.

In pre-partitioned India, which constituted modern day India, Pakistan and Bangladesh, criminalisation of abortion can be traced to colonial times in 1803 when the prohibition against abortion (when a woman was "quick with child") carried a punishment of death in Great Britain and Ireland. These laws

continued to remain in force through their incorporation in the Penal Codes of each of these countries under colonial rule and continued even after they gained independence.

Similarly, in Pakistan, abortion law under the Pakistan Penal Code, 1860 (PPC) was amended in 1990 through an ordinance and later legislated in 1997 to "conform better to Islamic teachings regarding offences against the human body."[8] Therefore, the penalties for illegal abortion depend on whether the organs of the 'foetus' have fully developed. Before the organs are formed, abortion is permitted to save the life of the pregnant woman or to "provide necessary treatment." If these conditions are not fulfilled, the offence is penalised under *Ta'zir*** by imprisonment for a period of three to ten years under Section 338-A of the PPC. After the organs are formed, abortion is only permitted to save the pregnant woman's life, and if the condition is not fulfilled, traditional Islamic penalties in the form of fine and imprisonment for up to seven years are imposed as per Section 338-C of the PPC.

In Bangladesh, abortion is criminalised under Sections 312-316 of the Penal Code of 1860. The only exception is when abortion services are provided to save a woman's life. However, Menstrual Regulation (MR) has been permitted by the government since 1979 as part of its family planning policy. MR is used to "regulate the menstrual cycle when menstruation is absent for a short duration"[9] through manual vacuum aspiration (MVA) or a combination of mifepristone and misoprostol. It can be used by doctors up to 12 weeks from the last menstrual period (LMP) and up to ten weeks by paramedics and nurses.

In Sri Lanka, pregnant persons do not have access to abortion except under life-saving circumstances. It is one of the most restrictive laws in South Asia, and the criminalisation of abortion finds its roots in the colonial legal order, where British colonisers sought to "protect the sanctity of foetal life" and deemed abortion to be a "sin".[10] Consequently, the Sri Lankan Penal Code of 1883 deemed abortion a crime, except when conducted to save the life of the woman and the code continues to remain in operation.

It is pertinent to note that while colonial legal order has played a significant role in eight of the ten countries, the two remaining countries, i.e., Nepal and Thailand have never been formally subject to colonial rule. Therefore, it is imperative to understand the complexity of legal regulation of abortion beyond the colonial legal order.

Prior to the liberalisation of abortion laws, the *Muluki Ain* (Nepal's legal code that is based on ancient Hindu scriptures), criminalised abortion by equating it to "infanticide", which resulted in malicious incarceration of women to ensure that they forfeited their right to property. Nepal became a constitutional monarchy in 1990 and had a democratically elected government by 1991. Women's rights saw significant expansion during Nepal's political transition from an absolute monarchy to a

parliamentary monarchy. The Constitution of 1990 mandated the fundamental right to equality for both men and women. The movement towards liberalisation of abortion laws has spanned over three decades, with positive legal developments to this effect in 2002, which made access to abortion available on-request up to 12 weeks of gestation. Subsequently, in 2018, the Right to Safe Motherhood and Reproductive Health Rights Act (RSMRHR Act) was passed to expand access to abortion services. Even though Nepal currently has a very liberal abortion law, there continues to exist a parallel criminal law framework.

Notably, though Thailand was never under colonial rule, it does have a semi-colonial history, as argued by Singh,[11] who notes that semi-colonialism is where a metropolitan country exerts power and influence in an asymmetrical relationship, without such power being exerted as outright domination and formal sovereignty over the colonial State. The semi-colonial status of Thailand was what prompted the establishment of international law and cemented its validity by means of unequal treaties between the colonial powers and the semi-colonial States, like Siam. This also meant that the legal framework in these semi-colonial States was not free from the influence of colonial era laws. Consequently, similar to the colonial states, abortion has been historically criminalised under Sections 301–305 of the Thai Criminal Code of 1908, and is punishable except under limited circumstances. The criminalisation provision extends to consensual abortion by a pregnant woman, abortion without consent and attempted abortions. The only exceptions are to save the life of the pregnant women in case of an "indecent act" or a rape. However, a Supreme Court ruling in 2020 held that the criminalisation of abortion was unconstitutional, pursuant to which abortion has been partially decriminalised in Thailand up to 12 weeks.[12]

Global calls for decriminalisation of abortion arose recently. Initially, the global abortion rights movement was focussed on "safe legal abortion." While legalising abortion refers to making abortion permissible under the law and identifying the grounds on which it is allowed, decriminalising abortion means removing all criminal sanctions against abortion services.

As per the United Nations, as of 2013,[13] the countries where:

- Abortion was legally permitted to save the life of the woman **(97%)**

The proportion of countries allowing abortion on other grounds was as follows:

- To preserve the woman's physical health **(67%)**
- To preserve the woman's mental health **(64%)**
- In case of rape, sexual abuse, or incest **(52%)**
- Foetal anomaly or impairment **(52%)**
- Economic or social reasons **(36%)**
- On request **(30%)**

As per data as recorded by the Center for Reproductive Rights up to June 9, 2023,[14] the global status of abortion laws is as follows:

Number of countries worldwide that

- Have completely prohibited abortion **22**
- Permit abortions to save the pregnant woman's life **43**
- Permit abortions to preserve the woman's health **47**
- Permit abortions for socio-economic reasons **12**
- Permit abortions on request, subject to upper gestational limits **77**

Several countries have recently decriminalised (partially or completely) abortion including Mexico, Chile, Argentina, South Korea, Thailand and Colombia, among others.

Stakeholders from across South Asia and Southeast Asia have been working towards legal reforms to centre access to safe abortion services. Vietnam and Thailand have made some progress in the fight towards decriminalisation (partial in the case of Thailand), with the Constitutional Court of Thailand's recent decision in 2020, holding the criminalisation of abortion to be unconstitutional. Nepal and Bangladesh have witnessed recent constitutional challenges seeking decriminalisation of abortion. Indonesia recently revised the Health Law in 2023, allowing abortions up to 14 weeks (as opposed to the previous duration of six weeks) of pregnancy under the specified conditions. It also now provides abortion services in all cases of "sexual assault" (previously, only in cases of rape). In the Philippines, we see a continued struggle for liberalisation of abortion laws as feminist movements fight to counter the religious stigma and opposition associated with abortions despite severe backlash and, in some cases, penal consequences for advocating for expansion of safe abortion services. There is, therefore, a need to critically assess the legal regulation of abortion services, the factors contributing to the same, and the manner in which a path towards decriminalisation may be paved.

Through this study, we seek to examine the legal status of abortion and its impact on access to abortion services in ten countries of South Asia and Southeast Asia. In doing so, the study builds on the argument for moving away from a criminal framework in regulation of abortions services.

RATIONALE AND OBJECTIVE OF THE STUDY

A review of abortion laws in the ten countries that form the subject of this study, and an comparative analysis thereof, especially in the context of colonialisation, demonstrate that the history of criminalisation of abortion is a direct result of colonial penal provisions from British, French, Dutch and Spanish laws in at least eight countries. We have selected five countries from South Asia and five countries from Southeast Asia, namely, the Philippines, Thailand, Indonesia, Vietnam, Malaysia, Nepal, Pakistan, India, Sri Lanka and Bangladesh. In all postcolonial States, with the exception of Vietnam, the original and mostly unmodified clauses that criminalise abortion services continue to endure. The severity of these provisions is mitigated only by additional specific laws that delineate exceptions for such punitive measures.

While much scholarship has focused on the abortion law framework in the Global North, there is limited literature and analysis on abortion laws in the Global South, especially in South Asia and Southeast Asia. The study engages with the impact of a criminal law framework on access to abortion services in these countries and the subsequent need to decriminalise abortion. The study also reveals ongoing efforts

towards decriminalisation of abortion in some jurisdictions and concludes with broad recommendations.

METHODOLOGY

The study seeks to examine the legal status of abortion in South Asian and Southeast Asian countries, focusing on recent legal reforms. We selected five countries from each region, considering both those with liberal (Nepal and Vietnam) and highly restrictive (Sri Lanka and Philippines) legal frameworks to provide a comprehensive understanding. The selection criteria include the deliberate choice of five countries from each region, as this approach is designed to offer a diverse and inclusive perspective on abortion in Asia. By including a varied mix of countries, the study seeks to capture the complexity and nuances of legal frameworks, taking into account the cultural, social, and political diversity across the regions.

The emphasis is on comparing different regulatory approaches, prioritising countries like Nepal, Thailand, India, and Bangladesh with recent developments in decriminalisation of abortion. While this report focuses on these countries, it acknowledges the existence of other Asian countries such as Cambodia, Bhutan, Laos, Myanmar, etc., that also have significant legal developments on abortion.

The research employed a qualitative approach, using semi-structured open ended interviews as the primary data collection method. 81 key stakeholders, including feminists, academics, lawyers, healthcare providers, policymakers, and grassroots activists, were interviewed over 14 months. The interviews lasted from 45 mins to 1.5 hours. The study specifically engaged experts who had substantial experience working on gender, sexuality, criminal law and reproductive rights and justice. Ethical approval was obtained from the Jindal Global University Research and Ethics Review Board in September 2021, ensuring participant anonymity by quoting Respondents as 'Respondent A, B, C, D, E, F, G, and H' in Chapter III. This chapter draws extensively from these interviews, supplemented by a literature review for each country. Each of the Respondents signed a consent form and have approved their quotations in the report.

The voluntary interviews, conducted both online and in person, were recorded, transcribed verbatim and analysed thematically using a thematic analysis framework. While English was the primary language, professional interpreters were utilised for interviews in countries like Thailand, Indonesia, and Vietnam.

RESEARCH QUESTIONS

The key questions this study seeks to answer are:

1. What is the legal status of abortion in each country?
2. How does a criminal legal framework contribute to hindrances in accessing abortion services?
3. How does the criminalisation of abortion impact access to abortion services?

LIMITATIONS*

In this study, we explore the status of abortion in ten countries, tracing the legislative frameworks and the impact of criminalisation on abortion access. We recognise the diverse contexts shaping SRHR, including religious, social, and cultural differences, historical legal constructs and political economies. However, the scope of the study is confined to understanding the consequences of restrictive legal framework on access to services and propose broad recommendations to achieve a reproductive justice framework. We acknowledge the limitations in capturing the intricate political and demographic nuances of each country.

While we gathered information in each country through at least five interviews, we faced challenges in obtaining comprehensive data from Vietnam. Language barriers, as many Vietnamese laws lack English translations, posed difficulties in analysing the country's legal landscape. However, we were generously guided by two Respondents from Vietnam. We used translations for legal documents in Indonesia, Vietnam, the Philippines, Thailand and Nepal.

ROADMAP

This study has been divided into five chapters. This introductory chapter provides a brief background on the colonial and local legal framework of abortion in each country detailing the rationale and methodology adopted for the research and analysis undertaken for the ten countries mentioned above.

Chapter II outlines the legal framework for abortion in each of the ten countries - the Philippines, Thailand, Indonesia, Vietnam, Malaysia, Nepal, Pakistan, India, Sri Lanka and Bangladesh. Chapter III

delves into the shared thematic challenges and barriers to accessing abortions that persist in the ten countries of South Asia and Southeast Asia. It is essential to note that with the exception of Vietnam, all these countries have a criminal legal framework regulating abortion services. Some countries have incorporated exceptions to create more enabling frameworks, such as Nepal, India, and Malaysia, while others continue to maintain restrictive laws, like the Philippines and Sri Lanka.

The analysis in Chapter III paves the way for comprehensive recommendations aimed at decriminalising abortion services within a reproductive justice framework and implementing other related and necessary reforms. These recommendations are detailed in Chapter IV of the study and highlight common concerns and challenges shared across the countries.

The final chapter of the study summarises the key findings and insights drawn from the interviews and offers concluding observations. It provides an overall assessment of the study's significance and implications.

NOTES

* The report does not aim to provide a comprehensive historical analysis of the colonial and postcolonial legal order, an in-depth theoretical analysis of postcolonial legal implications, a detailed examination of individual themes, or a thorough comparative assessment across all ten countries. Some of these analyses will be published in academic journals.

Instead, the report presents an overview of the legal barriers affecting access to abortion services in the specified ten Asian countries. Furthermore, it underscores the impact of criminal provisions and their chilling effect on abortion services, especially for marginalised persons, including adolescents. Notably, the report provides recommendations primarily derived from the perspectives of Respondents in these countries, aiming to establish comprehensive access to abortion care within a reproductive justice framework.

** Ta'zir refers to punishments for crimes which are to be determined at the discretion of judges.[15]

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THE RIGHT TO SAFE MOTHERHOOD AND REPRODUCTIVE HEALTH ACT, 2075 (2018)

CHAPTER II

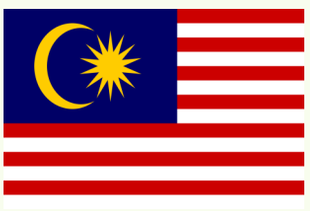
LEGAL FRAMEWORK ON ABORTION IN ASIA: COUNTY-WISE MAPPING

INTRODUCTION

The countries that form the subject matter of this study have historically experienced contestation when it comes to sexual and reproductive health and rights (SRHR), particularly abortion. Of the ten countries that inform this study, eight are postcolonial states and two (i.e. Thailand and Nepal) have never been colonised. All except Vietnam have a criminal law framework to regulate abortion services with exceptions to varying degrees. The laws and policies of the aforementioned eight postcolonial states continue to carry forward the colonial legacy of criminalisation of abortion services, while also witnessing significant legal and judicial developments that have prompted large-scale reforms to the legislative framework governing abortions. The remaining two countries of Thailand and Nepal have confronted their own sets of challenges in liberalising abortion laws.

This section briefly highlights the current legal framework of abortion laws in each of these countries.

PHILIPPINES

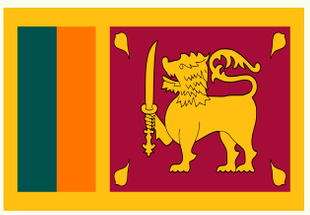


MALAYSIA

INDONESIA

VIETNAM

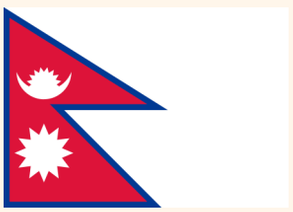
BANGLADESH



SRI LANKA

PAKISTAN

INDIA



NEPAL

THAILAND

1. Philippines

- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- SPECIFIC LEGISLATION ON REPRODUCTIVE HEALTH - RPRH, 2012
- BILL FOR DECRIMINALISATION OF ABORTION IS CURRENTLY PENDING

Constitutional Provision on Abortion

Under the Constitution of the Philippines, an 'unborn child' is entitled to protection from the State at the time of the conception. Section 12, Article II of the 1987 Constitution provides that the State shall:

> ***"protect the life of the mother and the life of the unborn from conception."***[1]

Criminal Provisions on Abortion under the Revised Penal Code, 1930

Articles 256-259 of the Revised Penal Code, 1930 (RPC) make abortion a punishable offence. A distinction is also drawn between intentional and unintentional abortion. Specific penalties are classified under Article 25 of the RPC and defined under Article 27 of the RPC. These laws penalising abortion do not provide any exceptions, not even in the case of emergency situations or rape. Post-abortion care (PAC), however, is legal and available in the Philippines. PAC was widely available until

2018 when an Administrative Order by the Department of Health restricted its availability, with only doctors being authorised to provide these services.

Article 256 of the RPC criminalises intentional abortion, the penalty for which varies based on different circumstances. In cases where an intentional abortion involves the use of violence, the punishment is '*reclusion temporal*' which refers to imprisonment ranging from 12 years and one day to 20 years. Where there is an intentional abortion caused without the consent of the pregnant woman, but there is no violence, the penalty imposed can range from imprisonment for six years and one day to 12 years.

For instances of abortions done with the consent of the pregnant woman, the penalty imposed is '*prision correccional*' in its medium and maximum periods under Article 256. Unintentional abortion caused by violence is also penalised by '*prision correccional*' in its minimum and medium period under Article 257. The duration of imprisonment under '*prision correccional*' ranges from six months and one day to six years.

Under Article 258, if the crime of abortion is committed by the pregnant woman or by someone else with her consent, the penalty is '*prision correccional*' in its medium and maximum periods.

Facilitators of abortion services such as physicians or midwives are penalised under Article 259 of the RPC with the same penalties provided under Article 256 in its maximum period. Pharmacists who dispense 'abortives' without a proper prescription from a physician will suffer a penalty of imprisonment for one month and one day to six months and a fine not exceeding 1,000 Philippine pesos (PHP). In 2017, the RPC was amended to increase the fine a hundredfold for pharmacists who dispense 'abortifacients' without prescription-from a fine not exceeding 1,000 PHP under the RPC to a fine not exceeding 100,000 PHP.

In addition to the provisions under the RPC, the Philippines also has a separate set of laws that regulate the provision of abortion services in the country. These include Section 25 of the Midwifery Act of 1992, Section 24(8) of the Medical Act of 1959 and Section 13(e) of the Republic Act No. 5921: An Act Regulating the Practice of Pharmacy and Setting Standards of Pharmaceutical Education in the Philippines and for Other Purposes, which allows for reprimand or suspension or revocation of the license of a pharmacist for malpractice which includes aiding or abetting a criminal abortion through dispensing 'abortive drugs'.

Significant Legislative & Judicial Developments

Responsible Parenthood and Reproductive Health Act of 2012

The "Responsible Parenthood and Reproductive Health Act of 2012" was enacted in 2012. Section 3(j) states:

> ***"While this Act recognizes that abortion is illegal and punishable by law, the government shall ensure that all women needing care for post-abortive complications and all other complications arising from pregnancy, labor and delivery and related issues shall be treated and counseled in a humane, non-judgmental and compassionate manner in accordance with law and medical ethics."***[2]

The constitutionality of the Responsible Parenthood and Reproductive Health Act was challenged in the Supreme Court in the case of *James M. Imbong v. Hon. Paquito N. Ochoa*. In 2014, the Court, affirmed the law's constitutionality while invalidating certain crucial provisions and held:

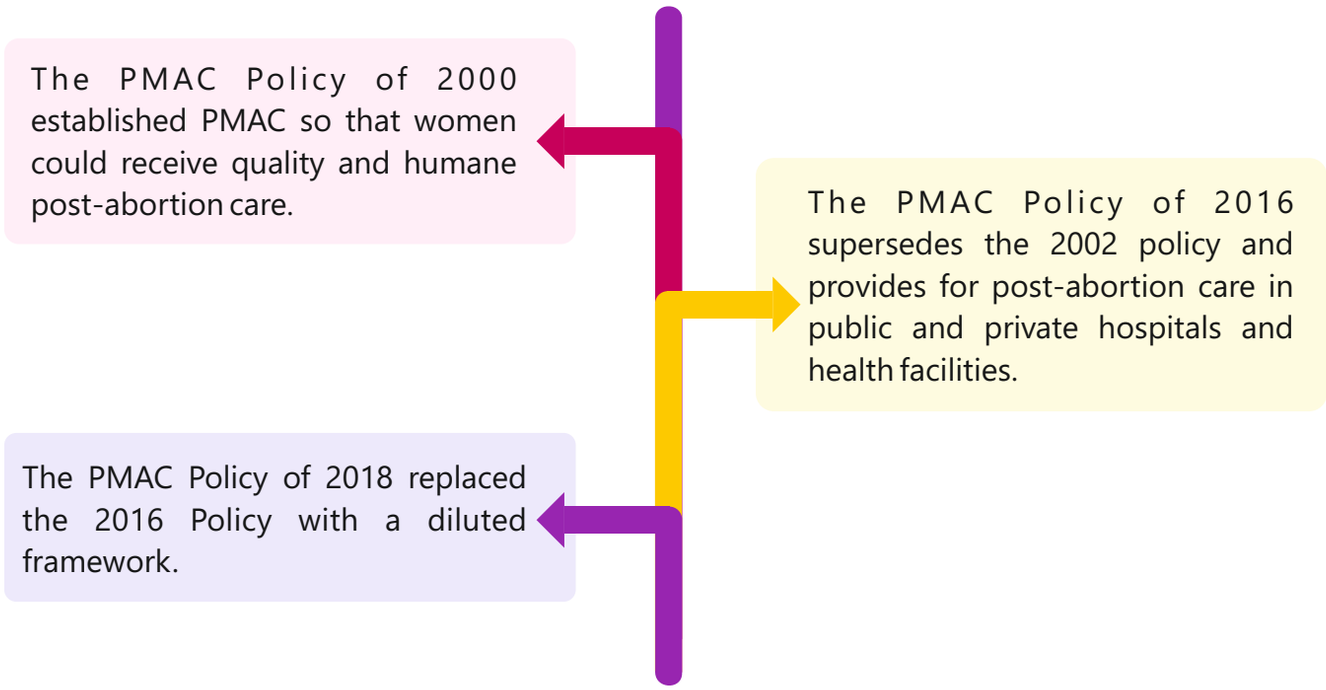
- It is legally mandated that minors seeking medical attention for pregnancy or miscarriage must obtain parental consent for all procedures.
- Women requiring reproductive healthcare in non-life-threatening situations must obtain spousal consent.
- Healthcare professionals have the right to refuse reproductive health services on religious grounds, except in life-threatening cases that require emergency procedures.

In 2020, a Bill for the decriminalisation of abortion was drafted by Clara Rita Padilla and members of Philippine Safe Abortion Advocacy Network (PINSAN). The Bill is titled "Act Decriminalising Induced Abortion to Save the Lives of Women, Girls and Persons of Diverse Gender Identities, Amending Article 256-259 of the Revised Penal Code."[3] The Bill calls for the repeal of Articles 256-259 of the RPC and immediate release of persons convicted under these provisions. It also proposes a protocol on comprehensive safe abortion care, emergency abortion care and post abortion care while making health care providers duty bound to provide ethical, compassionate and non-judgemental safe abortion care, emergency abortion care and PAC.

The most recent development in the landscape of abortion rights in the Philippines is by way of a letter by the Commission on Human Rights, Republic of Philippines to the President of the Senate of Philippines voicing its opposition to decriminalisation of abortion in the country.

In the letter dated November 15, 2023, the Commission has noted its stance against abortion except when provided in extreme circumstances such as termination of a pregnancy for medical reasons. The Commission's letter notes that it adheres to the principles of the Constitution of 1987 to 'equally protect the life of the mother and the life of the unborn from conception.'[4]

The National Policies on the Prevention and Management of Abortion Complications



The National Policies on the Prevention and Management of Abortion Complications

The first Prevention and Management of Abortion Complications (PMAC) policy was adopted in 2000. This was in response to the Philippine Reproductive Health Program created in 1998. The Program had ten elements of which PMAC was one. The 2000 policy established PMAC with the goal of ensuring that "women who have abortion are given quality and humane post-abortion care services by competent, compassionate, objective and non-judgmental service providers in a well-equipped institution, complemented by a supportive environment."[5]

In 2016, the Department of Health introduced a new PMAC policy via an Administrative Order [Order No. 2016-0041], which supercedes the 2002 Policy. The policy provides for the provision of PAC in both public and private hospitals and all health facilities.

The 2016 PMAC policy included comprehensive preventive and medical health care services on six key elements:

- **Prevention of threatened abortion;**
- **Treatment of complications from spontaneous and induced abortion;**
- **Counselling;**
- **Family planning including contraceptive services;**
- **Linking PMAC services to other Reproductive Health Services including sexually transmitted infection (STI) evaluation and treatment and Human Immunodeficiency Virus (HIV) counselling and testing and cancer screening;**
- **Integration of PMAC in the Service Delivery Network.**

Under the 2016 PMAC policy, healthcare professionals (obstetricians and gynaecologists (OB-GYN) and general practitioners), nurses and midwives could provide PAC services only if they are certified and trained by government approved institutions. The guidelines specifically stated that "women and girls suffering abortion complications are entitled to humane, non-judgmental and compassionate post-abortion care, hence, no woman or girl shall be denied appropriate care and information on the ground that she is suspected to have induced an abortion."[6]

The 2016 Policy provided that the healthcare providers should ensure the privacy and confidentiality of women and girls seeking post-abortion care. For example, the policy unequivocally stated that there is "no law requiring service providers to report women and girls suffering abortion complications to the law enforcement authorities"[7] and that there will be no legal consequences for those providing PAC.

Pertinently, the 2016 PMAC Policy has been rescinded via an administrative order in 2018 and replaced by the National Policy on the Prevention of Illegal and Unsafe Abortion and Management of Post-Abortion Complications, 2018. The new Policy of 2018 is regressive to the extent that it moves away from a holistic, rights-based approach to reproductive health. It is envisioned to strengthen "the country's commitment to women's health to deal with the health impact of illegal and unsafe abortion as a major public health concern and to prevent the preference for illegal and unsafe abortion through an improved family planning program implementation and service provision."[8] Further, the new Policy, according to guideline B.1(1)(i), allows midwives and nurses to provide post-abortion services only in emergency situations.[9]

Child Protection Laws in the Philippines

The increased instances of child marriage prompted the enactment of "An Act Prohibiting the Practice of Child Marriage and Imposing Penalties for Violations Thereof"[10] in 2021. As per this law, a child is defined as:

> ***"any human being under eighteen (18) years of age, or any person eighteen (18) years of age or over but who is unable to fully take care and protect oneself from abuse, neglect, cruelty, exploitation or discrimination because of a physical or mental disability or condition."***[11]

The law further states that a person above the age of 18 shall be considered a 'child' if they are unable to care for themselves or protect themselves from abuse, neglect, cruelty, exploitation or discrimination owing to physical or mental disability. The law categorises child marriages as *void ab initio* i.e. invalid in law from the time of solemnisation. Any person who performs or officiates a marriage involving a 'child' will be penalised with '*prision mayor*' in its maximum period and a fine of no less than 50,000 PHP. If the offender is a public official, they shall also be dismissed from service and may be permanently disqualified from holding office at the discretion of the courts. The law prohibiting child marriage also penalises cohabitation by an adult with a child outside of wedlock, imposing a penalty of '*prison mayor*' in its maximum period and a fine of no less than 50,000 PHP. If the offender is a public official, they shall also be dismissed from service and may be permanently disqualified from holding office at the discretion of the courts. With respect to the offence of cohabitation, the law also clarifies that the penalties imposed shall be without prejudice to any higher punishment under the RPC and other special laws.

Further, as of 2022, the Philippines partially decriminalised adolescent sexuality by way of an amendment to The Special Protection of Children Against Child Abuse, Exploitation and Discrimination Act of 1992 through the Anti-Rape Act of 2022 (Republic Act No. 11648). The 2022 Act has raised the age of consent from 12 to 16 years of age for all persons, irrespective of gender. An exception has also been carved out for consensual sexual interactions where the partners' age difference is three years or less (unless one of them is less than 13 years old).

Medical Abortion in Philippines

According to a 2021 Public Health Warning by the Food and Drug Administration, Department of Health, Republic of Philippines (FDA), Misoprostol (CYOTEC) 200mg tablet is not registered with the FDA. However, it is still widely available online and through vendors. In 2010, a Bill to ban the sale of Misoprostol was introduced, which was not passed.

2. Thailand

- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- SPECIFIC LEGISLATION ON REPRODUCTIVE HEALTH
- ABORTION HAS BEEN PARTIALLY DECRIMINALISED

Criminal Provisions on Abortion under the Thailand Criminal Code

The Thai Government undertook several legal reforms from 1880 to 1935 to modernise their laws in line with the 'foreign laws' since their domestic laws were 'not civilized'.[12]

The Criminal Code 1908

"Article 260 - every woman who aborts herself, or consents to having an abortion performed by another person, shall be punished by imprisonment for up to three years and by a fine of up to 100 ticals, or by one of these two penalties alone.

Article 261 - a person who performs an abortion on a woman with her consent shall be punished by imprisonment from one month to three years and by a fine of 20-500 ticals.

Article 262 - when the offence mentioned in Article 261 is committed by a doctor, a midwife or a person acting in expectation of payment, the penalties shall be increased by one-third."[13]

The Criminal Code 1957

The Criminal Code was revised in 1957 to include exceptions under which abortion services could be provided.

"Section 301 penalises any woman who causes herself to abortion or allows another person to provide abortion services to her. The punishment imposed is not more than three years jail term and a fine not exceeding 6,000 baht, or both.

Section 302 penalises a person who procures abortion and section 303 penalises a person who procures abortion without consent.

Section 304 exempts from prosecution any unsuccessful or unfinished abortion attempts.

Section 305 allows abortion to be performed by a medical practitioner if necessary for a woman's health, or if the pregnancy is due to offences such as rape, seduction of a girl under 15, fraud, deceit or violence in procuring sex or seduction."[14]

Miss Srisamai Chueachat Constitutional Court Ruling No. 4/2563 (2020)

Following the Constitutional Court Ruling No. 4/2563 (2020) in Thailand, significant changes were made to the Criminal Code 1957. The Court, deeming certain sections related to abortion as partially unconstitutional, particularly Section 301, emphasised that prioritising 'foetal' rights over those of a pregnant woman violates bodily autonomy and self-determination. As a result, the Court directed legislative action, instructing State agencies to align the Code with its reasoning within 360 days, taking into account current practices and circumstances.

In response, the Thai National Assembly, on January 25, 2021, amended the Criminal Code, effectively decriminalising abortion services up to 12 weeks of gestation. The revised Code came into effect in February, 2021.

The Criminal Code of 2021

In February, 2021, the Council of State of Thailand amended Sections 301 and 305 to increase access to safe and legal abortion services. There is an exemption of penalty for 'women' who access abortion services up to 12 weeks under Section 301. Section 305 exempts the healthcare provider for providing abortion services up to 12 weeks and not beyond 20 weeks to the 'pregnant woman' if they fall within the criteria laid down by this section.

Section 301 states that:

"Any woman who causes herself to 'abort' or 'let others cause her to abort' a pregnancy which is more than 12 weeks of gestation, "shall be liable to imprisonment for a term not exceeding six months or a fine not exceeding ten thousand baht or both."[15]

Section 305 states that,

"If the commission of an offense under section 301 or section 302 is an act of a medical practitioner and in accordance with the rules of the Medical Council in the following cases the offender is not guilty.

1. **It is necessary to act because if the woman continues to become pregnant, there will be a risk of harm for the physical or mental health of the woman.**
2. **It is necessary to do so because there is a substantial risk or there is a medical reason; It should be believed that if the baby is born there will be abnormalities to the extent of serious disability.**
3. **A woman confirms to a medical practitioner that she is pregnant due to the act. sexual offenses**
4. **A woman whose gestational age is not more than twelve weeks confirms the termination of the pregnancy;**
5. **A woman whose gestational age exceeds twelve weeks; but not more than twenty weeks confirm to terminate pregnancy after examination and alternative counseling from a medical practitioner and other professional practitioners in accordance with the rules and procedures prescribed by the Minister of Public Health with the advice of the Medical Council and relevant agencies under the law on prevention and correction teen pregnancy problems."**[16]

Section	Penal Code 1957	Criminal Code 2021
301	Imprisonment for not more than three years, and a fine of not more than six thousand baht or both.	Imprisonment for not more than six months, or a fine of not more than ten thousand baht or both.
302	Imprisonment for not more than ten years, and a fine of not more than 20,000 baht.	Imprisonment for not more than five years, or a fine not more than one hundred thousand baht or both. If the act causes other grievous bodily harm, the penalty imposed is imprisonment for not more than seven years, or a fine of not more than one hundred thousand forty thousand baht or both.

Section	Penal Code 1957	Criminal Code 2021
303	Imprisonment for not more than 20 years, and a fine of not more than 40,000 baht or both.	Imprisonment for not more than seven years, or a fine not more than one hundred forty thousand baht or both. If the act causes other grievous bodily harm, the penalty imposed is imprisonment ranging from one year to ten years and a fine of twenty thousand two hundred thousand baht. If the act causes death, the penalty imposed is imprisonment ranging from five years to 20 years and a fine ranging from one thousand to four hundred thousand baht.
304	*Exemption clause.*	*Exemption clause.*
305	*Exemption clause.*	*Exemption clause.*

The 2022 Ministry of Public Health Announcement

The 2022 Ministry of Public Health Announcement stipulates that a woman seeking to terminate her pregnancy, within the gestational range of more than 12 weeks but less than 20 weeks, is required to communicate her intent to the option counselling (alternative counselling) service for further guidance. The woman has the option to convey her intention through in-person visits, written communication, telephone contact or electronic media. The Department of Health will subsequently disclose specific information about the alternative counselling service unit to the public. The healthcare providers must carry out the diagnosis for gestational period and provide options. This service emphasises empathy, non-judgmental support and upholds the importance of informed consent, allowing individuals to make choices without coercion or undue influence her decision.

Post-Abortion Care in Thailand

Post-abortion care in Thailand is covered under the universal health coverage scheme which is available to all Thai women. The Standard Practice Guidelines for Comprehensive Abortion Care (CAC) launched in 2018 also provide for the measures that must be taken to comply with the CAC framework. A revised version of the Standard of Practice for Comprehensive Safe Abortion Care was introduced in 2021, which elaborates on the training of healthcare professionals to provide PAC.

Child Protection Laws in Thailand

Thai Criminal Code

As per the provisions of the Thai Criminal Code, the age of consent in the country is 15 years. Section 277 of the Code states that:

"Whoever sexually assaults a child not yet over fifteen years of age and not being his own husband or wife, whether that child shall consent or not, shall be punished with imprisonment of four to twenty years and fined of one hundred thousand to four hundred thousand baht.

If the commission of an offence under the first paragraph is an act against a child under thirteen years of age, it shall be punished with imprisonment of seven to twenty years and a fine from one hundred and forty thousand baht to four hundred thousand baht or life imprisonment."[17]

Section 277 also specifies that during court hearings concerning consensual sexual activity, various factors, such as encompass age, behavior, education, mental state and the nature of the relationship between the perpetrator and the minor involved, among others, will be taken into consideration and the sentencing will be relatively lenient.

Child Protection Act, 2003

Section 4 of the Child Protection Act defines a child to be a person below 18 years of age, excluding those who attain legal adulthood through marriage.

Civil and Commercial Code of Thailand, 1925

In accordance with Section 1448 of the Civil and Commercial Code of Thailand, marriage is permissible only between a man and a woman who have reached the age of 17. Nevertheless, the law directs the courts to authorise marriage before this age under compelling and justified circumstances.

Act for Prevention and Solution of the Adolescent Pregnancy Problem, 2016

Under Section 3, reproductive health, for the purposes of this legislation, encompasses "a state of healthy physical and mental well-being resulting from the functional processes of sexual health and the reproductive system at all stages of life, enabling a person to have a good quality of life and live happily in society."[18]

Section 5 outlines that adolescents possess the right to make decisions autonomously. They also have the right to information and knowledge, reproductive health services, confidentiality, privacy and social welfare provisions, all on an equal and non-discriminatory basis. Additionally, adolescents are entitled to any other rights specified in the legislation.

Under Section 7, service establishments are required to address the prevention and resolution of adolescent pregnancy. This involves providing accurate, comprehensive and adequate information and knowledge regarding the prevention and resolution of adolescent pregnancy to recipients of the service. The establishment must also deliver counseling and reproductive health services to adolescents in accordance with the standards and rights outlined in Section 5. This includes establishing a referral system to ensure the receipt of appropriate social welfare provisions.

In 2019, the Ministry of Health issued a Ministerial Regulation in alignment with this Act. Article 12 of the Regulation states that adolescents, aged 15 and older, can decide to receive reproductive health services, including abortion services, without requiring parental consent.

Medical Abortion in Thailand

The Department of Health, Ministry of Public Health, officially permitted the registration of Medical Abortion (MA) pills on December 30, 2014. Both Mifepristone and Misoprostol were approved for use for termination of pregnancies in a hospital setting. MA pills can only be dispensed to the Department of Health, the Government Pharmaceutical Organisation and any health facility that is either under the supervision of the Department of Health or is registered with the Department for the use of MA pills. It is available only on prescription and can be administered only by a physician who must submit a report to the Medical Council of Thailand.

3. Indonesia

- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- SPECIFIC LEGISLATION ON REPRODUCTIVE HEALTH-HEALTH LAWS
- LEGAL EXCEPTIONS TO CRIMINALISATION-14 WEEKS FOR RAPE OR SEXUAL VIOLENCE & MEDICAL EMERGENCY

Criminal Provisions under the Indonesian Criminal Code

Abortion is regulated under the Indonesian Medical Ethics Code and the Indonesian Criminal Code (ICC). The exceptional circumstances under which abortion services can be legally availed are laid out under the Indonesian Health Laws.

Articles 346-349 of the ICC penalise a woman with four years of imprisonment in case she causes her own miscarriage (Article 346) and any person who assists the pregnant woman will be sentenced to a maximum five and a half years of imprisonment (Article 348(1)) which will extend to seven years if the act causes death of the woman (Article 348(2)). A person who causes the termination of a pregnancy without the consent of the woman is liable to be punished with a maximum of 12 years of imprisonment (Article 347(1)). If such an act results in the death of the pregnant woman, the person can be punished with a maximum of 15 years of imprisonment (Article 347(2)). Finally, if a physician, midwife or pharmacist is an accomplice to the termination of pregnancy under Article 346 or is guilty of or is an accomplice under Articles 347 and 348, the punishment is enhanced by one-third of the maximum

sentence and their medical licence may be revoked (Article 349). Article 299 of the ICC imposes criminal penalties on any person who deliberately provides treatment to a pregnant woman with the intention of terminating her pregnancy or prompts a pregnant woman to undergo any treatment with the belief that such treatment will result in the termination of her pregnancy. The maximum punishment imposed is four years of imprisonment.

Article 283 criminalises exposing minors to means of terminating pregnancies and prescribes a maximum punishment of nine months of imprisonment. Articles 534 and 535 penalise any person who openly exhibits information related to the prevention and disturbance of pregnancy with a maximum imprisonment of two months and three months respectively.

In January 2023, Indonesia introduced revisions to the Criminal Code, which will become effective in January 2026. Article 463 of the new Criminal Code:

- **maintains the current criminalisation of abortion and imposes a maximum sentence of four years of imprisonment.**
- **provides an exception to this in cases of pregnancies under 14 weeks of gestation arising out of rape and 'other crimes of sexual violence' or in cases of 'medical emergency'.**

The law has expanded the category of persons who fall within the purview of "victims of rape and sexual violence experiencing pregnancy"[19] to include instances of pregnancy that result from forced prostitution, sexual slavery and sexual exploitation. This is in consonance with the Law on the Elimination of Sexual Violence, 2022 which recognises nine distinct forms of sexual violence and abuse, including forced contraception and sterilisation, forced marriages, physical and non-physical sexual abuse, sexual torture, sexual exploitation, electronic means based sexual violence and sexual slavery.

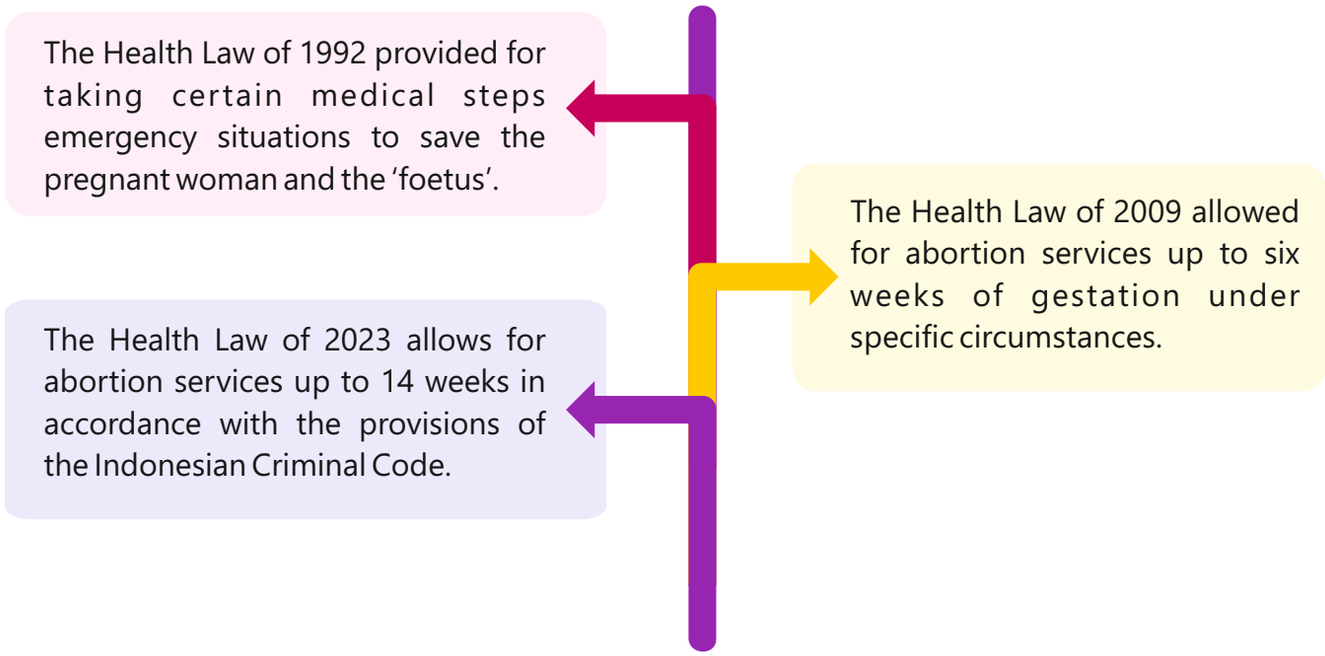
Article 464 criminalises abortion, with and without the consent of the pregnant person. It imposes imprisonment for a maximum of five years (eight years if it results in the death of the woman) for performing an abortion with the consent of the pregnant person and 12 years (15 years if it results in the death of the woman) for performing an abortion without their consent. This provision does not make note of any exceptional circumstances under which abortion services can be provided. This is contrast with the specific stipulations of exceptions under Articles 463 and 465 thus creating legal ambiguity with respective to the application of the law governing abortion services.

Article 409 further prohibits the demonstration of abortion equipment. The exception in Article 410(2) is if it is carried out in the interest of science/education. An exception to the prohibition under these provisions and the consequential penalisation is carved out in Article 410, clauses (1) and (3) is if the demonstration is by "authorised officials" (or their volunteers) in the context of implementing family planning, prevention of sexually transmitted infectious diseases, or for the benefit of health education

and counselling and if it is carried out for scientific/educational purposes.[20] Additionally, Article 251 penalises the provision of drugs to a pregnant person with the aim of causing an abortion with imprisonment for a maximum sentence of four years.

However, abortion is conditionally allowed under the Health Law.

Laws on Health



In Indonesia, the legal landscape surrounding abortion has undergone significant developments over the years. Beginning with Law No. 23 of 1992 on Health, which allowed medical interventions in emergencies, the framework evolved in 2009 to permit abortions within the first six weeks under specific conditions. The latest legislation, Law No. 17 of 2023 on Health, further expands the scope, allowing abortions up to 14 weeks in cases of sexual violence in accordance with the provisions of Section 463(2) of the revised ICC and emphasising individuals' rights to a safe reproductive life.

Health Law 1992

Article 15 of the Law No. 23 of 1992 on Health specified that certain medical steps shall be taken in case of emergency to save the pregnant woman and the 'foetus' on the basis of:

- **"medical indications which force health officers to take such steps;**
- **by health officers who have expertise and obligation to do so in accordance with the professional responsibility and consideration of a team of experts;**
- **with an approval from the pregnant woman concerned or her husband or other family members**
- **by the use of certain health facilities."**[21]

Health Law 2009

Article 75 of the Law No. 32 of 2009 on Health allowed for the provision of abortion services up to six weeks of gestation under the following conditions: (1) medical emergency at early stages of pregnancy that threaten the life of the pregnant woman or the 'foetus', or is suffering from severe genetic anomalies; or (2) if the pregnancy is the result of rape and may cause psychological trauma to the pregnant woman. Article 76 states that abortion services as noted under Article 75 may be provided:

- **before pregnancy attains the age of six weeks counting from the first day of the last menstruation, except in the case of medical emergencies;**
- **by health workers with skill and authority with a certificate issued by Minister;**
- **with the consent from the pregnant 'mother' concerned;**
- **with the permission from the husband, except in cases of rape; and**
- **health service provider satisfying requirements stipulated by Minister.**

Health Law 2023

The most recent Law No. 17 of 2023 on Health regulates abortion under Articles 60, 61 and 62 and allows abortion up to 14 weeks according to the provisions of Section 463(2) of the ICC: (a) by medical personnel and assisted by health workers who have the competence and authority; (b) at Health Care Facilities that meet the requirement set by the Minister; and (c) with the consent of the pregnant woman concerned and with the consent of the husband, except for survivors of rape. The law is also supplemented by government regulations on abortion services. Article 63 of the Law states that family planning services must be made available to all reproductive age individuals, irrespective of their marital status. Moreover, Article 55 of the 2023 Law on Health states that every person has the right to:

a. **live a reproductive and sexual life that is healthy, safe and free from discrimination, coercion and/or violence by respecting noble values that do not degrade human dignity in accordance with religious norms;**

b. **obtain information, education and counselling on reproductive health that is correct and accountable; and**

c. **receive health services and recovery due to acts of sexual violence.**

Articles 427-429 of the Law No. 17 of 2023 stipulate the punishment for any abortion that does not satisfy the requirements of Article 60 of the law.

As per Article 427, any woman who receives abortion services beyond the scope of the exempted criteria under Article 60 is liable to be punished with a maximum imprisonment of four years.

Article 428 stipulates that a person providing abortion services to a woman with her consent, that is not in accordance with Article 60, shall be punished with a maximum imprisonment sentence of five years. If the abortion results in the death of the pregnant woman with her consent, the maximum punishment imposed will be eight years and without her consent for 12 years. If an abortion has been provided without the consent of the pregnant woman results in her death, the maximum punishment imposed is 15 years of imprisonment.

Article 429 deals specifically with healthcare professionals stating that medical or health personnel who commit a criminal offence under Article 428 shall be punished with an enhanced punishment of one third. Further, healthcare professionals who commit a 'criminal offence' under Article 428 may be subject to additional punishment in the form of revocation of certain rights, including the right to hold public office and/or the right to practice a particular profession. The provision also exempts healthcare professionals from criminal liability for providing abortion services due to indication of medical emergency or for survivors of rape or other sexual violence that causes pregnancy as intended in Article 60.

Abortion Provisions under Shariah Law

The *Shafi'i* school of Islam is predominant in Indonesia, and the religious scholars *(Ulema)* agree that abortion is allowed within 40 days of conception. In 2005, the Majelis Ulama Indonesia (MUI) (Indonesia Ulemas Council) issued a *Fatwa* (a ruling on a point of Islamic law given by a recognised authority)

Number 4/2005 that affirmed that abortion is permissible within 40 days of conception under certain circumstances of necessity *(darūra)* and need *(hāja)*. Necessity is when (1) the pregnant woman has been infected by a lethal disease like tuberculosis and cancer; (2) if the pregnancy threatens the pregnant woman's life. Need based circumstances include cases where (1) the 'foetus' has genetic anomalies; (2) the pregnancy is due to rape. Pertinently, abortion is forbidden in case it is caused 'fornication' or illicit sexual intercourse.

However, it must be noted that the Shariah Law is applicable only in the province of Aceh in Indonesia. The Government of Aceh can create its own local regulations *(qanuns)* on Shariah Law in certain cases, but no such local regulation currently exists on abortion.

Post-Abortion Care in Indonesia

In 2020, Indonesia introduced National Guidelines on PAC as a policy measure to ensure availability and standardisation of services. Prior to this, there was no official guideline or policy on PAC in Indonesia. PAC is available for incomplete abortions, abortions with complications or complete abortions, regardless of whether the abortion is spontaneous or induced. According to a 2021 Guttmacher Institute study, PAC is provided only by OB-GYNs and not by general physiciansm midwives and other providers, thereby limiting the availability of PAC. Further, the study also notes that basic or comprehensive PAC services are available in 86% of the largest referral hospitals; "only 53% of maternity hospitals and 34% of local hospitals offer the necessary services, treatments and staffing."[22]

Child Protection Laws in Indonesia

In Indonesia, Law No. 23 of 2002 on Child Protection defines a child as anyone who is below 18 years and also includes 'children who are still in the womb.'[23] Further, Article 17 of the Act notes that every child whose liberty has been compromised has the right to receive humane treatment and receive legal aid if subjected to sexual abuse and be placed separately from adults. This Act was amended in 2016 to impose stricter punishment of 20 years imprisonment for conviction for sexual violence against children, and depending on the circumstances, chemical castration and/or implantation of microchips that track the offender's location. Punishment in such instances is to be decided on a case-to-case basis. The amended law also stipulates that the names of those convicted of sexual offences must be made public.

Through an amendment, Article 45A of Law on Child Protection prohibits abortion of 'children who are still in the womb' except for reasons and procedures as prescribed by the law. Under Article 77A, anyone who carries out an abortion under Section 45A of the law shall be punished with imprisonment for a maximum sentence of ten years and a maximum fine of one billion Indonesian Rupiah.

Medical Abortion in Indonesia

In Indonesia, mifepristone is not registered, while misoprostol is available under different brand names but is only registered for treating gastric ulcers and can only be purchased with a prescription. Imports of misoprostol-containing drugs have surged in the past three years, although no precise data exists. In 2015, the Ministry of Communications and Information blocked 300,000 sites selling illegal drugs "which were mostly used for abortion", following a report from the Indonesian Drug & Food Authority popularly known as BPOM.[24] BPOM reported that in 2018, the Ministry of Communications and Information blocked or took down 2,217 websites selling drugs that require a prescription or are illegal in Indonesia, including sites that sold misoprostol for abortion purposes.[25]

4. Vietnam

- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- SPECIFIC LEGISLATION ON REPRODUCTIVE HEALTH
- LAW PROHIBITING GENDER-BIASED SEX SELECTION

Abortion is permissible up to 22 weeks of gestation on request in Vietnam, except for the purposes of gender-biased sex-selection. The gestational limit of 22 weeks is recorded in the National Guidelines for Reproductive Health Services 2003 and 2009 issued by the Minister of Health. The Guidelines define abortion as the intentional use of "different methods to terminate a pregnancy up until the end of 22 weeks gestational age."[26]

Abortion was legalised in 1945 after Vietnam gained independence. In 1960, the Ministry of Health institutionalised access to abortion services on request in governmenat health facilities.

The Law on Protection of Public Health, 1989

Abortion is legal and widely available in Vietnam up to 22 weeks. The Law on Protection of People's Health, 1989 made it possible for all pregnant women to access abortion services, prior to which, women had to be married and required a letter of consent from their 'husband' to access abortion services. Article 44 of the 1989 Law provides that abortion is available on request and mandates the Ministry of Health to consolidate and expand the network of obstetrics to ensure medical care for women.

Article 44 reads as follows:

"(1) Women shall be entitled to have an abortion if they so desire, to undergo medical examinations and treatment for gynecological diseases and to receive prenatal care and medical services during delivery at medical institutions.

(2) The Ministry of Public Health shall have the duty to consolidate and expand the network of obstetric and neonatal health care to the grassroots level, in order to ensure medical care for women.

(3) Medical institutions and individuals may not perform abortions or remove IUDs unless permitted to do so by the Health Ministry or [competent] services."[27]

1992 Constitution of the Socialist Republic of Vietnam

Article 39 of the Constitution provides that the State makes investment in, ensures the development of and exercises unified management over the protection of the people's health; it mobilises and organises all social forces in the building and development of Vietnamese medicine following a far-sighted orientation; that prevention shall be combined with treatment, traditional medicine with modern medicine and pharmacology, State health services with people's health services; and that the State shall see to the organisation of health insurance and create the necessary conditions for all citizens to enjoy health care. Priority is given to the programme of health care for highlanders and national minorities. It is strictly forbidden for private organisations and individuals to dispense medical treatment and to produce and trade in medicaments illegally, thereby damaging the people's health.

Article 40 of the Constitution states that it is the responsibility of the State, society, the family and the citizen to ensure care and protection for mothers and children; to carry into effect the population programme and family planning.

Law on Social Insurance, 2014

Article 33 of the Law on Social Insurance, 2014, titled 'Leave period upon miscarriage, abortion, stillbirth or pathological abortion', states that:

"1. When getting miscarriage, abortion, stillbirth or pathological abortion, a female employee may take a maternity leave as prescribed by a competent health establishment. The maximum leave period is:

a). 10 days, for pregnancy of under 5 weeks;

b). 20 days, for pregnancy of between 5 weeks and under 13 weeks; c/ 40 days, for pregnancy of between 13 weeks and under 25 weeks; d/ 50 days, for pregnancy of 25 weeks or more.

2. The maternity leave period specified in Clause 1 of this Article is inclusive of public holidays, New Year holidays and weekends."[28]

The Vietnam Labor Code 2019

Article 141, titled 'Allowances while taking care of sick children, pregnancy and implementing contraceptive methods', states that:

"During time off for taking care of sick children less than 7 years old, pregnancy check-ups, miscarriage, abortion, stillbirth, and implementing contraceptive or sterilization methods, workers are entitled to social insurance allowances in accordance with the law on social insurance."[29]

Criminal Provisions on Illegal Abortion

Untill 1985, abortion was not mentioned in the Penal Code.

Illegal abortions were first criminalised under Article 243 of the Criminal Code of 1999. The Criminal Code was amended in 2015 and the amendments were to come into effect on July 1, 2016. However, the notification of the amended Code was delayed on account of supplemental amendments that were under consideration by Vietnam's National Assembly and an amended Criminal Code came into effect in 2018.

Article 316 of the amended Criminal Code criminalises illegal abortions and imposes different penalties, depending on the consequences of such illegal abortion. Under this provision, any person who "illegally performs an abortion on another person" is liable to punishment ranging from up to three years of community service to an imprisonment sentence of one to 15 years.[30] The severity of the punishment varies as the provision makes a distinction between acts of illegal terminations that result in the bodily harm leading to physical disability from those resulting in the death of one or more persons. The provision also notes that a person charged with an offence under Article 316 may also be liable for a fine of VND 5,000,000 to VND 50,000,000 or prohibited from holding certain positions or doing certain jobs for one to five years.

Ministry of Health Guidelines

During the 1990s, the government's focus was on maternal and child health care. In the view of the Ministry of Health, Vietnam required "a reproductive health strategy to provide healthcare to the

people, particularly to women, mothers and children, in a broader sense and with a more comprehensive approach."[31] In 2001, the Ministry formulated a National Strategy on Reproductive Health Care, for 2001-2010 which became the primary government policy on reproductive health. The strategy, it was noted, had to be consistent with the principles set forth in the International Conference for Population and Development's (ICPD) Programme of Action.

2003 Guidelines

The Ministry of Health's National Standards and Guidelines for Reproductive Health Care Services of 2003 provide for safe abortion services and lay down the types of clinics and healthcare professionals who can legally provide different abortion services.

Abortion services can be provided up to 22 weeks of gestation at central hospitals from the provincial level and upwards. Regulations determine the eligible clinics and providers authorised to offer various abortion services. Community health centres are limited to providing abortion services within the first six weeks. District health stations are permitted to conduct abortion services up to 12 weeks, while central clinics, as well as provincial hospitals, are authorised to provide abortion services up to 22 weeks of gestation. Private clinics must adhere to specified criteria established by Provincial Health Services to offer abortions up to six weeks gestation period.

2009 Guidelines

The Ministry of Health revised its guidelines in 2009 in light of technological advances and with the objective of improving the quality of care and diversifying reproductive healthcare to meet the needs of the people. Chapter VII of the Guidelines on safe abortion introduced several methods for abortion for 13 to 22 weeks.

Most significantly, it introduced "medical method using only Misoprostol or using combination of Mifepristol and Misoprostol applied for gestation age[32] from 13 to 22 weeks which was not provided in the 2003 Policy.

Prohibition on Gender-biased Sex-Selection

The prohibition of gender-biased sex selection was brought into force under the Population Ordinance that came into effect on January, 2003. Clause 2, Article 7 of the Ordinance guided by Article 10 clause 3 of Decree No. 104/2003/ND-CT prohibits "eliminating the foetus for reasons of sex selection using abortion, supply, use of chemicals, drugs and other measures."[33]

Article 84 of Decree No. 176/2013/ND-CP of November 14, 2013 lays down administrative sanctions in the form of fines for different situations in which abortion services are provided for the purpose of gender-biased sex-selection.

Article 100 of Decree 117/2020/ND-CP of September 28, 2020, lays down the penalties (fines) which may be imposed on those seeking or providing abortion services for the purposes of gender-biased sex-selection. Additional penalties under Clause 7 of Article 100 include suspension of the license for medical operations and/or practicing certificate for a period of three to 12 months and suspension for one to three months for establishments prescribing chemicals, drugs and other measures for terminating a pregnancy on the basis of gender-biased sex-selection.

Post-Abortion Care in Vietnam

The National Guidelines on Reproductive Healthcare[34] published in 2016 stipulate the kind of post-abortion care that should be provided in cases of surgical and medical abortions. This includes monitoring and care of the recipient, prescription of antibiotics, post-procedure consultation, provision on contraceptives, symptoms of complications and post-procedure check-up, etc. The guidelines specify that the recipient must take antibiotics 30 minutes before the procedure and that the providers should monitor pulse, blood pressure, temperature, vaginal bleeding, abdomen pain and uterine contraction for every 30 minutes for one to two hours after the procedure is complete. Further, the guidelines note that consultations may be provided before, during or after the procedure, which also covers instances of medical abortion, and recommend that providers should give information on post-abortion contraception and provide contraceptives. Post-abortion counselling is also available.

Child Protection Laws in Vietnam

In Vietnam, the Law on Children, 2016 defines a child to be someone below 16 years of age. As per Article 14 of the Law, children have the right to the best healthcare services and "priority in access to and use of disease prevention and examination and treatments services."[35]

Article 21 of the 2016 Law confers the right to privacy on children. Under Article 25, each child is afforded the right to protection from all forms of sexual abuse.

Criminal Code, 2015

Article 141 of the Criminal Code, 2015 defines the offence of rape and distinguishes the punishment in cases of non-consensual sexual intercourse with a person between the ages of 16-18 years, imposing a

higher punishment of imprisonment for a period ranging from five to ten years.

Article 142 imposes penalties for non consensual sexual acts with a person below the age of 16 years for the following acts:

(a) use of violence and non consensual sexual activity with a person between 13 to under 16.

(b) engaging in sexual intercourse or other sexual activities with a person under 13.

In both Articles 141 and 142, there is an enhanced punishment when the offence results in pregnancy of the survivor.

Articles 144-146 of the Code criminalise acts of sexual abuse, molestation or other sexual activity with persons between 13-16 years of age who are in the care of the perpetrator or in otherwise vulnerable circumstances.

In 2019, the Council of Justices of the Supreme People's Court, Vietnam adopted a resolution on sexual exploitation and abuse of persons under 18 years of age. This resolution guides the application of Article 141 to 147 of the Criminal Code, 2015. As per Article 2 of the resolution, the term sexual exploitation or abuse of a person under 16 years means "using violence, threatening to use violence, forcing, persuading or enticing a person under 16 to participate in sexual activities, including rape, sexual abuse, sexual intercourse and molestation of a person under 16 and using a person under 16 for pornographic or prostituting purposes in any shape or form (e.g. sexual exploitation or abuse committed with consent of a person under 13), via force or promises of financial interests (money or property) or non-financial interests (e.g. high grades, favourable evaluation, advancement opportunity, etc.)."[36]

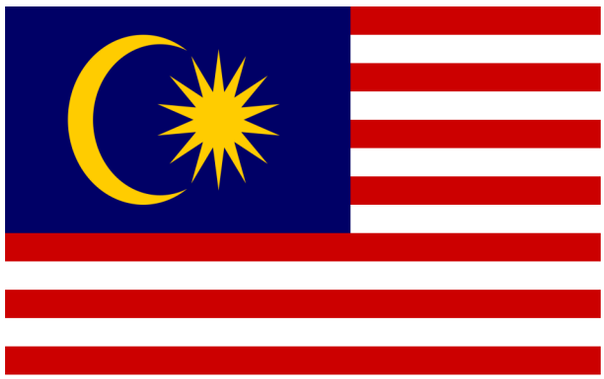
Vietnam has enacted progressive legislation and policies concerning Sexual and Reproductive Health (SRH) and the rights of adolescents. Notably, the revised Youth Law, endorsed in June 2020, affirms in Article 5 that the rights and responsibilities of young individuals are acknowledged, respected, safeguarded and upheld. According to the Youth Law, it is the duty of the State, organisations, educational institutions, families and individuals to facilitate the exercise of the rights and responsibilities outlined in the Constitution and legislation by young people. Further, the Youth Law includes explicit provisions supporting individuals aged over 16, who are not covered by Vietnam's 2016 Law on Children, to ensure the protection of their rights in accordance with the Convention on the Rights of the Child.[37]

Medical Abortion

The Ministry of Health's National Standards and Guidelines for Reproductive Health Care Services of 2003 introduced Mifepristone and Misoprostol as a method of abortion upto 7 weeks.[38]

The Ministry of Health's National Standards and Guidelines for Reproductive Health Care Services of 2009 extended the use of MA Pills upto 9 weeks at the district, provincial and central levels. It also extended the administration of MA pills from 13 up to 22 weeks by OBGYNs who are trained in MA in hospitals in pronvicial and higher levels.

5. Malaysia



- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- GUIDELINES ON TERMINATION OF PREGNANCY
- DUAL SYSTEM OF COMMON & SYARIAH LAW ON ABORTION

The legal landscape surrounding abortion in Malaysia reflects a nuanced approach that has, over time, resulted in laws that are notably more permissive than in many other jurisdictions. Abortions services are regulated under the Malaysian Penal Code, 2017. The Indian Penal Code was amended and adopted as the Malaysian Penal Code in 1936 and applied to a few federated Malay States and then became applicable to the entire country in 1976.

The consolidated amendments are found in the Malaysian Penal Code 1997.

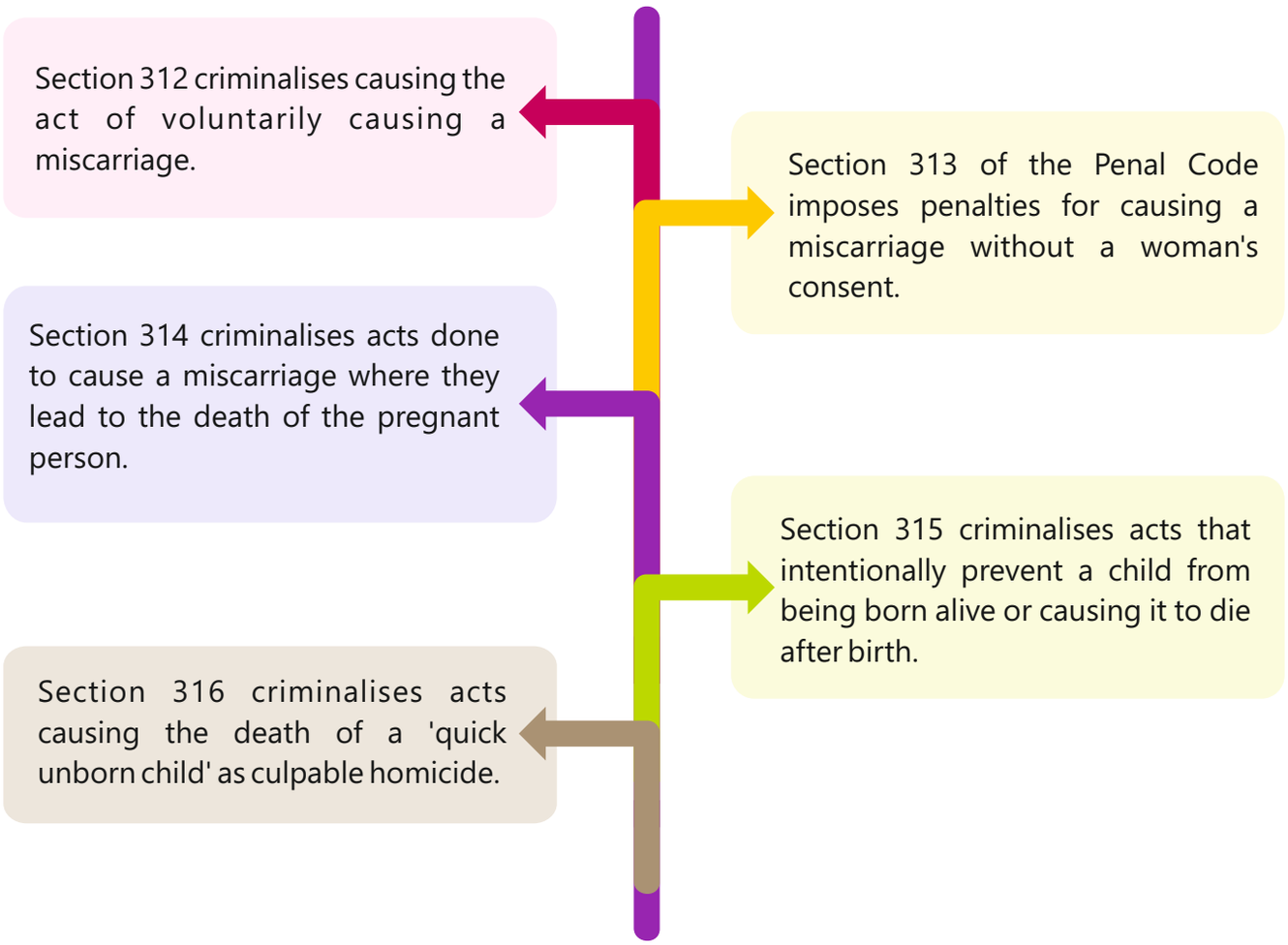
Malaysian Penal Code

Amendment 1989

The 1989 Amendment to the Code aimed to broaden access to abortion services. The revision involved the removal of the clause "if such miscarriage be not caused in good faith for the purpose of saving the life of the woman"[39] from a specific section and the introduction of an exception. This exception specifies that the section does n ot apply to a medical practitioner registered under the Medical Act 1971 who terminates a woman's pregnancy. The exemption is granted if the medical practitioner, in

good faith, believes that the continuation of the pregnancy poses a greater risk to the life or mental and physical health of the pregnant woman than if the pregnancy were terminated.

Malaysian Penal Code of 1997



Section 312 of the Code states that:

> ***"Whoever voluntarily causes a woman with child to miscarry shall be punished with imprisonment for a term which may extend to three years or with fine or with both, and if the woman is quick with child, shall be punished with imprisonment for a term which may extend to seven years, and shall also be liable to fine."***[40]

Explanation: **"A woman who causes herself to miscarry is within the meaning of this section."**[41]

***Exception:* "This section does not extend to a medical practitioner registered under the Medical Act 1971 *[Act 50]* who terminates the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated."**[42]

The term 'good faith' is defined in Section 52 of the Penal Code and states that "nothing is said to be done or believed to be done in good faith"[43] where an is action performed with due care and attention.

The Ministry of Health Guideline on Termination of Pregnancy, 2012 defines abortion "as the expulsion or removal of an embryo or foetus from the uterus at a stage of pregnancy when it is incapable of independent survival (500gms or 22 weeks gestation)."[44] This can occur spontaneously or be induced for medical or social reasons. Although there is no universally accepted medical definition for 'quick with child,' in the Malaysian context, it generally refers to a pregnancy between 20 and 22 weeks of gestation. In the context of terminating a pregnancy, the Guideline notes that the pregnant woman's consent is essential, and if she is under 18, the consent of a parent or guardian must be obtained.

Section 313 of the Penal Code imposes penalties for causing a miscarriage without a woman's consent. Section 314 addresses death caused by an act intended to cause a miscarriage, with varying punishments depending on the presence or absence of the woman's consent. Section 315 penalises acts done with the intent to prevent a child from being born alive or causing its death after birth, with potential imprisonment for up to ten years or a fine or both. Section 316 penalises acts causing the death of a quick unborn child as culpable homicide, with a maximum penalty of ten years' imprisonment and a fine.

The Ministry of Health's Guideline on Termination of Pregnancy (TOP), 2012 lay down the requirement of two doctors for determining whether a pregnancy can be terminated in Government hospitals.

Malaysia also introduced universal access to healthcare services, including SRH services, across all healthcare facilities in 2012. Although young girls, regardless of marital status, have access to pregnancy termination services at government healthcare facilities, restrictions remain, requiring parental or guardian consent for those under the age of 18.

Abortion Regulation under Syariah Law

Malaysia has a dual system of law – common law and Islamic law. Under the Syariah law, which is only applicable to Muslims in Malaysia, a *Fatwa* (a ruling on a point of Islamic law given by a recognised authority) allows for abortion services to be provided under 120 days of gestation if there is a threat to the life of a pregnant woman or in the case of 'foetal' anomalies. The application of Syariah law also varies from state to state.

Post-Abortion Care in Malaysia

With respect to post-abortion care in Malaysia, the Guidelines on Termination of Pregnancy (TOP) For Hospitals in Ministry of Health introduced in 2012 provide for post-termination management. These are restricted to PAC only for hospitals governed and regulated by the Ministry of Health. Under these guidelines, there is mention of the kind of information that must be recorded after the termination procedure, clinical assessment and future contraception options etc. Further, the Guidelines also lay emphasis on the role played by trained counsellors and mandate hospitals to ensure that counsellors are trained with post abortion issues.

Child Protection Laws in Malaysia

Section 375 of the Penal Code of Malaysia categorises all sexual intercourse with a person below the age of 16 years as rape, thereby legislating the age of consent at 16 years. However, the Domestic Violence Act, 1994 defines a child to be someone below the age of 18 years for the purpose of that law.

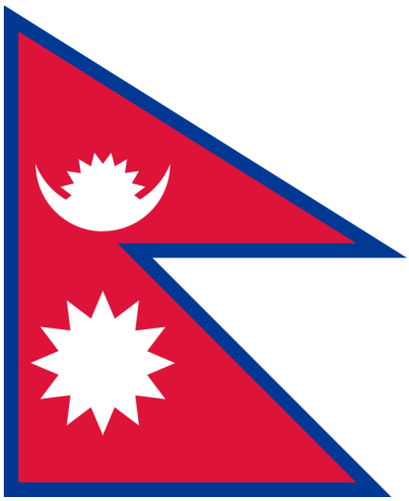
With respect to specific legislation on child protection, the Child Act, 2001 is a protective legislation which stipulates certain roles and duties for 'protectors' and family members for the well-being of children. The law under Section 2 defines a 'protector' to include (a) the Director General; (b) the Deputy Director General; (c) a Divisional Director of Social Welfare, Department of Social Welfare; (d) the State Director of Social Welfare of each of the States; or (e) any Social Welfare Officer appointed under the law.

The Child Act, 2001 also imposes a duty on medical officers and practitioners to notify the protector in any instance where such officer has reasonable ground to believe that a child has been physically or emotionally injured or sexually abused. It also authorises a medical officer to take temporary custody of such injured or abused child before they are placed in the custody of the protector. A similar duty to inform the protector is also imposed on any member of the family of a child or the child care provider who believes, on reasonable grounds, that the child is physically or emotionally injured as a result of being ill-treated, neglected, abandoned or exposed or is sexually abused.

Medical Abortion in Malaysia

The Ministry of Health provides termination of pregnancy services within the context of the law, including medical and surgical methods of termination. Mifepristone (RU486) is not registered for use in Malaysia. Previously, off-label use of Misoprostol for medical abortion and softening the cervix before manual vacuum aspiration (MVA) was common but Misoprostol is only registered for use for treatment of gastric ulcers.

6. Nepal



- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- SPECIFIC LEGISLATION ON REPRODUCTIVE HEALTH - SMRHR, 2018
- LAW PROHIBITING GENDER-BIASED SEX SELECTION
- DECRIMINALISATION PETITION PENDING

Criminal Provisions under the Penal Code of Nepal

Prior to 2002, Nepal had very restrictive abortion laws that prosecuted and imprisoned women and their family members for terminating pregnancies. In 2002, Nepal amended its Penal Code *(Muluki Ain)* 1959 to allow abortion on certain grounds and ensure Nepalese women's right to decide on their reproductive choices.[45]

The 2002 amendment to the Penal Code allowed abortion under the following conditions:

- up to 12 weeks' gestation on any ground, with the consent of the woman;
- up to 18 weeks' gestation in cases of rape or incest; and
- at any gestation if the pregnancy posed a danger to the woman's life, physical health or mental health or if there was a 'foetal' anomaly.

Termination of the pregnancy based on gender determination was legally prohibited.

The 2002 Penal Code was replaced in 2017 by the Muluki Aparadh (Sanghita) Act, which has the retained the legal provisions on abortion.

Sections 188 and 189 of the National Penal (Code) Act, 2017 criminalise abortion in Nepal.

Under Section 188, abortion is prohibited, unless it comes within the contours of Section 189.

Under Section 189, abortion is allowed when provided at a licensed institution by a licensed health worker with the consent of the pregnant woman:

- **up to 12 weeks of gestation;**
- **upon the opinion of a licensed doctor that her life may be in danger, or her physical or mental health may deteriorate or a 'child will be born with a disability' if pregnancy is not terminated;**
- **up to 18 weeks if the pregnancy is due to rape or incest;**
- **where a pregnant woman has human immunodeficiency virus (HIV) or an incurable disease of similar nature.**

The Explanation to Section 189 states that only a health worker with a license is allowed to terminate a pregnancy.

Under Section 188, abortion is penalised when caused by coercion, threat, lure or offer to the pregnant woman and when done outside the contours of Section 189. The punishment stipulated is imprisonment for one year and a fine not exceeding 10,000 rupees (when pregnancy is up to 12 weeks), three years and a fine not exceeding 30,000 rupees (when the pregnancy is between 12-25 weeks) and five years a and a fine not exceeding 50,000 (when a pregnancy is over 25 weeks).

This section also penalises any act done with 'premeditation' against a pregnant woman irrespective of whether the act is done with the intention to cause abortion with the same penalties as above.

Under Sections 188(7) and (8), any act to identify the gender of the 'foetus' for the purpose of abortion is penalised with imprisonment for a term ranging from three months to six months.

In case of abortion provided after gender determination and is penalised with imprisonment for a term not exceeding one year.

Importantly, under Section 190, no complaint can be made for an offence under Sections 188 and 189 after the expiry of six months from the date of knowledge of commission of the offence.

The National Abortion Policy 2003 and Safe Abortion Service Procedure 2003

The National Abortion Policy 2003 and the Safe Abortion Service Procedure 2003 define clinical procedures for safe termination of pregnancies, service provision facilities and client consent, and lay down criteria for approving a healthcare facility as a provider of CAC.

In 2015, Nepal announced about the access to free abortion services at public health facilities.

The Right to Safe Motherhood and Reproductive Health Rights Act, 2018

The conditions under which abortion was legally permitted were revised in 2018 with the implementation of the Right to Safe Motherhood and Reproductive Health Rights Act (RSMRHR Act).

Section 15 of the Act grants women the right to access safe abortion services upon request with the consent of the pregnant woman. Additionally, termination is permissible up to 28 weeks' gestation under specific conditions:

- **If, according to a licensed physician, the absence of abortion services may pose a danger to the life of the pregnant woman, or her physical or mental health may deteriorate, or in cases of 'foetal' anomaly.**
- **In situations where the conception is a result of rape or incest.**
- **If the pregnant woman is infected with HIV or a similar incurable disease.**
- **If, based on the healthcare professional's opinion, the 'foetus' is likely to become non-viable or is unlikely to survive after birth, or if it is expected to suffer from other fetal anomalies due to a genetic disorder or any other.**

Post-Abortion Care in Nepal

In 2021, Ministry of Health and Population, Department of Health Services, Family Welfare Division introduced the Safe Abortion Service Program Management Guidelines, 2021. The Guidelines were introduced with the aim of improving implementation of quality and free safe abortion services in line with the provisions of the RSMRHR Act.

The Guidelines stipulate that PAC will be managed free of cost for any complications resulting from induced or spontaneous abortions. This also includes post abortion counselling, family planning services and contraception methods.

As per the Guideline on Adolescent Health, an adolescent is defined as anyone between the ages of ten years to 19 years. The Guideline has been issued by the Ministry of Health and Population to ensure access to quality health services, including reproductive health services to adolescents. The Guideline aims to create an environment for them to receive quality family planning, reproductive health, safe abortion and motherhood, reproductive healthcare and other related care including PAC.

Child Protection Laws in Nepal

Chapter 18 of the National Penal Code of 2017 deals with sexual offences.

As per Section 219(2) of the Code:

> ***"Where a man has sexual intercourse with a woman without her consent or with a girl child below eighteen years of age even with her consent, the man shall be considered to commit rape on such woman or girl child."***[46]

The age of consent is 18 years in Nepal.

The Act Relating to Children, 2018

The Act Relating to Children was enacted in 2018, one year after the revised Penal Code of 2017 came into effect.

According to Section 7(5) of the 2018 Act, every child has the right to protection against any form of physical or mental violence, torture, hatred, gender or untouchability based treatment or any kind of exploitation or harassment, including sexual harassment which may be caused by the parents, family members, guardians, teachers and other persons.

The law also has a mandatory reporting requirement under Section 50 and any person who has information about a child in need of special protection at any place must inform the Child Welfare Authorities of such cases under this provision.

Significant Judicial Developments

Lakshmi Dhikta v. Government of Nepal

In 2009, the Supreme Court of Nepal issued a landmark judgement in Lakshmi Dhikta v. Government of Nepal) and recognised abortion as a fundamental right under the Constitution. Lakshmi Dhikta, a woman from a socioeconomically marginalised background, who was already a mother of five children and residing in rural Nepal, was pregnant for the sixth time. In light of Lakshmi's deteriorating health and their economic status, neither she nor her husband wanted to have another child. The hospital they approached asked for 1,130 rupees (approximately USD 8.46) and since they could not afford to pay this amount, Lakshmi was compelled to continue her pregnancy.

- The Supreme Court held that the right to abortion can only be realised when abortion services are affordable and accessible.
- It further recognised that this right must be applicable in cases of unwanted pregnancy. Imposing an obligation to reproduce or forcing pregnancy is violative of the rights of a woman.
- The Court further clarified that Nepalese law does not recognise the rights of a 'foetus.'
- **Most importantly, the Court recognised that women who were forced to carry out an unwanted pregnancy were entitled to compensation from the State.**

National Guidelines for Disability Inclusive Health Service Guidelines, 2019

The Guideline for persons with disabilities mandates that healthcare professionals must ensure that the SRH needs and rights of persons with disabilities including those of older persons are integrated into existing programmes and service delivery at each level of service provision.

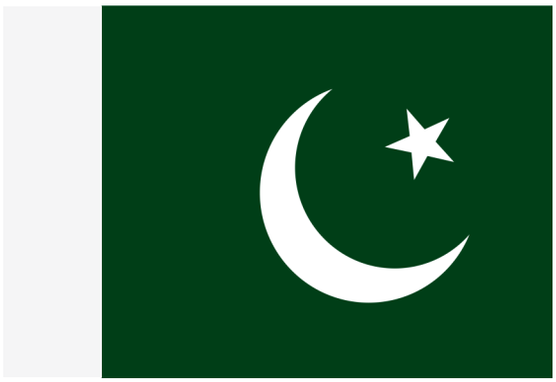
Decriminalisation Petition, 2022

In February 2022, the Forum for Women, Law & Development (FWLD), a non-profit organisation based in Nepal, approached the Supreme Court of Nepal with a plea for the complete decriminalisation of abortion. This request aligns with constitutional protections and recommendations from the United Nations. The organisation's petition aims to shift from a restrictive legal framework for abortion towards a rights-based approach, advocating for improved access to abortion services. The petition relies heavily on the precedent set by the *Lakshmi Dhikta* case and urges the repeal of criminal provisions related to abortion services in the 2017 Criminal Code. The goal is to safeguard rights guaranteed by the Constitution of Nepal and the legal provisions of the RSMRHR Act. Additionally, the petition seeks amendments to the RSMRHR Act, focusing on changes to gestational limits and allowing conditional safe abortions beyond 28 weeks. It advocates for the removal of regulatory barriers to enable safe abortion services through self-managed procedures and telemedicine. The petition emphasises the need for a clear distinction between miscarriages and self-induced abortions to prevent criminalisation of the abortion services.

Medical Abortion in Nepal

MA was introduced on a pilot basis in Nepal in 2009. The success of the pilot study encouraged the approval of MA services at a country-wide scale, and the Family Division of the Ministry of Health and Population issued Guidelines in 2009 to permit Auxiliary Nurses and Midwives (ANM) to administer MA pills. The safety, efficacy and acceptability of MA provided by ANMs is now well established in Nepal. The Government of Nepal registered MA brands (combined regime of mifepristone and misoprostol) have been available only on prescription through government-accredited safe abortion providers since 2009.

7. Pakistan



- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- SPECIFIC LEGISLATION ON REPRODUCTIVE HEALTH [PROVINCIAL LEVEL]
- PETITION FOR DECRIMINALISATION OF ABORTION IS CURRENTLY PENDING

The Pakistan Penal Code criminalises abortion and the extent of punishment varies depending on the developmental of the 'foetus.' The Penal Code of Pakistan was revised in 1990 and the amendments came into effect in 1997.

Pakistan Penal Code, 1860

Under the Amended Code, the conditions for accessing legal abortions depend on the stage of 'foetal' development. Section 338 of the Pakistan Penal Code states:

> ***Isqat-i-Hamal: Whoever causes a woman with child whose organs have not been formed, to miscarry, if such miscarriage is not caused in good faith for saving the life of the woman or providing necessary treatment to her, is said to cause isqat-i-hamal.***
>
> ***Explanation: A woman who causes herself to miscarry is within the meaning of this section.***[47]

Section 338 of the Code criminalises causing miscarriage of a 'foetus' where the organs are not formed unless it is done in good faith for saving the life of the woman or providing necessary treatment to her. This is called '*isqat-i-hamal*'. There is no clarity on what constitutes 'necessary treatment',[48] which leaves the law open to interpretation and the provision of abortion services to the discretion of a healthcare professional.

The punishment for such an act is provided under Section 338-A; '*Ta'zir*' with maximum imprisonment of three years when the act 'causing the miscarriage' is done with the consent of the woman and maximum imprisonment of ten years where such act is done without her consent.

Further, Section 338-B of the Code titled '*Isqati-janin*' penalises acts resulting in a miscarriage where the 'foetus' has not developed some limbs or organs unless it is caused in good faith for saving the life of the woman.

The punishment for this under Section 338-C is (a) one-twentieth of the *diyat* if the child is born dead; (b) full diyat if the 'child' is born alive but dies as a result of any act of the offender; and (c) imprisonment of either description for a term which may extend to seven years as *ta'zir*. '*Diyat*' is a form of punishment under Section 53 of the Code and refers to a form of financial compensation defined under Section 323.

While 'necessary treatment' is an exception under Section 338 '*Isqat-i-hamal*', it is not specified under Section 338-B '*Isqati-janin*'.

To sum up the legal position on abortion in Pakistan, abortion is legal when the services are provided in good faith to save the life of the woman or to provide 'necessary treatment'. The gestational limit within which pregnancies may be terminated under the law, as accepted by Islamic legal scholars, is 120 days.[49] Abortion services can only be lawfully provided after the expiration of 120 days of gestation in cases where it is necessary to save the life of the woman.

State Legislations of Reproductive Health

Specific legislations addressing reproductive health rights have been passed in the provinces of Punjab, 2015 (the Punjab Reproductive, Maternal, Neonatal and Child Health Authority Act, 2014), Sindh (the Sindh Reproductive Healthcare Rights Act, 2019) and Khyber Pakhtunkhwa (the Khyber Pakhtunkhwa Reproductive Healthcare Rights Act, 2020).

Post-Abortion Care in Pakistan

The Women-Centred Post-Abortion Care: Reference Manual 2015 (developed by the Ministry of Health along with IPAS) offers a comprehensive and human rights approach to care focused on ensuring choice, access and quality.

Adopted from the Postabortion Care Consortium, 2002, PAC consists of 5 elements:

- **"Treatment of incomplete and unsafe abortion and abortion-related complications that are potentially life-threatening;**
- **Counselling to identify and respond to women's emotional and physical health needs and other concerns;**
- **Contraceptive and family-planning services to help women prevent an unwanted pregnancy or practice birth spacing;**
- **Reproductive and other health services that are preferably provided onsite or via referrals to other accessible facilities in providers' networks;**
- **Community and service-provider partnerships to prevent unwanted pregnancies and unsafe abortion, mobilise resources to help women receive appropriate and timely care for complications from abortion and ensure health services reflect and meet community expectations and needs."**[50]

Guidelines on PAC may also be developed at the provincial level. The Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Post-abortion Care advanced by the Department of Health in the province of Punjab have been developed "to provide health workers with prerequisites and guidance for reference during service delivery, improving service quality as well as to provide health administrators/managers with standards to evaluate quality of care as well as checklists for monitoring and supervision."[51]

Standard 36 notes that women presenting for PAC must be stabilised before assessing for abortion-related complications and if necessary, be referred to another facility in case of life-threatening complications or any pre-existing conditions that require additional resources. Standard 49 further notes that healthcare staff must recognise and be able to treat or make the appropriate referral for

complications that might occur during PAC, during a uterine evacuation procedure, in the recovery period or later.

The National Guidelines for High-Quality Safe Uterine Evacuation/Post-Abortion Care in 2018 set the standard of care and provide guidance to healthcare workers on the provision of high-quality, comprehensive uterine evacuation care for the first trimester. Notably, Standard 26 of the Guidelines notes that while healthcare professionals have a right to conscientious refusal to providing abortion services, they cannot impede or deny access to lawful abortion services because it delays care for women and girls, putting their health and life at risk. In such cases, they must refer the pregnant person to a willing and trained provider and where such referral is not possible, provide safe abortion to save the woman/girl's life and to prevent serious injury to her health. Standard 27 of the Guidelines notes that "all women and girls who experience complications from an unsafe abortion must be treated urgently and respectfully, as any other emergency patient, without punitive, prejudiced or biased behaviours."[52]

In the province of Sindh, the Post-abortion Family Planning Policy and Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Post-abortion Care were adopted by the Health Department, Government of Sindh, in February 2020. The policy was developed after extensive consultation with stakeholders and stipulates the inclusion of midwives in PAC training and service delivery programs; the inclusion of safe abortion and contraception messages in lady health workers trainings and curriculum; the inclusion of PAC and family planning in government funded health insurance schemes.

Child Marriage Law & Access to Abortion Services

The prohibition of child marriage law is a huge deterrent to access for SRH for adolescents. The Child Marriage Restraint Act (CMRA) enacted in 1929 defines a child as a male under the age of 18 and a female under the age of 16. The Act penalises: (1) a male above the age of 18, marrying a child; (2) individuals responsible for facilitating and solemnising the marriage; and (3) the parent or guardian of the child in such instances of marriage with imprisonment up to one month which may also include a fine up to 1,000 rupees.

The Constitution of Pakistan was amended via the Constitution (Eighteenth Amendment) Act, 2010 to significantly alter the federal structure of the country, pursuant to which the subject of child marriages was delegated to the provinces. Therefore, each province in Pakistan is empowered to pass their own legislation on the subject of child marriage. Only two provinces in Pakistan, i.e. Sindh and Punjab, have

passed legislations. The Punjab Child Marriage Restraint (Amendment) Act 2015 amended parts of the CMRA, including the punishment which was enhanced to imprisonment for six months and a fine of 50,000 rupees. The law retained the legal age of marriage for boys and girls to be 18 and 16 respectively. The Sindh Child Marriage Restraint Act, 2013 (SCMRA) prescribes a uniform minimum age of 18 for both males and females for marriage in the province of Sindh.

In 2013, the province of Khyber Pakhtunkhwa proposed to raise the legal age of marriage for girls to 18 years, but this has not been enacted into legislation yet.[53] In Islamabad, after the decision of the Islamabad High Court in *Mumtaz Bibi v. Qasim* (2021), all marriages of children under the age of 18 years are *void ab initio* i.e. illegal from the outset. As of March 2023, the Government from Balochistan has also prepared a draft law to prevent child marriages which is to be submitted to the Provincial Assembly for approval.[54]

Medical Abortion

In Pakistan, Misoprostol, originally designed for treating gastric ulcers, has been used for inducing labour and evacuating the uterus in hospital settings since the 2000s. It was registred for use in Pakistan in 2009. It was not until 2012, following the inclusion of Misoprostol in the WHO Model List of Essential Medicines, that its usage was sanctioned for addressing postpartum hemorrhage and managing incomplete abortion.

8. India

- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE & MA IS AVAILABLE
- SPECIFIC LEGISLATION ON REPRODUCTIVE HEALTH-MTP ACT, 1971
- LAW PROHIBITING GENDER-BIASED SEX SELECTION

Abortion is recognised as a qualified right in India and is shaped by the legal framework established through the Indian Penal Code, (IPC) 1860 and Medical Termination of Pregnancy (MTP) Act of 1971. Initially enacted to regulate and facilitate conditional abortion services and protect medical practitioners from criminal liability stemming from the IPC, the MTP Act has undergone amendments to broaden the scope for access to safe and legal abortion services.

Criminal Provisions under the Indian Penal Code (IPC), 1860

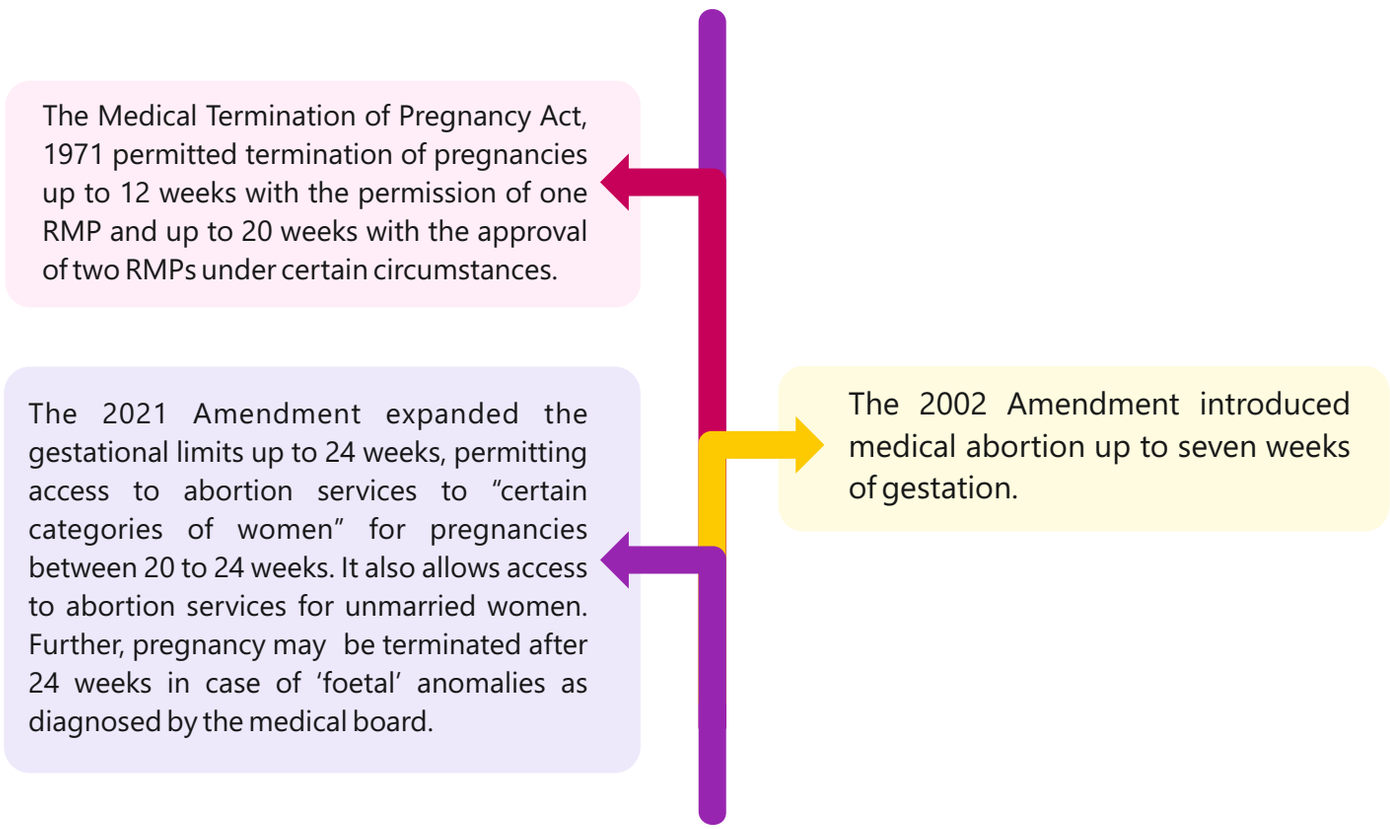
Abortion in India is criminalised under Sections 312 to 318 of IPC, 1860. Section 312 states:

> ***"Whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.***
>
> ***Explanation. — A woman who causes herself to miscarry, is within the meaning of this section."***[55]

Statutory Framework

The introduction of the MTP Act as an exception to Section 312 of the IPC, and the subsequent amendments to the Act have played a pivotal role in shaping the legal landscape of abortion access in India. The MTP Act originally permitted the termination of pregnancies under specific circumstances, allowing abortion within 12 weeks of gestation with the approval of one Registered Medical Practitioner[56] (RMP) and up to 20 weeks with the approval of two RMPs. This was applicable in cases of rape, 'foetal' anomalies, contraception failure in case of a married woman, and to safeguard a woman's life. An amendment in 2002 introduced MA pills in India for terminating pregnancies up to seven weeks.

Further, new amendments to the MTP Act were enacted in April 2021, with corresponding rules notified in October 2021. These changes mark a significant evolution as they permit the termination of pregnancy up to 20 weeks of gestation regardless of marital status. Moreover, the gestational limit has been extended from 20 to 24 weeks for 'specific categories of women', and a pregnancy may be terminated at any gestational age where there is a case of substantial 'foetal' anomalies as diagnosed by a Medical Board.



The Medical Termination of Pregnancy Act, 1971

This law permitted termination of pregnancies up to 12 weeks with the approval of one RMP and up to 20 weeks with the approval of two RMPs where,

"the continuance of the pregnancy would involve a risk to the life of the pregnant woman or result in grave injury to her physical or mental health; or there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities to be seriously handicapped."[57]

The Act further stated that if the pregnancy was a result of rape, or contraceptive failure between a woman and her husband, termination was permissible.[58] The law was thus restricted in its application to married women for termination on account of failure of contraception.

2002 Amendment

The first amendment to the MTP Act was via the Medical Termination of Pregnancy (Amendment) Act 2002 which was accompanied by the amended MTP Rules and Regulations 2003. Under these amendments, regulation of abortion facilities was decentralised from the State level to District Committees that are empowered to approve and regulate abortion facilities. The amendment also introduced punitive measures of two to seven years imprisonment for individual healthcare professionals and owners of facilities that are not approved by or maintained by the Government.

Mostly significantly, the amended MTP Rules recognised MA, allowing a RMP to provide mifepristone and misoprostol in a clinic setting to terminate a pregnancy up to seven weeks of gestation, provided that the RMP has either on-site capability or access to a facility capable of providing surgical abortion in the event of a failed or incomplete medical abortion.

2021 Amendment

The MTP Act was significantly amended for a second time in 2021. The key amendments include:

- Allowing the termination of pregnancy of 12-20 weeks with the opinion of one RMP (instead of two prior to the amendment).
- Allowing the termination of pregnancies between 20-24 weeks of gestation, thereby increasing the upper gestation limit for 'certain categories of women'. The 'categories of women' for this purpose are listed under Rule 3(B) of the Medical Termination of Pregnancy Rules, 2021. These categories include survivors of sexual assault or rape or incest, minors, persons who have experienced a change in marital status (widowhood or divorce), women with physical disabilities, mentally ill women, in cases where there is a likelihood of severe 'foetal' anomalies or

the child being born with severe disabilities and women with pregnancies in humanitarian settings or disaster and emergency situations as may be declared by the State. In these cases, if the pregnancy is between 20-24 weeks of gestation, the termination requires seeking an opinion of two RMPs. The scope of special 'categories of women' was expanded by the Supreme Court in 2022, which is discussed below.

- Removing an upper gestation limit in cases of substantial 'foetal' anomalies for pregnancies beyond 24 weeks as diagnosed by a Medical Board.

- Failure of contraception is also recognised as a basis for seeking abortion services, for all women, irrespective of marital status, as opposed to the provisions of the earlier law which were restricted to married women.

Section 4 of the MTP Act notes that a pregnancy can be terminated in accordance with the provisions of the Act at any hospital that is established or maintained by the Government or at a facility that has prior approval from the Government of a District Level Committee constituted by the Government.

Section 5 of the MTP Act carves out an exception in cases where abortion services must be provided immediately to save a woman's life. In such cases, the healthcare professional need not have the stipulated experience or training but still needs to be an RMP. Further, the requirement of two RMPs for pregnancies exceeding 20 weeks is also relaxed under such circumstances.

Section 8 of the MTP Act also confers full protection to a RMP against any legal or criminal proceedings for any injury caused to a woman seeking abortion, provided that the abortion was done in good faith at an approved facility in accordance with the provisions of the Act.

The Pre-Conception and Pre-Natal Diagnostics Techniques Act, 1994

The Pre-Conception and Pre-Natal Diagnostics Techniques Act, 1994 (PCPNDT Act) prohibits pre-natal diagnostic techniques for sex determination. It must be noted that the PCPNDT Act does not, in any way, regulate access to abortion services. It is a legislation regulating the misuse of diagnostics techniques to address the issue of gender-biased sex selection. The strict penal provisions of this law carry penalties ranging from extensive fines to imprisonment sentences for a maximum period of five years and the possibility of suspension licenses for healthcare professionals with no distinction between offences for paperwork and sex-determination. These have had an indirect impact on access to abortion services. Healthcare professionals have been targeted under the law for providing late-term abortion services on the assumption that they are facilitating gender-biased sex selection. They are thus fearful of attracting penal consequences under the PCPNDT Act and reluctant to provide late-term abortion services. Despite the differential purposes of the PCPNDT Act and the MTP Act, the two are

conflated in practice and administrative implementation. This is compounded by the lack of awareness amongst stakeholders regarding the differences between the two laws.

The Protection of Children from Sexual Offences Act, 2012

The Protection of Children from Sexual Offences Act, 2012 (POCSO Act) criminalises child sexual abuse and simultaneously imposes a blanket criminalisation on all sexual activity with persons below 18 years of age. Under Section 19(1) of the POCSO Act, individuals have an obligation to mandatorily report such sexual activity between persons below 18 years. The reporting requirement also extends to anyone who has an apprehension that there is a likelihood of the commission of an offence under the POCSO Act. This mandatory reporting requirement has served as a deterrent for adolescents in consensual sexual relationships seeking abortion services. They are reluctant to approach healthcare professionals, fearing criminal consequences. Healthcare professionals are also hesitant to provide abortion services to adolescents owing to the fear of prosecution in instances where they fail to meet the mandatory reporting requirement obligations under the POCSO Act. As a result adolescents are compelled to seek unsafe abortion services. Recognising this issue, the Supreme Court of India in *X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT of Delhi* harmonised the MTP Act and the POCSO Act. This case is discussed in detail below.

The Rights of Persons with Disabilities Act, 2016

It is also pertinent to take note of the legal complexity that results from the conflicting provisions under the Rights of Persons with Disabilities Act, 2016 (RPD Act). Section 92(f) of the RPD Act penalises anyone that conducts a medical procedure, when such procedure results in the termination of the pregnancy of a woman with disability without the consent of the woman. However, the provision carves out an exception for instances of 'severe disability' pursuant to which a pregnancy can be terminated without the consent of the woman with disability, with the consent of her guardian. It must be noted that the term 'severe disabilities' has not been defined or explained in the law.

The criminal framework, comprised of Sections 312-318 of the IPC, in conjunction with the POCSO Act, PCPNDT Act and RPD Act fosters a system of state surveillance that instils fear in both healthcare professionals and those seeking abortion services.

Significant Judicial Developments

X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT Of Delhi

In 2022, the Supreme Court delivered landmark judgment in *X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT Of Delhi*. The court ruled that all pregnant individuals in India possess

the right to reproductive autonomy, extending the application of the MTP Act to transgender and gender-diverse persons. Every individual is entitled to reproductive health, encompassing the availability of secure, efficient, and cost-effective family planning methods, access to contraception, and comprehensive sex education. A summary of the key ruling by the Court in this case is provided below:

- The Court declared that the distinction between married and unmarried women provided under Rule 3(b) of the MTP Rules was unconstitutional and that all women are entitled to termination of pregnancy arising out of consensual sex from 20 to 24 weeks of gestation.

- Further, the Court expanded the definition of categories of women and held:

  "A change in material circumstance may also result when a woman is abandoned by her family or her partner. When a woman separates from or divorces her partner, it may be that she is in a different (and possibly less advantageous) position financially. She may no longer have the financial resources to raise a child. This is of special concern to women who have opted to be a homemaker thereby forgoing an income of their own. Moreover, a woman in this situation may not be prepared to raise a child as a single parent or by coparenting with her former partner. Similar consequences may follow when a woman's partner dies. Women may undergo a sea change in their lives for reasons other than a separation with their partner...They may find themselves in the same position (socially, mentally, financially, or even physically) as the other categories of women enumerated in Rule 3B but for other reasons. For instance, it is not unheard of for a woman to realise that she is pregnant only after the passage of twenty weeks. Other examples are if a woman loses her job and is no longer financially secure, or if domestic violence is perpetrated against her, or if she suddenly has dependents to support. Moreover, a woman may suddenly be diagnosed with an acute or chronic or life-threatening disease, which impacts her decision on whether to carry the pregnancy to term. If Rule 3B(c) was to be interpreted such that its benefits extended only to married women, it would perpetuate the stereotype and socially held notion that only married women indulge in sexual intercourse, and that consequently, the benefits in law ought to extend only to them. This artificial distinction between married and single women is not constitutionally sustainable. The benefits in law extend equally to both single and married women." [59]

- The Court also recognised a married woman's right to abortion if the pregnancy was a result of forced or non-consensual sex. While reaffirming a woman's right to bodily autonomy, the court condemned the widespread practice of imposing extra-legal conditions/requirements as done by RMPs.

- In regard to adolescent sexuality, the Court read down the mandatory reporting requirements under Section 19 of the Protection of Children from Sexual Offences Act, 2012 (POCSO Act), stating that the identity and personal information of the minor need not be disclosed by the medical practitioner in their report under Section 19 or during any criminal proceedings that follow therefrom.

- Most significantly, the court took cognisance of the chilling-effect of a criminal framework on healthcare professionals and the consequent barriers to safe abortions for pregnant persons, noting that access to abortions was not an issue restricted to cis-gender women alone, but one that affected all persons with capacities for pregnancies, which includes transgender and gender diverse persons. It further noted the pressing need for decriminalisation of abortion to counter the social stigma as well as legal barriers that hamper access to abortions, especially for marginalised persons.

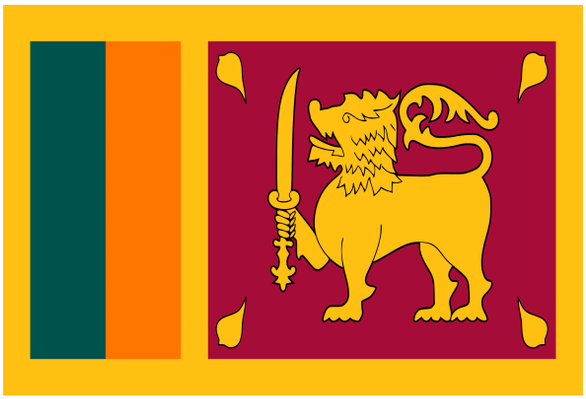
Post-Abortion Care in India

The Ministry of Health and Family Welfare updated the Comprehensive Abortion Care (CAC) package in April 2023 which includes the provider's manual for conducting CAC services. They also released Operational Guidelines for programme managers to implement and monitor the services. These manuals and guidelines include post-abortion care, counselling and contraception.

MA Pills

In 2003, the MTP Rules notified under the 2002 Amendment to the MTP Act introduced MA Pills, allowing RMPs to provide the combipack of Mifepristone and Misoprostol in a clinic setting for terminating pregnancies up to seven weeks of gestation, provided that the RMP has either on-site capability or access to a facility capable of providing surgical abortion in the event of a failed or incomplete medical abortion. As per the 2021 Amendments, MA pills are now allowed upto nine weeks.

9. Sri Lanka



- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- ABORTION IS PERMITTED ONLY TO SAVE THE LIFE OF THE WOMAN
- LAW PROHIBITING GENDER-BIASED SEX SELECTION

Criminal Provisions under the Sri Lankan Penal Code

In Sri Lanka, abortion is illegal unless a pregnancy is terminated because the life of the pregnant woman is at risk. Section 303-307 of the Sri Lankan Penal Code of 1883 criminalise abortion. Section 303 of the Code states:

> ***"Whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to a fine.***
>
> ***Explanation- A woman who causes herself to miscarry is within the meaning of this section."***[60]

Section 304 of the Code criminalises acts penalised under Section 303 where the act causing the miscarriage is done without the consent of the pregnant woman. The maximum punishment imposed under this provision is imprisonment of either description for a maximum term of 20 years along with a fine.

Section 305 criminalises any act which is done with the intention of causing a miscarriage and results in the death of the pregnant woman. In such cases, the law imposes a penalty with maximum imprisonment of 20 years and fine. For a conviction under Section 305, it is not necessary that the individual charged with an offence under this section should have prior knowledge that their act will result in the death of the pregnant woman.

Section 306 criminalises an act done with intent to prevent a child being born alive or to cause it to die after birth, unless it is done in good faith to save the life of the 'mother' with a punishment of ten years or fine, or both.

Section 307 criminalises acts causing the death of a 'quick unborn child' by any act amounting to culpable homicide which is penalised with a maximum imprisonment of ten years or fine or both.

There have been several attempts at reforming the colonial-era abortion laws in Sri Lanka, the first being in the late 1990s when the abortion issue was discussed by several members of the parliament during the parliamentary debate, but there was no development. The debate was revived in 2011, when the Minister of Child Development and Women's Affairs raised the issue of abortion law reform in Parliament.[61] The National Action Plan for Human Rights 2011 also included the goal to decriminalise abortion in instances of rape and significant 'foetal' anomalies. In 2013, a draft bill was prepared by the Law Commission that permitted abortion if it was a result of rape, incest or in case of significant 'foetal' anomalies. However, the bill did not pass. The Catholic Church of Sri Lanka opposed the bill, and Buddhist clergymen also voiced opposition in interviews.

In 2017, Justice Aluvihare of the Special Committee on amending the Penal Code and the Code of Criminal Procedure Act recommended allowing for abortions in cases of rape, incest, and cases of serious 'foetal' anomalies, or where the pregnant person was below 16 years of age. The cabinet approved a draft Bill allowing for abortion in cases of rape and "lethal congenital impairments."[62] However, the Bill drew much opposition, especially from religious lobbyists, following which it was put on hold. On March 8, 2022, Justice Minister Ali Sabry requested Members of the Parliament to initiate a conversation on the issue of legalising abortions in cases where the pregnancy results from rape.

National Guidelines for Post Abortion Care

Unlike other countries, Sri Lanka has no statutory framework on the legal procedure for providing abortion services. There are, however, the National Guidelines for Post Abortion Care, 2015 published

by the Ministry of Health, Nutrition and Indigenous Medicine that provide best and safe practices for healthcare professionals who respond to women seeking PAC in cases of a self-induced or procured abortion in the public and private sector healthcare institutions. Under the Guidelines, abortion is defined as the "loss or termination of a pregnancy beyond 28 weeks."[63] The guidelines also allow women who may have undergone illegal abortions to seek care for any complications without facing criminal consequences. Under these guidelines, healthcare professionals are not allowed to refuse care on the basis of personal or moral reasons.

Child Protection Laws in Sri Lanka

Section 363(e) of the Penal Code of Sri Lanka categorises all sexual intercourse by a man with a woman as rape, irrespective of the consent of the woman if she is under 16 years of age, unless she is his wife who is over 12 years of age and is not judicially separated from the man.

There was a significant amendment to the law in 1995 with the addition of Section 365B (1)(b), making it a criminal offence to engage in sexual acts with an individual under 16 years old, irrespective of their gender. Consequentially, any sexual activity not covered under 363 involving adolescents under 16 is considered a crime.

A clarification was provided by way of a Ministry of Health Circular of January 2015 which aimed to provide SRHS to adolescents. As per the circular:

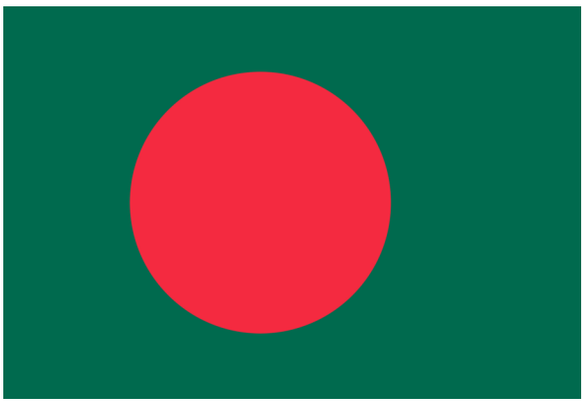
"Since non-disclosure of rape does not fall within the ambit of section of the Code of Criminal Procedure Act and is therefore not punishable under section 199 of the Penal Code, healthcare workers including Medical Officers do not have a legal duty to inform law enforcement authorities of pregnancies among adolescents aged. below 16 years, who access a SRH services."[64]

The 'best interest of the child' must drive the provision of SRHS. The Circular notes that even in the absence of parental consent in the case of a minor, a healthcare provider must be guided by the best interests of the child.

Medical Abortions in Sri Lanka

In December 2010, the Ministry of Health was scheduled to deliberate on the registration of Misoprostol, but this decision was postponed indefinitely. Misoprostol was finally registered in 2015, following which the Ministry of Health introduced Guidelines for Use of Misoprostol in Gynaecology and Obstetrics. These Guidelines were last updated in 2021 and prohibit the use of Misoprostol during the first and second trimesters, unless it is confirmed that the pregnancy is non-viable. The Guidelines also recommend its use during the third trimester only in cases of "women with foetuses dead in utero. It is contraindicated in the presence of a uterine scar."[65]

10. Bangladesh



- HISTORY OF COLONISATION
- ABORTION IS CRIMINALISED UNDER THE PENAL CODE
- POST-ABORTION CARE IS AVAILABLE
- STATE POLICY ON MENSTRUAL REGULATION
- PETITION FOR DECRIMINALISATION OF ABORTION IS CURRENTLY PENDING

In Bangladesh, abortion is criminalised in Bangladesh under Sections 312-316 of the Penal Code of 1860. The only exception is when abortion is provided to save a woman's life. However, Menstrual Regulation (MR) is permitted up to 12 weeks for Manual Vacuum Aspiration (MVA) and 10 weeks for Menstrual Regulation with Medicine (MRM) as part of the family planning policy since 1979.

Criminal Provisions under the Bangladesh Penal Code

Section 312 of the Penal Code states:

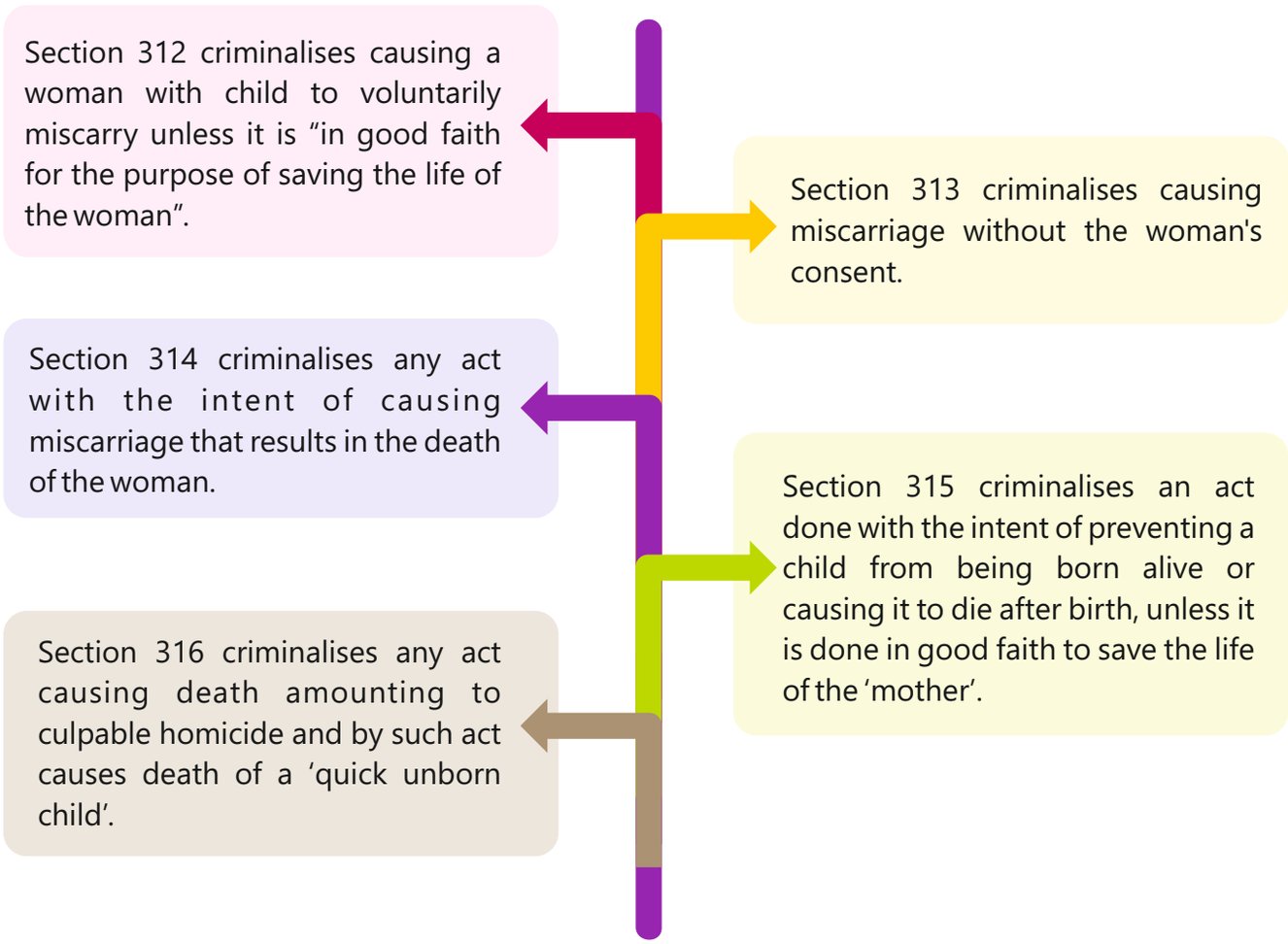
> ***Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.***
>
> ***Explanation.–A woman who causes herself to miscarry, is within the meaning of this section.***[66]

Section 313 penalises causing a miscarriage without the woman's consent with imprisonment for life or for a maximum of ten years and fine.

Section 314 criminalises any act with the intent of causing miscarriage that results in the death of a pregnant woman. The penalty imposed is maximum imprisonment of ten years and fine. But if the act is done without the woman's consent, the punishment could extend to imprisonment for life.

Section 315 criminalises an act done with the intent of preventing a 'child' being born alive or causing it to die after birth, unless it is done in good faith to save the life of the 'mother'; and is punishable for a maximum of ten years, or with fine, or both.

Section 316 criminalises any act causing death amounting to culpable homicide and by such act causes death of a 'quick unborn child' is penalised with a maximum imprisonment of ten years and fine.



Menstrual Regulation

In 1978, the Pathfinder Fund initiated and funded the Menstrual Regulation Training and Service Programme (MRTSP) in seven government medical colleges, located throughout the country, two district hospitals and one family planning clinic.[67] In Bangladesh, MR is a part of the healthcare and birth control policy which facilitates abortion services up to 12 weeks. It does not conflict with abortion laws. Through a government circular in 1979, MR was included in the national family programme stating that MR services should be available in all government and private healthcare facilities. A trained paramedic can provide MR services in cases up to ten weeks of gestation. For cases between 10-12 weeks, MR services can only be provided by a RMP.

Menstrual Regulation involves the use of MVA which uses manual suction equipment to evacuate uterine contents. In Bangladesh, this can be performed up to 12 weeks from the last menstrual cycle. The Bangladesh National Comprehensive Menstrual Regulation and Post-Abortion Care Service Guidelines, published by the Ministry of Health & family Welfare in 2021, approved MR up to ten weeks of gestation. The Guidelines also stipulate that MR and PAC constitute essential healthcare services and must be maintained even when non-urgent or elective services may be suspended.

Post- Abortion Care

The Bangladesh National Guidelines for Comprehensive Menstrual Regulation and Post-Abortion Care Services, 2021 outline post-abortion care in Chapter 1. Post-abortion care is recognised as a critical life-saving measure and is categorised as a 'signal function of emergency obstetric care.' Comprehensive post-abortion care encompasses five essential components:

"**a.** Treatment of incomplete and unsafe abortion and abortion-related complications that are potentially life-threatening.

b. Counselling to identify and respond to women's emotional and physical health needs and other concerns.

c. Contraceptive and family-planning services to help women prevent an unwanted pregnancy or practice birth spacing.

d. Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities in providers' networks.

e. Community and service-provider partnerships to prevent unwanted pregnancies and unsafe abortion, mobilise resources to help women receive appropriate and timely care for complications from abortion, and ensure health services reflect and meet community expectations and needs."[68]

Child Protection Laws

Section 375 of the Bangladesh Penal Code criminalises all sexual activity with a person below the age of 14 years, thus determining the age of consent as 14 years for the purpose of the law penalising rape. The only exception is where the sexual activity is between a man and his wife, and the wife is not below 13 years of age.

The Prevention of Oppression Against Women and Children Act, 2000 also defines child to be a person below 14 years of age.

National Child Policy, 2011

In 2011 the Ministry of Women and Children Affairs introduced the National Child Policy. As per this policy, a child includes any individual under the age of 18 and adolescents are defined as persons between the age of 14-18 years. The policy also stipulates that steps must be taken to ensure the safety and security of children against all forms of abuse and violence and there should be effective public awareness programs to this end. Necessary steps must also be taken to preserve the physiological and emotional health of adolescents by providing education of necessary issues including reproductive health.

The Children Act, 2013

As per the provisions of the Children Act of 2013, all persons under the age of 18 years are defined as children. Section 90 of this Act mandates that any person or organisation that encounters a "disadvantaged child or any child in contact with law or any child in conflict with law"[69] or gets information in this regard shall send the concerned child to the nearest police station or Probation Officer or Social Worker, or in the alternative to the Child Affairs Department or its nearest office. A child in contact with law is defined as any child who has been the victim of an offence under the law, which includes offences under the provisions of the Penal Code. The Probation Officer or Social Worker may asses the child and may then place the child in institutional care as per the provisions of the law.

Decriminalisation Petition, 2020

In 2020, Dr. Syeda Nasrin, a Supreme Court lawyer, filed a petition mounting a Constitutional challenge to Sections 312-316 of the Penal Code. Dr. Nasrin had previously sent a legal notice to the government to draw their attention to the concerns with the criminal provisions impacting access to abortion services. She filed the writ petition after not having received a response. The petition also highlighted the prevalence of abortions in clandestine conditions which lead to health complications. In response, a bench of the High Court Division of the Supreme Court (HCD, popularly known as the High Court), composed of judges Tariq-ul-Hakim and S.M. Kuddus Zaman issues a show-cause notice to the respondents (i.e., four parties, including secretary of the Ministry of Law and the Supreme Court's Registrar General) "to explain within four weeks why five 'anti-abortion clauses' in the penal code should not be revoked and declared illegal."[70]

Medical Abortion in Bangladesh

On September 13, 2012, Mifepristone was approved by the Drug Control Committee (DCC) to be manufactured, sold and administered locally.[71] After receiving approval of mifepristone only, the MRM working group (a network of professional bodies keen to introduced MRM in the country). initiated the process of approval of local manufacturing of mifepristone-misoprostol combination pack for MR. The approval process specifically emphasised the availability of the combination pack, recognising it as a measure to deter the indiscriminate or improper usage of the medicines when employed. The apprehension was that, if mifepristone and misoprostol were dispensed in separate packets, users may utilise only one of them which would decrease the effectiveness and eventually lead to increased incomplete MR, which is a health risk for women. In February 2013, mifepristone-misoprostol combination was introduced for MR to manufacture, sell and administer locally.[72] Notably MA pills may be prescribed up to ten weeks of gestation and pregnancies can be terminated through MVA up to 12 weeks since last menstrual period (LMP).

NOTES FOR CHAPTER II

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3. *Act Decriminalizing Induced Abortion to Save the Lives of Women, Girls, and Persons of Diverse Gender Identities, Amending Article 256-259 of the Revised Penal Code*, SAVE WOMEN'S LIVES: DECRIMINALIZE ABORTION NOW! (2023), https://decriminalizeabortion.ph/wp-content/uploads/2020/12/Proposed-Bill-Decriminalizing-Abortion-v9-Sept-28-CPadilla-10am-launch-final.pdf; About the Campaign, SAVE WOMEN'S LIVES: DECRIMINALIZE ABORTION NOW!, https://decriminalizeabortion.ph/about/.
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10. REPUBLIC ACT NO. 11596 (AN ACT PROHIBITING THE PRACTICE OF CHILD MARRIAGE AND IMPOSING PENALTIES FOR VIOLATIONS THEREOF) (Philippines).
11. *Id.*
12. ANDREA WHITTAKER, ABORTION, SIN AND THE STATE IN THAILAND (RoutledgeCurzon, 2004).
13. *Id.*
14. Andrea Whittaker, *The Struggle for Abortion Law Reform in Thailand,* 10(19) REPROD HEALTH MATTERS 45 (2002).
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16. *Id* at §305.
17. *Id* at §277.
18. ACT FOR PREVENTION AND SOLUTION OF THE ADOLESCENT PREGNANCY PROBLEM, B.E. 2559 (2016), §3 (Thailand).
19. LAW NUMBER 1 OF 2023 ON CRIMINAL CODE (Indonesia), §463(2).
20. Id, at §410 (Indonesia); Jakarta Feminist, *Indonesia's New Criminal Code Strengthens Abortion Provisions but Threatens Democracy and Human Rights,* SAAF (Dec. 9, 2022), https://saafund.org/indonesias-new-criminal-code-abortion/.
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31. Charlotta Siösten, *A minor field study on abortion legislation and practice in Vietnam,* FACULTY OF LAW, LUND UNIVERSITY (Mar. 2014), https://lup.lub.lu.se/luur/download?func=downloadFile&recordOId=4392145&fileOId=4392146.
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CHAPTER III

FINDINGS AND ANALYSIS

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INTRODUCTION

This chapter aims to provide an understanding of barriers to accessing safe and legal abortion services and the relationship with jurisdictional legal frameworks across ten countries in South and Southeast Asia. It undertakes a comprehensive thematic discussion on restrictive laws and the consequent barriers these create or exacerbate, which in turn affects the ability to access abortion services. It uses rich perspectives from the interviews with various stakeholders and experts in the region to inform the arguments around the impact of restrictive laws and the criminalisation of abortion.

The persistent criminalisation of abortion in these countries is deeply rooted in religious, cultural and social norms regarding gender roles and expressions. These norms often confine women's sexuality within highly regulated, patriarchal and cis-heteronormative structures. This societal rigidity gives rise to significant social taboo around abortion services, which manifest differently in diverse socio-cultural settings, particularly concerning the religious perspectives on abortion in some countries.

In many of these countries, individuals who become pregnant often have limited or no decisional autonomy when it comes to their sexual and reproductive health (SRH). Moreover, the few narratives surrounding reproduction and sexuality that do exist are fraught with misinformation and stigmatisation. Abortion services are often associated with moralistic judgments against pregnant individuals, labelling them as promiscuous and likely to engage in 'immoral' behaviour such as extramarital relationships.

The criminalisation of abortion primarily affects the accessibility of abortion services and does not necessarily reduce the total number of abortions being sought. In countries where abortion is criminalised, healthcare professionals often fear legal consequences for providing abortion services, which can include harassment by law enforcement, the imposition of fines and even imprisonment. This fear and reluctance on the part of healthcare professionals to offer abortion services compel pregnant persons to resort to unsafe, back-alley abortion, which can have severe and detrimental health consequences.

Furthermore, this chapter briefly examines the impact of social movements in advocating for legal reforms related to abortion. In some countries, feminist movements have played crucial roles in driving these legal reforms. These movements often take an intersectional approach, recognising and addressing the diverse experiences of individuals in different societies. For instance, countries like Indonesia, Thailand and the Philippines have relatively inclusive feminist movements that consider the perspectives and experiences of persons with disabilities, sexual minorities, transgender and gender-

diverse individuals and others. In Bangladesh, the feminist movement has also made strides in inclusivity by incorporating viewpoints from LGBTQIA+ groups and persons with disabilities. These movements aim to create a more comprehensive and equitable legal framework for abortion services.

This chapter subsequently delves into the hindrances faced by adolescents in obtaining abortion services, stemming from various factors such as laws and regulations concerning the age of consent, moralistic discourses surrounding adolescent sexuality in certain countries, societal prejudices and child protection legislation. In certain regions, the focus of family planning policies is solely on married adult women, thereby limiting the availability of abortion and contraception services to the detriment of adolescents and unmarried persons. The adverse impact of paternalistic child protection laws is the criminalisation of adolescent sexuality, which, when combined with mandatory parental or guardian consent for reproductive services, can impede adolescents' access to abortion services.

Each country encounters unique challenges and opportunities in its pursuit of realising abortion rights. This journey involves enhancing access to abortion services and post-abortion care access, challenging stigmatising socio-political narratives and employing advocacy strategies to advance the decriminalisation of abortion, as elucidated below. These strategies may encompass building robust coalitions among diverse groups working in healthcare and gender rights and employing legal approaches and judicial avenues.

I. Religion, Culture, Social Stigma and Their Relationship with Criminalisation of Abortion

Given the diverse and pluralistic characteristics of South and Southeast Asia, including religion, gender and sexuality norms; colonial and postcolonial legacies; political structures and legal traditions; it is impossible to establish a uniform narrative concerning the multitude of factors influencing abortion access in the region. It is safe to argue that abortion is considered a taboo and is regulated by the law. The concept of abortion taboo is multifaceted and multi-dimensional, constituting a complex stigma that intersects with other forms of discrimination and structural injustices.

A. Stigmatised Status of Abortion

Abortion has been historically contentious across South and Southeast Asia. Outlook on abortion in different societies has been largely informed by how women and their rights are perceived in those respective societies. In many countries, abortion is considered ‘sinful’ and is subject to 'stigma', which is a collective opinion that it is ethically wrong and societally disallowed. Such stigma both causes and results in reproductive inequality, which exists at all levels of society and confuses people about

whether abortion is legal. For instance, in Nepal and Indonesia, abortion is painted in mainstream narratives as a quick fix for irresponsible couples, with additional taboos incurred against unmarried women who seek abortion services.

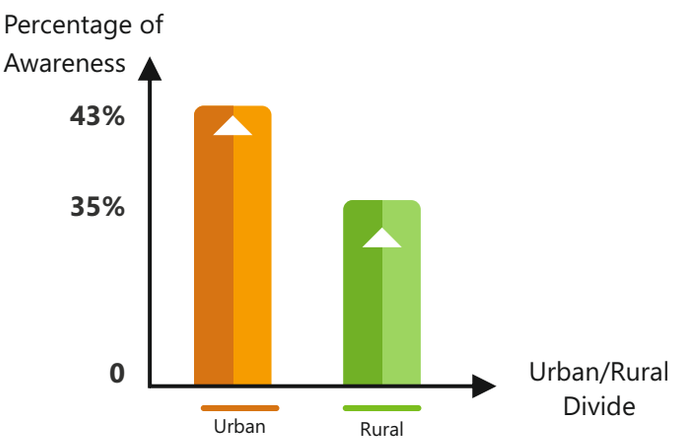
The role of stigma in limiting the availability of abortion services is a multifaceted issue deeply entrenched in societal attitudes and cultural norms surrounding sexuality and reproductive choices. Stigma operates as a formidable barrier that extends beyond legal frameworks, shaping public perception and influencing the accessibility of abortion services in various ways.

First, social stigma contributes to the perpetuation of misinformation and ignorance regarding the legal status and existence of abortion services. Even in countries where abortion is legally sanctioned, the stigma attached to the procedure often leads to a lack of awareness. This lack of knowledge can result in individuals, particularly those in marginalised communities, being unaware of their rights and the availability of resources for safe and legal abortion services.

Second, the fear of judgment and societal condemnation associated with seeking abortion services can deter individuals from accessing the care they need. The stigma surrounding abortion often leads to a culture of silence, where individuals may be hesitant to openly discuss their reproductive needs due to the fear of being ostracised or stigmatised by their communities. This secrecy can create an environment where individuals are forced to resort to unsafe and clandestine abortion practices, risking their health and well-being.

Despite the legality of abortion in several countries, social stigma creates a basic presumption in many people's minds that abortions are illegal and/or unavailable. For instance, Bangladesh has allowed Menstrual Regulation (MR) services since 1979. However, a 2019 study shows that the majority of unmarried women were completely unaware of the existence of such services.[1] Additionally, Nepal has legalised abortion since 2002 and the government has been providing abortion services comprehensively since 2015, but a 2016 study shows that only 41% of women are aware of this in Nepalese society.[2]

Further, there is an urban-rural divide of awareness in Nepal, with 43% of urban women being aware, as opposed to 35% of rural women.[3]



Additionally, the urban-rural divide in awareness, as seen in the case of Nepal, underscores how cultural stigma can intersect with geographical and socioeconomic factors, creating disparities in access to information and services. Rural areas may experience heightened levels of stigma, making it challenging for individuals to access abortion services without facing significant social barriers. Further, in Vietnam, the topic of abortion was rarely addressed in public discourse until the introduction of the draft Population Law in 2015. This proposed bill aimed to prohibit abortions after 12 weeks of gestation, except in cases where the pregnancy resulted from a crime, posed a threat to the health of the pregnant person, or if the 'foetus' was at risk of congenital defects. However, the law never came into effect, and the existing abortion regulations in Vietnam, permit the procedure up to 22 weeks except in cases of gender-biased sex selection.

Additionally, cultural norms that stigmatise sexuality and reproductive autonomy contribute to the perpetuation of restrictive attitudes towards abortion. These norms may be deeply ingrained in societal structures, influencing how individuals perceive and make decisions about their reproductive health. The resulting stigma can manifest in judgmental attitudes from healthcare professionals, further limiting access to safe and non-judgmental abortion services.

Therefore, the role of stigma in the availability of abortion services extends beyond legal considerations and permeates societal attitudes, influencing awareness, decision-making and access to safe and legal reproductive healthcare. Addressing and dismantling this stigma is crucial for ensuring that individuals have the information and resources they need to make informed choices about their reproductive health without fear of judgment. The role of stigma in access to abortion services is linked with specific cultural mores that govern sexuality and bodily autonomy across society. This is discussed in the following section.

B. Cultural Norms, Abortion & Regulation of Women's Sexuality

The cultural prejudices against abortion stem from unjust power structures and the imposition of gender roles that aim to rigidly govern women's sexuality and regulate their decision-making autonomy. Respondent A from India noted that ***"in order to uphold hegemonic structures of power, it is necessary to control women's sexuality, which is considered their 'innate nature' to serve the new social and political arrangements organised by men of the dominant sections of society."*** [4]

These attitudes also persist in Thailand and Indonesia, where abortion seekers are automatically judged as being promiscuous, having inappropriate sexual relations such as premarital sex and are considered immoral. Activists and academics from Indonesia agree that criminalising abortion implicitly criminalises certain sexual behaviours, with women's sexuality always being targeted for such societal moral policing. In Pakistan, healthcare professionals note the highly taboo nature of abortion, which

discourages public discourse around the subject and further misconceptions like only people who wish to hide their extra-marital affairs opt for abortion. Further, in Pakistan, like other countries, abortion-related stigma is highly dependent upon a person's marital status – effectively denying unmarried women their decisional and bodily autonomy. In Sri Lanka, it emerged from interviews that the highly patriarchal and ethnocentric society creates and furthers a collective atmosphere that is restrictive about sexuality, SRH and public discourse. This, in turn, ensures that abortion criminalisation continues in the country.

In South Asia, caste and social relations are inalienably intertwined, with Kiruba Munusamy[5] arguing that Brahminical patriarchy forms the basis for systemic violence against Dalit and Adivasi women in India. Manjula Pradeep[6] highlights how eliminating caste and dismantling patriarchy are interrelated with each other, due to the connection between caste and patriarchy. Srujana Bej, Nikita Sonavane, and Ameya Bokil state that **"[w]hile upper-caste women in independent India have been able to reconfigure their identities and sexuality as being honourable due to the dictates of Brahminical patriarchy, Vimukta and Adivasi women who lie outside the caste system have not been offered the same "redemption." The historical oppression of these communities through colonial practices and the free reign of the caste system have continued their oppression."**[7]

Uma Chakravarti has stated that "caste hierarchy and gender hierarchy are the organising principles of the Brahmanical social order."[8] The entrenchment of the caste system in Indian society involved the regulation of women as the gatekeepers of 'caste purity' away from the perceived threat of Dalit men. Women's sexuality, viewed as their 'innate nature', became highly regulated, to "serve the new social and political arrangements organised by men of the dominant sections of society."[9] In terms of attitudes around abortion, Sundari Ravindran[10] did significant work with Dalit women in the Indian state of Tamil Nadu and found that younger women in the community thought of abortion as sinful and were hesitant to engage in abortion-related discussions, despite admitting that they would seek abortion services if required. Ravindran ascribed this stance by younger women to the relationship between abortion and 'modernisation', where young Dalit women would replicate the values espoused by upper caste, so-called mainstream women around them. In Nepal, interviews indicated that despite an active Dalit movement advocating for Dalit women's rights in the country, Dalit women's perspectives have not been integrated comprehensively into the mainstream women's movement.

The State-sanctioned control of women's sexuality stems from the presumption that women are incapable of making their own reproductive decisions, which is echoed in the highly doctor-centric legal framework around abortion in India that summarily disregards pregnant person's wishes.

Cultural norms that affect perceptions around abortion are significantly affected by religious practices of particular communities and regions. Religious mores that stem from notions of 'sin' impact abortion directly, which in turn affects the construction of legal frameworks governing abortion services.

C. Law and Religion

Religious factors, along with other factors outside the realm of law, impact the overall criminalisation of abortion services in society. Sarah Pugh notes that people's ability to access SRHR is highly **"influenced by the shifting tides of politics and the various configurations of political power that hold sway in specific times and specific places."**[11] In such situations, the priorities of people in power, to retain or grow their power, inform policies that affect the realisation of SRHR. The ways in which people live their lives have been informed, to a great extent, by religious leaders and institutions, which render religious morals as significant factors that influence the law.

The opposition to abortion by religion relies on several moralistic arguments. For example, Christianity, amongst other religions, states that "abortion violates the sanctity of life and is a rebellion against God's design."[12] Further, religion has been used to define 'promiscuity' and restrict acts associated with it, reinforcing traditional moralities and restricting women to the private or domestic sphere. These arguments are ubiquitous when it comes to religious opposition to abortion.

The cultural and social impediments to abortion have a significant impact on accessing abortion services, even when the law is permissive. For example, Vietnam legalised abortion in 1945 and made it widely available since 1960, but social stigma persists, with studies showing that unmarried persons experience grave stress when seeking abortion services due to their self-perceived disregard for traditions.[13] Despite the wide availability of abortion through Vietnam's healthcare system and the *doi moi* reforms,[14] unregulated abortion has witnessed an increase and is frequently administered by State employees in homes or private clinics. In the Philippines, the Catholic Church has been instrumental in fostering a conservative political atmosphere and an overarching pro-life public narrative that criminalises abortion services. The power of the Church to influence policy is seen through the Philippines' regulation of abortion services and contraception access by adolescents. Respondents emphasised that Filipino society considers abortion a 'sin', with the majority of the population being Catholic. They further stated that pro-abortion advocacy has been stymied by the Catholic Church, along with political leaders and candidates.

Approximately 95% of Thai individuals[15] and 70.2%[16] of Sri Lankans adhere to Theravada Buddhism. Within this Buddhist tradition, there is a staunch opposition to abortion, grounded in the fundamental principle of never taking a life. Both traditional Theravada Buddhism and contemporary interpretations

of the faith share the belief that life begins at the moment of conception.[17] Consequently, abortion is explicitly labelled as 'murder' within the framework of this Buddhist perspective on the sanctity of life. Thai laws also criminalise abortion through the Three Seals Laws, the Ayutthayan laws, which provide punishment for those who cause death to another's 'foetus', both intentionally (e.g., by providing MA pills) and unintentionally (e.g., through a fight).[18]

A study conducted by the Family Planning Association of Sri Lanka published in January 2023 relies on findings from survey responses and focus group discussions conducted across 25 districts in Sri Lanka. The study was conducted to determine public perceptions and attitudes towards abortion in Sri Lanka and also notes the religious opposition to abortion. As per this study,[19] women who considered abortion to be a 'sin' were significantly influenced by religious factors. For Christian female respondents, abortion was considered 'murder' as per their religious beliefs. In Buddhism, the opposition to abortion came from the recognition of prenatal (foetal) personhood and therefore abortion was an 'inhuman act' and a 'sin'. For the women who were Muslim, the 'opposition to abortion' was because abortion was perceived to be against their religion unless the abortion services are provided in unavoidable circumstances where there are health issues or the possibility of transmission of disease. Some Hindu women also considered abortion a 'sin', but it was not because it goes against their religion.

Nepal, which was a Hindu Kingdom till 2008, criminalised abortion under the Criminal & Civil Country Code, 1854, and provided penalties for causing abortion.[20] Religious and moral norms substantially affected the development of Nepalese society, especially that of Hinduism. In Nepalese Hindu religious scriptures, abortion is considered a 'sin'. This resulted in the criminalisation of abortion in Nepal and pregnant persons seeking abortions were often abandoned by their husbands, for fear of penal consequences. Despite the subsequent partial decriminalisation of abortion in Nepal, prevalent religious views around abortion persist in the backdrop of mainstream societal views which consider having many children a 'blessing'. Only in recent times have contraceptives and abortion services become slightly more acceptable in society.

In Indonesia, six religions are legally recognised, including Hinduism, Buddhism, Islam, Christianity, Catholicism and Confucianism. All of them significantly impact culture and politics in the country, which, in turn, affect social attitudes and legal reform, especially around abortion. Malaysia's abortion laws are relatively less restrictive in nature, but issues such as lack of sex education and awareness of SRHR and pervasive religious narratives contribute towards the ongoing taboo against abortion. In India, religious institutions play a relatively minor role in shaping abortion narratives, with some exceptions in states like Kerala, where the Catholic Church has been involved in opposing abortion.

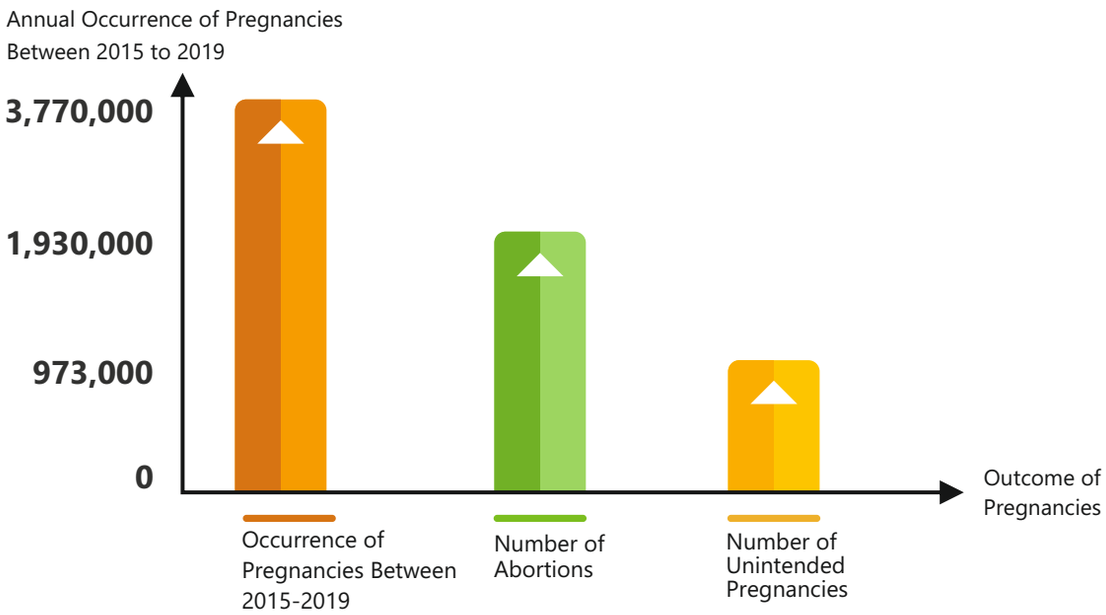
Both religious beliefs and sociocultural norms significantly influence public attitudes towards abortion and can be accompanied by laws that criminalise abortion services and impose restrictions on access to these services. The restricted access to abortion services disproportionately affects marginalised communities, which already grapple with the complex interplay of factors such as gender, sexuality, age, disability, caste, class, religion, and ethnicity among others, when trying to exercise their healthcare rights. The criminalisation of abortion also affects the willingness of healthcare professionals to provide abortion services due to the potential risk of criminal prosecution. Further, religious beliefs can influence legal regulations and this manifests through provisions that support conscientious objection.

Conscientious objection has been recognised as creating impediments for access to safe abortion services, potentially compromising reproductive rights. The objection regarding reproductive health services presents varying perspectives across Bangladesh, the Philippines and Indonesia. In Bangladesh, healthcare providers are mandated by guidelines to prioritise the immediate health and life of women, ensuring that services like Menstrual Regulation (MR) and Post-Abortion Care (PAC) are not denied. Refusals based on personal convictions or skill deficiencies require providers to promptly refer clients to alternative caregivers. Conversely, within the Philippines' judicial landscape, the Supreme Court allowed healthcare providers to decline reproductive health services due to religious beliefs. However, emergency situations, where the life of the pregnant individual is jeopardised, necessitate immediate intervention. In Indonesia, where explicit regulations are lacking, providers can decline services based on competence or facility limitations, but they must ensure timely referrals. The following section delves into the impact of criminalisation on abortion access, highlighting the severe consequences for marginalised persons and adolescents.

III. Impact of Criminalisation on Access to Abortion

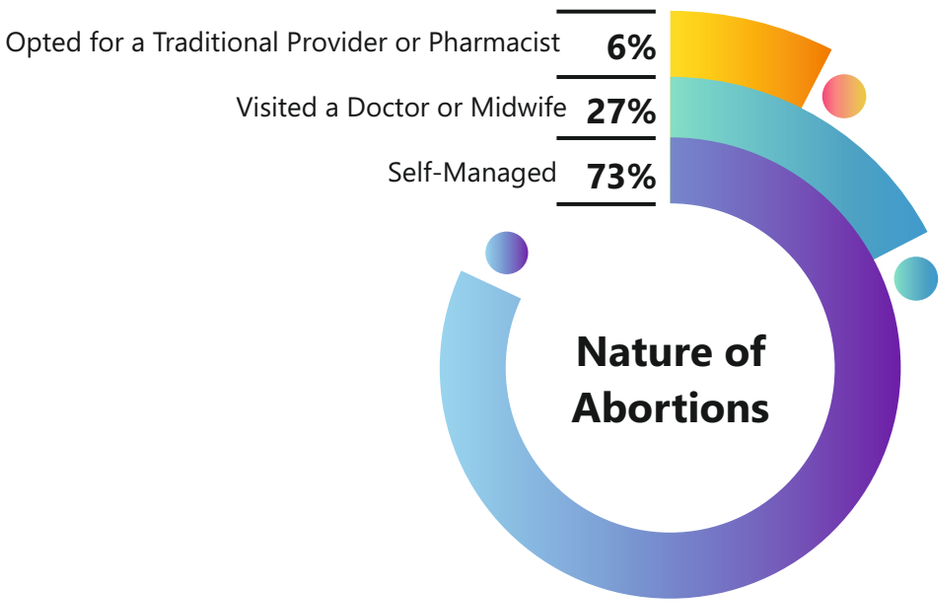
Stigma surrounding abortion can be correlated with criminal provisions that punish abortion as a crime. This has been seen in the Philippines, where pregnant persons are left without any options, apart from getting an unsafe abortion or carrying an unwanted pregnancy to term.

A 2022 report from the Guttmacher Institute highlights the situation in the Philippines between 2015 and 2019, revealing a total annual occurrence of 3,770,000 pregnancies. Alarmingly, 1,930,000 of these pregnancies were unintended, leading to 973,000 abortions.[21]



Further, the University of the Philippines' recent estimate in 2020 notes an increase in the rates of induced abortions during the time of the Covid-19 pandemic, estimating that 1.1 million abortions occur in the Philippines annually.[22]

The situation is similar in Indonesia, where a 2018 study showed that 73% of abortions were self-managed in nature. Of the remaining 27%, 21% women reported going to a doctor or midwife and 6% opted for either a traditional provider or pharmacist.[23]



In line with the global discourse, the criminalisation of abortion has not reduced the number of abortions in Indonesia, with the 2018 study showing the occurrence of 1.7 million abortions in Java – which is much higher than the regional abortion rate in Southeast Asia.[24]

Earlier, abortion-related debates mainly consisted of decriminalising these services to promote access to safe and legal abortion, but now, medical abortion that are self-administered have irrevocably altered the discourse. MA is the 'safest type of abortion available' for early-stage pregnancies, using a combination of mifepristone and misoprostol to terminate pregnancies till a gestation of 12 weeks as prescribed by the WHO in the updated guidelines on medical abortion.[25]

However, accessing these pills in many countries remains a challenge. For instance, in the Philippines, misoprostol is not listed as an essential drug and the tablet of Misoprostol 200 mcg is branded as "CYTOTEC". Although Cytotec is mentioned as a treatment for duodenal and gastric ulcers, it is listed as an unregistered drug by the Food and Drug Authority of the Philippines and is therefore not available even for duodenal and gastric ulcers.[26] In Indonesia, Misoprostol is registered only for gastric ulcers.[27] In Thailand and Vietnam, it was seen that MA pills can only be obtained from specific clinics or hospitals under prescriptions, rather than being easily accessible at pharmacies. In Malaysia, misoprostol is only registered for the treatment of gastric ulcers and is difficult to access, due to social stigma around abortion that render service providers hesitant or unwilling to stock and provide these pills. Respondent C, a Doctor from Malaysia also noted how the unavailability of MA pills (Misoprostol) was not so much on clinical grounds but to restrict access to abortion services, which has compelled individuals to seek online avenues for purchasing these pills. Further, with the outbreak of Covid-19, there has been an increase in requests for terminations after 15 weeks given the lack of access to MA during the pandemic via telemedicine, this has meant that abortion services are expensive for those seeking them.[28]

Moreover, in Sri Lanka, the widespread use of MA pills as over-the-counter drugs has emerged as the predominant approach for terminating pregnancies. It is important to highlight that both Misoprostol and Mifepristone are not officially approved for obstetric use in Sri Lanka. Misoprostol has been categorised as a Class 3 drug by the Cosmetics Devices and Drug Authority of Sri Lanka, designated for hospital use in managing incomplete abortion and postpartum haemorrhage.[29] The surge in the availability and popularity of MA through private channels, combined with the elimination of legal consequences for seeking post-abortion care, has contributed to a reduction in complications and maternal deaths related to abortion.[30] However, Respondents noted that Misoprostol is not readily accessible since it is not registered for use as an 'abortifacient'. The healthcare professional who provides this option to a pregnant person will likely refer them to the pharmacies that have the drug, and the purchase is likely to be surreptitiously done as the pharmacist risks losing their licence. This effectively means that MA pills are easily available in the black market without proper guidance on their usage for abortion services and are effectively inaccessible for socioeconomically marginalised persons.

MA PILL ACCESSIBILITY

Key

Maroon- Not available.

Red- Deregistered for MA.*

Orange- Registered but not for MA.**

Blue- Approved for use in hospital settings.

Green- Legally Available***

* In Malaysia, Mifepristone is not registered and misoprostol has been deregistered for use for MA.

** In Indonesia, only Misoprostol is registered for gastric ulcers. Mifepristone is not registered.

*** In Sri Lanka, Misoprostol is registered but has restricted use for MA.

The stigma around abortion is perpetuated by criminalisation, which actively contributes to the gender stereotyping of women,[31] as universal 'mothers' to impede abortion access. Such stereotypes ascribe a 'selfless' and self-sacrificing nature to pregnant persons, which when compounded with a criminalising legal framework, influences pregnant people's decision to carry unwanted pregnancies to term, opt for safe abortion (if available and accessible) or avail back-alley, unsafe abortion.

Aside from the clear effect of criminalisation in restricting (or cutting off entirely) safe avenues of abortion services for pregnant persons in different countries and perpetuating a 'chilling effect' amongst healthcare providers that discourages the provision of even legal abortion services, criminalisation violates pregnant persons' basic autonomy to make reproductive decisions that impact their bodies. Autonomy entails that pregnant people must be able to make free and voluntary decisions with respect to their bodies, without any type of coercion, intimidation or pressure. The situation wherein pregnant persons are forced to carry unwanted pregnancies to term because of oppressive systems around them, including criminalisation, that disregard their autonomy can have grave consequences on their physical and mental health. The autonomy of pregnant persons is curtailed in many countries based on notions of prenatal (foetal) personhood that have more public visibility in American debates but are used more marginally in the South and Southeast Asian discourse (it is used in the Philippines). Despite country-wise variations on how abortion is perceived, restrictive laws are based on some common justifications, including those of prenatal personhood and consequent 'murder' through abortion as well as the paternalistic idea of 'future regret' by the pregnant person.

Both domestic and international human rights frameworks do not support criminalisation of abortion services. The WHO states that restrictions on abortion increase the deaths and maternal morbidity associated with unsafe procedures.[32]

Other international human rights organisations have gotten involved in certain cases to reiterate how criminalisation reinforces patriarchal gender stereotypes that grant primacy to the 'foetus' over the life and well-being of the pregnant person, a view which has been echoed by the United Nations Human Rights Council (UNHRC) and the Inter-American Commission on Human Rights (IACHR). The Committee on Elimination of Discrimination Against Women (CEDAW Committee) spoke out against banning contraceptive access, characterising it as 'grave and systemic violations' of women's rights, labelling the non-provision of abortion services as a human rights violation against women's right to health. The criminalisation of abortion creates varied impediments for different demographics, which are delineated and explored in the following section.

IV. Criminalisation Creates Fear of Prosecution

Globally, unsafe abortion is one of the substantial causes of maternal death, particularly in marginalised groups.

Comparison of maternal mortality ratio (MMR), number of maternal deaths and percentage change in MMR, by United Nations Sustainable Development Goal (SDG) regions, 2000 and 2020[33]

SDG subregion	2000		2020		Overall change in MMR between 2000 and 2020 (%)
	MMR point estimate	Number of maternal deaths	MMR point estimate	Number of maternal deaths	
Southern Asia	**408**	**166 000**	**134**	**47 000**	**67.1**
South-Eastern Asia	**231**	**26 000**	**134**	**15 000**	**41.8**
World	**339**	**446 000**	**223**	**287 000**	**34.3**

The countries analysed in this report show significant prosecution rates that ultimately impede access to safe, timely and affordable abortion services as discussed next.

A. Evidence of Prosecution and Intimidation in Southeast Asia

The criminalisation of abortion through legal provisions that are vague, ambiguous and/or punitive in nature shows significant prosecution rates in countries like Indonesia, the Philippines and India among others.

In 1989, Malaysia made amendments to its Penal Code aimed at broadening the scope for legal abortion. Over the past few years, there has been a notable surge in advocacy related to SRHR in the country. As a result, the incidence of unsafe abortion has considerably decreased, with the most recent prosecution related to abortion occurring back in the 1980s. For instance, in the case of *Public Prosecutor v. Dr. Nadason Kanagalingam,* a medical practitioner faced charges of 'causing miscarriage' for administering saline injections to treat a pregnant woman's varicose veins, which subsequently led to premature labour within 24 hours. The doctor argued that he had performed the procedure in good faith to save the woman's life. However, the court ruled that the "act of causing miscarriage was not conducted in good faith" and emphasised that abortion should only be considered as a last resort.[34] Nevertheless, this specific case does not accurately represent the broader context. Activists and healthcare professionals argue, contrary to popular belief, that Malaysia's abortion laws are liberal and have effectively kept the abortion rates low in the country due to their permissive framework.

However, a distinct case highlights the vulnerability of marginalised individuals, such as migrant workers, who continue to face significant barriers to accessing timely, safe, and affordable healthcare services. In this instance, a Nepalese migrant worker, whose name has been changed to Mala for confidentially purposes, was arrested in 2014 for seeking an abortion and subsequently sentenced to one year in prison. Mala had been six weeks pregnant when she sought an abortion at a local clinic, fearing that disclosing her pregnancy would lead to the loss of her job. The medical practitioner argued that he had acted 'in good faith' given the circumstances. Nonetheless, the trial court convicted Mala, and she spent 16 weeks in prison before being acquitted by an appellate court and released, with the court citing the potential risks to her life if the pregnancy continued.[35]

Respondent C clarified in the interview that "the case involving Mala in 2014 was unique, being the sole instance of prosecution under the 1989 Penal Code. Notably, the prosecution under Section 315, which addresses the prevention of live birth and is typically relevant to late-term termination cases, was deemed inappropriate in this context. Mala was only six weeks pregnant, making Section 312 more applicable to her situation. Her acquittal was achieved by presenting the Court with the specific circumstances she faced as a migrant worker, emphasising the distress she would have endured if compelled to carry the pregnancy to term. The use of section 315 may create a precedent to nullify section 312. Its ambiguity is worrying, and its application must be clarified."[36]

As noted in Chapter II, abortions are regulated by the relevant provisions of the Malaysian Penal Code and are permitted under certain conditions. Annually, approximately 100,000 abortions occur in the country,[37] the majority being safe abortion carried out by healthcare practitioners. The government has taken steps to reduce maternal mortality by allowing abortion in cases where childbirth poses a physical or mental health risk to the pregnant individual.[38] In 2012, the Ministry of Health introduced guidelines for pregnancy termination, which were distributed to affiliated hospitals.[39] **Additionally, a significant legal precedent was set in the case of *Chin Yoke Teng v. William Ui Ye Mein*. The Court of Appeal ruled that a 'foetus' is a distinct biological entity from the 'mother', not recognised as a legal person, and thus, legal abortion does not constitute an offence under the law**.[40]

In Indonesia, abortion is criminalised through Articles 346-349 of the Indonesian Criminal Code (ICC), without any specified exceptions. However, Health Law No.36 of 2009 (Health Law 2009) permits abortion services under certain conditions. The recent Omnibus Health Law allows for termination of pregnancies up to 14 weeks for survivors of sexual assault as discussed in Chapter II.

In Indonesia, Respondents spoke about an incident in 2018, where a 15-year-old adolescent was imprisoned for abortion, which she obtained pursuant to being raped repeatedly by her brother. She was sentenced for six months for the abortion that was carried out beyond the legal gestational limit of six weeks, at the first stage of trial. She filed an appeal to the High Court in Jambi and was subsequently acquitted, as her application was supported by women activists and NGOs working for women's rights, who supplied amicus briefs, and whose contribution was also acknowledged as valuable input by the High Court.[41] The case garnered global attention, with women's rights activists expressing outrage and frustration over the punitive measures meted out to the adolescent. The Respondents also highlighted how healthcare professionals are routinely harmed and prosecuted after they provide abortion services, with frequent clinic raids by the law enforcement agencies. Many Respondents brought up

one such instance of a very senior healthcare professional's clinic being raided because he was providing abortion services. In 2020, three doctors others along with 14 nurses were arrested on the suspicion of providing illegal abortion services. The Clinic where the arrests had been made was operating in Senen, Central Jakarta for five years. One of the doctors arrested died while in custody owing to Covid-19 related complications at the National Police Hospital in Kramat Jati, East Jakarta on September 30, 2020.[42] Another incident that took place in 2020 involved the arrest of six healthcare professionals (three doctors, two nurses and one midwife) for providing abortion services in Jakarta along with two couples at the clinic who were seeking abortion services.[43] Further, an incident involved a 12-year-old girl who was raped in 2021 and whose request for legal abortion was rejected by Jombang police officials.[44]

Instances of prosecutions can also be traced through an analysis of court cases on abortion. A rigorous study was conducted by one of the Respondents to map Court decisions on abortion and analyse the implications of the regulation of abortion. The study found that the people most often criminalised are companions and/or spouses/partners of persons getting abortion, creating a chilling effect on supporting persons getting an abortion. The study also found that the Court often invoked child protection laws to penalise violations of the rights of 'child in womb' as these laws attribute the status of a "child" to the 'foetus'. Thus, apart from formal criminal action taken against abortion seekers and healthcare professionals, they also experience significant harassment, coercion and intimidation at the hands of the law enforcement agencies. The criminal laws, particularly around abortion, are enforced only in certain cases where accused persons have been 'bothersome' to authorities or against political minorities, with little to no bargaining power in such situations.

The legal framework in the Philippines follows colonial patterns of criminalisation of abortion services, as stated by several Respondents. Philippines' national policy asserts that abortion services are illegal, removing protection for women, such as confidentiality and reporting mechanisms for any abuses, setting the stage for poor access to safe abortion services. These restrictive laws translate into frequent media reports in the country about women being arrested and prosecuted. One such case occurred in 2013 where a couple had bought 16 Cytotec pills (misoprostol) to induce an abortion but were constrained to visit a hospital due to later complications – and were arrested.[45] In another incident, a woman from Manila had taken an unregistered medicine to induce an abortion but started haemorrhaging, due to which she had to visit a healthcare facility.[46] The medical practitioner denied her treatment unless she confessed to obtaining an illegal abortion, after which they immediately reported her to law enforcement, and she was arrested. Another case involved the arrest of an 88-year-old midwife and her assistant for providing abortion services to an 18-year-old, who died two days after the procedure. The arrests took place pursuant to an undercover 'entrapment' operation, where a police official posed as an abortion seeker and approached them.[47] This is not an uncommon occurrence in the

Philippines, where doctors are fearful of providing abortion services because of possible entrapment by the police.

In Thailand, the right to avail of public health services is protected by the Constitution, but pregnant persons are still unable to realise such rights because of restrictive laws in the past. Abortion was decriminalised in Thailand on request up to 12 weeks and permitted the termination of pregnancies between 12-20 weeks with prior consultation from one medical practitioner. Women seeking abortion between 12 to 20 weeks of pregnancy need to have prior counselling and consultation with and receive approval from an authorised medical practitioner. However, abortion services beyond 20 weeks of gestation are not allowed. A more liberal draft that sought to permit abortion up to 24 weeks was rejected by the House of Representatives.[48]

As in other countries, healthcare professionals hesitate to provide abortion services on account of fear of prosecution, and even when they provide abortion services, they try to protect themselves using narrow interpretations of the law. Before the decriminalisation of abortion services, several incidents of prosecution were reported in Thailand, against both healthcare professionals and abortion seekers. For instance, a 2015 raid in the Muang district of a drugstore and beauty salon that was providing abortion services to adolescents led to arrests of prior offenders (under the same law) who had already spent a year in jail.[49] In 2017, law enforcement arrested and charged a nurse for providing abortion services to university students, under legal provisions that punished the running of an unauthorised clinic, disallowed the running of a medical institute without proper licenses and selling medicines without appropriate permission.[50] Another case involved the arrest of a 17-year-old for late-stage abortion of her 8-month pregnancy, under both illegal abortion as well as potential 'murder' charges.[51] In 2018, law enforcement arrested a medical practitioner along with their assistants, for providing abortion services in Prachuap Khiri Khan.[52]

Evidence from Southeast Asia shows that criminalisation manifests frequently in prosecution, or harassment and intimidation by law enforcement or lack of access to legal abortion services as is seen in Malaysia. Similarities exist in the South Asian context around abortion as well, as seen in the next section.

B. Evidence of Prosecution and Intimidation in South Asia

The widespread criminalisation of abortion and associated criminal prosecutions that are evident in Southeast Asia are also commonplace in South Asia. Legal frameworks around criminalisation of abortion services often stem from colonial laws or their underlying mores. Further, when there is no

rights-based framework around abortion laws, rampant criminalisation of abortion seekers and providers occurs in countries such as Bangladesh, India, Nepal, Pakistan and Sri Lanka. Instances of prosecution are provided below.

Under the Indian Penal Code, the British criminalised 'causing miscarriage' or abortion that applied to Bangladesh, Pakistan and India. The law allowed for prosecution of both for the abortion provider as well as the abortion seeker, with the only exception being when the abortion was "caused in good faith to save the life of the pregnant woman."[53]

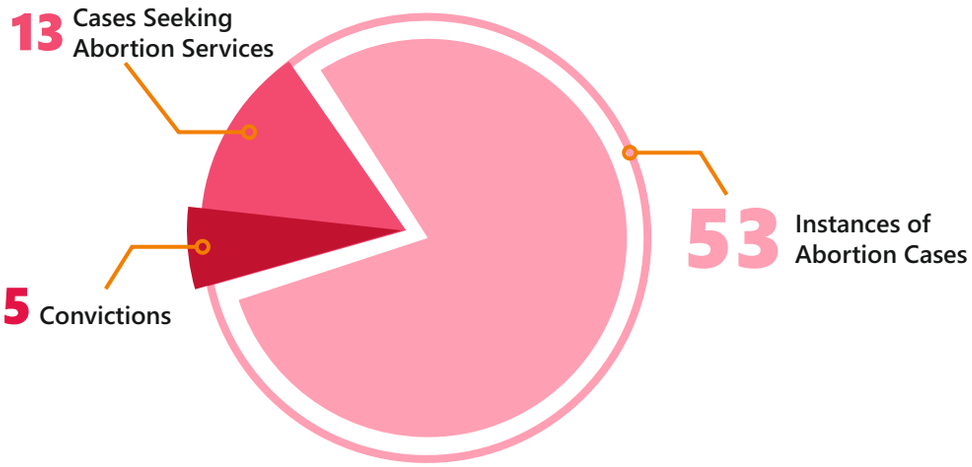
In Bangladesh, Respondents stated that the majority of medical practitioners who accede to abortion requests often require parental or spousal consent (that is not a legal requirement) to protect themselves from prosecution. In 2022, a law enforcement authority arrested a medical practitioner providing abortion services, who was later sentenced to imprisonment. It was argued before the Court that the law uses the term 'miscarriage', and not 'abortion', which ascribes legislative intent to protect pregnant women from abuse, but the implementation has served to deter pregnant women from seeking safe abortion services.[54]

India has seen its fair share of prosecutions of healthcare professionals for providing deemed illegal abortion services. As recently as 2021, a law enforcement authority arrested a medical practitioner for providing abortion services to an adolescent who falsely stated that she was 19 years old to terminate her pregnancy without having to obtain parental consent. The facts of the case show that first, the doctor who was arrested was a registered medical practitioner (RMP) legally authorised to provide abortion services and second, he did not actually provide the service since the patient changed her mind before the procedure. The doctor was arrested under Section 312 of the Indian Penal Code, 1860 (IPC), Section 23 of the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PCPNDT) and Section 5(3) of The Medical Termination of Pregnancy Act, 1971, (MTP) and was detained for a month. He had to go through the entire criminal justice process despite not even providing the actual abortion service.[55] In another case, the police blocked an entire hospital in Tamil Nadu, on the basis that the healthcare professionals were unauthorised to provide abortion services - this escalated to the High Court, which noted the illegality of such police actions.[56]

As discussed in Chapter II, the legal framework around abortion in India is muddied by other laws including the POCSO and the PCPNDT Acts that further the ambiguities around the legality of abortions, fostering an oppressive and punitive framework. This contributes to the overall legal obstacles surrounding abortion services in India. Such barriers dissuade healthcare professionals from offering even legally permissible abortion services as mandated by Indian law.

In Nepal, prior criminalisation of abortion continues to result in prosecution for 'illegal' abortion across the country, despite legal reforms in 2002. One specific instance occurred in Siraha district, where an abortion seeker, her partner and the healthcare providers were all arrested and prosecuted for suspected abortion. They were convicted by the trial court but later acquitted on appeal, because the police failed to prove the offence with sufficient evidence.[57] Another incident occurred when a 15-year-old rape survivor became pregnant and terminated the pregnancy at 20 weeks' gestation by consuming MA pills that she obtained from a local pharmacy. She, her father and the pharmacist who sold her the MA pills were all arrested and charged with providing an illegal abortion, with the Court ultimately convicting the adolescent based on her confession that she had taken the pills to protect her family's reputation. The Court acquitted the father and the pharmacist on the grounds that the former had tried to stop the adolescent from taking the MA pills. Further, there was a lack of evidence to prove that the latter was also culpable.[58]

Moreover, a research investigation conducted in 16 districts of Nepal aimed to document the practical implications of criminalisation for pregnant individuals. The study[59] revealed that between 2011 and 2016, there were 53 instances of abortion cases brought before the courts. Among these, 13 cases were directed at those seeking abortion, resulting in 5 convictions.



Between 2011 - 2016

The study demonstrated women's vulnerability to being prosecuted based on suspicion by law enforcement, without any comprehensive inquiry or investigation. Further, ambiguity among the police on how to define and distinguish between miscarriage, stillbirth, infanticide and abortion has resulted in situations where they prosecute women for "intentional homicide even when the cause of a newborn's death was undetermined, or for illegal abortion for experiencing a miscarriage."[60] However, there are no reported cases of prosecution after 2018.

In Pakistan, there is no publicly known record of prosecuting individuals seeking abortion or healthcare providers involved in the procedure. However, there have been cases where criminal proceedings were initiated through First Information Reports (FIRs).[61] A study[62] documented three such instances in Karachi. Of these, one was a case of a pregnant woman who had complained against her abusive husband for causing her miscarriage. Another complaint had been filed by the father-in-law of the woman for seeking abortion services while she was still married, and giving birth had been one of the conditions for grant of alimony in the separation agreement with her husband. The third complaint was filed by a woman against the family of her second husband who she alleged had forced her to terminate a pregnancy from her first marriage. Despite the absence of publicised prosecutions, respondents have indicated a 'chilling effect' due to the criminalisation, impacting the willingness of healthcare providers to offer abortion services. In Sri Lanka, there are frequent reports of prosecution for illegal abortion. In Ekala in 2010, law enforcement raided an abortion clinic and arrested a doctor for providing abortion services.[63] Two pregnant abortion seekers were also taken into police custody before being sent to another healthcare facility to carry out medical checks.[64] Two other raids of abortion clinics have also been highly publicised in Sri Lanka, where police arrested the doctors in charge.[65] Police also arrested a medical officer from Maskeliya on grounds of providing an abortion service to an 18-year-old.[66] Further, in 1996, numerous individuals, including two doctors in the Kandy district, faced arrests for providing abortion services.[67] As recently as 2020, a Telegraph article reported that due to the restrictive legal framework, several women resorted to backstreet abortion, putting their lives and long-term health at risk.[68] Efforts for legal reforms, including recommendations from the Justice Aluminate Special Committee to permit abortion under specific conditions such as rape and severe foetal anomalies, have encountered delays and obstacles.[69]

In the interviews, Respondents spoke about the criminalisation of abortion services through legal structures as well as other institutional barriers. For instance, many Respondents pointed out that abortion services were readily available in private facilities but came with exorbitant expenses. This discrepancy mainly arises due to the stringent legal framework, subjecting the availability of services in public hospitals to intense scrutiny. The following section discusses how marginalised persons bear a disproportionate burden of the structural barriers and criminal regulation of abortion services.

V. Disproportionate Impact of Criminalisation on Marginalised Persons

In Jakarta, Indonesia, Rara (name changed), a student, was in a consensual relationship that resulted in a pregnancy she needed to terminate. Rara's partner had been in another relationship at the time, which cemented her decision to proceed with an abortion, also for the sake of her conservative and traditional parents. Given the restrictive laws on abortion, Rara sought an abortion in a small local clinic that had a reputation for providing illegal abortion services, where she was treated rudely by the doctor and staff

alike. She thereafter experienced post-abortion complications with severe pain during menstruation, but due to her prior trauma at the clinic and the overall taboo around abortion, she resisted seeking medical attention for a whole year.[70] This story is merely illustrative of the larger problems around abortion access plaguing pregnant persons, particularly marginalised persons, for whom criminalisation has all but precluded access to safe, legal and affordable abortion services.

The international community has criticised the criminalisation of abortion services, as highlighted by the WHO.

In countries where abortion services are restricted either structurally or legally, the WHO observes that only affluent individuals can afford costly, private-sector abortion services, leaving economically disadvantaged individuals with no choice but to resort to unsafe, clandestine procedures as is seen in the case of Sri Lanka. This socioeconomic disparity contributes to severe health repercussions for those with limited financial means, leading to elevated morbidity rates. Additionally, there exists a notable disparity among individuals unable to access private healthcare facilities, particularly affecting marginalised groups such as Indigenous persons, gender and sexual minorities and immigrants. These groups face barriers even when attempting to utilise public facilities, often resorting to unsafe abortion methods at home.

The improper self-administration of abortions can result in serious health complications. Unfortunately, the criminalisation of abortion deters marginalised individuals from seeking post-abortion healthcare services, as illustrated by the example from Indonesia. Further, a study[71] from September 2023 reported that survivors of sexual violence in Indonesia have not received legal abortion care due to bureaucracy and apathy, and this has resulted in unwanted pregnancies at an early age.

As previously mentioned, beyond the legal criminalisation of abortion, several systemic obstacles hinder marginalised individuals in India from accessing safe abortion services. These barriers include the unavailability of accessible public healthcare facilities, especially for persons with disabilities, as well as the prejudiced behaviour exhibited by healthcare staff towards the marginalised groups. Additionally, the substandard quality of these facilities further discourages safe abortion services. Interestingly, despite widespread scepticism about public healthcare, statistics indicate that women, individuals from rural areas, indigenous persons and economically disadvantaged groups tend to rely on these facilities for hospital care.[72] Similarly, in Bangladesh, the accessibility of SRH services for persons with disabilities is heavily influenced by the biases and preconceptions of healthcare providers. Numerous factors, including societal taboo, stigmatisation, limited knowledge, financial limitations and geographical isolation, obstruct various ethnic minorities from obtaining safe abortion services, pushing them towards riskier traditional methods. In Nepal, one Respondent highlighted the

challenges faced by marginalised communities, like persons with disabilities and Dalit persons, in securing safe abortion services due to discriminatory attitudes from healthcare professionals and the societal prejudices tied to their background.[73]

A study covering 18 countries in South Asia and Southeast Asia shows that particular groups, such as migrants from Burma working on Thailand's territory at the Thailand-Burma border and slum-dwelling adolescents from Dhaka, Bangladesh face heightened barriers to accessing abortion services.[74] Women from these groups face insurmountable barriers to abortion access (even at public facilities), forcing them to either self-administer unsafe abortion at home or approach unqualified abortion providers.

The criminalisation of abortion through restrictive and punitive laws as well as extensive prison infrastructure shows that the entire system is based on a 'victim-perpetrator' dichotomy that delivers pre-determined punishments as equivalent to justice.[75] Marginalised groups' exacerbated vulnerability to criminalisation is disregarded by this system, which contains no nuance that accounts for societal inequalities, power disparities and hierarchies, with the associated violence and oppression of specific groups.

Respondent D from Bangladesh critiqued this ubiquitous carceral framework of justice, stating that criminal law in its current form arbitrarily applies its morality and beliefs to criminalise specific persons, despite pluralities in such norms amongst different communities and environments.[76] Therefore, a departure from carcerality[77] becomes imperative to ensuring equitable access to SRH services, including safe, affordable and accessible abortions services for marginalised persons.

Further, the availability of MA pills in Sri Lanka is primarily through informal channels, as noted above. Given that private providers and pharmacies have a monopoly over these drugs as far as medical terminations are concerned, availability is restricted in remote areas and access is also hindered owing to the pricing which ranges from 8000-20000 Sri Lankan rupees.[78] This results in a disproportionate impact on women from socioeconomically weaker backgrounds.

Several Respondents brought up the challenges faced by adolescents in their respective countries in accessing safe and legal abortion services. Historical perceptions of adolescent sexuality and how they translated into prevailing laws must be considered when looking at the unique impact of criminalisation of abortion services on adolescents, discussed in the following section.

VI. Disproportionate Impact on Adolescents

A 1999 case in Nepal that was highly publicised as an abortion 'scandal' involved a 16-year-old adolescent who had self-administered an abortion termination method at 14 years of age after her

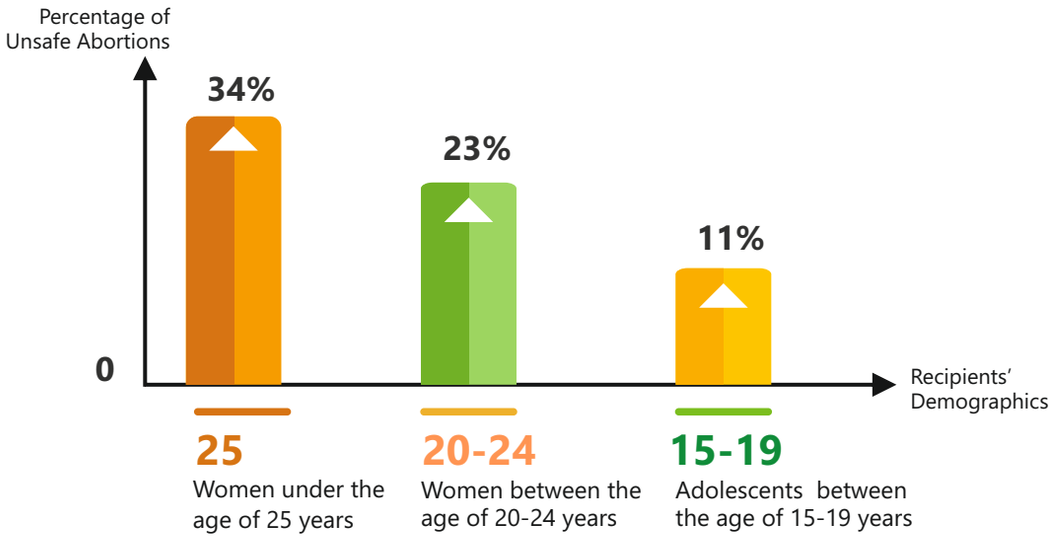
pregnancy resulted from a rape by a relative. She obtained the drug to induce abortion from her sister-in-law, who later reported her to the police and misrepresented her age as that of an adult. The adolescent was prosecuted, convicted and sentenced to 12 years in prison for an illegal abortion, only being acquitted by a higher Court after two years of imprisonment.[79]

Adolescents bear a disproportionate burden from criminalisation of abortion, not only from the regular barriers that affect other groups but also because of added layers of complexity around the age of consent as well as the legal age of marriage in different jurisdictions. The linking of adolescent abortion to child marriage results in situations where unmarried pregnant adolescents can experience significant taboos, social ostracism, punitive consequences at school, forced marriage and even violence and suicide.

Gayle Rubin notes that the "primary mechanism for ensuring the separation of sexual generations"[80] occurs through laws around the permitted age of consent, which do not differentiate between consensual and non-consensual sexual acts. Pitre and Lingam observe that laws "enforce hierarchical social norms, discipline "wayward" behaviour, and establish parental controls"[81] over adolescents, purportedly for their protection. These age of consent laws find their roots in colonial perceptions of women as 'property' or 'chattel', criminalising their sexuality unless it is expressed within the institution of marriage, where 'marital rape' is not a crime. Such colonial conceptions had their place in the USA and England in the 19th century, where mainstream views discouraged 'premature' interest in sex, sexual stimulation and release amongst children, as they believed it would harm their 'normal' maturing process and their health. These views, when supplemented with notions of morality that labelled sex as detrimental to children and adolescents, have led to the development of highly protectionist social and legal frameworks that restrict access to knowledge, awareness and expressions of sexuality. These laws gravely affect access to SRH care and abortion services for adolescents, as seen in the interviews.

Though adolescent sexuality may be restricted through laws or policies, it does not mean that adolescents are not engaging in sexual activity, however clandestinely. The United Nations Children's Fund (UNICEF) has stated that in low and middle-income countries, about 10–12% of adolescents have engaged in sexual activity before the age of 15 years.[82] Gayle Rubin,[83] however, has pointed out the 'erotic hysteria' surrounding child sexuality results in the enactment of laws to regulate sexual behaviour by routinely disregarding the sexual civil liberties of adolescents under a protectionist agenda, for example, the POCSO Act in India. **Approximately 11 million unsafe abortions were provided in 2008 in Asia,** 65% occurred in Southeast Asia, leading to 17,000 deaths and 2.3 million hospitalisations on account of complications.[84]

Women under the age of 25 accounted for 34% of all unsafe abortions, with 11% of abortion services being provided to adolescents between 15-19 years of age and 23% to those between 20-24 years.[85]



Research in Indonesia and the Philippines, which have strict abortion laws, shows that the majority of young women resort to unsafe abortion methods by default, only approaching healthcare facilities if they experience complications or failures in terminating their pregnancies. The widespread criminalisation of adolescent sexuality equates adolescent sexual acts with sexual assault that results in adverse outcomes when there are unintended adolescent pregnancies. For instance, the Philippines raised the age of consent from 12 to 16 years of age. However, penalties for consensual adolescent sexual activity have been removed if the partners' age difference is three years or less, with the exception being if one of them is less than 13 years old. This will play an important role in differentiating between consensual adolescent relationships versus sexual assault, reducing the scope for criminal prosecution and improving avenues for adolescents to access all SRH services including abortion.

In Malaysia, sexual relations between adolescents are criminalised within the legal framework of child protection, which characterises adolescent sexual activity as assault.[86] It is also common for unmarried pregnant adolescents to get married rather than terminate a pregnancy.[87] In Malaysia, the Government did finally constitute an SRH clinic, but it actually promotes abstinence, rather than any comprehensive sex education or information and it does not even provide contraceptives to adolescents or unmarried people. Respondents from Malaysia also highlighted that though there is a permissive law, there are some structural barriers to access that hinder the availability of safe abortions and post-abortion care in the country. For instance, despite the provision of abortions services for all persons, irrespective of age or marital status, adolescents' access to safe abortion services remains restricted. Respondents also

noted similar issues with respect to PAC, where there has been a lack of political will for the effective implementation of the Guidelines for Termination of Pregnancies in Hospitals of the Ministry of Health of 2012.

The exclusion of unmarried people and adolescents from family planning and contraception initiatives also occurs in Indonesia, where misogynistic and paternalistic laws render even married women unable to obtain contraceptives without the prior consent of their husbands. Such laws are in effect, discriminatory to unmarried persons, further complicated by the commonness of child marriage that in turn, does not offer any protection to adolescents for marital rape. It was only in 2023, when the revised Health Law was enacted that family planning services were made available to individuals of all reproductive ages, irrespective of their marital status. However, given the social taboos and stigma, the extent of implementation of this law is yet to be seen.

The same situation occurs amongst adolescents in Bangladesh, where unmarried persons and adolescents need to obtain parental consent to be eligible to receive SRH services. The mandatory requirement by healthcare professionals for parental, guardian or spousal consent to provide abortion services is also seen in countries like Vietnam, deterring adolescents from obtaining safe abortion care. In Nepal as well, the Right to Safe Motherhood and Reproductive Health Act, 2075 (2018) allows adolescents to avail of SRH services, including safe abortion but requires parental consent for persons below 18 years of age. Adolescents may not want to reveal their pregnancies to their families for fear of being stigmatised, abused or even abandoned. The legal compulsion to tell their families violates adolescents' right to privacy and confidentiality, and their ability to access safe and legal abortion services. The stigma around abortion, therefore, in countries like Nepal that have progressive laws still prevents adolescents from seeking safe abortion services and timely post-abortion care. Pakistan exhibits a similar landscape, with Respondents stating that even though child marriages are common, adolescent sexuality is still criminalised among unmarried persons. There is a legal prescription of the minimum age of marriage as 18 and sex outside of marriage is criminalised. Thus, adolescents are excluded from the legal framework on abortion both owing to their age and the discourse around sexuality being focused on married adult women, which in turn results in them being the primary users of the healthcare system and abortion services.

The Penal Code of Sri Lanka under Section 363(e) categorised sexual intercourse by a man with a woman, with or without her consent as rape, if the woman is under 16 years of age. A significant amendment occurred in 1998 with the addition of Section 365B, making it a criminal offence to engage in sexual acts with an individual under 16 years old, irrespective of their gender. Consequentially, any sexual activity involving adolescents under 16 is considered a crime, and it is imperative to report such

cases to law enforcement authorities. A clarification has been provided by way of a Ministry of Health Circular of January 2015 as noted in Chapter II. As per the Circular, the 'best interest of the child' must drive the provision of SRHR. The Circular carves out an exception for 'Medical Officers', exempting them from the legal duty to report adolescent pregnancies to law enforcement officials. An inconsistency arises when comparing the legal age of consent in Sri Lanka with the legal age of marriage, which is set at 18 years, except in cases governed by Muslim family law. The differing ages of consent and marriage and the resultant inconsistency in the law is pertinent to take note of given the highly restrictive and stigmatised status of abortions in Sri Lanka. This leads to restricted access to SRH services, which is often framed keeping in mind married, cis-gender women and can work to the exclusion of adolescents seeking access to safe abortion services on account of marital status.

In India, the POCSO Act was enacted to protect all minors below 18 years of age from child sexual abuse, but in effect, serves to govern child sexuality through a highly punitive framework. The POCSO Act equates consensual sexual activity among adolescents with sexual assault and adversely impacts access to abortion services for adolescents. A hospital-based study of unmarried adolescents seeking abortions in India revealed that a shocking majority of 75% of adolescents had waited till their second trimester to seek abortion services because they were afraid to disclose their pregnancies, had financial constraints and had no external support system.[88] This environment exacerbates the possibility of adolescents experiencing abortion-related health complications and even higher rates of mortality in some circumstances.

The differentiation between married and unmarried women in terms of the ability to access SRH services is also seen in India, with one study in the states of Bihar and Jharkhand showing that fear of disclosure to families was a major deterrent for adolescents seeking safe abortion services.[89] Further, a study in Thailand amongst adolescents who had availed of abortion services showed that they overwhelmingly desired confidentiality, especially exercised against their families who would stigmatise them.[90] Further, sex education, widely available information about abortion, coupled with the availability of adolescent-friendly legal abortion services were critical factors in influencing adolescent decision-making around obtaining safe abortion services.

On the global stage, there have been discussions around adolescent capacities to engage in consensual sexual activities, translating into a departure from protectionist laws that criminalise all adolescent sexual expression. This is reflected in the Convention on the Rights of the Child, 1991 (CRC), which asks States to "avoid criminalising adolescents of similar ages for factually consensual and non-exploitative sexual activity."[91] This is an important step to tackle the barriers experienced by adolescents to accessing safe abortion and SRH services.

Globally, there has been a discourse on moving away from a framework of blanket criminalisation and developing legal frameworks that recognise the evolving capacities of adolescents to enter into consensual sexual relations. This would better respond to the challenges that plague adolescent access to abortion and SRH services at large.

This move, though complex given the considerations around balancing the legitimate concerns of child sexual abuse, can be navigated legally in a manner that recognises adolescents' sexual capacities. An illustrative example of this can be seen in postcolonial South Africa, where the law has recognised consensual sex among adolescents between the ages of 12 years and 16 years as well as between a person who is 12-16 years old and a person who is 16-17 years old, as long as they are no more than two years apart in age.[92]

There have been several initiatives towards framing abortion in a rights-based narrative in different countries, which are discussed in the next section.

VII. Status of Legal Reforms

The potential of feminist movements to catalyse widespread legal reform around abortion is evidenced in Colombia, where the feminist movement spent decades on grassroots mobilisation and advocacy, finally resulting in the decriminalisation of abortion in the country. Colombian lawyer Monica Roa represented Women's Link Worldwide before the Court in a petition that finally succeeded in decriminalising abortion conditionally.[93] Thereafter, poor implementation of the legal reforms led to advocacy by feminist groups through litigation, which called out the State for insufficient infrastructure that impeded abortion access.

Bangladesh also witnessed legal intervention around the decriminalisation of abortion in 2020, when a petition was filed before the Supreme Court of Bangladesh challenging the constitutionality of certain provisions in the Penal Code that criminalise abortion services. However, in the interviews conducted, some Respondents expressed scepticism as to the effectiveness of litigation as an advocacy strategy. In this regard, Respondent D from Bangladesh clarified that "there has not been a clear translation of the Court's activism into legislative reform in the past."[94] Nepal has seen more success in judicial intervention, with a petition filed by the Forum for Women Law & Development (FWLD) in 2022 praying for decriminalisation of abortion.[95]

In Indonesia, Respondents stated that universal access to abortion is the overarching reform sought, with activists focusing on Health Law reform to expand the scope for abortion services, for instance, by increasing the gestation period which will allow for better access to abortion services. Another focus

point is making corresponding changes in the Penal Code, as well as in the child protection framework, to minimise ambiguity around whether abortion services are legal for different groups. Further, Indonesian lawyers and activists have been attempting to align the legal gestational period with Syariah rulings (*Fatwas*), issued by the National Fatwa Committee, which prescribe 120 days from conception as being the stage of 'quickening' or the time when life can be ascribed to the 'foetus.' The Kongres Ulama Perempuan Indonesia (KUPI) or the Indonesian Women Ulama Congress Network recently held their second congress in November 2022 and issued five *Fatwas*, one of which related to pregnancies resulting from rape. The *Fatwas* declared that the protection of women whose pregnancies result from rape is mandatory, including by completion or termination of pregnancy based on medical and/or psychiatric emergencies, irrespective of the duration of the gestation period.[96] Women activists and organisations advocated for allowing abortion services up to 14 weeks of gestation, which has been incorporated in Law No. 17 of 2023 on Health for pregnancies resulting from rape and sexual violence. Another primary focus of the Indonesian feminist movement has been the 2012 Bill that aims to address issues of gender-based violence (GBV). The Bill was initiated in 2012 owing to the increase in cases of sexual and sex crime in the country. It was passed recently, on 12 April 2022, and aims to increase awareness on the issue of sexual violence while also working towards eliminating the problem.[97] Here, it must also be noted that gender-based violence has been a national priority for women's political groups in Indonesia. The mass sexual violence committed against women of Chinese ethnicity during the 1998 riots in the country which were triggered by economic issues and corruption, as noted by scholars, served as the impetus for mobilisation of women's political groups and facilitated the establishment of the National Commission on Violence against Women (Komnas Perempuan).[98]

In the Philippines, there is strict criminalisation of abortion services, but the feminist movement is also very dynamic, consisting of organisations such as Philippine Safe Abortion Advocacy Network (PINSAN) and Likhaan Center for Women's Health that have been focusing on legal reforms for abortion laws for many years. In 2018, feminist groups protested against certain mysogynist comments made by President Duterte situating their protest within a wider protest against his administration.[99] The Respondents stated that since 2022 was a national election year in the Philippines, feminist groups were calling for a candidate who would usher in a regime that would stand up for women's equality and rights. This is particularly relevant in the context of a recent Bill on decriminalisation of abortion titled *"Act Decriminalizing Induced Abortion to Save the Lives of Women, Girls, and Persons of Diverse Gender Identities, Amending Article 256-259 of the Revised Penal Code"*.[100] Respondent B from the Philippines notes that a major obstacle facing the Bill is the entrenched misogynistic mindset among many Senate and House Representatives. This attitude has led to minimal or no backing of the Bill. [101]

In Malaysia, the focus has not been on legal reform but on generating awareness on the legality, availability and accessibility of abortion services to combat the stigma surrounding abortion. Reproductive Rights Groups like the Reproductive Rights Advocacy Alliance Malaysia (RRAAM) have collaborated with youth and other advocacy groups to run campaigns that illustrate the barriers to abortion access faced by pregnant persons using interactive media like art and films to generate awareness in public. There has been a conscious effort to move the focus away from legal reform and work towards improving on-ground access by developing the regulatory framework and developing the healthcare system's capacity by increasing availability of medication, among other things. One of the Respondents from Malaysia noted how, while there are efforts to push for the removal of abortion regulation from the penal laws, the movement's focus has been to work with diverse groups like transgender and gender-diverse persons and also look at the intersection of reproductive rights and disability rights.[102]

In Thailand, the feminist movement has largely focused on advocacy for issues around inheritance, marriage law, gender-based violence and human trafficking. However, Thailand experienced widespread pro-democracy protests in 2021, and the movement highlighted issues pertaining to both queer rights as well as abortion law reforms. The movement used strategies like protesting in front of the Parliament and calling for abortion rights and the right to bodily autonomy through songs and performance. Thereafter, Thailand passed a law that allowed abortion on demand till 12 weeks' gestation and amended the existing punishments for abortion, but feminist groups still protested strongly that the law did not tackle all their concerns – including the failure to acknowledge that gender and sexual minorities still did not have access to abortion and SRH services.

> Scholars argue that early advocacy on abortion law reform was conceptualised through the lens of maternal mortality and health and has now expanded within a rights-based approach.

Abortion is not a priority for feminists or other movements in other countries such as Sri Lanka and Bangladesh, where the primary focus for feminists has been on issues of gender and sexual violence. This is mirrored in most countries, pointed out by Marge Berer, whilst analysing abortion laws across the world. Respondent G, from Sri Lanka, explained that "the mainstream feminist movement is not focused on SRHR, but a few activists and grassroots groups are demanding access to legal abortion services."[103] In the case of Pakistan, feminist movements and other organisations redirected their attention from abortion reform due to backlash in terms of financial constraints, including the Global Gag Rule and the repercussions of the COVID-19 pandemic. Despite these challenges, civil society coalitions such as the Pakistan Alliance for Postabortion Care (PAPAC) persisted in their efforts. They continued to encourage the provincial governments and private sector stakeholders to maintain the provision of safe abortion services, post-abortion care and contraception as essential components of healthcare during the

pandemic. This resilience reflects ongoing commitment amid challenging circumstances in advancing reproductive health initiatives. Over the last decade, the Pakistani government has taken measures to reduce morbidity and mortality associated with unsafe abortion. A significant majority of the 2.2 million induced abortions annually in Pakistan are deemed unsafe, leading to an estimated 700,000 complications that pose life-threatening risks. To address and mitigate the impact of unsafe abortions, the government approved national training standards for post-abortion care in 2015.

In 2016, misoprostol was added to the national essential medicines list for post-abortion care. Furthermore, in 2018, the government published national service delivery standards and guidelines aimed at ensuring high-quality safe uterine evacuation and post-abortion care. The recent inclusion of therapeutic abortion and post-abortion care services in Pakistan's essential package of health services represents a significant stride toward enhancing access to these crucial services.[104]

Further, there have been several attempts at legal reform as far as the abortion laws in Sri Lanka are concerned. The most significant among these was the proposal tendered by the Law Commission of Sri Lanka in 2013 to legalise abortion on certain grounds including in instances of rape and severe 'foetal' anomalies.[105] However, this proposal did not result in any changes to the law.

In India, it has been noted by some Respondents that the focal point of the feminist movement tends to centre around issues related to gender and sexual violence rather than placing a primary emphasis on abortion law reforms. This observation may be attributed to the existence of the MTP Act, which has historically governed abortion services in India ensuring a qualified right to abortion. However, it is important to highlight that this perception does not negate the fact that there has been a concerted effort within feminist circles to advocate for legal reforms aimed at expanding access to abortion services. This advocacy seeks to create an environment that facilitates safe, legal and stigma-free reproductive rights. The culmination of these efforts is evident in the most recent amendments made to the MTP Act in 2021. Similarly in Vietnam, Respondents highlighted the unique challenges surrounding abortion advocacy, as it has a strong women's rights movement but never had to fight for abortion as it was already legal. With international assistance, Vietnam has made tremendous progress which is evident from the fact that in 2001, the Ministry of Health and Ipas launched an initiative known as the Comprehensive Abortion Care (CAC) project to revamp delivery of abortion services. This particularly targeted modernising and standardising clinical abortion practice puts women's needs at the centre of service delivery. Further, there has also been the inclusion of detailed content on abortion services in the National Standards and Guidelines for Reproductive Health. In 2016, Asia Safe Abortion Partnership led the initiative where 24 individuals and organisations supported the move to submit an advocacy letter on the occasion of Women's Day to draw attention to the need for second-trimester abortion services and the adverse consequences of restricting abortion access in the second trimester. The letter

also proposed suggestions to implement policies enabling safe abortion access. Efforts towards expanding abortion access have thus been ongoing, despite the distinct socio-political constraints in each of the countries.[106] **It is notable that Vietnam initially did not have a specific legal criminal framework regulating abortion services. However, in 2003, the Government introduced guidelines from the Ministry of Health setting a gestational limit of 22 week for abortion services. Additionally, in 2018, the Government made 'illegal abortion' a criminal offence by amending the Criminal Code. In the last two decades, Vietnam has progressively tightened its regulations on abortion services.**

Additionally, there is palpable concern amongst these movements around lack of consultation with women, and transgender and gender-diverse persons on the law making process. According to Subha Wijesiriwardena et al,[107] the discourse surrounding abortion in Sri Lanka underscores a significant gap in acknowledging the lived experiences and perspectives of women and transgender individuals who may be directly affected by regulatory decisions. Decision-making processes often prioritise the voices of medical professionals, overshadowing the valuable insights of those most impacted. This highlights the need for a more inclusive approach in discussions and policy recommendations. It is important to note that neglecting direct engagement with pregnant persons not only diminishes their agency but also risks formulating inadequate policies that fail to address their diverse needs.

Similarly, in Indonesia, the recent enactment of the 2023 Health Law was enacted without consultation. Respondent I from Indonesia notes that:

"Activists were taken aback by the passage of the new Health Law no. 17/2023 in August 2023. Usually, when formulating health legislation, the Ministry of Health would involve non-governmental organizations (NGOs) in the process. However, this time, during the drafting of government regulations for law implementation, discussions were conducted without the inclusion of NGOs. Although attempts were made by activists to reach out to several NGOs, particularly the Women's Health Foundation, for information and suggestions, there was no response or involvement, posing challenges in devising a strategy. Activists also expressed disappointment and frustration because major medical professional organisations, including the Indonesian Obstetrician Gynaecologist Association, the Indonesian Medical Association, and the Indonesian Midwifery Association, do not support access to safe abortion services. Furthermore, some governmental entities like the National Population and Family Planning Board (BKKBN) leverage child protection laws to oppose abortion. This stance overlooks the connection between the high Maternal Mortality Rate (MMR), child marriage, stunting and the lack of attention, respect for women's rights, education and efforts to empower women. These factors contribute to deteriorating reproductive health conditions for women. The very medical professional organisations expected to comprehend women's needs have become impediments to endeavours aimed at ensuring the development of a high-quality care." [108]

However, concerns have arisen due to the lack of clarity on the regulations for implementing safe abortion services. Closed discussions on derivative regulations have made it challenging for NGOs to participate in the Ministry of Health's deliberations. Furthermore, there has been a notable absence of responses to public suggestions, fostering pessimism among activists and the public regarding women's access to safe abortion in Indonesia. The persistent struggle, dating back to the 1980s, against restrictive laws has failed to curb unsafe abortion services, leading to tragic deaths of women.

In India, the 2021 amendments were passed without adequate consultation and deliberation, despite considerable opposition from civil society. The new law institutionalises third-party authorisation through Medical Boards, introduces inconsistent criteria for approval after 24 weeks of termination and fails to centre the decisional autonomy of pregnant persons.[109] This structural change raises concerns about potential delays, particularly affecting individuals in rural areas. The failure to engage in meaningful consultations with affected communities reveals a troubling pattern in the legislative process, emphasising the importance of a participatory approach that prioritises the voices of those directly impacted.[110]

Similarly, in Ireland, a historical lack of consultation on abortion laws led to restrictive anti-abortion statutes. The absence of diverse perspectives hindered the development of a nuanced legal framework. Only after a nationwide referendum in 2018 did Ireland repeal its Eighth Amendment, highlighting the need for inclusive consultations to address societal shifts and values.[111]

Therefore, the examination of abortion policies in Sri Lanka, Indonesia and India highlights a shared imperative for inclusive decision-making that prioritises women's perspectives and experiences. The deficiencies in these countries' approaches underscore the risks of formulating policies without direct engagement with affected communities. As the struggles against restrictive abortion laws persist, it becomes apparent that meaningful consultations are not only a legal necessity but also a moral imperative.

An examination of the trajectories of reforms around abortion in different countries shows that there are dynamic and longstanding efforts towards decriminalisation in many places. In several countries, including Nepal, Thailand and Vietnam, unified movements have experienced significant success in decriminalisation. Movements that seek to decriminalise abortion require intersectional perspectives to comprehensively understand barriers to accessing abortion services for even the most marginalised groups. The following section elaborates on the importance of an intersectional approach and highlights how a reproductive justice framework can be adopted, which considers differential marginalisation as affecting access to safe and affordable abortion services for marginalised individuals and groups.

VIII. Reconceptualising Abortion Legislation: Addressing the Arbitrary Nature of Gestational Limits

The arbitrariness of gestational age limits in determining abortion access becomes more apparent when juxtaposed with the progressive legislative frameworks adopted by several countries. Many countries have recognised the nuanced nature of reproductive decisional autonomy and have crafted legislation allowing abortion based on both gestational and gradational considerations. However, a common pattern emerges wherein late-term abortions are generally restricted. This regulatory approach has profound implications for the decisional autonomy of pregnant persons, potentially violating their fundamental rights and exposing them to undue physical and psychological distress.

Restrictions on late-term abortion services force pregnant individuals to carry pregnancies to term against their will, infringing upon their autonomy in making decisions about their bodies and lives. This restrictive approach, in essence, may be perceived as a form of torture, compelling individuals to endure a situation against their wishes. Additionally, it pushes some individuals towards seeking clandestine and unsafe abortion services, posing severe risks to their health and well-being. This dichotomy in legislation, where safe termination is only permitted up to a certain gestational age, creates a precarious situation for pregnant individuals, leaving them with limited options that may compromise their safety and reproductive health.

The issue of gestational age as a determinant for abortion access raises critical concerns within the framework of reproductive rights and human rights. In March 2022, the WHO revised its Abortion Care Guidelines, unequivocally asserting that abortion is a safe and uncomplicated medical procedure feasible "regardless of gestational age."[112] This revision challenges the conventional notion of imposing gestational age limits for abortion, contending that such restrictions lack evidence-based support. The Guidelines emphasise the adverse consequences of denying abortion based on gestational age, as it results in the undesired continuation of pregnancy, contradicting established international human rights laws.

Further, the 8 March Principles, 2023[113] elucidate the profound violation of international human rights law resulting from the failure to address discriminatory laws and associated human rights infringements. They emphasise the broad societal repercussions, extending to heightened health risks and exacerbated social exclusion. It provides a robust foundation for comprehending the intricate interplay between legal frameworks and societal well-being, offering insight into the urgency of rectifying unjust criminal laws.

Moreover, the 8 March Principles are particularly noteworthy as they address the intricate nuances of criminalisation, examining behaviors related to sexual and reproductive health, consensual sexual activities, gender identity, HIV non-disclosure, drug use and homelessness. Further, the Principles call to assess the punitive nature of laws beyond traditional criminal statutes, encompassing subsidiary legislation, disciplinary laws, civil laws and administrative regulations, and contribute to a nuanced discourse on the intersection of law, human rights and societal well-being. By elucidating the intricate relationship between discriminatory laws, human rights violations and societal impacts, the principles provide a robust foundation on the urgency of legal rectification.

The arbitrary nature of gestational age limits is further underscored by research conducted in the United States, revealing instances where women sought late-term abortion services due to the discovery of their pregnancies in the third trimester, despite regular menstrual cycles. Joanna Erdman's scholarly examination in "Theorizing Time in Abortion Law and Human Rights"[114] amplifies this argument, positing that gestational limits pose a formidable barrier to abortion access, thereby raising significant human rights concerns. Erdman contends that the various approaches to determining gestational age, lacking clear guidelines in abortion laws, result in inherent challenges, rendering the use of gestational age as an arbitrary means to regulate access to legal and safe abortion services.

Furthermore, Erdman highlights the ambiguity surrounding the concept of viability, an integral factor often considered alongside gestational age. The absence of a universally accepted method for determining viability, coupled with advancements in ultrasonography and shifting perspectives on when a 'viable foetus' is considered alive, further compounds the arbitrary nature of gestational age as a regulatory parameter.

In light of these challenges, it becomes imperative to reevaluate and redefine the regulatory landscape surrounding abortion access. A more nuanced and rights-based approach involves permitting terminations as long as they can be conducted safely. Recognising the decisional autonomy of pregnant individuals in decision-making is not only a matter of ethical consideration but also aligns with international human rights standards. By moving away from rigid gestational age limits and adopting a framework that prioritises the safety and well-being of pregnant individuals, societies can ensure a more equitable and compassionate approach to reproductive healthcare.

IX. Towards Intersectionality[115] and Reproductive Justice

Two distinct groups have traditionally existed in relation to the Global North's abortion movement, labelled as 'pro-life' and 'pro-choice', primarily distinguished by their stances on whether prenatal

personhood exists. The two factions of the movement differ on whether abortion is ethical and whether it should be legal, with pro-life narratives equating abortion with 'murder' that should be illegal, and the pro-choice movement denying prenatal personhood, upholding the pregnant person's autonomy and seeking the legalisation of abortion. However, this is a reductive division even in the Global North itself, where it does not reflect the experiences of persons of colour or Indigenous persons. In Asian countries as well, such a binary division is inapplicable amidst political narratives where neither faction is supported. This paves the way to reframe the issue in terms of achieving reproductive and gender justice that considers circumstances and impacts on marginalised groups.

The vocabulary of 'reproductive justice' came from a Black feminist caucus in 1994 at a pro-choice conference called the Cairo Conference where the group found that their "ability to control what happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia and injustice."[116]

The proposed framing of reproductive rights was to contextualise them in terms of intersectional oppression: "[t]he reproductive justice framework recognises the importance of linking reproductive health and rights to other social justice issues such as poverty, economic injustice, welfare reform, housing, prisoner's rights, environmental justice, immigration policy, drugs policies and violence."[117] The link between people's reproductive autonomy (or lack thereof) and their positions in structural hierarchies is demonstrated in several situations, such as the conditional access to contraceptives dependent on employment status, the marital situation and the presence of insurance coverage. Here, it is pertinent to note that though the vocabulary of reproductive justice may only have emerged in 1994, many countries in Asia and Latin America had previously been articulating their demands and struggles for a justice-based approach to SRH by centring the experiences of marginalised women.

Historical narratives confine the framing of abortion to women's rights, whereas the concept of reproductive justice places primacy on accessing reproductive services for everyone. **The reproductive justice framework situates abortion within other social injustices that significantly influence marginalised persons' experiences: "issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race and sexual orientation and a host of other community-centred concerns."**[118] This becomes valuable in identifying the reproductive marginalisation of gender-diverse groups, as well as transgender persons that can catalyse burgeoning queer advocacy initiatives around abortion rights, to dismantle the reductive gender binary and the 'man'-'woman' dichotomies that do not reflect marginalised identities. In Thailand too, the pro-democracy protests in 2021 prioritised issues relating to queer rights and abortion law reforms.[119] The movement including groups such as the Tamtang Group, the Feminist for Freedom and Democracy

Group and the Safe Abortion Action Fund (SAAF) organised a protest in front of the Parliament and funeral wreaths were placed as a symbolic gesture.[120] A Thai version of the Chilean feminist anthem "A Rapist in Your Path," with the lyrics rewritten to call for abortion rights and a person's right to their own body, was performed by the group.[121] In 2021, Teerantanabodee evaluated the pro-democracy movement and feminist demands that are ensconced within certain factions of the pro-democracy movement.[122] Such factions argue that hetero-patriarchy and authoritarianism are interlinked in a way that the demand for democracy must include demands for queer and women's liberation.[123] Furthermore, the passing of legislation that legalised abortion on demand up to 12 weeks and revised penalties that criminalised abortion led to protests from feminists who visibly articulated their displeasure with a law that did not go far enough.[124] In order to secure access to safe and legal abortions for pregnant persons, legal reforms must be embedded in an anti-carceral justice framework, for the adoption of a reproductive justice framework that takes note of the intersectional and varied experiences of barriers to SRH which result from socioeconomic disparities. It is therefore pertinent to frame demands for access to safe abortion services using the vocabulary of reproductive justice which calls for the decriminalisation of abortion as a first step towards securing structural changes in the landscape of SRH, as the regulation of abortion using criminal or penal laws disproportionately hinders access for marginalised persons and also strengthens the stigma around abortion.

Pregnant persons face significant variations in their experiences of accessing healthcare services and treatment by healthcare service providers, reflected in studies conducted in India, where the ability of persons to access healthcare is highly influenced by economic status and caste, rendering Dalit and Adivasi women subject to 'triple discrimination' by the healthcare system.[125] India has seen several cases that illustrate such triple discrimination, such as that of Shanti Devi, who was a Dalit, landless migrant woman and Amita Kujur, an adolescent Adivasi rape survivor, both of whom faced grave obstacles in accessing safe and timely abortion services.[126] The Medical Termination of Pregnancy (MTP) Act in India, despite ostensibly providing a legal pathway for abortion, introduces a concerning element of disability exceptionalism. This is particularly evident in the stipulation that allows abortion irrespective of gestational age only in cases of foetal anomaly after 24 weeks. This approach fails to recognise the diverse and individualised nature of disability experiences, thereby reinforcing a narrow and potentially discriminatory perspective on reproductive rights. Furthermore, the inclusion of the provision allowing 'forced abortion' for persons with severe disabilities under the Rights of Persons with Disabilities Act, 2016 raises profound ethical and human rights concerns. This provision not only demonstrates a paternalistic attitude towards persons with disabilities but also perpetuates discriminatory beliefs by suggesting that their reproductive choices can be superseded solely on the basis of their disability status.[127]

These experiences are acknowledged in a reproductive justice approach, which considers factors such as race, religion, caste, class, age, ethnicity, sexuality, disability and gender as deterministic elements in accessing healthcare.

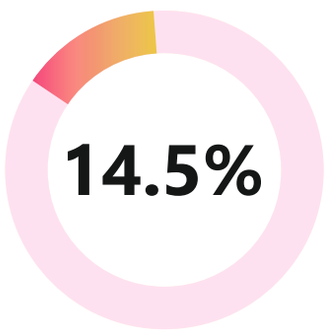
Beyond safe abortion being inaccessible, evidence from 16 studies demonstrates that criminalisation contributes to opportunity costs. Opportunity costs can be broadly understood as financial and health harms.[128] They include the travel to access abortion services, delayed and poor-quality post-abortion care, distress, financial burdens, stigma and exploitation. They disproportionately affect single women, socioeconomically disadvantaged women and those accessing care in public rather than private healthcare sectors.[129]

In contrast to historical pro-choice and pro-life debates that do not consider structural injustices and the effect of power disparities on abortion access, the framework of reproductive justice holds a more intersectional approach. The lack of such intersectional vocabulary in SRHR was noted by Respondents from Sri Lanka, India, Bangladesh, Pakistan and Nepal, who pointed out the barriers experienced by Dalit persons, indegenous persons, persons with disabilities, adolescents and transgender and gender diverse persons in accessing abortion services. Further, the use of gender-neutral language while discussing SRHR and abortion is imperative, to ensure an inclusive approach.

X. The Need for Decriminalising Abortion

The use of criminal law to regulate access to abortion services, as noted above, plays a significant role in restricting access to safe and legal abortion to the detriment of the SRHR of pregnant persons. The criminalisation of abortion services negatively affects women, girls and gender-diverse individuals in multiple ways. First, it serves as a significant legal obstacle to obtaining safe abortion services. Research has shown that restricting abortion does not eliminate the demand; it simply limits access to safe procedures. Additionally, criminalising abortion pushes pregnant persons into seeking illegal procedures in less-than-ideal conditions, increasing the risk of medical harm. As a result, unsafe abortion services remain a major contributor to maternal mortality worldwide. In India, for example, approximately two-thirds of abortion services are unsafe.[130] A study conducted in Thailand also found that unsafe abortions accounted for 35.7% of all abortions and were significantly associated with maternal, financial or family problems.[131]

As of 2015, unsafe abortions accounted for 14.5% of all maternal deaths globally, and nearly all these deaths occurred in countries with restrictive abortion laws.[132]



Therefore, one of the main goals of criminalising abortion, which is to eliminate abortion from society, is ineffective as pregnant persons continue to seek abortion services through non-legal and unsafe means. Second, criminalisation fosters a culture of stigma as abortion is kept hidden under a cloud of secrecy and criminality. The social taboo surrounding abortion have serious implications for women's health and influence their decisions about whether to have a safe or unsafe abortion and whether to disclose it to others. This combined effect significantly limits the exercise of reproductive and decisional autonomy. Third, criminalisation is in contradiction with fundamental human rights and is inconsistent with both international and domestic law as it fails to regard the right to life, dignity, health, privacy and equality within a reproductive justice framework.

In order to ensure that abortion services, among other SRH services, are provided in an affordable and accessible manner within a framework that centres the decisional autonomy of the pregnant person, there is an imminent need to decriminalise abortion. The decriminalisation of abortion entails the removal of penal laws and will facilitate the development of healthcare systems and institutions that can respond to the heterogeneous needs and experiences of pregnant persons.

The goal of decriminalisation of abortion then is to destigmatise abortion and facilitate access to safe abortion services as an essential healthcare service, and not as a transgression from the normative structures. In simple terms, the decriminalisation of abortion refers to the removal of criminal sanctions against abortion in the law, indicating that there will be no punishments for providing or availing abortion services. It also means not involving law enforcement agencies in prosecuting the procurement or delivery of safe abortion services, to uphold the rights of pregnant persons. Additionally, the decriminalisation of abortion enables a rights-based regulatory framework for SRH which ensures that courts are not the institutions authorising or denying requests for abortions, thus taking away the third-party authorisation for abortion that often results in inordinate delays and detrimental health consequences for pregnant persons. It is imperative to understand that decriminalisation of abortion treats pregnant persons as full citizens, noting the **"inseparable nature of reproductive rights and women's right to bodily autonomy, even in countries where legislative intent may not necessarily be along those lines."**[133]

The decriminalisation of abortion also counters the 'chilling effect' on healthcare professionals who are reluctant to provide abortion services fearing criminal consequences of their actions and leaving pregnant persons with limited avenues for securing safe and legal abortion services. This will also respond to the issue of unsafe abortions, for in the absence of penal laws, pregnant persons will be able to access abortion services in a safe manner, as the criminalisation of abortion does not reduce the incidence of abortion, but only leads to a sharp increase in clandestine, unsafe abortion which results in higher maternal mortality rates and adverse health consequences for pregnant persons.

It is also important to clarify that the call to decriminalise abortion does not extend to persons who provide abortion services with no qualifications to the detriment of the pregnant person's health or persons who provide abortion services without the pregnant person's consent.

Further, marginalised criminalised identities, encompassing sex workers, transgender persons, LGBTQI individuals, immigrants and economic migrants, face heightened vulnerability to the criminalisation of abortion due to intersecting layers of discrimination. In societies where these identities are stigmatised and targeted by punitive laws, accessing safe and legal abortion services becomes an even more precarious endeavour. Structural inequalities and systemic biases result in limited access to comprehensive reproductive healthcare, pushing individuals from these marginalised groups towards the fringes of society. The criminalisation of abortion further compounds the challenges they face, leaving them disproportionately susceptible to unsafe, clandestine procedures that jeopardise their health and well-being. Addressing the criminalisation of abortion must thus be seen within the broader context of social justice, recognising the interconnectedness of reproductive rights with the rights and dignity of marginalised communities. Reforms should aim to not only decriminalise abortion but also to dismantle the broader systems of oppression that exacerbate the vulnerability of these marginalised identities.

Sheldon,[134] in their work on the impact of decriminalisation of abortion through legislations in Australia, notes how laws decriminalising abortion result in a 'profound shift' in the dynamic of the relationship between the State and the persons with capacity for pregnancy. Such legislative moves have the potential of changing 'both nothing and everything', for the law does not reduce the rate of incidence of abortion but it does shift the power of decision-making in the hands of the pregnant person. This sentiment captures the contradictory duality of decriminalisation and emphasises the fact that criminalised abortion does not stop abortion; rather it stops safe abortion. It also exemplifies the inseparable nature of reproductive rights and a pregnant person's rights/bodily autonomy, even in countries where legislative intent may not be along those lines.

Conclusion

An exploration of abortion laws and barriers around South and Southeast Asia shows that one basic societal barrier to accessing abortion services is the cultural taboo associated with it, stemming largely from patriarchal and cis-heteronormative rationales for governing women's sexuality. The cultural taboos are supplemented by religious stigma, that influences societal perceptions of 'sin', impeding discourse around the legality of abortion and basic awareness about SRHR. Laws and policies that criminalise abortion have originated from religious stigma and/or even colonial laws – which form the primary basis for barriers to accessing safe, timely and affordable abortions. Several laws in many countries in South and Southeast Asia serve to criminalise both healthcare professionals who provide

abortion services as well as persons who seek abortion services. Such criminalising legal frameworks deter healthcare professionals from providing safe abortion services – and when contextualised in a public health framework with woefully inadequate infrastructure and intersecting socioeconomic and cultural marginalisation, lead to many abortion seekers availing of illegal, back-alley abortion that may result in morbidity or mortality.

A review of feminist movements across South and Southeast Asia reveals the presence of dynamic, long-term initiatives that have advocated for abortion law reform, through protests, performance, legislative efforts and judicial intervention, amongst other methods. These movements have had differential success around abortion reform, with some experiencing success, but others shifting focus away from this contentious subject on account of state backlash. In some countries, abortion reform is not a priority for feminist movements, which instead focus on issues such as gender violence and matrimonial rights. At this stage, the legal frameworks of several countries need to be reformed to ensure universal access to safe, affordable and timely abortion services. Such reform needs to frame universal abortion as a fundamental right of persons through a reproductive justice framework that centres access and accounts for intersecting marginalisation of various individuals and groups.

The following section makes certain recommendations to situate abortion within a rights-based narrative that comprehensively seeks to eliminate barriers to accessing these services by the most marginalised persons, through an intersectional perspective.

Age of Consent	
Philippines	16 years
Thailand	15 years
Indonesia	18 years
Vietnam	16 years
Malaysia	16 years
Nepal	18 years
Pakistan	No age of consent. Minimum age of marriage for men is 18 years and for women is 16 years.
India	18 years
Sri Lanka	16 years
Bangladesh	14 years

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CHAPTER IV

RECOMMENDATIONS


RECOMMENDATIONS
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RECOMMENDATIONS

The issue of abortion impacts anyone with capacity for pregnancy. Legislative limitations, such as legal consequences for healthcare providers and pregnant individuals, along with arbitrary gestational restrictions, as highlighted by numerous Respondents, continue to pose a significant obstacle to the availability of safe abortion services. As established in Chapter III, fear of prosecution discourages healthcare professionals from providing abortion services and fuels social stigma towards abortion. This, along with structural, socioeconomic and cultural barriers, the absence of comprehensive legal frameworks that address intersectional barriers and the lack of public healthcare facilities that have free and affordable sexual and reproductive health services (SRH) and sexual and reproductive health and rights (SRHR), has led to abortion services being significantly stigmatised and inaccessible, particularly for marginalised groups.

Therefore, the legal regulation of abortion must be revisited and reformed to enable rights-based access to abortion services. There is an imminent need for radical legal reforms that centre the decisional autonomy of the pregnant person and articulate abortion as a right: a facet of the fundamental rights to equality, dignity, life and liberty. It is imperative that such legal reforms are informed by intersectional approaches and articulated within a reproductive justice framework. This chapter lists out broad recommendations that are drawn from the interviews and literature review to inform future efforts towards legal reforms. These recommendations remain broad in nature, considering the heterogeneous nature of the approach towards abortion regulation taken by these countries and their diverse sociolegal backdrops.

1. Decriminalisation of Abortion

Abortion remains subject to stringent regulations, featuring diverse levels of carceral frameworks. As established in the study, healthcare professionals are very concerned about being trapped, criminalised, harassed and punished for providing abortion services. Different countries show varied incidents of prosecution under the criminal law framework. Indonesia, India, Philippines and Sri Lanka demonstrate that healthcare providers and pregnant persons are prosecuted and harassed by law enforcement agencies. It is therefore imperative to decriminalise abortion and encapsulate it within a rights-based framework of reproductive justice (rather than a criminal law framework) by centring access to safe abortion services and the decision-making capacity of pregnant persons. Pregnant persons can then avail abortion services without fear or intimidation and at will.

The laws criminalising abortion do not operate in silos but are significantly influenced by extra-legal factors and have long-term repercussions for SRH access. Where criminalisation of abortion

exacerbates the structural inequalities that impede pregnant persons' access to SRH services, decriminalisation of abortion can provide pathways for addressing such systemic violence and oppression that is the result of compounding inequalities of caste, class, race, sexuality, ethnicity, gender, religion, age and disability among others. Efforts towards decriminalisation of abortion must be informed by a comprehensive understanding of the structural barriers and inequalities and therefore must address concerns beyond the legal terrain, including lack of adequate public healthcare infrastructure, economic empowerment and lack of awareness among healthcare providers on legality of abortion, among other factors. The framework of choice is therefore limiting because it fails to account for these structural barriers.

Some Respondents emphasised the crucial need for access to safe and legal abortion services, highlighting that it requires comprehensive SRH care. This encompassing care should address contraception, post-abortion care and menstrual regulation. As efforts for abortion law reform progress, studies support the idea that a robust healthcare infrastructure and supportive legal policies play a vital role in realising SRHR. Examples from Bangladesh and Sri Lanka illustrate how policies that address aspects beyond abortion, such as Menstrual Regulation and Post Abortion Care Guidelines, contribute to mitigating the harmful consequences of criminalisation. This dual approach recognises the immediate importance of holistic SRH care while advocating for ongoing abortion law reform, as restrictive laws remain a significant obstacle to the availability of safe abortion care.

2. Legal Reforms around Child Protection Laws & Adolescent Sexuality

There is an urgent need to revisit the way adolescent sexual capacities and desires are regulated under the law. As this study reveals, the issue of adolescent access to abortion becomes complicated in many countries with differential ages of consent. The focus on married adult women in family planning policies in several countries creates an atmosphere where doctors may refuse to provide contraception and abortion services to adolescents and penal provisions mentioned in Child Protection Laws (such as the mandatory reporting provision in the Indian POCSO law and Section 363 (E) of the Sri Lankan Penal Code) create an additional deterrent effect on adolescents seeking abortions. They are compelled to inform their guardians about their unplanned and unforeseen pregnancies. The criminalisation of consensual adolescent relationships, as well as legal frameworks that do not grant adolescents easy access to comprehensive sexuality education and reproductive health care, result in the perpetuation of existing cultural and social stigmas that deter them from availing SRH services.

As opposed to blanket criminalisation, legal recognition of the evolving sexual capacity of adolescents

would better respond to the challenges that plague adolescent access to SRH services, including abortion. This move, though complex given the legitimate concerns of child sexual abuse, can be navigated legally in a manner that recognises adolescents' ability to have consensual sexual relationships.

An illustrative example of this is South Africa,[1] where the law recognises that adolescents have a right to engage in sexual activity without incurring criminal sanctions. Sexual behaviour amongst adolescents who are between 12 and 16 years old is legal, as long as it is consensual and with others within this age group, as well as with persons who are 16 or 17 years old, as long as they are no more than two years apart in age. Further, Zambia provides another noteworthy example, as outlined in the Standards & Guidelines for Reducing Unsafe Abortion Morbidity and Mortality issued by the Ministry of Health in 2009.[2] According to these Guidelines, healthcare professionals in Zambia are mandated to act in good faith and in the best interest of minors.[3] The Guidelines emphasise the importance of respecting the decisional autonomy of adolescents and minors without requiring third-party authorisation. Notably, this may extend to situations where healthcare providers forego the need for parental or guardian consent when delivering services.[4]

3. Comprehensive Sexuality Education

The criminalisation of abortion implies that there is a societal reluctance to openly discuss and accept matters related to sexuality and reproduction. This reluctance often stems from the influence of religious and cultural norms, particularly those associated with Islamic, Hindu, Buddhist and Catholic traditions, depending on the country in question. These cultural norms are deeply rooted in cis-heteropatriarchal gender norms and contribute to the stigma surrounding abortion, thus diminishing the autonomy of pregnant persons in making decisions about their own bodies.

In many countries, the authority over reproductive rights and health decisions is not granted to the pregnant person. Even in regions where abortion is partially decriminalised, cultural stigmatisation persists, creating obstacles for access. The insufficient provision of comprehensive SRHR education exacerbates this problem, resulting in a restricted availability of contraception and reproductive health services, including abortion.

Effectively addressing this stigma requires an inclusive and proactive approach, particularly by encouraging open discussions about gender and sexuality from an early age. To accomplish this, countries should take measures to incorporate comprehensive sexuality education into school

curricula. By doing so, young individuals can be equipped with the knowledge needed to comprehend and advocate for their SRHR and needs. Moreover, integrating comprehensive sexuality education can play a crucial role in challenging and normalising societal stigmas. By fostering open conversations in educational settings, society can break down ingrained norms and misconceptions surrounding reproductive health. Such an educational approach helps shift perspectives, promotes understanding and acceptance and contributes to the broader destigmatising of abortion, contraception and reproductive rights discussions.

Asian countries have aligned their Comprehensive Sexuality Education (CSE) policies with international best practices. In Vietnam, the National Action Plan on Reproductive and Sexual Health Care for Adolescents and Young Adults for the period 2020-2025 mandates the implementation of comprehensive sexual and reproductive health education specifically designed for adolescents and young adults. Additionally, a decision from 2006 and a Circular on the General Education Programme issued in 2018 emphasise the necessity of incorporating content related to sex education at the primary level. Vietnam launched CSE programs in 2002 and updated the program in 2007 through the development of an Action Plan in accordance with national legislation. Teachers are equipped with comprehensive methodologies and guidelines, and state budgets allocate funds to each school to support the implementation of the CSE program.[5]

4. Inclusive Framework for Activism and Reforms

In the push for the decriminalisation of abortion, it is crucial to recognise and address the intersectional challenges faced by individuals seeking abortion services. Many existing legal reforms are limited by cis-heteronormative and gender-binary perspectives, which also invisibilise the experiences of persons with disabilities. The resultant legal and policy frameworks often confine access to abortion services to able-bodied, married, cisgender women while overlooking the SRH experiences of queer, transgender and gender-diverse individuals and persons with disabilities.

This underscores a broader limitation within feminist and abortion advocacy movements in South and Southeast Asia, highlighting the necessity for a more inclusive approach that embraces the language of reproductive justice. For example, in Bangladesh, efforts have been made in recent years to broaden the movement's scope, by actively welcoming women with disabilities, members of the LGBTQIA+ communities.

There are also differing perspectives, exemplified by the conflict between the disability rights and abortion rights movements, particularly concerning disability exceptionalism and varying decision-making models. Advocates of reproductive rights and justice must actively engage with and address these disagreements, striving to establish a non-eugenic and inclusive framework for abortion access. This approach will facilitate a more robust and inclusive intersectional strategy in the pursuit of reproductive justice. This inclusivity can be advanced by fostering solidarity across various social

movements, including Indigenous, LGBTQIA+, disability, anti-caste and anti-racist movements as well as collaborations with youth and adolescent coalitions.

5. Respecting International Obligations

Comprehensive attention to SRHR is enshrined in a rights-based framework, exemplified by documents such as the Beijing Declaration and Platform for Action unanimously adopted by 189 countries in 1995. The international legal context concerning abortion advocates for the elimination of barriers, including legal impediments, targeting both individuals seeking abortion and healthcare providers. Additionally, it emphasises acknowledging the evolving capacity of adolescents and urges the removal of restrictive age of consent laws criminalising consensual sexual activities among adolescents.

The countries under consideration in this study are parties to various international treaties and conventions, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), The Convention on the Rights of Persons with Disabilities (UNCRPD), and the Universal Declaration of Human Rights (UDHR). These agreements impose international human rights obligations that necessitate compliance at the domestic level. Therefore, it is crucial to frame SRHR within a culturally sensitive, rights-based framework that respects domestic and customary laws and practices.

Date of Ratification of UN Treaties

	ICCPR	ICESCR	CEDAW	CRC	CRPD
Bangladesh	6 Sep 2000	5 Oct 1998	6 Nov 1984	3 Aug 1990	30 Nov 2007
India	10 Apr 1979	10 Apr 1979	9 Jul 1993	11 Dec 1992	1 Oct 2007
Indonesia	23 Feb 2006	23 Feb 2006	13 Sep 1984	5 Sep 1990	30 Nov 2011
Malaysia	-	-	5 Jul 1995	17 Feb 1995	19 Jul 2010
Nepal	14 May 1991	14 May 1991	22 Apr 1991	14 Sep 1990	7 May 2010
Pakistan	23 Jun 2010	17 Apr 2008	12 Mar 1996	12 Nov 1990	5 Jul 2011
Philippines	23 Oct 1986	7 Jun 1974	5 Aug 1981	21 Aug 1990	15 Apr 2008
Sri Lanka	11 Jun 1980	11 Jun 1980	5 Oct 1981	12 Jul 1991	8 Feb 2016
Thailand	29 Oct 1996	5 Sep 1999	9 Aug 1985	27 Mar 1992	29 Jul 2008
Vietnam	24 Sep 1982	24 Sep 1982	17 Feb 1982	28 Feb 1990	5 Feb 2015

6. Structural and Systemic Changes

Liberalising the law on abortion by itself will not be sufficient to improve abortion access, as law does not exist in a vacuum. The existing healthcare systems in numerous South Asian and Southeast Asian countries pose significant barriers to abortion accessibility. This is due to the large-scale erasure of the experiences of persons with disability, biases held by healthcare professionals, as observed in Indonesia, Malaysia and India and widespread distrust in underfunded public hospitals, particularly in India and Indonesia where healthcare professionals may lack sensitivity. Additionally, a general lack of accessible, affordable and high-quality care further contributes to the challenge.

Achieving reproductive justice for marginalised individuals requires a comprehensive approach to reproductive healthcare. Healthcare professionals need training in gender-affirming care to prevent physical and emotional trauma for transgender and gender-diverse individuals who may be misgendered. Discrimination based on factors such as ethnicity, religion, caste, disability and class also serves as a substantial obstacle to abortion healthcare. Many marginalised individuals face financial barriers to accessing reproductive healthcare services. Evidence indicates that public hospitals often fail to provide free, affordable and quality healthcare services, leading individuals to either carry the pregnancy to term against their will or resort to unsafe methods. Therefore, systemic changes in the healthcare sector are imperative to improve abortion access.

These changes should encompass the availability of trained, non-judgemental and empathetic healthcare professionals who are willing to serve individuals with marginalised identities. The development of sensitivities and capacities of healthcare professionals to have a more rights-based approach to SRH services delivery can facilitate a long-term shift in the way healthcare establishments and infrastructure respond to the heterogenous reproductive health needs of individuals. Healthcare professionals in particular are vital stakeholders in shaping the landscape in safe abortion access and must therefore be a key constituency for efforts targeting structural changes.

Moreover, universal access to comprehensive and free healthcare services is essential. Lastly, substantial funding is required to establish a robust healthcare infrastructure at the rural level. For example, abortion and post-abortion care is fully covered under insurance and is available free of cost in Thailand.[6] The Universal Coverage Scheme (UCS) mandates that its members register with a provider network offering comprehensive outpatient, prevention and health promotion services.[7] Rural areas rely on district health systems with district hospitals and health centres, while urban areas utilise the Ministry of Public Health's provincial or regional hospitals and health centres, along with some private

hospitals. Thailand has achieved full geographical coverage with district hospitals in all 800 districts and health centres in all sub-districts, ensuring accessibility to healthcare services.[8]

Additionally, limitations on the healthcare professionals authorised to offer abortion services pose a significant obstacle to accessing such services. It is crucial to broaden the pool of healthcare providers and permit mid-level practitioners such as nurses, midwives and community health workers to administer abortion services. In certain countries, mid-level providers are allowed to offer abortion services, particularly through medical abortion (MA) for a duration of up to 12 weeks. For instance, in Ethiopia, the Federal Ministry of Health (FMOH) played a crucial role in transforming abortion services by issuing technical guidelines in 2006, authorising providers, particularly midlevel ones like nurses and midwives, to deliver abortion services in the first trimester.[9] Analysis revealed that midlevel providers exhibited higher-quality care than physicians, showcasing proficiency in technology use, pain management and postabortion family planning.[10] Ethiopia's success resulted from a comprehensive approach, including legal reform, proactive guideline dissemination and rapid midlevel provider training. Similarly, Bangladesh permits midlevel providers, such as Senior Staff Nurses and Staff Nurses, to provide abortion services.[11] This inclusive approach, involving a range of healthcare professionals, reflects the commitment of Bangladesh towards ensuring the availability of MR/PAC services across diverse healthcare settings.

Finally, the adoption of 'no refusal' policies by clinics can help to ensure that all persons who approach such clinics can be provided abortion services with care, notwithstanding their capacity to pay charges. The 2022 WHO Guidelines emphasise that 'conscientious objection' to offering abortion care creates substantial obstacles to obtaining safe and legal abortion services, leading to violations of rights.[12] Therefore, the Guidelines recommend that countries must ensure that, when permitted by law, conscientious objections by healthcare professionals do not lead to the denial of legally available abortion care.[13] Moreover, such refusals should not impede or hinder access to quality abortion services.

It has been found that this approach has helped with trust-building between local women who travel long distances to access abortion and contraceptive services. For example, in Mexico, healthcare professionals who refuse to provide abortion services are obligated to refer the pregnant individual to another service provider.[14] In 2021, the Supreme Court of Mexico deemed 'conscientious objection' invalid.[15] In South Africa, only the primary provider of termination of pregnancy (TOP) has the authority to decline care; other healthcare or support staff members cannot refuse.[16] Consequently, a direct TOP provider refusing care based on personal beliefs must refer the individual to a colleague or facility capable of providing such services.[17]

7. Harmonisation of Conflicting Laws

One significant obstacle to obtaining safe abortion services is the existence of contradictory laws, leading to uncertainties regarding the legal status of abortions. This results in healthcare professionals refusing to provide services and a lack of awareness among the general population. Vietnam, Nepal and India serve as examples illustrating these challenges.

In India, the Pre-Conception and Pre-Natal Diagnostics Techniques Act, 1994 (PCPNDT Act), initially aimed at prohibiting pre-natal gender determination and pre-conception determination of gender, has significantly affected access to abortion services. The law targets the misuse of diagnostics techniques to address the issue of gender determination. However, aggressive implementation has led to a crackdown on healthcare professionals and has created an anti-abortion rhetoric. A similar scenario is observed in Vietnam, where laws regulating gender determination are an exception to legal abortion. Nepal, under the National Safe Abortion Policy of 2003, punishes prenatal sex determination to counter gender-biased sex-selective terminations. While there may not be a direct legal conflict with abortion laws in these contexts, the lack of awareness and the fear of criminal consequences among healthcare professionals have limited access to abortion services, especially for late-term abortion.

The impact of conflicting laws extends to adolescent access to abortion services, given disparities in age of consent provisions and stringent child protection laws. The penal laws on child sexual activity in Sri Lanka, India and Indonesia exemplify these challenges. To address this, a concerted effort is needed to harmonise all relevant laws, ensuring that legal ambiguities and conflicts do not compromise access to abortions. This should be complemented by capacity-building initiatives to clarify the legal position and facilitate access to safe and legal abortion services, as emphasised in the second Recommendation.

8. Sensitisation and Training to Address Stigma

Legal changes can address some obstacles to accessing abortion services by enacting rights-based legislations. Even in countries like Thailand, with change of law and universal health coverage, there continue to be implementation challenges. The persistent and deeply ingrained challenge of social stigma in SRHR requires attention beyond the legal realm. The literature review and qualitative interviews underscore the significant prevalence of stigma surrounding abortion, particularly in the perspectives of healthcare professionals and influential figures such as public officials and religious leaders. Experiences in countries with permissive laws, such as Nepal and Vietnam, demonstrate that the mere existence of favourable laws does not guarantee easy access to safe abortion services.

This stigma is exacerbated by media coverage that sensationalises abortion issues, promoting a restrictive and binary view of gender. Media narratives play a crucial role in shaping public perceptions of abortion, often linking it to terms like 'murder' and 'foeticide,' and associating it with societal problems such as imbalanced sex ratios. Communication materials and awareness campaigns tend to adopt a moralistic tone, using graphic imagery and slogans that equate abortion with 'sin', targeting both pregnant persons and abortion providers directly. It is crucial to ensure that individuals seeking abortion services receive accurate and comprehensive information about available methods and the latest technologies.

Additionally, it is crucial to initiate curriculum reforms in medical and law schools, emphasising key concepts like confidentiality and consent, and destigmatising abortion and contraception. Currently, medical schools provide limited training on abortion services, making it imperative to offer students essential learning opportunities to ensure the delivery of safe and effective reproductive health care for all. Some Respondents recommended the institutionalisation of Values Clarification and Attitude Transformation Training (VCAT). WHO echoes the positive impact of values emphasising its role in equipping providers to deliver high-quality, non-judgmental services. This recognition underscores the broader societal benefits of VCAT, acknowledging its potential to foster a more informed, compassionate and professional approach to abortion care among healthcare professionals. Healthcare professionals, including doctors and support staff, must invest time and effort to empower pregnant individuals to make informed decisions. Access to information on contraception to prevent unplanned pregnancies should also be promoted.

Therefore, efforts to reform laws should be complemented by parallel engagement through dialogue and advocacy with key stakeholders, including healthcare professionals, religious leaders, the judiciary, lawyers, public officials, members of Parliament, journalists and media personnel, among others. Such a collaborative approach aims to foster a destigmatised understanding of abortion, ensure that accurate information is disseminated and the advancement of a rights-based approach.

9. Promoting Acceptance and Access to Medical Abortion Services

As per the WHO guidelines, MA is considered safe and effective for pregnancies up to 12 weeks. The WHO also asserts that self-management of abortion up to 12 weeks is feasible with accurate information, a qualified healthcare professionals and post-abortion care facilities. However, research and interviews informing this study reveal that despite WHO recommendations, MA services are seldom accessible due to limited awareness, the scarcity of MA pills and lack of registeration in some countries as seen in Indonesia and Malaysia. The availability of MA pills is, in turn, influenced by the global political

economy of SRHR. For instance, the Global Gag Rule's impact on SRHR access in Pakistan illustrates the direct consequences of such political dynamics.

In India, self-managed abortion could be a safe and viable option for women seeking abortion services in the first trimester and beyond, provided systems are established to ensure safety and access to healthcare in case of emergencies or complications. However, it is imperative that MA pills are easily accessible and readily available over the counter and are free of cost or affordable. For instance, in August 2023, the Therapeutic Goods Administration (TGA) in Australia removed the restrictions on mifepristone and misoprostol, enabling any healthcare professional, including nurses, to prescribe it. Prior to this, only specialist doctors could prescribe the pills, and pharmacists had to be registered to dispense it. Additionally, the TGA eliminated the requirement for pharmacists to hold special certification or registration to dispense the pills.[18] As a result of this policy change, Queensland passed a law allowing midwives and nurses to dispense the pill. The TGA has delegated the determination of specific qualifications for healthcare professionals authorised to prescribe the pill to individual states.[19]

Initiatives should include widespread campaigns and awareness drives, targeting both healthcare professionals and individuals capable of becoming pregnant. Additionally, efforts are needed to make MA pills widely accessible at free or affordable prices, ensuring that safe abortion services are available to all individuals, especially those from marginalised communities. Some Respondents highlighted that accessibility of drugs like misoprostol enhances a pregnant person's ability to pursue safe abortion services and exercise decisional autonomy.

10. Abortion Services in Times of Crisis/Emergency Preparedness

In specific settings during emergencies, vulnerabilities and access challenges pose additional obstacles to reproductive services. In the broader context of emergency and crisis situations, encompassing natural disasters and calamities, pandemics, ongoing conflict and wars and similar events, these challenges exacerbate the existing difficulties faced in accessing reproductive health services. To tackle these issues effectively, it is crucial to implement a comprehensive approach involving legal, policy and infrastructural measures tailored to the specific dynamics of each emergency and address heightened susceptibility and restricted access in these critical situations.

11. A Rights-Based Approach to Abortion Legislation and Reproductive Healthcare

To reform existing abortion laws, policymakers should consider adopting a comprehensive and rights-

based approach that prioritises the well-being and autonomy of pregnant persons. First, gestational age limits should be reconsidered, moving away from arbitrary restrictions and towards a more flexible framework that considers the diverse circumstances surrounding unplanned pregnancies. Drawing inspiration from countries with progressive legislations, policymakers can explore models that allow safe abortion access throughout the gestation period while ensuring appropriate medical oversight.

Second, it is essential to emphasise the importance of providing comprehensive reproductive healthcare and education to empower individuals to make informed decisions about their reproductive lives. This includes fostering an environment where individuals feel supported in seeking timely and safe abortion services, free from judgment or undue obstacles. Additionally, efforts should be directed towards reducing societal stigma associated with abortion and promoting open discourse to challenge misconceptions. By reframing abortion laws to align with a rights-based framework, pregnant person centric perspective and concurrently fostering a supportive societal attitude, policymakers can contribute to a more compassionate, inclusive and equitable provision of reproductive healthcare. This is also likely to reduce maternal mortality and contribute towards a gender just society.

NOTES FOR CHAPTER IV

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CHAPTER V

CONCLUDING OBSERVATIONS

CONCLUDING OBSERVATIONS

This study delves into the complex landscape of sexual and reproductive healthcare and rights (SRHR), with a particular focus on the contentious issue of abortion in ten countries. Each country has witnessed a history marked by significant legal and socio-cultural dynamics. The exploration extends to countries that were once colonies of the British, Spanish and French empires, to highlight the profound impact of colonisation on the evolution of abortion laws, and countries like Nepal and Thailand, which did not experience colonial occupation but faced distinct religious and cultural factors contributing to the pervasive stigma surrounding abortion. Emphasising the historical underpinnings rooted in Victorian morals and Christian ideology, the research sheds light on the legal status of abortion services and its impact on access to safe and legal abortion services.

The societal stigma surrounding abortion is primarily shaped by prevailing attitudes towards women's rights, characterising abortion as morally reprehensible acts and associating them with premarital sex and sexual promiscuity among women. This stigma is perpetuated by legal frameworks that criminalise abortion in numerous countries, impeding access to accurate information regarding the legality and availability of abortion services. This can be witnessed even in jurisdictions where abortion is legally permitted like Vietnam and Nepal, erecting significant barriers to obtaining safe abortion procedures.

The impact of abortion stigma extends to medical policies, contributing to shortages of medical abortion pills and a lack of state approvals for the distribution of essential abortion drugs in countries such as Malaysia, Indonesia and the Philippines. Stringent regulations surrounding medical abortion also discourage healthcare professionals from prescribing these to pregnant persons.

Moreover, cultural norms play a pivotal role in shaping regulations related to decisional bodily autonomy and formalising societal attitudes toward individuals' sexuality and their relationship with their bodies. Cultural taboo against abortion are rooted in a systemic desire to control women's sexuality and deny them decisional bodily autonomy. This cultural association deems abortion a ‘sinful’ and clandestine activity, as evidenced in Thailand, Philippines and Sri Lanka. In these contexts, cis-heteropatriarchy and ethnocentrisms reinforce conservative stances on sexuality and SRHR. In countries like India and Nepal, the situation is further complicated by caste hierarchies, directly impacting the access to rights for marginalised individuals.

Cultural attitudes are further influenced by religious traditions, with many religions considering

abortion a 'sin'. Individual and societal perspectives on abortion, morality and legality are deeply influenced by religious norms. Even in countries with liberal abortion laws like Vietnam and Malaysia, cultural and religious barriers can impede access to abortion services. For instance, the availability of abortion services in Vietnam is influenced by religious views on reincarnation, while restrictive abortion laws in the Philippines align with the pro-life movement of the Catholic Church. In Thailand, the opposition to abortion is also rooted in religious beliefs stemming from Buddhism.

The religious, social and cultural influences and the criminalisation of abortion within the legal frameworks of various countries has a profound impact on abortion access. Such criminalisation not only reinforces societal stigma, as seen in the Philippines where pregnant persons are compelled to endure unwanted pregnancies, but also perpetuates gender stereotypes that confine women to the role of 'caregivers' and impede their access to abortion. This criminalisation does not deter the actual incidence of abortion but rather compels pregnant persons to seek unsafe, clandestine abortion services. Consequentially, there is increased maternal mortality.

Moreover, the fear of prosecution among healthcare professionals and individuals seeking abortion services is prevalent in countries like Indonesia, Pakistan, Sri Lanka, India and the Philippines. Even in countries with ostensibly liberal abortion laws, the looming fear of legal repercussions can severely hinder access to safe and legal abortion services. In instances where strict laws or other factors limit access to abortion, safe abortion services become a privilege accessible primarily to the affluent, leaving poor and marginalised individuals to resort to unsafe alternatives due to insufficient public and rural health infrastructure as seen in the case of Nepal, Malaysia, India and Sri Lanka.

The criminalisation of adolescent sexuality and abortion further obstructs abortion access for young individuals. In countries like India, Sri Lanka and Indonesia, restrictive laws around adolescent sexuality drive many adolescents towards unsafe abortion methods. In the Philippines, the lack of legal agency also hinders the provision of essential sexual education to adolescents. Additionally, certain countries frame abortion within a strong 'family planning' discourse, excluding adolescents and unmarried pregnant individuals from its scope.

The integration of post-abortion care into broader reproductive health services is essential, aligning with the principles of holistic care that recognise the multifaceted nature of women's reproductive health. Experiences from Bangladesh and Sri Lanka highlight the effectiveness of strategies that go beyond abortion alone, such as incorporating guidelines on Menstrual Regulation and Post Abortion Care. These approaches play a crucial role in mitigating the adverse effects of criminalisation. Recognising the pivotal role of post-abortion care, its implementation and promotion become

integral for fostering comprehensive reproductive health services. To fully realise its potential, it is imperative to advocate for increased awareness, accessibility and integration of post-abortion care within healthcare systems. This advocacy is crucial not only for addressing the immediate needs of pregnant individuals but also for creating a healthier and more supportive environment for their overall reproductive care.

Finally, legal reforms on abortion are underway in various countries, often driven by social movements. Feminist groups in countries like Indonesia and the Philippines are at the forefront of abortion rights movements, while others, such as those in Sri Lanka, India and Bangladesh prioritise issues of sexual and gender violence. Pakistan has made progress on access to affordable abortion services. Ambiguities in legal frameworks, as observed in Indonesia, Bangladesh and India, pose additional barriers to abortion access. Thus, liberalising abortion laws is very important but insufficient for improving abortion access. In numerous South Asian and Southeast Asian nations, existing healthcare systems present formidable challenges to abortion accessibility. Achieving reproductive justice for marginalised individuals necessitates a comprehensive approach to reproductive healthcare. This perspective underscores the imperative for a multifaceted approach that transcends legal amendments, acknowledging the integral role of healthcare accessibility, affordability and decisional autonomy in achieving true reproductive justice. Meaningful legal reform within a reproductive justice framework necessitates viewing abortion rights through an intersectional lens within the larger SRHR framework. Addressing intersectional barriers is crucial, particularly for marginalised individuals who bear disproportionate consequences under carceral and criminal policies. Echoing Angela Davis's reminder, “an attempt to create a new conceptual terrain for imagining alternatives to imprisonment involves the ideological work of questioning why “criminals” have been constituted as a class and, indeed, a class of human beings undeserving of the civil and human rights accorded to others.”[1]

NOTES FOR CHAPTER V

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JGU @ A GLANCE

11000+ Students — FEMALE **49%** | MALE **51%** | UNDERGRADUATE **80%** | MASTERS/DOCTORAL **20 %**

1100+ Faculty — FEMALE **55%** | MALE **45%**

35 Average age of faculty members

45% Faculty members are alumni of the top **200** global universities

129 International faculty from **51** countries

1:9 Faculty-Student Ratio

10000+ Alumni Network World-Wide

28 Indian States & Union Territories represented by students

12 SCHOOLS

45+ Programmes

30+ Undergraduate Programmes
15+ Postgraduate Programmes
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- Jindal Global Law School — India's First Global Law School
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- Jindal School of Government and Public Policy — India's First Public Policy School
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- Jindal School of Art & Architecture — India's First Interdisciplinary School of Built Environment
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- Jindal School of Environment & Sustainability — India's First Interdisciplinary Environment & Sustainability School
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3 Research & capacity building institutes

- JILDEE — Jindal Institute of Leadership Development and Executive Education
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ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Established in 1993, it envisions an equal, just, and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

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