Report on Launch of

"My Body, My Choice – A Human Rights Perspective of Abortion Law in India"

and

"Claiming Dignity, Using Law to advance Reproductive and Sexual Health Rights"

1st November, 2019

Women's Press Corps, New Delhi

HRLN

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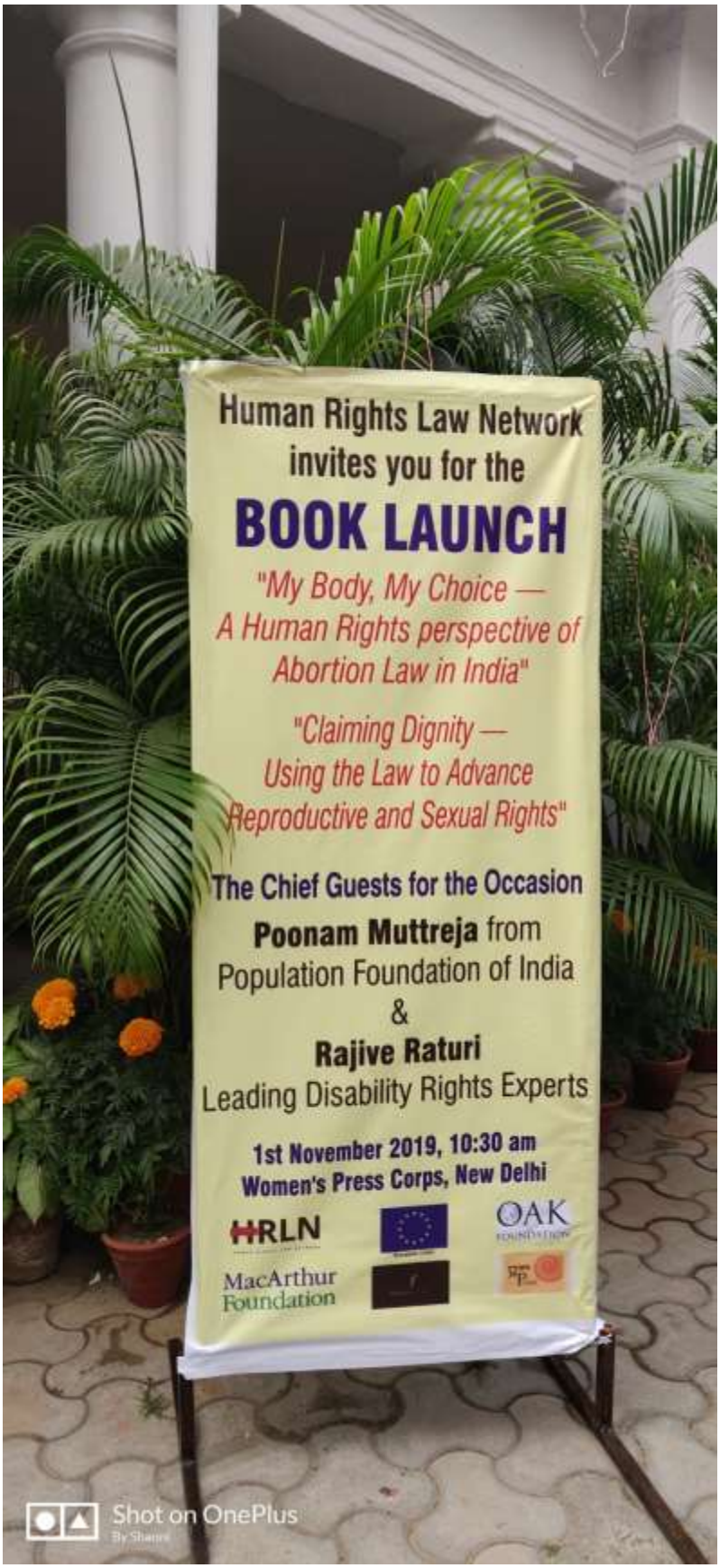
Human Rights Law Network
invites you for the
BOOK LAUNCH
"My Body, My Choice —
A Human Rights perspective of
Abortion Law in India"
"Claiming Dignity —
Using the Law to Advance
Reproductive and Sexual Rights"
The Chief Guests for the Occasion
Poonam Muttreja from
Population Foundation of India
&
Rajive Raturi
Leading Disability Rights Experts
1st November 2019, 10:30 am
Women's Press Corps, New Delhi
HRLN
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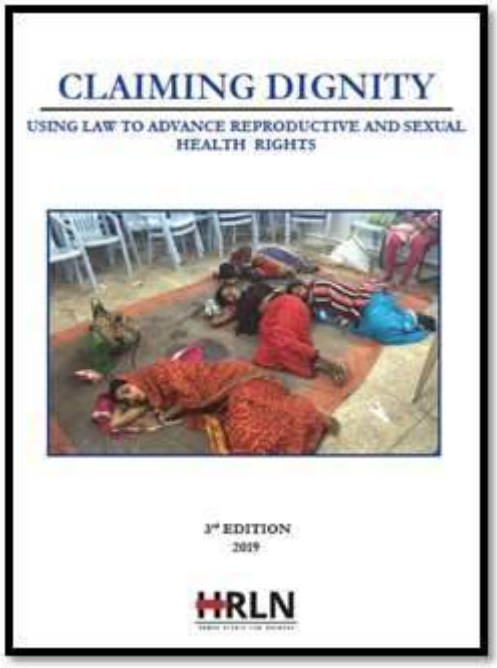
Shot on OnePlus

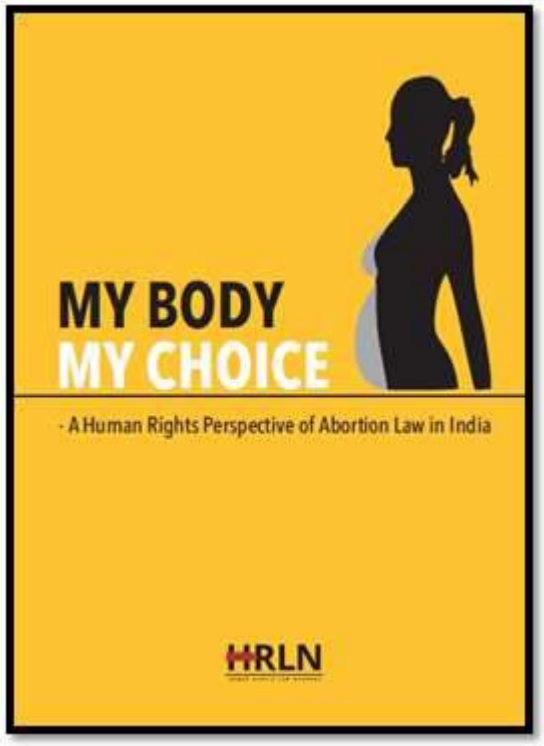
The discourse around Reproductive Health Rights so far has been as women being mere subjects of the narrative, acted upon by policies. Seldom have they been made central to the policies that are made for them which make legal recourse and medical facilities inaccessible to women, in a blatant disregard for their right to a dignified life. The third edition of the book "Claiming Dignity, Using Law to advance Reproductive and Sexual Health Rights" addresses "the idea of reproductive rights and all that they encompass. It will outline the major issues that India continues to face today in terms of reproductive health. These areas can be identified as: quality of care, implementation of government schemes, child marriages, unmet need for contraception, rights of the ground level health workers, access to abortion services and access to adequate nutrition." with an overarching view of domestic laws and policy.



"Claiming Dignity"
Using law to advance Reproductive and Sexual Rights
A collection of cases illustrating themes of sexual and reproductive rights, with its various facets of legal protection and schemes, access to safe abortion, coercive sterilization, child marriages, contraception, maternal health, medical and health care services, nutrition, hygiene and sanitation.

Part of the Reproductive Rights of women, is the right to Abortion. Abortion in India is a highly contested issue, with legislations that although do not take an absolutist stance on the illegality of abortions but also make abortions very inaccessible. The book "My Body, My Choice – A Human Rights Perspective of Abortion Law in India" explores abortion as a human right and

discusses how “The tension between the individual’s autonomy, communal social and religious influences and legal restrictions has always frustrated the fates of pregnant people, whose lives and bodily integrity are deeply impacted by either the continuation or termination of pregnancy. Courts have often been assigned the role of ultimate arbiter in abortion cases across the world.” As the Introduction to the book reads, “The central assumption of this book is that access to abortion is a right. All pregnant persons are rights holders, by virtue of their personhood and human dignity. When recognised as a right, access to abortion places certain obligations on States to respect, protect and fulfil this right, and the project of this book will be to examine how this has been, and could be, achieved.”



“My Body, My Choice – A Human Rights Perspective of Abortion Law in India”

A book tracing the context of abortion in India, recent case laws, trends in abortion law and abortion as a human right internationally, with interviews of petitioners; to realising the Right to Abortion in India.

The book launch began with Sarita Barpanda from HRLN elucidating how the Reproductive Rights Initiative of HRLN has been working for the past 5 years and in its course has seen landmark judgements and cases of negligence alike, including that of a woman who bled to death

in front of a hospital for the lack of access to facilities and a 13 year old girl who had to give birth because the court did not allow her to terminate her pregnancy. On one hand the court directed the state government of Bihar to act on the "contraceptives at doorstep" initiative while on the other hand, the cases of coercive insertion of Post Partum Intra-Uterine Contraceptive Devices (PPIUCDs) are rife. It is evident that the health system is crumbling with dilapidated buildings, budget allocations not being spent and the lack of health centres or sub-centres with the presence of all of the required facilities. She further added that violence against women within the health set up has increased, including violence on women on the Operation Table, recalling an incident where a woman had to have her thumb amputated due to medical negligence on the operating table during her delivery. The existing sub-centres are not in workable conditions and the ASHA system has no defined process due to the lack of existing sub-centres. Although the judiciary is not the sole avenue to address these issues, it is of significant with advocacy supported by networks of people working in the field.

Sarita Barpanda then went on to introduce the guests of honour for the book launch. She described herself as a fan of Poonam Muttreja from the Population Foundation of India as she spoke of being an ardent listener of all her discourses. Poonam Muttreja is the Executive Director of the Population Foundation of India (PFI), New Delhi. She has over 40 years of experience in development – setting up and heading NGOs, contributing to policy and advocacy, creatively building a field, improving organizational capacity, strengthening communications for social good, promoting innovations and scaling up pilots, making grants, teaching, advising, and

mentoring. Next, she introduced Dr. Mira Shiva, a leading feminist and public health figure. She has also been one of the biggest allies of HRLN, contributing a lot to the Reproductive Rights realm. She is also the director at Initiative for Health Equity & Society. While introducing Mr. Rajive Raturi, Sarita mentioned that he is her mentor and also a leading disability rights expert.

When asked to speak about reproductive rights, Poonam Muttreja briefly touched upon the history of Human Rights groups advocating for reforms in the health sector, particularly those aimed at reproductive rights. She recalled wanting to make a grant in the year 2000 for quality care as a human right to HRLN since what activists kept talking about seldom translated into action. It was important for Human Rights Organizations to talk about women and Reproductive Rights.

Setting a precedent when HRLN successfully negotiated for a grant for quality care as a human right, other human rights organizations followed suit with investing in sexual and reproductive health rights. Reminiscing the history of women's health movement, she spoke about how around 30-40 years ago, the feminist groups were not working with the health advocacy groups because they perceived family planning measures as controlling women's fertility. However, over the years, there has been a shift to focus on the agency of women to decide if, when and how they want to bear children. Amidst the global euphoria around the International Conference on Population and Development, 1994 (ICPD), with raging debates between feminists and religious groups on abortion, India made a progressive population policy. Despite it being incentive based, there was an aspect of coercion to it with the lack of counselling services and the mismanagement of contraceptives and their side effects. This led to sterilization becoming the mainstay of women. Poonam flagged three issues with the overemphasis on sterilization. Firstly, focusing solely on sterilization was a violation of the human rights of women. This focus

resulted in sterilization camps with horrible, unhygienic and undignified conditions, increasing morbidity with no method for spacing pregnancies adequately being advised. There is a conflation of abortions and sex-selective abortions which overlooks the fact that majority of the abortions are stand-ins for contraception. Secondly, the camp approach to sterilization is highly problematic as is evident from the several reports on the deplorable conditions of the camps. Thirdly, women tend to have more children than they want which then leads them to opt for sterilization, but it also creates the problem of unwanted pregnancies, the children born as a result of which are neglected. Poonam cited the 2014 Bilaspur deaths of 13 women, with 65 others being hospitalised in critical condition after a botched up mass sterilization process to illustrate the administrative pressure on sterilization as the sole method for contraception in order to control the growth of the population.

Poonam commended HRLN as strategic and intuitive for its PIL in the court for quality care in reproductive health. The court in this case ordered that the government is required to report every quarter its focus on spacing pregnancies, moving from the camp approach to quality care and the budget allocation and its expenditure for the same. She went on to say that despite the increasingly volatile political atmosphere, especially regarding human rights, evidence based advocacy for the people of India (as opposed to vested interests) and working with the government eventually yields significant results.

Poonam then addressed the coercive element in the two child norm, manifested in a private member's bill in the Rajya Sabha, coinciding with the Assam Governments bill on the same. She spoke of the need for this norm being fuelled by the myth and fear of a certain minority community having enough children to threaten the existing majority population. The norm is anti-women and anti-poor because of its restriction on parents of more than two children accessing government jobs and facilities which are ideally intended for those very people. There have been instances of men divorcing their wives when they had more than two children, just to access government jobs, putting the onus of following the two child norm completely on women. The two child norm that was prevalent in China was abandoned because of its consequence of an adverse sex ratio, which could be critical in India where the sex ratios are already adverse without the norm. In the mainstream discourse, India's biggest problem seems to be population and according to Poonam, we are fighting it on a discourse of women's bodies and not facts and reality.

This issue doesn't only need a legal push but also movements, advocacy and policy change. Most importantly, with the two child norm, the pending MTP bill must be enacted, with a collective focus on facts. The current MTP Act fails to recognise the decisional and access aspects of abortion with requirements of going to court for permission for abortion, denying a woman the absolute right to abortion and thus destroying her dignity. Further, the act is not keeping up with the advancement in technology by failing to increase the upper gestational limit for abortion from 20 to 26 weeks. Poonam spoke of the books being launched - "My Body, My Choice – A Human Rights Perspective of Abortion Law in India" and "Claiming Dignity, Using Law to advance Reproductive and Sexual Health Rights"- being a great contribution to changing the minds of the government and judiciary. She also said that the information from the books must be disseminated widely, quoting Pt. Nehru in conclusion by saying, "The health of a nation is judged by the health of its women."

Dr. Mira spoke of the several dimensions of health including the social, economic, cultural and psychological while addressing the issue of women's health. She illustrated how in medical education, there is no emphasis on the gender of the patients thus inadequately equipping doctors with gender sensitivity and thus education must take a right based and gender sensitive approach. A lot of government programmes do not account for inflicted pregnancy, as in cases of rape. They only look from the perspective that says "don't get pregnant" to women, where the onus is on the women only to not conceive, thus denying them dignity as a partner in a relationship. Opposition to sterilization is seen as anti-women, anti-national and anti-development as articulated by Mira and she emphasized that women's bodies cannot be used for another's pleasure. She then spoke of the role that patriarchy played in this, where the X or Y chromosome that determines the sex of the child is given by the husband but it is wife who bears the social brunt of bearing a girl child.

Emphasizing that women are more than wombs and tubes, Mira spoke of no funds being allotted for treating Reproductive Tract Infections, but funding being given for Intra-Uterine Contraceptive Devices (IUCDs). Although vasectomies are much easier and simpler procedures with less adverse side effects, they are not done because the understanding of health in our culture leads men to fear impotency from sterilization procedures which results in restricting the Reproductive Rights of women. The onus of climate change is put on rising populations of the third world countries, effectively shifting focus from the excessive consumption in the first world countries. As a consequence of this, undesirable coercive methods of population control are being used. The two child norm in Himachal Pradesh saw that on the conception of a third child women were packed off, casting aspersions on their character with the men completely absolving themselves of responsibility of bearing a third child. Further, it is essential to introspect whether the rights of the two children under the two child norm are ensured or not, before denying them

to the third child. When women are blind spotted from policy, it is critical to humanise issues by taking into account patriarchy, gender sensitivity and the rights of the poor. The handling of diseases must be gender sensitive, along with the recommendations by the JS Verma committee of a 'One-Stop Crisis Centre' for emergency contraception for victims of sexual assault being pursued. Going to court to seek permission for the abortion of a rapist's child and the ensuing trauma must be avoided. Women have a right to Reproductive Healthcare and contraception that is gender sensitive. In conclusion, Mira congratulated HRLN for the books it launched which she spoke of as contributing to continue fighting for the Sexual and Reproductive Health Rights of women.

Sarita then went on to emphasize that the two child norm will be seriously taken up, and it will be ensured that the majority of the states have a fact finding conducted for sterilization camps. She also spoke of a petition about PPIUCDs being disposed off because the judge didn't take a gendered perspective. Within Sexual and Reproductive Health Rights, Sarita expressed regret about not being able to aggressively take up the rights of disabled persons. She invited Mr. Rajive to further elucidate on this.

Rajive began by congratulating HRLN for launching the two books, giving special mention to the chapter on reproductive rights of women with disabilities. He said that it was ironic that section 3 of the Medical Termination of Pregnancy Act 1971, which delineates the circumstances under which the medical termination of a pregnancy may be allowed and which is the basis of most of the cases under this act, is one that disability rights activists have been trying to get repealed as it severely impairs the rights of persons with disabilities. Similarly the Pre-Conception & Pre-Natal Diagnostic Techniques Act, 1994 (PCPNDT Act) enables pre natal diagnostics to check for genetic and chromosomal abnormalities which results in abortion of a foetus that might have genetic aberrations that could cause disabilities. However, there has been a case where the Supreme Court disallowed the abortion of a foetus with Down syndrome. He recalled another case where the Supreme Court disallowed abortion to a girl who wanted to discontinue her pregnancy that was caused by rape. Citing the UN Convention on the Rights of Persons with Disabilities 2007 and the Rights of Persons with Disabilities Act 2016, he spoke of the disabled person's right to

fertility which cannot be denied to them without informed consent which is denied to them in instances of hysterectomies being conducted on women with disabilities. He also mentioned Section 92 of the Rights of Persons with Disabilities Act, which says, “Whoever performs, conducts or directs any medical procedure to be performed on a woman with disabilities which leads to or is likely to lead to termination of pregnancy without her express consent except in cases where medical procedure for termination of pregnancy is done in severe cases of disability and with the opinion of a registered medical practitioner and also with the consent of the guardian of the woman with disabilities, shall be punishable with imprisonment for a term which shall not be less than six months but which may extend to five years and with fine.”

He concluded by saying that there was a need to talk about the Reproductive Rights of persons with disabilities and mainstream the discourse. Mira added that knowledge about the teratogenic effects of certain medications would help in preventing the instances of disabilities in children and that women must have a say when it comes to taking care of their health.

Sarita added that almost 140 of the 170 cases that HRLN has under the MTP Act come from the poorest of the poor. Recalling a case wherein a woman argued that she cannot afford to raise a foetus with Down syndrome and hence, must be allowed to terminate her pregnancy; the court did not consider it as a valid enough ground for the termination of pregnancy. However, in a recent case that was similar to this, the Bangalore High Court allowed the termination of pregnancy, and hence it was evident that the verdict of different courts was dependent on the judges and not absolutely guided by principles of the right to self determination and bodily integrity of women. She hoped that the books being released would contribute to understanding how best the right of women to self determination and bodily integrity could be ensured. The books were then released at the hands of the guests of honour after which the conference broke for tea.Beginning the session on ‘Debates around Abortion in India’, Advocate Sneha Mukherjee spoke of the journey in courts, with HRLN having done more than a 100 cases so far seeking the medical termination of pregnancy post the upper gestational limit of 20 weeks, with important cases like the 2009 Nikhil Datar case in the Bombay High Court that put into perspective the constitutional validity of the MTP Act 1971. The MTP Act reads as more provider centric than women centric as it does not give any choice

to women in termination of a pregnancy, when ideally the decision on pregnancy should be a woman's alone. In cases of foetal abnormality where life post birth is not viable, courts allow termination of pregnancy but need constant reinforcement from medical boards. Accounting for the various possible interpretations of the phrase "save the life of a woman" in the MTP Act, especially with regards to section 3 and 5 of the act, Pratigya, Jindal and HRLN are arguing to introspect the constitutional validity of the MTP Act.

V.S Chandrashekar from the Pratigya Campaign, who also is the CEO of Foundation for Reproductive Health Services India, spoke next, first elaborating on the work that he does. The Foundation for Reproductive Health Services India is the largest service provider of family planning services working with Primary Health Centres and Community Health Centres, also providing abortions. Pratigya is a network of 100 grass roots working in women's health rights with regards to the MTP and PCPNDT acts. He illustrated an important aspect of the non availability of abortion services because of the intersection of the Protection of Children from Sexual Offences (POCSO) Act, 2012 and the MTP Act 1971. A provider of services under these two acts has two conflicting roles. While on one hand, they must provide services which include abortion, under the POCSO Act along with reporting these cases to the police, while on the other the MTP Act regulates procedures of medical terminations of pregnancy.

In cases of consensual sex between minors, the service provider is obligated to report the cases. This scares the minors away from certified abortion service providers to seek unsafe abortions, with these incidents happening in metropolises too. He recalled a case where consensual sex between minors resulted in conception and both the parties, including their families wanted to terminate the pregnancy, but since the provider had to mandatorily report the case under the POCSO Act, the police were involved. The police then went on to ask the girl not to terminate the pregnancy as it would make for concrete evidence for a strong case under the POCSO Act. Fortunately the service provider knew the law and took a stand for his clients. Chandrashekar said that the best

thing to happen was the medical abortions (as opposed to surgical) with a combination pack of drugs for abortion reflecting technological advancement and more people adopting safe and simple abortions. This inadvertently gave agency to women, mooted out the provider and made way for a non invasive procedure.

He also debunked the myth of all abortions being sex selective as being unfounded, as most abortions happen before the period when it is possible to determine the sex of the foetus. He also clarified the difference between unsafe and other classifications of abortions as given by the WHO which include safe, less safe and the least safe abortions. Safe abortions mean those performed by recommended medical professionals through proper procedure; less safe abortions mean using recommended methods but the provider probably not being trained and the least safe abortions are performed neither by recommended professionals or procedures. The number of abortions in India classified as unsafe are only 5% but they still affect morbidity and mortality rates. He added that there is confusion regarding the laws which leads people to believe that abortions are illegal, bad which in turn leads them to seek unsafe abortions. There have been cases where it was not necessary to go to court but petitioners still went because of fear and confusion regarding law. Unfortunately a clarification was never given by the judiciary, perhaps because the disproportionate burden on judiciary, especially the Bombay High Court where the majority of the cases are filed.

Dipika Jain from the O.P. Jindal Law School gave a legal – academic perspective on what reform should look like. She spoke of the problem of third party authorisation where court intervention is unnecessary and yet sought because of the fear of criminalization. It is necessary to decriminalize abortion to create an enabling environment to access abortions under the MTP Act, abortion must be looked at as a healthcare service and not a matter of legal intervention as is in Canada or it must be covered by a pro active legislation like the Vietnamese law which gives women an absolute right to abortion.

Dipika recommended that we borrow from the international framework and the judiciary establish a linear, progressive precedent of Reproductive Rights as Fundamental Rights. Although the jurisprudence of the law is health and dignity, it is not that of equal citizenship, accounting for

socio-economic and cultural factors. The effect of an anti-abortion law on Dalit, Bahujan and Adivasi women must be looked at. In the case of Anita Kujur in Chhattisgarh, where she was raped and filed a complaint when she was pregnant for 12 weeks, the court procedures went on for long enough that she had crossed the upper gestational limit for termination (20 weeks) but fortunately was allowed to terminate her pregnancy at 21 weeks. Studies indicate that DBA women find it harder to access abortion services and thus, it is essential to ensure equal citizenship. Dipika also added that larger socio-cultural narratives are hinged on women thus leaving people who are trans and need access to abortion services, out of the conversation. Hence, it is pivotal to take the multiple stakeholders' perspectives and engage with larger movements.

The panel then took questions, the first of which was whether there were any subsequent studies to validate data from earlier ones. Responding to this, Chandrashekar replied in the negative, elaborating on the reasons behind it too. The reporting of abortion cases is very low, with most abortions happening in the private sector and the National Family Health Survey (NHFS) under-reporting abortions. Further the risk of carrying the pregnancy to term is much higher than having an abortion, even an unsafe one, which women are willing to pay for. When asked whether the focus on the physical nature of abortion, with majority of the judgements around the premise, will diminish with the equal citizenship perspective; Dipika said that she didn't think so, since certain gender stereotypes disproportionately impact women.

Sneha narrated an incident where she met gynaecologists working in the rural areas and heard of a doctor asking a minor who was a few months short of the age of majority to come back after attaining the age of majority, to get an abortion done. However, by then, she would have been past the upper gestational limit for the medical termination of pregnancy under the MTP Act. She then asked the panellists how they would recommend that we work towards bringing an understanding amongst service providers. Chandrashekar then spoke of how the stigma around unmarried women seeking abortion, even in cities, is appalling. Rural service providers are often more empathetic towards patients and understand the context of pregnancies of minor girls. There is a need to use channels of communication to sensitize people and make them aware. Doctors are unaware of legal provisions, and since they have no security system in place for them under the act, they take the self protection angle to play safe, thus making abortions inaccessible.

Following up, Sneha deliberated on expanding the provider base, raising questions like who should or should not be included as medical practitioners certified to perform abortion procedures, beyond gynaecologists.

Chandrashekar then elaborated that since the MTP Act is 48 years old, it only takes into account the Dilation and curettage (D&C) procedure as a possible method for abortion thus requiring the medical practitioner to have the skill to perform a risky, complicated procedure. The MTP Act was made to protect the allopathic provider of abortions. However, with changes in technology, abortion has become far simpler. It is a safe obstetric procedure with the least possible consequences; in fact, safe abortion is far less risky than a normal delivery.

Sarita added that services should be reformed regardless of the law and we must make a firm demand for services to be more progressive without the complications of law bearing on it. Chandrashekar agreed, adding that unfortunately abortion is criminalized and overly regulate in the scope of legislation. The current providers are inadequate to provide large scale services. Further, there is a belief that only allopathic practitioners can provide abortion services. However, there is enough evidence to suggest that Aayush providers in the PHCs, nurses, skilled birthing attendants and auxiliary nursing midwifes can perform abortion procedures since they already perform much more complex procedures for insertion of IUCDs, etc. If we allow other doctors to perform abortions then the service providers will increase, which is necessary.

The next question was why there was a need to make the law women centric, given that it was currently provider centric and did not see women as sexual beings capable of engaging in intercourse without the desire to reproduce. Dipika responded to this saying that the laws were never framed as a woman's issue but a mother's issue that reflected the heteronormative understanding and a gendered criminalization of abortion. Abortion being not just a medical but a moral issue, the feminist movement itself is divided over it and so are the POCSO, PCPNDT and MTP acts in conflict with each other, thus rendering legislations ineffective. Soft guidelines that encourage self use of abortion procedures under medical guidelines are critical, as the polarised debate only complicates accessing abortions. The patriarchal and patronizing framework of laws reflects that there is no understanding of social realities while drafting laws and thus, there is a need for more conversations and discussions around it.

Sarita added that laws do not take into account other diet and health related issues that might affect pregnancy. For example, an anaemic woman with an irregular menstrual cycle would possibly not know that she is pregnant and by the time she does, it might be too late to terminate the pregnancy. Thus, pregnancy needs to be opened up for discourse and debate, with the discourse that separates women's bodies from their environment being in dire need of change.

Chandrashekar added that increasing the visibility of the affected people would result in acknowledging the problem of abortion and open up the scope for conversation around it. He also acceded that since women considered abortion as a moral wrong, it was difficult to get women's voice into the mainstream, but also necessary. Law and policy must evolve with women at the centre, with their credible voices being heard.

Sneha then thanked the panellists and concluded the session, hoping that the books being launched would contribute to the discourse on the Reproductive Rights of Women in India. The launch concluded with a vote of thanks by Shaoni from HRLN.