MY BODY MY CHOICE

- A Human Rights Perspective of Abortion Law in India

2019

HRLN
HUMAN RIGHTS LAW NETWORK

My Body, My Choice:

A Human Rights Perspective of Abortion Law in India

HUMAN RIGHTS LAW NETWORK: OUR VISION

- To protect fundamental human rights, increase access to basic resources for marginalised communities, and eliminate discrimination.
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- To work towards an increased awareness of rights as universal and indivisible, and their realisation an immediate goal.

'My Body My Choice - A Human Rights Perspective of Abortion Law in India'

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LIST OF ABBREVIATIONS

BPL	Below the Poverty Line
CAT	Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, 1984
CEDAW	Convention on the Elimination of Discrimination Against Women, 1979
D&C	Dilatation and curettage
HPS	High Performing States
ICCPR	International Covenant on Civil and Political Rights, 1966
ICESCR	International Covenant on Economic, Social and Cultural Rights, 1966
ICPD	International Conference on Population and Development
IPL	Indian Penal Code, Act No. 45 of 1860
MA	Medical Abortion
MTP	Medical Termination of Pregnancy Act, 1971
MVA	Manual Vacuum Aspiration
SA	Surgical Abortion
UDHR	Universal Declaration of Human Rights
UNHRC	United Nations Human Rights Committee
WHO	World Health Organisation

Note on Terminology

In the book, the terms 'woman' and 'women' are occasionally used to describe those persons who are pregnant or exercise reproductive rights. The more precise and correct term to describe this group is: "people who are physically capable of becoming pregnant". This description is wholly inclusive of transgender individuals and those who identify as queer. The terms 'woman' and 'women' is simply used for the sake of shorthand.

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Introduction : Abortion Law

Abortion has always been a highly contentious issue in the spheres of philosophy, religion, culture and politics. However, at the core of the debate on abortion is the question: who gets to decide to terminate a pregnancy? 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. But courts have always had a particularly complicated response to cases in which abortion issues are raised. Whether legislation criminalises, regulates or protects access to abortion services, its effect and courts' judgments have significant implications for pregnant persons' right to health and their ability to live a life with dignity. In the past, underlying public moral and social contexts have often determined the direction courts have taken in dealing with cases on abortion. However with a shift towards employing a human rights-based approach when analysing access to healthcare in foreign jurisdictions, it could be argued that the role of the judiciary in matters of reproductive health and rights is shifting.

To an extent, this changing role of courts is evident when analysing the gradual development of jurisprudence related to abortion in India. Since the introduction of the Medical Termination of Pregnancy (MTP) Act in 1971 (see Appendix A), courts have reinterpreted its provisions by assessing individual cases more holistically and taking into consideration more specific factual circumstances. Most significantly, courts are now taking into account a pregnant person's different medical and personal contexts, employing more flexible interpretations when analysing individual cases. This is in stark contrast to past approaches, in which courts uncritically followed previous judgments, strict time limits and dismissed matters that did not fit exactly within the grounds for termination under the MTP Act. However, in order to understand steady, but slight, shifts in courts' approaches to interpreting and implementing the MTP Act, it is also important to

understand what the right to abortion, reproductive autonomy and reproductive health actually encompasses.

According to the World Health Organisation, reproductive health refers to the ability of people "to have a responsible, satisfying and safe sex life and…have the capability to reproduce and the freedom to decide if, when and how often to do so".[1] When considering how the right to reproductive health may be fulfilled, it soon becomes evident that this right encompasses numerous other rights, commonly understood as the right to legal, safe abortion; freedom from coerced sterilisation and contraception; the right to access quality reproductive healthcare and the right to family planning education. In 1995, this definition was supported with the drafting of the non-binding Beijing Declaration and Platform for Action:

> The human rights of women include[s] their **right to have control over and decide freely** and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences.[2]

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. When understood as a human right, the right of access to abortion becomes a direct concern for policymakers to meet the obligations it involves to realise the right in legal, political and practical terms. Reproductive rights have emerged from international human rights movements, led by pregnant persons the world over. This unity between pregnant persons reflects the universality of the right to access to abortion and highlights the need to integrate the right in every State. The right to abortion has two dimensions that mutually reinforce one another. It involves both the right to reproductive autonomy and the right to health. They have frequently been framed as negative rights, protecting the rights of the individual to make autonomous reproductive decisions, grounded in civil and political rights to privacy, liberty, equality, autonomy, and dignity. This interpretation centres on the *decisional* aspects of abortion and seeks to protect those factors which ensure the right to choose without coercion.[3] The right to health, on the other hand, is viewed as a socio-economic right, focusing on the provision of access to health services. This interpretation centres on the *foundational* aspects of abortion. In other words, it focuses on the services and materials needed for the right to reproductive health to be realised. The book will rely on this two dimensional understanding of the right to abortion in order to assess the current state of abortion law in India and abroad. It should be obvious that autonomy and self-determination are the primary factors that should influence the exercise of the rights defined above.

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[1]World Health Organisation, 'Reproductive Health', available from: http://www.who.int/topics/reproductive_health/en/.
[2]World Health Organisation, 'Reproductive Health', available from: http://www.who.int/topics/reproductive_health/en/.
Lance Gable, 'Reproductive Health as a Human Right', *Western Law Review,* 2010, vol. 60(4), p.980.

Nevertheless, State institutions have often intervened in this complex decision-making process, which is already complicated by socioeconomic, religious and cultural factors. One such institution is the judiciary and its interpretation of the operation of the MTP Act. In India, courts' role in understanding the MTP Act and the application of its provisions has often been impacted by wider public policy considerations. As will be seen, this has often directly led to a conflict with objectively assessing an individual's specific case. This conflict often occurs due to complex questions that arise in the course of reading the MTP Act. First, with the MTP Act's strict time limit barring terminations after 20 weeks,[4] questions arise as to the symbolic and medical implications for the rights and agency of the pregnant person. Second, is there flexibility as to how the grounds for termination are understood? Should the words in the statute be understood in a strict, literal sense or could courts recognise how changes in technology and social attitudes justify abortions in other cases? Instead of interpreting the MTP Act's provisions as a closed list of grounds for termination, could courts adopt purposive construction to recognise an individual's reproductive autonomy and their right of access to abortion services in different circumstances? If so, could the MTP Act been seen as more adaptive and flexible than it at first appears? Third, how do you protect the health of

the pregnant person, from either an unsafe abortion or unsafe labour process, by taking account of medical professionals' advice? What degree of certainty from professionals is required for a court to determine whether there is simply a 'risk' or a 'substantial risk'? Fourth, how is a pregnant person's

[4]Unless the pregnancy poses an immediate threat to the pregnant person's life under Section 5 of the MTP Act.

right to an adequate standard of physical and mental health affected by other factors? For example, what impact will carrying a foetus, with either a fatal or non-fatal abnormality, have upon the pregnant person's health and how should the court assess this impact?

This book seeks to examine how courts have addressed these questions and explain issues related to abortion through the lived experience of pregnant persons in India, considering their socioeconomic and cultural contexts. Understanding the factors driving individuals to seek abortions and the factors that bar them from accessing abortion services should be an essential element when considering how a court and medical practitioners intervene in matters so personal to the individual. As such, Chapter One will briefly explore the drafting and impact of the MTP Act and how it has affected pregnant persons, their families, medical practitioners and abortion service providers. Also, the current state of the healthcare system and its treatment of pregnant persons in India will be briefly examined to determine the current practical barriers to realising the right to abortion, in spite of the specific protections of the MTP Act.

The core of the book will focus on specifically tracing the trends in Indian courts' interpretations of the provisions of the MTP Act and the underlying implications of these shifts toward holistically examining the situation of each pregnant person. Factors will be examined including statutory interpretation, the role of medical professionals' testimonies and consideration of the right to life, as enshrined in Article 21 of the Constitution of India. Analysing the changing approach in the Supreme Court of India and other High Courts by outlining landmark judgments will be the focus of Chapter Two. Additionally, specific focus will be given to examining the trajectory of the Bombay High Court's approach to illuminate a new innovative interpretation of the MTP Act.Chapter Three will then analyse recent political and legislative challenges to the MTP Act, particularly in the light of severalpending amendment bills. Determining what these proposed amendments represent in practical and rhetorical terms for the rights of pregnant persons will also reveal the public's and the government's changing perception of the right to abortion.

Finally, Chapter Four will examine the developing characterisation of abortion as a distinct human right in international law and how national jurisdictions have dealt with cases of abortion from differing moral, religious and political perspectives. This section will highlight examples of best practice, in countries that protect both the decisional and foundational dimensions of the right to abortion.It will also explore the indivisible and interdependent nature of the right to abortion with other rights, including the rights to health, privacy, non-discrimination and freedom from cruel and inhuman treatment. Additionally it will determine the scope of India's obligation to provide access to abortion under international law according to its ratification of particular international conventions.

It should be noted that the progression to realise the right to abortion is not only facilitated by the courts. Litigation can be risky, uncertain, and can take away scarce resources from other effective actors working toward change. The law cannot, however, be ignored by either activists or advocates. Despite its shortcomings the law can serve as a catalyst for social change by legally validating the reproductive rights of individuals from the perspective of a State institution. Furthermore, the political power held by the courts in India, and particularly the Supreme Court, can allow even small

legal reforms to improve the lives of millions of ordinary pregnant persons.As will be seen, in terms of adopting a true human rights-based approach, India must commit to actively decriminalising abortion in the Indian Penal Code, amending or repealing the MTP Act and situating issues of reproductive rights, and particularly the right to abortion, within the existing framework and values of the Constitution of India.

CHAPTER ONE

Contextualising Abortion in India

The decision to terminate a pregnancy is a deeply complex individual choice, influenced by a particular person's social, economic, familial and cultural circumstances. However, as with many legal interventionist approaches, due to India's prescription of a highly specific set of legislative rules to regulate abortion, this individual decision-making process is limited. At the general level, under the Indian Penal Code, abortion is categorically criminalised. However, according to the Medical Termination of Pregnancy Act, 1971, certain exceptions legally permit pregnant persons to access abortion services. Understanding the specific moral and philosophical underpinnings of the current Indian legal framework illustrates the particular historical context in which this legislation arose. Additionally it assists in explaining the judiciary's attempts to implement and interpret this legal framework, which currently does not necessarily reflect the public's thinking and attitudes to abortion.

This chapter will first briefly describe the historical development of abortion law in India and the legal system regulating the practice of abortion for pregnant persons, medical practitioners and abortion service providers. It will explore possible symbolic reasoning underlying this development. Simultaneously it will also examine the dire reality on the ground facing all people affected by abortion, and the practical ramifications of seeking an unsafe abortion when the law fails to allow or facilitate the exercise of pregnant persons' reproductive autonomy.

I. History of Abortion Law in India

The crime-and-punishment model of abortion law and policy was inherited from the period of British colonial rule. The British Raj criminalised abortion in Section 312 of the Indian Penal Code of 1860. Induced abortion or 'causing miscarriage' was banned except where necessary to save the life of the woman. Even today, this provision still governs the practice of abortion, and evidently for pregnant persons who obtain abortions and abortion service providers, this criminalisation

symbolically isolates them. It inadvertently condemns them to having committed a morally repugnant act. This public condemnation ensures that a patriarchal hierarchy dominates by denying a person's autonomy and forcing parenthood upon them. The reasons for this initial abortion ban are unclear, however it could stem from a strict moral and patriarchal incrimination of the pregnant person's exercise of their autonomy. Historical scholars have found that "abortion law was not just about reproduction but employed to police gender. As such abortion laws played an unexpected role in defining masculinity".[1]

Additionally, abortion prohibitions may have been introduced on religious grounds in order to punish and deter women from committing the 'sin' of ending pregnancy. According to various religious teachings the act of terminating a pregnancy is seen as an infringement on the right of God. It is often suggested that abortion was outlawed in order to protect the life of the foetus, which was valued as highly as that of the mother.[2] The significant element evident in all of these arguments is that abortion is a matter of morality.

However, moral and religious paradigms were not the only factors influencing legislative measures taken to criminalise abortion. Public health policy was also a consideration for British colonial authorities, concerned with maintaining and restricting health epidemics across the British Empire. During the nineteenth century, the professionalisation of maternal medicine was still in its infancy and women seeking abortion often resorted to taking unsafe measures including the ingestion of toxic, poisonous and noxious substances, the insertion of objects into the vagina, or pummelling the abdomen in order to disrupt pregnancy or induce labour. These 'traditional' methods were very risky and often led to injury, death or widespread health problems, which were a major public health concern for authorities.

By the twentieth century, activists across the world were struggling for the repeal of abortion bans and the disastrous consequences of criminalisation on individual pregnant persons. In Western countries, particularly the UK, this movement was driven by the struggle to improve women's equality and liberty. They argued that the bans amounted to restrictions on essential medical care, and illustrated the danger of illicit, unsafe abortions when pregnant persons felt isolated enough to seek unsafe measures to end unwanted pregnancies. This movement asserted the right of all women to control their reproductive capacities and fought for access to safe and legal abortion.[3]

In the Indian context though, another factor had a great impact on the movement to incrementally liberalise access to abortion from the general ban – social population policy. In the mid 1960s, exponential population growth and high rates of maternal mortality led the ruling elite in government to engage in discussions concerning the liberalisation of access to abortion. With this

[1]Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries 1870-1930*, 1997, University of Chicago Press, London, p. 72.
[2]Marge Berer, 'Abortion Law and Policy Around the World: In Search of Decriminalization', *Health and Human Rights Journal,* 2017, vol. 19(1), pp. 13–27 available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5473035/#r23.
[3]Barbara Hayler, 'Abortion', *Signs: Journal of Women in Culture and Society*, 1979, vol. 5(2), p.313.

wider public health and family planning agenda in mind, the Medical Termination of Pregnancy (MTP) Act was introduced in 1971.

II. The Introduction of the Medical Termination of Pregnancy (MTP) Act, 1971

In 1964 the government appointed Shanti Lal Shah to head the Committee to study the possible implications and necessity to legalise abortion. The Committee was tasked with examining the socio-cultural, legal and medical aspects of abortion in India.[4] In 1966, the Shah Committee published a 'Report on Legalisation of Abortion'. The Committee placed a strong emphasis on the high number of maternal deaths caused by illegal abortions, and cited with approval a statement made by Lord Bilkin during the House of Lords debate on liberalising abortion laws in 1967 in which he noted that:

> [Women] take drugs and pills, which are calculated to end pregnancy; they insert things into their wombs running a grave risk of serious injury… where these methods are unsuccessful many of them resort to unqualified abortionists.

The Committee considered the various reasons why women sought abortions.[5] They found that most women had abortions due to contraceptive failures, uncertain socio-economic and inter-personal circumstances, the difficulty of raising children, and illness. Subsequently, the committee expanded their investigation to consider the justifications for abortion in various countries and identified four categories of legally permissible abortion.

First, abortion should be available for medical and therapeutic reasons such as where the woman is ill or physical complications or defects arise during pregnancy. Second, abortion should be an option if socio-economic status and environmental reasons would negatively impact the woman's physical and mental strength. Third, for humanitarian reasons, in cases of rape and incest, where the woman is unmarried, or when the woman was a minor or had a developmental disability or where there is a risk that hereditary or contagious disease may be inherited. Fourth, abortions should be permitted where the foetus suffered or would suffer an illness or abnormality. The Committee suggested that abortions only be permitted if:

- Three doctors agreed that it was necessary,
- The procedure was carried out with the utmost quality of care, and
- They were only made available up to the thirteenth week of pregnancy.

The Committee also felt that socio-economic factors alone should not be influential, and that where a woman already had three children and sought to terminate the fourth pregnancy she should be forced to give birth and then undergo forced sterilisation. It was also recommended that the government invest in abortion facilities and campaigns to increase family planning awareness and contraceptive usage.

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[4] K. D. Gaur, 'Abortion and the Law in India', *Cochin University Law Review*, 1991, vol. 15, p. 131.

[5] Committee to Study the Question of Legalisation of Abortion, 'Report of the Committee on Legalisation of Abortion', Ministry of Health and Family Planning, Department of Family Planning, [1967].

Notably, the committee declared that a law, which prohibits an activity, which nevertheless occurs regularly, should require re-examination. Additionally, the committee focused on finding a proper balance between the problem of 'the wastage of maternal life and health' and the moral objection to abortion. This framework set the basis of the current law governing abortion, and the Committee's findings still determine women's fate today.

Following consideration and deliberation of the Shah Committee's findings and recommendations, the government introduced The Medical Termination of Pregnancy (MTP) Act in 1971. The MTP Act provided exceptions to the general criminalisation of abortion by the Penal Code in certain strict circumstances, mirroring the recommendations of the Shah Committee. Additionally it also mirrored the model set by the United Kingdom's Abortion Act of 1967, in which the legislative intent "was to provide a qualified 'right to abortion' and the termination of pregnancy has never been recognised as a normal recourse for expecting mothers".[6]

Section 3 of the Act allows for the termination of an unwanted pregnancy up to the 20th week of pregnancy. A woman requires the approval of one specialist doctor up to 12 weeks, and two doctors up to 20 weeks. A doctor may only certify an abortion request where the pregnancy poses a threat to the woman's life or physical and mental health, or in the case of foetal abnormality. Section 4 provides that only facilities that are run by the public sector or have prior approval may provide abortion services. Section 5 of the Act permits abortions at any point where necessary to save the pregnant person's life.

Tracing these historical developments, it becomes evident that India's particular legislative framework has been unique in the regulation of access to abortion. A combination of moral, religious, historical and public policy motivations have all impacted the legal framework regulating abortion that currently exists in India. Population control in the 1960s and 1970s were strong primary factors influencing its drafting,[7] and in this respect the Act did not acknowledge pregnant persons as autonomous individuals, capable of making their own decisions with regard to their reproductive health. Scholars have supported this proposition, particularly Nivedita Menon, who stated that the MTP Act "originated from the population control imperatives of the Indian state, not from feminist politics."[8] The impetus driving the MTP Act was still based on State interventionism. This was later supported by measures such as the introduction of the 'Two Child Norm', which reaffirmed to Menon that "the legal sanction for abortion does not arise from an understanding of women's choices and women's rights over our bodies. It is, rather, a socially mandated consequence of the economic imperatives of the state".[9] Another scholar, Rosalind Petchesky, described the phenomenon of reproductive rights as "'the fulcrum of a much broader ideological struggle in

[6]Suchita Srivastava & Anr vs. Chandigarh Administration Civil Appeal No. 5845 of 2009.

[7]See; Paul Ehrlich, *The Population Bomb,*1968, Ballantine Books, New York; Betsy Hartmann, *Reproductive Rights and Wrongs*, 1987, Haymarket Books, Boston.

[8]Nivedita Menon, *Recovering Subversion: Feminist Politics Beyond the Law,*2004, University of Illinois Press, Chicago, p.66.

[9]ibid.

which the very meanings of the family, the state, motherhood, and young women's sexuality are contested".[10] The relative ambiguity of the MTP Act reflects this complex nexus and it seems clear that the court's role as adjudicator is made all the more difficult with these wider policy concerns in mind.

III. Current State of the Legality of Abortion

In order to avoid widespread moral backlash, the MTP Act does not decriminalise the practice of abortion, either by pregnant mothers or abortion service providers. Rather, it adds exceptions to the criminalisation of abortion in Section 312 of the IPC. It should be reiterated here that this is merely a symbolic recognition that in a limited number of cases abortion may be considered legal. The onus is not on the pregnant person's autonomy or their reproductive rights but rather on a predetermined set of circumstances that demand special differential treatment.

The starting point for courts when an abortion decision by medical practitioners is appealed against, is always the recognition that abortion, or the 'causing [of] miscarriage', is a criminal offence, as set out in Sections 312 to 318 of the IPC. The only legal exception in the IPC is if the purpose of the intentional miscarriage is to save the life of the woman. The MTP Act supplements this exception by elaborating other circumstances in which abortion may be legally justified. First, it is important to note, that a legal abortion must be conducted and approved by a medical practitioner and the MTP protects their liability from a criminal charge under the IPC. Again the framing of this wording is symbolically significant. A pregnant person's right to access abortion is not being legalised, but rather the acts taken to provide an abortion by medical practitioners in

[10]Rosalind Petchesky, *Abortion and Women's Choice: The State, Sexuality and Reproductive Freedom*, 1990, Northeastern University Press, Boston.

certain circumstances are being legalised. In terms of policy this reflects how the MTP Act was not originally drafted in the interest of the pregnant person's exercise of their reproductive rights, but rather as a means to enable the wider family planning and moral conservatism of government policy.

The two major aspects to examine the legality of abortion in any case, according to the MTP Act, relate to time limits and the grounds justifying medical termination of a pregnancy. Under Section 3 of the MTP Act, in relation to timing, if the pregnancy does not exceed twelve weeks, the pregnant person need only have the approval for termination from a single medical practitioner, however if the pregnancy is between the twelfth and twentieth week, approval from two medical practitioners is required. For approval to be given, the medical practitioner must be of the opinion "formed in good faith" that:

> "**3.**_(2) (i)_ the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or
> _(ii)_ there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped."

In the Act's explanations, it is clarified that these provisions specifically include other circumstances. One of which is when a person's pregnancy is the result of rape, which impliedly causes grave injury to their mental health. Another situation that immediately justifies termination before the 20th week is when pregnancy has resulted after a contraceptive device, used by a married couple for the purpose of limiting the number of children they conceive, has failed. The unwanted pregnancy is similarly imputed to amount to grave injury to the mental health of the pregnant person. Importantly, Section 3 (3) specifies that when determining whether continuance of pregnancy would constitute "such a risk of injury to the health" of the pregnant person, the court may also consider "the pregnant woman's actual or reasonably foreseeable environment".

The other significant section of the MTP Act is Section 5, which somewhat mirrors the exception in the IPC to abortion, such that the time limits or grounds listed in Section 3, need not be fulfilled:

> "In a case where [the medical practitioner] is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman."

In R and Anr. vs. Haryana,[11] Justice Singh summarised the outline of the MTP scheme as follows:

1. Reasons to seek termination of pregnancy should be as mentioned under Section 3 of MTP Act. If those reasons are not present, no pregnancy can be legally terminated.
2. Length of pregnancy is a vital factor to give green signal for termination.
3. Pre-requisites of doctor's opinion to declare fit for termination as per law. The length of pregnancy determines the need for opinion of one or more doctors.
4. Consent of woman or her guardian (minor and mentally ill) is mandatory.

[11] R and Anr. vs. State of Haryana, Writ Petition (C) 6733 of 2016, High Court of Punjab and Haryana, para. 30.

5. To save life of woman, Section 5 lifts the embargo of termination on post 20 weeks pregnancy and requirement of more than one doctor's opinion. But the language used is 'immediately'.
6. No provision stipulates judicial authorisation of MTP in any case including those necessitating termination on account of mental anguish in woman due to rape committed on her.

This last element of the MTP scheme is crucial to understand, as it places the role of the court in a precarious position. It is not necessary for a court to 'authorise' every decision made by a pregnant person and their medical practitioner. But when a case reaches the court, the problem arises of weighing both a medical and legal assessment, which are influenced by different standards in terms of developments in medical science and judicial precedent. It also places pressure on practitioners' decision making, for while they may be certain of their own medical assessment, it may be unclear whether this accords with the law's threshold for certainty. This has had a great chilling effect on many medical practitioners, both in India and abroad. Nevertheless, the court will always be the forum of last determination and this poses many issues in terms of timing. Accessing the court, and potentially appealing lower courts' decisions, can be an extremely lengthy process, which puts significant pressure on pregnant persons with the ever present risk of passing the 20 week time limit impacting the MTP Act's operation. Many recent cases in High Courts and the Supreme Court have resulted because the pregnant person seeking an abortion is approaching the court for authorisation of termination after the 20 week time limit. As will be seen, the courts are beginning to make more and more allowances for 'special cases' and reinterpretations of MTP provisions under Section 5.

This scheme outlines the major exceptions to the Pica's general criminalisation of abortion, and has governed the development of abortion law since the MTP Act's inception in 1971. They were further clarified by rules and regulations introduced in 1975, 2002 and 2003, through various Acts passed in Parliament. The Medical Termination of Pregnancy Rules and Regulations 1975 specified that an abortion conducted at a hospital or other facility required prior consent from the Government and the onus rested with the hospital to obtain such consent. The Medical Termination of Pregnancy (Amendment) Act 2002 and amended Regulations and Rules Acts, 2003 (See Appendix C and Appendix D respectively) expanded the provisions of prior legislative provisions in order to increase the efficiency of the existing system and avoid unnecessary bureaucratic delays. According to scholars, this legislation aimed to:

> [Decentralise] regulation of abortion facilities from the State level to District Committees that [were] empowered to approve and regulate abortion facilities. It also [provided] punitive measures of 2-7 years imprisonment for individual providers and owners of facilities not approved by or maintained by the Government…To reduce administrative delays, the amended MTP Rules [defined] a time frame for registration and mandate the District Committee to inspect a facility.[12]

While these amendments provided for the theoretical expansion in the number of abortion facilities, as bureaucratic processes for approval would be streamlined due to decentralised regulation, in

[12]Siddhivinayak Hirve, 'Abortion Law, Policy and Services in India: A Critical Review' *Reproductive Health Matters*,2004, vol. 12, p. 116.

reality this has not been the case. Often District Committees are non-functional and with localised regulation this may lead to differences in the standards applied across different districts and states.[13] Also, these provisions are far from absolutely clear. Some have noted,

> Abortion law is always open to differing interpretations and though the present socio-political environment allows a more liberal interpretation in most cases, there is always the theoretical danger of more restrictive interpretations under different socio-political and demographic compulsions, without a single word of the text of the law being altered.[14]

The current provisions do not specify how a court will assess a doctor's judgment of what constitutes a 'risk to life' or 'grave injury to…physical or mental health'. Neither does the Act specify what is exactly meant by 'immediately necessary to save the life'. Is 'life' in this section considered simple basic survival, or is there a higher threshold to define 'life'? In other words, does a life 'lived with dignity' require a higher threshold of meeting a person's needs, including ensuring access to appropriate and adequate socioeconomic provisions? The other interesting element to consider is: if a court adopted a purposive approach to interpreting the MTP Act, how is the 20 week time limit justified? Is it simply an arbitrary fixed time that does not bear upon the medical development of the individual pregnancy? A purposive approach would involve investigating the aim of the legislation, and determining whether confirming the legality of an abortion under the MTP Act in a certain instance accords with the purpose of ensuring safe abortions on both compassionate and medical grounds. For example, surely there is a glaring flaw considering many pregnant people only learn of their pregnancy or a foetus' abnormality after the 20th week? How do you define or measure a serious handicap? Which other facts should a court, or medical practitioner, take account of when determining the impact of continuation of the pregnancy on the health of a pregnant person. The MTP Act chooses to completely replace the lived reality of the pregnant person with the official medical knowledge of their doctor, which is then weighed by the court.

While the language is superficially clear, courts do have a wide mandate to determine the legality of different abortion appeal cases, particularly with regard to what evidence they admit to pass judgment. How does a court evaluate an assessment made by qualified medical practitioners on the risk or potential for risk of injury to life, physical or mental health? To what extent should courts admit, or solely rely on the medical evidence provided by medical practitioners, particularly if it relates to 'probability of survival'? As will be seen in later chapters, these are all questions that courts have been faced with since the Act's implementation and its changing shifts in interpretation reflect subtle changes in the underlying rationale for a pregnant person's right to terminate a pregnancy.

It is interesting to note that the language of the MTP Act specifically excludes the term 'abortion', and in that respect distances 'termination' from the more morally and politically charged term 'abortion'. However the MTP does incorporate certain conservative terms, particularly when referencing the grounds in Explanation II regarding the failure of a contraceptive device. This ground is only applicable to 'married' couples, indirectly excluding unmarried couples, which could

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[13]Melissa Stillmanet. al., 'Abortion in India: A Literature Review', December 2014, *Guttmacher Institute*, p. 10.
[14]Hirve, op. cit., p. 117.

be interpreted as discouraging unmarried women from engaging in sexual relations at all. This language is particularly concerning as it is couched in a conservative moral philosophy that decreases the agency of many women, who find themselves facing an unwanted pregnancy that still poses a 'grave injury to her physical or mental health'. As will be seen in later chapters, the problematic nature of this terminology reflects the conservatism of the period in which the MTP Act was enacted.

IV. The Unmet Need for Access to Safe Abortion Providers

In order to properly challenge the existing legal framework, it is vital to contextualise the need for change. In India, the current reality for many pregnant people seeking terminations of pregnancy reflects the dire need for the policy framework to improve service delivery, even according to current provisions, to facilitate rather than regulate access to abortion.

It is difficult to accurately assess the number of women voluntarily seeking medical and surgical abortions in India as statistics vary greatly, and many cite chronic underreporting due to stigmatisation of the practice. The Indian government reported that 700,000 abortions take place each year. However, in 2015, the medical journal, Lancet, used community-based outreach sources, to estimate that 15.6 million abortions took place that year, with 29% of Indian women reporting having had an abortion. Additionally the estimate revealed that[15] % of women had terminated their pregnancy by using unprescribed abortion pills. This report suggests that 48% of the 48.1 million pregnancies in India in 2015 were unwanted, and one in three resulted in abortion. In 2015, the overwhelming majority, 11.5 million or 73%, of abortions in India were medical abortions performed outside health facilities and of these 800,000 were conducted by informal providers. A mere 3.4 million abortions (22%) were performed in public health facilities. Surgical abortions in clinics and hospitals accounted for 14% of all abortions. The discrepancy between these figures is staggering and reflects the obvious stigma and pressure facing pregnant persons who seek abortion.

[15]Susheela Singh et. al., 'The Incidence of Abortion and Unintended Pregnancy in India, 2015', *The Lancet*, 2018, vol. 6, available from: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30453-9/fulltext.

Also, it further points to the motivation for pregnant persons to seek services that provide 'unsafe abortions'. Abortion is considered safe when performed according to the WHO guidelines on 'Safe Abortion: Technical and Policy Guidelines for Health Systems' 2012. WHO provides that a combination of a combined oral dosage of mifepristone and misoprostol tablets is ideal in most circumstances. The Indian Government has affirmed the utility of these drugs as they are both listed on the 2015 National List of Essential Medicines. However without access to legal procedures and trained practitioners, pregnant persons will seek help from untrained chemists and illicit practitioners, in environments "lacking minimal medical standards". Some abortion methods are inherently unsafe such as the insertion of intrauterine foreign bodies, vaginal preparations, and the infliction of trauma to the abdomen. Other methods such as oral and injectable methods become unsafe when performed without proper medical supervision. Unsafe abortions can lead to numerous health complications including haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus and abdominal organs. Partial abortion or excessive bleeding, which have a relatively low risk of occurring, can become fatal without treatment. Those seeking abortions in abortions have certainly been affected by the results of unsafe abortions. According to the Ministry of Health and Family Welfare, in 2017, 8% of maternal deaths in India were due to complications associated with abortion.[16]

Considering the grave public health implications of seeking unsafe abortions, policymakers need to investigate the motivations of pregnant persons who are willing to risk having such procedures. Again, there are few academic sources examining the reasons and characteristics of pregnant persons seeking termination of pregnancies. However of those that have been conducted, it was found that in India the primary reason pregnant persons seek abortion is to limit family size.[17] Other reasons included: an increase of spacing between births; protection of health in cases in which underlying medical conditions would complicate pregnancy or birth; poverty and economic constraints; and a minority cited having problems with the foetus or having a female foetus as the reason for seeking an abortion.

It is also important to recognise that a wide range of qualitative and quantitative studies have found that "[pregnant persons] seeking abortion come from all socioeconomic groups, live in both rural and urban areas, and belong to all age-groups.[18] According to the 4th National Family Health Survey 2015-2016, there is very little difference in the percentage of women seeking abortions across different age groups, geographical residence, religious affiliations, level of schooling and wealth indices.[19] The only trends of significance were that women aged 40 to 49 were more likely to have had an abortion in the five years prior to the study, and women in the highest quintile of wealth were slightly more likely to have had an abortion. These statistics all point to the universal demand for access to abortion services.

Nevertheless, in reality, this demand is not being met, forcing a significant proportion of pregnant persons to seek non-certified services and risk having unsafe abortions. Of the few exceptions to the criminalisation of abortion in the MTP Act, even for pregnant people eligible to obtain a legal termination of pregnancy, practical barriers often complicate matters. For many, issues of geography,

[16]Ministry of Health and Family Welfare, 'Health and Family Welfare Statistics in India 2017', available from the Health Management Information Centre.

[17]Stillmanet. al., op.cit.

[18]ibid, p. 19.

[19]International Institute for Population Sciences, 'National Family Health Survey-4, 2015-2016', 2018, p. 181.

poverty, religion, culture and familial pressures impact their ability to access service providers willing to provide safe abortion services.

V. Barriers to Abortion Access

Despite the liberalisation of the law, Indian women face many structural barriers to access abortion services. The statutory provision restricting the practice of abortion to highly trained doctors in government-approved facilities increases systemic inequalities felt by poor and rural women. This provision places a significant legal barrier on marginalised communities, in addition to existing unequal access to abortion services. As such, they cannot effectively realise their right to reproductive freedom.

Many of the available abortion services are woefully inadequate, lacking quality equipment and skilled staff. They often fail to ensure privacy and confidentiality and do not offer post-abortion care and counselling. Some approved centres offer abortion procedures sporadically due to a shortage of trained physicians and functioning equipment. The few well-equipped centres with trained staff providing adequate abortion services are overwhelmingly located in major urban centres. This poses a serious problem for a country with 67% of its 1.3 billion people living in rural areas.[20] Rural, often poor, women must travel great lengths, using their own or borrowed money, to access a health service that is essential for the realisation of their human rights. Lisa Pruitt suggests that rural women not only have to overcome the structural disadvantages associated with sparse economic and educational opportunities, but must deal with specific barriers caused by deficient health services and transportation.[21]

[20]'Rural Population as a Percentage of Total Population', The World Bank, available from: https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?page=1.

[21]Lisa Pruitt, 'Towards a Feminist Theory of the Rural', *Utah Law Review*, 2007, vol. 2007(2), p.271.

The rights of women are particularly complicated by the spatial isolation of rural life. Distance from jobs and opportunities pushes women to remain at home and prevents liberation from the patriarchal control experienced through their roles as wives and mothers. Pruitt argues that 'by relegating women to a sphere that is conceptually and spatially private, society limits their access to knowledge and power'.[22] Spatial isolation and low population density in villages has a detrimental effect on the autonomy and privacy of women. This may increase gendered violence, discourage women from reporting crimes, and remove any independent control over a woman's reproduction. These are just a few of the barriers that will now be discussed further.

Abortion Service Providers: Facilities and Medical Practitioners

While geographical distance from health centres is already a major barrier for many rural women, the number of healthcare facilities that actually provide abortion services also complicates the reality for pregnant persons seeking abortions. In the years immediately following passage of the MTP Act, India saw only a marginal increase (8 - 10%) in the number of approved abortion facilities and the number of abortions reported by those facilities.[23] In the late 1980s and 90s there was a decline in the amount of abortions reported in approved facilities. By 1997, two-thirds of all approved facilities were clinics in large cities, reflecting the on going disparity between urban and rural access to health care. Even where approved health facilities are available, only a small minority actually provide abortion services.

A facility survey in 2005 found that only 6% of India's primary health centres and 31% of community health centres provided abortion services.[24] A Center for Operations Research and Training (CORT) study of Rajasthan in 2004 showed that 65% of community health centres and 21% of primary health centres offered abortion services. Only 35% of the 105 approved facilities offering abortion services were public, and of those operating in rural areas only 28% were public.[25] A 2010 study found that the majority of primary facilities had at least one medical officer, but only 5% were certified to provide abortion services.[26] Of all health facilities offering abortion services, only 83% were located in just nine of thirty-three districts, and of these the vast majority were clustered in urban areas. Evidence from multiple studies suggests that even trained and qualified providers working at public health facilities may not provide abortions because they are unaware of its legal status or believe their facility is not legally approved.[27] Lower-level health facilities are often the only service points for rural or poor women, if these facilities do not provide abortion services

[22]Lisa Pruitt, 'Gender, Geography & Rural Justice',*Berkeley Journal of Gender, Law & Justice*, 2008, vol. 23, p. 338.
[23]Hirve, op. cit.
[24]IIPS and Macro International, 'India Facility Survey (Under Reproductive and Child Health Project) Phase II, 2003', Ministry of Health and Family Welfare, 2005, New Delhi.
[25]S. Barge et al., 'Formal and Informal Abortion Services in Rajasthan, India: Results of a Situation Analysis', Population Council, 2004, New Delhi.
[26]Shireen Jejeebhoy et al., 'Increasing Access to Safe Abortion in Rural Rajasthan: Outcomes of a Comprehensive Abortion Care Model', Population Council, 2011, New Delhi.
[27]Sushanta Banerjeeet. al., 'Results of a Government and NGO Partnership for Provision of Safe Abortion Services in Uttarakhand, India', IPAS Development Foundation India, 2009, New Delhi.

then these women may have no choice but to obtain an abortion from unsafe providers. While data recording abortion rates occurring in unapproved facilities is scarce and unreliable, official statistics estimate that anywhere between two and eleven illegal abortions are performed for every legal abortion.

Due to the lack of localised services, pregnant people must travel to urban hubs in order to access abortion services. This means that the average rural woman must find someone to accompany her to an unfamiliar town or city, arrange for childcare, and gather together the money for transport and services. Confidentiality and privacy is therefore virtually non-existent in rural villages and the added difficultly imposed by raising money and securing transport creates a substantial barrier to access. Sometimes, as women have to hide pregnancies from husbands, family and community members to avoid social repercussions, there is an emotional toll to conduct a medically safe abortion in the open. As a result of these barriers, 80% of the Rajasthani women surveyed did not travel to the urban referral facility, choosing instead to continue the unwanted pregnancy or obtain an unsafe abortion.[28]

The provision of abortion services is similarly inhibited in the private sector. Public facilities are automatically approved to provide abortion services but private facilities must obtain government certification. As a result, medical practitioners who are trained and competent to provide abortions may work at health facilities that are unregistered and unable to provide abortion services. The lack of private services is partly caused by poor regulatory design and bureaucratic failure. A 2005 study in Rajasthan found that certain rules barred the private provision of abortion services, for example; a private provider is only eligible to receive training in abortion provision if she works at a facility certified to offer abortion services, however a private facility can only be certified if there is a trained provider working there.[29]

[28]Barge et al., op.cit.

[29]Sharad Iyengar, 'Situational Analysis of Abortion Services in Rajasthan',Action Research & Training for Health (ARTH),2005, Udaipur.

Section 4 of the MTP gives States and Union Territories absolute power to approve and accredit facilities. Thus private services are often subjected to unnecessary or arbitrary regulations, aimed at controlling, rather than facilitating abortion services. Maharashtra, for example, requires that abortion clinics be located within 5 km of a blood bank, effectively ruling out any rural abortion facilities. Delhi and Haryana both require the architectural plans of private facilities and their car parks to be submitted for registration, preventing smaller localised community health care providers to operate.[30] Bureaucratic hurdles such as delays, lack of responses, and corruption have rendered the certification process in many states impossible. As a result, many abortion providers do not seek certification at all. This makes it impossible to regulate the quality of services and to ensure the safety of pregnant persons visiting these facilities. Indeed, in Bihar and Jharkhand, as of 2010 none of the private facilities providing abortion were registered.[31] In fact, only 46% of the districts had actually set up a District Level Committee capable of registering facilities.[32]

Section 4 also mandates that terminations may only be legally induced by a registered medical practitioner "who has such experience or training in gynaecology and obstetrics" in a place that is sanctioned by the appropriate authority. This may seem a reasonable provision however given that most abortions can be induced with the use of a pill and the scarcity of obstetrician-gynaecologists in India, the provision unreasonably restricts reasonable abortion policy.

Public sector facilities are often run-down and offer inadequate services, especially in rural regions and only a small amount of the population can afford private sector health care. This leaves the majority of Indian women cut off from legal and safe abortion services. The language of the Act prevents any effort to train mid-level providers to induce abortion and results in women undergoing unsafe abortions due to a lack of an accessible safe provider.

As obstetrician-gynaecologists are the only healthcare professionals permitted to provide abortion services under the MTP Act, there is a further gap between demand and the staff required to meet this demand. As of 2009 there were 27,000 obstetrician-gynaecologists working in India, compared to 800,000 physicians, 500,000 Ayurvedic physicians, and 1,000,000 nurses. Practitioners trained in Ayurveda, yoga, naturopathy, Unani, Siddha, and homeopathy (AYUSH) are not allowed to perform abortions, nor are they allowed to write prescriptions, however due to budgetary constraints many of these untrained health workers provide abortion services which often leads to health complications. Nurses are the main health service providers in primary health centres. Many doctors trained in AYUSH have been absorbed into the health care system and have been deployed as medical officers in charge of public facilities.

Due to a combination of all these factors, legally authorised abortion providers perform only a minority of abortions in India. Training lower-level providers will decrease the costs of abortion and ensure more women receive legal and safe services. A study in Bihar and Jharkhand found that with adequate training, nurses were as able as physicians to perform manual vacuum aspiration, and

[30]Hirve, op. cit.
[31]Aich Paramita et al., 'Situation Analysis of MTP Services in Bihar: February–May 2011', IPAS Development Foundation India, 2011, New Delhi.
[32]ibid.

assess gestational age and abortion completion. A study in rural Rajasthan found that when women sought treatment for post-abortion complications by nurses and midwives at primary health centres, 75% were successfully treated while the remainder were referred to specialist facilities.[33] When provided with proper training, support and supervision, and a robust emergency referral system, health care professionals other than physicians (and crucially other than obstetrician-gynaecologist) can provide safe and effective first trimester abortion services and care.

The MTP Act only allows obstetrician-gynaecologists to perform abortions. According to a survey of community health centres in 2012, 4,833 obstetrician-gynaecologists are required to meet the Indian Public Health Standards (i.e. one per facility), yet only 1,615 are actually in position. Similarly, Indian Public Health Standards requires 4,833 physicians, but only 940 are working in community health centres. Indian demand for abortion far outstrips the ability of the health sector to provide abortion services. The reality of abortion is that most procedures simply require a medical practitioner to supervise a pregnant person as they take abortion pills. Surgical abortion cases do not require a specialist as most of the procedures are straightforward and most practitioners can be trained to perform them. A rational approach to ensuring women are not forced to continue unwanted pregnancy or driven to unsafe abortions is to train as many medical practitioners (including nurses and midwives) as possible to supervise and perform abortions, and to ensure referral and transportation services are widely available where needed.

Method of Termination

Many women in India have reported a preference for medical abortion. This is in part due to the notoriously poor quality of public abortion services, a fear of health complications from surgery, and perceptions of what is natural. Many abortion facilities, however, do not offer medical abortion and insist on surgical abortion. Additionally, many women cannot afford to see a qualified provider for medical abortion services. This results in many women resorting to informal providers and chemists for medical abortions. A survey of 577 chemists revealed that 80% sold mifepristone and misoprostol. The vast majority of these women have no knowledge of proper dosage or side effects. The annual sales of these abortion pills is estimated at 1,10,00,000 doses while the number of reported medical abortions is just 7,00,000.[34]

It is unsurprising that medical abortions obtained from a chemist without a prescription, being the most economical method, are the most common. While these pills are safe when taken in a clinical setting with proper supervision, without consulting a doctor or assessing possible complications, serious health issues can emerge. If taken during the later stages of pregnancy, such issues include haemorrhaging and incomplete abortion, which may then lead to surgical intervention. Additionally, chemists reported selling more Ayurvedic and homeopathic drugs intended to induce abortion than mifepristone-misoprostol. Pregnant people will take these drugs, despite the uncertainty of their effectiveness or safety, because of their lower prices. Data from several states shows that 11-53%

[33]Stillmanet. al., op.cit., p. 31.
[34]Singh et. al, op. cit.

of women seeking abortion at a health facilities reported having attempted abortion home, the majority using home remedies or Ayurvedic or allopathic pills obtained from chemists without prescription.[35]

Cost

Considering the aforementioned barriers, the majority of abortions that take place in India are done through a private provider. Women have reported that private facilities offer better services, have better equipment and facilities, and better maintain the woman's confidentiality and dignity. Of the 334 facilities offering abortion services in 2010-11 in Bihar, 79% were private.[36] In Jharkhand 77% of all 169 registered facilities were private.[37] Pregnant people may be barred from accessing private abortion providers due to financial constraints. While abortion is technically free at public facilities pregnant people incur expenses by paying for anaesthesia, medication, and transportation. At private facilities, however, providers set their own prices. Charges for abortion can vary depending on several factors including the pregnant person's age, the gestational age of the pregnancy, the abortion method, whether the woman agrees to post abortion contraception, location of the clinic, and whether the provider is certified and the facility is registered.

The cost of accessing an abortion procedure from well-equipped and qualified providers can range from early abortion for 500 - 1,000 rupees for an early abortion and 2000 - 3000 rupees for a late abortion.[38] This is often prohibitively expensive and can put a significant strain on family resources. A study in rural Tamil Nadu found that the majority of women preferred expensive but good quality private providers to less-reputable and cheaper public services. Poor women were willing to borrow money from family members and neighbours rather than risk health complications from public abortion services.[39]

Low levels of wealth and income have left households increasingly at risk of being bankrupted by health expenses. Only 15% of Indians have health insurance, meaning most people must pay out-of-pocket for health expenses. Due to the low level of government expenditure on healthcare these out-of-pocket payments make up 62% of total national health spending.[40] This exposes individuals to 'catastrophic payments', taking up a devastating portion of household expenditure. The prevalence of such payments has risen in recent years, occurring in 11% of households in 1993, and 17% in 2014. An estimated 8% of households are pushed below the poverty line (BPL) by enormous debts each

[35]S. Bhattacharya et.al., 'Safe abortion-still a neglected scenario: a study of septic abortions in a tertiary hospital of rural India', *Online Journal of Health and Allied Sciences,* 2010, vol. 9(2), pp.1–4.

[36]Paramita et al., op. cit.

[37]ibid.

[38]Ravi Duggal et. al., 'Abortion Assessment Project-India: Key Findings and Recommendations', *Reproductive Health Matters*, 2004, vol. 12(24), pp. 122-129.

[39]Lakshmi Ramachandar et. al., 'Abortion Providers and Safety of Abortion: A Community- Based Study in a Rural District of Tamil Nadu, India', *Reproductive Health Matters*, 2004, vol. 12.

[40]WHO Bulletin, 'Trends in Catastrophic Health Expenditure in India: 1993 to 2014', WHO, November 2017, available from: http://www.who.int/bulletin/volumes/96/1/17-191759/en/.

year, resulting in the sale of assets and increased loan taking.[41] This status quo leads to the unnecessary deaths of one million Indians each year.[42] The rise of private health care due to the government's market fundamentalist approach has deprived poor Indians of essential services and pushed others into deep poverty. It is necessary that public health facilities receive adequate levels of funding to provide family planning information, counselling, and abortion services at no cost to the pregnant person.

In September 2018, the Indian government launched 'ModiCare' to prevent the suffering caused by catastrophic healthcare payments. The program would provide poor families with insurance of up to 500,000 rupees in hospitals. The government also announced its intention to open 150,000 health and wellness centres to be staffed by nurses and AYUSH practitioners by 2020.[43] It remains to be seen whether implementation of this plan will improve the health outcomes of poor Indians and avoid catastrophic health costs.

Awareness, Misconceptions and Social Stigma

Further, access to safe abortion is affected by women's and abortion providers' awareness of the law and prevailing societal attitudes. A lack of knowledge and the many misconceptions about abortion services leave women vulnerable to poor care and financial exploitation. Many people, influenced by social and cultural norms and legal uncertainty, believe abortion to be illegal. Indeed, a 2016 study of medical students in Maharashtra found that many young doctors would refuse to perform an abortion due to fear of criminal prosecution.[44] While the law does not specify any need for spousal or third party consent to an abortion, many abortion providers and medical practitioners are afraid of incurring any social or legal liability in cases of health complications or death.[45] Otherwise, many providers follow patriarchal belief that a husband's consent is required for the procedure to be conducted. These misperceptions about legal requirements including the permissible justifications for abortion, requirements of spousal notice, and time-limits can drive many pregnant persons to coerced birth, illegal abortion services, or suicide.

Another vulnerable group facing particular difficulties accessing abortion services are young and unmarried women. They may be turned away by qualified providers due to their age or marital status, or avoid qualified providers due to the cost or privacy concerns. Their relative lack of economic power and lack of social support due to the stigma of pre-marital sex and abortion creates significant barriers to receiving safe abortion services. This can lead to significant delays and an increased risk of

[41]ibid.

[42]'Lacking Healthcare, A Million Indians Die Every Year: Oxford University', *Economic Times*, 2 February 2009, available from: http://economictimes.indiatimes.com/Healthcare/Lacking-healthcare-amillionIndiansdieseveryyearOxfordUniversity/articleshow/4066183.

[43]Vidhi Doshi, 'India launches 'Modicare,' the world's biggest government health program' *Washington Post*, 23 September 2018, available from: https://www.washingtonpost.com/world/asia_pacific/india-launches-modicare-the-worlds-biggest-government-health-program/2018/09/21/46c275d6-bb6e-11e8-adb8-01125416c102_story.html?noredirect=on&utm_term=.62f259c8c6ee.

[44]Susanne Sjöströmet. al., 'Medical Students are Afraid to Include Abortion in their Future Practices: In-Depth Interviews in Maharastra', *BMC Medical Education*, 2016, vol. 16(8).

[45]Hirve, op. cit., p. 118.

health complications. A study of unmarried women in Bihar and Jharkhand found that the majority of young people do not use any form of contraception, resulting in 8-12% of sexually experienced college-aged women having an unintended pregnancy and abortion. Younger, less educated, or rural women were reported to be more likely to delay the decision to terminate their pregnancy, leaving them more vulnerable to risks associated with a second trimester abortion.[46]

In the case of young and unmarried women, the barriers they face may be countered by improving the quality of public services by introducing up-to-date technology, improving communication with women, and instituting guarantees of confidentiality and counselling. The vulnerability faced by young and unmarried women may be alleviated by providing contraception, improving sexual education, equalising the difference in power with her doctor, and by working to reduce the stigma attached to pre-marital sex and abortion.

Conclusion

Abortion is a phenomenon that is widely practised throughout India, among all demographic groups. While pregnant persons cite various reasons for seeking a termination of their pregnancy, the evidence points to a clear demand for the service, and irrespective of its legality or not, it seems evident that many pregnant persons will voluntarily seek out any service provider, including unqualified providers in spite of possible health risks it might pose. Pregnant persons across all ages, religions, geographic regions, cultures, relationship statuses, and different political affiliations seek abortions, reflecting the universal nature of this issue. As such, it traverses moral and political opinion. Thus, promoting abortioninvolves empowering the individual pregnant person so that they may realise and enjoy their reproductive rights.

The substantial lack of investment in public health care both in terms of infrastructure and services has created a two-tiered system of expensive and high-quality private care and cheap but miserable public services. Within this system, safe abortion services are a luxury, available only to wealthy women, which ultimately inequitably restrains the reproductive rights of poorer women. An economic system that prioritises individual wealth and private ownership of resources will invariably result in rights violations, especially in the absence of a robust welfare state. As economist and philosopher, Amartya Sen, remarked, 'sometimes the lack of substantive freedoms relates directly to economic poverty, which robs people of the freedom to satisfy hunger, or to achieve sufficient nutrition, or to obtain remedies for treatable illnesses, or the opportunity to be adequately clothed or sheltered, or to enjoy clean water or sanitary facilities'.[47] Examining access to abortion services in India reveals the impossible situation for a vast number of women suffering from economic and social marginalisation, which directly leads to serious violations of their human rights.

For policymakers, international research has shown that there is no reported correlation between the availability of legal abortion and an increase in abortion rates. It merely shifts so-called 'back-alley

[46]Shireen Jejeebhoyet. al., 'Experience Seeking Abortion Among Unmarried Young Women in Bihar and Jharkhand, India: Delays and Disadvantages',*Reproductive Health Matters*, 2010, vol. 18(35), pp. 163-174.
[47]Amartya Sen, *Development as Freedom*,1999, Oxford University Press, Oxford.

abortions' to the realm of regulated health care.[48] Indeed, abortions occur as frequently in countries with the most restrictive laws as in those with the least restrictive laws: 37 and 34 per 1,000 women, respectively.[49] The overwhelming majority of states with the most restrictive abortions laws are in developing regions. The states with the most liberal abortion laws are primarily located in Europe, North America, and the more developed zones of East Asia.[50]

Countries with liberal pregnancy termination laws, which also ensure *access* to abortion services, have not experienced a noticeable increase in demand. Indeed, the Netherlands has extremely permissive abortion laws and very low abortion rates.[51] Social factors determine demand, while availability ensures safety. Effective efforts to reduce abortion rates or population growth focus on the socio-economic conditions of the population, health outcomes, educational attainment, contraceptive use, and the laws and norms governing family life and sexuality. As WHO has commented, "fifty-seven countries, representing almost 40% of the world's women, allow abortion upon request of the pregnant woman…[and] in this context, the ultimate decision on whether to continue or terminate her pregnancy belongs to the woman alone".[52]

[48]David Grimes, 'Unsafe Abortion: The Silent Scourge', *British Medical Bulletin*, 2003, vol. 67(1), pp. 99–113, available from: https://academic.oup.com/bmb/article/67/1/99/330367.
[49]Elisabeth Rosenthal, 'Legal or Not, Abortion Rates Compare', *New York Times*, 12 October 2007, available from:https://www.nytimes.com/2007/10/12/world/12abortion.html.
[50]ibid.
[51]United Nations Population Policy Data Bank, 'Abortion Information: Netherlands', available from: www.un.org/esa/population/publications/abortion/doc/nether.doc.
[52]WHO, 'Safe Abortion: Technical and Policy Guidance for Health Systems', WHO, 2012, 2nd edition, p. 90, available from: http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=260B2C924FD64F0C1D48687884B308EA?sequence=1.

Legal abortion will always be available for those who can afford private services, however access is a major issue for disenfranchised pregnant persons living in impoverished circumstances or in remote areas. As the Indian economy encourages more people to leave traditional rural life and move to urban centres, delaying marriage in pursuit of careers, and engaging in casual sex, there will be a further need to control fertility and avoid unwanted pregnancy. This clearly requires the availability of abortion services. It is necessary however to ensure that abortion does not become a right only for the urban elite, but is accessible to pregnant people of all backgrounds. The current abortion regime, with its coercive measures and market-approach to access, by disenfranchising poorer pregnant persons, fails to protect reproductive rights in India.

Finally, considering the context in which the MTP Act is operating, it is clear that the current system regulating access to abortion services, whether legal or not, is unjust, inaccessible and inadequate to meet the needs of women to exert their reproductive autonomy. At present the provisions of MTP Act do not serve as sufficient protections for all pregnant persons. The framing of the Act reinforces the need to protect healthcare professionals from conducting abortions rather than serving as an empowering mechanism for pregnant persons to exert their reproductive autonomy by enshrining a legal right to abortion.

It is obvious that the MTP Act and its current implementation have proven highly problematic for pregnant persons' access to abortion services considering its vast demand. However, it is also vital to understand how the judiciary has interpreted the MTP Act in recent years and whether its interpretation of its provisions is changing. If so, could the courts' approach align further with a human rights based approach, to overcome these numerous barriers and provide greater flexibility for pregnant persons to exercise their reproductive autonomy? Consequently, this issue and the diverse questions that have been raised in litigation in the past ten years will be explored in the following chapter.

CHAPTER TWO

Recent Case Law on Abortion in India

This chapter will examine significant recent judgments related to cases of pregnant people seekinglegal abortion under the MTP Act in the Supreme Court and various High Courts. These cases usually arise in the context of pregnant persons seeking to terminate a pregnancy after the 20th week time limit under s 3 of the MTP Act. Often the grounds for termination are those already found under s 3, specifically the discovery of a foetal abnormality or in cases of sexual abuse or rape. As such, courts have had to determine whether these cases fall under the exception provided by Section 5, in which at least two medical practitioners may perform an abortion if they are of the opinion that a "termination of such pregnancy is immediately necessary to save the life of the pregnant woman". Otherwise, the court will consider whether it is appropriate in the circumstances for the time limit to be lifted if it is in the 'best interests' of the pregnant person. This test was first established in the context of reproductive rights in *Suchita Srivastava*. The precedent that this case set is an important starting point to understand the changing nexus between reproductive and human rights in Indian jurisprudence.

The chapter will also examine the varying approaches different courts have taken when determining the legality of an abortion in a certain case, andwhether some factors distinguish cases from one another and amount to an exception to time limits under provisions of the MTP Act. Such factors include:

- The age of the pregnant person;
- The mental anguish they suffer as a result of the trauma of sexual abuse;
- The prospect of delivering a stillborn or nonviable foetus;
- The medical probability of survival or quality of life of the newborn;
- The socioeconomic circumstances of the pregnant person; and others.

The chapter will conclude with a final compilation of recent cases arising from the High Court of Bombay, whose judges have adopted a progressive approach to their interpretation of the MTP

Act. These judgments cumulatively reflect the shifts courts have had when interpreting the rights of pregnant persons, more and more recognising a rights-based approach, taking account of proportionality, purpose of the MTP Act and the significance of a pregnant person's own consent and relying on advice from healthcare experts. The first case to definitively characterise reproductive rights as personal rights derived from the personal liberty and integrity of the person, as protected under Article 21 of the Constitution, was *Srivastava*. Before examining other subsequent abortion cases, it is crucial to understand the presumption underlying the reasoning from this case.

Reproductive Rights and Personal Liberty

Suchita Srivastava vs. Chandigarh Administration (2009)[1]

Facts

Medical staff and the Board of a government run welfare institution discovered one of its orphan residents, the petitioner, was pregnant. A multi-disciplinary Medical Board was established to assess her mental state, confirming that her condition was that of 'mild to moderate mental retardation'. This Board recommended termination of the petitioner's pregnancy after determining that she would not be able to cope with the continuation of the pregnancy and its subsequent implications. The administrative authority, the Chandigarh Administration, sought legal clarification from the High Court of Punjab and Haryana to provide a judicial opinion on whether the petitioner should undergo a termination or not. The High Court directed that an Expert Body assess what would be in her 'best interests', considering the effect of her mental condition; the extent of her reliance on others; her understanding of the events occurring; including the sexual abuse she underwent; her physical, socioeconomic and mental capacity to raise a child in the future; and the impact of others on her decision-making; the potential impact of abortion, hypertension, prematurity, low birth weight and foetal distress. The significant finding from the Expert Body was that "She knows that she is bearing a child and is keen to have one. However, she is unable to appreciate and understand the consequences of her own future and that of the child she is bearing".[2] Nevertheless, the Expert Body found that her physical status did not pose a threat to bearing the child and if she were provided with a suitable environment and support system, it may be in her best interests to continue with the pregnancy. Despite this, the High Court ordered for termination.

Issue

Does the petitioner's mild mental retardation amount to mental illness as referred to in s 4 of the MTP? Is the petitioner capable of giving informed consent as a woman who has attained the age of majority, but who suffers from a mental impairment? Would it be in her 'best interests' to continue with the pregnancy or have an abortion considering her mental impairment and foreseeable environment?

[1]Civil Appeal No. 5845 of 2009, Supreme Court of India.
[2]ibid, para. 9.

Arguments

Counsel for Srivastava argued that there is a difference between mental retardation and mental illness as interpreted under the MTP Act is s 4(b), and Srivastava was not classified as mentally ill. Therefore she was capable of consenting to either a termination or a continuation of the pregnancy, and the Court was bound to comply with this reproductive choice. Additionally, as the medical experts predicted that the pregnancy would not pose any physical risk to the petitioner's health, or have the potential to cause her significant mental anguish or result in a new born with severe handicaps, a holistic assessment should lead to a finding that continuation would be in the Srivastava's best interests. Further, it was argued that even if her impairment amounted to a legal definition of mental illness, her consent would still be required to terminate the pregnancy as her reproductive choice is an inherent exercise of her personal liberty, which is protected under Article 21 of the Constitution.

Outcome

The Supreme Court disagreed with the High Court's direction to terminate the pregnancy. The Court found that on a plain reading of the MTP Act's provisions, the pregnant person's consent is a vital element to the legality of conducting an abortion, and as the petitioner had expressed her desire to bear the child to term, her reproductive choice should be followed. The Court affirmed that

> The right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution of India…The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices…However, in the case of pregnant women there is also a 'compelling state interest' in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled.[3]

The court found that the petitioner did not fall into the category of 'mentally ill persons' when considering the 2002 amendment to the MTP Act. Taking a purposive approach to interpreting the amendment, the Court found that it sought to reduce the number of individuals requiring consent from guardians to terminate a pregnancy. The Court went on to argue that considering that the petitioner did not fall under the category of 'mentally ill persons', and even if she did reproductive choice is a fundamental element of her personal liberty, it would be illogical to deny her that agency. The court further supported this finding by citing international law protecting the rights of those with disabilities. The Supreme Court was unique in applying a holistic approach to evaluating an abortion case, by setting up the 'best interests' test as a benchmark by which to consider all medical, legal and social circumstances affecting the pregnant person.

While the Court provides an interesting and vital insight into the treatment of persons with disabilities and the significance of their consent, the judgment is revolutionary as it directly

[3]ibid, para. 11.

refers to the right to reproductive choice as a dimension of personal liberty. This represented an important shift when recognising the indivisible link between human rights and decision making on reproductive and sexual health. It allowed for issues of reproductive choice to enter discussions on Constitutional protections of the right to personal liberty and living a dignified life.

Sexual Abuse and Rape

A pregnancy resulting from a criminal sexual offence can be a devastating outcome for victims, and this has been reflected in the construction of the MTP Act and their right to seek an abortion. Section 3(2)(b)(ii) of the MTP Act includes an exception for abortions where the pregnancy threatens the pregnant person's mental health. In Explanation 1 of the section, it is presumed that if a pregnancy has been caused by rape, the pregnant woman will suffer a "grave injury to [her] mental health". However, the overarching time limit of 20 weeks still applies to all provisions in Section 3, restricting even victims of sexual abuse from terminating pregnancies. In some cases relating to the right to terminate for rape victims, confirmation of pregnancy only comes after the time limit and unilaterally bars them from seeking an abortion, despite the suffering of both the initial crime and the on going mental turmoil of continuing such a pregnancy. Consequently, many matters have reached courts in order to challenge the constitutional validity of maintaining an arguably unjust time limit in cases of sexual abuse.

Rape survivor struggles to terminate her pregnancy caused due the assault

In *Bhavikaben v State of Gujarat* the High Court set aside the 20 week time limit after acknowledging the serious negative impact of continued pregnancy on the petitioner's mental health. As a result of

becoming pregnant after being raped, the petitioner attempted suicide, posing a serious threat to her physical health and future mental health. In finding for the petitioner, the Court followed the 'best interests' test, as set down in *Srivastava*, holistically considering her 'frail condition', 'impossibility of looking after herself' and her family's socioeconomic background.

In *R v State of Haryana*, the High Court of Punjab and Haryana assessed whether a teenager, who had been raped, should be allowed to undergo an abortion after a prolonged, mishandled, criminal investigation caused her to pass the MTP Act's 20 week time limit. The Court thoroughly critiqued the arbitrariness of the 20 week time limit, and recommended that the MTP Act be revised to accord with the 24 week time limit in other jurisdictions. The judgment also focussed specifically on respecting the right of the pregnant person to privacy, dignity and bodily integrity and the chilling effect on medical practitioners of the risk of prosecution under the MTP Act. Nevertheless, as the previous Medical Board had not recommended proceeding with a termination of the pregnancy, the Court relied on their expertise in determining that an abortion would not legally conform with the MTP Act's provisions.

The argumentation in *Murugan Nayakkar v Union of India*, focussed on the circumstances of the petitioner, an alleged victim of sexual abuse and rape, whose young age posed a unique, dangerous challenge to have a safe delivery. Her health was equally at risk if having an abortion or giving birth, and considering the delivery would be preterm, the lasting health defects of the newborn, and her on going trauma, justified conducting a termination.

Following these Supreme Court decisions, the High Court of Bombay in *Gausiya Gulam Pathan v Union of India*, followed the reasoning of *Murugan Nayakkar,* but went further arguing that termination was justified due to the constitutional right to live a life of dignity under Article 21. This right is so fundamental as to ensure that prolonging the petitioner's misery by continuation of the pregnancy would not be appropriate or in the interests of justice. This was a true assessment that reflected a medico-legal consensus supporting termination in this case.

As will be seen, these cases indicate the courts' growing acceptance and flexibility to acknowledge the additional severe trauma victims of sexual abuse and rape may undergo if faced with continuation of pregnancy. Nevertheless, each case takes a holistic approach to assessing facts on an individual basis, reflecting the 'best interests' test from *Srivastava*, particularly relying on the evidence provided by Medical Boards. Ultimately, while it may not be explicitly stated, it is more and more evident that courts will set aside the 20 week time limit in such cases for the purpose of ensuring that the right of the pregnant person to live a life free from 'misery'.

Bhavikaben vs. State of Gujarat (2016)[4]

Facts

The petitioner was an 18-year-old woman, who, as the result of rape, was 24 weeks pregnant. When

[4](2016) 3 RCR (Civil) 312.

her attacker refused to marry her she attempted suicide by consuming acid. This left her in need of throat surgery, which could not be performed while she was pregnant.

The Court of first instance ordered a team of doctors to examine the petitioner 'and after an interaction with her, [gave] in writing an opinion at the earliest, bearing in mind the advanced stage of pregnancy and her physical and mental condition, whether there [would] be a substantial risk to the life of the petitioner, if the child was born, or that the child would suffer from such physical or mental abnormalities as to be seriously handicapped'.

Issue

In the context of having experienced such traumatic experiences as a result of rape and the consequent severe impact on the petitioner's mental health, would it be justifiable to terminate the pregnancy? How should the Court integrate the petitioner's own surgical needs and her foreseeable environment, with her poverty-stricken parents, into their reasoning?

Arguments

The petitioner argued that the Court was bound to respect the opinion of the doctors, who concluded that 'the continuation of the pregnancy [was] going to affect her mental status'. The petitioner urged that the Court adopt the 'best interests' approach, set down in *Srivastava*, which involves holistic consideration of the petitioner's interests, including their medical and socio-economic circumstances, not those of 'other stakeholders' (such as family or community members).

It was argued that the pregnancy posed a threat to her physical and mental health, which may create complications for the child as well. The petitioner submitted that due to her socio-economic background - her parents were landless agricultural labourers - she did not have the financial resources to cope with pregnancy, not to mention raising a child.

Outcome

The Court looked to the jurisprudence of the Supreme Court in previous cases dealing with abortion. The Court noted that in *Chandrakant Jayantilal* the bench had "left it to the discretion of the medical practitioners, considering the peculiar facts, who were to decide after interaction with the victim, [if] termination of pregnancy was immediately necessary to save life of the victim herself, it did not want the doctors to wait for the permission of the Court". Additionally, *Srivastava* was cited in noting that the "Apex Court has laid down the theory of best interest test to hold that the Court is required to ascertain the course of action which would serve the best interests of the person in question. The Court must undertake a careful inquiry of the medical opinion on the feasibility of the pregnancy as well as social circumstances faced by the victim. The Court's decision should be guided by the interest of the victim alone and not those of stakeholders such as guardians or society in general".

The Medical Team appointed by the High Court reported that;

After reviewing history and detailed examination, blood reports and sonography done at Civil Hospital, Sola, our opinion is as follows:

- Psychiatric evaluation suggest[s] patient is not suffering from any psychiatric disorder and patient is psychiatrically fit. Considering involuntary pregnancy and unwillingness of victim to continue pregnancy her mental trauma may increase if pregnancy continues.
- Anesthetic evaluation suggest[s] that slightly more risk of anesthesia if pregnancy [is] terminated at present.
- Medical and surgical evaluation suggest[s] that if proper nutrition and care is maintained through feeding jejunostomy, there is no physical harm in continuation of pregnancy or termination of pregnancy at present.
- There is same or slight increase risk to victim if pregnancy is terminated before term than physiological normal delivery at term.
- As per the MTP Act, termination of pregnancy can be done up to 20 week[s] of pregnancy. At present, patient [has a] 24 week live pregnancy.
- If the child [is] born at present, the chances of survival of new born [are much] less due to extreme prematurity. But, if it delivers at term there will not increase chance of physical or mental abnormalities or seriously handicapped.[5]

In response, the Court declared,

> If the opinion of the team of Doctors is taken into consideration, it could be noticed that her mental status will adversely be affected, if pregnancy continues. She, therefore, falls under the criteria set out in the MTP Act. This continuance of pregnancy since it involves grave injury to her mental health as her pregnancy being the result of rape, the anguish caused also is to be constituted as a grave injury to the mental health of the victim, and therefore also, termination of pregnancy is permitted.[6]

The Court did not seek to determine whether her life was under 'immediate threat'. While the Section 5 requirement that the procedure be 'immediately necessary' may have been satisfied by her previous and possibly foreseeable suicide attempt, it is notable that the Court did not investigate such a connection. Rather, the Court appeared moved by the appalling situation of the petitioner and found that the case fell within the scope of the exception to the criminalisation of abortion under the MTP Act on humanitarian grounds:

> Her frail physical and mental health is on account of the trauma of rape she underwent and it appears almost an impossibility for her to look after herself. She also attempted suicide when humiliated by the accused. All these factual circumstances that emerge on record, particularly very young age of the petitioner leads this Court to conclude in favour of grant of her request. Delay in approaching this Court has placed statutory constraints, which is because of various grounds narrated - chief amongst the same is her poor health and poverty stricken condition of

[5]ibid, para.13.
[6]ibid, para.15.

parents. However, when medical opinion does not indicate this act of termination to risk her life, following the best interest test, request warrants to be acceded to.[7]

In conclusion the Court "directed that with best medical facilities available and on ensuring the proper care and supervision, termination of pregnancy shall be carried out".[8]

In this case, the Court relied upon the best interests test, following Suchita Srivastava, as a mechanism to imply consent. It appears to give the Court a legal basis to look beyond the black and white text of Section 3 to allow a post-20 week abortion. Upon first reading of the MTP Act it seems that only an immediate threat to life under Section 5 will legally justify a 24th week abortion, yet the Court in this case allowed the termination, basing their reasoning on the Section 3 protections of mental and physical health. The emphasis placed on the doctors' medical assessment of the petitioner suggests an unwillingness to overturn their recommendations. The Court may continue to transfer practical decision-making from the judges' chambers to the operating theatre. However, this does decrease the petitioner's agency if she could not determine what was in her 'best interests', as the Court treated this test merely as a medico-legal question.

R and Anr. vs. State of Haryana (2016)[9]

Facts

A minor, R, was kidnapped while asleep in her house. When her parents eventually found her she claimed that she had been raped. The police's investigation of the rape allegation was long and likely corrupt. The investigating officers 'did not discharge their duty with due diligence and faithfully, rather they connived with the accused persons'. The police claimed she was not kidnapped but rather willingly left with her attacker. R did not receive a medico-legal exam and her pregnancy went undetected until she felt the foetus move several months later. The delays caused by the police investigation caused R's pregnancy to pass beyond the statutory threshold. In her 25th week of pregnancy she applied to the High Court for an abortion under Section 5 of the MTP Act.

Issue

Should the State's delays in the investigation of the sexual abuse claim, pushing the petitioner's request for an abortion beyond the 20th week, affect an assessment of her best interests? Should the Court ignore the previous Medical Board's unwillingness to proceed with an abortion considering the petitioner's explicit consent to terminate after being informed of the medical risks involved?

Arguments

The petitioner's advocate, Mr. Gorpal Sharma, argued that R "is the sole decision maker on the basis

[7]ibid, para.16.
[8]ibid, para.17.
[9]Writ Petition (C) No. 6733 of 2016, High Court of Punjab and Haryana.

of the medically-informed consent either to continue or terminate the pregnancy. As there cannot be any termination of pregnancy without the express and voluntary consent of the woman, in the same manner the pregnancy should not be forced to be continued without her voluntary consent, especially when the facts of the case show that the very act which led to the conception was an involuntary act".[10] The petitioner submitted that her choice was 'snatched away' by the ignorance of medical experts, lawyers, and investigating officers.

The petitioner claimed that she would rather die by suicide than continue the pregnancy. In response, the Court noted that "the language of the statute … as contained in Section 5 of the Act which unambiguously gives power to the doctor to carry out medical termination of pregnancy, unfettered by any legal bars, to save the life of the victim/ woman".[11]

The petitioner conceded that "the protection of the right to life of the unborn child is an obligation cast upon the State under the Constitutional provisions"[12] however it was claimed that 'the unambiguous language of Section 5 of the [MTP]' indicates that "the conflict between the right to life of the mother and the right to life of the unborn child would yield in favour of the right to life of mother".[13] It was further argued that "to force a woman to continue with the pregnancy which she does not want to continue is an infringement of the right to privacy and dignity of the woman as well as an infringement of the right to a healthy and dignified life of the nascent life in her womb".[14] There is however no clear guidance as to the human rights enjoyed by the unborn, nor has it been established that the State owes any duty to a foetus.

An amicus curiae brief submitted by Ms. Tanu Bedi suggested that "registered medical officers are required to understand the spirit behind the provisions of the MTP Act lifting the embargo on termination of pregnancy beyond 20 weeks in cases as contemplated under Section 5 of the MTP Act. The opinion mentioned therein can be formed by a single doctor also".[15] It was further contended "the provisions of the MTP Act do not contemplate authorisation or approval from any court. In fact, whenever a matter concerning medical termination of pregnancy on any ground whatsoever comes before the courts, the courts have invariably based their decision on the opinion of the medical board. There is not a single instance where the courts have given directions against the conclusions drawn by the medical board. In fact, the very exercise of approaching the courts in such situations results in unnecessary wastage of time and often renders the remedy sought unavailable to the victim".[16]

Outcome

The Court denied the petitioner's request for several reasons. The Court paid great heed to the implications of a 25th week abortion set out by the examining Medical Board. The Medical Board

[10]ibid, para.10.1.
[11]ibid, para.10.8.
[12]ibid, para.10.1.
[13]ibid.
[14]ibid.
[15]ibid, para.10.4.
[16]ibid.

advised that the abortion be denied because “if the delivery is conducted at this stage, the chances of the child being born alive are there and the long term complications of premature birth for the surviving child will have to be weighed”.[17] This decision was not taken in consideration of R’s health or interests, but rather that of the foetus. The Court expressed concern that because the foetus had attained the theoretical age of viability at 24 weeks the “pregnancy could not be terminated without harming the newborn child. In addition this will have severe ethical considerations because the foetus is viable”.[18] Despite the immediate threat to R’s life posed by her potential suicide the Court found this to be persuasive evidence in rejecting her request for a Section 5 termination.

The Court examined the anti-choice language of previous court decisions in support of their stance. The case of *Jacob George v Kerala* reinforced the notion that “life is said to be the most sublime creation of God” and “that God alone can take life because He alone gives it”.[19] The Court looked to *Ashaben v Gujarat*, which espoused the views of American anti-choice activist David Reardon, “finally we must recognise that children conceived though sexual assault also deserve to have their voices heard. Rebecca Wasser-Kiessling, who was conceived in a rape, is rightfully proud of her mother’s courage and generosity and wisely reminds us of a fundamental truth that transcends biological paternity. ‘I believe that God rewarded my birth mother for the suffering she endured, and that I am a gift to her. The serial rapist is not my creator, God is”.[20] The Court presumably found no contradiction in raising religious fundamentalist views in an institution of a ‘secular, democratic republic’.

The Court also cited a 1938 decision of the UK King’s Bench and a ruling from the now defunct West German Constitutional Court to support its position. Indeed, the Court sought to apply *Roe v Wade*, stating,

> The State can regulate the abortion procedure during the second trimester in ways that are ‘reasonably related to maternal health’ and in the third trimester of demarcating the viability of the fetus, a State can choose to restrict or even to prescribe abortion as it would deem fit.[21]

The US Supreme Court recognised in *Roe* a State interest in the potentiality of life after the point of viability, which justifies interference with the pregnant person’s choice if it is in the interest of both maternal and foetal health. The US Supreme Court also made it clear that foetal life cannot take precedence over maternal health and that abortion must be available where the mental and physical health of the woman would be better served by an abortion.

The Court recognised that the Indian Penal Code allows for termination of pregnancy if it is done “in good faith for the purpose of saving the life of the woman”.[22] The Court drew upon the decision in *Vijender* which held that a government hospital should terminate the pregnancy of a rape victim “without wasting any time” and that a “rape victim shall not be further traumatised by putting through a needless process of approaching courts for taking permission”.[23] Indeed, the

[17]ibid, para.10.24.
[18]ibid, para.10.23.
[19]ibid,para.10.25.
[20]ibid, para.10.13.
[21]ibid, para.25.20.
[22]ibid, para.24.4.
[23]ibid, para.10.22.

Court looked to the decision of the Supreme Court of Canada in *Morgentalor v R* that found that the abortion application procedure "infringed the guarantee of security of a person".

They noted that the act of rape caused great psychological trauma to the petitioner, which was increased by the knowledge that she was carrying the foetus of her attacker, and it would be in her 'best interest' to terminate the pregnancy. Indeed, "the doctors in such circumstances cannot be penalised when they act in good faith and help a hapless victim to abort the pregnancy caused due to rape".[24] It appears that in this case doctors did not carry out termination of pregnancy for fear of prosecution. The Court decided not to direct an abortion because,

> The board decided according to their wisdom not to go ahead with the same and came to a conclusion that the termination of pregnancy should not be carried out at this stage. In view of the opinion of Medical Board of PGIMER, this court cannot pass the order to terminate the pregnancy.[25]

The Court ordered the Board to explore the possibility of abortion as there is "a possibility of harm to the patient due to social and emotional consequences of continuation of pregnancy, then the inference can be drawn that it will certainly cause grave injury to her physical and mental health",[26] however if the Board rules against abortion an adoption will be arranged.

In its ruling the Court declared that "some abortions are necessary beyond the statutory limit in the light of circumstances under which they are sought and, therefore, we require to streamline the system in this regard".[27] This presumably includes abortion falling under the guise of Section 3, as Section 5 - abortion to save the woman's life - has no statutory limit. Additionally, the Court recognised that viability is difficult to assess and belongs to the area of 'abstract theory'. Indeed the Court believes "the MTP is an inadequate act and only appears to have been designed to serve the interest of the family planning programme".[28]

Impact

The Court struggled to deal with the competing interests of the foetus, which may be 'seen as an individual in its own right', and the 'exclusive and inalienable right over [the pregnant person's] body and her reproduction'. The Court erroneously cited the right to life under Article 21 of the Indian Constitution and the 'prohibition of arbitrary deprivation of life' contained in Article 6 of the ICCPR as granting human rights to the foetus, which are then to be balanced against the rights of the woman. The Court noted that on one hand the foetus 'does not enjoy independent legal personality', but on the other hand 'foeticide of girl child is a sin'. The Court used language of both human rights and sex-selection to impart legal rights onto the foetus.

This judgment is deeply disheartening. The Court did not engage in any substantive probing

[24]ibid, para.10.37.
[25]ibid, para.10.38.
[26]ibid, para.10.39.
[27]ibid, para.33.2.
[28]ibid, para.33.3.

of the central considerations of the case - whether there was a threat to R's life allowing a post 20th week abortion - nor did they consider whether the 20 week limit ought not to apply where the state is at fault for delay. Despite these deficiencies, this judgment cannot be dismissed out of hand. This ruling starkly portrays the deficits in a legalistic approach to abortion. Courts are rarely the ideal forum to debate the morality of abortion and it is doubtful whether the Supreme Court would provide a coherent and cogent response to the many fundamental questions posed by reproductive rights cases. The judgment's overt critique of the MTP Act sent a strong signal to the legislature of its unworkability and need for change.

Murugan Nayakkar vs. Union of India (2017)[29]

Facts

The petitioner brought a case to the Supreme Court on behalf of his daughter, seeking clarification on the legality of a post-20th week abortion on the facts of his case. His daughter was raped at 13 years old causing her to become pregnant. Her pregnancy was not discovered until the 28th week of pregnancy when she developed difficulty breathing. She was under such immense pressure and fear that she would not identify her attacker. Because she did not report the attack or recognise her pregnancy she did not receive emergency contraception or obtain an abortion. At the 30th week of pregnancy the petitioner approached the Supreme Court seeking recognition of the legality for his daughter to obtain an abortion to alleviate some of the psychological pain and prevent the potentially irreversible health problems caused by continuing the pregnancy to delivery.

Issue

Considering the petitioner's daughter's very young age, would it be in the interests of justice to set aside the 20 week time limit, when childbirth at her age endangered her physical and mental health so dramatically?

Arguments

The petitioner submitted that the pregnancy would be a serious risk to the victim's health and life. The 20 week time limit prevents the victim taking steps necessary to preserve her health and life and as a result the time limit should not apply in this case or be struck down altogether as a violation of fundamental constitutional rights. Specifically the petitioner argued:

I. The victim's age and physical stature puts her at great risk of complications in pregnancy and delivery

Young pregnant people are more likely to suffer from obstructed delivery and other severe complications caused by pregnancy and childbirth and pregnancy, such as obstetric fistula, perineal

[29] Writ Petition (C) No. 749 of 2017, Supreme Court of India.

tear, prolapse. This results in higher morbidity and mortality for the pregnant person and infant. Indeed, the rate of maternal mortality is five times higher for women ages ten to fourteen than twenty to twenty four. Complications from pregnancy and childbirth are the leading causes of death among girls aged 15-19 years in many low and middle income countries. Stillbirths and newborn deaths are 50% higher among the children of adolescents, who are also more likely to have low birth weight, which can have a long-term impact on their health and development.

In this case, an ultrasonography revealed that she was 30 weeks pregnant. A senior gynaecologist reported that the victim suffered severe physical stress and disturbed mental anguish. The continuation of pregnancy will increase her risk of not only developing further complications such as preeclampsia, anaemia and other medical disorders. The victim would require a caesarean section to prevent serious trauma to the perineum and pelvic floor muscles.

II. Carrying the pregnancy to term will have a disproportionate negative effect on the life of the victim because she is an adolescent

In regions with weak health care systems, childbirth can have serious consequences for the health of the adolescent mother and her child. In some countries, adolescents are less likely than adults to obtain skilled care before, during and after childbirth. This can cause several health issues, including:

(1) Unsafe abortions - an estimated three million unsafe abortions occur globally every year among girls aged 15-19 years. This can lead to long term health problems and maternal deaths.
(2) Premature labour - young pregnant people face a greater risk of premature labour. They have immature reproductive organs that may not be prepared to carry an infant to term.
(3) High blood pressure - the increased demand for blood flow during pregnancy can put a strain on a young pregnant person's undeveloped cardiovascular system to carry the extra circulatory load. High blood pressure during pregnancy and other complications like preeclampsia and eclampsia can result in reduced foetal birth weight and child growth. This exposes the pregnant person to risks of many grave health complications and death.
(4) Anaemia - the nutritional demands of pregnancy combined with a diet lacking iron-rich foods, which is common among adolescents, can result in an iron deficiency.

The body of a 13 year old girl is not fully developed and the continuation of pregnancy caused an increased risk of physical and mental injury. The petitioner prayed that the Court admit the legality of an abortion under the Section 5 exception in cases where a pregnancy threatens the pregnant person's life.

III. Forcing the petitioner's daughter to continue her pregnancy constituted cruel, inhuman and degrading treatment under international law

The petition cited *Mellet v. Ireland*,[30] wherein the UNHRC found that the interference in the author's decision to terminate her non-viable pregnancy was unreasonable and arbitrary, and

[30] CCPR/C/116/D/2324/2013.

amounted to cruel, inhuman or degrading treatment under Article 7 of the International Covenant on Civil and Political Rights. It was also held that the balance that Ireland tried to draw between the protection of the foetus and the rights of the woman was unjustifiable and that Ireland's failure to provide her with abortion services amounted to gender-based discrimination.

IV. Adolescent pregnancy is a common phenomenon and the MTP Act should specifically provide for persons in the victim's position

The petition looked to global adolescent pregnancy rates to illustrate the need for a specific policy for women in the victim's situation. According to a fact sheet published by the World Health Organisation (WHO) in 2014, about 16 million girls aged between 15 to 19 and around 1 million girls under the age of 15 give birth every year, most in low and middle income countries. The 2014 World Health Statistics indicate that the average global birth rate among 15 to 19 year olds is 49 per 1000 girls. Adolescent pregnancy remains a major contributor to maternal and infant mortality and to the cycle of ill- health and poverty.

Pregnancy and childbirth complications in adolescents continue to be the second most prominent cause of death among 15 to 19 year olds globally, with approximately three million unsafe abortions among girls aged fifteen to nineteen taking place every year worldwide, which can lead to death or lasting health problems. Child-bearing at a young age increases the risks for both the pregnant person and infant. In low and middle income countries, infants born to mothers under 20 years of age face a 50% higher risk of still birth or dying in the first few weeks as compared to infants born to mothers in their 20s. They are also likely to have low birth weight and long term, persistent health defects.

V. An abortion would be safer than continuing the pregnancy to term

An abortion is less risky than continuing the pregnancy to term delivering either vaginally or by Caesarean section. Delivery by surgical intervention, which could involve anaesthesia, major abdominal surgery, potential complications, blood loss and wound healing. Further, on full term delivery, she would also require lactation suppression to stop breast milk production. An abortion would additionally allow relief from the petitioner's daughter's mental anguish and begin a process of recovery from the trauma caused by the pregnancy and her rape.

Young pregnant people also face an increased risk of obstetric fistula - a hole between the cervix and bladder or rectum - caused by prolonged, obstructed labour, without access to timely, high-quality medical treatment. It leaves women leaking urine, faeces or both, and often leads to chronic medical problems, depression, social isolation and may deepen poverty. More than 2 million women in sub-Saharan Africa, Asia, the Middle Eastern region, Latin America and the Caribbean are estimated to be living with fistula, and approximately 50,000 to 100,000 new cases are recorded annually. Fistula is almost entirely preventable. Its persistence is a sign of global inequality and an indication that health systems are failing to protect the health and human rights of the poorest and most vulnerable women and girls. Without emergency intervention, obstructed labour can last for

days, resulting in death or severe disability. The obstruction can cut off blood supply to tissues in the woman's pelvis. When the dead tissue falls away, she is left with a fistula. Tragically, there is a strong association between fistula and stillbirth, with research indicating approximately 90 per cent of women who develop obstetric fistula end up delivering a stillborn baby.

Obstetric fistula has been essentially eliminated in developed countries through the availability of timely, high-quality medical treatment for prolonged and obstructed labour – namely, Caesarean sections. Today, obstetric fistula occurs mostly among women living in extreme poverty, especially those living far from medical services. Childbearing in adolescent women before the pelvis is fully developed, small stature, as well as malnutrition and generally poor health conditions are among the social and physiological factors that contribute to obstructed labour.

The Protection of Children from Sexual Offenses Act 2012 (POCSO) establishes a set of rules, which provide for immediate medical assistance. The provision of medical services may include discussion of different options where the pregnancy is the result of rape. However, due to an increase of late reporting of sexual assault against children and adolescents, pregnancy is usually discovered at a later stage of gestation. The MTP Act however, restricts abortion beyond 20 weeks unless it is immediately necessary to "save the life" of the pregnant person. This prevents the victim of a rape from availing safe abortion services.

The petitioner prayed that the Court seek to harmoniously interpret these conflicting provisions. The Court ought to adopt a purposive approach to statutory interpretation such that where two constructions are reasonably possible, preference should be given to the interpretation which furthers the purpose of the Act.

Outcome

The Court held for the petitioner in allowing an abortion. The Court considered "the age of the petitioner and the trauma she had suffered because of the sexual abuse and the agony she is going through" to be determinative in this case. The Court was persuaded by the near certainty that the infant would be born pre-term, suffer health complications and that abortion posed a lower risk to the daughter's health than childbirth. The Court made no reference to the risk to life exception to the 20 week limit contained in Section 5 of the MTP Act.

Gausiya Gulam Pathan vs. Union of India (2017)[31]

Facts

The petitioner in this case, a 13 year old girl, complained of abdomen pain and was brought to a local doctor. She was refused anultrasonography by several clinics, and when she finally obtained one from a government hospital it revealed that she was 24 weeks pregnant. She then revealed her

[31]Writ Petition (C) No. 13228 of 2017, High Court of Bombay.

cousin's brother had raped her, while he was staying with her family. He had threatened to kill her if she spoke about the attack.

The petitioner went to the High Court of Bombay seeking a post-20 week abortion on the basis that due to her young age, the pregnancy posed a distinct threat to her life.

Issue

Should the 20 week time limit be set aside in a rape case of a minor in order to protect her health and wellbeing and respect her right to live a life of dignity?

Arguments

This petition challenged the constitutional validity of the 20 week time limit in Section 3(2)(b) of the MTP Act, as the limit was arbitrary in the light of technological and scientific advances. It was further argued that the petitioner's personal rights under Articles 14 and 21 of the Constitution were infringed by the limit. Additionally, it was argued that an unduly narrow interpretation of 'life' in Section 5 does not fully account for the pregnant person's and the foetus's health.

Specifically, this petition submitted that the pregnancy was a serious risk to the victim's health and life. The 20 week time limit prevents the victim taking steps necessary to preserve her health and life and as a result the time limit should not apply in this case or be struck down altogether as a violation of fundamental constitutional rights.

Similar to the *Murugan Nayakkar* case, it was argued that (i) the victim's age and physical stature puts her at great risk of complications in pregnancy and delivery, (ii) carrying the pregnancy to term will have a disproportionate negative effect on the life of the victim because she is an adolescent, (iii) forcing the petitioner's daughter to continue her pregnancy constituted cruel, inhuman and degrading treatment under international law, (iv) adolescent pregnancy is a common phenomenon and the MTP Act should specifically provide for persons in the victim's position, (v) an abortion would be safer than continuing the pregnancy to term.

Outcome

The Court held for the petitioner in allowing an abortion. The Court considered "the age of the petitioner and the trauma she has suffered because of the sexual abuse and the agony she is going through"[32] to be determinative in this case. The Court was persuaded when considering the near certainty that the infant would be born pre-term and both mother and child would likely suffer health complications as opposed to the lower health risks associated with an abortion. The Court made no reference to the risk to life exception to the 20 week limit contained in Section 5 of the MTP Act.

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[32]ibid, p. 2.

II. Foetal Abnormalities

Foetal abnormalities are conditions that affect a foetus or embryo and may cause disease or chronic abnormalities after birth, which may require on going medical assistance or surgery. Abnormalities can be fatal or incompatible with life, leading to death in the womb or shortly after birth. Section 3 of the MTP Act allows for abortion where the foetus is likely to suffer a significant disability in life, which can be indicated by foetal abnormalities in the womb. However the Section 3 time limit of 20 weeks still applies. This is especially problematic considering that a scientific diagnosis of an abnormality often occurs after this. Many foetal abnormalities can only be detected after 18 and 20 weeks, leaving very little time to pregnant people to decide whether to continue the pregnancy, before access is completely barred. Both international, national research and socio-legal policy have found that when a foetus has a significant anomaly, the resulting trauma can have severe implications. In *Mellet v Ireland*, the UN Human Rights Council found that continuing a pregnancy with the knowledge that the foetus may die in-utero, be stillborn, or die shortly after birth causes significant mental injury through anxiety, stress and worry. The operation of the 20 week time-limit in these cases is especially cruel and directly harms the health of the pregnant person.

As diagnostic equipment may only reveal a foetal abnormality in the latter stages of pregnancy, most litigation challenging the 20 week time limit has involved matters of foetal abnormality. Dr. Nikhil Datar, an obstetrician-gynaecologist and activist based in Mumbai, brought a case to the High Court of Bombay in 2008 challenging the time limit as an unjust interference with the reproductive rights of pregnant people. Following the disappointing result from this case, there have been numerous cases of pregnant people pleading for the Court to analyse the MTP Act in such a way so as to legalise abortions after the 20th week. The cases challenging the constitutional validity of the 20 week time-limit, which followed the reasoning in *Meera Santosh Pal v Union of India*, focussed on the effect of constraining reproductive freedom on the rights of pregnant people and its impact on their health. The time limit was challenged as being unjustifiably restrictive with no scientific basis. The Supreme Court has set aside this impugned provision in many cases of foetal abnormality but has not explicitly declared that it infringed upon the rights of the pregnant person under the Constitution and international law.

In cases of fatal foetal abnormality, petitioners have been consistently successful in setting aside the 20 week time-limit. In *Ms X v Union of India* the Court ruled that a risk that the foetus will die in the womb and thereby threaten the life of pregnant person justified an abortion under Section 5 of the MTP Act. In *Meera Santosh Pal v Union of India* the Court endorsed this position and further expressed the view that a pregnant person is legally empowered to take all necessary steps to preserve their life. In *Mamta Verma v Union of India* the Court considered the impact of the pregnancy on the pregnant person's mental health in setting aside the time-limit. The Court has been willing to set aside the time-limit and recognise the legality of an abortion as late as 28 weeks.

After *Ms X,* it became generally accepted that in cases of fatal abnormalities, where the foetus is incompatible with life, abortion is generally justified under Section 5 of the MTP Act after 20 weeks. However, ambiguity still exists in cases of uncertainty over the likelihood of survival or degree of severe abnormality or impairment. In *Sheetal Shankar Salvi v Union of India* the petitioner

was denied an abortion because her foetus was likely to survive through childbirth, even though it may only be for a short time. In *Sarmishtha Chakrabortty v Union of India,* the Court departed from previous jurisprudence and considered the impact of the pregnancy on the petitioner's mental health. The Court allowed an abortion in *Sonali Sandeep Jadhav v Union of India* after a lengthy consideration of the potential impact of the infant's condition on its quality of life.

Throughout these cases the Supreme Court accepted the unworkability of the time-limit and was willing to set it aside or apply it according to its normative judgments. The Court consistently maintained its reliance on the evidence and opinions provided by Medical Boards and assessed post 20 week abortions on a case by case basis. This often involved relying on precedent in which factual circumstances were similar. The Court gradually introduced more rights-based language and moved away from considerations of the foetus' odds of survival to a more holistic assessment of the quality of the potential infants life and the interests of the pregnant person. It is clear from these judgments that there is pressure to replace, or even repeal, the 20 week time-limit.

Dr Nikhil D. Datar, Mr X, Mrs Y vs. Union of India and State of Maharashtra (2008)[33]

Facts

In her 22nd week of pregnancy, Niketa Mehta discovered that her foetus showed signs of severe abnormality. A scan in the 24th week revealed that the foetus had severe heart defects and would likely not survive childbirth. Dr. Datar, an obstetrician, concluded that if the foetus were to survive childbirth it would suffer extreme physical disabilities which would make it nearly impossible for it to lead a normal, healthy life, which would in turn place a great deal of hardship on its parents. As abortion is limited after 20 weeks, Ms. Mehta and Dr. Datar appealed to the High Court of Bombay requesting recognition of the legality to terminate the pregnancy in her case.

Mrs. Y and Mr. X were in a similar position. Mrs. Y was pregnant with a medically nonviable foetus with a severe heart defect. As such, Mrs. Y was unable to provide full and informed consent for an abortion before the 20th week as she and her husband were still at that time unaware of the abnormality. Dr. Datar filed a petition challenging the 20 week limit in Section 3 of the MTP Act as it would result in a violation of women's fundamental rights and was medically unnecessary and arbitrary.

Issue

As the petitioners were unaware of the foetal abnormalities present in their pregnancies prior to the 20th week due to inadequacies in diagnostic equipment, should the time limit be set aside, as they never had the opportunity to decide whether to terminate or not?

[33]Writ Petition (C) No. 1816 of 2008, High Court of Bombay.

Arguments

Advocates for the petitioners argued that the limited right to abortion under Section 3 was rendered irrelevant by the 20 week limit. Section 3(2)(b)(i) of the MTP Act legalises an abortion in the case of 'grave injury' to the woman's health, or where there is a foetal abnormality under Section 3(2)(b)(ii). However these grounds are still subject to a time limit of 20 weeks. Section 5 allows for abortions after the 20thweek when the woman's life is at risk, but does not refer to the health of the foetus. In this case the petitioners argued that Section 3 requires the protection of the mental health of the mother, which is affected by the knowledge of a foetus's abnormality.

The petitioners submitted that a 20 week time limit in all cases except where the woman's life is in danger undermines the humanitarian, eugenics, and personal liberty interests of the MTP Act. The difference in treatment occurring after 20 weeks goes against the purpose of the Act and arbitrarily creates inequality by treating the pregnant person who discovers a foetal abnormality in the 20th week differently from one whose foetus is diagnosed in the 21st week.

The petitioners suggested that the Court fill in this gap in the law by reading in an exception to the time limit for those cases in which a woman's health is at grave risk of injury and where there is a foetal abnormality diagnosed after the 20th week. It was argued specifically that reading in the Section 3(2)(b)(ii) phrase '[where] there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped' into Section 5 of the MTP Act would cure this 'bad law'. It was submitted that the non-inclusion of foetal abnormality into the exception under Section 5 results in the law being ultra vires the Constitution.

Outcome

The High Court rejected the petitions and denied the women post-20thweek terminations. The Court disagreed with the petitioners on the facts of the case and rejected the assertion that the bench had the authority to re-write the law. The Court acknowledged that Section 5 "strictly restricts [termination of pregnancy] to case[s] where [the] life of the pregnant woman would be in danger in case the pregnancy is not terminated and does not refer to any other circumstances".[34] The Court went on to state that Section 3(2)(b)(ii) "clearly provides a right to terminate the pregnancy where there is a substantial risk in allowing the child to take birth as it would suffer from such physical or mental abnormalities as to be seriously handicapped".[35]

On the facts of the case, the Court determined that the foetal abnormality exception of Section 3(2)(b)(ii) was not met as they disagreed with the petitioners' assertion that the child would suffer a requisite level of disability during their lifetime. The Court determined that if the child were to survive birth, the child's heart condition not to be appropriately debilitating, finding no substantive justification for a termination of pregnancy.

[34]ibid, para. 11.
[35]ibid, para. 12.

Having denied the petition on the facts of the case the Court went on to express its disapproval of the nature of the petition. The Court noted that at no point did the petitioners call into question the reasonableness of the Act, there was "[no suggestion] that the period so prescribed by the statute has been arbitrarily prescribed or that there is no logic behind the period prescribed by the legislature in that regard".[36] With no factual material to justify using judicial discretion in this case, the Court found their role to be quite restrictive in this case.

The Court made several statements refuting the Court's role to "enlarge the scope of the legislation or the intention of the legislature…when the language of the provision is plain and unambiguous".[37] The Court expressed concerns of potential violations of the principle of the separation of powers stating, "the power to legislate has not been conferred to the courts", rather courts have the responsibility to "[decide] what the law is and not what it should be". This reflects a conservative interpretation of the MTP Act, employing a strictly literal approach, rather than specifically exploring the more concrete purpose behind the legislation:

> "The Court cannot rewrite, recast or reframe the legislation for the very good reason that it has no power to legislate. The power to legislate has not been conferred on the courts. The Court cannot add words to a statute or read words into it which are not there. Assuming there is a defect or an omission in the words used by the legislature, the Court could not go to its aid to correct or make up the deficiency."[38]

Extracts

DR NIKHIL D. DATAR; MR X, MRS Y
VERSUS
UNION OF INDIA AND ORS
WRIT PETITION NO.1816 OF 2008

High Court of Bombay…

2. By the present petition, the petitioners are seeking declaration that Section 5 of the Medical Termination of Pregnancy Act, 1971…to the extent it does not include the eventualities specified under Section 3(2)(b)(ii) of the said Act is ultra vires and that, therefore, the Section 5(1) of the said Act should be read down to include the said eventualities, and consequently should be read to include the following words "and when there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped"…

[36]ibid, para.21.
[37]ibid, para. 25.
[38]ibid.

18. It was sought to be argued on behalf of the petitioners that the pre-amble of the said Act clearly provides that there is avoidable wastage of the mother's health, strength, and sometimes, life, and therefore, the legislation in the form of the said Act seeks to liberalise certain existing provisions relating to termination of pregnancy which is nothing but a health measure in cases where there is danger to the life or risk to physical or mental health of the woman as also on humanitarian grounds…and considering the eventualities under which the pregnancy can be terminated in terms of Section 3, the same should be read in Section 5 also. According to the learned Advocate, there was lapse on the part of the legislators in not including such eventualities under Section 5 of the said Act…that the said lacuna is required to be filled in by reading down Section 5 to include such eventualities.
19. We are afraid the contention on behalf of the petitioners if accepted would virtually amount to legislating upon Section 5 of the said Act…
20. …It is not mere desire to terminate the pregnancy that will entitle either pregnant woman to go for termination of pregnancy or for the doctors to assist the pregnant woman to terminate the pregnancy by taking resort to Section 5 of the said Act…undoubtedly, the experts have to ascertain whether there is danger to the life of a pregnant woman on account of pregnancy.
21. …The legislature in its wisdom has imposed [a] certain period within which the pregnancy can be terminated. Nothing is placed on record on behalf of the petitioners even to remotely suggest that the period so prescribed by the statute has been arbitrarily prescribed or that there is no logic behind the period…
25. …Assuming there is a defect or an omission in the words used by the legislature, the Court could not go to its aid to correct or make up the deficiency. Courts shall decide what the law is and not what it should be…

Ms. X vs. Union of India (2016)[39]

Facts

An obstetric examination in the 24th week of Ms X's pregnancy revealed several anomalies. A subsequent scan revealed several abnormalities - 1) Excencephaly, i.e. evidence of no skull vault above orbit, with presence of brain tissue floating in amniotic fluid, 2) Omphalocele (presence of liver, intestines and stomach bubble outside the abdomen and in the amniotic cavity), 3) Heart is bulging into the omphalocele sac, 4) Kyphoscoliosis which is an anomaly of the spine involving the thoracolumbar vertebrae with polyhydramnios (excessive amniotic fluid) with closed vertix. The petitioner's doctors advised that the foetus' condition is fatal and posed a risk to her health. However, she was denied an abortion as her pregnancy had advanced beyond 20 weeks.

[39]Writ Petition (C) No. 593 of 2016, Supreme Court of India.

Issue

Should the 20 week time limit be set aside in a case of fatal foetal abnormality, when diagnosis only occurred in the 24th week of pregnancy?

Arguments

It was argued that the medical evidence was so clear in highlighting that the foetus was not viable and that continuation of the pregnancy would pose a grave injury to the Petitioner's physical and mental health, that the time limit in Section 3 should be set aside, or the case should fall under a Section 5 exception.

Outcome

The Court held for the petitioner and confirmed the legality of a post 20 week abortion under Section 5 of the MTP Act on the basis that the exencephalic pregnancy posed a threat to the life of the petitioner, as defined under Section 5. The Court did not address the mental health of the petitioner or the constitutionality of the time-limit. The Court's orders suggested that the judgment was simply an affirmation of the Medical Board's evidence and that it was merely approving of the thoroughness of its recommendations.

In *Ms X*, the Supreme Court set the precedent for recognising the legality of abortions after 20 weeks in cases of fatal foetal abnormality. In relying on Section 5 as the legal foundation to recognise the exception to the 20 week rule, the Court set out the presumption that the death of a foetus in the womb threatened the pregnant person's life and where there is such a risk it falls within the scope of the Section 5 exception.

Subsequent judgments would recognise the legality under the MTP Act of late term abortions in cases where a foetus' abnormalities rendered it incompatible with life, regardless of whether the foetus was likely to die in the womb. The jurisprudence in these cases indicate that the Court is unwilling to apply restrictions to a woman's right to an abortion where the foetus has limited chance of long-term survival. The judgment in this case however rested purely on the actual and potential harm to the petitioner.

Meera Santosh Pal vs. Union of India (2017)[40]

Facts

The petitioner in this case, Meera Santosh Pal, was 22 and came from a low-income background in Mumbai. An anomaly scan detected that the foetus, with a gestational age of 21 weeks, suffered from anencephaly, which led to the underdevelopment of the skull. She requested and was denied

[40]Writ Petition (C) No. 17 of 2017, Supreme Court of India.

an abortion because the pregnancy had advanced past 20 weeks. Forcibly continuing the non-viable pregnancy had caused the petitioner extreme anguish.

Issue

Should the 20 week time limit be set aside in a case of anencephaly, an accepted fatal foetal abnormality according to medical experts, where continuation of pregnancy also posed a grave risk to the mother's physical and mental health?

Arguments

This petition challenged the constitutional validity of Section 3(2)(b) and Section 5 of the MTP Act. Section 3(2)(b) was challenged on the basis that the 20 week time limit was no longer justified due to technological and scientific advancements. Further, a determination of foetal abnormality can usually only be done after the 20th week, rendering the foetal abnormality exception inoperable. Maintaining an arbitrarily low time-limit causes unnecessary pain and agony for women forced to continue unwanted and potentially dangerous pregnancies to term. Thus, it was prayed that the Court find the 20 week limit provision in Section 3(2)(b) to be arbitrary, harsh, and discriminatory.

The phrase 'termination of such pregnancy is immediately necessary to save the life of the pregnant woman' contained in Section 5 was additionally challenged as being unduly restrictive, arbitrary, harsh, discriminatory, and in violation of Articles 14 and 21 of the Indian Constitution. Indeed, it was submitted that the term 'life' has been interpreted in an overly literal and narrow sense - allowing for abortions only where the woman will die otherwise. This animalistic construction of 'life' goes against constitutional jurisprudence, which emphasises the importance of dignity in life. It was argued that this understanding of 'life' should be replaced as it fails to incorporate the physical and mental health and well being of the woman. The physical and mental trauma of continuing an unwanted pregnancy, especially in a case of foetal abnormality, is detrimental to a woman's ability to live a life of value.

The petitioner raised several objections against present provisions of the MTP Act, attacking both its validity and the legitimacy of its impact upon pregnant women, specifically:

I. The MTP Act is an outdated law that endangered the petitioner's health.

In India 2-3% of births have a severe congenital abnormality with many more suffering intrauterine foetal death (IUFD) or being delivered stillborn. 3D and 4D sonographic technology makes it possible to detect some abnormalities before 20 weeks, while other abnormalities can only be detected after 20 weeks. Many of these abnormalities cause risk to the pregnant person's health during pregnancy and delivery. In India, where many pregnant people do not have access to antenatal care, foetal abnormalities may only be detected during the first antenatal check-up late in the pregnancy. Given advancements in technology and scientific knowledge since the passage of the MTP Act, there is presently no increased risk to the mother having an abortion at 25 weeks as compared to 20 weeks.

The MTP Act's time limit leads people to continue mentally and physically injurious pregnancies, or desperately seek and undergo unsafe abortions. These clandestine abortions are the third most prominent cause of maternal death in India, accounting for 8% nationally and 13% internationally. Given the severe impact on the health and risk of death imposed by the MTP Act, the National Commission for Women proposed an amendment inserting various exceptions, including risk to health and foetal abnormality, to the application of an upper limit on gestational age for access to abortion:

> 'Provided that where the pregnant woman is minor; pregnancy is a result of rape or incest, pregnant woman is physically challenged; or continuance of pregnancy would involve risk to the life of the pregnant woman; or grave injury to her physical or mental health; or there is a substantial risk that if the child were born it would suffer physical or mental abnormalities then the upper limit on gestational time shall not apply to the termination of pregnancy.'

It was submitted that without such an exception the MTP Act violates fundamental human rights guaranteed by the Constitution and international law. Time restrictions cause physical and mental trauma and judicial intervention is necessary to redress the resulting rights violations. Several European and North American countries do not have strict time limits, relying instead on the determinations of medical professionals.

It is questionable whether the right to life exception to the post 20th week abortion ban is enough to ensure the safety of the mother. Dr. Anne Davis remarked that abortion laws with a 20 week limit, with only 'nominal exceptions for the health and life of the mother in these laws can make otherwise safe abortions dangerous by forcing doctors to wait until their patient's condition deteriorates before they can legally act to terminate a pregnancy and save their lives'.

II. The MTP Act prohibited the petitioner from undergoing an abortion in the case of foetal abnormality.

The 20 week time limit for abortion in the case of foetal abnormality prevents any real choice whether to continue or terminate an abortion where the foetal deformity is only discoverable after 20 weeks gestation.

The Australian Medical Journal reported that the accuracy of prenatal testing is compromised where access to abortion is limited to 20 weeks or prior. The report also finds that in cases of foetal abnormalities, denying abortion may only delay the inevitable death of the child and extend the suffering of the family. According to a report by The Hindu, doctors agree that in certain cases of foetal abnormality such as anencephaly, an abortion is the only safe option for the pregnant person. Waiting for the foetal abnormality or a pregnancy's complication to end the life of the foetus or risk the life of the mother is medically dangerous and morally repulsive.

An article published by the Australian Medical Journal stated:

> The uterus is indeed the best intensive care unit; fetuses with the most terrible abnormalities usually do not die before birth. Denying abortion may only delay the inevitable and extend the suffering of the family.

The MTP Act forbids the petitioner from terminating her pregnancy following a diagnosis of foetal abnormality. The continuation of the pregnancy in spite of the knowledge of the inevitable death of the foetus, inhumanly prolongs the suffering of the petitioner.

A study by the American Psychological Association Task Force on Mental Health and Abortion found that women who terminate a previously wanted pregnancy, even late in the pregnancy, experience less severe psychological harm than women who deliver a child with severe abnormalities. The study also found that eight weeks into pregnancy, women who had terminated their pregnancy expressed significantly less trauma than those who suffered spontaneous child loss. The only response to foetal abnormality that respects the health, dignity and autonomy of the pregnant person is to allow her the option of ending the pregnancy.

III. Indian abortion law is in violation of international law

In the case of *K.L. v Peru*, the United Nations Human Rights Committee (UNHRC) found that the denial of access to abortion for a young woman who was carrying a foetus with an impairment (anencephaly) and was experiencing a life-threatening pregnancy constituted cruel, inhuman and degrading treatment. The UNHRC specifically noted that Peru's abortion laws permitted abortion to preserve a woman's life or health and criticized the government for its restrictive interpretation of the 'life and health' exception in the law.

Similarly, in *Mellet v Ireland*, the UNHRC declared that prohibiting and criminalising abortion and preventing a person with a non-viable pregnancy accessing abortion services in Ireland caused 'a condition of intense physical and mental suffering' and violated her rights to freedom from cruel, inhuman or degrading treatment, privacy and equality.

IV. The prohibition of abortion after the 20th week of pregnancy for any reason other than a risk to life, can actually create a risk to the life of a pregnant person and therefore violates both an expansive and narrow interpretation of the right to life.

Article 21 of the Constitution of India guarantees the right to life and personal liberty. In *Pt. Parmanand Katara v. Union of India* the Supreme Court held that Article 21 of the Constitution bound the State to preserve life, and because the obligation to preserve life is 'total, absolute and paramount', laws of procedure which 'interfere with the discharge of this obligation cannot be sustained and must, therefore, give away.' The MTP Act forces pregnant people after the 20th week of pregnancy, to compromise their own personal safety and welfare by carrying abnormal foetuses to term. Alternatively, the MTP Act forces pregnant people to obtain unsafe abortions. Both of these scenarios put the lives of pregnant people in extreme danger. The enforcement of the MTP Act without effective access to abortion after 20 weeks not only fails to protect the life of the petitioner, but actively endangers it, therefore violating Article 21 of the Constitution. The petitioner prayed that the Court read an exception into the 20 week time-limit for unsafe and non-viable pregnancies.

V. The effect of the 20 week time-limit is to force the petitioner to continue the unwanted pregnancy to term, in violation of her right to be free from inhuman and degrading treatment

The right to be free from torture, cruel, inhuman, and degrading treatment is guaranteed at international level by the ICCPR and was recognized by the Supreme Court in *Francis Coralie Mullin* to form a part of the right to life of Article 21 of the Constitution. This imposes a general obligation on the State to protect individuals from ill-treatment and includes a duty to guard against unnecessarily prolonged physical or mental suffering. Forcing the petitioner to carry a non-viable foetus to term was not medically necessary and would foreseeably cause depression and distress, and thus amounted to inhuman and degrading treatment and is prohibited by Article 7 of the ICCPR and Article 21 of the Indian Constitution.

This argument is supported by the decision of the UNHRC in *KL v Peru*. According to international law, the anguish suffered by pregnant people forced to carry a non-viable or severely abnormal foetus amounts to cruel, inhuman and degrading treatment. Thus, restrictive abortion laws like the MTP Act violated Meera Santosh Pal's fundamental rights under Article 21 of the Constitution.

VI. The ban on abortions after 20 weeks violated the right to health

The 20 week time limit exposes pregnant people to significant damage to their physical and mental health, amounting to a denial of their basic freedom through the imposition of a forced, unwanted or potentially dangerous pregnancy.

In *Consumer Education and Research Center v Union of India* the Supreme Court found the right to health to be a 'most imperative constitutional goal' deriving from the right to life in Article 21. India is a signatory to the International Covenant on Economic, Social and Cultural Rights (ICESCR), which, in Article 12, requires States to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. This right bears with it the right to reproductive decision-making.

The right to health includes both physical and mental well-being. The MTP Act does recognise the importance of mental health. For example, Section 3 allows for abortions before 20 weeks where the pregnancy poses a risk to the pregnant person's mental health. Yet pregnant people who require an abortion after 20 weeks are forced to risk their own physical and mental health, resulting for continuance of the pregnancy.

The MTP Act's 20 week restriction also placed a traumatic sense of urgency on the petitioner, forcing her to undergo significant emotional distress when deciding whether to go forward with an abortion without adequate available medical information. Even if a pregnant person receives a diagnosis before 20 weeks, they will have a very short time period in which to make a decision. This petition argued that the enforcement of the MTP Act in a manner which inflicts mental distress upon pregnant women is a clear violation of the right to health under Article 21 of the Constitution of India and Article 12 of the ICESCR.

The MTP Act takes complete control over the petitioner's reproductive freedom and choice after 20 weeks of pregnancy. An exception to a termination ban in the case of high-risk pregnancies, as

contemplated by the ICESCR, would have allowed the petitioner and her doctor to make the best choice for her mental and physical well-being. Denying the pregnant person the ability to decide the best course of action for their mental and physical needs violates their right to health. There must, at a minimum, be some exception in extreme cases to protect the woman's mental health.

The right to physical health is similarly infringed by an outright ban after 20 weeks. Pronouncing upon the right to health in General Comment 14, the Committee for Economic, Social, and Cultural Rights stated that State actions, policies or laws that contravene the standards of the Covenant, and which are likely to result in bodily harm, unnecessary morbidity and preventable mortality violate the state party's international obligations. Additionally, in General Comment No. 22 (2016) on the right to sexual and reproductive health, the committee clarified that;

> The right to sexual and reproductive health is also indivisible from and interdependent with other human rights. It is intimately linked to civil and political rights underpinning the physical and mental integrity of individuals and their autonomy, such as the right to life; liberty and security of person; freedom from torture and other cruel, inhuman or degrading treatment; privacy and respect for family life; and non-discrimination and equality. For example, lack of emergency obstetric care services or denial of abortion often lead to maternal mortality and morbidity, which in turn constitutes a violation of the right to life or security, and in certain circumstances can amount to torture or cruel, inhuman or degrading treatment.

Enforcement of the MTP Act as it stands has a significantly detrimental effect on the health of the pregnant mother and results in the preventable mortality of pregnant people, who have no choice but to resort to unsafe abortion services.

The petitioner was forced to undergo severe psychological stress and trauma and was needlessly compelled to carry a foetus to term, which had a substantial anomaly and no probability of independent survival. Thus, the State's enforcement of the MTP Act violates its obligation to protect the health rights of women under Article 12 of ICESCR. The MTP Act's ban on abortion after the 20th week endangers pregnant people's physical and mental health and in cases of substantial foetal abnormalities, prolongs the suffering of the pregnant person when she is aware of the prognosis and is compelled to continue the pregnancy against her will.

VII. Enforcement of the MTP Act violated the petitioner's right to live a life of dignity

In *Francis Coralie Mullin v Union Territoryof Delhi* the Supreme Court declared that 'every act which offends against or impairs human dignity would constitute deprivation pro tanto of this right to live'. Additionally, Article 12(1) of the ICESCR states that 'every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity'. Forcing the petitioner to carry a non-viable foetus for months caused her acute mental anguish, despair and physical pain. She was deprived of dignity by being forced to continue with her pregnancy and having no ability to make decisions about her own health, or control her own body. A person's ability to live a dignified life is seriously constrained where an outside force takes control of their bodily functions. It is unconstitutional to limit a woman's decision-making ability to the point where she is unable to live a life of dignity.

VIII. The MTP Act violated the petitioner's right to personal liberty and privacy

The Supreme Court in *PUCL v Union of India* declared that the right to privacy is implicit in Article 21 of the Constitution:

> 'Acitizen has a right to 'safeguard the privacy of his own, his family, marriage, procreation, motherhood, childbearing and education among other matters.' We have, therefore, no hesitation in holding that right to privacy is a part of the right to 'life' and 'personal liberty' enshrined under Article 21 of the Constitution'.

By forcing the petitioner to continue an unwanted pregnancy she lost her right to safeguard the privacy of procreation, motherhood and childbearing, as the MTP Act prescribes the choices she may make.Additionally, CEDAW explicitly affords women the right to freely decide the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights. The CEDAW Committee, in General Recommendation 24, recommends that States 'require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice'. By imposing personal decisions and restricting a pregnant person's choice, the State fails to respect, protect and fulfil the right to privacy of all persons.

IX. Enforcement of the MTP Act violated her right to choice and informed consent

Samira Kohli v. Dr. Prabha Manchanda set the requirement that a doctor should secure the consent of the patient before commencing any treatment. The consent obtained must be real and valid. This means that 1) the patient should have the capacity and competency to consent, 2) their consent should be voluntary, and 3) their consent should be based on adequate information. The 'adequate information' providedmust enable the patient to make a balanced judgment as to whether they should submit themselves to the particular treatment or not. Amniocentesis tests are advised if a defect in the foetus is detected during anultrasonography. Thisultrasonography, used to find abnormalities, can only be done after the 18th week of pregnancy. The subsequent amniocentesis test requires at least two to three additional weeks for analysis.

It is impossible to determine the extent of a foetal abnormality until after the 20 week time limit for abortion has elapsed. Thus, a pregnant person cannot give informed consent regarding the decision to continue or terminate the pregnancy at 20 weeks as they are unable to access and respond to adequate medical information. The 20 week deadline effectively bars pregnant people, who discover foetal cerebral abnormalities, from access to safe abortions.

It was submitted that the deadline be extended to allow women to make an informed choice.

X. The enforcement of the MTP Act violated the petitioner's right to equality before the law

Article 14 of the Constitution of India guarantees equality before the law and Article 15 prohibits discrimination on the grounds of religion, race, caste, sex or place of birth. Indeed, the Supreme Court describes gender equality as one of the 'most precious Fundamental Rights guaranteed by the Constitution of India'. The burdens of pregnancy, delivery, and child rearing are inequitably

borne by women. Accordingly, women's quality of life and ability to pursue personal development are disproportionately affected by the decision to carry a pregnancy involving foetal impairment to term. Further, poor women tend to have less access to information and resources related to reproductive health services.

It was then contended that the criminalisation of therapeutic abortion constitutes discrimination against women on the basis of sex, and socio-economic status. Nevertheless, the MTP Act provides no exception to account for this disproportionate impact on the health and welfare of the pregnant person and therefore, violates the right to equality before the law as guaranteed under Article 14 and 15 of the Constitution of India.

General Recommendation 24 of CEDAW declared, 'State parties that have laws that criminalise medical procedures only needed by women punish women who undergo those procedures'. Abortion is a medical procedure only obtained by women, and as such it is women's lives and health that are disproportionately put at risk by the MTP Act's restrictions. Therefore, the MTP Act's prohibition on abortion after 20 weeks of pregnancy amounted to an unjustifiable discrimination on the basis of sex. Of particular importance in this case is that the right to non-discrimination under CEDAW requires that abortion be lawful when necessary to protect women's health as a measure to eliminate discrimination against women in the field of health care.

Outcome

The Supreme Court held for the petitioner and allowed her to undergo an abortion. The case was decided upon narrow lines and the ruling only briefly dealt with the overarching fundamental human rights concerns of the petition. The Court determined that due to the diagnosis of anencephaly the pregnancy constituted a danger to the petitioner's life. The Court held that the petitioner had the right to preserve her life in view of the foreseeable danger of continuing the pregnancy. Thus, the petitioner fell within the exception to the 20 week time limit created by Section 5. This decision suggests that medical professionals may take measures, including abortion, to preserve a woman's life before the pregnancy becomes a direct threat to her survival. Medical professionals are not required to wait until the last moment to terminate an 'immediately' dangerous pregnancy.

The Court accepted that the foetus' condition 'is certain to cause the infant's death during or shortly after birth'. The Court found it persuasive that 'there is no point in allowing the pregnancy to run its full course since the foetus would not be able to survive outside the uterus without a skull'. This statement might be interpreted as signalling that the certain death of the infant invalidates any restrictions on the reproductive decision making on the pregnant person. It is clear however that the Court delineates between a fatal and non-fatal abnormality. By focusing on the impossibility of survival rather than quality of life the Court has made it clear that it will not recognise the legality of an abortion after 20 weeks for purposes of eugenics or mercy. It is arguable that this judgment legalises abortion, at any stage of pregnancy, where medical experts determine that the foetus is unlikely to survive.

Notably, the Court questioned, "whether the right to bodily integrity calls for…permission to

allow her to terminate her pregnancy".[41] The Court expressed the belief that the petitioner had the right to take all necessary steps to preserve her own life against the avoidable danger to it. To the Court this is certainly a permissible expression of 'reproductive autonomy'. However, the full extent of permissible action in the exercise of reproductive autonomy remains unclear. Despite focussing on the preservation of life the court refused to define 'life', presumably relying on the conception of 'life' as mere physical survival.

The significant result from this judgment is that pregnant people and medical professionals can now be legally assured, at any stage of gestation, of the opportunity to obtain or perform an abortion when the pregnancy represents a threat to the woman's life and the foetus is certain to die. While many of the constitutional, rights-based arguments and issues raised in the original petition were not directly addressed in the judgment, these arguments have been used in subsequent cases, reflecting how they set the foundation for a direct challenge of the MTP Act.

Extracts

MEERA SANTOSH PAL AND ORS VERSUS UNION OF INDIA AND ORS

WRIT PETITION (CIVIL) NO.17 OF 2017

[The Petitioner] apprehended danger to her life, having discovered that her fetus was diagnosed with Anencephaly, a defect that leaves foetal skull bones unformed and is both untreatable and certain to cause the infant's death during or shortly after birth. This condition is also known to endanger the mother's life…

By its report dated 12.1.2017, the Medical Board has examined petitioner no.1 with specific reference to their special expertise for general, medical, radiological, psychiatric and anaesthetic evaluation…The said Board has further reported that obstetric examination shows 24 weeks pregnancy, external ballottement present, fetal parts not well felt with mild polyhydramnios. On internal examination, the cervix is posterior and OS is closed. Ultrasonography diagnosis has revealed a single live fetus with anencephaly with mild polyhydramnios with hypotelorism.

We have been informed that the fetus is without a skull and would, therefore, not be in a position to survive. It is also submitted that petitioner no.1 has undergone psychiatric evaluation. She is reported to be coherent, has average intelligence and with good comprehension. She understands that her fetus is abnormal and the risk of fetal mortality is high. She also has the support of her husband in her decision making…

The condition of the fetus is not compatible with extra-uterine life. In other words, the fetus would not be able to survive outside the uterus…Importantly, it is reported that the continuation

[41]ibid, p. 3.

of pregnancy can gravely endanger the physical and mental health of petitioner no.1 and the risk of her termination of pregnancy is within acceptable limits with institutional back up…

This Court, as at present being advised, would not enter into the medico-legal aspect of the identity of the fetus but consider it appropriate to decide the matter from the standpoint of the right of petitioner no.1 to preserve her life in view of the foreseeable danger to it, in case she allows the current pregnancy to run its full course. The medical evidence clearly suggests that there is no point in allowing the pregnancy to run its full course since the fetus would not be able to survive outside the uterus without a skull…

The crucial consideration in the present case is whether the right to bodily integrity calls for a permission to allow her to terminate her pregnancy. The report of the Medical Board clearly warrants the inference that the continuance of the pregnancy involves the risk to the life of the pregnant woman and a possible grave injury to her physical or mental health as required by Section 3 (2)(i) of the Medical Termination of Pregnancy Act, 1971. Though, the pregnancy is into the 24th week, having regard to the danger to the life and the certain inability of the fetus to survive extra uterine life, we consider it appropriate to permit the petitioner to terminate the pregnancy. The overriding consideration is that she has a right to take all such steps as necessary to preserve her own life against the avoidable danger to it. In these circumstances given the danger to her life, there is no doubt that she has a right to protect and preserve her life and particularly since she has made an informed choice. The exercise of her right seems to be within the limits of reproductive autonomy.

In the circumstances, we consider it appropriate in the interests of justice and particularly, to permit petitioner no.1 to undergo medical termination of her pregnancy under the provisions of Medical Termination of Pregnancy Act, 1971.

Mrs. X vs. Union of India (2017)[42]

Facts

During the obstetric anomaly ultrasonography conducted during the 21st week of pregnancy it was discovered that Mrs X's infant suffered from gross oliogohydraminos with dilated right atrium, hypoplastic kidneys and no presence of stomach and urinary bladder. Subsequently, an ultrasound revealed that the foetus suffered from anhydramnios, bilateral renal agenesis, due to which there was amniotic fluid around the foetus and there was no development of kidneys in the foetus. The foetus also suffered from single umbilical artery, cardiac defect and foetal growth restriction. The foetus was virtually certain to die before or shortly after childbirth. Upon learning of the foetus' condition, the petitioner requested Dr. Datar to perform an abortion. Dr. Datar denied her request as the gestational period of the pregnancy had passed the 20 week time-limit for abortion under the MTP Act. After being denied an abortion, Mrs X underwent severe psychological, physical and emotional trauma.

[42]Writ Petition (C) No. 81 of 2017, Supreme Court of India.

Issue

Should the time limit be set aside where continuation of pregnancy posed a grave risk to the petitioner's mental health as the foetus was almost certain to die before or shortly after birth due to multiple abnormalities (non-anencephaly)?

Arguments

The petitioner argued that as the precedent had been set for abortion after the 20th week in cases of anencephaly, it could this be expanded to include cases of multiple abnormalities which would amount to foreseeable mortality pre- or post- delivery. Additionally, the petitioner argued that the trauma she was undergoing as a result of the foetus's abnormality was so significant as to endanger both her physical and mental health.

Outcome

The Court held for the petitioner in allowing an abortion due to the threat to the petitioner's life posed by the foetus' condition. The Court noted that 'the pregnancy involves a risk to the life of the petitioner and a possible grave injury to her physical or mental health'. Due to the danger to her life and the inevitable death of the foetus outside the womb, the Court allowed an abortion in the 24th week of pregnancy. The Court did not address the validity of the MTP Act as the petitioner's case fell within the circumstances provided for by Section 5.

The Court in this case allowed a post-20 week abortion where the foetus had a condition other than anencephaly. The certainty of the foetus' death, potentially while in utero, inherently implies a threat to the pregnant person's life. Supreme Court jurisprudence has established that a fatal foetal abnormality that may result in the foetus dying in utero justifies an abortion under the provisions of Section 5 of the MTP Act.

Extracts

Mrs. X AND ORS.
VERSUS
UNION OF INDIAN AND ORS

WRIT PETITION (CIVIL) NO. 81 OF 2017

There is thus a clear diagnosis of the single live fetus which is said to have bilateral renal agenesis which means the means the fetus has no kidneys and anhydramnios which means that there is an absence of amniotic fluid in the womb. Further, there is a clear observation that there is a risk of intrauterine fetal death, ie. death within womb and there is no chance of a long term post natal survival. What is important is that there is no curative treatment available at present for bilateral renal agenesis…

From the point of view of the petitioner the report has observed risk to the mother since continuation of pregnancy can endanger her physical and mental health…

In these circumstances we find that the right of bodily integrity calls for permission to allow her to terminate her pregnancy.

Savita Sachin Patil vs. Union of India (2017)[43]

Facts

The petitioner was in her 26th week of pregnancy when the foetus she was carrying was diagnosed as having Trisomy 21, otherwise known as Down Syndrome.

Issue

Did a diagnosis of Trisomy 21 pose a significant enough danger to the life of the mother and the life of the foetus, such that the 20 week time limit could be set aside?

Arguments

The petitioner's anguish on discovering that her foetus suffered from Trisomy 21, a condition that may cause severe physical and mental retardation, posed a danger to her mental health and justified a termination of the pregnancy.

Outcome

The Court refused to give legal recognition of the right to undergo an abortion in this case on the basis that the Medical Board did not conclude that the foetus *would* have severe mental and physical challenges. The Board only suggested that the newborn would be *likely* to have such challenges. Additionally, the medical report found that there was equal medical risk to the petitioner whether she terminated or continued with the pregnancy and "it is not possible to discern the danger to the life of Petitioner 1 in case she is not allowed to terminate her pregnancy".[44]

The Court's determination in this case was based on the particular facts of the case and suggests that depending on the diagnosis certain abnormalities will be considered to pose a graver risk to the life and wellbeing of the pregnant person than others. The Medical Board's inability to estimate the degree of severity of possible impairments the child would suffer, coupled with the lack of additional physical risk to the mother, led the Court to find that this did not fall within the precedent set in previous cases.

[43]Writ Petition (C) No. 121 of 2017, Supreme Court of India.
[44]ibid, para.8.

Sheetal Shankar Salvi vs. Union of India (2017)[45]

Facts

The petitioner was in her 27th week of pregnancy and came from a middle-class background in Mumbai. During an ultrasonography, it was detected that the foetus suffered from ventriculomegaly with dangling choroid plexus and hydrocephaly. Two further ultrasonographies detected that the foetus was suffering from severe ventricumegaly with dilated atrium of lateral ventrium measuring 16 mm, along with Khyphotic deformity of lumbar spine, spina bifida (myelomeningocele) and possibly Arnold Chiari Malformation Type II.

Myelomeningocele, which is a neural tube defect, is a defect of the backbone (spine) and spinal cord. Foetuses with spina bifida have a high stillbirth rate. Approximately 20% of live born infants that undergo surgery die in the first year of life and approximately 35% die within the first five years. 25% of patients are totally paralysed, 25% are almost totally paralysed, and only 17% of infants have normal continence. It is impossible to predict precisely in utero the severity of impairment of affected foetuses. The petitioner was denied an abortion as her pregnancy had advanced beyond 20 weeks. This caused the petitioner immense mental anguish.

Issue

Does a foetal diagnosis of spina bifida, a neural tube defect, which does not necessarily lead to a fatal diagnosis, constitute a grave danger to the life of the foetus and mother?

Arguments

The petitioner asserted that being forced to carry an unwanted pregnancy to term is a violation of her reproductive rights. Further, she argued that the 20 week time limit was arbitrary, and the MTP Act generally infringed on several of her constitutional rights, particularly those under Articles 14 and 21.

Outcome

The Court held against the petitioner and did not allow her to undergo an abortion. The Court noted that the Medical Board was unable to determine how long a newborn would survive after birth, but acknowledged that the Board found that the infant was not likely to live a normal life. As with *Savita Sachin Patil*, the focus of the Court's decision was on the life expectancy of the foetus, because "the baby may be born alive and may survive for variable period of time".[46] Additionally there was no danger to the petitioner's life and, on the evidence the Court was not convinced that she was actually suffering mental anxiety about the health of the infant.

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[45] Writ Petition (C) No. 174 of 2017, Supreme Court of India.
[46] ibid, para.6.

The Court accepted that the child would likely suffer severe disabilities in life. But unlike other benches of the Supreme Court, in this case this acceptance alone was not enough to justify an abortion after 20 weeks. Further they gave no positive reasons as to why the time limit *should* apply in this case. In assessing the life expectancy of the foetus, the Court focused on the fact of the uncertainty of the medical prognosis rather than the finding that it was still 'likely' it would die shortly after birth. This seems to reflect the view that if there is still a remote possibility that the infant could survive months or years, abortion cannot be justified. The legality of abortions after 20 weeks could only be based on medical consensus on the certainty of mortality.

The petitioner, Sheetal Shankar Salvi, delivered her baby shortly after the judgment was handed done. The infant was born with severe anomalies and was kept in the neonatal intensive care unit immediately after birth due to the severity of its condition. The petitioner and the infant were eventually discharged from hospital, as doctors could not offer any further assistance. The parents were told to care for the infant until its likely imminent death. The petitioner went through immeasurable mental trauma while her infant suffered phenomenal physical pain.

Extracts

SHEETAL SHANKAR SALVI AND ANR
VERSUS
UNION OF INDIA AND ORS

WRIT PETITION (CIVIL) NO.174 OF 2017

… However, having regard to the fact that there is no danger to the mother's life and the likelihood that 'the baby may be born alive and may survive for variable period of time, we do not consider it appropriate in the interests of justice to direct the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy. In fact, the aforesaid Medical Board has itself stated that it does not advise medical termination of pregnancy for petitioner no.1 on medical grounds.

The only other ground that appears from the observations made in the aforesaid medical report apart from the medical grounds, is that petitioner no.1 is anxious about the outcome of the pregnancy. We find that the termination of pregnancy cannot be permitted due to this reason.

Sarmishtha Chakrabortty vs. Union of India Secretary (2017)[47]

Facts

An anomaly scan in the 20th week of pregnancy revealed that the foetus had a cardiac anomaly which suggested Tetralogy of Fallot, which is a combination of several defects causing blood low in oxygen to flow from the heart. A subsequent foetal echocardiography confirmed Tetralogy of Fallot and

[47]Writ Petition (C) No. 431 of 2017, Supreme Court of India.

other cardiac abnormalities. If the pregnancy continued, the petitioner would need to deliver the newborn in a highly well equipped centre with a neonatal cardiac intervention and surgical facility. Additionally, if the foetus survived birth, it would require multiple surgeries, which would each pose high risk of mortality. The petitioner was denied an abortion as her pregnancy had advanced beyond 20 weeks, causing the petitioner immense mental torment knowing she was carrying a foetus with cardiac abnormalities.

Issue

What impact does a combination of foetal cardiac abnormalities have on an assessment of the danger to a mother and foetus' physical and mental health? Does such a diagnosis constitute a 'substantial risk' and justify a termination after 20 weeks?

Arguments

As with previous cases, the petitioner argued that the MTP Act was arbitrary, setting an arbitrary time limit without scientific evidence. Additionally, she argued that the MTP Act's provisions generally infringed on her reproductive rights, and in turn her constitutional rights under Articles 14 and 21, related to equality before the law and the right to life.

Outcome

The Supreme Court found for the petitioner and allowed her to undergo an abortion. The judgment was based on the mental injury to the petitioner if the pregnancy continued and the "multiple problems if the child [was] born alive".[48] The Court was persuaded by the fact that in this 'special case', the Medical Board recommended termination even after 20 weeks. The Court drew upon the language of Section 5 of the MTP Act, stating "unless the pregnancy is allowed to be terminated, the life of the mother as well as that of the baby to be born will be in great danger". The Court is accordingly empowered to prevent a danger to the pregnant person's life, regardless of any statutory time-limits.

This case was the first time the Court was willing to acknowledge the legality of an abortion as late as 27 weeks. Additionally, the Court appeared convinced by the petitioner's mental injury and did not singularly focus on the foetus' condition. Moreover, the Court allowed a post 20 week abortion where the foetus' condition was serious, but not necessarily fatal. The foetus had reached 27 weeks gestation and medical evidence indicated it could, with great difficulty, be able to continue to birth and beyond.

This represents significant progress in the Court's abortion rights jurisprudence. The Court considered the petitioner's mental health interests, reproductive freedom, and bodily integrity and allowed an abortion even where the foetus was compatible with life. The opinion of the Medical

[48] ibid, para.11.

Board remained influential in this case, with the Court closely following their recommendation to terminate due to the foetus' condition and the petitioner's mental health.

Extracts

SARMISHTHA CHAKRABORTTY & ANR
VERSUS
UNION OF INDIA SECRETARY & ORS.

WRIT PETITION (C) NO.431 OF 2017

5. On a perusal of the [Medical Board's] report, it is clear as crystal that the Medical Board is of the view that it is a case for termination of pregnancy, as a special case…the Board has mentioned that the patient is at the threat of severe mental injury, if the pregnancy is continued. It has also opined that the child, if born alive, needs complex cardiac corrective surgery state by stage after birth. But there is high mortality and morbidity at every step of this staged surgeries…
10. …Frankly speaking, cases of this nature have to rest on their own facts because it shall depend upon the nature of the report of the Medical Board and also the requisite consent as engrafted under the Medical Termination of Pregnancy Act, 1971.
11. In the instant case, as the report of the Medical Board…clearly reveals that the mother shall suffer mental injury…
12. …The Court has expressed the view that the right of a woman to have reproductive choice is an insegregable part of her personal liberty, as envisaged under Article 21 of the Constitution. She has a sacrosanct right to have her bodily integrity. The case at hand, as we find, unless the pregnancy is allowed to be terminated, the life of the mother as well as that of the baby to be born will be in great danger.

Sonali Sandeep Jadhav vs. Union of India (2017)[49]

Facts

The petitioner in this case was a 21 year old woman from an extremely poor background in Mumbai. During the course of the pregnancy she saw a gynaecologist at the Bombay Municipal Hospital. The gynaecologist skipped the anomaly scan at 18 weeks, opting to perform it at 21 weeks instead. During the foetal brain neurosonogram it was detected that the foetus suffered from isolated ventriculomegaly (SIV) with atrial diameter of 13mm. A second anomaly scan at the Lilavati Hospitals and Research Centre, Bandra, confirmed this diagnosis. An MRI revealed that the foetus'

[49]Writ Petition (C) No. 551 of 2017, Supreme Court of India.

brain suffered from moderate symmetric obstructive hydrocephalus, cerebral aqueductal stenosis, and a thinning of the brain. Such anomalies most often result from chromosomal and genetic abnormalities, intrauterine haemorrhage or congenital infection. The prognosis usually includes high incidences of chromosomal abnormalities, cerebral maldevelopment such as lissencephaly or destructive lesion such as periventricular leukomalacia and most commonly, neurodevelopmental delay.

Issue

Did the abnormalities, including hydrocephalus, detected on the petitioner's scan after the 20th week fall within the factual exception to the provisions of the MTP Act as with previous cases? As healthcare professionals had delayed the scan by 3 weeks, should the 20 week limit still apply in the petitioner's case as she would have been aware of the abnormalities before the time limit?

Arguments

Counsel for the petitioner argued that according to several doctors' testimonies the foetus' abnormal condition, potential post-birth impairments, future expensive surgeries risked causing the petitioner severe mental injury. Additionally it violated the petitioner's reproductive and constitutional rights.

Outcome

The Supreme Court held for the petitioner, recognising the legality of her application for abortion, even though the foetus's abnormalities were substantial, but not necessarily fatal. Additionally, the Court recognised the legality of seeking an abortion, even in a case in which there was no evidence of a physical risk to the mother's life.

The Court was willing to engage in an assessment as to the level of impairment caused by the foetus' abnormality, without only considering its possible life expectancy. In this case, the Court acknowledged the legality of having an abortion when it found that the foetus' abnormality would impact fundamental aspects of life, rendering its ability to live a healthy life impossible.

However this flexibility appeared to arise from an unwillingness to deviate from the Medical Board's final opinion:

> Patient spontaneously expressed her desire not to continue with the pregnancy. She has also submitted a letter which states that she desires termination of pregnancy since there is substantial risk of mortality and morbidity in the fetus if born alive. We find that continuation of pregnancy shall pose severe mental injury to her.

The Court cited *Sarmishtha Chakrabortty*, noting that the Court's primary regard should be upon the Medical Board's evidence. Unsurprisingly then, the Court did not deal with the constitutional validity of the MTP Act's provisions.

Mamta Verma vs. Union of India (2017)[50]

Facts

An anomaly scan during the 18th week of pregnancy revealed that the petitioner's foetus suffered from anencephaly and the foetal skull was undeveloped. Verma was living in Palghar, a rural district of Maharashtra and came from an extremely poor background. When the anencephaly was detected Verma's doctors informed her that the local public health centre, a nursing home, did not provide abortion services. The doctors at the local public hospital did not offer abortion services nor did they provide Verma with any information about abortion access. Verma and her family could not afford abortion services at a private clinic.

As a result, by the time the petitioners could approach a gynaecologist in Mumbai, Verma's pregnancy had already passed 20 weeks and she was denied an abortion. The denial of her right to an abortion and being forced to continue the pregnancy to term caused the petitioner extreme anguish.

Issue

Should the precedent set in *Meera Santosh Pal* regarding termination post 20 weeks after a diagnosis of anencephaly apply in this case?

Arguments

Verma petitioned the court to undergo an abortion and to challenge the constitutional validity of the MTP Act.The petitioner also cited relevant ratio from case law and provisional legislation in support of their arguments, including:

- *Ms X v Union of India*: Abortionis permissible in cases where carrying a foetus with anencephaly gravely endangers the physical and mental health of pregnant person.
- *Meera Santosh Pal v Union of India*: The pregnant person has the right to take all possible steps to preserve life from an avoidable danger to it.
- *Mrs X v Union of India*: A pregnant person's right to make reproductive choices is a dimension of 'personal liberty' as understood under Article 21 of the Constitution and that the right to bodily integrity calls should allow her to terminate her pregnancy.
- *Sarmishtha Chakraborty v Union of India*: Reproductive agency is an important aspect of bodily integrity and abortion is permissible where the pregnancy threatens the life of the mother. Requests for abortion after 20 weeks will be dealt with on a case-by-case basis and be decided on the facts of the case with due regard being paid to the opinion of the medical board.
- The petition additionally mentioned the draft Medical Termination of Pregnancy

[50]Writ Petition (C) No. 627 of 2017, Supreme Court of India.

(Amendment Bill) 2014, which extends the gestational limit for abortion from 20 weeks to 24 weeks and provides for specific foetal anomalies after this period.

Outcome

The Court found for the petitioner, allowing her to terminate the pregnancy. The Court recognised that the diagnosis of anencephaly in the foetus created a danger to the petitioner's life. Given the certainty of 'the infant's death during or shortly after birth' there is "no point in allowing the pregnancy to run its full course since the foetus would not be able to survive outside the uterus without a skull".[51]

The Court emphasised the possibility for severe mental injury as a determinative factor in considering Verma's petition. They also noted that termination at 25 weeks posed no risk to the life of the petitioner. This judgment, however, is far from a declaration that a post 20 week abortion is legally acceptable wherever there is a risk of injury to the pregnant person's health. As the complaint was resolved on the grounds of the risk to life exception in Section 5 of the MTP Act, the court did not consider the constitutional validity or human rights concerns of the MTP Act.

As in the *Meera Santosh Pal* case, the Court applied the risk to life exception in Section 5 of the MTP Act to decide the case on narrow factual grounds. However, unlike in *Santosh,* the Court expressed support for the importance of the woman's mental health and recognised the detrimental impact carrying a non-viable foetus can have on a woman's mental health.

Tapayasha Umesh Pisal vs. Union of India (2017)[52]

Facts

The petitioner was a 23 year old woman from Satara District, Maharashtra. A foetal echocardiography detected that the foetus, at the gestational stage of 20 weeks and 6 days, suffered hypoplastic tricuspid valve and pulmonary artresia, which is a severe cardiac anomaly. The test's finding indicated that delivery would have to take place at a tertiary health centre with cardiac surgery facilities. The newborn infant would then require 2-3 cardiac surgeries. Typically, children born with this problem need multiple operations, and throughout their limited lifespan will only have one ventricle. The body's oxygen content will always be low, which can significantly impact organ function. Most children with this condition do not live until adulthood and are entirely dependent on others for care due to low levels of oxygenation. This abnormality poses substantial or near certain chance of severe disability or sudden death of the child.

Issue

Does the combination of a cardiac anomaly, pulmonary atresia, and other abnormalities pose a

[51] ibid, para. 6.
[52] Writ Petition (C) No. 635 of 2017, Supreme Court of India.

substantial risk to the life of the mother and the child's foreseeable future, so that the 20 week time limit may be set aside?

Arguments

As doctors have testified, most children with pulmonary atresia do not live till adulthood, so it was argued that it would violate the petitioner's rights to force her to continue with an unwanted pregnancy that posed her mental knowledge, knowing that her child would be severely handicapped.

Outcome

The Court held for the petitioner and admitted the legality of terminating the pregnancy in this case, thereby setting aside the 20 week time limit. The Court justified setting aside the time limit in this case by looking to the language of Section 3(2)(b) and past precedent, assessing that the foetus faced a substantial risk of severe disability. Interestingly the Medical Board did not explicitly recommend termination, but rather they focussed on the severity of the impact on the foetus of the abnormality.

Despite the petitioner Counsel's arguments, the Court did not consider the effect of the pregnancy on the physical or mental health of the petitioner nor did they not comment on the constitutional validity of the time-limit. Again in this case, the Court relied solely on the Medical Board's evidence that the cardiac anomaly would significantly decrease the child's life span if it were to survive birth. Additionally, while there is no cure for this anomaly, several surgeries would be necessary post-birth, and each of them would carry a high risk of morbidity and mortality. This decision reconfirms that the Court may be willing to allow the legality of a third trimester abortion even if it is not medically certain that the foetus will die in utero or shortly after birth, as the quality of life of the child would be so impaired and face such high risks of morbidity and mortality so as to justify termination.

Extracts

TAPAYASHA UMESH PISAL
VERSUS
UNION OF INDIA

WRIT PETITION (CIVIL) NO.635 OF 2017

5. We also have on record the opinion of an eminent surgeon Dr Devi Shetty of Bangalore who has stated that most of the children do not live till their adult life. Their life is precarious because of the problems resulting from low oxygenation in the body. According to Dr Nityanand Thakur, Cardiac Surgeon, and member of the Medical Board, there is a near certain chance of severe handicap or sudden death of the baby after birth.

6. Upon evaluation of the petitioner, the aforesaid Committee/Medical Board has concluded that the baby if delivered alive, would have to undergo several surgeries after birth which is associated with a high morbidity and mortality.

Mrs. A vs. Union of India (2017)[53]

Facts

The petitioner came from a poor background in a rural area of Pune. During Mrs A's foetal ultrasonography scan, at 20 weeks and one day, doctors discovered that her foetus suffered from anencephaly and that the skull was undeveloped. Doctors also noted that there might also be other maternal complications, such as polyhydromnios. Her only access to medical care was the local nursing home or hospitals. She was denied an abortion as she was past the 20 week time limit under the MTP Act. Enforcement of the 20 week time-limit compelled her to undergo severe psychological, physical and emotional trauma by denying her an abortion of a non-viable foetus.

Issue

Should a termination of pregnancy be allowed and fulfilled in another case of anencephaly, where the petitioner struggled to access abortion services?

Arguments

As with previous cases, she petitioned the court for recognition of the legality of seeking an abortion in her case. She also submitted that the time limit invalidated the MTP Act and its compliance with the Constitution. Mrs A additionally submitted that due to her poverty and geographic location her restricted access to treatment was a further violation of her rights on the basis of discrimination. She received only basic maternal care, limited to regular checkups in the local municipal nursing home. This frustrated the already harmful and painful situation created by the MTP Act's strict 20 week time limit. Additionally, she relied on the precedent set in *Meera Santosh Pal* to support legal recognition of the right to terminate pregnancies in cases of anencephaly. The Medical Board also noted that there would not be any risk to the petitioner's life if she were allowed to terminate the pregnancy at this stage.

Outcome

The Court found for the petitioner, allowing her an abortion at 26 weeks. The Court found it determinative that the foetus' condition posed a risk to the petitioner's physical life during delivery. As in *Meera Santosh Pal,* the Court was further persuaded by the certainty of the foetus' death and

[53]Writ Petition (C) No. 728 of 2017, Supreme Court of India.

the severe mental injury caused by the forced pregnancy on the petitioner's health. Again though the framing of the Court's orders suggests that their determination was based on fulfilling the Medical Board's findings and recommendations.

The Court appears to have created a de facto right to an abortion after 20 weeks in cases of anencephaly. This abnormality is fatal and threatens the pregnant person's mental and physical health from the physical and mental effects felt before, during and after delivery. It sets a framework to justify termination in cases of other abnormalities that mirror the factual prognoses of anencephaly. If it is likely that a foetus will not survive outside the uterus, the diagnosis will by implication cause mental injury to the pregnant person and a termination does not pose additional risk to their health, termination after the 20th week is justified.

Poonam Chandan Yadav vs. Union of India (2017)[54]

Facts

The petitioner received a foetal ultrasonography exam during the 20th week of pregnancy. The scan revealed that the foetus suffered from bilateral multicystic dysplastic kidneys along with severe oligohydraminos/ anhydraminos. A subsequent ultrasonography confirmed that the foetus suffered from bilateral multicystic dysplastic kidneys, the bladder and stomach had not developed, and the foetus had severe anhydraminos. These conditions were incompatible with life. A medical report indicated that the infant would require numerous heart surgeries, would suffer low brain and organ function, and would be unable to live a normal life during its short lifespan. The petitioner was denied an abortion as her pregnancy had advanced beyond 20 weeks. Enforcement of the MTP Act compelled her to undergo severe psychological, physical and emotional trauma by denying her an abortion of a non-viable foetus and forcing her to continue the pregnancy.

Issue

Should a termination of pregnancy be allowed in a case of abnormal renal and digestive organs, where the prognosis suggested that it would be impossible for the child to live a normal life?

Arguments

The petitioner argued that the multiple abnormalities present on the scan created such mental anguish for her that it amounted to severe mental injury. Additionally the medical experts' dire prognosis for the foetus and its incompatibility with life and the minimal risk in conducting an abortion at this stage led the Medical Board to recommend termination if approved by the Court.

[54]Writ Petition (C) No. 930 of 2017, Supreme Court of India.

Outcome

The Court held for the petitioner in allowing her an abortion. The Court did not address the constitutional validity of the MTP Act and its various restricting provisions, instead relying on the precedent set by *Meera Santosh Pal*. The foetus' condition and certain death, the petitioner's mental anguish, and the relatively low risk of the termination procedure were persuasive factors in the Court granting relief.

It appears evident that the Court will approve any request for an abortion where the foetus has a fatal abnormality according to the framework already mentioned. This decision provides a degree of certainty, which could be solidified by the Supreme Court explicitly reading this position into law. If the Supreme Court read a further exception into Sections 3 or 5 to the 20 week time limit in cases of fatal abnormality, doctors and lower courts would be empowered to determine whether a post-20 week abortion is legally acceptable under the MTP Act.

Sonali Kiran Gaikwad vs. Union of India (2017);[55] Nisha Suresh Aalam vs. Union of India (2017)[56]

Facts

Anultrasonography and foetal MRI revealed multiple serious neurological and skeletal anomalies – A Chiari II malformation along with a large neural tube defect in the lumbosacral region along with acute kyphoscoliosis. The petitioner's doctors advised that these anomalies have high chances of morbidity and mortality and could lead to meningitis, intellectual disability, paralysis of the lower limbs, and loss of urine and bowel control. The petitioners' doctors advised that the infants would require several surgeries. The petitioners were denied abortions as their pregnancies had advanced beyond 20 weeks.

Issue

Do multiple serious neurological and skeletal anomalies, including a large neural tube defect, constitute a substantial risk to the pregnant person and the foetus, even where a fatal prognosis is not absolutely certain, but severe impairments are inevitable?

Arguments

The petitioners maintained that as doctors have confirmed, the combination of foetal abnormalities would result in high chances of morbidity and mortality. Additionally, if the foetus were to survive birth, several high risk surgeries would still be required, and even then the child would be at risk of suffering other major impairments. Counsel argued that this amounts to a substantial risk to the life

[55]Writ Petition (C) No. 928 of 2017, Supreme Court of India.
[56]Writ Petition (C) No. 929 of 2017, Supreme Court of India.

of the mother and the mental injury she would suffer as a result of continuation of the pregnancy could not be in the interests of justice.

Outcome

The Court found for the petitioners in allowing post-20 week abortions. This decision was founded in the fact that continuing the pregnancy would not be safer than abortion and actually pose more risk as the mental injury the petitioners would suffer would be significant. These views merely reiterated the views of the Medical Board and acknowledgement of the petitioners' wish to terminate their pregnancies.

This decision affirmed the approach of previous benches, as in *Meera Santosh Pal*, by focusing on the pregnant person's mental health and their wishes, rather than only relying on the survival chances of the foetus. If an abortion does not pose any additional risks to the pregnant person's health, and the Medical Board recommends termination, the Court is bound to set aside the time limit, instead of unduly forcing further mental injury on the pregnant person. The Court prefers to avoid unnecessary suffering and allows abortions in such cases.

This shift toward prioritising the interests of the pregnant person, rather than being solely concerned with the stage of the pregnancy and the viability of the foetus, reflects a new judicial approach to interpreting the MTP Act. This interests-based approach has been extended further in the cases that will follow.

IV. Purposive Construction: Cases from the High Court of Bombay

The High Court of Bombay has taken a significant step toward reinterpreting the MTP Act's provisions, by reading Sections 3 and 5 together such that the exceptions in Section 3 may apply when determining the level of risk to save the mother's life in Section 5. In a series of cases of foetal abnormality between 2017 and 2018, the High Court adopted the arguments from *Nikhil Datar*. Employing purposive construction, the Court has begun to read the whole MTP Act together, recognising that first and foremost the Act seeks to protect the reproductive rights and bodily integrity of the pregnant person, in accordance with *Suchita Srivastava*. Unlike previous cases, the Court has explicitly recognised the legality of setting aside the time limit in certain cases, as it is in the interest of protecting their inherent right to life and personal liberty as enshrined in Article 21 of the Constitution. This landmark approach was first fully expressed in the case *Shaikh Ayesha Khatoon*. Previous cases employed the best interests test in finding in favour of petitioners seeking terminations, but as will be seen below the language of judgments altered after this decision on 9th January 2017.

It is yet to be seen whether this innovative, progressive approach will be confirmed by the Supreme Court or adopted by other High Courts, but it certainly represents a major step toward establishing greater flexibility for medical practitioners and courts to allow abortion in more cases post 20th week.

Priti Mahendra Singh Rawal vs. Union of India (2017)[57]

Facts

A scan in the 22nd week of the petitioner's pregnancy revealed several abnormalities in the foetus, including;

(i) Neural tube defect is seen at dorso-lumbar junction, (ii) A meningomyelocele [30 x 30 mm] is seen at this level, (iii) Secondary brain changes of hydrocephalus [16 mm] and Arnold Chiari malformation are noted, (iv) Bilateral rocker bottom feet are noted (v) Right renal pyelectesis is present.

The petitioner's doctors advised that these abnormalities would result in serious disability in life. The petitioner was denied an abortion as her pregnancy had advanced beyond the 20 week time-limit.

Issue

Does a diagnosis of spina bifida and neurological abnormalities fall within an exception to Section 3 of the MTP Act's 20 week time limit, or could it be considered when assessing whether the petitioner's case fulfilled the Section 5 exception?

Arguments

The petitioner argued that by continuing an unwanted pregnancy and delivering a child that would have a low chance of survival in later life, while still having to undergo multiple dangerous surgeries, would be a great mental injury to her health. Additionally, the prospect of the child developing other serious medical conditions, including meningitis, mental retardation, paralysis of lower limbs and loss of urine and bowel control, would significantly decrease their quality of life. In essence it would deny the petitioner's constitutionally protected reproductive rights to bar her from making the decision to terminate a pregnancy that would otherwise lead to some form of misery for her.

Outcome

The Court held for the petitioner in allowing her an abortion. The decision was based on the fact that, if born, the infant would suffer serious difficulties in life. The Court felt that these difficulties would amount to a 'severe handicap', reflecting the language of Section 3.

The language of this judgment was often repeated in subsequent orders to reflect how the Court was relying on the specific facts of each case to circumvent the time limit of Section 3 of the MTP Act.

[57]Writ Petition No. 11940 of 2017, High Court of Bombay.

Extracts

PRITI MAHENDRA SINGH RAWAL
VERSUS
UNION OF INDIA AND ORS

Writ Petition NO. 11940 OF 2017

4. Having regard to the aforesaid, it is very difficult for us to refuse the permission to the petitioner to undergo medical termination of the pregnancy. It is certain that if the petitioner's fetus is allowed to born, there is risk that it would suffer from lifelong serious physical handicap, which cannot be avoided. It appears that the baby will certainly not grow any further.
5. In view of the above peculiar situation and having due regard to the fundamental rights conferred on the petitioner under Article 21 of the Constitution of India to live [a] life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act,1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

Beenu Dharmendra Yadhav vs. Union of India (2017)[58]

Facts

The petitioner underwent anultrasonography in the 23rd week of pregnancy, which revealed a spinal deformity in the foetus. A subsequent foetal MRI exposed defects in the posterior elements of the spine in the lumbosacral region that suggested spina bifida, herniation of CSF cavity containing neural placode suggestive of myelomeningocele, small posterior fossa, with small 'banana' like cerebellum, interior herniation of cerebellar tonsils in the upper cervical canal, resulting in dilatation of both lateral ventricles and thinning of the cortical mantle. The petitioner's doctors concluded that it was "unlikely that the foetus will survive till term or after birth". The Medical Committee that later assessed the petitioner found that the condition of the foetus amounted to a substantial risk of serious handicap.

Issue

Does a diagnosis of spina bifida and neurological abnormalities fall within an exception to Section 3 of the MTP Act's20 week time limit, or could it be considered when assessing whether the petitioner's case fulfilled the Section 5 exception?

[58]Writ Petition No. 3323 of 2017, High Court of Bombay.

Arguments

The petitioner argued that by forcing the continuation of pregnancy the prospect of losing the foetus before or shortly after delivery would create such mental anguish in her as to violate her constitutionally protected reproductive rights.

Outcome

The High Court held for the petitioner in this case, allowing her an abortion at 25 weeks. The decision was determined by the fact that the foetus suffered a serious abnormality and that continuing the pregnancy would cause the petitioner 'irreparable injury'. The Court noted that the petitioner has a right to live a life of dignity and it would be in the interests of justice to allow an abortion.

The High Court closely followed the precedent set down in *Priti Mahendra Singh Rawal* by allowing a post 20th week abortion in this case of serious foetal abnormality which would likely lead to the death of the foetus. However, as with other cases, the Court did not comment on the constitutionality of the time-limit contained within Section 3 of the MTP Act.

Extracts

BEENU DHARMENDRA YADAV
VERSUS UNION OF INDIA & ORS

WRIT PETITION (L) No. 3323 of 2017

...

5. Considering the aforesaid and the peculiar facts and circumstances of the case and various orders passed by the Supreme Court from time to time, we are of the opinion that the petitioner would suffer irreparable injury in case the relief as claimed for is not granted. In these circumstances, it is very difficult for us to refuse permission to the petitioner to undergo medical termination of pregnancy. If the petitioner's fetus is allowed to grow, there is risk that it would suffer life long serious abnormality, which cannot be avoided. The baby will not certainly grow any further.
6. Having due regard to the fundamental rights conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, we deem it appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

...

Rajashri Nitesh Chadar vs. Union of India (2017)[59]

Facts

A scan in the petitioner's 19th week of pregnancy showed a giant cisterna magna in the petitioner's foetus. A subsequent MRI revealed that the foetus had:

> Large posterior fossa, (ii) Severe hypoplasia/ dysplasia of the vermis, (iii) Increased tegmento-vermian angle (iv) Fourth ventricle communicates with cisterna magna. This was suggestive of the Dandy Walker malformation.

The petitioner's doctors advised that the foetus was unlikely to survive until childbirth or for long thereafter. The petitioner was denied an abortion as her pregnancy had advanced beyond 20 weeks.

Issue

Does a diagnosis of spina bifida and neurological abnormalities fall within an exception to Section 3 of the MTP Act's20 week time limit, or could it be considered when assessing whether the petitioner's case fulfilled the Section 5 exception?

Arguments

It was contended that if the foetus were to be delivered, which was unlikely, it might suffer from mental retardation, seizures and ataxia, and the severity of these conditions could not be assessed until birth. Also, as Dandy Walker malformation has no cure, the likelihood of contracting a severe handicap is of great concern to the petitioner, potentially endangering her mental health.

Outcome

The Court held for the petitioner in allowing her an abortion. The decision was based on the future 'serious infirmities' the foetus would suffer in life. The Court's judgment was delivered outside of the framework of either Section 3 or 5 of the MTP Act. Interestingly, the Court ordered a thorough assessment from the Medical Board of the risks involved with termination at this stage of pregnancy, and on finding that they were minimal, classified the case as one eligible for legal abortion under the MTP Act. The Court was also concerned with ensuring that the petitioner was well informed of the possible risks involved in proceeding with an abortion and the extent of the abnormalities the foetus was suffering from. A best interests approach to assessing this case allowed the Court to pass orders without referring directly to provisions in the MTP Act.

[59]Writ Petition No. 13728 of 2017, High Court of Bombay.

Extracts

RAJASHRI NITESH CHADAR
VERSUS
UNION OF INDIA & ORS.

WRIT PETITION NO. 13728 OF 2017

…

5. Based upon the aforesaid findings, the Medial Board has stated as under;

   "1. The child if born, viable, has possible risk of mental retardation, ataxia and seizures, which cannot be quantified at present.

   2. If the pregnancy is terminated now as per the patient's and her family's request:

   (a) The most common complication of second trimester medical abortion is retained placenta, which is estimated to occur at a rate of 15% to 50%.

   (b) Other complications of medical abortion include hemorrhage requiring transfusion (,1%), infection (2.6%), and failed abortion.

   (c) In advanced gestational age cases induction time is longer and risk of hemorrhage is greater.

   (d) The mortality rate with abortions performed at eight weeks or earlier was 0.1 deaths per 100000 legal terminations, and rises to 8.9 deaths per 100,000 abortions for those at 21 weeks or later. Mortality with abortions after 20 weeks is higher than that with natural live births.

   (e) If induction fails, the patient may require hysterectomy for maternal indication; in that case, in future pregnancy there is small chance of rupture of scar (about 1%), the relative risk of morbidly adherent placenta is 3 to 5 (as per available statistics). At present there is no evidence of any physical risk to maternal health owing to the reported fetal malformations.

   In view of the above, the Medical Board is of the opinion that termination of pregnancy may have substantial physical risks for the patient. These risks are stated based on available scientific evidence."

6. The pros and cons of proposed termination of pregnancy, counseling to the petitioner and her family members was done by the said Medical Board and the petitioner has expressed her willingness to take the risk.

7. Having regard to the aforesaid, in our considered view it would be appropriate to allow the petitioner to terminate the pregnancy as the fetus after birth will be of various serious infirmities as reflected in the opinion as aforesaid, in the circumstances, we allow this petition and direct the petitioner to remain present in the said hospital on 19th December, 2017 so that the termination of pregnancy can be carried out within a day or two as may be deemed fit by the Medical Board.

…

Monisha Hironmoy Mazumder vs. Union of India (2017)[60]

Facts

During an ultrasound in the 20th week of pregnancy the petitioner's doctors discovered a cardiac anomaly in the foetus. A subsequent foetal ultrasound revealed:

(i) Single live intrauterine foetus of 23 weeks 3 days,
(ii) Complex Cardiac Abnormality- 1/ Truncus Arteriosus or 2/ Double Outlet Left/ Rt Ventricle,
(iii) Pulmonary appears small but origin is not clear but bifurcated,
(iv) Large vessel, probably Truncus shows override over ventricles more on left,
(v) Pulmonary veins dilated,
(vi) 3 vessel view shows 2 vessels,
(vii) No crossover is visualised.

The petitioner's doctors advised that if the pregnancy resulted in a live birth, her infant would still require multiple surgeries, have a significant "likelihood of severe physical and mental impairments, and low chances of survival in the later life". The petitioner was denied an abortion as her pregnancy has progressed beyond the 20 week time-limit under Section 3 of the MTP Act.

Issue

Does a diagnosis of spina bifida and neurological abnormalities fall within an exception to Section 3 of the MTP Act's20 week time limit, or could it be considered when assessing whether the petitioner's case fulfilled the Section 5 exception?

Arguments

Counsel for the petitioner argued that by continuing an unwanted pregnancy and delivering a child that would have a low chance of survival in later life, while still having to undergo multiple dangerous surgeries, would be a great mental injury to her health. In essence it would deny her constitutionally protected reproductive rights.

Outcome

The Court held for the petitioner in allowing her an abortion at 24 weeks. The Court set aside the time-limit because the infant had a low likelihood of survival even with numerous cardiac surgeries. Considering this holistically, accounting for the fundamental nature of the petitioner's rights and a forced pregnancy's effect upon her mental health, the Court allowed the abortion. This decision is consistent with existing precedent allowing for post 20th week abortions in cases where the foetus faces low odds of survival after childbirth.

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[60]Writ Petition No. 13848 of 2017, High Court of Bombay.

However, it is pertinent in this case that the High Court refused to address the constitutionality of Section 3's time limit and whether it violated Articles 14 and 21. In these cases it appears clear that it is simple for courts to overcome the 'plain and unambiguous' time limit of Section 3, by simply employing a purposive approach to interpretation of the MTP Act.

Extracts

MONISHA HIRONMOY MAZUMDER
VERSUS
UNION OF INDIA AND ORS

Writ Petition NO. 13848 OF 2017

...

5. In view of the aforesaid peculiar situation and having due regard to the fundamental rights conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971.

…

7. In the circumstances, we allow this Petition and direct that termination of the pregnancy of the petitioner would be performed within a day or two…Needless to say that we have not examined the petitioner's prayer for holding Section 3 of the Medical Termination of Pregnancy Act, 1971 to be unconstitutional and violative of Articles 14 and 21 of the Constitution of India.

Shaikh Ayesha Khatoon vs. Union of India (2017)[61]

Facts

A scan in the 26th week of pregnancy revealed that the petitioner's foetus suffered from several foetal anomalies, including a congenital malformation. Anultrasonography confirmed the diagnosis and made the following observations:

(i) Anencephaly,
(ii) Cerebellar hypoplasia,
(iii) Hydranencephaly,
(iv) Laryngeal Atresia,
(v) Atrium-Ventricular septal defect,

[61]Writ Petition No. 36727 of 2017, High Court of Bombay.

(vi) Double outlet single ventricle,
(vii) Stomach not visible.

The petitioner's doctors advised that the foetus had a low chance of surviving independently outside of the womb. The petitioner was denied an abortion as her pregnancy had advanced beyond the 20 week time limit. She approached the Court seeking confirmation of the ultrasonography's findings as grounds to substantiate a claim for the legality of a termination in her case.

Issue

Can Sections 3 and 5 of the MTP Act be read together to justify legalising an abortion on the basis of severe impairment to the foetus, in order to fall under the Section 5 exception to the time limit, as it poses a risk to the life of the pregnant person?

Arguments

The petitioner in this case relied on the arguments submitted in the *Meera Santosh Pal* case in the Supreme Court including that:

(i) The MTP Act is an out-dated law that endangered the petitioner's health;
(ii) The MTP Act prohibits the petitioner from undergoing an abortion in cases of foetal abnormality;
(iii) Indian abortion law is in violation of international law;
(iv) The 20 week time-limit threatens the life of the pregnant person;
(v) The effect of the 20 week time-limit is to force the petitioner to continue the unwanted pregnancy to term, in violation of her right to be free from inhuman and degrading treatment; and
(vi) The ban on abortions after 20 weeks violates her rights to health, to a life of dignity, to personal liberty and privacy, to choice and informed consent, and to equality.

The petitioner also cited other relevant ratio from case law from the Supreme Court:

- *Sarmishtha Chakraborty v Union of India*:[62] Reproductive agency is an important aspect of bodily integrity and abortion is permissible where the pregnancy threatens the life of the mother. Requests for abortion after 20 weeks will be dealt with on a case-by-case basis and be decided on the facts of the case with due regard being paid to the opinion of the medical board.
- *Sonali Kiran Gaikwad* &*Nisha Suresh Aalam v. Union of India*:[63] The Supreme Court stated that an abortion at 29 and 30 weeks respectively, is not more hazardous than spontaneous delivery at term. The Court allowed an abortion as continuing an unwanted pregnancy would cause mental anguish.

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[62]Writ Petition (C) 431/2017.
[63]Writ Petition (C) 928 of 2017 and W.P.(C) 929 and 2017.

Outcome

The High Court of Bombay held for the petitioner in allowing her an abortion at 27 weeks of pregnancy. The Court considered the medical evidence provided by her doctors and a Medical Board, which confirmed that "there is little doubt that there are foetal anomalies reported and the chances of survival of the foetus appear less and there is a substantial risk of severe physical handicap". The Court allowed the abortion, paying due regard to the foetus' condition and the violations of the rights of the petitioner.

The Court considered a purposive interpretation of the MTP Act so that they could employ a flexible approach and read Sections 3 and 5 together, to reinforce both provisions. The High Court determined that Section 5 must be interpreted in a manner that advances the cause of justice, and recognised that a denial of abortion affects a pregnant person's right to personal liberty and their mental health. The Court held that Section 5 provides similar grounds for abortion as Section 3, but without the time-limit. The Court felt that an interpretation of Section 5 which did not allow for abortions in the same circumstances as set out in Section 3 would rob the MTP Act of it ability to effect its purpose.

This judgment allows a Court unlimited scope to determine whether a pregnant person may receive an abortion without being bound to a time limit. As will be seen, the Court has followed this ruling in numerous subsequent judgments, recognising the legality of abortions after 20 weeks in many cases. Nevertheless, despite the interpretive precedent this case established, it is still noteworthy that the Court did not challenge the constitutionality of the MTP Act, merely that to accord with constitutional values, the MTP Act had to be read in a holistic, purposive manner. In assessing the purpose of the MTP Act, the High Court also acknowledged that purpose will be influenced by changing social attitudes and environments, which in the present case involved a consideration of the MTP (Amendment) Bill 2014. While the Bill was not passed, it provided an interesting insight to establish the current public feeling with regard to abortion law and rights in India, which the Court relied upon when passing judgment. The significance of this case cannot be understated and as such the majority of the judgment is reproduced below.

Extracts

SHAIKH AYESHA KHATOON
VERSUS
UNION OF INDIA & ORS.

WRIT PETITION(S)(ST) NO(S). 36727/2017

7. "COMMITTEE OPINION
   Upon examination & after careful study of multiple sonography reports, it is confirmed that the fetus suffers from serious neurological, cardiac & bowel abnormalities with a very high chance of morbidity & mortality.

The woman was been explained about the outcome in the language she understands.The condition of the fetus fulfills the criteria of "substantial risk of serious physical handicap" in the fetus.The pregnant woman has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the condition of fetus and its outcome. She is extremely anguished with the condition of the fetus inutero.The pregnancy has advanced to 27 weeks and is beyond 20 weeks cut of the Medical Termination of Pregnancy Act. Hence she has approached Honourable Court for termination of pregnancy.At this stage of a pregnancy, the risk of termination remains the same as that of natural labour at term.Thus if the Court permits the pregnancy can be terminated as desired by the woman."

…

11. …It is the contention of the petitioner that firstly the trauma that the petitioner is likely to suffer is life threatening and it shall be construed that exercise of a choice in the event there are foetal abnormalities found and the chances of survives of the baby, if allowed to take birth, are minimum, is a matter to be considered within the parameters of Section 5 of the Act of 1971. Apart from this, the petitioner contends that the provisions of sub-section (2) including clauses (i) & (ii) of sub-section (2)(b) of Section 3 are required to be read in Section 5 except the outer limit of twenty weeks that has been provided in sub-section (2)(b) of Section 3 of the Act of 1971.
12. The petitioner thus contends that if there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped, it will be open for the Court to accord permission to terminate the pregnancy by taking recourse to Section 5 of the Act of 1971. It is further contended that the concluding portion of Section 5 prescribing the limitation in permitting such a choice or issuing direction in respect of termination of the pregnancy only in the event to save the life of the pregnant woman shall have to be interpreted harmoniously and looking to the object of the provision. It also needs to be considered that a pregnant woman has a right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India…
13. …It would thus be logical to conclude that the contingencies referred in Clauses (i) & (ii) of sub-section (2)(b) of Section 3 will have to be read in Section 5 of the Act of 1971 and it would be relevant to consider the threat perception and substantial risk involved if the child were to born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. The contingencies laid down in Clauses (i) & (ii) of sub-section (2)(b) of Section 3 shall therefore equally apply to the request of a pregnant woman seeking permission to terminate the pregnancy beyond 20 weeks and accordingly Section 5(1) will have to be construed, to meet the object and purpose of enactment and to promote cause of justice.
14. …It shall also be taken into consideration that besides physical injury, the legislature has widened the scope of the termination of pregnancy by including "a injury" to mental health

of the pregnant woman. Thus, if continuance of pregnancy is harmful to the mental health of a pregnant woman, then that is a good and legal ground to allow termination of pregnancy if all the conditions incorporated in legal provision are met… The provisions of Section 5 of the Act of 1971 shall have to be interpreted in the manner for advancing the cause of justice. In this context it would be appropriate to refer to the judgment of Division Bench of this Court in the matter of High Court on its own motion vs. the State of Maharashtra, reported in 2017 Cri L.J. 218. In paragraph13 of the judgment, it is observed thus:

"13. A woman irrespective of her marital status can be pregnant either by choice or it can be an unwanted pregnancy. To be pregnant is a natural phenomenon for which woman and man both are responsible. Wanted pregnancy is shared equally, however, when it is an accident or unwanted, then the man may not be there to share the burden but it may only be the woman on whom the burden falls. Under such circumstances, a question arises why only a woman should suffer. There are social, financial and other aspects immediately attached to the pregnancy of the woman and if pregnancy is unwanted, it can have serious repercussions. It undoubtedly affects her mental health. The law makers have taken care of helpless plight of a woman and have enacted Section 3(2)(b)(i) by incorporating the words "grave injury to her mental health". It is mandatory on the registered medical practitioner while forming opinion of necessity of termination of pregnancy to take into account whether it is injurious to her physical or mental health. While doing so, the woman's actual or reasonable foreseeable environment may be taken into account."

15. While interpreting the provisions of Section 5 of the Act of 1971, it must be borne in mind the principle that the Section must be construed as a whole whether or not one part is a saving clause and similarly elementary rule of construction of Section is made of all the parts together and that it is not permissible to omit any part of it; the whole Section must be read together. The words of Statute are first understood in their natural, ordinary and popular sense and phrases and sentences are construed according to their grammatical meaning unless there be something in the context, or in the object of the statute in which they occur or in the circumstances in which they are used, to show that they were used in special sense different from their ordinary grammatical meaning. The basic principle that while interpreting the provisions of a Statute one can neither add nor subtract even a single word, has to be kept in mind. A Section is to be interpreted by reading all of its parts together, and it is not permissible to omit any part thereof. The Court cannot proceed with the assumption that the legislature, while enacting the Statute has committed a mistake; it must proceed on the footing that the legislature intended what it has said; even if there is some defect in the phraseology used by it in framing the statute, it is not open to the Court to add and amend, or by construction, make up for the deficiencies, which has been left in the Act. The Court can only iron out the creases but while doing so, it must not alter the fabric, of which an Act is woven. The Court, while interpreting statutory provisions, cannot add words to a Statute, or read words into it, which are not part of it, especially when a literal reading of the same produces an intelligible result…

…

17. A statute must be interpreted having regard to the purport and object of the Act. The doctrine of purposive construction must be resorted to. It would not be permissible for the Court to construe the provisions in such a manner, which would destroy the very purpose for which the same was enacted. The principles in regard to the approach of the Court in interpreting the provisions of a statute with the change in the societal condition must also be borne in mind. The rules of purposive construction have to be resorted to which would require the construction of the Act in such a manner so as to see that the object of the Act is fulfilled.

…

19. As has been observed by the Supreme Court in the matter of RBI Vs. Peerless General Finance and Investment Co. Ltd., reported in (1987) 1 SCC 424, the textual interpretation that matches the contextual is known to be best interpretation. It is observed in paragraph 33 of the judgment, thus:

"33. Interpretation must depend on the text and the context. They are the bases of interpretation. One may well say if the text is the texture, context is what gives the colour. Neither can be ignored. Both are important. That interpretation is best which makes the textual interpretation match the contextual. A statute is best interpreted when we know why it was enacted. With this knowledge, the statute must be read, first as a whole and then Section by Section, clause by clause, phrase by phrase and word by word. If a statute is looked at, in the context of its enactment, with the glasses of the statute maker, provided by such context, its scheme, the Sections, clauses, phrases and words may take colour and appear different than when the statute is looked at without the glasses provided by the context. With these glasses we must look at the Act as a whole and discover what each Section, each clause, each phrase and each word is meant and designed to say as to fit into the scheme of the entire Act. No part of a statute and no word of a statute can be construed in isolation. Statutes have to be construed so that every word has a place and everything is in its place..."

…

21. On analysis of the judgments and the narrations, as recorded above, one must while interpreting the provisions of law, bear in mind that the provision as to be interpreted by reading all of its parts together and it is not permissible to omit any part thereof. The golden rule of interpretation is that the provisions of law have to be read as it is without adding or subtracting anything therefrom. In an appropriate case, the Court can only iron out the creases but while doing so, it must not alter the fabric, of which an Act is woven.

22. In the instant matter, on reading of Section 5 of the Act of 1971, it does transpire that the contingencies and the parameters laid down in clauses (i) & (ii) of subsection (2)(b) of Section 3 shall have to be read in Section 5 except the bar of limitation as provided in Section 3(2)(b) of the Act of 1971. It would not be appropriate to over look the contingencies laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3 while considering the request of a pregnant woman for termination of the pregnancy if the conditions laid down in clauses

(i) & (ii) of subsection (2)(b) of Section 3 are satisfied it would provide a good ground for exercise of jurisdiction under Section 5 of the Act of 1971.

23. The Ministry of Health and Family Welfare, Government of Maharashtra has prepared the MTP (Amendment) Bill and the notification in that regard was published on 29.10.2014. The State Government has proposed amendment to Section 3 of the Act of 1973 and clause (C) is proposed to be added which reads thus:

    "(C) the provisions of subsection (2) of section 3 as relate to the length of the pregnancy shall not apply to the termination of a pregnancy by a registered health care provider where the termination of such pregnancy is necessitated by the diagnosis of any of the substantial foetal abnormalities as may be prescribed."

24. Considering the above proposed amendment, according to us, the interpretation which we have put to Section 5 of the Act of 1971 appears to be a logical and same is in consonance with the proposed changes as suggested by the State in the MTP (Amendment) Bill notified on 29.10.2014.

…

26. For the reasons recorded above, the Writ Petition is allowed. The petitioner is permitted to undergo medical termination of pregnancy at a medical facility of her choice.

Misabah Umarfaruk Tamboli vs. Union of India (2017)[64]

Facts

An ultrasound during the third trimester of the petitioner's pregnancy revealed that the foetus she was carrying suffered from Agenesis Corpus Collosum, a rare congenital defect. The petitioner's doctors advised that it would be unlikely for the foetus to survive until childbirth or for much longer thereafter. Otherwise it was likely to suffer from significant morbidities such as mental retardation or epilepsy. The petitioner's abortion request was rejected as her pregnancy had advanced beyond the 20 week time-limit. The petitioner approached the High Court after her 30th week of pregnancy.

Issue

Do the factual circumstances fall within the exception in Section 5 of the MTP Act to the 20 week time limit, as understood in *Shaikh Ayesha Khatoon*?

Arguments

It was argued that the mental torment for the petitioner on discovering her foetus's grave abnormality

[64] Writ Petition No. 187 of 2017, High Court of Bombay.

would amount to a substantial to her life and would justify termination of the pregnancy. This argument was founded on a direct challenge to the constitutionality of the time limit in Section 3(2)(b) of the MTP Act.

Outcome

The Court denied the petitioner's request for an abortion because her pregnancy had advanced to 32 weeks by the time the Court delivered judgment. While the Medical Committee found that when considering the foetal abnormality alone would justify termination, terminating the pregnancy at this late stage would pose significant medical risk to the petitioner's health.

The Court appears to take a holistic view of the pregnant person in assessing whether to recognise the legality in a case of a post-20th week abortion. Medical assessment indicated that it would be in the interests of the petitioner's health to continue the pregnancy, but she may undergo an abortion if she faced an immediate health hazard, such as intrauterine death, premature rupture of membranes or spontaneous labour. The Court's decision making was influenced by the belief that it would be inappropriate to recognise the legality of a potentially dangerous termination under the MTP Act, even if the petitioner were in favour of taking such a risk. This is an interesting judgment considering it was handed down a week after *Shaikh Ayesha Khatoon*, and reflects that ultimately the Court is still likely to follow the medical advice offered by expert committees, particularly if it recommends against termination.

Extracts

MISABAH UMARFARUK TAMBOLI
VERSUS
UNION OF INDIA AND ORS

WRIT PETITION NO.187 OF 2018

...

4. Considering the report of the committee and considering advance gestation age i.e. 32 weeks, it would not be prudent to exercise extraordinary jurisdiction and grant permission as requested. It is reported by the committee that the procedure of the termination of the pregnancy may pose a threat to the life of the mother. In the circumstances, we do not deem it appropriate to exercise an extraordinary jurisdiction under Article 226 of the Constitution of India for the issuance of directions as requested by the petitioner.

…

Siddamma Golsar vs. Union of India (2017)[65]

Facts

An ultrasound in the 20th week of the petitioner's pregnancy revealed that the petitioner's foetus suffered from truncus arteriosus with an AV canal in heart and borderline cerebral ventriculomegaly. An echocardiography confirmed the diagnosis and made the following observations:

(i) Congenital heart defect, (ii) Levocardia, (iii) Bilateral SVCs, (iv) Complete Atrioventricular Canal Defect, (v) Patent foramen ovale and additional large primum ASD with bidirectional shunt, (vi) Common A V valve. Mild right A V valve regurgitation, (vii) Single ventricle, (viii) Double outlet single ventricle, (ix) D-malposed great arteries.Anterior aorta, (x) Infundibular and valvar stenosis.

The petitioner's doctors advised her that the potential infant would require numerous risky heart surgeries, and would have a bleak and short life. The petitioner was denied an abortion as her pregnancy had advanced beyond 20 weeks.

Issue

Do the factual circumstances fall within the exception in Section 5 of the MTP Act to the 20 week time limit, as understood in *Shaikh Ayesha Khatoon*?

Arguments

Counsel for the petitioner argued that as the foetus' cardiac abnormalities were so grave they posed a substantial risk of serious physical handicap to the foetus. Consequently relying on arguments from previous cases, the petitioner argued that this risk posed a threat to her own life, through serious mental injury, and to deny her the reproductive right to terminate would be violating her constitutional right to exercise her personal liberty.

Outcome

The Court held for the petitioner in allowing her an abortion at 22 weeks. The decision was based on the substantial risk of the foetus suffering serious disability, reflecting the language of Section 3 of the MTP Act.

Relying on *Shaikh Ayesha Khatoon,* the Court determined that Section 5 of the MTP Act provided jurisdiction to direct an abortion "in the event of noticing substantial risk of physical or mental abnormalities in case the child were to [be] born or that it would suffer serious handicap".[66] The Court ordered an abortion even though the pregnancy did not affect the life of the petitioner, the foetus would suffer serious complications, which would render it seriously disabled.

[65] Writ Petition No. 766 of 2017, High Court of Bombay.
[66] ibid, para.7.

Extracts

SIDDAMMA GOLSAR,
VERSUS
UNION OF INDIA AND ORS

Writ Petition NO. 766 OF 2018

…

7. In view of determination by this Court on interpretation of provisions of Section 5 of the Act of 1971, it would be permissible to direct termination of pregnancy carried by the pregnant woman in the event of noticing substantial risk of physical or mental abnormalities in case the child were to born or that it would suffer serious handicap. The parameters laid down under Clause (ii) of subsection 2(b) of Section 3 gets attracted while interpreting Section 5 of the Act of 1971 and in such circumstances as noticed in the instant matter so also as noticed by this Court in Writ Petition (St.) No.36727/2017, it would be open for this Court to exercise the jurisdiction under Section 5 of the Act of 1971 and pass necessary orders as prayed for by the petitioner.

…

9. For the reasons recorded above as also considering the view taken by us while disposing of Writ Petition (Stamp) No.36727/2017, the instant Petition is allowed. The petitioner is permitted to undergo medical termination of pregnancy…

Rupali Chetan Kumbhar vs. Union of India (2017)[67]

Facts

Anultrasonography exam in the 21st week of the petitioner's pregnancy revealed that the petitioner's foetus suffered from several abnormalities, including-

(i) The cavum septum pellucidum was not visualized, (ii) The atria and occipital horns of both lateral ventricles were prominent, (iii) the atrium of the lateral ventricle measured 8.9 mm. An MRI revealed (ii) Absence of cavum septum pellucidum (ii) Squaring of frontal horns of both lateral ventricles (iii) Only genu and anterior one third of body of corpus callosum is identified (iv) Mild disproportionate dilatation of occipital horns of both lateral ventricles, suggestive of colpocephaly.

The petitioner's doctors advised her that if foetus were to survive birth it would likely suffer from delayed development, resistant epilepsy, intellectual impairments, visual defects and autism, among others. She was denied an abortion as her pregnancy had advanced beyond 20 weeks.

[67]Writ Petition No. 2020 of 2017, High Court of Bombay.

Issue

Do the factual circumstances fall within the exception in Section 5 of the MTP Act to the 20 week time limit, as understood in *Shaikh Ayesha Khatoon*?

Arguments

Counsel for the petitioner argued that as the foetus' neurological abnormalities were so grave they posed a substantial risk of serious physical handicap to the foetus. Consequently, as in *Siddamma Golsar*, the petitioner argued that this risk posed a threat to her own life, through serious mental injury, and to deny her the reproductive right to terminate would be violating her constitutional right to exercise her personal liberty.

Outcome

The Court held for the petitioner in allowing her an abortion at 24 weeks, following the Medical Committee's recommendation. The decision was based on the foetus' substantial risk of suffering serious disability, reflecting the language of Section 3 of the MTP Act.

Extracts

RUPALI CHETAN KUMBHAR
VERSUS
UNION OF INDIA AND ORS.

WRIT PETITION NO. 2020 OF 2018

4. …It appears that the Committee has reached the conclusion that there would be substantial risk of serious physical handicap.
5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the petitioner to undergo the medical termination of the pregnancy. It is certain that if the petitioner is allowed to give birth to foetus, there is substantial risk of serious physical handicap.
6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medial termination of pregnancy under the provisions of the medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

…

V. Conclusion

Tracing the shifts in courts' approaches to deciding abortion cases reveals the subliminal changes affecting the interpretation and operation of the MTP Act. No case has directly engaged with the constitutionality of its provisions, but recent jurisprudence highlights how the 'strict' time limit in Section 3 is being set aside in more and more cases. Different courts have justified this setting aside for different reasons, whether based on a best interests test, using purposive interpretation to 'read' Sections 3 and 5 together or simply in the exercise of the courts' extraordinary jurisdiction under the Constitution in special cases. Some of these approaches reflect a potential willingness in some courts to examine cases more holistically, setting aside provisions that at first seem so strict, like the 20 week time limit in the interests of the pregnant person. More and more judgments cite *Suchita Srivastava* as the determinative decision that first recognised reproductive rights as a dimension of personal liberty as protected by the Constitution. This is a significant step toward realising how reproductive rights, personal liberty and the right to life are interconnected and interdependent.

The next chapter will examine exactly how and why these shifts are evident in the jurisprudence and the potential implications they have for decision-making by courts in future cases on abortion matters. It will also discuss how abortion law has been and how it might be further shaped by courts' challenge the MTP Act's operation and how the legislature will respond to such challenges.

CHAPTER THREE

Trends in Abortion Law

Interpretation of the MTP Act and its application on the ground has not remained static since the statute was enacted. The previous chapter collated the most recent decisions related to abortion law and revealed how courts use different language and avenues to analyse the legality of terminating a pregnancy in a particular case. Courts have refused to directly challenge the constitutionality of the MTP Act, however over the course of several decisions they have liberalised their application of its provisions. This has usually involved confirming the legality of applications for an abortion after the statutory time limit in Section 3 of 20 weeks has passed. The reasons provided in judgments have varied according to different legal standards and tests, from following the strict 'plain and clear language' of legislation, to assessing cases holistically according to a 'best interests' test, to employing a purposive approach to 'fill the gaps' in an inadequate statute. The role of different evidence has also changed, focussing on a Medical Board's recommendations has now surpassed relying on moral argumentation from scholars and foreign jurisdictions and the pregnant person's own testimony. Essentially, this represents a shift in the medico-legal assessment courts conduct when assessing abortion matters, which has several implications for both the future of abortion law, changing public opinion and legislative responses.

This chapter will establish the exact trends and reasoning courts have used to justify their decisions, while first considering the legislative intent of the MTP Act when it was first introduced in 1971. It will then examine the various challenges from outside and inside the legislature to amending, repealing or replacing the MTP Act, particularly in the form of the proposed Amendment Bills from 2014 and 2017. As a whole, the chapter will seek to situate the role of the courts in adjudicating abortion matters, its appropriateness as a forum for such decision-making and its impact on the agency and rights of the pregnant person.

I. Investigating the Purpose of the MTP Act

Courts are charged with determining the precise scope and provisions of the law, and in fulfilling this

exercise it is vital to look to the original legislature's reasoning. As such, this section will examine the wording of the MTP Act's Preamble and compare other historical sources that influenced lawmakers of the 1970s in their drafting of the MTP Act, in order to determine the statute's underlying agenda. Some of the cases presented in Chapter Two referred to the original Statement of Objects and Reasons in the Preamble. As the foundational document for the liberalisation of abortion law in India, it is important to look to its words and phrases to understand the drafters' motivations driving. The Statement cites three primary objectives of the Act:

(1) As a health measure—where there is danger to the life or risk to [the] physical or mental health of the woman;
(2) On humanitarian grounds—such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic woman, etc.; and
(3) Eugenic grounds—where there is substantial risk that the child, if born, would suffer from deformities and diseases.

These three categories are directly mirrored in Sections 3(2)(b)(i), Explanation I of Section 3, and Section 3(2)(b)(ii), respectively. However, the more indicative comments appear earlier in the Preamble, in which the legislature acknowledged that the colonially inherited criminalisation of abortion and its effects on the health system in the 1960s and 1970s had had detrimental effects for both pregnant persons seeking unsafe abortions and their medical practitioners:

Statement of Objects and Reasons.—(1) The provisions regarding the termination of pregnancy in the Indian Penal Code which were enacted about a century ago were drawn up in keeping with the then British Law on the subject. Abortion was made a crime for which the mother as well as the abortionist could be punished except where it had to be induced in order to save the life of the mother. It has been stated that this very strict law has been observed in the breach in a very large number of cases all over the country. Furthermore, most of these mothers are married women, and are under no particular necessity to conceal their pregnancy.

(2) In recent years, when health services have expanded and hospitals are availed of to the fullest extent by all classes of society, doctors have often been confronted with gravely ill or dying pregnant women whose pregnant uterus has been tampered with a view to causing an abortion and consequently suffered very severely.

(3) There is thus avoidable wastage of the mother's health, strength and, sometimes, life.

The wording of this Preamble is interesting for several reasons. Firstly, it illuminates the statute's underlying public policy concerns. High rates of maternal mortality, resulting from criminalisation of abortion and an unmet need for family planning methods, was clearly a primary issue at the back of the minds of legislators. Secondly, by distinguishing 'married' women and their resort to clandestine abortion services, lawmakers also suggested that family planning was firmly on the policy agenda. However, the Statement also highlights that the MTP Act's purpose was not simply a matter of public health and reducing rates of maternal mortality, it was primarily a means of responding to an uncontrollable spurt of exponential population growth.

Thirdly, by assuming that the individuals who would seek abortion services would be unmarried

women, legislators morally condemned women engaging in premarital sex, reflecting the social mores and pressures of the era. Finally, the Preamble adopts a paternalistic attitude toward the treatment of pregnant persons, by using phrases such as the need to publicly address this 'avoidable wastage of… life'. This characterisation of the damage of unsafe abortions was directly opposed to an explanation of the forced practice of unsafe abortion as a violation of the pregnant person's reproductive rights. There is also a disconcerting subliminal suggestion that this trend is 'confronting doctors' or burdening the health system, which clearly reflects the value placed upon societal wellbeing, rather than on the welfare of the individual pregnant person. Additionally it refers to pregnant persons as 'mothers' rather than as 'pregnant women' or 'pregnant persons'. This symbolically emphasises the stereotypical notion that pregnant persons are merely reproductive vessels, enabling a State's "compelling interest in protecting the life of the prospective child".[1]

In India, the moral and social condemnation of seeking an abortion was already well established in legal understanding and was reflected in earlier explanations from lawmakers of the IPC (as quoted in *R v Haryana*):

The charge of abortion is one, which, even where it is not substantiated often leaves a stain on the honour of families. The power of bringing a false accusation of this description is therefore a formidable engine in the hands of unprincipled men. This part of the law will…[bring] much misery and terror to respectable families, and a large harvest of profit to the vilest pests of society.[2]

Justice Singh was scathing in characterising the MTP Act, arguing, "The MTP Act is an inadequate act and only appears to have been designed to serve the interest of the family planning programme".[3] When reading this description it is clear that before the introduction of the MTP Act it was well understood that Indian society socially and morally condemned the practice of abortion. This condemnation was particularly directed toward those practitioners who conducted abortions without regard to the health of their clients and saw it as an opportunity to make profit from the vulnerability of pregnant persons desperate to terminate a pregnancy. Additionally, it does not define the pregnant person by their individual traits and autonomy, but rather as a member of a family, and representative of their honour. The emphasis is perpetually on protecting the honour and reputation of the group as opposed to respecting the liberty and autonomy of the pregnant person. This also seems to explain the guarded language of the MTP Act, as highlighted in Chapter One. In order to fulfil the agenda of family planning and population control in a politically and socially acceptable manner, the statute's focus was on respecting the honour of well-intentioned medical practitioners in their practice of the 'termination of pregnancy'. Explanation II of Section 3 especially embodies the family planning agenda of the Act, by directing courts to assume that "the anguish caused by [the failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children] may be presumed to constitute a grave injury to the mental health of the pregnant woman".

As mentioned in Chapter One, the MTP Act was modelled after the United Kingdom's *Abortion*

[1]R vs. Haryana, Writ Petition (C) No. 6733 of 2016, para.11.
[2]ibidpara.6.
[3]ibid, para.33.3.

Act,1967.[4] The grounds for termination of pregnancy in Sections 3 and 5 of the MTP Act are almost exactly reproduced from the UK Act, but the pertinent difference is that the original UK statute was enacted without any prescribed time limit. This was partially due to the simultaneous operation of the *Infant Life (Preservation) Act*, 1929.[5] This Act barred the destruction of 'infant life', which was defined as beginning at the 28th week of gestation. Essentially, with the two Acts operating together, UK Courts could determine the legality in relation to timing of the abortion at their discretion at any point before the 28th week.

The omission of a time limit in the UK's original Act highlights the general arbitrariness of imposing any time limit at this period in history, considering the lack of knowledge surrounding gestational development, diagnostic technology and medical science. Subsequent UK legislation introduced a time limit of 24 weeks, which accords with WHO's scientifically based recommendations in the light of gestational changes in the uterus at this point.[6] This all seems to suggest that the MTP Act's introduction of the 20 week time limit was not motivated by following any other universally accepted precedent or standard. In the UK, imposing a time limit was unnecessary as courts could individually assess compliance with the *Abortion Act 1967* at their own discretion. Nevertheless, India imposed a time limit, presumably in the interest of reducing criticism from religious and conservative groups. However, there was no medical or scientific justification for 20 weeks as the point in time after which abortions were no longer legally acceptable. As such, the arbitrariness of this time limit has been the central focus of litigation on abortion matters.

After having examined these various sources, the original purpose of the MTP Act seems clear. Parliament did intend to sanction a population control measure in the guise family planning protections. While there were altruistic motivations, such as addressing the public health crisis of high maternal mortality rates and protecting the interests of rape victims, the overarching purpose centres on enabling a nationwide family planning scheme. However reflecting on the case law from Chapter Two, it appears that courts are less willing to interpret the MTP Act according to this public policy purpose. This is particularly clear after the *Suchita Srivastava* judgment and the recognition of reproductive rights as a dimension of personal liberty as understood under the Constitution. As will be seen in the last section of this chapter, amendments and public challenges to the provisions of the MTP Act reflect societal shifts in views on abortion and pregnant persons' reproductive rights. While the original purpose of the MTP Act may have been to respond to unmet family planning needs and thereby control and restrict population growth, as the case law has revealed, courts have become narrower in assessing matters on a case-by-case basis, assessing the circumstances according to their 'peculiar facts' and focusing on the individual. This is not to suggest that they prioritise the agency of each pregnant person, as they still greatly rely on the authority of the Medical Board's assessment, but rather the emphasis has shifted from public interest to individual liberty. The extent to which this interpretive shift in purpose of the MTP Act aligns with a human rights-based approach is yet to be seen.

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[4] *Abortion Act*,1967(United Kingdom) Chp. 87.

[5] *Infant Life (Preservation) Act*,1929(United Kingdom) Chp. 34.

[6] WHO, 'Safe Abortion: Technical and Policy Guidance for Health Systems', WHO, 2012, 2nd edition, p.4

II. Courts' Interpretations of the MTP Act

The MTP Act has now been in existence for a total of 47 years, but over this period, as Chapter Two illustrates, courts have adopted varying interpretations of its purpose and its provisions. Particular judgments have not necessarily depended on the individual bench hearing a termination application, there have been distinct trends in the development of abortion jurisprudence by both the Supreme Court and other High Courts. The following section will attempt to further identify the underlying socio-political rationale and legal standards courts have applied in these cases and others to further liberalise the MTP Act's regulations and shift focus to the interest of the pregnant person, not the State.

Morality in the Courtroom

The historically conservative view of abortion in India was best reflected in the judgment from *Dr Jacob George vs. Kerala*.[7] The case arose in a criminal matter invoking Section 314 of the IPC, in which a doctor was convicted for causing the death of a woman while intending to 'cause a miscarriage'. Justice Hansaria opened the judgment with the phrase: "Life is said to be the most sublime creation of God…This idea is so intense with some religious leaders that they would even oppose any measure of birth control".[8] This is very disconcerting considering the Constitution's Preamble explicitly recognises that India is a 'sovereign socialist secular democratic republic'. The Honourable Justice bolstered this argument by referring to Mahatma Gandhi, "Father of the Nation" and his pronouncement that "God alone can take life because He alone gives it".[9] It goes on to cite a passage from Rigveda, one of Hinduism's religious texts: "May we attain the long lives which have been ordained as from yore". Considering that the Hindu population in 1991 comprised 82% of the total population,[10] references to religious discourse from the Apex Court of India, reveals the controversial and taboo nature of abortion. At this point in time, even in the Apex body of the judicial institution, religious mores impacted courts' decision making, despite the Constitution's clear separation of religion and State. Abortion was a morally and politically charged issue and it drew clear distinctions between different philosophical and religious understandings of 'life'. In *Jacob George*, this conservative philosophy was blatant: "Life is beyond price and it is not only a legal wrong, but a moral sin as well, to take away life illegally".[11] The Court found that this applied in the case of abortion, as according to A. S. Taylor's definition of life, from the 19th century volume, *Principle and Practice of Medical Jurisprudence*, from the moment of fertilisation, the embryo is imbued with 'sacred foetal life'.

This clear moral condemnation against pregnant persons and medical practitioners, who enabled the practice of abortion, and courts' conservatism in this judgment and others from different State jurisdictions, reflected this deeply morally entrenched feeling against. This reinforced the social

[7] 1994 SCC (3) 430.
[8] Dr Jacob George vs. State of Kerala 1994 SCC (3) 430, para.1.
[9] ibid,para.2.
[10] *Census of India 1991*, Office of the Registrar General & Census Commissioner, India, available from: http://www.censusindia.gov.in/DigitalLibrary/TVDirectory.aspx.
[11] Dr Jacob George vs. State of Kerala 1994 SCC (3) 430, para. 3.

stigma attached to pregnant persons seeking abortions, and impacts the continued reluctance many pregnant persons have when seeking abortions, even if they fall under a legal exception under the MTP Act. As will be seen in the final section of this chapter, conservative thinking often still influences courts and Medical Boards. The language used by these bodies often reflects an unwillingness to acknowledge cases in which termination is legally possible, because certain groups may view this as 'endorsement' of the practice. Despite their tenets of objectivity and duty to the citizen patient, it could be argued that personal bias has crept into decision-making by judges and doctors alike, and this has inhibited the operation of the MTP Act.

The Plain, Restrictive Language of the MTP Act

In the light of the paternalistic health motives behind the enactment of the MTP Act, courts have often tended to strictly limit their interpretation of the statute to their exact, plain words, in order not to aggravate the existing moral condemnation of pregnant persons seeking abortions. The High Court of Bombay adopted this approach in the *Nikhil Datar* case. The case was directly and explicitly challenged the constitutionality of the MTP Act, arguing that without interpreting Sections 3 and 5 together in a harmonious reading, Section 5 would actually be ultra vires of the Constitution.[12] However, the Court was adamant in finding that Section 5 was sufficiently clear for the judges to refuse to interpret the 'eventuality' of a foetus born with substantial abnormalities as posing a risk to the life of the pregnant person. Instead, the Court felt that the omission of any specific eventuality was a definitive choice by the legislature to restrict the operation of Section 5 by defining the 'life' of the pregnant person as the minimum requirement for basic survival: "Section 5 nowhere speaks of any right of a pregnant woman to terminate the pregnancy on the ground that delivery of a child may result in some abnormalities in or to the child to be born".[13] This definition implies that courts are not willing to interpret 'life' in a holistic sense, taking account of the matrix of factors affecting a pregnant person's physical and mental health and foreseeable socioeconomic circumstances.

This very narrow interpretation of 'life' under Section 5 was supported by an earlier Supreme Court case, *Union of India & Anr. vs. Deoki Nandan Aggarwal*, in which it was held "that it is not the duty of the Court either to enlarge the scope of the legislation or the intention of the legislature when the language of the provision is plain and unambiguous".[14] This is a disappointing judicial approach to interpreting the MTP Act and reflected the conservatism of the Court and their determination to restrict the MTP Act to as few circumstances as possible. As explained in *Suchita Srivastava*, the purpose of the MTP Act was to establish a *qualified* right to abortion and it was never an opportunity to 'normalise' the practice and establish a hope in the minds of pregnant persons that they held an automatic right to abortion.[15] This approach was very unsettling as Section 5

[12]Dr Nikhil D. Datar, Mr X, Mrs Y vs. Union of vs. Union of India and State of Maharashtra Writ Petition (C) No. 1816 of 2008, High Court of Bombay, para. 2.
[13]ibid, para. 11.
[14]Union of India & Anr.vs. Deoki Nandan Aggarwal AIR 1992 SC 96.
[15]Suchita Srivastava vs. Chandigarh Administration, Civil Appeal No. 5845 of 2009, Supreme Court of India, para. 11.

is, objectively, very ambiguous. In terms of wording, the Section provides that a termination of a pregnancy that is "immediately necessary to save the life of the pregnant woman" is justified. To understand this provision requires a particular definition of 'life' and the minimum requirements for an individual to live. In the Act there is no mention of dignity or other definitions of life, beyond the minimum requirements for basic survival. It is quite possible for medical practitioners to be conservative in their own assessments of what constitutes 'saving a life'. With the combination of their inexperience with legal standards and subjective personal beliefs regarding the reproductive rights of pregnant persons, medical practitioners are open to more accusations of misunderstanding 'life' as defined under the MTP Act. The fear of prosecution can, and likely has, decreased their willingness to conduct abortion procedures, and led to a 'chilling effect'.[16] The 'plain and clear' intention approach to judicial interpretation of the MTP Act is problematic in many respects, but primarily it has allowed for a restricted application of the MTP Act and undermined its application, even in cases in which the legislature might assume abortion is possible.

The Best Interests Test and Personal Liberty

Since then, many cases have successfully challenged the courts' reluctance to equate the right to life with anything more than basic survival. The tragic *Laxmi Mandal* case resulted in a landmark judgment that recognised that the government had a positive duty to fulfil the right to life and all its associated dimensions, as enshrined in Article 21 of the Constitution. In that particular case, this involved fulfilling government schemes aimed to improve the health of pregnant persons, new mother and infants. The Court found that "in operationalising the schemes…as many people as possible get 'covered' by the scheme are not 'denied' the benefits of the schemes".[17] While the context of this case was very different from cases of applications for termination, both involved facilitating and protecting the reproductive rights of women and pregnant persons.

The judgment reflected a firm constitutional link between the rights to life and health, particularly reproductive health, as well as the recognition that the government has a duty to respect these rights, without arbitrary interference. The impact of the *Laxmi Mandal* decision was reflected in judgment of *Suchita Srivastava*.[18] As Chapter Two highlighted, the central issue of this case was whether the MTP Act required explicit consent from the pregnant person for a termination, if that person was defined as 'mentally ill'. While this case was significant as it recognised the agency of pregnant persons with impairments, the language of the orders revealed a significant symbolic shift in the judicial approach to considering applications for abortion. First and foremost, as was discussed in Chapter Two, the judgment recognised that reproductive *decision-making* was a dimension of the exercise of personal liberty and was constitutionally protected. The significance of this recognition cannot be understated. It recognises the agency of the pregnant person. It recognises the law's protection of the pregnant person and it divorces reproductive health and rights from the larger public policy agenda. This represents a major departure from the MTP Act's larger policy agenda in 1971 as related to maternal mortality,

[16] R vs. Haryana, Writ Petition (C) No. 6733 of 2016, para. 37.
[17] Laxmi Mandal vs. Deen Dayal Harinagar Hospital & Ors, Writ Petition (C) 8853 of 2008, para. 48.
[18] Suchita Srivastava vs. Chandigarh Administration, Civil Appeal No. 5845 of 2009, Supreme Court of India.

and impliedly population control. Of course, this new emphasis on individual decision making was qualified by the Court's paternalistic role as overarching arbiter, implementing the Parliament's laws restricting a pregnant person's choice whether to terminate or continue an unwanted pregnancy.

However it did reflect an important shift, which impacted future judicial approaches to interpreting the MTP Act. To reflect the focus on the individual rather than on the wider public policy or ethical impact of a decision, the Court applied the 'best interests' test. In abortion cases under the MTP Act, the Court noted that this involved two lines of inquiry. First, what is the expert medical opinion as to the viability and health implications of continuing or discontinuing the pregnancy? Second, what are the social circumstances faced by the pregnant person? This involved considering the matrix of factors influencing the pregnant person and the implications of the pregnancy on their life, however it still placed ultimate decision-making power with both medical practitioners and judges. Nevertheless, it retained much of the morally conservative rhetoric of earlier cases and commentators. The judges of the Supreme Court determined that the best interests test actually involved deciding matters by "keeping [the pregnant person's] best interests in minds *as well as those of her unborn child*…based on the holistic assessment of physical psychological and social parameters".[19] Semantics remained significant in this case, as the Court used terms such as 'child' and 'infant' rather than 'foetus', which was only used by medical practitioners. In this respect, the Court was simultaneously applying the best interests test twice, first with regard to the pregnant person and second with regard to the foetus. On its face, this interpretive approach does not appear to accord with the provisions of the MTP Act, as the relevant Section in *Suchita Srivastava* related to the consent of the pregnant person to a termination, not to the assumed consent of a foetus. Consequently, consideration of the rights of the 'foetus' also influenced the Court's approach in this case. In order to achieve this a brief assessment of the beginning of 'foetal life' was required. The judgment reiterated the significance of the timing of abortions stating, "There is a medico-legal consensus that a late-term abortion can endanger the health of the woman".[20] In the judgment itself, this statement was not substantiated by concrete evidence. It simply represented the archaic understanding of the rights and 'life' of the foetus, reflecting concepts from A. S. Taylor's original works on medical legal jurisprudence. This was reinforced by the argument that as the pregnancy progresses, the "compelling state interest"[21] in the viability of the foetus increases. Recognising the agency of Suchita Srivastava and her unwillingness to terminate the pregnancy, the Chandigarh Administration was barred from ordering an abortion. However this does not reflect the best interests test in its truest sense, as the interests of unborn foetus were considered so highly that it was considered a separate interested individual in its own right.

An Interests Based Assessment: The Pregnant Person, the State and the Unborn Foetus

The need to consider the foetus' 'rights' and the State's interests in its potentiality was also mentioned

[19]ibid, para. 9.
[20]ibid, para. 4.
[21]ibid, para. 11.

in *R v Haryana*.[22] The judgment referred to precedent and examples from foreign jurisdictions to establish how the right to abortion has been understood abroad. Justice Singh outlined the balance between State interests and individual interests by referring to the framework established by the US case, *Roe vs. Wade*.[23] The case interpreted timing in relation to trimesters. In the first trimester, it was outlined that the State could *not interfere* with a woman's choice to terminate a pregnancy. In the second trimester, the State could *regulate* abortion procedures in the interests of maternal health. In the final trimester, the State could *restrict* or *prescribe* abortion at its will. The Justice then cited a decision from the obsolete West German Constitutional Court,[24] in which the Court fixed the 14th day after conception as the first day of 'human life'. Further, the Court determined that the West German State had a positive obligation to protect this 'developing life' and make a "reasonable adjustment between the right of the unborn and the right of the pregnant woman". Citing a decision from a defunct judicial body is not a common phenomenon, however it also reflects upon the thinking of the High Court of Punjab and Haryana. The High Court clearly felt it necessary to determine the exact role of the State as the assigned protector of the foetus' interests, and in doing so implied that the Indian government likewise had a similar duty. Again, this assumption is not explicit anywhere in the MTP Act, and within the Act itself, there is no reference to protecting the foetus' interests, or considering its interests as separate from analysis of the interests of the pregnant person. This approach was reflected but qualified in the *Nand Kishore Sharma* judgment:

> This Court is not supposed to enter upon a debate as to when [the] fetus comes to life or the larger question touching upon the ethics of abortion. We are merely concerned with the validity of the relevant provisions of the Act…from a bare reading of the relevant provision it would appear that [the] Act aims at termination of pregnancy in the interest of the woman *or* the to-be-born child.[25]

This case upheld the constitutional validity of the MTP Act and endorsed a plain, clear words interpretation. However, it did specifically interpret the Act as protecting the interests of the unborn 'child', which are interpreted as potentially being separate from those of the pregnant person (see the emphasis in the above quote), which places a greater emphasis on Section 3(2)(b)(ii). This emphasis reflects the subjective power of interpretation that courts retain when analysing the provisions of the MTP Act. Nevertheless, the court in *R v Haryana* recognised, the language of Section 5 illustrates the general "conflict between the right to life of mother and the right to life of the unborn child would yield in favour of the right to life of mother".[26] Accordingly, any best interests test applied in applications for termination of pregnancy requires paramount consideration of the wellbeing of the pregnant person, and how they would hypothetically be impacted by the birth of a child in the general sense. In Section 2(b)(ii), medical practitioners' need to consider whether there is a substantial risk to the life of the 'unborn child', which would cause severe handicap, could be interpreted in many

[22] R vs. Haryana, Writ Petition (C) No. 6733 of 2016.
[23] 410 US 113 (1973).
[24] (1975) 39 B Verf GE.
[25] Nand Kishore Sharma & Ors.vs. Union of India AIR 2006 Raj. 166.
[26] R vs. Haryana, Writ Petition (C) No. 6733 of 2016, para. 10.1.

ways. One of which may simply be that the physical and mental burden imposed on the pregnant people would be a risk to their own wellbeing. These conclusions reflect how the application of the best interests test may provide a workable opportunity for courts to interpret the MTP Act with additional flexibility. It is easier for courts to identify the special cases that require the exercise of their extraordinary writ jurisdiction to address the particular interests of pregnant persons. As has been seen, the best interests test has allowed the setting aside of the 20 week time limit in other cases in which a holistic assessment reveals the grave implications of a pregnancy on a person's mental and physical health. Often the test, in combination with 'in the interests of justice' argument, has provided enough cause to set aside the time limit.[27] However, while this flexibility allows for greater flexibility, it could be argued that it does not actually engage with the provisions of the MTP Act and establish a consistent interpretive precedent in defining exactly what the law is.

Purposive Interpretation and Construction

However, in *Shaikh Ayesha Khatoon*,[28] a new reading of the MTP Act provided an avenue to avoid the blanket imposition of the 20 week time limit. As Chapter Two illustrated, the petition used the argumentation from the 2008 *Datar* case, and with strong testimony from medical experts of the certainty of the fatal foetal abnormality, the High Court of Bombay confirmed the legality of undergoing a termination by reading Sections 3 and 5 together. In order to do so, the High Court's approach to interpreting the MTP Act was to employ purposive construction. In applications for termination of pregnancies under the MTP Act, the significance of using purposive construction to interpretation was substantial. It allowed judges to truly assess what actual purpose the MTP Act, rather than take for granted that it was merely a strict list of highly specific circumstances in which abortion would be decriminalised. It also served to holistically evaluated the Act's impact on pregnant people and whether this aligned with its purpose.

In order to appreciate this judgment's significance it is appropriate to outline exactly how the High Court understood purposive construction to apply to the MTP Act. The judgment categorically outlined the Court's duty when interpreting a statute to first: understand the words of the provisions "in their natural, ordinary and popular sense".[29] Second, the court must be wary not to add nor subtract a single word from the statute. Third, when reading an individual section, it must be understood in the context of the whole statute's interconnected framework. Fourth, to achieve these goals the Court must attempt to determine the purpose of the legislation. The High Court quoted legal scholar Aharon Barak, explaining that the Court must assume that the enacting Parliament was comprised of reasonable people, with reasonable goals, attempting to achieve them in a reasonable manner. Further, the Court should presume that the legislature is discharging its duties in good faith, in the interest of respecting and fulfilling constitutional protections of the

[27]See, for example the Supreme Court Cases Sonali Sandeep Jadhav vs. Union of India, WP(C) No. 551 of 2017; Murugan Nayakkar vs. Union of India, WP (C) No. 749 of 2017; Tapayasha Umesh Pisal vs. Union of India, WP (C) No. 635 of 2017; Mamta Verma vs. Union of India, WP (C) No. 627 of 2017.
[28]Writ Petition No. 36 727 of 2017, High Court of Bombay.
[29]ibid, para. 15.

people.[30] The High Court also acknowledged that in determining the nature of the purpose of the Act, changes in societal conditions must be considered. For example, this has implications for the development of technology, and specifically prenatal diagnostic equipment, and its impact on the object and purpose of imposing time limits under Section 3.

Re-examining the judgment in *Shaikh Ayesha Khatoon*, the Court's use of purposive construction led to the logical conclusion that the 'eventualities' mentioned in Section 3 must equally apply in a legal or medical assessment under Section 5. In a Medical Board assessment or in a Court's orders, it would be absurd to ignore whether the continuation of the pregnancy would involve a risk to the life of a pregnant person, grave injury to their physical or mental health, or whether the foetus is likely to suffer physical or mental abnormalities, which would lead to severe handicap. These are major factors to take into account when deciding the present and future quality of life of the pregnant person. As such, according to purposive construction, these eventualities should impact any assessment of the need to save the life of the pregnant person. To arbitrarily consider them in one case before the 20 week time limit and deliberately ignore them in cases after the 20 week time limit cannot advance the purpose of the Act, if it is understood in the Statement of Objects and Reasons. To repeat, the Statement is phrased such that it explains the exceptions to the criminalisation of abortion according to health, humanitarian *and* eugenic grounds. Examining the words of the Statement itself, there is no mention of time limits.

According to purposive construction, this element of the Act must be understood as further clarifying Section 5, rather than operating in isolation from it. The Court also reiterated that this interpretation was the only resolution to "meet the object and purpose of enactment and to promote cause of justice".[31] The Court supported its conclusion and understanding of the purpose of the MTP Act by including a reference to the MTP (Amendment) Bill 2014, as drafted by the Ministry of Health and Family Welfare of the Government of Maharashtra.[32] The Bill included a provision that would lift the time limit in cases in which a diagnosis of a substantial foetal abnormality had been given. This Bill had not been passed by Parliament and held no hard legal precedent (the Bill's status will be outlined in the following section). However according to the High Court, it was still significant in persuading the Court that the purpose of the MTP Act involved considering the impact of foetal abnormalities in each case, irrespective of time limits. This reveals how purposive construction provides greater flexibility in the judiciary's interpretation, if they are able to consult other documents and sources of medico-legal understanding to clarify the purpose of the MTP Act and consider its application in the context of a changing Indian society. Thus, if other courts read the MTP Act by relying on purposive construction, it seems obvious that the 20 week time limit will need to be reconsidered.

The Role of Evidence from Medical Boards and Committees

In all of these judicial approaches to interpreting the MTP Act, from referring to religious moral understandings of 'life', to the best interests test, to purposive construction, there has always been

[30]ibid, para. 16.
[31]ibid, para. 13.
[32]ibid, para. 23.

a role for medical practitioners. The difference has always depended on the particular weight given to their recommendations according to each approach and according to the individual judges adjudicating a matter. In every domestic case referred to in Chapter Two, a Medical Board was established to assess the individual circumstances of the relevant pregnant person, in order to make 'recommendations' as to the feasibility of a termination of pregnancy. However courts' directions to Medical Boards and the phrasing of many of their reports reveal different understandings of their exact medico-legal role. Scholars have argued that this "makes [pregnant people] dependent on the doctor's interpretation of the law",[33] which is worrying considering they are not educated or updated with legal precedent and standards.

Nevertheless, some courts have solely depended on the testimony, recommendations and evidence from medical experts. As stated in *R v Haryana* any final court orders would have to take these findings into account before any ruling was made as the "court has to base its judgment completely upon the opinion of the experts in the field and cannot issue directions on its own".[34] The Court justified this approach by arguing that this would decrease the chilling effect on medical practitioners fearful of prosecution. Other judges have taken a more proactive approach. The Supreme Court judgment in *Suchita Srivastava* revealed that the High Court of Punjab and Haryana had previously ordered an 'Expert Body' to answer a series of medical, psychological and socioeconomic questions. In the lower court, the Expert Body recommended continuation of the pregnancy, so long as a social support system provided adequate care to the Petitioner and her potential infant. The High Court overruled this recommendation and directed termination of the pregnancy.[35] The Supreme Court overruled this direction on the basis that the pregnant person did not consent to a termination, however it certainly revealed the reluctance of courts to overrule a Medical Board's recommendations.

Today, it appears that most courts will seek medical approval from a Medical Board for termination, directly follow its recommendation by according it to legal standards, and then provide an opportunity to the pregnant person to consent to such a termination:

> Frankly speaking, cases of this nature have to rest on their own facts because it shall depend upon the nature of the report of the Medical Board and also the requisite consent as engrafted under the Medical Termination of Pregnancy Act, 1971.[36]

However, reading some judgments it appears somewhat unclear how courts and Medical Boards view their role and purpose. The question before courts concern assessing the legality of termination in a particular case, not whether they should grant or deny permission to undergo the procedure. Nowhere in the MTP Act does it mention a role for courts or the judiciary as an avenue for appeal. The language of Medical Board reports and court orders often assume that they are directing the Petitioner to undergo a termination procedure, rather than providing legal clarification to pregnant

[33]Shweta Krishnan, 'MTP Amendment Bill, 2014: Towards re-imagining abortion care', *Indian Journal of Medical Ethics*, 2015, vol. 12(1), p. 44.

[34]R vs. Haryana, Writ Petition (C) No. 6733 of 2016, para. 37.

[35]Suchita Srivastava vs. Chandigarh Administration, Civil Appeal No. 5845 of 2009, Supreme Court of India, para. 10.

[36]Sarmishtha Chakrabortty vs. Union of India Secretary, Writ Petition (C) No. 431 of 2017, Supreme Court of India.

people to allow them to make the ultimate decision to terminate a pregnancy. Courts actually prescribe exactly where and when a termination will take place once the orders confirming the possibility for a legal abortion has been given. This reflects the paternalistic attitude that medical practitioners and judges often maintain when involved in abortion matters under the MTP Act.

From a feminist and rights-based perspective, the greater weight given to recommendations from Medical Boards is highly problematic as it restrains the decision making of the pregnant person and reduces their reproductive autonomy. Instead of relying on the opinion of the individual pregnant individual and their understanding of their personal circumstances, medical practitioners who may be completely unfamiliar with their medical or personal history will usually have a greater influence on a court's orders. This aspect of current judicial decision making in abortion matters contravenes the heart of self-determination and reproductive, personal liberty, as understood according to a human rights approach. Various stakeholders and the public affected by access to abortion services and legal standards related to termination of pregnancy have not ignored this inequity. The following section will explore how these stakeholders have publicly and politically challenged the MTP Act and its current operation and interpretation by courts.

III. Amending and Challenging the MTP Act

Advocates and activists have challenged India's abortion law for years, however little legal traction has been gained since the MTP Act's amended Regulations and Rules were introduced in 2003. If the MTP Act is to remain in place, the current issues already identified in other Chapters need to be rectified. Reform of the MTP Act, and movements to repeal the statute altogether, have led the Ministry of Health and Family Welfare to consult with relevant stakeholders to address these issues and redraft provisions of the MTP Act. This resulted in the introduction of the Medical Termination of Pregnancy (Amendment) Bill, 2014. However, the Bill has not progressed through Parliament and with strong opposition, the likelihood of its enactment in its current form, and in subsequent versions, will be difficult to guarantee. Nevertheless, the Bill presents a major step forward in reframing the purpose of the MTP Act by shifting more decision-making power and access to abortion services to pregnant persons. The Bill represents a symbolic tool for reproductive empowerment and suggests that the potential for India to introduce a truly rights-based approach to abortion law may be on the horizon in years to come.

Major Issues to Address

As Chapter One illustrated, there are several major flaws with the current operation of the MTP Act and particularly with practical access to abortion services and providers. It is important to identify and address each of the major inadequacies of the Act in its present form in order to reimagine how the Act could be amended to best protect the interests and rights of pregnant persons.

• Time Limits

As shown by the existing jurisprudence, the most pertinent issue facing most pregnant persons, who hope to terminate a pregnancy in the second or third trimesters, is the 12 and 20 week time limits in Section 3 of the MTP Act. This feature of the Act has not only been critiqued by pregnant persons and their doctors, but also by judges. In *R v Haryana*, Justice Singh heavily critiqued the use of time limits and its influence over doctors:

> The revision of the legal limit for termination of pregnancy is long due. In fact, medical technology has leaped beyond the MTP Act and assumptions of medical ethics. Most of the doctors try to remain within law and do not consider the peculiar circumstances of the case before them…Some abortions are necessary beyond the statutory limit in the light of circumstances under which they are sought and, therefore, we require to streamline the system in this regard.[37]

These comments are significant for several reasons. Firstly, they reflect the need to ensure that medical practitioners must recognise the role they have when approving an abortion, and the particular and delicate consideration they must give to each case. Fearing prosecution and litigation should not serve as barriers for eligible pregnant persons to access abortion services. Medical practitioners under the MTP Act should feel confident to apply its provisions as appropriate, rather than err on the side of caution and hastily deny permission to pregnant people whose cases may be a little more ambiguous. Simultaneously, the comments reflect his belief that the MTP Act needs to be explicit in allowing post 20th week abortions in some cases. As courts continue to recognise the legality of post 20th week abortions in certain factual circumstances, the comments suggest that the MTP Act needs to formally integrate provisions setting out the factual circumstances, which are considered exceptions to the Section 3 time limits. This would also establish consistency across cases and serve as guidance for medical practitioners.

The arbitrariness of the 20 week rule has already been mentioned, but the most persuasive argument in favour of recognising the need to amend the time limits, comes from doctors and medical experts. After the *Datar* case in 2008, commentary from medical practitioners reflected a changing medical consensus in light of medical advances in diagnostic equipment. As the former chairman of the Committee for Medical Termination of Pregnancy from the Federation of Obstetrics and Gynaecological Societies of India (FOGSI) observed "The law needs to keep pace with advances in medical technology…We believe the cut-off date should be extended to 24 week…Certain fetal abnormalities are best detected only in the 20 to 24 week window".[38] It seems obvious that the 20 week time limit cannot be justified according to any scientific standard. Considering diagnostic equipment only detects most abnormalities by the 24th week, there is major discrimination against pregnant persons whose foetus is diagnosed with an abnormality between the 20th and 24th week. This is particularly the case when a pregnant person has not had access to advanced diagnostic technology, which could potentially detect abnormalities before the 20th week due to their lower

[37] R vs. Haryana, Writ Petition (C) No. 6733 of 2016, paras. 33.1-33.2.

[38] Ganapati Mudur, 'Doctors favour changes in India's abortion law', *British Medical Journal*, 2008, p. 337.

socioeconomic circumstances. They may only have access to basic scan technology at primary and secondary healthcare facilities, so the possibility for them to seek an abortion is always hopeless.

Further, many courts have cited the medical risk of conducting a late term abortion as the greatest factor influencing their assessment of the legality of a termination application. This argument is used to justify the implementation of the 20 week time limit. The growing body of clinical research has found that induced abortion when performed after the 20th week is just as safe, if not safer, than deliveries at term, if conducted according to safe medical standards.[39] With this in mind, doctors have continued to criticise the arbitrariness of the time limit, with the former President of FOGSI, Dr. Rishma Dhillon Pai, commenting to the Huffington Post, “There is greater focus on the time frame than what needs to be done in the best interest of the mother…You can’t say that abortion is safe at 19-and-a-half weeks, but unsafe at 20-and-a-half weeks”.[40] Voices from many stakeholders agree: amending the time limit provision under Section 3 should be high on the agenda for reform.

• Certification of Abortion Practitioners and Locations

As Chapter One outlined, physically accessing abortion services is often inhibited by many factors, from geography, personal expenses, work commitments and unawareness of the healthcare system and its benefits. This is particularly concerning as there is a significant lack of registered obstetrician gynaecologists or physicians certified with an MBBS[41] to conduct termination procedures. Many have argued that abortion law needs to legally certify more categories of healthcare providers to conduct first trimester abortions. These might include nurses, auxiliary nurse midwives and qualified Ayurvedic, Unani, Siddha and Homeopathy (AYUSH) practitioners. Before the mid 2000s there was very little academic study of the capability of such healthcare providers to provide early term abortions in India.

However, from 2006 to 2011, the international NGO, Population Council, conducted a study in Bihar and Jharkhand, investigating the feasibility of non-MBBS providers conducting medical abortion (MA) and manual vacuum aspirations (MVA) (both will be explained in the following section).[42] In one paper published from the study, the ability of nurses to conduct MVA procedures was well supported with “results [showing] that MVA can be provided with equal safety and effectiveness [as physicians]…with all clients who underwent an MVA procedure by a nurse indicating their willingness to seek abortion from nurses in [the] future”.[43] These results have

[39]International Campaign for Women’s Right to Safe Abortion, ‘India—Sexual abuse of girls followed by refusal of abortion: adding insult to injury’, 4 August 2017, available from: http://www.safeabortionwomensright.org/india-sexual-abuse-of-girls-followed-by-refusal-of-abortion/.

[40]Sonali Kokra, ‘Why is India’s Abortion Law Failing Its Women On So Many Fronts?’,*Huffington Post*, 4August 2017, available from: https://www.huffingtonpost.in/2017/08/04/why-is-india-s-abortion-law-failing-its-women-on-so-many-fronts_a_23063014/.

[41]Bachelor of Medicine, Bachelor of Surgery.

[42]Population Council, ‘Expanding the Provider Base in India: The Feasibility of Provision of MA and MVA by non-MBBS Providers’, Research: Project, 2012, available from: https://www.popcouncil.org/research/expanding-the-provider-base-in-india-the-feasibility-of-provision-of-ma-and.

[43]Shireen Jejeebhoy et. al., ‘Can nurses perform manual vacuum aspiration (MVA) as effectively as physicians? Evidence from India’, *Contraception*, 2011, vol. 84, p. 620.

been replicated in other countries, including Nepal and South Africa.[44] If studies have shown that certain practitioners are capable and successful at conducting abortions, there seems little sense in restricting the list of certified practitioners under the MTP Act to obstetrician gynaecologists. This is particularly true if monitoring mechanisms are established in the Rules and Regulations to the Act to ensure all public and private practitioners regularly comply with medical standards for conduction abortion procedures.

Additionally, there are other benefits for many pregnant persons in having a nurse or other healthcare provider at primary and secondary healthcare centres. First, this will significantly decrease the physical distance that pregnant persons in remote areas will need to travel and the expenses they incur for such a journey. Second, their sense of comfort, safety and satisfaction may be improved if they are familiar with the person or place conducting the abortion procedure. Third, awareness about the MTP Act and the possibility to terminate a pregnancy may spread.

Additionally, under the MTP Act, terminations of pregnancy may only be conducted at District Hospitals, other public tertiary healthcare institutions, and at approved private facilities. This presents further difficulties, as hospitals are often physically distant from many pregnant persons and gaining certification, as an approved private clinic, can be overly bureaucratic and lengthy.[45] The combination of expanding the provider base to practitioners working in secondary and primary healthcare centres and streamlining the system of certifying private clinics, seems an effective method to increase ease of access to abortion services to all pregnant persons in India.

• Abortion Procedures

Even though the MTP Act prescribes who and where an abortion procedure takes place, the manner of how it is conducted is left completely to the discretion of the medical practitioner. This discretion arises simply because the MTP Act has omitted any mention of how terminations should be conducted. While this may not appear significant, it does have implications for the cost, compliance mechanisms and future health of the pregnant person. Certain methods of abortion practice are more popular than others in India and each has different long-term health ramifications for the pregnant person. As such, it is important to understand the universally recommended medical standards for different forms of abortion procedures.

Generally, procedures are categorised into two: medical methods of abortion (MA) and surgical methods of abortion (SA). According to WHO, MA involves the use of pharmacological drugs to induce abortion, while SA includes any procedure using physical transcervical methods.[46] In a policy guide, WHO recommends that vacuum aspiration (VA) is the preferred method of SA. For MA, WHO prescribes a regimen of the drugs, mifepristone followed by misoprostol. This policy guide even rejects the use of certain procedures, specifically preferring VA to dilatation and sharp curettage

[44]ibid, p. 616.

[45]See Appendix A, Appendix C, and Mandira Paul et. al., 'The importance of considering the evidence in the MTP 2014 Amendment debate in India—unsubstantiated arguments should not impede improved access to safe abortion', *Global Health Action*, 2015, vol. 8.

[46]WHO, 'Safe Abortion: Technical and Policy Guidance for Health Systems', WHO, 2012, 2nd edition, p. iv.

(D&C). This is an issue for Indian medical practitioners as the prevailing method for first trimester abortions is D&C. Medical experts, including Mandira Paul from the United Nations Population Fund, have condemned the practice saying, "It is time that the public health system of India moves from the discredited 'dilatation & curettage' or 'D&C' to safer and modern methods of abortion such as medical abortion and vacuum aspiration".[47] MA and VA may both be implemented at the level of primary health care, in local, accessible Primary Health Centres and Community Health Centres. The path toward increasing access by promoting MA is supported by current policy, as both mifepristone and misoprostol appear on the National List of Essential Medicines 2015.[48] However, both drugs are currently only available at the tertiary level.

Without further direction from the MTP Act, pregnant persons' wellbeing is purely in the hands of the treating medical practitioner and their preferred method of termination. This is particularly disturbing when some doctors refuse to conduct the termination procedure unless the pregnant person also undergoes sterilisation.[49] Calls have been made for the prescription of approved methods of abortion to be included in the Act or in its accompanying Rules and Regulations in order to provide set standards for practitioners to comply with in order to avoid endangering pregnant persons with unsafe procedures, improve general access and maintain consistency and equality across providers. Additionally, apart from private clinics, presently tertiary public facilities are not audited to ensure safety compliance in the method of procedure. With set guidelines an auditing system would be easier to implement.

- **The Role of State Authorities**

In *Z v Bihar*, former Chief Justice, Dipak Misra, was cutting in his critique of state authorities who had failed to fulfil their statutory duties in responding to the request of a rape victim, who was HIV positive, to terminate a pregnancy:

> Her choice not to exercise her reproductive rights in the factual matrix has been completely shattered in contravention of the statutory provisions and the pronouncements of this Court as a consequence of which she is being compelled to carry the pregnancy to its full term that has caused incalculable harm and irreversible injury giving rise to emotional trauma…when there is violation of such right because of the negligence of the State functionaries, the victim is entitled to get compensation.[50]

The exact role of state authorities, including police, welfare administrators and the courts themselves, is ambiguous in relation to the operation of the MTP Act. Nowhere in the current Act or its associated Rules and Regulations is there a reference to the courts, police or welfare institution administrators. This has proved to be an issue in several cases, in relation to the need to obtain consent from family

[47]Mandira Paul et. al., op. cit.
[48]Ministry of Health and Family Welfare and WHO, 'Oxytocics and Abortifacients', *National List of Essential Medicines*, 2015,p. 63.
[49]Krishnan, op. cit., p. 45.
[50]Z vs. Bihar (2008) 11 Supreme Court Cases 572, para. 16.

members for minor or mentally ill pregnant persons or the need to file a FIR[51] in cases of rape or sexual abuse.[52] This is a problem as with protracted investigations and prolonged court hearings and delays, the 20th week time limit is often passed simply due to administrative process. When state authorities become involved in an abortion matter, for the purpose of clarifying the law, investigating a criminal matter or seeking consent for a termination procedure (in order to comply with Section 4 of the MTP Act), these extenuating circumstances should be fast-tracked in order to facilitate the decision making process of the pregnant person and their medical practitioner's approval for termination. Ultimately with this and all the other issues discussed, the State and its associated institutions and people should have the highest duty to respecting, protecting and fulfilling the rights of the pregnant person, which under the MTP Act includes the right to abortion in certain circumstances.

Amendment Bills

The issues identified so far are simply a few among many pitfalls of the MTP Act and its current provisions. It is no surprise then that multiple stakeholders have attempted to amend MTP Act through legislative avenues. In 2014, the Ministry of Health and Family Welfare proposed the most significant and comprehensive set of amendments to the Act. On the recommendation of the National Commission for Women, the Ministry drafted The Medical Termination of Pregnancy (Amendment) Bill, 2014 (See Appendix D), and sent it to relevant stakeholders and the general public via its website on 29th October 2014 for comments. The Bill included the following amendments:

- Expanding the categories of approved providers to include any medical practitioner registered on the Indian Medical Register or State Medical Register; registered AYUSH practitioners; nurses and auxiliary nurse midwives;
- Specifically defining 'termination of pregnancy' to include MA and SA;
- 'On request' abortions up to 12 weeks (i.e. the pregnant person does not need to give justification for seeking the abortion);
- Single provider approval for abortions between 12 and 24 weeks;
- Recognition of contraceptive failure as a ground for termination applying to all pregnant persons, not just married women;
- Time limit shall not apply in cases in which a diagnosis of a substantial foetal abnormality has been given;
- Prescription of the required training, experience and methods to be adopted by all healthcare providers conducting termination procedures;
- Prescription of set rules for eligibility as a place of termination, diagnosis procedure, record keeping and other relevant issues;
- Privacy protection of pregnant person's name and details; and
- Expansion of offences and penalties under the MTP Act.

[51] First information report.

[52] See R vs. Haryana, Writ Petition (C) No. 6733 of 2016; Suchita Srivastava vs. Chandigarh Administration, Civil Appeal No. 5845 of 2009, Supreme Court of India; Z vs. Bihar (2008) 11 Supreme Court Cases 572.

However the proposed Bill received significant backlash. Many individuals and associations from the medical community argued that non-allopathic healthcare practitioners were unsuitable to provide MA, let alone SA. Dr M. C. Gupta, a medico-legal expert based in Delhi accused the Ministry of Health and Family Welfare of "actively trying to promote quackery by legalising it".[53] The expansion of provider base had specifically been drafted with the results from the Population Council's study in mind, however many attacked the validity of the study itself, considering that its method had violated the law in the first place by allowing non-MTP Act approved practitioners to conduct abortions during the study. Some members of the non-allopathic medical community also shared this discontent. Dr V. K. Ajithkumar, current National President of the Indian Homoeopathic Medical Association, then claimed, "We are strongly against this proposition, because we simply don't have the practical experience or training to deal with the complications of abortion…it would compromise the credibility of homoeopathy".[54] Other AYUSH practitioners felt that even though there were Ayurveda oral medicines that could serve as MA, they usually led to incomplete abortions.[55]

These issues could potentially be addressed in amendments to the MTP Act's Rules and Regulations, to specifically address the required training needed for conducting either MA or SA procedures, however as these had not been formulated these complaints overrode further discussion on adding clarification to the proposed amendment. Members from the healthcare community who continued to support the Bill argued that increasing access to abortion procedures in remote areas was crucial and increasing the time limit to 24 weeks would accord with the state of diagnostic technology, especially in cases of ectopic pregnancies, in which abortion is "unquestionably required".[56] Nevertheless, many supporters of the Bill recognised that despite the concerns regarding expanding provider base, the amendments are far more wide-ranging. Sexual and reproductive health researcher, Shweta Krishnan, contended:

> Not only does the Bill recognise a woman's right to self-determination and autonomy…it also represents something of a shift in the focus of abortion law in India from the healthcare provider to the woman undergoing abortion. Such a shift decreases the vulnerability of women within the clinical setting and frees them from subjective interpretations of the abortion law.[57]

This rhetoric is mostly derived from the new provision allowing 'on request' abortions during the first trimester. In practical terms, this provision may have an impact on public health statistics as research has shown that "abortion rates are higher where it is restricted than where it is permitted".[58]

[53]See Vidhi Rathee, 'Doctors oppose proposal to legalize abortions by nurses, AYUSH practitioners', *India Medical Times*, 4 November 2014, available from: http://www.indiamedicaltimes.com/2014/11/04/doctors-oppose-proposal-to-legalize-abortions-by-nurses-ayush-practitioners/; Daulat Rahman, 'IMA opposes revision of act', The Telegraph, 8 November 2014, available from: https://www.telegraphindia.com/states/north-east/ima-opposes-revision-of-act/cid/1625152#.VJ_tVDEWUk.

[54]Sathish Kumar, 'Homoeopathy, Ayurveda Doctors objects the New MTP Amendment Bill, *KS Homeopathy*, 10 November 2014, available from: http://www.kshomeopathy.in/2014/11/homoeo-ayurveda-objetcs-mtp-bill.html.

[55]ibid.

[56]As quoted by Dr. Harsha Khullar from Sir Ganga Ram Hospital, New Delhi, in Rathee op. cit.

[57]Krishnan, op. cit., pp. 43-44.

[58]K.K. Sunitha, 'Medical Termination of Pregnancy (Amendment) Bill, 2014: A positive note', *Journal of Reproductive Health and Medicine*, 2016, vol. 2, p. 53.

This is a major development, representing a further recognition that the decision to terminate a pregnancy is a deeply personal matter, which should not need approval from a medical professional or a legal statute. Clearly this is qualified by the 12 week time limit, however the symbolism of such a provision is a major development from the transfer of decision making power from the State in the interest of public policy, to the individual pregnant person. This also reflects a rights-based approach by re-focussing attention on the State's obligations to respect, protect and fulfil the pregnant person's reproductive rights, under both national and international law. Despite the controversy of the 2014 Bill, it remains the most comprehensive set of amendments currently in consideration. However its delay in reaching Parliament suggests that several changes will be need to be made to the Bill before the Ministry of Health and Family Welfare are committed to promoting its passage through Parliament.

After a series of cases between 2016 and 2017, and frenzied international media scrutiny of apparently inconsistent court decisions in cases of the rape and sexual abuse of minors and foetal abnormalities,[59] renewed pressure was put on private Members of Parliament to respond to the inadequacies of the MTP Act. Since then two bills have been introduced to Lok Sabha and Rajya Sabha. The MP, Dr. Kanwar Deep Singh, introduced the first bill on 4th August 2017 in the Rajya Sabha (See Appendix E). Bill No. XXV of 2017 only sought two amendments, first to increase the time limit in Section 3 from 20 to 24 weeks, and second to extend the period of consideration in the Houses of Parliament of new rules to the MTP Act. In his Statement of Objects and Reasons, Dr. Singh explained that the numerous cases before the Supreme Court challenging the 20 week time limit on the discovery of foetal abnormalities motivated the drafting of the amendments. The Bill is simply too bare to address all the flaws already discussed in this chapter. If passed it would only allow for cases falling within the scope of Section 3; in which there is a grave risk to the physical or mental health of the pregnant person, or substantial risk of foetal abnormalities; to become eligible for legal termination if raised between the 20th and 24th week. This allows for later diagnosis of foetal abnormalities or discovery of pregnancy in rape cases, or other cases in which new factors influence the pregnant person's physical or mental health. It does provide a longer time frame for the legislature to continue to make rules for the MTP Act, however the efficacy of their decision making is up for debate (particularly considering that the 2014 Amendment Bill has not progressed in four years).

Overall, the Bill would represent a step forward, but would still direct focus on the power of medical practitioners. It would not clarify other issues related to increasing accessing to abortion and retaining the dignity of the pregnant person by maintaining privacy. Perhaps, it would be the path of least resistance in passing through both Houses of Parliament, but it would not allow for the true balance of power to rest with the pregnant person, nor would it reflect a rights-based approach.

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[59]See for example, 'India Supreme Court allows rape victim, 13, to terminate pregnancy', *BBC News*, 6 September 2017, available from: https://www.bbc.com/news/world-asia-india-41172796; Sonali Kokra, 'Why is India's Abortion Law Failing Its Women On So Many Fronts?',*Huffington Post*, 4August 2017, available from: https://www.huffingtonpost.in/2017/08/04/why-is-india-s-abortion-law-failing-its-women-on-so-many-fronts_a_23063014/.

On 19th February 2018, Shri Shrirang Appa Barne, introduced a lengthier amendment bill to Lok Sabha, specifically in response to other Supreme Court judgments that seemed to undermine the 'plain, clear' 20 week time limit (See Appendix F). This Bill is far ranging, however does not include any provisions regarding expanding the provider base to non-allopathic practitioners or nurses. Instead, it focussed on:

- Increasing the general time limit in Section 3 to 24 weeks, and specifically increasing this limit to 27 weeks in cases of rape survivors;
- Restricting place of termination to Government established or maintained hospitals or medical colleges; and
- Establishing an advisory Board to approve applications for termination at any time in a pregnancy if it is found to have an abnormality (from a new prescribed list, which would include chromosomal, congenital abnormalities and genetic metabolic diseases. This Board would consist of geneticists, gynaecologists and obstetricians, paediatricians, social scientists and representatives of women's welfare organisations.

This Bill certainly extends the scope of cases that will be considered for termination, setting aside the time limit in a list of cases with particular factual circumstances. However, in many respects it reinforces the powers of a third party board to maintain control over the decision making process. Additionally, it may even *further restrict* access to abortion services, if they cannot be conducted at certified private clinics with a certified obstetrician gynaecologist. It does avoid the need to go to court for post-24 week abortions; however it may simply replace the current use of Medical Boards in matters before courts. Having a central Board may streamline the system and reduce subjectivity of individual Medical Boards, however it still fails to align with a rights-based approach, as it does not symbolically recognise the ultimate rights-holder as the individual pregnant person.

Analysing the two bills, it soon becomes evident that each places a particular emphasis on different flaws in the current MTP Act. Both are clear in the extension of the time limit to 24 weeks and if any change is to be made to the MTP Act it seems this is the most pressing for the majority of interested stakeholders. Nevertheless, both bills remain pending in each House and it is yet to be seen whether they have any genuine impact. Increasing access to abortion services and increasing the reproductive autonomy of pregnant persons in the decision making process appear to be the major points of contention currently preventing the passage of all, or at least some, of the provisions of the 2014 Amendment Bill. While there appears to be a general consensus that the MTP Act needs to be amended, with critique arising from courts, government institutions (including the National Commission for Women and the Ministry of Health and Family Welfare), doctors, other health providers, and most significantly from pregnant persons and their families, there is currently little agreement on the exact purpose and nature of the required amendments. The problematic question remains: who has the right to decide to terminate a pregnancy, and how should this decision be made, according to what, if any, standards?

Conclusion

Abortion law in India has not remained completely inflexible or unchanged since the implementation of the MTP Act in 1971. Apart from amendments in the Rules and Regulations in the early 2000s, to increase access to abortion service providers, courts have had the greatest role in reinterpreting the MTP Act and reconsidering its role as an arbiter in the process of deciding whether to terminate a pregnancy or not. In part, confusion and ambiguity has arisen due to conflicting understandings of the purpose of the MTP Act. Originally it was intended to address public policy needs: to reduce rates of maternal mortality; to facilitate mass family planning strategies, and thereby address the exponential population growth India was experiencing at the time. Since then, there has been shift from focusing on the public need to ensuring the best interests of the individual pregnant person. Previously some courts were inhibited from interpreting the law liberally in cases that did not necessarily conform to a strict interpretation of the plain words of the statute. However with the courts' recognition of reproductive rights as constitutionally protected rights in *Suchita Srivastava*, as well as the specific use of the 'best interests' test, the willingness of courts to set aside the Section 3 twenty week time limit increased. With socioeconomic changes impacting attitudes of the times, and advancements in technology changing medical practitioner's treatment during pregnancy, courts became compelled to set aside the time limit in some cases 'in the interests of justice'. Many other courts have purely relied on the opinions of Medical Boards to determine the legality of terminations in certain contexts.

However, there now appears to be ambiguity surrounding the possibility of terminating a post 20th week abortion, with different courts giving seemingly contradictory orders. The High Court of Bombay has been the most progressive in interpreting the MTP Act using purposive construction to take into account changing social attitudes and technological advances by reading Sections 3 and 5 together, however as the Supreme Court has not yet adopted such an approach, the law remains somewhat unclear, and most courts and Medical Boards continue to adopt a paternalistic, subjective role in 'granting' or 'denying' abortions in certain cases. In the light of this inconsistency, and other major issues including restricted access to services, methods of abortion practice and the role of state authorities, the trend seems to be toward amending the MTP Act in its current form. Since 2014, numerous attempts to introduce legislative change have been made. However none has had any impact as they are all pending before the two houses or in government departments. Many disagree as to the exact amendments that are needed for the law to properly acknowledge that the 20 week time limit is arbitrary, discriminatory and contrary to current diagnostic capability. However stakeholders, particularly those from the healthcare community, both allopathic and non-allopathic practitioners, are preventing recognition that the pregnant person is the ultimate holder of the right to exert their reproductive autonomy and until provisions such as the first trimester 'on request' terminations from the 2014 Amendment Bill are integrated, a true rights-based philosophy will not be reflected in abortion law. If changes to India's current abortion law are on the horizon it is useful to draw upon the successes and failures of foreign jurisdictions in respecting, protecting and fulfilling the reproductive rights of pregnant people.

CHAPTER FOUR

Abortion as a Human Right Internationally

Internationally, the precedent has already been set to define the right to abortion as a human right. International law and practice and numerous nations have already integrated liberal protections and access to abortion services within their legislative frameworks. As a result significant numbers of pregnant persons have been granted the freedom to exercise their reproductive autonomy and realise their right to health. This first reveals the universality of the issues posed by abortion, as it provokes moral and political controversies across vastly different national contexts. Though secondly, it also reflects the unifying aspect of empowering pregnant people by situating abortion within a human rights framework. The arguments for and against criminalising and regulating abortion have been raised in countless cases the globe over. As in India, recurring questions have arisen, related to: the timing of termination, the balance of rights between parent and foetus, differing reasons to justify abortion, the overall health of the pregnant person (particularly in relation to mental trauma in cases of rape and sexual abuse), the role of medical expert testimony in a court's assessment, and the impact of foetal abnormality.

Examining the development of abortion law abroad provides examples of the most effective argumentation and best practice human rights models that could effectively address gaps in Indian abortion law. Also, it is crucial to investigate the extent of India's obligations as a State Party to many crucial human rights treaties, including the Covenant on Civil and Political Rights 1966; Covenant on Economic, Social and Cultural Rights 1966 and Convention on the Elimination of All Forms of Discrimination Against Women.

I. Abortion, the Interdependency of Human Rights and International Law

While there is no single international treaty dealing explicitly with abortion rights, existing international law does provide a legal basis to support the right to abortion. This support has allowed for the international promotion and prioritisation of pregnant persons' dignity and

autonomy. International jurists and bodies have argued that restrictions on abortion inhibit international guarantees of the rights to health, privacy, equality and protections against torture and cruel, inhuman and degrading treatment. This reinforces the interdependency of human rights. For example, the right to an adequate, accessible and quality standard of health cannot be met without also providing access to abortion in certain cases. This is the case with all rights already mentioned. As such, abortion restrictions may be challenged under international law and violations will constitute a breach that may incur consequences for State parties. This has been the case in the past and will be later explored in this chapter. First, it is vital to understand how access to abortion is woven and protected within the international human rights framework, particularly as this protection depends on other human rights and vice versa.

The right to enjoyment of the highest attainable standard of reproductive health is most obviously related to the more general right to health. This right is enshrined in several legally binding international treaties, including in Article 12 of the International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR)[1] and Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women 1979 (CEDAW).[2] The right to health was also further elaborated by the UN Committee on Economic, Social and Cultural Rights in General Comment No. 14.[3] The Comment confirmed that reproductive health is a necessary component of the right to health and the Committee also recommended that national strategies to decrease discrimination against women should involve developing policies to "provide access to a full range of high quality and affordable health care, including sexual and reproductive services".[4]

It is also linked with the right to privacy, for the right to access abortion simultaneously involves the right not to have a pregnant person's privacy concerning the state of their reproductive health or their family interfered with. The human right to privacy is upheld in Article 17 of the International Covenant on Civil and Political Rights 1966 (ICCPR).[5] Of course, the right to abortion also involves the right to equality and non-discrimination, on the basis that all people, irrespective of sex, should receive equal access to all relevant health services in order to obtain the highest attainable standard of health. This right is entrenched in numerous binding provisions under international law, including Article 3 of the ICESCR and Articles 3 and 12 of CEDAW. Finally, the right of access to abortion is often necessitated by the physical or mental trauma a pregnant person might undergo before, during and after labour, which may be exacerbated if they are refused an abortion. Additionally, many pregnant persons seek out unsafe abortions when they are barred access and it seems obvious that with the increased risks involved with unsafe abortions, maternal mortality is likely to increase. In either of these circumstances, the

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[1]UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations.

[2]UN General Assembly, International Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations.

[3]UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, Doc E/C.12/2000/4.

[4]ibid, para. 21.

[5]UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations.

physical and mental impact of the pregnancy on the person may amount to cruel, inhuman or degrading treatment, and in some cases even torture. The right to freedom from torture and these other forms of treatment is protected under Article 7 of the ICCPR and in Articles 2 and 16 of the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment 1984 (CAT).[6]

The above rights are further supported by the soft law standards and commitments contained in the Universal Declaration of Human Rights 1948 (UDHR), in its Preamble and in Articles 5 (freedom from torture), 12 (privacy) and 25 (health). Additionally, the international commitment to ensuring reproductive rights are fulfilled was further strengthened at the 1994 International Conference on Population Development (ICPD), at which reproductive rights were recognised as human rights that should be guaranteed by international and domestic law. The Conference's Programme of Action called on states to 'strengthen their commitment to women's health by addressing unsafe abortion, to ensure access to abortion when legal and to guarantee all women quality post-abortion care'.[7] [8] This directive 'established an important entry point to address unsafe abortion and promote abortion access as a human rights imperative'.[9] The following year, 1995, the Beijing Platform for Action was drafted, in response to the Fourth World Conference on Women, which also affirmed that access to abortion fit within the human rights framework.[10] While these documents only serve as soft law standards and do not legally bind nations to adhere to them, they are significant political statements from the international community, lending weight to the need to preserve a pregnant person's autonomy and reproductive health through access to abortion.

Finally, the right to sexual and reproductive health was also categorically linked to other rights protections under international law in General Comment No. 22 from the UN Committee on Economic, Social and Cultural Rights in 2016.[11] The Committee clearly stated, 'the right to sexual and reproductive health is also indivisible from and interdependent with other human rights. It is intimately linked to civil and political rights, underpinning the physical and mental integrity of individuals and their autonomy'. In essence, the international consensus is that the right of access to abortion services empowers pregnant persons to assert their reproductive rights, which in turn allows them to realise their other human rights.

[6]UN General Assembly, International Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 10 December 1984, United Nations.

[7]Programme of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, UN Doc.A/CONF.171/13/Rev.1 (1995).

[8]Johanna B Fine et. al.,'The Role of International Human Rights Norms in the Liberalisation of Abortion Laws Globally', Health and Human Rights, 2017, vol. 19(1), Special Sections: Abortion and Human Rights Drug Control and Human Rights.

[9]ibid.

[10]Fourth World Conference on Women, 'Platform for Action', 1995, para.106 (k).

[11]UN Committee on Economic, Social and Cultural Rights, General Comment No. 22, Doc E/C.12/GC/22 (2006).

In a guiding document, the Office of the High Commissioner on Human Rights (OHCHR) produced a summary of State obligations with regard to abortion under international law:

> **'States have obligations to respect, protect and fulfil women's rights related to abortion services**
> Respect: States should remove legal provisions, which penalise women who have undergone abortion or medical practitioners who offer these services.
> Protect: States must organise their health system to ensure that women are not prevented from accessing health services by health professionals' exercise of conscientious objection. For example, where abortion is legal, if a doctor refuses to perform it, the health system must refer women to an alternative health care provider.
> Fulfil: States must take steps to ensure access to appropriate health-case services for women and "to eliminate such barriers to the provision of abortion services and that lead women to resort to unsafe abortions, including eliminating unacceptable delays in providing medical attention.'[12]

Obviously, while sovereignty places the final implementing power with national governments, the significance of recognising the indivisibility and interdependency of human rights in international law puts pressure on States to acknowledge and protect the right of access to abortion. As such, any nation that has committed itself to human rights, particularly in the form of ratification of treaties, is bound to protect this right, with necessary qualifications according to context, and integrate it appropriately into its national legislative framework.

India and its International Obligations

India is a State Party to many of these treaties and has agreed to be legally bound to their provisions and the soft law standards and guidelines already mentioned. In 1948 India voted in favour of passing the UDHR in the UN General Assembly; in 1979 India ratified both the ICCPR and ICESCR; and in 1993 India ratified CEDAW. India signed CAT in 1997, however it is yet to ratify the treaty and be legally bound by its conditions. In 2014, the Indian Ambassador to the UN reaffirmed India's commitment to fulfilling the goals of the ICPD's Programme of Action, which included 'securing and promoting' the sexual and reproductive health of people through several essential services, including 'Comprehensive Abortion Care'.[13] Under international law at least, India has committed to legally ensuring that pregnant persons are positively empowered to exercise their reproductive autonomy.[14]

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[12]Office of the High Commissioner on Human Rights, 'Information Series on Sexual and Reproductive Health and Rights: Abortion', 2015, available from: https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf.

[13]Permanent Mission of India to the United Nations, 'Statement by Ambassador Bhagwant Singh Bishnoi, Deputy Permanent Representative on the "Follow up to the Programme of Action of the International Conference on Population and Development Beyond 2014"', 69th Session of the United Nations General Assembly, 9 October 2014, available from: https://www.unfpa.org/sites/default/files/resource-pdf/india_1.pdf.

[14]Article 14, UN General Assembly, Vienna Convention on the Law of Treaties, 23 May 1969, United Nations Treaty Series, vol. 1155.

Nevertheless, considering critiques from previous chapters and the generally problematic nature of the MTP Act's provisions and implementation, it is clear that India is failing to meet its international obligations. Through the MTP Act's narrow restrictions on grounds and timing for termination, India is violating international human rights law by forcing many pregnant people to continue unwanted pregnancies or undergo unsafe abortions. Considering the weak enforcement mechanisms under international law, this may have little practical effect, however it is particularly important to situate the role of international law and practice within the Indian legal framework. Generally, the efficacy of international law depends on whether it is transformed, or integrated, into domestic law. In India, the integration of international human rights norms has and may continue to occur in different manners, both through domestic legislation and interpretation of the Constitution.

With the introduction of the Protection of Human Rights Act 1993 (PHRA), the Indian government promised that 'the rights relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the International Covenants [i.e. ICCPR and ICESCR] and enforceable by courts in India' form part of Indian human rights law. In this respect, the provisions and interpretive comments from UN treaty bodies are incorporated into Indian domestic law, to the extent that they do not conflict with existing law. Additionally, in interpreting the Constitution, courts and legislators alike have recognised that it is a living document, evolving over time as understandings of justice, liberty, equality and fraternity within a sovereign democratic republic change.[15] In this respect, Indian courts may interpret Acts, including the MTP Act, and their compliance with the Constitution and particularly the right to life in Article 21, by also considering the shifts in international human rights standards, particularly in the area of reproductive health.[16] This interpretive approach grants courts flexibility to align the MTP Act within a human rights framework, and potentially view its provisions, not as exceptions to the general criminalisation in the IPC, but rather as firm obligations the State is obliged to meet.

Considering these various sources of international obligations and the manner in which India has and could incorporate further human rights standards in its existing domestic legal system, it is undeniable that India recognises the right to exercise reproductive rights and its relation to realising the highest attainable standard of reproductive health. In turn, this also includes recognition of the right of access to abortion. However, while the right may be implicitly recognised, the difficulty lies in how to legally define the scope and entitlements the right grants. This is the task for legislators and courts, but their legislative drafting or judgments have the greatest impact on how the right is realised for pregnant persons in their day-to-day lives. The following sections will explore how other international and national judicial bodies have defined the scope of the right of access to abortion and whether their examples may similarly be followed in India.

[15]Preamble, Constitution of India.

[16]See Sandra Fredman, 'Foreign Fads or Fashions: The Role of Comparativism in Human Rights Law',International and Comparative Law Quarterly, 2015, vol. 64, p.631.

Key Cases in International Law

In practice, medical practitioners, courts and legislatures across the globe have violated national laws and international human rights protections, by frequently blocking access to abortion. Consequently, many complaints have been raised with treaty bodies, including the United Nations Human Rights Committee and the Committee on the Elimination of All Forms of Discrimination Against Women. Each of these bodies has been tasked with assessment of the right of access to abortion services and defining the exact scope of this right in individual contexts. The following key cases provide great insight into how international treaties are interpreted so as to firmly integrate the right to access to abortion into international law. The communications made to these treaty bodies addressed issues including rape, foetal abnormalities and access to safe abortion services.

KL v Peru (2005) UNHRC[17]

Facts

The author of the communication was a 17 year old girl, a legal minor, was pregnant with an anencephalic foetus. A hospital director refused to authorise an abortion procedure due to an unfounded fear that the hospital would be liable for criminal prosecution, even though domestic Peruvian law allowed for abortions when the pregnancy posed a threat to the woman's life or health. The hospital director's concern rested on the lack of clear regulations under Peruvian law in medically assessing the threshold of a 'threat to the woman's life or health'. Despite the support of a social worker, other public healthcare providers also refused to conduct the procedure. A psychiatrist also assessed KL and found that carrying a nonviable foetus to term, and which may threaten her physical safety, would, and had, caused serious harm to the mother, triggering depressive symptoms which were particularly worrying considering KL's young age. Nevertheless, KL was forced to take the pregnancy to term and delivered an anencephalic baby, who died four days after, during which KL had to breastfeed the newborn. After the death of the newborn, KL continued to suffer severe mental anguish and some physical trauma to her uterus.

Issue

Did the refusal to provide abortion services to KL, even though Peru had legally decriminalised therapeutic abortion in certain cases amount to a denial of her rights to equality, life, freedom from cruel, inhuman or degrading treatment, privacy, and any of her further rights by virtue of being a minor?

Arguments

KL argued that she had suffered discrimination in access to specific healthcare services, as a result

[17]UNHRC, CCPR/C/85/D/1153/2003, Communication No. 1153/2003.

of her sex. The State had failed to protect her by offering her alternative arrangements to facilitate a therapeutic abortion from other healthcare providers. She also argued that continuing the pregnancy constituted a threat to her right to life (Article 6) and right to freedom from cruel, inhuman and degrading treatment (Article 7). Considering the mental and physical trauma of witnessing her daughter's deformities and anticipating her short life span. It was also argued that this trauma would be exacerbated by KL's own young age. Further, her right to privacy had been interfered with as her decision to terminate the pregnancy had been arbitrarily denied, and as a minor, she deserved special protection from such State actions. Finally, she claimed that the State medical authorities' belief that her case did not amount to a therapeutic abortion as it did not necessarily involve a threat to her 'physical health', which would be authorised under law, involved a highly restrictive interpretation that failed to account for the true scope and understanding of the right to health.

UNHRC Recommendations

The author's doctor had explicitly assessed the author's condition during her pregnancy after the diagnosis of anencephaly and found that it did constitute a life-threatening risk and this finding was supported by the severe mental anguish the author later suffered. As such, the UNHRC found that the State was aware of the risk to the author's life and her special circumstances as a minor, and yet still failed to offer her with safe abortion services, despite the protection under domestic law. Therefore the UNHRC considered that this amounted to a violation of Article 7. However, it did not consider whether this violated the right to life, and in turn failed to determine what positive steps a State must take to ensure that pregnant persons do not resort to unsafe abortions. Further, considering the domestic legal protection of the decision to terminate pregnancies such as those in the case of KL, denying the service also amounted to a violation of privacy. As a consequence, Peru was ordered to provide an effective remedy, including compensation, in addition to taking steps to avoid such violations in the future.

Outcome

This case is a landmark judgment for reproductive rights. This ruling was the first time an international human rights body held a State accountable for failing to ensure access to legal abortion services. By declaring KL's treatment to be a human rights violation, this decision provides a legal tool in the fight for reproductive freedom. According to Lillian Sepulveda of the Centre for Reproductive Rights, 'this ruling establishes that it is not enough to just grant a right on paper. Where abortion is legal it is governments' duty to ensure that women have access to it'.[18] The decision confirms that abortion is a human right and adds to its legitimacy by making States accountable for the failure to meet their obligations to realise the right. Indeed, the UNHRC put its institutional weight behind the assertion that a denial of abortion leads to a violation of several well-established international and national human rights.

[18]'UN Human Rights Committee Makes Landmark Decision Establishing Women's Right to Access to Legal Abortion', Centre for Reproductive Rights, available from:https://www.reproductiverights.org/press-room/un-human-rights-committee-makes-landmark-decision-establishing-womens-right-to-access-to-.

Peru did not however implement the judgment.[19] The government offered KL a token amount of compensation, which she declined, and refused to acknowledge that her rights had been violated. In the years following the judgment, activists and rights groups brought petitions to Peru's courts, the UNHRC and other UN treaty bodies leading to further condemnation of Peru's continued denial of access to safe and legal abortion. In 2014, immediately before a CEDAW national review, the Peruvian government introduced guidelines for providing safe abortions that provided legal clarity for medical professionals and the public. However, this protocol has been scarcely implemented. The Ministry of Health has only recorded 16 therapeutic abortions since its adoption, which appears to indicate a chronic level of underreporting.[20] In 2015, ten years after the decision of the UNHRC, the government of Peru paid KL appropriate compensation in recognition of its illegitimate infringement of her rights. In response Fabian Salvioli, then head of the UNHRC, said 'when a State complies with a ruling of the Committee, it is honouring its obligations and providing hope to the rest of the victims involved in cases before the Committee. States must comply with their human rights obligations under the Covenant, because that would contribute to create fairer societies'.[21]

LMR v Argentina (2007) UNHRC[22]

Facts

VDA, the author of the communication, was the mother of LMR, who had become pregnant as a result of rape. LMR had been diagnosed as having the mental age of 8 to 10 years old and was considered as having a permanent mental impairment. Under the Argentinian Criminal Code, an exception to the general criminalisation of abortion was made for women with mental disabilities who become pregnant as the result of rape. The right to abortion for these women is protected under the Code, however it does not specify set time limits or the types of medical procedures to be conducted. Judicial authorisation for the abortion is also not required. The only requirements are a formal diagnosis of disability, consent from the victim's legal counsel and performance of the procedure by a licensed healthcare provider.

The hospital staff that first discovered LMR's pregnancy refused to conduct the abortion procedure and referred her to a public hospital and advised the family to file a police complaint concerning the rape claim. LMR attended the other hospital, which was very far from her home causing the family great expense to access services, instigated medical examinations to determine the

[19] 'K.L. v. Peru' ESCR-Net available from: https://www.escr-net.org/caselaw/2016/kl-v-peru-ccprc85d11532003-communication-no-11532003.

[20] 'Peruvian Government Gives Monetary Reparations As Part of Historic United Nations Abortion Case' Centre for Reproductive Rights available from: https://www.reproductiverights.org/press-room/peruvian-government-gives-monetary-reparations-as-part-of-historic-united-nations-abortion.

[21] Office of High Commission for Human Rights 'Peru Abortion Compensation' available from: https://www.ohchr.org/EN/NewsEvents/Pages/PeruAbortionCompensation.aspx.

[22] UNHRC, CCPR/C/101/D/1608/2007, Communication No. 1608/2007.

possibility for abortion. Before any procedure could be conducted, an injunction was issued against the hospital, barring them from proceeding with the abortion. The juvenile court judge argued that 'righting' the 'wrongful assault' with another 'wrongful assault', in other words terminating the unborn child, was unacceptable. This decision was only overturned after reaching the Supreme Court of Buenos Aires, but by this stage, the pregnancy had progressed to an advanced stage, leading other hospital authorities to refuse conducting an abortion due to its advancement. Facing significant pressure from social and religious groups, LMR was forced to obtain an illegal abortion. Throughout the litigation process, LMR and her family underwent significant mental, social and economic disadvantage.

Issue

Did the State's actions, particularly in relation to the judicial interference by issuing an injunction against an abortion, despite the legal protection of accessing abortion services in this case, constitute a violation of LMR's rights to access a safe termination through the public health system? Further, did it constitute discrimination and violate her right to privacy?

Arguments

The author's central argument rested on the State's failure to 'guarantee access to a safe abortion [as] there are sufficient grounds to maintain that if the termination had been performed in due time and form its damaging consequences could have been minimized'.[23] In essence, the State had failed to respect the right by interfering via the judiciary, failed to act to protect LMR from hospital staff's refusal to conduct the procedure and failed to fulfil the right by not facilitating access to abortion. The author argued that in LMR's case this was particularly egregious as she was poor, disabled and was the victim of a serious criminal sexual assault. The communication also referred to the UNHRC's prior concluding observations on Argentina, noting that abortion is an issue almost exclusively affecting women, which is complicated by social prejudices from the community, healthcare providers, judicial and legislative authorities. Additionally, the author complained that the lack of regulations, which would clarify the ambiguity of the Criminal Code, allowed hospitals to interpret its provisions arbitrarily and without due diligence. The complaint also highlighted that unsafe, illegal abortions have resulted in a major public health crisis in Argentina and is a direct contributor to higher levels of maternal mortality. Finally, the factual circumstances of the case amounted to a violation of the right to freedom from cruel, inhuman and degrading treatment, considering the mental trauma felt by the author, LMR and their family.

UNHRC Recommendations

Ultimately, the Committee found that as Argentina had codified the right to abortion in certain cases in its own Criminal Code, its failure to guarantee fulfilment of this right when LMR's family

[23] ibid, para. 3.1.

had explicitly requested it had been a significant factor in exacerbating the physical and mental suffering she experienced as a result of the rape. As such the UNHRC found that it amounted to a violation of Article 7 of the ICCPR. The State's failure was made more serious as it had contradicted its own law through the judicial interference in a matter that should have been confined to LMR, her guardians and her physician, which constituted a distinct violation to her right to privacy. The Committee also found that this interference increased the trauma felt by LMR due to the courts' unnecessary delays. Accordingly, VDA and LMR were granted redress, including compensation, and Argentina was ordered to take steps to avoid such violations in the future.

Outcome

This case confirmed the Committee's willingness to recognise the right to legal abortion as a human right according to the ICCPR, as had been established in *KL v Peru*. This affirmation served to bolster the growing international consensus on the right to legal abortion access and State obligations to fulfil this right, particularly when it is explicitly integrated into domestic law. It also reflected how abortion cases could be examined using the human rights based approach by considering and defining particular State obligations and the gravity of LMR's situation, as she was disabled.

Mellet v Ireland (2016) UNHRC[24]

Facts

In her twenty-first week of pregnancy, Mellet's doctor informed her that the foetus she was carrying had congenital heart defects, and after further testing it was found, a few days later, that the foetus had trisomy 18. This led to a prognosis of death in utero or shortly after birth. Under both the Irish Constitution and national law, under the Protection of Life During Pregnancy Act 2013,[25] abortion is illegal in Ireland, except in cases where the pregnant person's life is at real and substantial risk. In two consultations with a hospital doctor and midwife, Mellet was informed that her options were to either to travel to term or to 'travel'. She was not told what 'travelling' entailed and was simply referred on to an Irish family planning organisation. After meeting with their advisors, she made the decision to travel to the UK to obtain an abortion there, where on inducement she delivered a stillborn baby girl.

She returned to Ireland merely 12 hours after delivery, still feeling weak and bleeding. She could not remain longer in the UK due to personal financial restraints and the lack of financial assistance from the State or from private health insurers in Ireland. She was not allowed to take her newborn's remains with her, and only had her ashes returned to her in Ireland a few weeks later. She was not eligible for bereavement or psychological counselling on her return to address her trauma, as she had 'chosen' to terminate the pregnancy. Mellet personally felt that having the termination in Ireland

[24] UNHRC, CCPR/C/116/D/2324/2013, Communication No. 2324/2013.
[25] Act No. 35 of 2013.

and receiving direct psychological counselling there would have alleviated some of the grief and unresolved trauma she experienced.

Issue

Did the State's failure to provide her with the opportunity to access a safe abortion in Ireland, forcing the author overseas, amount to cruel, inhuman or degrading treatment under Article 7? Further, did the State's failure to provide advice regarding obtaining a legal abortion overseas and denial of bereavement counselling amount to a breach of the right to freedom of information under Article 19 of the ICCPR?

Arguments

Mellet's complaint relied on four lines of argument: a violation of her rights to freedom from cruel, inhuman and degrading treatment, privacy, freedom of information and non-discrimination. The severity of her mental anguish she suffered was based on "(a) denying her the reproductive health care and bereavement support she needed; (b) forcing her to continue carrying a dying foetus; (c) compelling her to terminate her pregnancy abroad; and (d) subjecting her to intense stigma".[26] If she had received timely and effective access to abortion services in Ireland, Mellet argued that the mental anguish suffered as a result of the termination of her pregnancy would have been greatly diminished. She was unsupported by the State and her family by having to make arrangements for an abortion abroad, she underwent a serious medical procedure in a foreign environment and the financial expense of the entire procedure was significant. Additionally, the shame of committing an illegal act, which supposedly reflected the moral condemnation of her home country, further exacerbated her trauma.

By offering Mellet two courses of action, either of which would impose great mental suffering on her, her reproductive autonomy and physical and psychological integrity was denied. It was also argued that by refusing an abortion on the moral basis of the unborn's right to life, the test of proportionality was not met under the ICCPR's right to privacy. A limitation on her choice to terminate a pregnancy that could not result in a viable child, an obvious invasion of her privacy, was not proportionate to the constitutional aim of protecting the foetus.

Mellet also argued that the right to freedom of information under Article 19 of the ICCPR, included the right to information that would assist in decision making on matters of the reproductive health of pregnant persons. Her healthcare providers did not explicitly provide such information, even that which is domestically legal to provide (likely effects of abortion, abortion services in Ireland and abroad) for fear that any such advice would be construed as promoting or advocating for abortion. Instead, they used euphemisms, which only served to increase the shame and stigma felt by the author. Mellet argued that clear regulations should give healthcare providers a clear understanding of what information may be imparted to patients.

[26]UNHRC, CCPR/C/116/D/2324/2013, Communication No. 2324/2013, para. 3.1.

Finally, Mellet argued that laws criminalising abortion were discriminatory and reinforced stereotypes that women are merely instruments for reproduction. This criminalisation denies women their moral autonomy in relation to their reproductive health. Mellet argued that this discrimination was structurally and pervasively entrenched in Irish abortion law and practice and clearly violated tenets of the ICCPR.

UNHRC Recommendations

The Committee found that although abortion could be criminalised under domestic law, it could still infringe the ICCPR and international law, particularly considering the State had subjected Mellet to "conditions of intense physical and mental suffering".[27] This suffering was compounded by multiple factors including her inability to receive medical care and health insurance (from Ireland), the choice to carry a dying foetus or travel to obtain an overseas abortion at great personal expense, the shame and stigma of committing a criminal act under Irish law, the abandonment of her baby's remains and the flat denial of crucial post-abortion care and bereavement counselling. Further, her known and trusted healthcare professionals' refusal to provide transparent advice regarding appropriate avenues for care for Mellet reflected the chilling effect on practitioners to provide any information about lawfully available abortion services in Ireland and overseas, for fear of prosecution for 'promoting' or 'advocating' for the termination of pregnancy. Considering these facts, the Committee found that there had been a violation of Article 7 and the treatment of the author was cruel, inhuman and degrading.

When considering the right to privacy, the UNHRC found that even though under the Constitution the removal of Mellet's choice was lawful, its arbitrariness and disproportionality to the legitimate aims of the ICCPR, render it a violation of the right to privacy. Because when considering the balance between the protection of the foetus and the rights of the woman, Mellet's rights were breached in the present circumstances as both the choice to terminate and continue to term with a dying foetus would cause intense suffering to her, which was unreasonable in the circumstances.

In relation to the discussion of discrimination, the Committee found that the State's protection of women who choose continue to term with a foetus with a fatal abnormality, by providing them with appropriate public healthcare and bereavement counselling, and denial of such services to Mellet, who was medically and socioeconomically disadvantaged, did not meet the needs of reasonableness, objectivity and legitimacy of purpose.[28]

In response, the UNHCR recommended that Ireland provide Mellet with adequate compensation, much needed psychological treatment and outline steps to be taken to avoid such violations in the future. The Committee went further and specified that such steps should involve legislative, and potentially constitutional change, to establish "effective, timely and accessible procedures for pregnancy termination in Ireland, and take measures to ensure that health-care providers are in a position to supply full information on safe abortion services without fearing they will be subjected to criminal sanctions".[29]

[27]ibid, para. 7.4.
[28]ibid, para. 7.11.
[29]ibid, para. 9.

Outcome

This case is ground-breaking for several reasons. First, the UNHRC explicitly recommended the amendment of statutory and constitutional provisions on the basis that criminalisation of abortion constituted a human rights violation. The Centre for Reproductive Rights remarked that this decision 'not only directs the Irish government to change its laws, it also puts governments in other countries with highly restrictive abortion laws on notice as to the human rights imperative of law reform and the international legal and policy consequences of inaction'. In response to this decision the Irish government paid Mellet €30,000 in compensation. Further, following a referendum, the Irish government removed Article 40.3.3 from the Constitution and has announced that abortion will be made free, safe, and legal.

It is difficult to assess the impact of the *Mellet* decision on the later liberalisation of abortion in Ireland. A 2015 poll conducted on behalf of Amnesty International revealed that 67% of the Irish population favoured decriminalisation of abortion, and 64% did not know that abortion was illegal. By 2017 polling found that 60% of Ireland supported the availability abortion on request, either outright or within specific gestational limits, while 89% believed a woman should have access to abortion where there is a risk to her health.[30] However, the interventions of the UN - in *Mellet v Ireland, Whelan v Ireland*[31] and the findings of the Committee Against Torture in 2017[32]- came during this time of political struggle. As a significant international institution, the Committee's condemnation strengthened national and public pressure on the need for governmental action in Ireland. The Statements of the treaty bodies received significant media attention in Ireland which highlighted the cruelty inflicted by its regressive abortion law to a national audience and forced the government to defend the status quo.[33] This kept the abortion question in the news and aided in framing the issue as one of human rights. As the referendum campaign progressed this international

[30]'Amnesty International/Red C Poll Reveals 60% Support Access to Abortion on Request' Amnesty International Ireland, available from: https://www.amnesty.ie/amnesty-internationalred-c-poll-reveals-60-support-access-abortion-request/.

[31]Whelan v. Ireland, Human Rights Committee, Communication No. 2425/2014, U.N. Doc. CCPR/C/119/D/2425/2014 (2017).

[32]Committee against Torture, 'Concluding observations on the second periodic report of Ireland', 2017, available from: https://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/IRL/INT_CAT_COC_IRL_28491_E.pdf.

[33]Elaine Edwards, 'UN says Ireland's abortion ban 'cruel, inhuman or degrading'', *The Irish Times,* 9 June 2016, available from: https://www.irishtimes.com/news/health/un-says-ireland-s-abortion-ban-cruel-inhuman-or-degrading-1.2678246 ;Sarah Bardon, 'UN will challenge Ireland further if abortion law unchanged, Oireachtas told', *The Irish Times,* 8 November 2017, available from: https://www.irishtimes.com/news/politics/un-will-challenge-ireland-further-if-abortion-law-unchanged-oireachtas-told-1.3284727; Henry McDonald, 'UN repeats criticism of Ireland's 'cruel and inhumane' abortion laws', *The Guardian*, 13 June 2017, available from: https://www.theguardian.com/world/2017/jun/13/un-denounces-ireland-abortion-laws-as-cruel-and-inhumane-again; Ellen Coyne, 'Abortion Law will be Decided by Voters, Varadkar tells UN', *The Times Ireland Edition*, 29 July 2017, available from: https://www.thetimes.co.uk/article/abortion-law-will-be-decided-by-voters-varadkar-tells-un-lvgd6vvpl; Pat Leahy, 'UN Abortion Ruling is "Not Binding", Enda Kenny says', *The Irish Times*, 15 June 2016, available from: https://www.irishtimes.com/news/politics/un-abortion-ruling-is-not-binding-enda-kenny-says-1.2684762.

support boosted the pro-choice side's claim to moral supremacy and resulted in the anti-choice side challenging the legitimacy of the United Nations' interventions and position on human rights.[34] The condemnation of the international community assisted in pointing out to ordinary people the contradictions presented by Ireland's abortion regime and helped advance a mandate for political reform.

In November 2016 the Irish Parliament constituted a Citizen's Assembly to deliberate upon the repeal of the Eighth Amendment.[35] The Assembly was composed of a chairperson, appointed by the government, and 99 individuals 'randomly selected so as to be broadly representative of Irish society' in terms of age, gender, social class, and regional spread. Over the course of five sessions members were given information on the topic, heard from 25 experts and reviewed 300 submissions from members of the public and interest groups. By the end of the deliberations, 87% of the Assembly members overwhelmingly agreed that the constitutional provision on abortion was unfit and that Article 40.3.3 should be, at least partially, removed. A majority of members recommended amending or replacing the amendment and allowing Parliament to legislate on matters relating to termination of pregnancy. The movement for abortion rights in Ireland succeeded in repealing Article 40.3.3 in May 2018. An overwhelming majority of 64% voted, through popular referendum, to repeal the Eighth Amendment and to allow the Irish parliament to legislate on the issue.

LC v Peru (2011) CEDAW[36]

Facts

LC, the daughter of the author of the communication, became pregnant after being sexually abused from the age of 13. As a result of the pregnancy and consequent severe depression, LC attempted suicide by jumping from a building. She suffered severe injuries to her back, leaving her paralysed. On being admitted to a public hospital, she was told that she required emergency surgery to reduce or cure the paraplegia. Before the scheduled surgery, LC revealed the sexual abuse to a psychologist. The surgery on her spinal cord was delayed because of this discovery. In the Peruvian Penal Code, the right to terminate a pregnancy is protected if it is "the only way to save the life of the mother or to avoid serious and permanent harm to her health",[37] and on this basis LC and her mother requested

[34]Niamh Uí Bhriain, 'Opinion: 'Sorry, UN. Ireland's abortion laws are progressive, modern and compassionate' *The Journal*, 15 August 2017, available from: http://www.thejournal.ie/readme/opinion-irelands-abortion-laws-are-progressive-modern-and-compassionate-3545529-Aug2017/; BWilliam Binchy, 'UN Committee's View on Abortion Contradicts Core Ethical Value of Human Rights', *The Irish Times*, 18 August 2014, available from: https://www.irishtimes.com/news/politics/un-committee-s-view-on-abortion-contradicts-core-ethical-value-of-human-rights-1.1899802.

[35]Michela Palese, 'The Irish abortion referendum: How a Citizens' Assembly helped to break years of political deadlock', *Electoral Reform Society*, 29 May 2018,available from: https://www.electoral-reform.org.uk/the-irish-abortion-referendum-how-a-citizens-assembly-helped-to-break-years-of-political-deadlock/.

[36]CEDAW, Communication No.CEDAW/C/50/D/22/2009, 2011.

[37]Article 119 of the Penal Code of Peru.

a termination from the medical board of the hospital. After an inexplicable delay, the medical board refused the request as they did not consider that LC's life was in danger. A report from the High-Level Commission on Reproductive Health of the Medical College of Peru supported LC's requestconsidering her young age and with the neurological lesion her physical and mental health were in serious danger of deteriorating if the pregnancy continued.

In the 17th week of pregnancy, LC miscarried spontaneously. Almost a month later, surgery for LC's spinal injuries was conducted. At this time, it was three and a half months since it was first decided that LC required 'emergency' surgery. She then only remained in the National Rehabilitation Institute for two months due to a lack of financial means to support a longer stay. As a result, she remained paralysed from the neck down and her hands were only partially mobile. She was completely reliant on her family to meet all her needs. Her brothers had to abandon school in order to support the family budget to purchase the medicines and equipment required for LC. Due to her immobility she was also unable to attend school.

At this time in Peru, access to services for a therapeutic abortion was complicated as legislation did not specify regulations on the process of consent and as such it was left to the discretion of the hospital authorities, which allowed such unjustifiable delay. Additionally, there was no effective judicial recourse for LC that would either grant consent for a therapeutic abortion or provide a sufficiently speedy remedy.

Issue

Did the hospital doctors' refusal to conduct a therapeutic abortion violated LC's rights to health, a life of dignity and equality of access to healthcare services, amount to a violation under Articles 2, 3, 5, 12 and 16 of CEDAW? Further, as a minor and a victim of sexual abuse, was the State's failure to act more serious as it had a 'double duty' to LC to protect her rights and guarantees in legislation?

Arguments

LC argued that she had been denied the possibility to walk again, due to the unjustified delay in her crucially needed surgery, and the barrier to access to the essential service of abortion and other legal medical services, which are only required by women, directly led to a deterioration in her mental state. It was argued that, as the pregnancy was a direct threat to her physical and mental health, a therapeutic abortion was appropriate and necessary and Peru was obliged to fulfil LC's right to healthcare services under Article 12 of CEDAW. Additionally, it barred her from deciding the number and spacing of her children under Article 16. The legal vacuum of provisions regulating access to abortion in Peruvian law, led to the absolute discretion of healthcare professionals' refusal to terminate, which was disproportionate and illegal. The communication also emphasised that LC's suffering was made more serious as it was on going, "shattered her life prospects",[38] and occurred when she was a minor from a family with limited economic resources.

[38]CEDAW, Communication No.CEDAW/C/50/D/22/2009, 2011, para.2.4.

CEDAW Committee Recommendations

The UNHRC found that, on the available evidence, it was "unquestionable that the surgery was necessary; that it should have been performed as early as possible".[39] Without the surgery and the continuation of the pregnancy, the likelihood of maternal mortality or morbidity dramatically increased. Consequently, the Committee found that LC had been arbitrarily denied access to a medical service, which she evidently required in the light of her physical and mental condition, due to her status as a pregnant woman in violation of CEDAW. Additionally, if Peru had legalised therapeutic abortion, it was also obliged to establish a legal and administrative framework to ensure access to medical services. This would also involve establishing a judicial framework to assess cases rapidly, taking account of the pregnant person's opinion and health and protecting the right of appeal. As a result of these violations, the Committee ordered that reparations were made to LC, including compensation for actual, future and moral damages, and that Peru specifically amend its laws to integrate regulations governing therapeutic abortions and to decriminalise abortions in the case of pregnancy resulting from rape or sexual abuse.

Outcome

LC v Peru was the CEDAW Committee's first communication in which a State was held accountable for failing to provide adequate medical services to facilitate an abortion. It determined that abortion laws and regulations must be transparent, sufficiently clear to provide healthcare providers with guidance as to the process for conducting an abortion. It also went beyond mere commentary on therapeutic abortions, but also endorsed the view that abortion should be decriminalised in cases of rape and sexual abuse, providing an additional ground for abortion, which is missing in many State Parties' legislative framework. It also recognises the primary need to take into consideration both the physical and mental health of the pregnant person and maintain their right to appeal medical professionals' initial determination.

In 2014, under pressure again from the CEDAW Committee, Peru established guidelines, in order to avoid a case such as LC's in the future. These guidelines were drafted three years after the decision in LC and on the eve of a CEDAW national review. It took the efforts of Peruvian civil society to achieve this needed reform. It is evident that a ruling by an international treaty body will not bring change overnight. Sustained national political pressure is needed to ensure compliance with and adoption of international laws and norms. Governments are ultimately accountable to the people.

IV. Abortion Law in Other National Jurisdictions

Outside the realm of international law, courts and legislatures in many nations have dealt differently with issues related to the regulation, criminalisation, protection and provision of abortion. The following section will briefly discuss the development of abortion law in other regions and countries

[39] ibid, para.8.12.

in the world and the legal, philosophical, moral or human rights-based approach each has taken to justify such development.

North America

In both the United States and Canada abortion law has been shaped by the constitutional interpretation of their respective Supreme Courts. The Canadian Court viewed abortion restrictions as unjustly interfering with the rights of women and decriminalised abortion altogether. The US Supreme Court struck a balance between competing government interests and the role of federalism.

• USA

The United States protects the right to abortion at the federal level, but specific policies are left to individual States. Under federal law, abortion must be legal without need for reason up to the point of viability (set at 20 weeks gestation). After this time, States have discretion as to their own regulation based on the interests of the pregnant person and foetus. However, any restriction on abortion must have an exception to protect the life, physical and mental health of the mother. Some individual States have imposed restrictions on abortion access by requiring female minors to receive parental consent, imposing mandatory waiting periods and forcing abortion providers to distribute anti-choice material to women seeking abortion.

The Supreme Court decisions in *Roe v Wade* and *Doe v Bolton* (1973)[40] [41] affirmed that abortion is a fundamental constitutional right. In both decisions, the Court defined the right as an aspect of the right to privacy, under the 14th Amendment's guarantee of due process. In *Roe* the court affirmed that an abortion ban would unjustifiably violate a pregnant person's right not to be pregnant or give birth, which could harm their physical and mental health. Socially, it could stigmatise them, characterising them only as 'unwed mother' or reduce their socioeconomic circumstances. In *Doe*, it was held that the need to respect the health of a pregnant person includes a medical assessment of their mental health and emotional well-being. If a medical professional determines that the woman's mental health would be better served by terminating an unwanted pregnancy, it would be unconstitutional to prevent her having an abortion. This applies to the entirety of pregnancy.

The decision in Roe led to the striking down of numerous regulations restricting abortion services, which were then viewed as illegitimate barriers designed to prevent access. Statutes requiring parental consent for minors were required to include a judicial by-pass for a child to prove that her parents should not be notified. Hospitalisation requirements, viability testing, and second physician requirements were all struck down as medical interferences designed to impede choice. In *Casey v Planned Parenthood* (1992)[42] the Supreme Court held that while the life and health of the mother must always outweigh any interest of the foetus, a regulation aimed at protecting maternal or foetal health is acceptable so long as it is not an undue burden on the right to choose. An undue burden

[40] 410 U.S. 113 (1973).
[41] ibid.
[42] 505 U.S. 833 (1992).

is defined as a substantial obstacle to abortion, as determined by a reasonableness test. Specifically, the Court upheld 'waiting periods' and 'informed consent'. Consequently an individual State may require counselling services for pregnant people seeking abortion, or implement a waiting period of between 18 hours and 3 days before having an abortion to ensure an informed decision is made.

While these landmark judgments enshrined the pregnant person's right to choose, the practical reality of State regulation often serves as a scare tactic to discourage abortions. Waiting periods result in women making two trips to the provider instead of one. Working women must take two days off work instead of one, women with children must arrange for childcare twice, and women that travel great distances for health services may have to stay overnight in an unfamiliar city.[43] Similarly, the information passed on by abortion providers to ensure 'informed consent' is often biased and uses loaded language designed to personify the foetus and make the woman feel morally culpable for committing such an act against the foetus.[44]

The peak of rights-based American jurisprudence on abortion can be found in the dissenting judgment of Justice Ginsberg in *Gonzalez v Cohart* (2003).[45] Ginsberg J declared that in order to be a full member of society, a woman must have unrestricted and unapologetic access to abortion. She found that the right to abortion is central to a woman's ability to order her life, and that people are entitled to have sex as part of their self-identification and to rely on the availability of abortions should they become pregnant. The right to have sex is part of being a full member of society and it is an imposition for the State to assert 'should you get pregnant, you must have a child'. Ginsberg J viewed it is an indignity to state that the full enjoyment of one's life should be determined by the unfortunate circumstance of an unwanted pregnancy. Unfortunately, Ginsberg J was in the minority of this decision and her judgment was merely a dissenting statement, however it reflected the most liberal interpretation of the right to reproductive autonomy.

Through *Roe* and subsequent judgments the right to abortion was established as a matter of non-interference. The right was upheld so long as states did not interfere too much, and did not restrict access too obviously. There was no requirement that States actively provide for access to abortion, which would meet the 'fulfil' criterion in a human rights framework. Nevertheless, it does reflect an interpretive approach to abortion that prioritises the rights of the pregnant persona and their decision-making in maintaining their reproductive and sexual health.

• Canada

Abortion is decriminalised inCanada and there is no legislation specifying a closed list of circumstances in which abortion is permitted. Illegal abortion is legislated for in the same manner as any other crime; an abortion without consent is assault and an abortion performed in unsuitable

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[43]Guttmacher Institute, 'Evidence You Can Use: Waiting Periods for Abortion', July 2018, available from: https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion.

[44]Rachel Benson Gold and Elizabeth Nash, 'State Abortion Counseling Policies and the Fundamental Principles of Informed Consent', Guttmacher Institute, 2007, available from: https://www.guttmacher.org/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent.

[45]550 U.S. 124 (2007).

conditions or by an unqualified provider is a violation of medical regulations. In *R v Morgentaler* (1988),[46] the Supreme Court held that the restrictive abortion provision in the Criminal Code was unconstitutional because it violated a woman's right to security of the person, under Section 7 of the Canadian Charter of Rights and Freedoms ("the Charter"). As Section 251 of the Criminal Code only permitted lawful abortion if performed at an accredited hospital and upon a determination, by a Therapeutic Abortion Committee (TAC), that the continuation of a pregnancy would cause a woman medical harm, the petitioners argued that Section 7 also protected an individual's autonomy from governmental interference.

The Court held that the effect of Section 251 is to force some women to carry a pregnancy to term irrespective of her own 'priorities and aspirations'. Further, the delay created by the mandatory certification procedure put the woman at increased risk of physical harm and caused psychological injury. Also, Dickson J found it to be a violation of fundamental justice as it prevented smaller hospitals from providing abortion services, which effectively prevented some women from applying for and accessing an abortion. Additionally, the administrative system failed to provide adequate evaluation criteria for TACs, which granted these bodies the power to grant or deny abortion services arbitrarily. Both Dickson J and Beetz J found that the aims could not justify these deficient means and it therefore failed a proportionality test.

Wilson J held that Section 251 violated the right to security of the person and the right to liberty. She emphasised that Section 251 violates a woman's personal autonomy by preventing her from making decisions affecting her and her foetus' life. A woman's decision to have an abortion is personal and profound, incorporating social and ethical considerations that are even beyond the professional understanding of a medical team. Removing such a decision from the personal sphere and handing it to a bureaucratic committee, essentially surrendering control of a woman's reproductive capacity is a fundamental violation of liberty and security of the person. Moreover, the provisions are so onerous and difficult to overcome that they prevent a woman exercising any agency at all.

• South America

Originally outlawed by colonial powers, abortion bans were imposed upon the people of Central and South America in the nineteenth century. Cuba liberalised its abortion laws under the Communist Party in 1965, becoming the first country in the Americas and Caribbean to do so. The Cuban Penal Code of 1979 outlawed abortion only where it is performed a) without the consent of the pregnant woman, or b) is unsafe, or c) is offered for profit. Under Cuba's national health system, abortion is available on request and free of charge up to the tenth week of pregnancy through Cuba's national health system.

In recent years, Central and South America has seen a number of legal reforms, court rulings, and health regulations, which have improved access to safe abortions. For example, abortion was made available on request in the first trimester of pregnancy in Mexico (2007) and Uruguay

[46][1988] 1 SCR 30.

(2012). In Argentina, Bolivia, Brazil, Colombia, and Costa Rica, higher courts have considered the constitutionality of laws banning abortion and have set down specific grounds for abortion, opening up access to many more women. However, many of these judgments have not been given statutory effect by legislatures. Further, in many of the countries where abortion is made legal, there are massive practical barriers to access safe abortions. In all, 97% of women in Latin America live in a country with restrictive abortion laws.[47]

• Colombia

Colombian law permits abortion in cases of pregnancy resulting from rape, incest, artificial insemination without consent; medically assessed risk to the pregnant person's health or life and fatal foetal abnormality. This is the result of a hard-fought campaign by abortion rights activists, which led to the *Martha Sulay Gonzalez* case.[48]

In this case, a mother of three, diagnosed with cervical cancer, was denied chemotherapy and radiotherapy as it would necessitate terminating her fourth pregnancy. While the doctors were convinced that treating the cancer, and thus terminating the pregnancy, was ethically and medically necessary, they feared criminal prosecution. They refused to conduct an abortion, and without cancer treatment Gonzalez later died after giving birth. When her case was challenged in court it was argued that the denial of an abortion amounted to a violation of her right to the free development of her personality and autonomy, which was protected under the Colombian Constitution. By interfering with a solely personal issue for women, the criminalisation was challenged as being disproportionate and discriminatory. In response, the Court found that the total ban on abortion in Colombia was a violation of Gonzalvesz' personal rights under both the Constitution and the ICCPR by implicitly characterising her only purpose as that of a child bearer.

The court continues to play an active role in guaranteeing the right to abortion in the face of widespread barriers to access. However, the certification process can be extremely onerous, judges and doctors may deny abortion due to conscientious objection. Also, in practical terms, there is inadequate access to facilities outside of Bogotá. In October 2013, the Guttmacher Institute reported that in 2008 an estimated 400,400 abortions were performed in Colombia, of which only 322 were reported as legal procedures.[49]

• Argentina

Abortion is illegal in Argentina except in cases of rape, or to save the life and health of the mother. Even for women who fall into these exceptional categories, abortion services are difficult to access. Nevertheless abortion is still a common practice. According to official statistics from the Ministry of

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[47] Guttmacher Institute 'Abortion in Latin America and the Caribbean', March 2018, available from: https://www.guttmacher.org/fact-sheet/abortion-latin-america-and-caribbean.

[48] Martha Sulay Gonzalez v Colombia (2006) Supreme Court of Colombia, C-355 of 10 May 2006.

[49] Guttmacher Institute 'Unintended Pregnancy and Induced Abortion in Colombia', October 2013, available from: https://www.guttmacher.org/fact-sheet/unintended-pregnancy-and-induced-abortion-colombia.

Health, 500,000 clandestine abortions are performed each year, in a country of 44 million people. Indeed, abortion is a leading cause of maternal mortality. Of the 245 maternal deaths in Argentina in 2016, 43 were caused by abortions.

A 2012 Supreme Court decision, citing international law, ruled that abortion is legal in cases of rape or when the person's life is threatened. Under this ruling, women would not require judicial authorisation and an affidavit would be sufficient evidence. In June 2018, the House of Deputies, the lower house of Argentina's legislature, narrowly passed a bill that would decriminalise abortion, making it free, safe, and legal up to 14 weeks. While the Senate ultimately voted down the bill, the pro-choice movement leaders considered its drafting as a temporary victory.[50]

Asia

Abortion is legally available for most women in Asia, in large part because India and China have relatively liberal abortion laws. Seventeen Asian countries allow abortion without need for justification. However issues of access continue to strip women of their reproductive rights. According to the Guttmacher Institute, in Eastern Asia, which includes China, 89% of abortions are safe, however in Southern Asia, which includes India, and Central Asia less than half of abortions are safe. This has led to 8 out of every 1,000 women of reproductive age being treated for complications from unsafe abortions in 2012. Most women who have an abortion became pregnant unintentionally. 53.8 million unintended pregnancies occur every year, 65% of which end in abortion. There is a clear and urgent need to reduce the legal and political barriers to abortion and expand health coverage to as many women as possible.[51] While the right may be recognised it is yet to be properly fulfilled and realised.

• China

Abortion is available in China for free and without restriction at any stage of pregnancy. The Chinese government introduced strict family planning with the one-child-per-couple policy in 1979. Prior to 1979 the abortion rate hovered between 4 and 5 million per year. By 1983 the abortion rate reached 14.4 million.[52] To limit population growth, the government forcefully imposed induced abortions, and punitive economic sanctions for couples with multiple children. During this time abortions were very prevalent amongst well-educated, urban women, of Han ethnic descent. A woman was far more likely to have an abortion in cases where her last child was a son, showing a clear preference for sex, exacerbated by the one-child policy. After 1994 the family planning policy was slightly relaxed

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[50]'Argentina abortion: Senate defeats bill after polarising debate' *BBC News*, 9 August 2018, available from: https://www.bbc.com/news/world-latin-america-45125687.

[51]Guttmacher Institute 'Abortion in Asia: Fact Sheet', March 2018, available from: https://www.guttmacher.org/fact-sheet/abortion-asia.

[52]'China',The Population Policy Data Bank, Department of Economic and Social Affairs of the United Nations Secretariat available from:www.un.org/esa/population/publications/abortion/doc/chinas1.doc.

and women-centred abortion emerged alongside contraceptive use as a consensual means of limiting family size.[53]

• Bangladesh

Under the Penal Code imposed by the British, abortion is illegal in Bangladesh, except where necessary to save the life of the mother. However, 'menstrual regulation' is a commonly practiced method of terminating early pregnancies through vacuum aspiration and is legal up to 10 weeks since the woman's last period. In 2012 the government legalised the use of mifeprostone and misoprostol, opening the door for medical abortion. Menstrual regulation centres are publicly run and free of charge, yet many women are barred access due to location, poverty, and social stigma. A study in the rural region of Matlab found that seeking an unsafe abortion was widespread due to a lack of affordable official providers, leading to higher maternal mortality rates. The safe and legal process of 'menstrual regulation' made up 79% of terminations in Matlab between 2000 and 2008, and the situation for women continues to improve with greater access and acceptance of abortion.[54]

Nepal

Abortion is available without restriction up to 12 weeks gestation, up to 18 weeks in cases of rape or incest, and at any time if the pregnancy poses a danger to the woman's life or physical or mental health or in the case of foetal abnormality. Since legalisation in 2002 there has been a noted decline in maternal mortality, falling from 580 deaths per 100,000 live births in 1995 to 190 in 2013. Barriers such as a lack of information about abortion services, a lack of legal certainty, a lack of transport, cost, and prevailing stereotypes and stigma continue to prevent women in Nepal obtaining safe and legal abortions. Nepal has more permissive laws than India, yet faces similar issues of access and risks associated with unsafe abortions.[55]

A major legal development regarding the right to access abortion services was made in the Supreme Court of Nepal's judgment in *Lakshmi Dhikta v Government of Nepal* (2009).[56] In this case a woman was unable to obtain an abortion as the cost at the government hospital exceeded 1000 rupees, which was more than the average monthly salary. In the Court's assessment they referred to the ICESCR and international jurisprudence on the right to health to establish whether Nepal's abortion law adhered to requirements of availability, affordability, accessibility and adequacy, without which the

[53]Cuntong Wang, 'Induced Abortion Patterns and Determinants Among Married Women in China: 1979 to 2010',*Reproductive Health Matters*, 2014, vol. 22(43), Population, Environment and Sustainable Development, pp. 159-168.

[54]Guttmacher Institute, 'In Bangladesh, Unsafe Abortion is Common Despite Availability of Safer Pregnancy Termination Procedure', September 2014, available from: https://www.guttmacher.org/news-release/2014/bangladesh-unsafe-abortion-common-despite-availability-safer-pregnancy-termination.

[55]Guttmacher Institute, 'Abortion and Unintended Pregnancy in Nepal: Fact Sheet', February 2017, available from: https://www.guttmacher.org/fact-sheet/abortion-unintended-pregnancy-in-nepal.

[56]Excerpts of the judgment have been translated into English and are available from: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20-%20English%20translation.pdf.

right could not be fulfilled. The Court found for Dhikta on the basis that the government had failed to ensure access to safe and legal abortion services for women, particularly those from poor, rural areas, who suffered from prohibitively high fees, physically inaccessible facilities and a lack of knowledge of the legality of abortion. This also amounted to discrimination as it forced poor, rural women to obtain an unsafe abortion or continue with an unwanted pregnancy. The Court additionally determined that respect for privacy necessitates that women be given a real choice over such personal matters. Further, freedom from violence means that women must not be denied autonomous reproductive decision-making, with the Court noting that 'a woman is the master of her own body'.[57]

Finally, the court ordered the replacement of the crime-and-punishment model of abortion. They found that the foetus does not constitute human life and a woman's reproductive capacity should not be used to punish her. As such, legal provisions on abortion should be removed from the sphere of criminal law. The Court directed the government to introduce a comprehensive legal framework to facilitate abortion, develop a budget to cover the cost of abortion services for poor women, ensure safeguards for women's privacy, promote access to safe services for women, and spread information about safe abortion services to health service providers and the public. The Court's orders reflected a deep understanding that the right of access to abortion, stemming from the right to life in the Constitution, required a complete overhaul to establish an effective legislative framework to promote and maintain accessibility.

Europe

Abortion is offered without restriction or prior authorisation up to a certain week of pregnancy in 22 European countries. While the time limit may differ the principle remains clear, women have the right to abortion without the need for justification.

• UK

The abortion regime in the United Kingdom (except Northern Ireland) is similar to India as abortion is illegal with certain exceptions. It is available where a doctor certifies that continuation of the pregnancy would pose a risk of harm to the woman's maternal life and physical and mental health that would outweigh the risks of an abortion. Two doctors must approve termination, also taking account of the woman's material circumstances. However, the law differs from India as first, the cut-off point in the UK is a more medically lenient 24 weeks, and second, abortion is allowed after this point where there is a risk of injury to the life or health of the mother, or where the foetus suffers from an abnormality.[58]

However, in Northern Ireland, abortion law remains highly restrictive. It is only recently, after

[57]Center for Reproductive Rights, 'Lakshmi Dhikta v. Nepal: Legal Abortion Must be Available to All Women', available from: https://www.reproductiverights.org/sites/crr.civicactions.net/files/flash/LBS_LAKSHMI%20DHIKTA_FINAL%20NOV2010.pdf.

[58]*Abortion Act*,1967(United Kingdom) Chp. 87, Section 1.

the momentum behind the liberalisation or abortion law in Ireland, that a criminal trial will serve as an opportunity to challenge the law's criminalisation. With backing from international human rights NGO, Amnesty Northern Ireland, a woman who obtained abortion pills for her pregnant teenage daughter is appealing against her criminal conviction.[59] As in *Mellet v Ireland*, without obtaining abortion pills illegally, pregnant persons are forced to travel to Britain to seek abortion services. Depending on the outcome of this case, public pressure may transform a positive legal judgment into genuine legislative reform.

- **Sweden**

In Sweden, abortion is available without restriction up until the end of the 18th week of the pregnancy. After the 18th week, a woman needs permission from the National Board of Health and Welfare to have an abortion. Permission for post-18th week abortions is usually granted in cases in which the foetus or mother is unhealthy. Abortion is further restricted at the point of viability, usually the 22nd week, except where the foetus is unlikely to survive following childbirth.[60] Out of a population of 9.98 million people, 37,000 abortions were registered in Sweden in 2017. More than 90% of these abortions were carried out within the first 12 weeks of pregnancy, with an increasing number of people undergoing the procedure at home. Abortions, like any other health service, are subsidised by the State and cost 350 – 700 SEK, equivalent to 2-4 hours of work at the average hourly wage.[61]

Russia

Russia allows abortion on demand up to 12 weeks. However abortions are permissible up to 22 weeks where the pregnancy is a result of rape, and abortion is available where medically necessary at any point in pregnancy. The Soviet Union was the first country to legalise abortion in 1920, making it available without restriction. In 1936, Stalin introduced a highly unpopular ban on abortion and imposed a tax on childless adults in order to encourage population growth. The ban was overturned following his death in 1955. In 2010, Russia had the highest number of abortions (1.2 million) per women of childbearing age (total population of 141.9 million). In 2011, the Russian Parliament introduced time limits and grounds-based restrictions. However, these grounds do not include socio-economic considerations. Additionally, mandatory waiting periods were introduced to discourage abortions. As the Russian economy and simultaneously the birth rate, continue to fall, more regressive measures will likely be introduced, to prevent women exercising autonomy over their reproductive capacity, and in turn disenfranchise marginalised communities.[62]

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[59]'Woman to challenge prosecution for getting abortion pills for her daughter', *The Irish Times*, 5 November 2018, available at: https://www.irishtimes.com/news/crime-and-law/woman-to-challenge-prosecution-for-getting-abortion-pills-for-her-daughter-1.3687430.
[60]Abortion Act of 1974 (SFS 1974:595).
[61]Note that Sweden's average hourly wage is 173.60 SEK/ Hour as of June 2018'. See 'Sweden Average Hourly Wages', *Trading Economics*, available from: https://tradingeconomics.com/sweden/wages.
[62]Amy Ferris-Rotman, 'Putin's Next Target Is Russia's Abortion Culture',*Foreign Policy*, 3 October 2017, available from: https://foreignpolicy.com/2017/10/03/putins-next-target-is-russias-abortion-culture/.

Africa

According to the Guttmacher Institute, the annual rate of abortion in Africa is 34 per 1,000 women of reproductive age (15–44).[63] This is equivalent to roughly 26 per 1,000 for married women and 36 per 1,000 for unmarried women. 93% of women of reproductive age in Africa live in countries with restrictive abortion laws. Even where abortion is legally available very few women are able to obtain a legal and safe procedure. Indeed, only 25% of abortions in Africa are estimated to be safe. This has led to 7 out of every 1,000 women of reproductive age being treated for complications caused by these procedures and resulting in 9% of all maternal deaths. The Guttmacher Institute estimates that 21.6 million unintended pregnancies occur each year, stemming largely from a lack of contraception, of which 38% end in abortion. It is estimated that liberalising abortion laws will improve the safety of abortions if accompanied by a widening of health services and spreading of information about legal abortions.[64]

South Africa

South Africa liberalised its abortion law in 1997. The current law allows for abortion on demand up to 13 weeks. Abortion is permissible after this point in cases where the woman's physical or mental health is at stake, the foetus suffers from severe mental or physical abnormalities, the pregnancy is a result of rape or incest, or the woman believes that her socio-economic conditions necessitate the termination of pregnancy. Abortion is available after 20 weeks where the foetus' life is in danger or is likely to suffer serious birth defects.[65] The liberalisation of abortion laws in South Africa led to a 91% decline in abortion-related maternal mortality between 1994 and 2001.[66]

• Nigeria

Abortion is illegal in Nigeria, and may only be performed to save a woman's life. A 2013 study revealed that only 16% of women of reproductive age (15-49) use contraception. The percentage of women wanting to control their reproduction, but who do not use contraceptives, known as the 'unmet need for contraception', is 14% for married women and 22% for unmarried women. This has led to 59 unintended pregnancies per 1,000 women of reproductive age, 56% of which are terminated.

Despite its prohibition, an estimated 1.25 million abortions occurred in 2012, equivalent to 33 abortions per 1,000 women of reproductive age. 14% of all pregnancies ended in abortion in

[63]Guttmacher Institute, 'Abortion in Africa: Fact Sheet', March 2018, available from: https://www.guttmacher.org/fact-sheet/abortion-africa.

[64]SeeLouise Finer and Johanna Fine, 'Abortion Law Around the World: Progress and Pushback' *American Journal of Public Health*, 2013, vol. 103(4), pp. 585–589 available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673257/#bib47.

[65]Choice on Termination of Pregnancy Act (Act 92 of 1996).

[66]Rees Jewkeset. al., 'The Impact of Age on the Epidemiology of Incomplete Abortions in South Africa After Legislative Change', *BJOG: An International Journal of Obstetrics and Gynaecology*, 2005, vol. 112(3), pp. 355–359.

2012. Abortion levels have increased with the number of women that delay marriage and couples that seek to limit family size. Due to its legal status many women are forced to obtain clandestine abortions, leaving them vulnerable to exploitation and health risks. According to the Guttmacher Institute "about 40% of women undergoing abortion experience complications serious enough to require medical treatment".[67]

Reflections on Foreign Jurisprudence

The state of abortion law in foreign jurisdictions provides great insight into the varying approaches and philosophies behind protecting, regulating or criminalising the practice of abortion. Several of these philosophies overlap with India's current abortion regime, however many provide a more nuanced approach, integrating rights-based judicial analysis.

In most nations, restrictions on abortion originate from discriminatory sociocultural structures favouring the patriarchal characterisation of the woman as the child bearer, the 'receptacle' for greater reproductive social purposes. In others, religious ideology has led legislatures to criminalise abortion on the basis that it constitutes a violation against divine creation. As with India, Bangladesh inherited its total ban on abortion from the British colonial era, however unlike India, its current exceptions to this ban are far narrower and a greater proportion of women resort to clandestine methods of termination. In Colombia, before the precedent set by *Gonzalez* reflected a deeply entrenched moral focus, originating from Catholic philosophy, on the 'God-given' right to the life of the unborn foetus. Additionally, in nations like Nigeria, traditional conceptions of the 'family unit' are altering as younger generations delay marriage and demand greater access to contraception. While this has not necessarily led to legislative change, the change in social trends and attitudes is bound to affect governments in years to come, as it may in India too.

Strict constitutional interpretation allowed for the wide legalisation of abortion in the US and Canada. With the existing constitutional entrenchment of civil and political rights guaranteeing the right to privacy, the right to non-interference of bodily autonomy, and by corollary, reproductive autonomy. Criminalisation evidently violates this right, and it then becomes a matter of ensuring that the right is respected by governmental non-interference. In the US, States' 'administrative' regulation of abortion access certainly affects the realisation of the right in actuality, however in theory it is decriminalised in order to recognise the individual right of the pregnant person. In Canada, this approach was taken further and stipulated the positive obligation of the government to ensure that the right was protected. Without legislation 'regulating' abortion, and the only statutory reference to abortion in terms of the crime of forced abortion, the Canadian state has symbolically protected the pregnant person's true sense of autonomy and the ability to realise the right by not restricting the conditions under which abortion may be sought. It is the most emblematic of a human rights based approach. If these approaches were to be adopted by Indian courts, it would be easy to link the right to life under Article 21 with the additional fulfilment of the right to reproductive health.

[67] Guttmacher Institute, 'Abortion in Nigeria: Fact Sheet', October 2015, available from:https://www.guttmacher.org/fact-sheet/abortion-nigeria.

The question would simply remain as to the scope of this right and the government's obligation in its fulfilment.

In several developing countries, the gradual liberalisation of abortion law was initiated by exponentially growing populations. This was certainly the case in China, and coupled with the 'one-child policy', dramatically affected the whole of society. The emphasis was not on facilitating the autonomy of the individual pregnant person, but rather on instigating change among the wider population. Legalising access to abortion was a means for the realisation of a larger policy initiative, and did not reflect human rights based frameworks for empowerment. Population control has been on India's policy agenda for a long time, and it certainly was a large factor in the establishing the MTP Act, however as has been seen, the larger implications of recognising the individual rights of the pregnant person is beginning to challenge a strict policy approach to abortion law. Other public policy concerns have also influenced governments' approach in many developing countries. This was certainly the case in South Africa, with the dramatic rise of maternal mortality rates and correlating levels of unsafe abortions. This public health crisis, which is also prevalent in India, necessitated liberalisation of abortion and shifted the focus from the question of a moral assessment to one of the larger social implications of forcing pregnant persons to seek unsafe abortions.

When States recognise the right of access to abortion services, many jurisdictions have also acknowledged that when viewed as a human right, the State has the responsibility not to interfere with this right and protect it from others' interference, but also to take positive, tangible steps to fulfil the right. The *Lakshmi Dhikta* case in Nepal illustrated the socioeconomic factors that impede impoverished pregnant people from accessing abortion services. The right requires both formal and substantive equality of access healthcare services, including to abortion providers. This judgment was a significant step toward recognising that the right to abortion, even when a statutory exception to a general criminalisation, cannot simply be theoretical. When interpreted through a human rights based lens, the government has a positive duty to provide a sufficient number of quality abortion services and information to all pregnant persons, irrespective of their economic or geographical circumstances. In India, the courts have not yet adopted this interpretive approach, however it provides a sound comparison for potential developments in India's facilitation and promotion of abortion services. This socioeconomic approach to accessing abortion is most distinctive in the Swedish system, where unrestricted abortion is available and even subsidised by the State.

VI. Conclusion

To conclude, the international human rights law framework already reveals how crucial it is to respect, protect and fulfil the right to abortion considering its interrelatedness with other fundamental rights. This framework could easily be aligned with India's system of abortion law. Numerous individual communications against States have come before the UNHRC and other treaty bodies, and their recommendations have time and time again affirmed the dire need to recognise access to abortion as a human right as it intersects with a pregnant person's rights to health, privacy, equality and freedom from torture, cruel, inhuman and degrading treatment. Another consideration with regard

to international law is that as a State Party to many of the relevant international human rights treaties, India is obliged to follow treaty bodies' precedent. Generally, this accords with treaty bodies' interpretation that the right of access to abortion constitutes a right under the umbrella of the right to live a life with dignity, which in turn reflects India's own Constitutional values.

Further, while the right has also been integrated into international jurisprudence, several national courts have also grappled with the difficulties posed by abortion cases. As has been seen, the perspectives of each jurisdiction has emphasised different legal, moral or rights-based approaches. Some provide interesting comparisons for India and others illustrate examples of best practice when integrating a fully rights-based approach into the legislative framework and as an interpretive guide for courts to implement such a framework.

In India, many of the issues dealt with on international platforms highlight how abortion could be redefined in the Indian context to better suit the changing social attitudes of abortion and the practical needs of pregnant persons. Additionally, international examples of best practice could provide an interpretive model for Indian courts to apply the MTP Act, considering tests of proportionality, legitimacy of purpose, reasonableness and objectivity when the State imposes limitations on the right. Holistically, the cases in this chapter reveal how the human rights values already enshrined in the Indian Constitution could align, integrate and conform to international law and jurisprudence.

CHAPTER FIVE

Interview with Petitioners

VAIDEHI BHANDARI (THE PETITIONER)

The Petitioner was 22 weeks pregnant. The Court referred the matter to a Board of JJ Hospital. The Board after clinical examination and investigations concluded that the foetus shows complex and multiple abnormalities. It noted that the baby if born alive will require multiple surgeries with high morbidity and mortality. The Court granted permission for termination in October, 2018.

The interview of the same is as follows :

1. Did you know that safe, legal abortion services are available? If so, where did you receive this information?	Yes, I came to know about these services from the doctor of the Government Hospital
2. Which week of the pregnancy did you discover that you were pregnant? How did you discover your pregnancy?	we discovered it in the 2nd month of my pregnancy through medical examination by the doctor
3. Why did you decide to get an abortion? How did you feel about accessing abortion services in your community? Did you have any worries or concerns?	Abortiowas suggested by doctor who confirmed the abnormalities in the baby . Yes , due to delayed diagnosis and carelessness of govt. hospital doctor it became a matter of concern . The Doctor behaved negligently by not paying any heed to the problem thus my pregnancy crossed 20 weeks when we came to know about the complications or else we would have undergone the procedure much earlier

4. Were you offered any counseling before deciding to seek an abortion?	No we never received any counseling Abortion was directly suggested by doctor without any sort of counseling
5. Do you think individual/group counseling should be mandatory for a woman seeking an abortion?	Yes , It should be mandatory so as to ensure clarity of thought while undergoing the procedure
6. Do you or did you use any method of contraception? Which method do you think is the most suitable and easiest to access?	No we never used any method of contraception
7. Once you decided to seek abortion services, were the services reading available at the nearest government hospital/ PHC?	No , they were not available ,They did my sonography and after doing the same suggested me to abort .
8. If the services were not available, did the hospital/ doctor give you a positive referral to avail abortion services?	No , The doctor only suggested me to abort he never referred me to any other doctor even after a raised this concern before him . We had to find out the doctor ourselves as the government hospital doctor shut us out.
9. Did your doctor ask for consent from a parent, husband or guardian to complete an abortion procedure?	Yes, consent was given by my husband
10, Were you aware of the procedure for accessing an abortion under the Medical Termination of Pregnancy Act 1971 (MTP Act)? What do you think the law requires a pregnant woman and her doctor to do?	No, I was not clear about any such procedure . This was referred to us by the second doctor (private hospital)
11. How did you come to know about the MTP Act? Did you seek legal help? Why and who from?	From lawyer ,yes, from Ms. Meenaz because pregnancy had crossed 20 weeks and the abortion couldn't be done without involvement of Court
12. Did your doctor tell you that you had the option to have your information confidential?	Yes, the doctor of the private hospital told us so

13. Did you have any ultra-sonographies done while you were pregnant? Were you informed of any abnormalities found in these and other medical tests? What did your doctor/gynecologist advise you if/ when an abnormality was found?	Yes , earlier I had 2 sonographies in the government hospital where the doctor came to know about such abnormalities in the fetus at the very first instance even then ignored the same and told us about it after the second sonography and becaue of this there was a delay in deciding about going for abortion Yes , the doctor of the private hospital conducted the further Anomaly scan Doctor advised to abort
14. What was your experience with the Medical Board? Did you feel comfortable with the questions asked?	my experience with the Medical Board was good .Earlier I was hesitant but later I was comfortable
15. How was your experience in Court? Was your case rejected, and if so, were you told/ understood why?	No , my case was not rejected
16. If your case was admitted, what were you told about the role of the Medical Board examination they conducted at hospital?	I was told that the Board would conduct the medical examination again and access the report of the same to reach to a final conclusion which would decide the fate of my pregnancy
17. Was it important for you to have the court make a decision quickly? How quick was the whole court proceeding?	Yes, it was really important for me to have the decision quickly as the pregnancy had already crossed the 20 week period and may complicate further if not acted upon soon and complying to the same the Court also did not take much time and gave the order in 2-3 weeks
18. Do you feel that the Court and the law in the MTP Act treated you fairly in your case?	Yes, it treated m fairly
19. After your experience in court, how have your family, community and others reacted?	They all accepted the decision

20. Do you think it is important for the Court and the Medical Board to consider the best interests of the pregnant woman, which includes other social, economic factors, not just medical tests?	Yes it is very important for the court to consider both financial and medical interest of the pregnant woman.
21. Are there any services that would be/would have been helpful to you after receiving orders from the Court e.g. counseling?	Yes , some counseling would have helped me know the present condition of the fetus
22. Has late abortion had any negative impact on any future pregnancy or delivery you have had? Has it impacted the health of the fetus?	No , I have not experienced any negative effects up till now
23. Did the Court, lawyers or doctors advise what treatment was available to treat the abnormality or the medical risks involved in an abortion procedure? Did you feel you had enough information from these individuals to make the decision to terminate the pregnancy? Were other people in your family or community pressuring you to decide to abort or continue the pregnancy?	Yes I was informed by the doctor of the Private hospital that the baby did not have a stomach and many other such disabilities in the baby which would need a lot of medical surgeries. Thus we,after these insights . decided to have an abortion No one pressurized me to undergo or not to undergo abortion . My husband was standing in my support
24. Do you have any suggestions for anyone seeking support to access safe abortion services ?	Do have regular checkups in hospitals with senior doctors . Prefer hospitals which are government and reputed

BEENU YADAV

The foetus of the Petitioner was at a gestational age corresponding to 25 weeks. The foetus was found to be suffering from serious neurological skeletal abnormalities - hydrocephalus and lumbosacral spinal defects. Accordingly the court referred the matter to JJ Hospital for its medical opinion.

The Board of JJ Hospital noted that the condition of the foetus was very serious with high mortality and morbidity. The court accordingly granted permission.

The interview of the petitioner is as follows:

1. Did you know that safe, legal abortion services are available? If so, where did you receive this information?	No, I did not have any information about such services
2. Which week of the pregnancy did you discover that you were pregnant? How did you discover your pregnancy?	I discovered my pregnancy in the 3rd week through pregnancy test
3. Why did you decide to get an abortion? How did you feel about accessing abortion services in your community? Did you have any worries or concerns?	I decided to get an abortion when I was informed by the doctor about the neurological abnormalities in the fetus . Earlier I went to the nearest government hospital where the doctor firstly ignored my reports and asked me to continue the pregnancy . It was only when due to an extreme pain I visited another doctor that I came to know about these problems with the fetus.
4. Were you offered any counseling before deciding to seek an abortion?	Yes , I was told about abortion and its consequences by the doctor of Nana Hospital not the one where I went at the first instance
5. Do you think individual/group counseling should be mandatory for a woman seeking an abortion?	Yes, I think it should be mandatory so the women involved can take a rational decision
6. Do you or did you use any method of contraception? Which method do you think is the most suitable and easiest to access?	No ,we never used any method of contraception

7. Once you decided to seek abortion services, were the services reading available at the nearest government hospital/ PHC?	No, the services were not available in the nearest hospital and the doctor did not even refer me to another doctor or hospital
8. If the services were not available, did the hospital/ doctor give you a positive referral to avail abortion services?	No, the doctor did not give me a positive referral.
9. Did your doctor ask for consent from a parent, husband or guardian to complete an abortion procedure?	Yes, the Doctor asked for the consent from my husband and family
10. Were you aware of the procedure for accessing an abortion under the Medical Termination of Pregnancy Act 1971 (MTP Act)? What do you think the law requires a pregnant woman and her doctor to do?	No, I was not aware of any such procedure .I was sent to Ms. Meenaz for legal help to whom I gave information regarding all the pat events
11. How did you come to know about the MTP Act? Did you seek legal help? Why and who from?	No , I didn't knoew about such act but the same was told to me by my lawyer and my doctor, I seeked legal help from Ms. Meenaz
12. Did your doctor tell you that you had the option to have your information confidential?	Yes, The doctor told me so
13. Did you have any ultra-sonographies done while you were pregnant? Were you informed of any abnormalities found in these and other medical tests? What did your doctor/gynecologist advise you if/ when an abnormality was found?	Yes, I had two sonographies in the government hospital in my 2nd and 3rd month of pregnancy but the doctor claimed everything to be normal due to her uninterested nature and careless attitude. Later in the 5th month the abnormality became prominent and we were informed of the same but at the same time discouraged to have an abortion. Soon after experiencing extreme pain I referred another doctor who advised us to undergo abortion but til that time the 20 week duration had passed and thus we decided to go for a legal way out.

14. What was your experience with the Medical Board? Did you feel comfortable with the questions asked?	my experience with the medical board was good . I was comfortable while answering them
15. How was your experience in Court? Was your case rejected, and if so, were you told/ understood why?	My experience with the court was nice , the court gave the decision within a month
16. If your case was admitted, what were you told about the role of the Medical Board examination they conducted at hospital?	we were asked to answer all the questions asked by the board as they shall conduct the medical examination again and access the report of the same
17. Was it important for you to have the court make a decision quickly? How quick was the whole court proceeding?	Yes it was important for the court to make the decision quickly because my health was deteriorating day by day and so was the fetus', The court proceeding took around a month
18. Do you feel that the Court and the law in the MTP Act treated you fairly in your case?	Yes, it treated me Fairly
19. After your experience in court, how have your family, community and others reacted?	earlier they resented but later everything turned out to be smooth
20. Do you think it is important for the Court and the Medical Board to consider the best interests of the pregnant woman, which includes other social, economic factors, not just medical tests?	Yes, it is very important for the board to consider the best interest of the pregnant woman with respect to her financial status , social background and medical condition.
21. Are there any services that would be/would have been helpful to you after receiving orders from the Court e.g. counseling?	No ,I did not feel the need of any such services after the order passed by the court
22. Has late abortion had any negative impact on any future pregnancy or delivery you have had? Has it impacted the health of the fetus?	late abortion did not have any negative impact after the abortion but I haven't had any pregnancy after this thus i don't have any idea if it would result then

23. Did the Court, lawyers or doctors advise what treatment was available to treat the abnormality or the medical risks involved in an abortion procedure? Did you feel you had enough information from these individuals to make the decision to terminate the pregnancy? Were other people in your family or community pressuring you to decide to abort or continue the pregnancy?	Yes , it was after I visited the other doctor that I came to know about the ground realities about the abnormalities in the baby . Yes , after the doctor informed me about the complete scenario I felt equipped to take the right decision Yes the doctor to whom I went till the 5th week pressurized me to not abort the child
24. Do you have any suggestions for anyone seeking support to access safe abortion services ?	Donot go to careless doctors or unauthorized clinics and hospitals ,like medical college s or reputed government hospitals

SONALI KIRAN GAIKWAD

The medical report was that if the pregnancy of the petitioner were to be terminated at that stage it was not going to be more hazardous than spontaneous delivery at term. On the contrary, continuing pregnancy would have caused more mental anguish to the petitioner. Having regard to the report and the law laid down by this Court in various judgments, the prayer made in the writ petition was allowed to the extent the petitioner be free to undergo medical termination of her pregnancy. The interview of the petitioner is as follows:

1. Were you offered any counseling before deciding to seek an abortion?	Yes, the doctor provide us conseling for the same. She told us about what effects it could have and further impact sthat it may have
2. Do you think individual/group counseling should be mandatory for a woman seeking an abortion?	Yes, it is important as one needs to be sure before making any decision
3. Do you or did you use any method of contraception? Which method do you think is the most suitable and easiest to access?	No, we have never used any method of contraception
4. Once you decided to seek abortion services, were the services reading available at the nearest government hospital/ PHC?	No, the abortion services were not available in the nearest hospital but the doctor referred me to another hospital where such services were available.
5. If the services were not available, did the hospital/ doctor give you a positive referral to avail abortion services?	Yes , the hospital doctor was very helpful. He did all the paper work and talked to the other doctor too regarding my case.
6. Did your doctor ask for consent from a parent, husband or guardian to complete an abortion procedure?	Yes, when the procedure was done in the hospital (as per Court Order) the doctor asked for the consent of my husband
7. Were you aware of the procedure for accessing an abortion under the Medical Termination of Pregnancy Act 1971 (MTP Act)? What do you think the law requires a pregnant woman and her doctor to do?	No, I was not aware of anything like this but later I came to know from the doctor

8. How did you come to know about the MTP Act? Did you seek legal help? Why and who from?	Through the Doctor, I seeked legal help from Ms. Sneha Banerjee who handled everything free of cost.
9. Did your doctor tell you that you had the option to have your information confidential?	Yes, The doctor told us about the confidentiality clause
10. Did you have any ultra-sonographies done while you were pregnant? Were you informed of any abnormalities found in these and other medical tests? What did your doctor/gynecologist advise you if/when an abnormality was found?	Yes, an ultra-sonography was done by the government hospital doctor once a nd then when he found abnormalities in the fetus I was referred to a more experienced doctor in another hospital and there I underwent 2 ultra-sonographies and the anomaly scan. After looking into the condition of the fetus the doctor advised us to undergo abortion and also asked us to take legal help from Ms. Sneha.
11. What was your experience with the Medical Board? Did you feel comfortable with the questions asked?	Very good, the board asked my husband certain questions and he answered all those and all the tests were conducted again that too twice to ensure the outcome.
12. How was your experience in Court? Was your case rejected, and if so, were you told/understood why?	It was not bad but there was a delay in the proceedings of the case which lasted for 2-3 months . no, my case was accepted by the court at the first instance
13. If your case was admitted, what were you told about the role of the Medical Board examination they conducted at hospital?	I was told by the doctor that they shall conduct the medical examination again and analyase the reports
14. Was it important for you to have the court make a decision quickly? How quick was the whole court proceeding?	Yes, it was delayed and took 2-3 months to complete because of many non – working days in between
15. Do you feel that the Court and the law in the MTP Act treated you fairly in your case?	Yes, the court treated me fairly even when there was a delay

16. After your experience in court, how have your family, community and others reacted?	Everyone in my family was very supportive. They helped me to get out of the trauma after my abortion.
17. Do you think it is important for the Court and the Medical Board to consider the best interests of the pregnant woman, which includes other social, economic factors, not just medical tests?	Yes, it is very important for the court to consider the situation of the pregnant woman so as to give the decision which is best for her.
18. Are there any services that would be/would have been helpful to you after receiving orders from the Court e.g. counseling?	Yes, I was counseled by the doctor of JJ Hospital where my abortion was going to take place.
19. Has late abortion had any negative impact on any future pregnancy or delivery you have had? Has it impacted the health of the fetus?	No It has not led to any negative impacts since then.
20. Did the Court, lawyers or doctors advise what treatment was available to treat the abnormality or the medical risks involved in an abortion procedure? Did you feel you had enough information from these individuals to make the decision to terminate the pregnancy? Were other people in your family or community pressuring you to decide to abort or continue the pregnancy?	Yes, The doctors told me everything about the fetus and also the consequences if the child is born or aborted . after all that she told me I discussed with my family and they agreed upon getting an abortion. The other people in the community raised questions but I came over that due to my families support
21. Do you have any suggestions for anyone seeking support to access safe abortion services ?	Be more careful and consult more than one doctor.
22. Has late abortion had any negative impact on any future pregnancy or delivery you have had? Has it impacted the health of the fetus?	No It has not led to any negative impacts since then.

23. Did the Court, lawyers or doctors advise what treatment was available to treat the abnormality or the medical risks involved in an abortion procedure? Did you feel you had enough information from these individuals to make the decision to terminate the pregnancy? Were other people in your family or community pressuring you to decide to abort or continue the pregnancy?	Yes, The doctors told me everything about the fetus and also the consequences if the child is born or aborted. After all that she told me I discussed with my family and they agreed upon getting an abortion. The other people in the community raised questions but I came over that due to my families support
24. Do you have any suggestions for anyone seeking support to access safe abortion services ?	Be more careful and consult more than one doctor.

NISHA ALAM

The medical report was that if the pregnancy of the petitioner were to be terminated at that stage it was not going to be more hazardous than spontaneous delivery at term. On the contrary, continuing pregnancy would have caused more mental anguish to the petitioner. Having regard to the report and the law laid down by this Court in various judgments the prayer made in the writ petition was allowed to the extent the petitioner be free to undergo medical termination of her pregnancy.

1. Did you know that safe, legal abortion services are available? If so, where did you receive this information?	No, I did not know.
2. Which week of the pregnancy did you discover that you were pregnant? How did you discover your pregnancy?	In the 3rd month, I was having problems due to which the doctor gave a checkup date and finally my pregnancy was confirmed in the fourth month,
3. Why did you decide to get an abortion? How did you feel about accessing abortion services in your community? Did you have any worries or concerns?	I found out that the child, if born, would face many health problems, would not even be able to walk or sit. I was also at danger. Therefore, I decided to abort. Accessing abortion services was relatively easier for me as my husband supported it but there were some conservative elements in the family such as mother-in-law who were not completely okay with it. I was worried about any side-effects which might result out of the abortion, I was also concerned about the child-what if it turned out fine after all? Maybe we are giving up too early?
4. Were you offered any counseling before deciding to seek an abortion?	A homeopathic doctor living nearby counseled me against getting an abortion.
5. Do you think individual/group counseling should be mandatory for a woman seeking an abortion?	Yes, many women fear getting an abortion therefore counseling would be helpful

6. Do you or did you use any method of contraception? Which method do you think is the most suitable and easiest to access?	No, we never used contraception.
7. Once you decided to seek abortion services, were the services reading available at the nearest government hospital/ PHC?	Yes, proper services were indeed available.
8. If the services were not available, did the hospital/ doctor give you a positive referral to avail abortion services?	-
9. Did your doctor ask for consent from a parent, husband or guardian to complete an abortion procedure?	No, I went with my brother and the doctor never asked for the husband's consent.
10. Were you aware of the procedure for accessing an abortion under the Medical Termination of Pregnancy Act 1971 (MTP Act)? What do you think the law requires a pregnant woman and her doctor to do?	No, I had no idea about the procedure
11. How did you come to know about the MTP Act? Did you seek legal help? Why and who from?	There was this doctor-cum-lawyer who recommended us to approach Nanavati hospital, where we were recommended to approach Sneha Mukherjee ma'am from the HRLN.
12. Did your doctor tell you that you had the option to have your information confidential?	Yes, my doctor informed me and assured me of confidentiality.
13. Did you have any ultrasonographies done while you were pregnant? Were you informed of any abnormalities found in these and other medical tests? What did your doctor/gynecologist advise you if/ when an abnormality was found?	Yes. The doctor advised me to approach a lawyer for an abortion.
14. What was your experience with the Medical Board? Did you feel comfortable with the questions asked?	My experience with the Medical Board was okay. I was comfortable with the questions as I had been briefed by the doctors before.

15. How was your experience in Court? Was your case rejected, and if so, were you told/ understood why?	I did not personally go to the court, it was my brother handling it.
16. If your case was admitted, what were you told about the role of the Medical Board examination they conducted at hospital?	I was told by the doctor that the medical board was going to ask some questions, on the basis of which I may be asked to either terminate the pregnancy or keep it.
17. Was it important for you to have the court make a decision quickly? How quick was the whole court proceeding?	Yes, it was very important for me that the court makes a decision quickly. However, there was a delay of around two months. There was a time when the judge himself was not available. The proceedings were very slow.
18. Do you feel that the Court and the law in the MTP Act treated you fairly in your case?	Yes, they did treat me fairly eventually but they were very slow.
19. After your experience in court, how have your family, community and others reacted?	They were happy.
20. Do you think it is important for the Court and the Medical Board to consider the best interests of the pregnant woman, which includes other social, economic factors, not just medical tests?	Yes, definitely. The burden, both financial and social, is much higher for a disadvantaged person and the courts should be cognizant of it.
21. Are there any services that would be/would have been helpful to you after receiving orders from the Court e.g. counseling?	Yes, it is the depression which is the toughest to deal with. Therefore, I feel that there should be some counseling which is done, not just for the woman but the close family members too, who are equally affected.
22. Has late abortion had any negative impact on any future pregnancy or delivery you have had? Has it impacted the health of the fetus?	No

23. Did the Court, lawyers or doctors advise what treatment was available to treat the abnormality or the medical risks involved in an abortion procedure? Did you feel you had enough information from these individuals to make the decision to terminate the pregnancy? Were other people in your family or community pressuring you to decide to abort or continue the pregnancy?	Yes, the lawyers and doctors advised us. However, there was still a concern for the side effects and the possibility of the child being treated. But that being said, I still feel that I had enough information, considering that the child would face immense health problems on being brought to this world. Yes, there were indeed some people in the family who were pressuring me against the abortion and telling me to continue with the pregnancy,
24. Do you have any suggestions for anyone seeking support to access safe abortion services?	Be quick, go according to law, complete all the ultrasonographies and doctor visits swiftly
25. Any suggestions otherwise?	I feel that there should be an extra judge who is there just to quickly deal with these cases. Or if not this, there should be some institutional mechanism in place to ensure that cases are dealt with speedily. Three months in toto went in this episode. Every day was extremely depressing for me.

SARMISHTHA CHAKRABORTY

The report of the Medical Board, which produced in entirety, clearly reveals that the mother shall suffer mental injury if the pregnancy is continued and there will be multiple problems if the child is born alive. That apart, the Medical Board had categorically arrived at a conclusion that in a special case of this nature, the pregnancy be allowed to be terminated after 20 weeks.. The case at hand, as was found by the court, unless the pregnancy was allowed to be terminated, the life of the mother as well as that of the baby to be born would have been in great danger and thus the court gave an order in favour of the the medical termination of pregnancy .

The interview of the petitioner's husband (2nd petitioner) is as follows:

1. Did you know that safe, legal abortion services are available? If so, where did you receive this information?	Yes, got to know from doctors in the family
2. Which week of the pregnancy did you discover that you were pregnant? How did you discover your pregnancy?	1st week only. We were planning for the pregnancy so we were looking forward to it and were checking up on it.
2. Why did you decide to get an abortion? How did you feel about accessing abortion services in your community? Did you have any worries or concerns?	The child was sure to be unable to lead a normal life, multiple open heart surgeries would have needed to be performed with no surety of success. Therefore, me and my wife were clear on aborting. No, I did not have any worries as I was advised well and completely beforehand.
4. Were you offered any counseling before deciding to seek an abortion?	I was counseled by the doctors in the family as well as the doctor who we approached. Both were unequivocal about the abortion.
5. Do you think individual/group counseling should be mandatory for a woman seeking an abortion?	There should be some counseling, sure.

6. Do you or did you use any method of contraception? Which method do you think is the most suitable and easiest to access?	We use contraceptives. Condoms are the most suitable and easiest to access.
7. Once you decided to seek abortion services, were the services reading available at the nearest government hospital/ PHC?	Yes, the services were available but the conditions at the hospital were not that good. It was very dirty and shabby.
8. If the services were not available, did the hospital/ doctor give you a positive referral to avail abortion services?	-
9. Did your doctor ask for consent from a parent, husband or guardian to complete an abortion procedure?	The whole family went with the wife, therefore the question of this didn't arise.
10. Were you aware of the procedure for accessing an abortion under the Medical Termination of Pregnancy Act 1971 (MTP Act)? What do you think the law requires a pregnant woman and her doctor to do?	Yes, we were aware of the broad procedure under the MTP Act, even if not all technicalities. Under 20 months, abortion could be allowed under certain scenarios, above 20, it would not be allowed unless there are special and compelling reasons.
11. How did you come to know about the MTP Act? Did you seek legal help? Why and who from?	Our doctor Bhaskar Pal informed us regarding this and then subsequently put us in touch with Dr. Nikhil Datar, who referred us to HRLN.
12. Did your doctor tell you that you had the option to have your information confidential?	Yes
13. Did you have any ultrasonographies done while you were pregnant? Were you informed of any abnormalities found in these and other medical tests? What did your doctor/gynecologist advise you if/ when an abnormality was found?	Yes, we got the ultrasonographies done properly. Once the abnormality was sound, the doctor advised us to get a legal counsel as it had been twenty two weeks of pregnancy. He told us that we should get a favourable outcome, looking at the facts of the case.

Question	Response
14. What was your experience with the Medical Board? Did you feel comfortable with the questions asked?	It was a good experience. We were comfortable with the questions.
15. How was your experience in Court? Was your case rejected, and if so, were you told/ understood why?	It was an ok-ok experience. It's the aftermath of the case which was really painful because of the media being at my tails.
16. If your case was admitted, what were you told about the role of the Medical Board examination they conducted at hospital?	We were informed well regarding the role of the Medical Board examination. I had even met the Chairman of Board before.
17. Was it important for you to have the court make a decision quickly? How quick was the whole court proceeding?	Yes, it was very important for the court to reach a decision quickly. However, there was a painful delay. Abortion happened after 26 weeks. We were sitting at home for days on end, completely helpless. There was even a vacation in the court in between, which delayed matters further.
18. Do you feel that the Court and the law in the MTP Act treated you fairly in your case?	Yes
19. After your experience in court, how have your family, community and others reacted?	Family reacted positively. However, it is the reaction of the media which was the biggest problem for me. They hounded me for days on end, pestering me for photos and comments during an extremely trying period. They kept on making live footages as if we were just an object of entertainment.
20. Do you think it is important for the Court and the Medical Board to consider the best interests of the pregnant woman, which includes other social, economic factors, not just medical tests?	Yes, I feel there should be more empathy. The system should not be so technocratic that it fails to keep in mind the mental stress one undergoes as a result of these other social and economic factors.

21. Are there any services that would be/would have been helpful to you after receiving orders from the Court e.g. counseling?	Yes, absolutely. Counseling would have proven to be a boon.
22. Has late abortion had any negative impact on any future pregnancy or delivery you have had? Has it impacted the health of the fetus?	No. There is only the mental stress that we got, there was no physical consequence that renders my wife incapable to bear babies.
23. Did the Court, lawyers or doctors advise what treatment was available to treat the abnormality or the medical risks involved in an abortion procedure? Did you feel you had enough information from these individuals to make the decision to terminate the pregnancy? Were other people in your family or community pressuring you to decide to abort or continue the pregnancy?	Yes, we were advised well. I also think that the information given by them was sufficient for us to reach the decision of abortion. No, our family was supportive, and no one except the near family was informed about it.
24. Do you have any suggestions for anyone seeking support to access safe abortion services?	Do all the tests, trust your doctor and lawyer
25. Any suggestions otherwise?	Something must be done regarding the delay in procedure and the mental stress that the parents go through. More empathy should be infused in the system.

SONALI SANDEEP JADHAV

The Medical Board is of the view that it is a case for termination of pregnancy, as a special case.The Board has mentioned that the patient is at the threat of severe mental injury, if the pregnancy is continued. It has also opined that the child, if born alive, needs complex cardiac corrective surgery stage by stage after birth. But there is high mortality and morbidity at every step of this staged surgery. Thus considering the condition the court allowed the medical termination of pregnancy . The interview of Sandeep Jadhav (2nd petitioner) is as follows:

1. Did you know that safe, legal abortion services are available? If so, where did you receive this information?	No
2. Which week of the pregnancy did you discover that you were pregnant? How did you discover your pregnancy?	4th week. Pregnancy was discovered at a checkup at the doctor.
3. Why did you decide to get an abortion? How did you feel about accessing abortion services in your community? Did you have any worries or concerns?	The child, if born, would not have lived for long. Multiple problems would have to be dealt with, such as an enlarged head and multiple operations on the brain, with slim chances of any results. It would have been a lifetime of pain and struggle. There were no concerns as I was fortunate enough to be advised well.
4. Were you offered any counseling before deciding to seek an abortion?	I wasn't offered any counseling at the government hospital but at the private hospital I had to go to subsequently, I did.
5. Do you think individual/group counseling should be mandatory for a woman seeking an abortion?	-
6. Do you or did you use any method of contraception? Which method do you think is the most suitable and easiest to access?	No, we don't use contraceptives
7. Once you decided to seek abortion services, were the services reading available at the nearest government hospital/ PHC?	Yes, the services were available
8. If the services were not available, did the hospital/ doctor give you a positive referral to avail abortion services?	-

9. Did your doctor ask for consent from a parent, husband or guardian to complete an abortion procedure?	-
10. Were you aware of the procedure for accessing an abortion under the Medical Termination of Pregnancy Act 1971 (MTP Act)? What do you think the law requires a pregnant woman and her doctor to do?	No, it was only the private hospital which made us aware of all this.
11. How did you come to know about the MTP Act? Did you seek legal help? Why and who from?	The government hospital we initially went to, not only gave us vague sonographic reports but also failed to equip us with the understanding of the process. On being advised by my employer, we went to a private hospital who, on the basis of the reports and the time elapsed since pregnancy, recommended us to approach Dr. Nikhil Datar who put us in touch with Advocate Sneha Mukherjee.
12. Did your doctor tell you that you had the option to have your information confidential?	-
13. Did you have any ultrasonographies done while you were pregnant? Were you informed of any abnormalities found in these and other medical tests? What did your doctor/gynecologist advise you if/ when an abnormality was found?	We were having ultrasonographies done at a government hospital. However they were very lax with our issue and failed to apprise us of our problems well. It seemed that they were hiding some critical information from us. Furthermore, the hospital officials were also extremely rude in their behaviour, with the doctor shouting at us. Therefore, being disillusioned with their conduct, we went to a private hospital with financial help from my employer Anuja ma'm. The private hospital conducted the ultrasonographies well and found out a huge problem, an abnormality so serious that we had to abort. On finding it, they immediately referred me to Dr. Datar.
14. What was your experience with the Medical Board? Did you feel comfortable with the questions asked?	It was a good experience. My wife was a little nervous but the board were still very patient.

15. How was your experience in Court? Was your case rejected, and if so, were you told/ understood why?	It was a good experience.
16. If your case was admitted, what were you told about the role of the Medical Board examination they conducted at hospital?	We were informed that the Board will submit a report to the court and that we had to cooperate and tell them truthfully what we know in order to ensure that we get a favourable order.
17. Was it important for you to have the court make a decision quickly? How quick was the whole court proceeding?	Yes, it was important for the court to reach a decision quickly. I was fortunate enough to have my matter settled in a month.
18. Do you feel that the Court and the law in the MTP Act treated you fairly in your case?	Yes.
19. After your experience in court, how have your family, community and others reacted?	Initially, my family and community were against me taking this long and tedious legal route but after some convincing by Anuja ma'am and her husband, they warmed up to the idea. After the verdict, they were very elated and surprised, and came out with renewed faith in the legal system.
20. Do you think it is important for the Court and the Medical Board to consider the best interests of the pregnant woman, which includes other social, economic factors, not just medical tests?	Yes, the economic condition needs to be kept in mind. Where will a poor man go with a child with serious health problems?
21. Are there any services that would be/would have been helpful to you after receiving orders from the Court e.g. counseling?	No.
22. Has late abortion had any negative impact on any future pregnancy or delivery you have had? Has it impacted the health of the fetus?	No.

23. Did the Court, lawyers or doctors advise what treatment was available to treat the abnormality or the medical risks involved in an abortion procedure? Did you feel you had enough information from these individuals to make the decision to terminate the pregnancy? Were other people in your family or community pressuring you to decide to abort or continue the pregnancy?	Yes, we were advised well and I felt that were informed enough. Yes, our family and community members, were pressurizing us, not to abort per se, but to not abort by the long, tedious and uncertain legal route but rather to do it illegally. This, they said, would be quicker and certain. However the private hospital strictly warned us against it. Not only would it be against the law but such illegal abortions are usually very dangerous for the women and many times can jeopardise their future pregnancy as well. Therefore, we took a measured decision to take the legal route, keeping in mind also the fact that a favourable outcome might incentivize people in the future to take the correct and safer option.
24. Do you have any suggestions for anyone seeking support to access safe abortion services?	Get a good doctor, and get the sonographies done properly. Keep asking the doctors for information if they don't seem that forthcoming themselves.
25. Any suggestions otherwise?	I do feel that the 20 weeks limit should be increased, to perhaps 28 weeks. I was lucky enough to get the right people to help me, who fetched a favourable order for me. However, there could be many others who would not be so lucky.

Conclusion: Realising the Right to Abortion in India

While some progress has been made toward recognising the reproductive rights of pregnant persons in India, one essential element, the right of access to abortion, remains insufficient, uncertain and unjust. While the MTP Act has been in place for almost fifty years, courts still struggle to uniformly interpret its provisions, and as a result medical practitioners are often fearful to conduct termination procedures without explicit confirmation from the courts. The courts in turn rely on evidence from expert Boards to medically assess the circumstances of the individual pregnant person. Only then will a court interpret the law in one way in one case, and potentially another in a new case. Additionally, while the MTP Act and its Rules and Regulations provide a framework for why, who and where abortion procedures are carried out, in actuality practical barriers significantly reduce the Act's operation in remote areas throughout the country.

The MTP Act in its current form fails to recognise both the decisional and foundational dimensions of the right of access to abortion. While the consent provision in Section 3(4) ensures that the pregnant 'woman' must be compliant in the decision-making process, their consent is first subordinate to the medical practitioner's determination. In relation to fulfilling the right to abortion, and the right to reproductive health in general, the narrow class of practitioners and places for the procedure restrict the provider basefor abortion services. This inhibits pregnant people's ability to have their legally protected right (if they fall within the prescribed categories under the MTP Act) realised, as the State is failing to take positive steps to increase coverage of access to quality services. Additionally, the current system does not necessarily ensure the confidentiality of pregnant people, which can be a disincentive when pregnant persons face social stigma from their family and environment for seeking an abortion. Further, certain medical practitioners have imposed their own conditions when approving an abortion or not, such as obtaining consent from close family members or the agreement to simultaneously undergo sterilisation. Also, it is possible for medical practitioners' and Medical Boards' subjective bias to undermine an objective assessment of a totally personal and impactful situation. Finally, the

language of the MTP Act is inherently discriminatory, only referring to the 'pregnant woman' and 'married woman' as being those eligible to have an abortion. Rhetorically, and practically, this excludes other pregnant people including single women, sex workers, transgender and queer individuals. The combination of these factors results in the ever present risk of forcing pregnant persons to seek unsafe abortions, endangering their health and lives. They also point to the conclusion that India does not currently treat access to abortion as a right.

In the Introduction, many questions were asked regarding how courts have, and should, interpret the MTP Act and its restrictions on time limits and grounds. Chapters Two and Three examined to what extent courts are willing to interpret this provisions more flexibly, allowing for abortions in cases post 20 weeks. However, since *Meera Santosh Pal*, the increase in the number of cases that are interpreted as exceptions the 20 week time limit reflects a shift in courts' interpretation of the MTP Act. While the facts of some of the cases before the Supreme Court and other High Courts did not appear to conform to a literal interpretation of Section 5, courts still found it in the interests of justice and the best interests of the pregnant person to set aside the time limit in these cases. The High Court of Bombay has provided some assurance as to how to interpret the MTP Act and its objects by specifically reading Sections 3 and 5 together using purposive construction. This shift in interpretation is both promising and frustrating. It is promising as it expands the category of cases in which abortions may be allowed and it suggests that the focus has moved from public policy considerations to a best interests assessment of the individual pregnant person. However it is frustrating as it suggests that there is ambiguity in the law, such that if a medical practitioner refuses or is unsure whether to approve a termination or not, a pregnant person will be forced to seek clarification from a court. Consequently, the process is longwinded, particularly when courts and other State actors fail to appreciate the urgency required to process these matters. Even some judges have acknowledged that courts need to be sensitised to matters involving reproductive health.[1]Nevertheless, this process and legal framework is not sustainable and demands reform.

While *Suchita Srivastava* recognised that reproductive rights and reproductive autonomy fall within the scope of the protection of the right to life under Article 21 of the Constitution, the MTP Act has created significant restrictions on this autonomy. Therefore, in the cases mentioned in this book, the constitutionality of the MTP Act has been challenged. No court has entertained this constitutional challenge, however following the dismissal of the initial *Nikhil Datar* case, Dr. Datar filed another petition in the Supreme Court, and along with multiple petitions, this challenge will hopefully be heard in the near future. Whether the MTP Act or some of its provisions are struck down on the basis of their unconstitutionality, it seems that many stakeholders are demanding reform of Indian abortion law. It should be acknowledged that many have argued that increasing the time limit in Section 3 would increase the risk of pregnant people seeking sex-selective abortions, which are illegal under the Pre-Conception Pre-Natal Diagnostic Techniques Act, 1994.[2] However academic studies have shown that only a small percentage of abortions are conducted for the

[1]See Justice Misra's comments in Z vs. Bihar (2008) 11 Supreme Court Cases 572, paras. 58-61.

[2]Roli Srivastava, '"Not a woman's choice": India's abortion limit puts women at risk, say campaigners', Thomson Reuters, 6 September 2017, available from: https://in.reuters.com/article/india-women-abortion/not-a-womans-choice-indias-abortion-limit-puts-women-at-risk-say-campaigners-idINKCN1BH262.

purpose of sex-selection.[3] This concern is neither substantiated nor sufficient to justify maintaining the current 20 week time limit. The need to increase or abolish the time limit should be on the basis that diagnosis of foetal anomalies is often only possible between the 18th and 24th week and pregnant people should be entitled to as much information as medically possible to inform their decision to terminate or continue a pregnancy.

In relation to fulfilling the right of access to abortion, researchers have long advocated for the expansion of the abortion service provider base, by adding other categories of authorised healthcare practitioners to conduct the procedure. Additionally, more guidance is required to ensure that abortion providers are complying with the highest standards of medical care, as advocated for by WHO, by avoiding D&C and promoting the use of MA. The greatest and most significant amendment that would recognise the autonomy of the pregnant person and their role as the rights holder would be to ensure that 'on request' abortions are made possible. These suggested reforms have not yet found universal support and with multiple amendment bills still pending in Lok Sabha, Rajya Sabha and government departments, the disagreements between different stakeholders, particularly among the healthcare community, presents serious blocks to making any progress in the near future.

As Chapter Four highlighted, several nations have established legal frameworks recognising the right to abortion and ensuring that the State realises this right. While India's MTP Act did not originate from a civil rights perspective, India could adopt the 'on request' system of Canada and the US to meet the decisional dimension of the right to abortion and integrate the policy guidelines from Nepal to ensure the foundational dimension is also met. At the level of international law, there is a united consensus that the right to abortion is inherent in the right to health, which is already enshrined in several legally binding international treaties, as well as in soft law declarations. India is party to many of these treaties and is thereby bound to translate the right into its national legal framework, however this is yet to be truly fulfilled. Yet, both international law and other nations provide examples of both best practice and the risks of over regulation and criminalisation. Envisaging reform for abortion law in the future can benefit from considering these examples and the applicability of their successes in the Indian context.

Ultimately, the combination of India's ambiguous, potentially lengthy, legal process to seek an abortion and the inadequate realisation of the MTP Act's purported goals reveals that the decision-making power does not rest with the pregnant person. It rests with State institutions, its officers and individuals appointed and authorised by the State to make the decision to terminate or continue a pregnancy. And first and foremost it must be remembered that abortion is criminalised in India. The MTP Act is supplementary to the IPC, providing exceptions to general criminal liability for medical practitioners, not pregnant persons. Clearly, this system does not reflect a rights-based approach, in which the individual would be viewed as the rights holder and the State had the responsibility in order to meet its obligations to have their rights realised. State intervention to limit the right to access abortion would be the exception, not the general rule. It is important to return to the fundamental question: who gets to decide to terminate a pregnancy? A rights-based approach would define the pregnant person as the principle decision-maker, whose choice cannot be interfered with

[3]Stillmanet. al., op.cit., p. 18.

except in extraordinary circumstances, which involve an interference that is proportionate to the need to restrict the right. Adopting a rights-based approach to assess a State's ability to realise the right to abortion is essential as it acknowledges that first and foremost, pregnant persons are imbued with dignity and the right to self-determination. To create a truly rights-based approach in India's abortion law requires significant legal, political and social developments. The constitutional challenge to the MTP Act in the second *Datar* case could serve as a direct catalyst for legislative change, but a united social movement seeking liberalisation of abortion in India will provide the ultimate pressure on policymakers to initiate reform. Protecting, respecting and fulfilling the rights of pregnant persons to adequate, accessible and quality standards of healthcare to independently exercise their reproductive rights, will be a crucial step forward toward general empowerment and equality.

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APPENDICES

APPENDIX A

The Medical Termination Of Pregnancy Act, 1971
(Act No. 34 of 1971)

An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto

Statement of Objects and Reasons—(1) The provisions regarding the termination of pregnancy in the Indian Penal Code which were enacted about a century ago were drawn up in keeping with the then British Law on the subject. Abortion was made a crime for which the mother as well as the abortionist could be punished except where it had to be induced in order to save the life of the mother. It has been stated that this very strict law has been observed in the breach in a very large number of cases all over the country. Furthermore, most of these mothers are married women, and are under no particular necessity to conceal their pregnancy.

(2) In recent years, when health services have expanded and hospitals are availed of to the fullest extent by all classes of society, doctors have often been confronted with gravely ill or dying pregnant women whose pregnant uterus has been tampered with a view to causing an abortion and consequently suffered very severely.

(3) There is thus avoidable wastage of the mother's health, strength and sometimes, life. The proposed measure which seeks to liberalise certain existing provisions relating to termination of pregnancy has been received (1) as a health measure—where there is danger to the life or risk to physical or mental health of the woman; (2) on humanitarian grounds—such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic woman, etc., and (3) eugenic grounds—where there is substantial risk that the child, if born, would suffer from

deformities and diseases.—Gazette of India, Pt. II, Section 2, Extra., dated November 17, 1969, p. 880.

Be it enacted by Parliament in the Twenty-second Year of the Republic of India as follows:

1. Short title, extent and commencement.-

(1) This Act may be called the Medical Termination of Pregnancy Act, 1971.
(2) It extends to the whole of India except the State of Jammu and Kashmir.
(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions.-In this Act, unless the context otherwise requires,-

(a) "guardian" means a person having the care of the person of a minor or a lunatic;
(b) "lunatic" has the meaning assigned to it in Sec.3 of the Indian Lunacy Act, 1912 (4 of 1912) ;
(c) "minor" means a person who, under the provisions of the Indian Majority Act, 1875 (9 of 1875), is to be deemed not to have attained his majority,
(d) "registered medical practitioner" means a medical practitioner who possesses any recognised medical qualification as defined in Cl.(h) of Sec. 2 of the Indian Medical Council Act, 1956 (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynecology and obstetrics as may be prescribed by rules made under this Act.

3. When Pregnancies may be terminated by registered medical practitioners.-

(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.
(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,-
  (a) where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or
  (b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are.

Of opinion, formed in good faith, that,-

  (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health ; or
  (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1.-Where any, pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2.-Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonable foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in C1.(a), no pregnancy shall be terminated except with the consent of the pregnant woman.

4. **Place where pregnancy may be terminated.**-No termination of pregnancy shall be made in accordance with this Act at any place other than,-
   (a) a hospital established or maintained by Government, or
   (b) a place for the time being approved for the purpose of this Act by Government.

5. Sections 3 and 4 when not to apply.-

(1) The provisions of Sec.4 and so much of the provisions of sub-section
(2 of Sec. 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by the registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.
(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

6. Power to make rules.-4

(1) The Central Government may, by notification in the Official Gazette, make rules to carry out the provisions of this Act.
(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely:
   (a) the experience or training, or both, which a registered medical practitioner shall have if he intends to terminate any pregnancy under this Act ; and

(b) such other matters as are required to be or may be, provided by rules made under this Act.

(3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty days which may be comprised in one session or in two successive sessions, and If, before the expiry of the session in which it is so laid or the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

7. Power to make regulations.-

(1) The State Government may, by regulations,-
   (a) require any such opinion as is referred to in sub-section (2) of Sec. 3 to be certified by a registered medical practitioner or practitioners concerned in such form and at such time as be specified in such regulations, and the preservation or disposal of such certificates;
   (b) require any registered medical practitioner, who terminates a pregnancy to give intimation of such termination and such other information relating to the termination as maybe specified in such regulations;
   (c) prohibit the disclosure, except to such persons and for such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.

(2) The intimation given an the information furnished in pursuance of regulations made by virtue of C1.(b)of Sub-section(1) of shall be given or furnished, as the case may be, to the Chief Medical Officer of the State..

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of any regulation made under sub-section (1) shall be liable to be punished with fine which may extend to one thousand rupees.

8. Protection of action taken in good faith.- No suit for other legal proceedings shall lie against any registered medical practitioner for any damage caused likely to be caused by anything which is in good faith done or intended to be done under this act.

APPENDIX B

Medical Termination Of Pregnancy Regulations, 2003
Ministry of Health and Family Welfare
(Department of Family Planning)

G.S.R. 486 (E) — In exercise of powers conferred by section 7 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following regulations, namely;

1. Short title, extent and commencement –

(1) These regulations may be called the Medical Termination of Pregnancy Regulations, 2003.
(2) They extend to all the Union territories.
(3) They shall come into force on the date of their publication in the Official Gazette.

1. **Definitions** - In these regulations, unless the context otherwise requires,

(a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971);
(b) "Admission Register" means the register maintained under regulation 5;
(c) "Chief Medical Officer of the District" means the Chief Medical Officer of the District by whatever name called;
(d) "form" means a form appended to these regulations;
(e) "hospital" means a hospital established or maintained by the Central Government or the Government of a Union territory;
(f) "section" means a section of the Act.

2. Form of certifying opinion or opinions, -

(1) Where one registered medical practitioner forms or not less than two registered medical practitioners form such opinion as is referred to in sub-section (2) of section 3 or 5, he or she shall certify such opinion in Form I.
(2) Every registered medical practitioner who terminates any pregnancy shall, within three hours from the termination of the pregnancy certify such termination in Form I.

3. Custody of forms, -

(1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under section 3 or section 5, as the case may be and the intimation of

termination of pregnancy shall be placed in an envelope which shall be sealed by the registered medical practitioner or practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.

(2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 3, there shall be noted the serial number assigned to the pregnant woman in the Admission Register and the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET".

(3) Every envelope referred to in sub-regulation (2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.

(4) On receipt of the envelope referred to in sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.

(5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, in Form II, a monthly statement of cases where medical termination of pregnancy has been done.

(6) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 5, there shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelope shall be marked "SECRET".

Explanation. – The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant woman in the Admission Register shall be left blank in Form I in the case of termination performed under section 5.

(7) Where the pregnancy is not terminated in an approved place or hospital, every envelope referred to in sub-regulation (6) shall be sent by registered post to the Chief Medical Officer of the State on the same day on which the pregnancy was terminated or on the working day next following the day on which the pregnancy was terminated :

Provided that where the pregnancy is terminated in an approved place or hospital, the procedure provided in sub-regulations (1) to (6) shall be followed.

4. Maintenance of Admission Register, -

(1) Every head of hospital or owner of the approved place shall maintain a register in Form III for recording there in the details of the admissions of women for the termination of their pregnancies and keep such register for a period of five years from the end of the calendar year it relates to.

(2) The entries in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial

number, for example, serial number 5 of 1972 and serial number 5 of 1973 shall be mentioned as 5/1972 and 5/1973.

(3) Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

5. Admission Register not to be open to inspection, -

The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorised by such head or owner and save as otherwise provided in sub-regulation (5) of regulation 4 shall not be open for inspection by any person except under the authority of law :-

Provided that the registered medical practitioner on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer;

Provided further that any such employer shall not disclose this information to any other person.

6. Entries in registers maintained in hospital or approved place, -

No entry shall be made in any case-sheet, operation theatre register, follow-up card or any other document or register other than the admission Register maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference to the pregnant woman shall be made therein by the serial number assigned to the woman in the Admission Register.

APPENDIX C

Medical Termination Of Pregnancy Rules, 2003
Ministry of Health and Family Welfare
(Department of Family Planning)

G.S.R. 485(E) – In exercise of powers conferred by section 6 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following rules, namely:-

1. Short title and commencement, -

(1) These rules may be called the Medical Termination of Pregnancy Rules, 2003.
(2) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions – In these rules, unless the context otherwise requires,

(a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971) and the Medical Termination of Pregnancy (Amendment) Act, 2002 (64 of 2002);
(b) "Chief Medical Officer of the District" means the Chief Medical Officer of a District, by whatever name called;
(c) "Form" means a form appended to these rules;
(d) "owner" in relation to a place means any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or place, by whatever name called, where the pregnancy may be terminated under this Act;
(e) "Committee" means a committee constituted at the district level under the proviso to clause (b) of section 4 read Rule 3.

3. Composition and tenure of District Level Committee, -

(1) One member of the District Level Committee shall be the Gynaecologist/Surgeon/Anaesthetist and other members from the local medical profession, non-governmental organisation, and Panchayati Raj Institution of the District.
(2) Provided that one of the members of the Committee shall be a woman.
(3) Tenure of the Committee shall be for two calendar years and the tenure of the non-government members shall not be more than two terms.

4. Experience and training under clause (d) of Section 2, -

For the purpose of clause (d) of section (2), a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely;-

(a) In the case of a medical practitioner, who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;

(b) In the case of a medical practitioner, who is registered in a State Medical Register:-

    (i) if he has completed six months of house surgency in gynaecology and obstetrics; or

    (ii) unless the following facilities are provided therein, if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or

(c) if he has assisted a registered medical practitioner in the performance of twenty-five cases of medical termination of pregnancy of which at least five have been performed independently, in a hospital established or maintained or a training institute approved for this purpose by the government.

    (i) This training would enable the Registered Medical Practitioner (RMP) to do only 1st trimester terminations (up to 12 weeks of gestation).

    (ii) For terminations up to twenty weeks the experience or training as prescribed under sub rules (a), (b) and (d) shall apply.

(d) In case of a medical practitioner who has been registered in a State Medical Register and who holds a postgraduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

5. Approval of a place, -

(1) No place shall be approved under clause (b) of section 4, -

    (i) Unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and

    (ii) Unless the following facilities are provided therein, namely:-

In case of first trimester, that is, up to 12 weeks of pregnancy:-

a gynaecology examination/labour table, resuscitation and sterilisation equipment, drugs and parental fluid, back up facilities for treatment of shock and facilities for transportation; and in case of second trimester, that is, up to 20 weeks of pregnancy:-

    (a) an operation table and instruments for performing abdominal or gynaecological surgery;

    (b) anaesthetic equipment, resuscitation equipment and sterilisation equipment;

    (c) drugs and parental fluids for emergency use, notified by Government of India from time to time.

Explanation. – In the case of termination of early pregnancy up to 7 weeks using RU-486 with Misoprostol, the same may be prescribed by a Registered Medical Practitioner (RMP) as defined under clause (d) of section 2 of the Act and section 4 of the MTP Rules, at his clinic, provided such a Registered Medical Practitioner has access to a place approved under section 4 of the MTP Act, 1971, read with MTP Amendment Act, 2002 and Rule 5 of the MTP Rules. For the purpose of access, the RMP should display a Certificate to this effect from the owner of the approved place.

(2) Every application for the approval of a place shall be in Form A and shall be addressed to the Chief Medical Officer of the District.

(3) On receipt of an application under sub-rule (2), the Chief Medical Officer of the District may verify any information contained, in any such application or inspect any such place with a view to satisfying himself that the facilities referred to in sub-rule (1) are provided, and that termination of pregnancies may be made under safe and hygienic conditions.
(4) Every owner of the place which is inspected by the Chief Medical Officer of the District shall afford all reasonable facilities for the inspection of the place.
(5) The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or inspection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic conditions, at the place, recommended the approval of such place to the Committee.
(6) The Committee may after considering the application and the recommendations of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.
(7) The certificate of approval issued by the Committee shall be conspicuously displayed at the place to be easily visible to persons visiting the place.
(8) The place shall be inspected within 2 months of receiving the application, and the certificate of approval may be issued within the next 2 months, or in case any deficiency has been noted, within 2 months of the deficiency having been rectified by the applicant.
(9) On the commencement of these rules, a place approved in accordance with the Medical Termination of Pregnancy Rules, 1975 shall be deemed to have been approved under these Rules.

6. Inspection of a place, -

(1) A place approved under rule 5 may be inspected by the Chief Medical Officer of the District, as often as may be necessary with a view to verify whether termination of pregnancies is being done therein under safe and hygienic conditions.
(2) If the Chief Medical Officer has reason to believe that there has been death of, or injury to, a pregnant woman at the place or that termination of pregnancies is not being done at the place under safe and hygienic conditions, he may call for any information or may seize any article, medicine, ampoule, admission register or other document, maintained, kept or found at the place.
(3) The provisions of the Code of Criminal Procedure, 1973 (2 of 1974), relating to seizure shall, so far as it may, apply to seizure made under sub-rule (2).

7. Cancellation or suspension of certificate of approval, -

(1) If, after inspection of any place approved under rule 5, the Chief Medical Officer of the District is satisfied that the facilities specified in rule 5 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Committee giving details of the deficiencies or defects found at the place and the Committee may, if it is satisfied, suspend or cancel the approval,

provided that the Committee shall give an opportunity of making representation to the owner of the place before the certificate issued under rule 5 is cancelled.

(2) Where a certificate issued under rule 5 is cancelled the owner of the place may make such additions or improvements in the place and thereafter, he may make an application to the Committee for the grant of approval under rule 5.

(3) In the event of suspension of a certificate of approval, the place shall not be deemed to be an approved place during the suspension for the purposes of termination of pregnancy from the date of communication of the order of such suspension.

8. Review, -

(1) The owner of a place, who is aggrieved by an order made under rule 7, may make an application for review of the order to the Government within a period of sixty days from the date of such order:

Provided that the Government may condone any delay in case it is satisfied that applicant was prevented by sufficient cause to make the application within time.

(2) The Government may, after giving the owner an opportunity of being heard, confirm, modify or reverse the order.

9. Form of consent. – The consent referred to in sub-section (4) of section 3 shall be given in Form C.

10. Repeal and saving, - The Medical Termination of Pregnancy Rules, 1975, are hereby repealed except as respects things done or omitted to be done before such repeal.

APPENDIX D

	THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) BILL, 2014	
	A BILL	
	further to amend the Medical Termination of Pregnancy Act, 1971.	
	BE it enacted by Parliament in the Sixty-fifth Year of the Republic of India as follows:-	
	1. (1) This Act may be called the Medical Termination of Pregnancy (Amendment) Act, 2014.	Short title and commencement
	(2) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.	
34 of 1971.	**2.** In the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as the principal Act), in the long title, for the words "by registered medical practitioners", the words "by registered health care providers" shall be substituted.	Amendment of long title.
	3. In section 2 of the principal Act, for clause (d), the following clauses shall be substituted, namely:- '(d) "registered health care provider" means – (I) a medical practitioner who possesses any recognised medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956, whose name has been entered in a Indian Medical Register or State Medical Register; or (II) a practitioner who possesses— (i) any recognised medical qualification of Ayurveda, Unani or Siddha as defined in clause (h) of section 2 of the Indian Medicine Central Council Act, 1970, whose name has been entered in the Central Register or State Register of Indian medicine; or (ii) any recognised medical qualification of Homeopathy as	Amendment of section 2. 102 of 1956 48 of 1970

	defined in clause (g) of section 2 of the Homeopathy Central Council Act, 1973, whose name has been entered in the Central Register or State Register of Homeopathy; or (III) a nurse or auxiliary nurse midwife who possesses any recognised qualification in general nursing or auxiliary nurse midwifery as defined in section 10 of the Indian Nursing Council Act, 1947 and who has been enrolled as a nurse or auxiliary nurse midwife in the Indian Nurses Register or the State Register; (e) "prescribed" means prescribed by rules made under this Act; (f) "termination of pregnancy" means a procedure to terminate a pregnancy by using medical or surgical methods.'.	59 of 1973 48 of 1947
	4. In section 3 of the principal Act,- (i) for the words "registered medical practitioners", wherever they occur, the words "registered health care providers" shall be substituted; (ii) for sub-section (2), the following sub-section shall be substituted, namely: - "(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered health care provider,- (a) on request of a woman, where the length of the pregnancy does not exceed twelve weeks; (b) (i) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks; or (ii) where the length of the pregnancy exceeds twenty weeks but does not exceed twenty-four weeks and the woman falls in one of the categories, as may be prescribed, if such health care provider is of the opinion, formed in good faith, that –	Amendment of section 3.

	(A) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (B) there is substantial risk that if the child were born, it would suffer from serious physical or mental abnormalities; *Explanation*—For the purposes of this clause— (i) where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman; (ii) where any pregnancy occurs as a result of failure of any device or method used by any woman or her partner for the purpose of limiting the number of children or preventing pregnancy, the anguish caused by such pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman. (C) the provisions of sub-section (2) of section 3 as relate to the length of the pregnancy shall not apply to the termination of a pregnancy by a registered health care provider where the termination of such pregnancy is necessitated by the diagnosis of the substantial foetal abnormalities as may be prescribed.".	
Qualification, training, experience, etc. of registered health care providers.	**5.** After section 3 of the principal Act, the following section shall be inserted, namely:- "3A. (1) For the purposes of clause (d) of section 2, the training, experience and the methods to be adopted by the registered health care providers who are qualified to terminate the pregnancy, shall be such, as may be prescribed. (2) For the purpose of sub-section (1), the place	Insertion of new section 3A

	where the pregnancy may be terminated, the modalities of diagnosis, record keeping and other matters, in addition to the provisions of section 4, shall be such, as may be prescribed.”.	
Substitution of section 5.	**6.** For section 5, the following sections shall be substituted, namely:- “5. The provisions of section 4, and so much of the provisions of sub-section (2) of section 3 as relate to the length of the pregnancy and the opinion of a registered health care provider shall not apply to the termination of a pregnancy by a registered health care provider in case where he is of the opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.”.	Sections 3 and 4 when not to apply.
	5A. No registered health care provider shall reveal the name and other particulars of a woman whose pregnancy has been terminated under this Act.	Protection of privacy of a woman.
45 of 1860.	5B. (1) Notwithstanding anything contained in the Indian Penal Code, the termination of pregnancy by a person who is not a registered health care provider shall be an offence punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years. (2) Whoever terminates any pregnancy in a place other than a place mentioned in section 4, shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years. (3) Any person being the owner of a place, which is not approved under clause (b) of section 4, shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years. *Explanation*—For the purposes of this sub-section, the expression “owner”, in relation to a place, means any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or place, by whatever name called, where the pregnancy may be terminated under this	Offences and penalties

	Act. (4) Whoever contravenes the provisions of section 9 shall be punishable with imprisonment which may extend to one year, or with fine, or with both.".	
Amendment of section 6.	**7.** In section 6 of the principal Act, in sub-section (2),- (i) in clause (a), for the words "registered medical practitioner", the words "health care provider" shall be substituted; (ii) after clause (a), the following clauses shall be inserted, namely:- "(aa) the categories of woman under sub-clause (ii) of clause (b) of sub-section (2) of section 3; (ab) the categories of registered health care providers who are qualified to terminate the pregnancy, the training and experience of such registered health care providers and the methods to be adopted by them in terminating the pregnancy under sub-section 3A; (ac) the place where the pregnancy may be terminated, keeping of records and other matters under sub-section (2) of section 3A; (ad) the categories of substantial foetal abnormalities under sub-section (2) of section 5.".	
Amendment of section 7.	**8.** In section 7 of the principal Act, in sub-section (1),- (i) in clause (a), for the words "the registered medical practitioner", the words "the registered health care provider" shall be substituted; (ii) in clause (b), for the words "registered medical practitioner", the words "registered health care provider" shall be substituted.	
Amendment of section 8	**9.** In section 8 of the principal Act, for the words "registered medical practitioner", the words "registered health care provider" shall be substituted.	

APPENDIX E

	THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) BILL, 2017	**Bill No. XXV of 2017**
	A BILL	
	further to amend the Medical Termination of Pregnancy Act, 1971.	
	BE it enacted by Parliament in the Sixty-eighth Year of the Republic of India as follows:-	
	1. (*1*) This Act may be called the Medical Termination of Pregnancy (Amendment) Act, 2017. (*2*) It shall come into force on such date, as the Central Government may, by notification in the Official Gazette, appoint.	Short title, and commencement
Amendment of section 3.	**2.** In section 3 of the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as the Principal Act), in sub-section (2), clause (b), for the word 'twenty', the words 'twenty four' shall be substituted.	34 of 1971
Amendment of section 6.	**2.** In section 6 of the Principal Act, in sub-section (3),- *(i)* after the words "one session or in two" the words "or more" shall be inserted; *(ii)* for the words "in which it is so laid or the session immediately following" the words "immediately following the session or the successive sessions aforesaid" shall be substituted.	

STATEMENT OF OBJECTS AND REASONS

The Sub-section (2) of Section 3 of the Medical Termination of Pregnancy Act, 1971, allows the abortion of terminally ill foetuses upto twenty weeks pregnancy. During the intervening period after the Act was enforced, several genuine cases have come up where the fact of foetuses with serious risk of abnormalities with grave risk to physical and mental risk to mother had been noticed after twenty weeks. As a result, many women were forced to move the Supreme Court for permission to end pregnancy beyond twenty weeks, leading to a lot of mental and financial hardship to such pregnant women.

The Bill intends to extend the permissible period for abortion from twenty weeks to twenty four weeks if doctors believe the pregnancy involves a substantial risk

to the mother or the child or if there are substantial foetal abnormalities. The Bill also intends to amend the provisions of sub-section (3) of section (6) relating to laying of rules before each House of Parliament and their notification etc. by the House.

DR. KANWAR DEEP SINGH

New Delhi, *4th August* 2017.

Rajya Sabha

APPENDIX F

	THE MEDICAL TERMINATION OF PREGNANCY (AMENDMENT) BILL, 2018	**Bill No. 55 of 2018**
	By Shri Shrirang Appa Barne, M.P. A BILL	
	further to amend the Medical Termination of Pregnancy Act, 1971.	
	BE it enacted by Parliament in the Sixty-ninth Year of the Republic of India as follows:-	
	1. (*1*) This Act may be called the Medical Termination of Pregnancy (Amendment) Act, 2018. (*2*) It shall come into force on such date, as the Central Government may, by notification in the Official Gazette, appoint.	Short title, and commencement
34 of 1971.	**2.** In section 3 of the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as the principal Act), in sub-section (*2*), in clause (*b*), for the words "twenty weeks", the words "twenty-four weeks and in case of rape survivor, anytime during the pregnancy but before twenty-seven weeks" shall be substituted.	Amendment of section 3.
	3. For section 4 of the principal Act the following section shall be substituted, namely:- "4. No termination of pregnancy shall be made in accordance with this Act at any place other than a hospital or medical college established or maintained by the Government of India".	Substitution of new section for section 4.
Central Supervisory Board	**4.** After section 4, of the principal Act the following section shall be inserted, namely:- "4A. (*1*) There shall be established a Board to be known as Central Supervisory Board which shall consist of such number of eminent medical Geneticists, Gynaecologists and Obstetricians, Paediatricians, Social Scientists and Representatives of Women Welfare Organisation as may be prescribed to	

	discharge functions assigned under this Act. (*2*) The Chairperson of the Board shall be appointed from amongst the members of the Board; (*3*) The terms and conditions of appointment of the Chairperson and members of the Board shall be such as may be prescribed.".	
Amendment of section 5.	**5.** In section 5 of the principal Act, in-section (*1*) the following provisos shall be inserted, namely:- "Provided that if in the majority opinion of the Central Supervisory Board, continuance of pregnancy may involve a substantial risk in case the child is born with following abnormalities:- *(a)* chromosomal abnormalities; *(b)* genetic metabolic diseases; *(c)* haemoglobinpathies; *(d)* sex-linked genetic diseases; *(e)* congenital abnormalities; or *(f)* another abnormalities or diseases as may be specified by the Central Supervisory Board, the pregnancy, irrespective of the length of the pregnancy, shall be terminated in accordance with the provisions of section 4: Provided further that if the pregnant woman irrespective of her age is a rape survivor, the pregnancy be terminated within twenty-seven weeks of such pregnancy in accordance with the provisions of section 4.".	

STATEMENT OF OBJECTS AND REASONS

The Medical Termination of Pregnancy Act was enacted in 1971. Since its enactment, there have been spectacular socio-economic changes in the society. The lifestyle of the people has also changed considerably. Besides, technology in medical science has improved very much and there have been new techniques, which can detect foetal abnormalities in the advanced stage of pregnancy also. These techniques were not known or available when the Act was enacted in 1971.

In our country abortion is legal only up to twenty weeks of pregnancy under specific conditions and situations, broadly defined as the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury of 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 as to be seriously handicapped.

Sometimes, it may happen that a defective child in the womb may cause substantial physical damage to the mother and it may result in death of the child or the mother. Therefore, it would be better if the abnormalities are detected and aborted in time with the latest technology.

Recently, the Supreme Court permitted a rape survivor to terminate her pregnancy at twenty-four weeks, which is beyond the permissible twenty weeks limit prescribed under the Medical Termination of Pregnancy Act, 1971. Their grounds were that continuing the pregnancy could greatly endanger her physical and mental health. In this instance, the Supreme Court directed the members of the appointed Medical Board to examine the petitioner and the viability of the pregnancy. The Board found that the foetus had multiple congenital anomalies and the severity of these anomalies posed a grave risk to the physical and mental health of the petitioner. Therefore, the Medical Board recommended that the petitioner be allowed not to continue the pregnancy. Based on these recommendations, the Supreme Court granted the petitioner permission to terminate her pregnancy.

This is not the first time that the Supreme Court has permitted a woman to abort a foetus older than twenty weeks. In 2015, the apex Court overturned a decision by the Gujarat High Court in a similar case. The Gujarat High Court had denied permission to a fourteen year-old rape survivor to abort her twenty-five week old foetus. Interestingly, while delivering its verdict, the High Court acknowledged the adverse physical, emotional and psychological implications of the decision on the petitioner's life, but ultimately chose to subscribe to the law. The girl then approached the Supreme Court, which recommended that a medical panel examine the girl and decide whether the termination of pregnancy was in her best interests; if the panel was in favour of the abortion, then the girl could go ahead with the termination.

There is a provision in the parent Act for termination of pregnancy if it is found that the continuance of the pregnancy would involve a substantial risk to the life of the women and the termination can be made at any time even in the advance stage, that is length of the pregnancy would not be a deciding factor. But, there is no provision for termination of pregnancy if the child to be born with abnormalities like genetics, severe heart

diseases and likewise. Therefore, it is proposed that a suitable amendment to the parent Act be made so that pregnancy can be terminated even in the advanced stage if continuance of pregnancy involves a substantial risk of the child being born with certain specified abnormalities. However, it is also necessary to ensure that the termination of pregnancy is conducted under the supervision of a Medical Board and that too in a designated place. Moreover, it is also required to ensure that if the pregnant woman is a rape survivor, the pregnancy be terminated without the supervision of any Medical Board but in a designated place within twenty-seven weeks of such pregnancy.

The Bill seeks to achieve the above objective.

SHRIRANG APPA BARNE

New Delhi, *January* 22, 2018.

Lok Sabha

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ITEM NO.106 COURT NO. 6 SECTION IX

SUPREME COURT OF INDIA
RECORD OF PROCEEDINGS

Civil Appeal No(s). 7702/2014

NIKHIL DATAR Appellant(s)

VERSUS

UNION OF INDIA & ANR. Respondent(s)
(With office report)

WITH

W.P.(C) No. 308/2014

(With Office Report)

Date:15/12/2016 These appeals were called on for hearing today.
CORAM: HON'BLE MR. JUSTICE MADAN B.LOKUR

HON'BLE MR. JUSTICE ADARSH KUMAR GOEL

For Appellant(s) Mr. Colin Gonsalves, Sr.Adv.

Mr. Kabir Ali, Adv. Mr. Zia Choudhary,Adv.

Ms. Jyoti Mendiratta,Adv.

For Respondent(s)

Mr. Aniruddha P.Mayee,Adv.

Ms. V. Mohana, Sr. Adv. Ms. Kiran Bhardwaj, Adv. Ms. Movita, Adv.

Mr. G.S. Makkar, Adv. Mr. D. S. Mahra,Adv.

Mr. Joseph Aristotle, Adv. Ms. Loreign Quung, Adv.

Ms. Tehmina Arora, Adv. Mr. Dheeraj Philip, Adv.

Ms. Arpit Rai, Adv.

Mr. Nishant Ramakantrao Katneshwarkar,Adv.

UPON hearing the counsel the Court made the following

O R D E R

Learned counsel appearing for the Union of India should take instructions and file an affidavit on what the Union of India proposes to do in the matter.

List after the needful is done

(Meenakshi Kohli) (Jaswinder Kaur)

Court Master Court Master

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (C) No. 593 OF 2016

MS.X...PETITIONER

VERSUS

UNION OF INDIA AND ORS..RESPONDENTS

O R D E R

By our Motion Bench order dated 22.07.2016, we had accepted the suggestion of the learned Solicitor General for India, and the learned counsel for the State of Maharashtra in directing respondent No.2 - the State of Maharashtra, to constitute a Medical Board at KEM Hospital and Medical College, Mumbai, to medically examine the petitioner.

In furtherance of the direction issued by this Court, a Medical Board comprising of the following seven doctors was constituted at the KEM Hospital and Medical College, Mumbai.

1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G&K) - Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital
3. Dr. Amar Pazare, Professor and HOD, Medicine, KEM Hospital
4. Dr. Indrani Hemant kumar Chincholi, Professor and HOD, Anaesthesia, KEM Hospital

5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics & Gynecology, LTMMC and LTMG Hospital
6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, KEM Hospital
7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital.

The Medical Board has submitted a report dated 23.07.2016, which is taken on record and marked as Annexure A. In its analysis, the report inter alia recorded as under:

4. From General Medical Examination she has no active medical complaints.
5. Obstetric examination shows 24 weeks pregnancy, with severe polyhydramnios, with fetal parts not felt. On internal examination, the cervix is closed and high up.
6. Radiological diagnosis is single live fetus with gestational age of 23 weeks 3 days with following malformations: 1) excencephaly, i.e. evidence of no skull valut above orbit, with presence of brain tissue floating in amniotic fluid, 2) Omphalocele (presence of liver, intestines and stomach bubble outside the abdomen and in the amniotic cavity). 3) Heart is bulging into the omphalocele sac. 4) Kyphoscoliosis which is an anomlay of the spine involing the thoracolumbar vertebrae with polyhydramnios (excessive amniotic fluid) with closed vertix."

Based on the above medical examination, the findings of the Medical Board were expressed as under:

"1. Current pregnancy is about 23-24 weeks by clinical and radiological evaluation.
2. In view of severe multiple congenital anomalies, the fetus is not compatible with extra-uterine life.
3. Risk to the mother of continuation of pregnancy can gravely endanger her physical and mental health.
4. Risk of termination of pregnancy is within acceptable limits.

Hence the Medical Board advises that the patient, Ms. X should not continue with this pregnancy."

The question that arises for our consideration is, whether it would be justified and legal, to terminate the pregnancy of the petitioner, which the Medical Report itself shows, as of 24 weeks duration? Learned Attorney General representing the Union of India has invited our attention to Section 3 of the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as `the Act') which is extracted below:

"3. When pregnancies may be terminated by registered medical practitioners.-

(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other

law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,-

(a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that-

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1.-Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2.-Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken to the pregnant woman's actual or reasonable foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a [mentally ill person], shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman."

A perusal of the above provision reveals, that the provision deals with termination of pregnancies of different durations, and the procedure contemplated there for. Section 3 leaves no room for doubt, that it is not permissible to terminate a pregnancy, after 20 weeks. However, Section 5 of the Act lays down exceptions to Section 3. Section 5 of the Act is also reproduced hereunder:

"5. Sections 3 and 4 when not to apply.-

(1) The provisions of section 4, and so much of the provisions of sub-section (2) of section 3 as

relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of pregnancy by a person who is not a registered medical practitioner shall be an offence punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years under that Code, and that Code shall, to this extent, stand modified.

(3) Whoever terminates any pregnancy in a place other than that mentioned in section 4, shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years.

(4) Any person being owner of a place which is not approved under clause (b) of section 4 shall be punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years.

Explanation 1.-For the purposes of this section, the expression "owner" in relation to a place means any person who is the administrative head or otherwise responsible for the working or maintenance of a hospital or place, by whatever name called, where the pregnancy may be terminated under this Act.

Explanation 2.-For the purposes of this section, so much of the provisions of clause (d) of section 2 as relate to the possession, by registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply."

A perusal of Section 5 of the Act reveals, that the termination of pregnancy, which is necessary to save the life of the pregnant woman, is permissible.

Having perused the Medical Report (relevant extracts whereof have been reproduced hereinabove), we are satisfied, that a clear finding has been recorded by the Medical Board, that the risk to the petitioner of continuation of her pregnancy, can gravely endanger her physical and mental health. The Medical Board has also expressed an advice, that the patient should not continue with the pregnancy. In view of the findings recorded in para 6 of the report, coupled with the recommendation and advice tendered by the Medical Board, we are satisfied that it is permissible to allow the petitioner to terminate her pregnancy in terms of Section 5 of the Medical Termination of Pregnancy Act, 1971. In view of the above, we grant liberty to the petitioner, if she is so advised, to terminate her pregnancy.

The writ petition is disposed of in the above terms.

As a sequel to disposal of the writ petition, pending interlocutory application also stands disposed of.

..........................J. (JAGDISH SINGH KHEHAR)

..........................J. (ARUN MISHRA)

NEW DELHI;

JULY 25, 2016.

IN THE SUPREME COURT OF INDIA CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO.17 OF 2017

MEERA SANTOSH PAL AND ORS PETITIONER(S)

VERSUS

UNION OF INDIA AND ORS RESPONDENT(S)

O R D E R

Petitioner No.1 - Meera Santosh Pal, is 22 years old, has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy. She apprehended danger to her life, having discovered that her fetus was diagnosed with Anencephaly, a defect that leaves foetal skull bones unformed and is both untreatable and certain to cause the infant's death during or shortly after birth. This condition is also known to endanger the mother's life.

By order dated 11.1.2017, while issuing notice to the respondents, this Court gave a direction for examination of petitioner no.1 by a Medical Board consisting of the following seven Doctors:

1. Dr. Avinash N. Supe, Director (Medical Education &Major Hospitals) & Dean (G&K) -Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital
3. Dr. Amar Pazare, professor and HOD, Medicine, KEM Hosptial

4. Dr. Indrani Hemantkumar Chincholi, Professor and HOD, Anaesthesia, KEM Hospital
5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics, KEM Hospitals
6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, LTMMC and LTMG Hospitals
7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital.

As on 12.1.2017, she was into her 24th week of pregnancy. This is also borne by the report dated 12.1.2017, received from the Director (ME & MH)'s Office, Seth G.S. Medical College & KEM Hospital, Parel, Mumbai - 400012.

By its report dated 12.1.2017, the Medical Board has examined petitioner no.1 with specific reference to their special expertise for general, medical, radiological, psychiatric and an aesthetic evaluation. An obstetric evaluation was done by two Obstetricians. Ultrasonography was performed at KEM Hospital on 12.1.2017 by the Additional Professor, Radiology. The said Board has further reported that obstetric examination shows 24 weeks pregnancy, external ballottement present, fetal parts not well felt with mild polyhydramnios. On internal examination, the cervix is posterior and OS is closed. Ultrasonography diagnosis has revealed a single live fetus with anencephaly with mild polyhydramnios with hypotelorism.

We have been informed that the fetus is without a skull and would, therefore, not be in a position to survive. It is also submitted that petitioner no.1 has undergone psychiatric evaluation. She is reported to be coherent, has average intelligence and with good comprehension. She understands that her fetus is abnormal and the risk of fetal mortality is high. She also has the support of her husband in her decision making.

Upon evaluation of petitioner no.1, the aforesaid Medical Board has concluded that her current pregnancy is of about 24 weeks. The condition of the fetus is not compatible with extra-uterine life. In other words, the fetus would not be able to survive outside the uterus.

Importantly, it is reported that the continuation of pregnancy can gravely endanger the physical and mental health of petitioner no.1 and the risk of her termination of pregnancy is within acceptable limits with institutional back up.

This Court, as at present being advised, would not enter into the medico-legal aspect of the identity of the fetus but consider it appropriate to decide the matter from the standpoint of the right of petitioner no.1 to preserve her life in view of the foreseeable danger to it, in case she allows the current pregnancy to run its full course. The medical evidence clearly suggests that there is no point in allowing the pregnancy to run its full course since the fetus would not be able to survive outside the uterus without a skull.

In Suchita Srivastava and Anr. vs. Chandigarh Administration [(2009) 9 SCC 1], a bench of three

Judges held "a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution". The Court there dealt with the importance of the consent of the pregnant woman as an essential requirement for proceeding with the termination of pregnancy. The Court observed as follows:-

"22. There is no doubt that a woman's right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Further- more, women are also free to choose birth control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. "

The crucial consideration in the present case is whether the right to bodily integrity calls for a permission to allow her to terminate her pregnancy. The report of the Medical Board clearly warrants the inference that the continuance of the pregnancy involves the risk to the life of the pregnant woman and a possible grave injury to her physical or mental health as required by Section3

(2) (i) of the Medical Termination of Pregnancy Act, 1971.

Though, the pregnancy is into the 24th week, having regard to the danger to the life and the certain inability of the fetus to survive extra uterine life, we consider it appropriate to permit the petitioner to terminate the pregnancy. The overriding consideration is that she has a right to take all such steps as necessary to preserve her own life against the avoidable danger to it.

In these circumstances given the danger to her life, there is no doubt that she has a right to protect and preserve her life and particularly since she has made an informed choice. The exercise of her right seems to be within the limits of reproductive autonomy.

In the circumstances, we consider it appropriate in the interests of justice and particularly, to permit petitioner no.1 to undergo medical termination of her pregnancy under the provisions of Medical Termination of Pregnancy Act, 1971. The learned Solicitor General Mr. Ranjit Kumar who took notice on the last date of hearing has not opposed the petitioners' prayer on any ground, legal or medical. We order accordingly.

The termination of pregnancy of petitioner no.1 will be performed by the Doctors of the hospital where she has undergone medical check-up. Further, termination of her pregnancy would be supervised by the above stated Medical Board who shall maintain complete record of the procedure which is to be performed on petitioner No.1 for termination of her pregnancy.

With the aforesaid directions, the instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy.

Mr. Colin Gonsalves, learned Senior Counsel appearing for the petitioners, submits that the petitioners do not press other prayers in the instant writ petition.

We take on record the aforesaid submission made by Mr. Gonsalves, learned counsel appearing for the petitioners.

.......................J

[S. A.BOBDE]

.......................J [L. NAGESWARA RAO]

NEW DELHI;

JANUARY 16, 2017.

ITEM NO.63 **COURT NO.9** **SECTION X**

SUPREME COURT OF INDIA
RECORD OF PROCEEDINGS

Writ Petition (s) (Civil) No (s). 17/2017

MEERA SANTOSH PAL AND ORS Petitioner(s)

VERSUS

UNION OF INDIA AND ORS Respondent(s)

Date: 16/01/2017 This petition was called on for hearing today.

CORAM:

HON'BLE MR. JUSTICE S.A. BOBDE

HON'BLE MR. JUSTICE L. NAGESWARA RAO

For Petitioner(s) Mr. Colin Gonsalves, Sr.Adv.

Ms. Sneha Mukherjee, Adv. Mr. Satya Mitra, Adv.

For Respondent(s) Mr. Ranjit Kumar, SG

Mr. R.K. Rathore, Adv.

Ms. Swaruprana Chaturvadi, Adv. Mr. G.S. Makker, Adv.

Mr. Nishant Ramakantrao Katneshwarkar, Adv.

UPON hearing the counsel the Court made the following

ORDER

The instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy, in terms of the signed order.

(Sanjay Kumar-II)	(Indu Pokhriyal)
Court Master	Court Master

(Signed Order is placed on the file)

**Copy of this Order be given today*

Reportable

THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO. 81 OF2017

Mrs. X AND ORS. PETITIONER(S)

VERSUS

UNION OF INDIA AND ORS RESPONDENT(S)

O R D E R

Application for non-disclosure of names and detail of petitioner No. 1 and 2 is allowed.

The Petitioner No. 1- Mrs. X is about 22 years' old. She has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy. According to her, fetus which is about 22 weeks old on the date of the petition has a condition known as bilateral renal agenesis and an hydramnios. She apprehends that the fetus has no chance of survival and the delivery may endanger her life.

In order to verify the condition of petitioner No. 1, this Court by order dated 03.02.2017 while issuing notice to the respondents directed examination of the petitioner by a medical Board consisting of following seven Doctors :

1. Dr. Avinash N. Supe, Director (Medical Education &Major Hospitals) & Dean (G&K) -Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital
3. Dr. Amar Pazare, professor and HOD, Medicine, KEM Hosptial
4. Dr. Indrani Hemantkumar Chincholi, Professor and HOD, Anaesthesia, KEM Hospital
5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics, KEM Hospitals
6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, LTMMC and LTMG Hospitals
7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital.

By its report dated 04.02.2017, the Medical Board as constituted by this Court has given its expert opinion upon reviewing the complete history as narrated by the petitioner No. 1 and her brother along with all the papers. The petitioner No. 1 was examined by all the Board Members with specific recourse to the specialty.

The learned Solicitor General who appears on behalf of Union of India had the report evaluated by Doctor Veena Dhawan from the Ministry of Health. The said Doctor does not disagree with the findings by the Medical Board and is also in agreement with the proposed action by the Medical Board. The salient features of the report are:

> ".. Ultrasonography diagnosis is single live fetus with gestational age of 24 weeks 3 days with bilateral renal agenesis with double outlet right ventricle with ventricular septal defeat with two vessel cord with anhydramnios....
>
> Opinion of Pediatric Surgeon in charge of Birth Defect Clinic : There is risk of intrauterine fetal death/ still birth and there is no chance of long term post natal survival, and no curative treatment is available at present for bilateral rengalagenesis.

There is thus a clear diagnosis of the condition of the single live fetus which is said to have bialateral renal agenesis wheich means the fetus has no kidneys and anhydramnios which means that there is an absence of amniotic fluid in the womb. Further, there is a clear observation that there is a risk of intrauterine fetal death, i.e. death within womb and there is no chance of a long term post natal survival. What is important is that there is no curative treatment available at present for bilateral renalagenesis.

The Medical Board has opined that the condition of the fetus is incompatible with extra-uterine life, i.e. outside the womb because prolonged absence of amniotic fluid results in pulmonary hypoplasia leading to severe respiratory insufficiency at birth. From the point of view of the

petitioner the report has observed risk to the mother since continuation of pregnancy can endanger her physical and mental health.

We have already vide order dated 16.01.2017 upheld the right of a mother to preserve her life in view of foreseeable danger in case the pregnancy is allowed to run its full course. This Court in that case relied upon the case of Suchita Srivastava and Anr. vs. Chandigarh Administration [(2009) 9 SCC 1], where a bench of three Judges held "a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution". In these circumstances we find that the right of bodily integrity calls for a permission to allow her to terminate her pregnancy. The report of the Medical Board clearly warrants the inference that the continuance of the pregnancy involves the risk to the life of the petitioner and a possible grave injury to her physical or mental health as required by Section 3 (2)(i) of the Medical Termination of Pregnancy Act, 1971. It may be noted that Section 5 of the Act enables termination of pregnancy where an opinion if formed by not less than two medical practitioners in a case where opinion is for the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

Though the current pregnancy of the petitioner is about 24weeks and endanger to the life and inevitable to the death of the fetus outside womb, we consider it appropriate to permit the petitioner to under go termination of her pregnancy under the provisions of the Medical Termination of PregnancyAct,1971. We order accordingly.

The termination of pregnancy of petitioner no.1 will be performed by the Doctors of the hospital where she has undergone medical check-up. Further, termination of her pregnancy would be supervised by the above stated Medical Board who shall maintain complete record of the procedure which is to be performed on petitioner No.1 for termination of her pregnancy.

Shri Ranjit Kumar, learned solicitor General rightly points out that the affidavit in the present case is not sworn by petitioner No. 1 who seeks termination of her pregnancy and is sworn by a Doctor who is petitioner No.3. We might note that a relator action may not be permitted in a case of this kind. There would be various circumstances about which the Court must be assured of before the order is made. Conceivably, in a given case petitioner No. 1 may be under some misconception or under coercion. We do not find that to be case here because Petitioner No. 1 has been examined by the Medical Board about her mental condition. In fact the Board has made a psychiatric evaluation of her and has stated that the patient is co-operative and coherent and has no psychiatric or emotional problems. Hence we do not propose to deny relief to petitioner No. 1. It is however, made clear that such action must be supported by affidavits of the petitioner No. 1 herself. Needless to state that KEM Hospital will take her consent before terminating her pregnancy.

With the aforesaid directions, the instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy.

.... [S. A. BOBDE]

.......................J [L. NAGESWARA RAO]

NEW DELHI;

FEBRUARY 07, 2017.

ITEM NO.4 **COURT NO.9** **SECTION X**

SUPREME COURT OF INDIA
RECORD OF PROCEEDINGS

Write Petition (s) (Civil) No(s). 81/2017

MRS. X AND ORS Petitioner(s)

VERSUS

UNION OF INDIA AND ORS Respondent(s)

(With appln. for non-disclosure of names and details of the petitioner Nos. 1 & 2 and office report)

Date : 07/02/2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE S.A. BOBDE HON'BLE MR. JUSTICE L. NAGESWARA RAO

For Petitioner(s) Ms. Sneha Mukherjee,Adv.

Mr. Satya Mitra,Adv.

For Respondent(s) Mr. Ranjit Kumar,S.G.

Ms. Sadhana Sandhu, Adv. Mr. G.S. Makker, Adv.

Mr. Nishant R. Katneshwarkar, Adv.

UPON hearing the counsel the Court made the following

ORDER

Application for non-disclosure of names and details of petitioner No. 1 and 2 is allowed.

With the directions contained in the signed order writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow petitioner No. 1 to undergo medical termination of her pregnancy.

[Charanjeet Kaur]
A.R.-cum-P.S.

[Indu Pokhriyal]
Court Master

[Signed reportable order is placed on the file]

OUT-T O D AY

ITEM NO.11 **COURT NO.8** **SECTION X**

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition (Civil) No.121/2017

SAVITA SACHIN PATILANDANR. Petitioner(s)

VERSUS

UNION OF INDIA AND ORS. Respondent(s)

(With office report)

Date : 28/02/2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE S.A. BOBDE HON'BLE MR. JUSTICE L. NAGESWARA RAO

For Petitioner(s) Mr. Colin Gonsalves, Sr. Adv. Sneha

Ms. Mukherjee, Adv.

Mr. Satya Mitra,Adv.

For Respondent(s) Mr. Ranjit Kumar, Ld. SG

Ms. Sadhana Sandhu, Adv.

Mr. G.S. Makker, Adv.

Mr. A.K. Panda, Sr. Adv. Kiran

Ms. Bhardwaj, Adv.

Mr. M.K. Maroria, Adv.

Mr. Kunal A. Cheema, Addl. Govt. Adv. Yogesh

Mr. K. Ahirrao, Adv.

Mr. Nishant R. Katneshwarkar, Adv.

UPON hearing the counsel the Court made the following

ORDER

Petitioner No.1 - Savita Sachin Patil, has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to under go medical termination of her pregnancy.

We are constrained to pass this order being conscious of the fact that any permission at this stage would be irreversible.

By order dated 23.2.2017, while issuing notice to the respondents, this Court gave a direction for examination of petitioner no.1 by a Medical Board consisting of the following seven Doctors:

1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G&K) -Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital
3. Dr. Amar Pazare, professor and HOD, Medicine, KEM Hosptial
4. Dr. Indrani Hemantkumar Chincholi, Professor and HOD, Anaesthesia, KEM Hospital
5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics, KEM Hospitals
6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, LTMMC and LTMG Hospitals
7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital.

Petitioner No.1 is 37 years old and she is into her 26 weeks of pregnancy as on 25.2.2017. This is also borne by the medical report dated 25.2.2017, received from the Dean & Director (ME &

MH)'s Office, Seth G.S. Medical College & KEM Hospital, Parel, Mumbai - 400 012.

It is not in dispute that the fetus of petitioner no.1 has been diagnosed with Trisomy 21, more commonly known as Down Syndrome, a condition that causes severe physical and mental retardation to the fetus.

As in all such cases, two important considerations are involved - (i) danger to the life of the mother, and (ii) danger to the life of the fetus.

The Medical Board has submitted its report dated 25.2.2017. On perusal of the said report, we find that the said report contains the following two significant features for the purposes of passing this order:

(1) As far as the mother is concerned, the report states that *"there is no physical risk to the mother of continuation or termination of pregnancy";*

(2) As far as the fetus is concerned, the report states that *"if the baby is born with Trisomy 21, it is likely to have mental and physical challenges".*

As regards the prognosis, the said medical report clearly does not and possibly cannot, observe that this particular fetus will have severe mental and physical challenges. It states that the *"baby is likely to have mental and physical challenges."*

In the earlier part of the said medical report, there is no observation made by the aforestated Medical Board that every baby with Down Syndrome has low intelligence, but it was observed that *"intelligence among people with Down Syndrome is variable and a large proportion may have an intelligence Quotient of less than 50 (severe mental retardation)".*

In any case, it is not possible to discern the danger to thelifeofpetitionerno.1incasesheisnotallow ed to terminate her pregnancy.

In the facts and circumstances of the case, it is not possible for us to grant permission to petitioner no.1 to terminate the life of the fetus.

In view of the above, as it presently advised, we decline the prayer (a) of the petitioners for directing the respondents to allow Petitioner No.1 to undergo medical termination of the pregnancy.

List the matter along with Civil Appeal No.7702 of 2014, for further considerations.

(Sanjay Kumar-II)	(Indu Pokhriyal)
Court Master	Court Master

(Copy of this order be given today)

IN THE SUPREME COURT OF INDIA CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO.174 OF 2017

SHEETAL SHANKAR SALVIANDANR PETITIONER(S)

VERSUS

UNION OF INDIA AND ORS RESPONDENT(S)

O R D E R

Petitioner No.1 - Sheetal Shankar Salvi, has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy.

By order dated 22.3.2017, while issuing notice to the respondents, this Court gave a direction for examination of petitioner no.1 by a Medical Board consisting of the following seven Doctors:

1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G&K) - Chairman
2. Dr. Shubhangi Parkar, Professor and HOD, Psychiatry, KEM Hospital
3. Dr. Amar Pazare, professor and HOD, Medicine, KEM Hosptial
4. Dr. Indrani Hemantkumar Chincholi, Professor and HOD, Anaesthesia, KEM Hospital
5. Dr. Y.S. Nandanwar, Professor and HOD, Obstetrics, KEM Hospitals

6. Dr. Anahita Chauhan, Professor and Unit Head, Obstetrics & Gynecology, LTMMC and LTMG Hospitals
7. Dr. Hemangini Thakkar, Addl. Professor, Radiology, KEM Hospital.
8. Petitioner No.1 is into her 27 weeks of pregnancy. This is also borne by the medical report dated 25.3.2017, received from the Dean & Director (ME & MH)'s Office, Seth G.S. Medical College & KEM Hospital, Parel, Mumbai - 400 012.

It is not in dispute that the fetus of petitioner no.1 has been diagnosed with polyhydramnios with Arnold Chairi malformation Type 2 severe hydrocephalus with lumbosacral meningo myelocele and spina bifida with tethered cord.

The Medical Board has submitted its report dated 25.3.2017. On perusal of the said report, we find that the said report contains the following significant features for the purposes of passing this order:

(1) The diagnosis of Arnold Chairi malformation Type 2 with meningo myelocele with tethered cord has been made on the basis of ultrasonography.

(2) The mother's physical condition is normal and there is no physical risk to the mother, due to continuation or termination of pregnancy. But she is anxious about outcome of pregnancy.

(3) The fetus has severe physical anomalies which will compromise post natal quality of life and the child will have severe physical and mental morbidity on survival.

(4) If the pregnancy is terminated at 27 weeks, the baby may be born alive and may survive for variable period of time.

Apparently, it has not been possible for the aforesaid Medical Board to determine the period of time for which the baby is likely to survive. It also appears from the said report that the baby is not likely to survive like a normal baby.

However, having regard to the fact that there is no danger to the mother's life and the likelihood that 'the baby may be born alive and may survive for variable period of time, we do not consider it appropriate in the interests of justice to direct the respondents to allow petitioner no.1 to undergo medical termination of her pregnancy. In fact, the aforesaid Medical Board has itself stated that it does not advise medical termination of pregnancy for petitioner no.1 on medical grounds.

The only other ground that appears from the observations made in the aforesaid medical report apart from the medical grounds, is that petitioner no.1 is anxious about the outcome of the pregnancy. We find that the termination of pregnancy cannot be permitted due to this reason.

In the facts and circumstances of the case, it is not possible for us to grant permission to petitioner no.1 to terminate the life of the fetus.

In view of the above, as at presently advised, we decline the prayer of the petitioners for directing the respondents to allow Petitioner No.1 to undergo medical termination of the pregnancy.

Hence, the writ petition is dismissed.

.......................J

[S. A.BOBDE]

.......................J [L. NAGESWARA RAO]

NEW DELHI;

MARCH 27, 2017.

ITEM NO.49 COURT NO.9 SECTION X

SUPREME COURT OF INDIA RECORD OF PROCEEDINGS

Writ Petition (Civil) No.174/2017

SHEETAL SHANKAR SALVIANDANR Petitioner(s)

VERSUS

UNION OF INDIA AND ORS Respondent(s)

(With office report)

Date : 27/03/2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE S.A. BOBDE HON'BLE MR. JUSTICE L. NAGESWARA RAO

For Petitioner(s)	Ms. Sneha Mukherjee,Adv.
	Mr. Satya Mitra,Adv.
For Respondent(s)	Mr. Ranjit Kumar, Ld.SG
	Ms. Sadhana Sandhu, Adv. Mr. G.S. Makker, Adv.
	Mr. Nishant R. Katneshwarker, Adv. Mr. Arpit Rai, Adv.

UPON hearing the counsel the Court made the following

ORDER

The writ petition is dismissed in terms of the signed reportable order.

(Sanjay Kumar-II)	(Indu Pokhriyal)
Court Master	Court Master

(Signed Reportable Order is placed on the file)

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (C) NO.431 OF2017

SARMISHTHA CHAKRABORTTY & ANR. Petitioner

VERSUS

UNION OF INDIA SECRETARY & ORS. Respondent

O R D E R

The petitioners, the husband and wife, have moved this petition under Article 32 of the Constitution with manifold prayers. In the course of hearing, Mr. Colin Gonsalves, learned senior counsel appearing for the petitioners, has restricted his argument to prayer (g) which pertains to issue of direction for constituting a medical board to assess the pregnancy of the 1st petitioner and direct for termination of the pregnancy.

When the matter was listed on 21.6.2017, the Court took note of the prayer for appointment of a panel of doctors at a Government hospital in Kolkata to examine the state of health of the mother and accordingly directed the matter to be listed on 23.6.2017. When the matter was listed on 23.6.2017, this Court had passed the following order:-

> I n pursuance of the previous order of this Court "dated 21.06.2017,
>
> ARORA learned standing counsel appearing on behalf of the State of West Bengal placed on the record his instructions indicating that a team of senior Doctors may be constituted

to evaluate the mental and physical health of the first petitioner and the state of health of the foetus. At this stage, the pregnancy is in its 25thweek.

The court has been apprised of the medical reports produced on record by the petitioners, including the opinion of Doctor Devi Shetty, which is annexed to the paper book. We accordingly constitute a Medical Board consisting of the following Doctors to examine the first petitioner and her foetus at the Institute of Post Graduate Medical Education & Research (SSKM Hospital) situated at 244 A.J.C. Bose Road, Kolkata -700020:

NAME	HOSPITAL ATTACHED
Prof.(Dr.) Arati Biswas	National Medical College & Hospital
Prof (Dr.) Suchandra Mukherjee	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Utpal Das	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Subhas ChandraBiswas	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Acchyut Sarkar	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Sujitesh Saha	I.P.G.M.E.R. (SSKM Hospital)
Prof(Dr.) Santanu Datta	I.P.G.M.E.R. (SSKM Hospital)

We request the Medical Board to examine the first petitioner and to submit its evaluation report of the first petitioner and the foetus to this court on 29.06.2017 in a sealed cover. A copy shall also be furnished to the Standing counsel for the State of West Bengal in sealed cover.

List on 29th June, 2017."

In pursuance of the aforesaid order, a Medical Board was constituted and a report was submitted before this Court on 29.6.2017. Thereafter, the matter was directd to be listed today.

It is submitted by Mr. Colin Gonsalves, learned senior counsel appearing for the petitioners that the medical report clearly stipulates the condition of the 1st petitioner and if the report is appositely appreciated, the direction, as prayed for, deserves to be granted. We think it appropriate to reproduce the observations and opinion of various members of the Medical Board. The report of the Medical Board reads as under :-

"Observation of Dr. Utpalendu Das, Professor& H.O.D. of Radiology, IPGMER-SSKM Hospital, Kolkata- As per the available medical records including anomaly scan dated 25/05/2017 at gestational age of 20 weeks 5 days reveals single life intrauterine fetus with

normal fetal anatomy and grown except cardiac anomally with suggestion of Tetralogy of Fallot:

Fetal Echocardiography done on 6th June, 2017 reveals-

Tetralogy of Fallot

Large perimembranous VSD with inlet extension (bidirectional flow)

Aorta from LV overriding the VSD Pulmonary atresia

Duct/MAPCA dependent pulmonary circulation Good Veticular Function

Opinion of Dr. Saroj Mondal, Asst. Professor of the Department of Cardiology, IPGMER-SSKM Hospita, Kolkata regarding continuation of pregnancy of Mrs. Sarmistha Chakrabortty, who is carrying 20 weeks 5 days as on 25.05.2017 of pregnancy with normal fetal growth having fetal cardiac malformation detected by fetal echo cardiography on 6th June, 2017 in the form of

Tetralogy of Fallot

Large perimembranous VSD with inlet extension (bidirectional flow)

Aorta from LV overriding the VSD Pulmonary atresia

Duct/MAPCA dependent pulmonary circulation Good Veticular Function

As the fetus has complex cardiac anomaly and if pregnancy continued mother will need delivery in a highly equipped centre with facility of neonatal cardiac intervention and surgical facility and will need multiple staged cardiac surgical operation and each occasion, it will have high morbidity and mortality risk.

This case, I already discussed with Dr. Acchyut Sarkar, Associate Professor of the Department of Cardiology, IPGMER-SSKM Hospital, Kolkata who is appointed as Pediatic Cardiologist of this Medical Board.

Impression of Dr. Santanu Dutta, Associate Professor of the Department of C.T.V.S.,

IPGMER-SSKM Hospital, Kolkata - As per the medical reports available, the fetal echocardiography shows Fetal complex congenital cyanotic heart disease.

Impression:

Pulmonary Artesia with Hypoplastic PAS, large VSD and collaterals arising from aorta.

It is evident from the report tha the neonate needs complex cardiac corrective surgery stage by stage after birth. But there is high mortality at every step of this type of staged surgeries

Opinion of Dr. Sujitesh Saha, Associate Professor of the Department of Paed. Surgery, IPGMER - SSKM Hospital, Kolkata

As per the medical reports and fetal echo cardiogram done on 6th June, 2017, the fetus is having tetralogy of Fallot, Pulmonary atresia and large VSD, Multiple Collaterals arising from aorta to support the pulmonary circulation. As per records, there is no other fetal congenital malformation detected.

On examination fetal growth parameters are normal. After birth multiple staged cardiac corrective surgery will be required which will be associated with high mortality and morbidity at every stage.

Opinion of Dr. Suchandra Mukherjee, Professor &HOD of Neonatology, IPGMER-SSKM Hospital, Kolkata

Pet the fetal echo-cardigraphy report dated 6th June, 2017, the fetus s having tetralogy of Fallot. Pulmonary atresia and large VSD, Multiple Collaterals arising from aorta to support the pulmonary circulation. No ther fetal congenital malformation was demonstrated in the anomalies scan done at 20 weeks of gestation on 25th May 2017 and fetal growth parameter was found to be normal.

In view of the cardiac malformation, the baby, after birth will require intensive cardiac monitoring and staged management through the surgical procedures which will have high risk of morbidity and mortality depending upon the postnatal course.

Finally in pursuance of the Notice of the Director, IPGMER, Kolkata vide Memo N. Inst./5445 dated 23rd June, 2017, a medical board has been convened at 10.00 am on 27th June, 2017 in the Office Chamber of Dr. S.C. Biswas, Professor of the Department of Gynae & Obst, IPGMER-SSKM Hospital, in presence of all members of the constituted Medical Board by the Hon'ble Supreme Court, India. However, Associate Professor Dr. Acchyut Sarkar, Department of Cardiology was absent. He deputed Dr. Saroj Mondal, instead of him to express the view of Pediatric Cardiologist, IPGMER-SSKM Hospital , Kolkata

The patient, 1st Petitioner of the case Mrs. Sarmisth Chakrabortty, 33 years old, w/o Mr. Anirban Chakrabortty was examined by the Board Members and all the members expressed their views. Two Gynaecologists, (1) Professor Subhash Chandra Biswas & (2) Professor

Arati Biswas, on good faith examined the patient physically and observed the following findings:

Her L.M.P.-27.12.2016 E.D.D.-4.10.2017

& she is G2Po+1+0+0

Previous pregnancy- she had sudden bleeding P/V & pain abdomen at approximately seven and half months and delivered in Appolo Hospital, Kolkata, a still born baby vaginally (as per previous records) in 2015.

On examination-

She is conscious and co-operative with profound mental agony.

Her Vitals-stable

Per abdominal examination reveals

1. Fundal height of gravid uterus- 24 weeks+ (approx 26 weeks) (Corresponding to period of amennaorhoea)
2. Liqour -adequate (as per period of gestation)
3. Fetal parts -Palpable
4. F.H.S.+ &Regular

Patient, herself spontaneously expressed her wish not to continue this pregnancy in view of the detected fetal cardiac anomalies so far. On reviewing of the available records of the patient i.e. U.S.G., Fetal Echo - Cardiography including the prescription of the attending Obstetrician in Apollo Hospital, Kolkata, the other members of the Board (Radiologist, Cardiologist, Neonatologist, Pediatric Surgeon and Cardiac Surgeon)have opined that "the fetus has been detected to have cardiac malformation in the form of Tetralogy of Fallot, Large perimembranous VSD with inlet extension (bidirectional flow), Aorta from LV overriding the VSD, Pulmonary Atresia, Duct / MAPCA dependent pulmonary circulation and Good Ventricular function. The child, if born alive, need complex cardiac corrective surgery stage by stage after birth. But there is high mortality and borbidity at every step of this staged surgeries". The cardiac anomaly has been confirmed by serial investigations.

In view of the above facts and opinion, we, the two Gynaecologists, in good faith like to opine that the patient is at the threat of severe mental injury, if the pregnancy is continued.

Therefore, if the patient wants termination of this pregnancy, she may be allowed with prior informed consent of inherent risk of her health for procedural inventions, because

> there is additional risk of termination of the pregnancy once it is beyond 20 weeks as the present case is. However, this is a special case and conclusion has been drawn on its individual merits."

On a perusal of the aforesaid report, it is clear as crystal that the Medical Board is of the view that it is a case for termination of pregnancy, as a special case. As the last paragraph would show, the Board has mentioned that the patient is at the threat of severe mental injury, if the pregnancy is continued. It has also opined that the child, if born alive, needs complex cardiac corrective surgery stage by stage after birth. But there is high mortality and borbidity at every step of this staged surgeries.

Mr. Gonsalves, learned senior counsel has drawn our attention to two orders, one passed in *Meera Santosh Pal & Ors.* vs. *Union of India & Ors.*[WP (C) No. 17 of 2017 decided on 16.1.2017], wherein this Court, after considering the report of the Medical Board, has held thus :-

> "Upon evaluation of petitioner no.1, the aforesaid Medical Board has concluded that her current pregnancy is of about 24 weeks. The condition of the fetus is not compatible with extra-uterine life. In other words, the fetus would not be able to survive outside the uterus.
>
> Importantly, it is reported that the continuation of pregnancy can gravely endanger the physical and mental health of petitioner no.1 and the risk of her termination of pregnancy is within acceptable limits with institutional backup."

Learned senior counsel has also drawn our attention to another order passed in Mrs. X & Ors. vs. Union of India & Ors.[WP (C) No.81 of 2017 decided on 7.3.2017] wherein this Court had allowed the termination of pregnancy. The Court had taken the Medical report into consideration which was to the following effect:

> "There is thus a clear diagnosis of the condition of the single live fetus which is said to have bialateral renal agenesis which means the fetus has no kidneys and anhydramnios which means that there is an absence of amniotic fluid in the womb. Further, there is a clear observation that there is a risk of intrauterine fetal death, i.e. death within womb and there is no chance of a long term post natal survival. What is important is that there is no curative treatment available at present for bilateral renal agenesis.
>
> The Medical Board has opined that the condition of the fetus is incompatible with extra-uterine life, i.e. outside the womb because prolonged absence of amniotic fluid results in pulmonary hypoplasia leading to severe 4 respiratory insufficiency at birth. From the point of view of the petitioner the report has observed risk to the mother since continuation of pregnancy can endanger her physical and mental health.

Mr. A.K. Panda, learned senior counsel appearing for the Union of India has drawn our attention to two other orders, one passed in Savita Sachin Patil & Ors.vs. Union of India and Ors.[WP (C)

No. 121 of 2017 decided on 28.02.2017]and another in Sheetal

Shankar Salvi & Anr.vs. Union of India & Ors.[W.P. No.174 of 2017 decided on 27.3.2017]. In the case of Savita Sachin Patil, the Court declined to grant permission by holding, thus:

> "As regards the prognosis, the said medical report clearly does not and possibly cannot, observe that this particular fetus will have severe mental and physical challenges. It states that the *"baby is likely to have mental and physical challenges."*
>
> In the earlier part of the said medical report, there is no observation made by the aforestated Medical Board that every baby with Down Syndrome has low intelligence, but it was observed that *"intelligence among people with Down Syndrome is variable and a large proportion may have an intelligence Quotient of less than 50 (severe mental retardation)".*
>
> In any case, it is not possible to discern the danger to the life of petitioner no.1 in case she is not allowed to terminate her pregnancy.
>
> In the facts and circumstances of the case, it is not possible for us to grant permission to petitioner no.1 to terminate the life of the fetus.
>
> In view of the above, as it presently advised, we decline the prayer (a) of the petitioners for directing the respondents to allow Petitioner No.1 to undergo medical termination of the pregnancy."

In *Sheetal Shankar Salvi*, after perusing the report, the Court observed that there is no danger to mother's life and the liklihood that the baby may be born alive and survive for variable period of time, and, therefore, it would not be appropriate to allow the petitioner No.1 to undergo medical termination of her pregnancy.

The orders which have been referred to by Mr. Panda, in our considered opinion, rest on their own facts. Frankly speaking, cases of this nature have to rest on their own facts because it shall depend upon the nature of the report of the Medical Board and also the requisite consent as engrafted under the Medical Termination of Pregnancy Act,1971.

In the instant case, as the report of the Medical Board, which we have produced, in entirety, clearly reveals that the mother shall suffer mental injury if the pregnancy is continued and there will be multiple problems if the child is born alive. That apart, the Medical Board has categorically arrived at a conclusion that the in a special case of this nature, the pregnancy should be allowed to be terminated after 20weeks.

In the case of *Suchita Srivastava & Anr.* vs. *Chandigarh Administration* [(2009) 9 SCC 1), the Court has expressed the view that the right of a woman to have reproductive choice is an insegregable part of her personal liberty, as envisaged under Article 21 of the Constitution. She has a sacrosanct

right to have her bodily integrity. The case at hand, as we find, unless the pregnancy is allowed to be terminated, the life of the mother as well as that of the baby to be born will be in great danger. Such a situation cannot be countenanced in Court.

Regard being had to the aforesaid and keeping in view the report of the Medical Board, we are inclined to allow the prayer and direct medical termination of pregnancy of the 1st petitioner at the IPGMER-SSKM Hospital. The termination procedure to be carried out forthwith by the competent authorities of the IPGMER-SSKM Kolkata. For the sake of clarity, we may hasten to add that Mr. Gonsalves, upon obtaining instructions, has agreed for the said hospital. When we say, 'carried out forthwith' it depends when the 1st petitioner and her husband go to the hospital, it shall be conducted without any delay.

Accordingly, the Writ Petition is disposed of.

....................,J.
(Dipak Misra)

New Delhi; July 3, 2017

....................,J.
(A.M. Khanwilkar)

ITEM NO.56 COURT NO.2 SECTION X

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition (s) (Civil) No(s). 431/2017

SARMISHTHA CHAKRABORTTY & ANR. Petitioner(s)

VERSUS

UNION OF INDIA SECRETARY & ORS. Respondent(s)

Date : 03-07-2017 This petition was called on for hearing today. CORAM: HON'BLE

MR. JUSTICE DIPAK MISRA

HON'BLE MR. JUSTICE A.M. KHANWILKAR

For Petitioner(s) Mr. Colin Gonsalves, Sr.Adv.

Ms. Sneha Mukherjee, Adv. Satya Mitra, AOR

For Respondent(s) Mr. Chanchal Kumar Ganguli,AOR

Mr Sankar Ch. Ghosh, Adv. Ms. Narmada, Adv.

Mr. A.K. Panda, Sr. Adv.

Mr. Swrapurna Chaturvedi, Adv. Mr. Vipin Kumar, Adv.

Mr. Gurmeet Singh Makker, AOR

UPON hearing the counsel the Court made the following

ORDER

The writ petition is disposed of in terms of the signed order.

(Gulshan Kumar Arora)
Court Master

(H.S. Parasher)
Court Master

(Signed order is placed on the file)

ITEM NO.39 **COURT NO.2** **SECTION X**

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition (Civil) No.551/2017

SONALI SANDEEP JADHAV & ANR. Petitioner(s

VERSUS

UNION OF INDIA & ORS. Respondent(s)

Date : 28-07-2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE DIPAK MISRA HON'BLE MR. JUSTICE A.M. KHANWILKAR

For Petitioner(s) Mr. Colin Gonsalves, Sr.Adv.

Ms. Sneha Mukherjee, Adv. Mr. Satya Mitra, AOR

For Respondent(s) Mr. Nishant Ramakantrao Katneshwarkar,Adv.

Mr. Arpit Rai, Adv.

UPON hearing the counsel the Court made the following

ORDER

On 24th July, 2017, this Court had passed the following order:-

"Heard Mr. Colin Gonsalves, learned senior counsel along with Ms. Sneha Mukherjee, learned counsel for the petitioners.

A copy of the writ petition has been served on Mr. Nishant Katneshwarkar, learned standing counsel for the State of Maharashtra-respondent No.2.

It is submitted by Mr. Colin Gonsalves, learned senior counsel that the petitioner is at present pregnant and her pregnancy is of 22 weeks who has been examined by Dr. K.N. Singh, a Paediatric Neurologist and has recorded the following findings:

> "Sonography examination of gravid uterus (anomaly scan) done at Lilavati Hospital and Research Centre on 24.06.2017 showed both lateral ventricles are moderately dialated. Lateral ventricle at atrium measures: 14 mm. Hence, fetal MRI which is more sensitive was performed at Global Hospitals, Parel on 28.6.2017 which revealed moderate symmetric dialatation of the lateral ventricles. Each ventricle measures approximately 1.6. cm at the level of the atrium. The cavum septum pellucidum is well visualised. There is mild dialation of the third ventricle. Fourth ventricle is normal. The cerebral aueduct is not visualised. No flow is detected in the cerebral aqueduct. There is thinning of the surrounding cortical mantle and white matter.
>
> Impression:
>
> MRI of the fetal brain reveals moderate symmetric obstructive hypocephalus. These findings are consistent with cerebral stenosis. There is thinning of the brain parenchyma.
>
> The dilatation of the ventricles is likely to increase with the passage of time and may increase significantly before delivery causing harm to the developing brain and possibly cognitive impairment. After birth bay will need neurosurgical procedure like shunting which may be quite costly."
>
> In view of the aforesaid, we are inclined to direct that the petitioner shall be examined by Medical Board consisting of Heads of the Departments of Gynecology, Neurology and Cardiology of J.J. Hospital at Mumbai. The examination shall take place within two days. Mr. Katneshwarkar, learned standing counsel appearing for the State of Maharashtra shall see to it that the authorities make all the arrangements.

Let the matter be listed on Friday, 28th July, 2017. The report shall be brought in a sealed cover by Mr. Katneshwarkar and produced before us on the date fixed for hearing."

In pursuance of the aforesaid order, the petitioner No.1 has been examined by a team of experts of Sir J.J. Group of Hospitals. The observations of the Obstetrician and Gynecologist reads as follows:-

"Pregnancy diagnosed in second month of preganancy at Matoshri Ramabai Ambedkar Nager, Prasuti Graha, Chembur Naka, Mumbai by Urinary Pregnancy Test. OPD No.564, dt.20/03/2017

- USG done by Dr. Anirudha Badade, MD. DMRD., on 27/03/2017 shows pregnancy of 8 weeks 4days.
- Her second visit was on 02/05/2017.
- In her third visit on 13/06/2017 she was advised fetal anomalyscan.
- Anomaly scan done on by Dr. Anirudha Badade, MD. DMRD., 23/06/2017 shows 21 weeks 1 day pregnancy.
- It shows ventriculomegaly (SIV) atrial diameter 13mm.
- USG done at Lilawati Hospital 24/06/2017 shows lateral ventricle 14 mm. Isolated bilateral moderate lateral ventriculomegaly.
- Fetal MRI done at Global Hospital dt.28/06/2017 showed moderate symmetrical obstructive Hydrocephalus consistent with cerebral aqueductal stenosis with thinning of parenchyma.
- Dr. Deepak Ugra, MD. (PAED) FRCPCH (London). Consultant Pediatricial at Lilawati Hospital, Research Centre, Mumbai on 30/06/2017 opined that the a very high probability that the baby will have a significant brain damage.
- On 04/07/2017 Dr. K.N. Shah, Pediatric Neurologist states that dilatation of ventricles is likely to increase with the passage of time and may increase significantly before delivery causing harm to the developing brain and possibly cognitive impairment. After birth, baby will need neurological procedure like shunting which may be quite costly."

The Neurologist, who examined the petitioner No.1, has opined thus:-

"As per fetal MRI done on 28/06/2017 the fetus has complex Neurological condition called Aqueductal Stenosis and Hydrocephalus. This condition will continue to progress putting pressure effect on the brain. After the delivery, surgical treatment may be offered

which entails risk of mortality and morbidity. In spite of best possible treatment the Neurological out come is guarded in nature."

The opinion of the Cardiologist is as follows:-

"I have gone through the Ultrasonographic records of the fetus. The records do not reveal any fetal heart structural abnormalities at this time."

The final opinion of the Committee reads as follows:-

"Patient spontaneously expressed her desire not to continue with the pregnancy. She has also submitted a letter which states that she desires termination of pregnancy since there is substantial risk of mortality and morbidity in the fetus if born alive.

We find that continuation of pregnancy shall pose severe mental injury to her. We have explained hazards of the procedure which she has understood. Such terminations can only be possible if awarded by Hon'ble Supreme Court."

In view of the individual opinions of the Obstetrician and Gynecologist and the Neurologist and the ultimate opinion of the Committee, we are inclined to allow the prayer (a), as prayed for by the petitioners in the writ petition.

Be it noted, almost on similar circumstances, in the case of *Sarmishtha Chakrabortty and Anothervs. Union of India Secretary and Others* in Writ Petition (C) No.431 of 2017, decided on 3rd July, 2017, we had passed the following order:-

"Regard being had to the aforesaid and keeping in view the report of the Medical Board, we are inclined to allow the prayer and direct medical termination of pregnancy of the 1st petitioner at the IPGMER-SSKM Hospital. The termination procedure to be carried out forthwith by the competent authorities of the IPGMER-SSKM Kolkata. For the sake of clarity, we may hasten to add that Mr. Gonsalves, upon obtaining instructions, has agreed for the said hospital. When we say, 'carried out forthwith' it depends when the 1st petitioner and her husband go to the hospital, it shall be conducted with out any delay."

In the present case, we direct that the medical termination of pregnancy of the petitioner No.1, shall be carried out forthwith at Sir JJ Group of Hospitals, Mumbai, by the competent doctors after the petitioner No.1 and her husband approach the hospital. Be it stated, no delay shall be brooked.

Let a copy of the order passed today be handed over to Ms. Sneha Mukherjee, learned counsel appearing for the petitioners and Mr. Nishant Ramakantrao Katneshwarkar, learned counsel for the State of Maharashtra so that they can do the needful. The medical report submitted by Mr.

Katneshwarkar be kept on record.

The writ petition stands disposed of. There shall be no order as to costs.

(Chetan Kumar)	(H.S. Parasher)
Court Master	Court Master

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO.627 OF 2017

MAMTA VERMA PETITIONER

VERSUS

UNION OF INDIA AND ORS. RESPONDENT(S)

O R D E R

Petitioner - Mamta Verma, aged 26 years, has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy. She apprehended danger to her life, having discovered that her fetus was diagnosed with Anencephaly, a defect that leaves foetal skull bones unformed and is both untreatable and certain to cause the infant's death during or shortly after birth. This condition is also known to endanger the mother's life.

By order dated 04.08.2017, while issuing notice to the respondents, this Court gave a direction for examination of the petitioner by a Medical Board consisting of the following Doctors of Sir J.J. Group of Hospitals, Mumbai:

1. HOD,Gynecology
2. HOD,Neurology

3. Dr. Anirudha Badade, MD,DMRD
4. Dr. Deepak Ugra, MD(PAED)

It is mentioned in the report dated 08.08.2017, received from the Dean, Grant Govt. Medical College & Sir J.J. Group of Hospital, Mumbai, that Dr. Anirudha Badade, MD, DMRD, and Dr. Deepak Ugra, MD (PAED) are no more associated with Sir J.J. Group of Hospitals, Mumbai. Hence, HOD Padiatric and HOD Radiology were included in Medical Board in their place and the following members of the said hospital were present in the Board :

1) Dr. Ashok Anand, Professor & HOD, Department of Obstetrics and Gynecology
2) Dr. Kamlesh Jagyashi, Professor & HOD, Department of Neurology
3) Dr. N.R. Sutay, Professor & Head, Department of Pediatric
4) Dr. Shilpa Domkundwar, Professor & Head, Department of Radiology

The aforesaid Medical Board has examined the petitioner and stated that as on 08.08.2017, she was into her 25th week and 1 day of pregnancy. The said Board has further opined as follows :

> "Patient wants pregnancy to be terminated as the fetus is not likely to survive. It is causing immense mental agony to her.
>
> After going through the Ultrasonography reports, Committee is of opinion that there is no point to continue the pregnancy as fetus has ANENCEPHALY which is non-compatible with life and continuation of pregnancy shall pose severe mental injury toher."

We have been informed that the fetus is without a skull and would, therefore, not be in a position to survive. It is also submitted that the petitioner understands that her fetus is abnormal and the risk of fetal mortality is high. She also has the support of her husband in her decision making.

Upon evaluation of the petitioner, the aforesaid Medical Board has concluded that her current pregnancy is of 25 weeks and 1 day. The condition of the fetus is not compatible with life. The medical evidence clearly suggests that there is no point in allowing the pregnancy to run its full course since the fetus would not be able to survive outside the uterus without a skull.

Importantly, it is reported that the continuation of pregnancy can pose severe mental injury to the petitioner and no additional risk to the petitioner's life is involved if she is allowed to undergo termination of her pregnancy.

In the circumstances, we consider it appropriate in the interests of justice and particularly, to permit the petitioner to undergo medical termination of her pregnancy under the provisions of Medical Termination of Pregnancy Act, 1971. Mr. Ranjit Kumar, learned Solicitor General appearing for the respondents, has not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

The termination of pregnancy of the petitioner will be performed by the Doctors of the hospital where she has undergone medical check-up. Further, termination of her pregnancy would be supervised by the above stated Medical Board who shall maintain complete record of the procedure which is to be performed on the petitioner for termination of her pregnancy.

With the aforesaid directions, the instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow the petitioner to undergo medical termination of her pregnancy.

.......................J

[S. A.BOBDE]

.......................J [L. NAGESWARA RAO]

NEW DELHI;

AUGUST 09,2017.

ITEM NO.13 COURT NO.8 SECTION X

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition(Civil) No.627/2017

MAMTA VERMA Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)

WITH W.P.(C) No. 635/2017(X)

Date : 09-08-2017 These petitions were called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE S.A. BOBDE HON'BLE MR. JUSTICE L. NAGESWARA RA

For Petitioner(s) Ms. Sneha Mukherjee, Adv.

For Mr. Satya Mitra, AOR

For Respondent(s) Mr. Ranjit Kumar, Ld.SG

Ms. Sadhana Sandhu, Adv. For Mr. G.S. Makker, Adv.

Mr. Nishant R. Katneshwarkar, Adv. Ms. Deepa Kulkarni, Adv.

UPON hearing the counsel the Court made the following

ORDER

Writ Petition (Civil) No.627/2017

The instant writ petition is allowed in terms of the signed order.

Writ Petition (Civil) No.635/2017

List the matter on 10.08.2017 at the top of the Board.

(SANJAY KUMAR-II)	(INDU KUMARIPOKHRIYAL)
COURT MASTER (SH)	BRANCH OFFICER

(Signed Order is placed on the file)

Copy of this Order be given today

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO.635 OF 2017

TAPASYA UMESH PISAL PETITIONERS

VERSUS

UNION OF INDIA AND ORS. RESPONDENT(S)

O R D E R

Petitioner - Tapasya Umesh Pisal, aged 24 years, has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy. She apprehended danger to her life, having discovered that her fetus was diagnosed with tricuspid and pulmonary atresia, a cardiac anomaly in the fetus.

By order dated 04.08.2017, while issuing notice to the respondents, this Court gave a direction for examination of the petitioner by a Medical Board consisting of Dr. Sambare, HOD, Gynaecology and Dr. Nityanand Thakur, Paediatric Cardiac Surgeon of B.J. Govt. Medical College, Pune, and authorised it to appoint other necessary doctors, if required, for the said purpose. As per the report dated nil, received from the dean, B.J Govt. Medical College & Sassoon General Hospital, Pune, Maharashtra, the following members of the said hospital were included in the Committee/Board:

1) Dr. Ajay Chandanwale, Dean BJGMC,Pune.
2) Dr. Pradip Sambarey, Professor & Head, Obstetrics and Gynecology, BJGMC Pune.
3) Dr. Nityanand Thakur, CVTS Department BJGMC Pune.
4) Dr. Aarti Kinikar, Professor & Head, Department of Pediatrics BJGMC Pune.
5) Dr. Shephali Pawar, Professor, Department of Radiology, BJGMC Pune.

The aforesaid Medical Board has examined the petitioner and stated that as on 07.08.2017, she was into her 24th week of pregnancy. She was accompanied by her husband and they are aware of the cardiac anomaly and the associated morbidity of the baby if born alive. The salient features of the said report are as under :

1) The fetus is diagnosed as having hypo plastic right heart with tricuspid and pulmonary atresia with small size pulmonary arteries.
2) The surgeries that will be necessary on the fetus have been reported to carry high morbidity and mortality.
3) It is also reported that in spite of the surgeries, such children do not achieve normal oxygen level and would remain physically incapacitated. The life span of these children even after corrective surgeries is limited as described in medical literature.
4) The Paediatrician has reported that it appears to be an isolated complex congenital heart disease with increased morbidity and mortality post delivery.
5) The Radiologist has reported a complete absent of right ventricle and pulmonary and tricuspid valve atresia.

We also have on record the opinion of an eminent surgeon Dr. Devi Shetty of Bangalore who has stated that most of these children do not live till the adult life. Their life is precarious because of the problems resulting from low oxygenation in the body.

According to Dr. Nityanand Thakur, Cardiac Surgeon, and member of the Medical Board, there is a near certain chance of severe handicap or sudden death of the baby after birth.

Upon evaluation of the petitioner, the aforesaid Committee/Medical Board has concluded that the baby if delivered alive, would have to undergo several surgeries after birth which is associated with a high morbidity and mortality.

But for the time period, it appears that the case falls under section 3(2)(b) of the Medical Termination of Pregnancy Act, 1971, which reads asunder:

"3.When pregnancies may be terminated by registered medical practitioners.- (1)....

(2)(b) Where the length of the pregnancy exceeds twelve weeks but does not exceed twenty

weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that -

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped."

In these circumstances, it is difficult for us to refuse the permission to the petitioner to undergo medical termination of pregnancy. It is certain that the fetus if allowed to born, would have a limited life span with serious handicaps which cannot be avoided. It appears that the baby will certainly not grow into an adult.

In view of the above, we consider it appropriate in the interests of justice and particularly, to permit the petitioner to undergo medical termination of her pregnancy under the provisions of Medical Termination of Pregnancy Act, 1971. Mr. Ranjit Kumar, learned Solicitor General appearing for the respondents, has not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

The termination of pregnancy of the petitioner will be performed by the Doctors of the hospital where she has undergone medical check-up. Further, termination of her pregnancy would be supervised by the above stated Committee/Medical Board who shall maintain complete record of the procedure which is to be performed on the petitioner for termination of her pregnancy.

With the aforesaid directions, the instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow the petitioner to undergo medical termination of her pregnancy.

.......................J

[S. A.BOBDE]

.......................J [L. NAGESWARA RAO]

NEW DELHI;

AUGUST 10,2017.

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO.728 OF 2017

MRS.A PETITIONER

VERSUS

UNION OF INDIA AND ORS. RESPONDENT(S)

O R D E R

Application for non-disclosure of name and details of the petitioner is allowed.

Petitioner - Mrs. A, aged 22 years, has approached this Court under Article 32 of the Constitution of India seeking directions to the respondents to allow her to undergo medical termination of her pregnancy. She apprehended danger to her life, having discovered that her fetus was diagnosed with Anencephaly, a defect that leaves foetal skull bones unformed and is both untreatable and certain to cause the infant's death during or shortly after birth. This condition is also known to endanger the mother's life.

By order dated 28.08.2017, while issuing notice to the respondents, this Court gave a direction for examination of the petitioner by a Medical Board consisting of the following Doctors of B.J. Govt. Medical College & Sassoon General Hospital, Pune, Maharashtra:

1) Dr. Ajay Chandanwale, Dean BJGMC, Pune.
2) Dr. Pradip Sambarey, Professor & Head, Obstetrics and Gynecology, BJGMC Pune.

3) Dr. Nityanand Thakur, CVTS Department BJGMC Pune.

4) Dr. Aarti Kinikar, Professor & Head, Department of Pediatrics BJGMC Pune.

5) Dr. Shephali Pawar, Professor, Department of Radiology, BJGMC Pune.

The aforesaid Medical Board/Committee has examined the petitioner and stated that as on 30.08.2017, she was into her 25th to 26th week of pregnancy. She was accompanied by her husband and they are aware of the anomaly in fetus and chances of survival of the baby if born alive. The salient features of the said report are as under:

1) The antenatal ultrasonography of the petitioner reveals that a single live intra uterine foetus of 26 weeks +/- 7 to 10 days. There is complete absence of fetal brain and skull vault suggestive of anencephaly.

2) The Cardiothoracic Surgeon has reported that the fetus has anencephaly and polyhydramnious. He further stated that this anomaly is not compatible with life.

3) The Paediatrician has reported that the survival rate post delivery is less than 10 to 20%. He further stated that majority of those who may survive, have serious form of morbidity and succumb within 24 to 48 hours of birth.

4) The Medical Board/Committee has reported that there is no treatment for anencephaly and there are possibilities of maternal complications like polyhydromnias.

We have been informed that the fetus is without a skull and would, therefore, not be in a position to survive. It is also submitted that the petitioner understands that her fetus is abnormal and the risk of fetal mortality is high. She also has the support of her husband in her decision making.

Upon evaluation of the petitioner, the aforesaid Medical Board has concluded that her current pregnancy is of 25 to 26 weeks. The condition of the fetus is not compatible with life. The medical evidence clearly suggests that there is no point in allowing the pregnancy to run its full course since the fetus would not be able to survive outside the uterus without a skull.

Importantly, it is reported that the continuation of pregnancy can pose severe mental injury to the petitioner and no additional risk to the petitioner's life is involved if she is allowed to undergo termination of her pregnancy.

In the circumstances, we consider it appropriate in the interests of justice and particularly, to permit the petitioner to undergo medical termination of her pregnancy under the provisions of Medical Termination of Pregnancy Act, 1971. Mr. Ranjit Kumar, learned Solicitor General appearing for the respondents, has not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

The termination of pregnancy of the petitioner will be performed by the Doctors of the hospital where she has undergone medical check-up. Further, termination of her pregnancy would be

supervised by the above stated Medical Board who shall maintain complete record of the procedure which is to be performed on the petitioner for termination of her pregnancy.

With the aforesaid directions, the instant writ petition is allowed in terms of prayer (a) seeking direction to the respondents to allow the petitioner to undergo medical termination of her pregnancy.

.......................J

[S. A.BOBDE]

.......................J [L. NAGESWARA RAO]

NEW DELHI;

AUGUST 31, 2017.

ITEM NO.6 **COURT NO.7** **SECTION X**

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition(Civil) No.728/2017

MRS.A Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)

(FOR ADMISSION and IA No.77151/2017-APPLICATION FOR NON-DISCLOSURE OF NAME AND DETAILS OF PETITIONER)

Date : 31-08-2017 This petition was called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE S.A. BOBDE HON'BLE MR. JUSTICE L. NAGESWARA RAO

For Petitioner(s) Ms. Sneha Mukharjee,Adv.

Mr. Satya Mitra, AOR

For Respondent(s) Mr. Ranjit Kumar, Ld. Solicitor General

Ms. Sadhana Sandhu, Adv. For Mr. G.S. Makker, Adv.

Mr. Nishant R. Katneshwarkar, Adv.

UPON hearing the counsel the Court made the following

ORDER

Application for non-disclosure of name and details of the petitioner is allowed.

The writ petition is allowed in terms of the signed order.

(SANJAYKUMAR-II)	(INDU KUMARI POKHRIYAL)
COURT MASTER(SH)	BRANCH OFFICER

(Signed Order is placed on the file)

Note : Copy of this order be given today

ITEM NO.14 COURT NO.1 SECTION X

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No(s). 749/2017

MURUGAN NAYAKKAR Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)

Date : 06-09-2017 This petition was called on for hearing today.

CORAM: HON'BLE THE CHIEFJUSTICE

HON'BLE MR. JUSTICE AMITAVA ROY HON'BLE MR. JUSTICE A.M. KHANWILKAR

For Petitioner(s) Ms. Sneha Mukherjee,Adv.

Mr. Satya Mitra,AOR

For Respondent(s) Mr. Ranjit Kumar,SG

Mr. Gurmeet Singh Makker, AOR

Mr. Nishant R. Katneshwarkar, Adv.

UPON hearing the counsel the Court made the following

ORDER

The petitioner who is a 13 year old girl and a victim of alleged rape and sexual abuse, has preferred this writ petition for termination of pregnancy. When the matter was listed on 28.8.2017, this court has directed constitution of a Medical Board at Sir J. J,. Group of Hospitals, Mumbai. Be it noted this Court has also mentioned the composition of the team of doctors. The petitioner has appeared before the Medical that the baby boy will be preterm and will have its own complications and would require Neonatal Intensive Care Unit (N. I. C. U.) admission.

We have heard Ms. Sneha Mukherjee, learned counsel appearing for the petitioner, Mr. Ranjit Kumar, learned Solicitor General appearing for the Union of India and Mr. Nishant R. Katneshwarkar, laarned standing counsel for the State of Maharashtra.

Considering the age of the petitioner, the trauma she has suffered because of the sexual abuse and the agony she is going through at present and above all the report of the Medical Board constituted by this Court, we think it appropriate that termination of pregnancy should be allowed.

In view of the aforesaid premise, we direct the petitioner to remain present at the Sir J.J. Group of Hospitals, Mumbai in the evening of 7.9.2017 so that the termination of pregnancy can be carried out preferably on 8.9.2017. Mr. Nishant R. Katneshwarkar shall apprise the Dean of Sir J.J. Group of Hospitals, Mumbai so that he/she can make necessary arrangements for termination of the pregnancy.

A copy of the order passed today be handed over to learned counsel for the petitioner and Mr. Nishant R. Katneshwarkar, learned standing counsel for the State of Maharashtra.

The writ petition is accordingly disposed of. There shall be no order as to costs.

(Gulshan Kumar Arora)
Court Master

(Shakti Parkash Sharma)
Assistant Registrar

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (C) NO.928 OF 2017

Sonali Kiran Gaikwad Petition (s)

Versus

Union of India Respondent(s)

WITH

WRIT PETITION (C) NO.929 OF 2017

Nisha Suresh Aalam Petitioner(s)

Versus

Union of India Respondent (s)

O R D E R

Pursuant to the direction of this Court the petitioners-Sonali Kiran Gaikwad and Nisha Suresh Aalam have been examined by the Medical Board and report dated 09.10.2017 has been submitted.

After detailed examination of the petitioners-Sonali Kiran Gaikwad and Nisha Suresh Aalam, the following opinion is expressed by the Medical Board:

> "Upon examination and after carefully studying the multiple sonography reports and fetal MRI reports, it is confirmed that there are multiple serious neurological and skeletal anomolies - A Chiari II malformation along with a large neural tube defect in the lumbosacral region along with acute kyphoscoliosis. These abnormalities have high chances of morbidity and mortality in the newborn. It also requires surgical treatment. There are high chances of meningitis, mental retardation, paralysis of lower limbs and loss of urine and bowel control.
>
> The woman has been explained the outcome in a language she understands. Thus the condition of fetus fulfills the criteria of "substantial risk of serious physical handicap" in the fetus.
>
> The pregnant woman has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the condition of fetus and its outcome. She is extremely anguished with the condition of the fetus in utero.
>
> The pregnancy has advanced to 28 weeks and is beyond 20 weeks cut off of the Medical Termination of Pregnancy Act. Hence, she has approached Honourable Court for termination of pregnancy.
>
> At this stage of pregnancy the risk of termination remains the same as the natural labour at term.
>
> Thus if the Honourable Court permits, the pregnancy can be terminated as desired by the woman."

A categorical view reflected in the above said report is that if the pregnancy of the petitioners is terminated at this stage it is not going to be more hazardous than spontaneous delivery at term. On the contrary, continuing pregnancy will cause more mental anguish to the petitioners. Having regard to the aforesaid report and the law laid down by this Court in various judgments including in judgment dated 16.01.2017 in W.P.

(C) No.17 of 2017 titled as Meera Santosh Pal & Ors. vs. Union of India & Ors., the prayer made in the writ petitions(s) is allowed to the extent the petitioners are free to undergo medical termination of their pregnancy. For this purpose, petitioners-Sonali Kiran Gaikwad and Nisha Suresh Aalam may visit the hospital on 12th October, 2017 and they would be attended immediately.

The writ petitions are disposed of.

However, we make it clear that any future such cases can be filed in the respective High Courts having territorial jurisdiction.

..........................J. (A.K. SIKRI)

New Delhi, October 09,2017.

…......................J. (ASHOK BHUSHAN)

REVISED

ITEM NO.58 **COURT NO.5** **SECTION X**

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition(s) (Civil) No.928/2017

SONALI KIRAN GAIKWAD Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)

WITH

W.P.(C) No. 929/2017 (X)

Date : 09-10-2017 These petitions were called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE A.K. SIKRI HON'BLE MR. JUSTICE ASHOK BHUSHAN

For Petitioner(s) Ms. Sneha Mukherjee,Adv.

Ms.Jyoti Mendiratta, AOR

For Respondent(s) Mr. Ranjit Kumar,SG

Ms. Sadhana Sandhu,Adv. Mr.G.S. Makker,Adv.

Mr. R.R. Rajesh, Adv. Mr.M.K. Maroria, Adv.

Mr. N.R. Katneshwarkar, Adv. Ms. Suvarna G., Adv.

UPON hearing the counsel the Court made the following

O R D E R

The writ petitions are disposed of in terms of the signed order.

(USHARANIBHARDWAJ)	(MALA KUMARI SHARMA)
ARCUMPS	BRANCH OFFICER

Signed order is placed on the file.

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION

WRIT PETITION (C) NO.928 OF 2017

Sonali Kiran Gaikwad ..Petitioner(s)

Versus

Union of India Respondent(s)

WITH

WRIT PETITION (C) NO.929 OF 2017

Nisha Suresh Aalam ..Petitioner(s)

versus

Union of India ..Respondent(s)

O R D E R

Pursuant to the direction of this Court the petitioners-Sonali Kiran Gaikwad and Nisha Suresh Aalam have been examined by the Medical Board and report dated 09.10.2017 has been submitted.

After detailed examination of the petitioners-Sonali Kiran Gaikwad and Nisha Suresh Aalam, the following opinion is expressed by the Medical Board:

> "Upon examination and after carefully studying the multiple sonography reports and fetal MRI reports, it is confirmed that there are multiple serious neurological and skeletal anomolies - A Chiari II malformation along with a large neural tube defect in the lumbosacral region along with acute kyphoscoliosis. These abnormalities have high chances of morbidity and mortality in the newborn. It also requires surgical treatment. There are high chances of meningitis, mental retardation, paralysis of lower limbs and loss of urine and bowel control.
>
> The woman has been explained the outcome in a language she understands. Thus the condition of fetus fulfills the criteria of "substantial risk of serious physical handicap" in the fetus.
>
> The pregnant woman has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the condition of fetus and its outcome. She is extremely anguished with the condition of the fetus in utero.
>
> The pregnancy has advanced to 28 weeks and is beyond 20 weeks cut off of the Medical Termination of Pregnancy Act. Hence, she has approached Honourable Court for termination of pregnancy.
>
> At this stage of pregnancy the risk of termination remains the same as the natural labour at term.
>
> Thus if the Honourable Court permits, the pregnancy can be terminated as desired by the woman."

A categorical view reflected in the above said report is that if the pregnancy of the petitioners is terminated at this stage it is not going to be more hazardous than spontaneous delivery at term. On the contrary, continuing pregnancy will cause more mental anguish to the petitioners. Having regard to the aforesaid report and the law laid down by this Court in various judgments including in judgment dated 16.01.2017 in W.P.

(C) No.17 of 2017 titled as Meera Santosh Pal & Ors. vs. Union of India & Ors., the prayer made in the writ petitions(s) is allowed to the extent the petitioners are free to undergo medical termination of their pregnancy. For this purpose, petitioners-Sonali Kiran Gaikwad and Nisha Suresh Aalam may visit the hospital on 12th October, 2017 and they would be attended immediately.

The writ petitions are disposed of.

However, we make it clear that any future such cases can be filed in the respective High Courts having territorial jurisdiction.

..........................J. (A.K. SIKRI)

…........................J. (ASHOK BHUSHAN)

New Delhi,

October 09,2017

ITEM NO.58 **COURT NO.5** **SECTION X**

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition(s)(Civil) No.928/2017

SONALI KIRAN GAIKWAD Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)

WITH

W.P.(C) No. 929/2017 (X)

Date : 09-10-2017 These petitions were called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE A.K. SIKRI HON'BLE MR. JUSTICE ASHOK BHUSHAN

For Petitioner(s) Ms. Sneha Mukherjee,Adv.

Ms.Jyoti Mendiratta, AOR

For Respondent(s) Mr. Ranjit Kumar,SG

Ms. Sadhana Sandhu,Adv. Mr.G.S. Makker,Adv.

Mr. R.R. Rajesh, Adv. Mr.M.K. Maroria, Adv.

Mr. N.R. Katneshwarkar, Adv. Ms. Suvarna G., Adv.

UPON hearing the counsel the Court made the following

O R D E R

The writ petitions are disposed of in terms of the signed order.

(USHARANIBHARDWAJ)	(MALA KUMARI SHARMA)
ARCUMPS	BRANCH OFFICER

Signed order is placed on the file.

ITEM NOS. 58, 59and60 COURT NO.6 SECTION X

SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition (Civil) No. 930/2017

POONAM CHANDAN YADAV Petitioner(s)

VERSUS

UNION OF INDIA & ORS. Respondent(s)

Writ Petition (Civil) No.928/2017

Writ Petition (Civil) No.929/2017

Date : 03-10-2017 These petitions were called on for hearing today.

CORAM :

HON'BLE MR. JUSTICE A.K. SIKRI HON'BLE MR. JUSTICE ASHOK BHUSHAN

For Petitioner(s)

Ms. Sneha Mukharjee, Adv. Ms. Jyoti Mendiratta, AOR

For Respondent(s)

UPON hearing the counsel the Court made the following

O R D E R

Learned counsel appearing for the petitioners submits that J.J. Hospital, Mumbai, has already constituted a Medical Board of the following Doctors for such cases:

1. Dr. Ashok Anand, Professor and Head of Department, Department of Obstetrics and Gynaecology.
2. Dr. Kamlesh Jagyashi, Professor and Head of Department, Department of Neurology.
3. Dr. N. R. Sutay, Professor and Head of Department, Department of Paediatrics.
4. Dr. Shilpa Domkandwar, Professor and Head of Department, Department of Radiology

1. Head of Department, Psychiatry.

She has also drawn our attention to the orders passed by this Court in various matters of similar kind.

Accordingly, let medical examination of the petitioners be done immediately by J.J. Hospital, Mumbai, in order to ascertain as to whether, at this stage, the pregnancy can be terminated. The report be submitted on the next date of hearing.

List the petitions on 06th October, 2017.

A copy of these petitions as well as this order shall be served on the standing counsel for the respondents.

(NIDHI AHUJA)	(MALA KUMARI SHARMA)
COURT MASTER	COURTMASTER

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION
WRIT PETITION NO. 6430 OF 2018

Neelam Choudhary .....Petitioner

V/s.

1.Union of India

2. State of Maharashtra

3. Ministry of Health and Family

Welfare, through its Secretary .....Respondents

Ms. Gayatri Singh Senior Advocate a/w Ms. Neha Philip a/w. Mr.

Kranti L. C. for the petitioner

Mr. S. L. Babar AGP for the State

CORAM : SHANTANU KEMKAR AND

NITIN W. SAMBRE, JJ.

DATE : JUNE 19, 2018.

ORAL ORDER: [PER: NITIN W. SAMBRE, J.]

Heard the learned senior counsel Ms. Gayatri Sing and the learned AGP for the respondent.

2 By way of present petition, the petitioner has sought following reliefs: "a. For a writ of declaration or any other appropriate writ, order or direction in the nature of declaration ,declaring section 3

(2) (b) of The Medical Termination of Pregnancy Act, 1971 to the limited extent that it stipulates a ceiling of 20 weeks for an abortion to be done under Section 3, as ultra vires Article 14 and 21 of the Constitution of India;

b. For a writ of declaration or any other appropriate writ, order or direction in the nature of declaration, declaring that the case of the Petitioner is a fit case for exercising jurisdiction under Section 5 of the Medical Termination of Pregnancy Act, 1971.

c. For a writ of mandamus or any other writ, order, or direction in the nature of mandamus directing the Respondents to-

i. Constitute a Medical Committee for the examination of the Petitioner to assist this Hon'ble court in arriving at a decision on the plea of the Petitioner;

ii allow the Petitioner to undergo Medical Termination of Pregnancy at a medical facility of her choice.

d. For a writ of mandamus or any other writ, order, or direction in the nature of mandamus directing the Respondents to set up appropriate Medical Committees in each district in the State of Maharashtra to assess the pregnancy and offer MTP to the Petitioner and other women in need of the procedure beyond the prescribed 20 weeks limit.

e. For an order directing Respondent No. 1 to produce the report of MTP Committee which included the Health Secretary, Mr. Naresh Dayal, former DirectorGeneral of the Indian Council of Medical Research and Dr. N K Ganguly as its members as stated in para 9 of the petition."

3 It is urged by the learned counsel for the petitioner that section3 of the Medical Termination of Pregnancy Act, 1971 (Here in after shall be referred to as 'the Act' for the sake of brevity) provides for the circumstances in which pregnancy may be terminated by registered medical practitioner. According to her, the petitioner got married in 2012 and initially she was not staying with her husband. It is further claimed that petitioner was pursuing her studies and thrice attempted unsuccessfully to clear 12th standard examination From 2016 onwards, the petitioner started residing with her husband and in laws, however, certain differences cropped up resulting into petitioner coming back and resided with her parents. In 2016, it is claimed by the petitioner that in view of the cruelty and violence practiced by her husband, an NC complaint for offence under section 323, 504 of the Indian Penal Code came to be registered.

4 It is the case of the petitioner that since the husband of the petitioner promised her of well being, she restored her relationship with her husband. According to her, the physical and mental harassment by her husband and in laws continued even thereafter.

According to her, she is a patient of epilepsy and is under constant medication from K.E.M. Hospital, Bombay.

5 While conceiving her marriage, the petitioner was time and again instructed her husband to have protective sex qua birth of a child. However, the husband of the petitioner does not pay any heed to the same. On the other hand, it is claimed that the petition being a patient of epilepsy is unable to consume oral contraceptives on account of potential reaction with the drugs that she has administered for treating her epilepsy.

6 In view of constant mental and physical cruelty, the petitioner came back to her parental house after having diagnosed of carrying pregnancy of about more than 20 weeks.

7 In the aforesaid factual background, the learned counsel for the petitioner submits that the petitioner does not intend to continue with the pregnancy as she intend to pursue her studies and apply for divorce. According to her, taking into account her health problem of epilepsy, it will not be advisable to continue with the pregnancy and also pursue her studies. A further submission is made that in the aforesaid background, the respondent be directed to constitute a Medical Board so as to ensure termination of pregnancy.

8 Per contra the learned AGP would oppose the claim and would urge that the petition is not maintainable as there is no medical advice to the petitioner to terminate her pregnancy of more than 20weeks. According to him, there is no substance in the petition and the petition is liable to be dismissed.

9 A foremost question that is required to be addressed in actual background raised in the petition is whether the petitioner's prayer for constitution of Medical Board for considering her claim for termination of pregnancy is required to be ordered and if no, whether this Court is required to go into examining the validity/virus of the provisions of the Act in question, particularly section 3 (2) (b) of the Act.

10 From the record, it is ex facie clear that it is the case of the petitioner that she is carrying as on date pregnancy of about 23weeks. The petitioner was got married in 2012 and started residing with her husband and in laws in 2016. The fact remains that she is educated up to 11th standard and pursuing further studies. It is also apparent that in 2016, an NC came to be registered for an offence under section 323, 504 of the Indian Penal Code in view of the complaint lodged by the petitioner against her husband and in-laws. It is apparently clear that the said NC complaint was not further prosecuted by the petitioner. Rather, in categorical terms she has admitted that, she has started residing with her husband. Out of the said relationship, she conceived a child and presently carrying pregnancy of 23 weeks.

11 In the aforesaid factual background, if the claim of the petitioner is examined qua her prayer for issuance of directions for permission to terminate pregnancy, it is required to be noted that the none of the medical papers which are placed on record certifies that there is imminent danger to life of the petitioner nor the condition of the foetus is in compatible with the extra uterine life. It is

even not the case of the petitioner that the foetus would not be able to survive. The petitioner has also not demonstrated that continuation of pregnancy can gravely endanger the physical and mental health of the petitioner.

12 Apart from above, it is required to be noted that the petitioner is seeking termination of pregnancy based on the cause viz. her matrimonial discord with her husband, her intention to initiate divorce proceedings and to pursue her career and improve her education qualification. If the aforesaid cause as cited by the petitioner are examined in the light of the provisions of the Medical Termination of Pregnancy Act, 1971, same not at all recognized to form basis for accepting the prayer of the petitioner to terminate the pregnancy. If the scheme of the Act is appreciated, the medical practitioner is permitted to terminate the pregnancy where the length of the pregnancy does not exceed 12 weeks. In case it exceeds12 weeks but does not exceeds 20 weeks, two registered medical practitioners should be of the opinion, formed in good faith that the continuance of pregnancy would involve risk to the life of the pregnant woman or of grave injury to her physical and mental health or there is substantial risk, if the child were born, same would suffer from physical or mental abnormality, has to be seriously handicapped. The explanation 1 provides for termination of pregnancy which was caused by rape and such rape is presumed to constitute a grave injury to the mental health of the victim woman. Explanation 2 to section 3 provides for the grave injury to the mental health of the pregnant woman, in case if the pregnancy occurs as a result of failure of any device or method used by married woman or her husband for the purpose of limiting the number of children.

13 Section 5 of the Act provides for non attraction of provisions of section 3, in case the opinion of two registered medical practitioners which is formed in good faith that the termination of such pregnancy is immediately necessary to save the life of the woman.

14 In the aforesaid background, what is to be noticed is the Statute provides for the termination of pregnancy by registered medical practitioner in the circumstances prescribed under section 3of the Act.

15 It is not the case of the petitioner that she is of unsound mind or there is any physical or mental deformity which prompts her not to continue with the pregnancy. As observed herein before, there is no material whatsoever brought on record to substantiate the said claim.

16 If the case of the petitioner in its entirety is appreciated, what is to be noticed is the petitioner is seeking permission to terminate pregnancy by issuing appropriate directions merely for asking when the fact remains that she is carrying pregnancy out of her marital life and she is major and educated.

17 That being so, in our opinion, the prayer put forth by the petitioner does not warrant any indulgence at the hands of this Court.

18 The Apex Court in the matter of Suchita Srivastava V/s. Chandigarh Administration has expressed that right of a woman to have reproduction, the choice is insegregable part of her personal liberty as envisaged under Article 21 of the Constitution. It is also observed by the Apex Court that such

woman has sacrosanct right to have her bodily integrity. The Apex Court in the matter of Suchita Srivastava [cited supra] had an occasion to consider the provisions of the Act qua fundamental rights. While dealing with the said issue, the Apex Court in para 11 has observed thus:

"11. A plain reading of the abovequoted provision makes it clear that Indian law allows for abortion only if the specified conditions are met. When the MTP Act was first enacted in 1971 it was largely modelled on the Abortion Act of 1967 which had been passed in the United Kingdom. The legislative intent was to provide a qualified 'right to abortion' and the termination of pregnancy has never been recognized as a normal recourse for expecting mothers. There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no 1 [2009 (9) SCC 1] restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth-control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a 'compelling state interest' in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices".

19 The Apex Court in the matter of Z V/s. State of Bihar andothers3 while dealing with the Statutory provisions of the a fore said Statute has observed thus:

"27. Thus, the opinion has to be formed by the registered practitioners as per the Act and they are required to form an opinion that continuance of pregnancy would involve a grave

mental or physical harm to her. We have already referred to Explanation 1 which includes allegation of rape. As is perceivable, the Appellant had gone from a women rehabilitation centre, had given consent for termination of pregnancy and had alleged about rape committed on her, but the termination was not carried out. In such a circumstance, we are obliged to hold that there has been negligence in carrying out the statutory duty, as a result of which, the 3 [AIR 2017 SC 3908] Appellant has been constrained to suffer grave mental injury.

30. In that context, the Court adverted to the distinction between the 'mental illness' and 'mental retardation'. It also noted that the expert body's findings were in favour of continuation of pregnancy and took note of the fact that the victim had clearly given her willingness to bear a child. In that context, the Court stated:

"The victim's reproductive choice should be respected in spite of other factors such as the lack of understanding of the sexual act as well as apprehensions about her capacity to carry the pregnancy to its full term and the assumption of maternal responsibilities thereafter. We have adopted this position since the applicable statute clearly contemplates that even a woman who is found to be "mentally retarded" should give her consent for the termination of a pregnancy."

And again:

"There is no doubt that a woman's right to make reproductive choices is also a dimension of "personal liberty "as understood Under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a "compelling State interest" in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices."

31 Explaining the provision of the Act, the Court opined that ordinarily a pregnancy can be terminated only when a medical practitioner is satisfied that a continuance of the pregnancy would involve risk to the life of the pregnant woman or of grave injury to her physical or mental health or when there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. While the satisfaction of on medical practitioner is required for terminating a pregnancy within twelve weeks of the gestation period, two medical practitioners must be satisfied about either of these grounds in order to terminate a pregnancy between twelve to twenty weeks of the gestation period.

32 The Court in Suchita Srivastava also took note of the provision that termination of the pregnancy has been contemplated when the same is the result of a rape or a failure of birth control methods, since both of the seeventualities have been equated with a grassve injury to the mental health of a woman. The Court emphasized that in all such circumstances, the consent of the pregnant woman is an essential requirement for proceeding with the termination of pregnancy. The threeJudge Bench referred to the Persons with Disabilities (Equal Opportunities, Protection of Right sand Full Participation) Act, 1995 (for short, '1995 Act') and opined that in the said Act also "mental illness" has been defined as mental disorder other than mental retardation.

37 The Court referred to the United Nations Declaration on the Rights of Mentally Retarded Persons, 1971 [GA Res 2856(XXVI) of 20121971] and relied on principle No. 7 of the same. Principle No. 7 reads as follows:"50. ....7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

61 The legislative intention of 1971 Act and the decision in Suchita Srivastava prominently emphasise on personal autonomy of a pregnant woman to terminate the pregnancy in terms of Section 3 of the Act. Recently, Parliament has passed the Mental Healthcare Act, 2017 which has received the assent of the President on 7th April, 2017. The said Act shall come into force on the date of notification in the official gazette by the Central Government or on the date of completion of the period of nine months from 7th April, 2017. We are referring to the same only to highlight the legislative concern in this regard. It has to be borne in mind that element of time is extremely significant in a case of pregnancy as every day matters and, therefore, the hospitals should be absolutely careful and treating physicians should be well advised to conduct themselves with accentuated sensitivity so that the rights of a woman is not hindered. The fundamental concept relating to bodily integrity, personal autonomy and sovereignty over her body have to be given requisite respect while taking the decision and the concept of consent by a guardian in the case of major should not be over emphasized."

20 Similar issue was considered by this Court in the matter of Shaikh Ayesha Khatoon [cited supra]. The Division Bench of this Court had an occasion to consider the provisions of section 3 & 5 of the Act. The Division Bench while dealing with same has observed as under:

"11. Section 3 of the Act of 1971 thus prescribes the outer limit of 20 weeks in the matter of termination of pregnancy in certain circumstances enumerated in Clauses (i) & (ii) of sub-section 2(b) of Section 3. Section 5 carves out an exception to Sections 3 & 4. It is provided that the provisions of section 4, and so much of the provisions of sub section (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is contended relying on the provisions of sub-section (1) of Section 5 by the petitioner that the bar contained in sub- section (2) of Section 3 laying down the conditions for according permission to terminate the pregnancy is not absolute bar and in appropriate cases such permission can be accorded. Section 5 of the Act of 1971 carves out an exception in relation to the outer limit provided under subsection (2) of Section 3 of the Act of

1971 i.e. 20 weeks in case where the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is the contention of the petitioner that firstly the trauma that the petitioner is likely to suffer is life threatening and it shall be construed that exercise of a choice in the event there are foetal abnormalities found and the chances of survives of the baby, if allowed to take birth, are minimum, is a matter to be considered within the parameters of Section 5 of the Act of 1971. Apart from this, the petitioner contends that the provisions of subsection (2) including clauses (i) & (ii) of subsection (2)(b) of Section 3 are required to be read in Section 5 except the outer limit of twenty weeks that has been provided in subsection (2)(b) of Section 3 of the Act of 1971.

12. The petitioner thus contends that if there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped, it will be open for the Court to accord permission to terminate the pregnancy by taking recourse to Section 5 of the Act of 1971. It is further contended that the concluding portion of Section 5 prescribing the limitation in permitting such a choice or issuing direction in respect of termination of the pregnancy only in the event to save the life of the pregnant woman shall have to be interpreted harmoniously and looking to the object of the provision. It also needs to be considered that a pregnant woman has a right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India. In this context reliance can be placed on the observations of Hon'ble Supreme Court in the matter of Suchita Srivastava vs. Chandigarh Administration reported in 2009 (9) SCC 1. In paragraph11 of said judgment, it is observed by the Hon'ble Supreme Court as narrated below :

"11. A plain reading of the abovequoted provision makes it clear that Indian law allows for abortion only if the specified conditions are met. When the MTP Act was first enacted in1971 it was largely modelled on the Abortion Act of 1967which had been passed in the United Kingdom. The legislative intent was to provide a qualified 'right to abortion' and the termination of pregnancy has never been recognized as a normal recourse for expecting mothers. There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth-control methods such as undergoing sterilisation procedures. Taken to their logical conclusion reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a 'compelling state interest' in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the

conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices."

21 From the observations made by the Apex Court in the matter of Suchita Srivastava and Z V/s. State of Bihar and others [cited supra] it is abundantly clear that provisions of the 1971 Act were examined in the backdrop of Article 21 of the Constitution of India. The Apex Court was sensitive to the women's right of reproduction choice qua operation as provided under the Statute. The right to terminate the pregnancy on the said grounds which were beyond the control of such victim women are dealt with in detail and the Apex

Court observed that in case a grave injury to mental health of a pregnant woman, in case of a rape, aids, mental incapacity such as mental retardation will be prevailing circumstances in exercising powers under section 3 of the Act. It is also required to be noted that in the matter of Suchita Srivastava [cited supra] the Apex Court has held that the provisions of 1971 Act can be viewed as putting reasonable restrictions on exercise of reproduction choice of a woman.

22 In the wake of law laid down and discussed herein before, the fact remains that the ground which is sought to be espoused by the petitioner seeking termination of pregnancy is no more germane to the requirement under section 3 of the Act. Her matrimonial discord cannot be considered as a reason for permitting her to have termination of pregnancy by invoking provisions of the Medical Termination of Pregnancy Act, 1971. For the eventualities which are spelt out in the petition, it is really difficult to consider and grant the request of the petitioner for permitting her to have termination of pregnancy.

23 Apart from above, though the petitioner has raised a plea of challenge to provisions of Section 3 of the Act being violative of Article 14 & 21 of the Constitution of India, the petitioner has hardly tried to justify her claim as no arguments are canvassed on the said issue.

24 That being so, this Court has reached to a conclusion that there is no substance in the present petition and same deserves to be dismissed and accordingly dismissed.

[NITIN W. SAMBRE, J.] [SHANTANU KEMKAR, J.]

IN THE HIGH COURT OF DELHI AT NEWDELHI

W.P.(C)12513/2018

SMT. SUSHMA SHARMA...Petitioner

Through: Ms. Sneha Mukherjee, Advocate

Versus

UNION OF INDIA AND ORS...Respondents

Through: Mr. Ripu Daman Bhardwaj, CGSC and

Mr. T.P. Singh, Advocate for R-1 andR-3

CORAM:

HON'BLE THE CHIEF JUSTICE

HON'BLE MR. JUSTICE V. KAMESWAR RAO

O R D ER

% 29.11.2018

In view of certain subsequent developments that have taken place, it is pointed out that now this petition pertaining to medical termination of pregnancy has been rendered infructuous.

Petition is accordingly disposed of as infructuous.

CHIEF JUSTICE

V. KAMESWAR RAO, J.

NOVEMBER 29, 2018

mamta

*** IN THE HIGH COURT OF DELHI AT NEWDELHI**

+ W.P.(C) 13104/2018 SMT. ANJU

..... Petitioner

Through: Ms. Sneha Mukherjee, Advocate

versus

UNION OF INDIA AND ORS.

..... Respondent

Through: Ms. Suparna Srivastava, CGSC,Ms. Sanjna Dua, Advocate for UOI Mr. Sanjoy Ghose, Additional Standing Counsel for GNCTD and Mr. Rishabh Jetley, Advocate

CORAM:

HON'BLE MR. JUSTICE S. RAVINDRA BHAT HON'BLE MR. JUSTICE PRATEEK JALAN

O R D E R

% 10.12.2018

The petitioner seeks a declaration that Section 3(2)(b) of the Medical Termination of Pregnancy Act, 1971 (hereinafter referred to as the MTP Act) is unconstitutional inasmuch as it stipulates ceiling of 20 weeks, within which an abortion of foetus is permissible; declaration that Section 5(1) to the extent that it restricts such abortions where it is absolutely essential to save the life of the pregnant women, is also sought.

The petitioner is pregnant with a foetus of 25 weeks gestation age. The pleadings as well as the documents brought on record reveal that the radiological Diagnostic Report, showed that the foetus suffers from some serious abnormality and that in the event the pregnancy is proceeded with, almost certainly, an abnormal child with significant impairment would be born. The petitioner relies upon previous precedents - notably the orders of the Supreme Court in Meera Santosh Pal & Ors. vs. Union of India & Ors. (W.P.(C) No. 17/2017, decided on 16.01.2017) and in Mrs. X & Ors. vs. Union of India & Ors. (W.P.(C) No. 81/2017, order dated 07.02.2017).

On the first date of hearing, i.e. on 04.12.2018 this court passed the following order:

> *"Issue notice to the respondents.*
>
> *Mrs. Suparna Srivastava, Advocate accepts notice on behalf of the respondent nos.1 and 3. Mr. Sanjoy Ghose, Additional Standing Counsel accepts notice on behalf of the Government of NCT of Delhi.*
>
> *The petitioner seeks a direction for various reliefs including a direction for quashing of Section 3(2)(b) of the Medical Termination of Pregnancy Act, 1971 inasmuch as it stipulates that beyond 20 weeks of pregnancy, abortion would not be permissible.*
>
> *The petitioner relies upon various orders and judgments of the Supreme Court and High Courts including the Bombay High Court which facially disclose that Medical Termination of Pregnancy (MTP) has been facilitated even in cases where the threshold of 20 weeks, was crossed - even to the extent of 27 weeks. In this case, the petitioner is stated to be in the 24th week of pregnancy. Further, the medical opinion, which the petitioner relies upon to seek the relief, states that "Fetal head shows hydrocephalus with small posterior fossa, effaced cistern magna, positive bana sign. Spine is short and deformed it open neural tube defect in lower-dorsal/lumbar region. Orbital and interorbital distances were normal. Facial profile was within normal limits. Four chamber heart, diaphragmatic contour, abdominal viscera, kidneys and urinary bladder were normal. Umbilical cord shows normal three vessels. Cord insertion is normal. Bilateral lower limbs show clubfeet deformity". It is stated that the medical condition of the fetus is abnormal and in all probabilities would result in severe brain damage to the fetus.*
>
> *Having regard to the materials on record, this Court is of the opinion that immediate and urgent steps are called for. In these circumstances, the Director, All India Institute of Medical Sciences (AIIMS) shall ensure that an appropriate Medical Board consisting of relevant experts is constituted within two days from today which shall then examine the petitioner and carry out such tests, as are necessary, to assess the condition of the fetus and furnish its report within five days from today. The Board so constituted shall also include a Psychiatrist, who can appropriately assess the mental condition of the mother and make appropriate observations in the report.*

A copy of this order shall be served immediately, without process fee, through the Registrar of this Court on the Director of AIIMS.

List on10.12.2018.

Dasti to the parties under signatures of the Court Master."

Pursuant to the directions of the court, the Director, All India Institute of Medical Science (AIIMS) constituted a seven member Board which independently considered the record after having the petitioner examined. The deliberations of the seven member Board were also attended by the Observer; its report on 06.12.2018- which was directly made available to the court through Registrar General, records as follows:

"Subject: Report of the medical board constituted at AIIMS for medical examination of Smt. Anju, in compliance of order dated 04.12.2018 of Hon'ble Mr. Justice S. Ravindra Bhat and Hon'ble Mr. Justice Prateek Jalan, High Court of Delhi vide W.P. (C.) 13104/2018 titled Smt. Anju Versus Union of India and Ors.

****

A medical board was constituted by the Medical Superintendent, AIIMS on subject noted above. The Board consists of the following members:

1.	*Dr. Vatsala Dadhwal* *Professor, Department of Obs. & Gynae*	*Chairperson*
2.	*Dr. Ramesh K. Agarwal* *Professor, Deptt. Of Paediatrics*	*Member*
3.	*Dr. Aparna Sharma* *Assoc. Professor, Department of Obs. & Gynae*	*Member*
4.	*Dr..Surabhi Vyas* *Assoc. Professor, Deptt. Of Radio-diagnosis*	*Member*
5.	*Dr. Raman Deep* *Assoc. Professor, Deptt. Of Psychiatry*	*Member*

6. *Dr. Abhishek Yadav* — *Member*

   Asstt. Professor, Deptt. of Forensic Medicine

7. *Dr. Puneeth T.* — *Member*

   Secy. Department of Hospital Administration

8. *Dr.Kshitija Singh* — *Observer*

   Department of HospitalAdministration

All the members of the medical board met on Thursday, 6th December, 2018 at 02:00 P.M. in V.l.P. Consultation Room No. 13, M.S. Office Wing, ground floor, AIIMS, NewDelhi.

The Medical board reviewed the case in detail by history, available records including a fetal USG done on 23.11.2018. The findings were:

- The patient is 26 weeks by dates and 25 weeks gestation by first trimester scan.
- USG done on 23.11 .2018 showed a gestational age of 22 weeks with open neural tube defect, hydrocephalus with bilateral club feet deformity.

The USG repeated at AIIMS on 6.12.2018 confirmed gross Cranio-spinal malformation.

The board opined that:

- The malformation is significant enough to cause gross neurodevelopmental problems in the baby.
- Since the pregnancy is pre-viable, MTP may be offered.

* There is no known psychiatric history. The clinical mental state examination was conducted which revealed no obvious abnormality."

In view of these developments, especially the report of 06.12.2018, this court is satisfied that the first claim of the petitioner,

i.e. for a direction to the respondents to allow her to undergo the medical termination of pregnancy should be granted. Accordingly a direction to that effect, in the light of the orders of the Supreme Court cited above.

During the hearing, this court was informed that the petitioner is admitted in the Lady Hardinge Medical College and is undergoing treatment. In the light of the report of AIIMS and the directions of the court that facility (Lady Hardinge Medical College) shall carry out the necessary procedure in accordance with law.

As far as other claims are concerned, this court is of the opinion that in the light of the directions, the challenge to the provisions of the law do not survive consideration.

With aforesaid directions, the writ petition is allowed and is disposed of as such.

A copy of this order be given dasti under signatures of the Court Master.

S. RAVINDRA BHAT, J

PRATEEK JALAN, J

DECEMBER 10, 2018

IN THE HIGH COURT OF DELHI AT NEW DELHI

W.P.(C)14064/2018

SHEETAL...Petitioner

Through: Ms. Sneha Mukherjee, Advocate

Versus

UNION OF INDIA & ORS..Respondents

Through: Mr. Dev.P. Bhardwaj, CGSC with Mr. Kamaldeep, Advocate for R-1 & 3 Mr. Anjum Javed, ASC with Mr. Devendra Kumar, Advocate for R-2/GNCTD

CORAM:

HON'BLE MR. JUSTICE PRATEEK JALAN HON'BLE MR. JUSTICE SANJEEV NARULA

O R D E R

% 04.01.2019

1. The petitioner in the present case is pregnant with a fetus of the gestational age of approximately 30 weeks. By this petition, she seeks medical termination of pregnancy, on the account that the fetus is suffering from a severe cardiac anomaly i.e. *tetralogy off a lot*.
2. By an order dated 02.01.2019, we had requested the Medical Board constituted by the Ram

Manohar Lohia Hospital to submit a further report on the consequences of the tentative diagnosis of *tetralogy of falot*. That report has been placed before us today.

3. The Court now has three Medical Reports for consideration:

(a) The first report dated 26.12.2018, submitted by Lady Hardinge Medical College, as recorded in Court's order dated 28.12.2018, stated as follows:

"The opinion of the board is as follows:-

- *As the pregnancy is in advanced stage i.e. 30 weeks period of gestation this foetus is viable.*
- *The cardiac anomaly detected on fetal echocardiography has standard Rx protocol including multi stage surgery.*
- *However the prognosis will depend upon not only on postnatal confirmation of cardiac anomaly and presence or absence of other associated anomalies which may not be visible on antenatal USG.*
- *The baby needs to be delivered where tertiary care paediatric cardiac facility is available, which is currently not available in Lady Hardinge Medical College, New Delhi."*

(b) The opinion of the Medical Board constituted by RML Hospital, contained in the report dated 01.01.2019 was as follows:

"1. Continuation of pregnancy would not cause grave physical or mental injury to the mother.

2. Based on available evidence the child if born is not likely to have substantial risk of physical handicap. Possibility of substantial mental handicap cannot be predicted with the available evidence.

3. As the pregnancy is 30 weeks and baby has attained viability, now this will be a preterm delivery of a live baby and not medical termination of pregnancy. Yes, the delivery shall result in additional risk compared to delivery at term to the baby and mother.

4. At present, she is worried in view of perceived serious consequences to the fetus out of cardiac problem. She may suffer from psychological problems/psychiatric disorders on continuation of pregnancy. The risk for psychological problems/psychiatric disorders is also possible with pre term delivery.

5. Yes, the fetus has Tetralogy of Falot (TOF) physiology (Tricuspid stenosis, hypoplastic RV and evolving functional pulmonary atresia). Final diagnosis needs to be confirmed in postnatalecho."

(c) The opinion of the Medical Board submitted today states as follows:

"The patient is suffering from tricuspid stenosis, hypoplastic right ventricle and functional pulmonary atresia which is considered a form of tetralogy of falot (TOF) physiology ***(decreased pulmonary***

__blood flow)__ which is a broad entity encompassing several defects of which the index case is one of them. The diagnosis needs to be confirmed in post natal echocardiography so as to precisely determine the requirement of intervention and or surgery in each of these cases.

The baby will require delivery at a tertiary care facility with pediatric cardiology and neonatal cardiac surgery back up. The current treatment of this condition is in the form of palliative multi staged surgery. Depending upon factors which will be clear only after birth (adequacy of pulmonary blood flow, patency of the patent ductus arteriosus as well as the size of the branch pulmonary arteries). Either one or two surgeries may be required in the first year of life. Subsequent surgery will be done in the first decade of life."

4. The picture that emerges from a consideration of these three reports is that the anomaly which has been detected does have a standard treatment protocol including surgery in various stages, both in the first year of life and thereafter in the first decade. Although the final diagnosis and required interventions will be determined only after post-natal tests, the Medical Board is of the opinion that the child is not likely to have substantial risk of physical handicap. The fetus is viable and that the procedure sought by the petitioner would involve pre-term delivery of a live baby and not a medical termination or pregnancy. The medical opinion also reveals that the continuation of the pregnancy would not cause grave physical or mental injury to the mother, and the risk of psychological problems / psychiatric disorders exists, both in the case of pre-term delivery, and also in case the pregnancy is carried to term. The report dated 01.01.2019 further categorically states that the delivery at this stage would result in an additional risk to the baby and mother, compared to the delivery at term.

5. In view of the medical opinion summarized above, we are unable to accede to the petitioner's request for permission to undergo medical termination of pregnancy at this stage. Unlike the present case, the orders of the Supreme Court cited by learned counsel for the petitioner, referred to in our order dated 02.01.2019, both concern cases where the opinion of the Medical Board was unequivocal. In *Sarmishtha Chakraborty vs. Union of India & Ors.* [order dated 03.07.2017 in W.P.(C) 431/2017], the Medical Board had opined that the multi-stage cardiac operations, which the child would be required to undergo, carried high risk of morbidity and mortality at each stage. The doctors were of the view that the patient was under threat of severe mental injury if the pregnancy is continued and that the patient's wish for termination of pregnancy may be allowed. Similarly in *Tapasya Umesh Pisal Vs. Union of India And Ors.* [order date 10.08.2017 in W.P.(C) 635/2017], the Court noted the medical opinion of high morbidity and mortality associated with the required surgeries, and the risk of continued physical incapacitation even after the surgeries. That was a case in which the pediatrician had reported that it appeared to be an isolated complex congenital heart disease

and the cardiac surgeon had noted that there was a near certain chance of severe handicap or sudden death of the baby at birth. In *Sarmishtha Chakarborty* (supra), the Supreme Court has specifically cautioned that cases of this nature have to rest on their own facts, depending *inter alia* upon the nature of the report of the Medical Board. It is on this basis that the Court had distinguished the cases of *Savita Sachin Patil & Ors. Vs. Union of India and Ors.* [Order dated 28.02.2017 in W.P.(C) 121/2017] and *Sheetal Shankar Salvi & Anr. vs. Union of India& Ors.*[order dated 27.03.2017 in W.P.(C) 174/2017]. In those two cases, the Supreme Court had declined permission to undergo medical termination of pregnancy in the absence of a categorical opinion regarding the prospect of mental and physical handicap to the child, and the risk to the life of the mother.

6. For the reasons aforesaid, we are unable to grant the relief sought by the petitioner. Learned counsel for the petitioner does not press any of the other prayers in this petition.

7. The petition, therefore, stands disposed of.

PRATEEK JALAN, J.

(VACATION JUDGE)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

Writ Petition NO. 11940 OF 2017

Priti Mahendra Singh Rawal ...Petitioner

Versus

Union of India and Ors. Respondents

Ms. Meenaz Kakallia with Ms. Bhavana Mhatre & Ms. Kranti L.C., for the Petitioner.

Mr. D.P. Singh, for Respondent Nos.1 and 3. Mr. Sandeep Babar, AGP for Respondent No.2

CORAM: SHANTANU KEMKAR&
G. S. KULKARNI, JJ.

DATE: NOVEMBER 6, 2017

P.C.:

Petitioner Priti Mahendra Singh Rawal has approached this Court under Article 226 of the Constitution of India, seeking direction to the first respondent to produce a report of the appropriate committee which may be constituted by this Court for her examination and submitting its report as to whether the petitioner can be allowed to get the pregnancy terminated.

1. On 3 November 2017 this Court while issuing notices to the respondents, constituted a committee of experts from Sir J.J. Groups of Hospitals, Mumbai. As per the Medical Board's report as constituted by this Court, the petitioner has been medically examined by the Committee. The Committee has submitted its opinion. A detailed opinions of various experts

are filed along with the said opinion of the dated 4 November 2017. The Committee which has examined the petitioner opined thus:

"OPINION OF THE COMMITTEE

DATE04/11/2017

THE WOMAN HAS BEEN EXPLAINED THE OUTCOME OF THIS PREGNANCY IN THE LANGUAGE SHE UNDERSTANDS. SHE IS MENTALLY SOUND & ABLE TO TAKE HER OWN DECISION ABOUT MEDICAL TERMINATION OFPREGNANCY.

THE CONDITION OF THE FETUS FULFILLS THE CRITERIA OF "SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP" IN THE FETUS.

THE PREGNANT WOMAN HAS VOLUNTARILY EXPRESSED HER DESIRE TO TERMINATE THE PREGNANCY AND IS WELL INFORMED ABOUT THE NATURE OF THE FETUS AND ITS OUTCOME.

THE PREGNANCY IS ADVANCED TO 25 WEEKS 6 DAYS AND IS BEYOND 20 WEEKS CUT OFF OF THE MEDICAL TERMINATION ACT. HENCE, SHE HAS APPROACHED HON. HIGH COURT, BOMBAY FOR TERMINATION OFPREGNANCY.

AT THIS STAGE OF PREGNANCY THE RISK OF TERMINATION REMAINS THE SAME AS THE NATURAL LABOUR AT TERMS.

THUS IF THE COURT PERMITS THE PREGNANCY CAN BE TERMINATED AS DESIRED BY THE WOMAN.

Sd/ 4/11/17	sd/	sd/
Dr. V.P. Kale.	Dr. Nita Sutay	Dr. V.N. Kurude
VICE DEAN &	PROFESSOR & HEAD	ASSO PROFESSOR
PROFESSOR & HEAD DEPT OF PSYCHIATRY	DEPT OF PAEDIATRICS GGMC, MUMBAI.	DEPT OF OBGY
GGMC, MUMBAI		GGMC, MUMBAI.

Sd/	sd/ 4.11.17
Dr. Shilpa Domkundwar PROFESSOR & HEAD PROFESSOR DEPT OF RADIOLOGY GGMC,MUMBAI.	Dr. Sachin Giri ASSISTANT DEPT OF NEUROSURGERY GGMC,MUMBAI."

2. We have gone through the aforesaid opinion as also the opinion of various other experts including Paediatrics Surgeon, Professor and HOD of Department of Paediatrics, Professor and HOD of Cardiovascular Surgery, Associate Professor and HOD of Department of Psychiatry. Upon examination of the petitioner and evaluation of the opinions, the aforesaid committee / Medical Board has concluded that there are multiple serious neurological and skeletol abnormalities in the fetus. There is arnoldchiari malformation with hydrocephalus with large lower thoracic and lumbar posterior spinal defect associated with a large meningomyelocele. The lower limb shows no movement associated with abnormal contour of the foot and an elongated urinary bladder. These appearances are suggestive of neurogenic etiology. These abnormalities have high chances or morbidity & mortality in the newborn. It also requires multiple surgeries. There are high chances of meningitis, mental retardation, paralysis of lower limbs and loss of urine and bowel control. It also appears that the petitioner has been explained the outcome of this pregnancy in the language she understands. As per the opinion, she is mentally sound & able to take her own decision about medical termination of pregnancy. The condition of the fetus fulfills the criteria of "substantial risk of serious physical handicap" in the fetus. It is also clear that the petitioner has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the fetus and its outcome.

3. Having regard to the aforesaid, it is very difficult for us to refuse the permission to the petitioner to undergo medical termination of the pregnancy. It is certain that if the petitioner's fetus is allowed to born, there is risk that it would suffer from lifelong serious physical handicap, which cannot be avoided. It appears that the baby will certainly not grow any further.

4. In view of the above peculiar situation and having due regard to the fundamental rights conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

5. The learned AGP as also the learned Counsel for Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

6. We further direct that the termination of the petitioner's pregnancy to be performed tomorrow by the Experts Doctors of Sir .J.J. Group of Hospital, Mumbai, where she has to undergo medical check up.
7. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this Court which shall maintain the complete report of the procedure which would be performed on the petitioner at the time of termination of the pregnancy.
8. With the aforesaid directions, we allow this petition in terms of prayer clause (b) seeking direction to the respondents to allow the petitioner to undergo medical termination of the pregnancy.
9. With the aforesaid directions, the petition is disposed of.
11. Parties to act on the authenticated copy of this order.

(G.S.KULKARNI, J.)

(SHANTANU KEMKAR)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO.12928 OF 2017

Rupali Nilesh Chavan ..Petitioner

V/s.

Union of India and Ors. ..Respondents

Ms. Minaz Kakalia with Mr. Kranti L.C. for the Petitioner. Mr.Y.R. Mishra with Mr. Upendra Lokegaonkar for Respondent Nos. 1 and 3Union of India.

Mr. A.I. Patel, Addl. G.P. for Respondent No.2State.

CORAM : SHANTANU KEMKAR AND G.S.KULKARNI, JJ.

DATE: NOVEMBER 30, 2017.

P.C. :

1. Learned counsel for the Petitioner seeks leave to withdraw the Petition.
2. The prayer is accepted. Writ Petition is allowed to be withdrawn and dismissed as such.

(G.S.KULKARNI, J.) **(SHANTANUKEMKAR, J.)**

….

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION

WRIT PETITION (L) No. 3323 of 2017

Beenu Dharmendra Yadav … Petitioner

Vs

Unioni of India & Ors. ..Respondents

....

Mr. Meenaz Kakalia I.b Ms. Kranti L.C. for Petitioner Ms. P.H. Kantharia Government Pleader for State

Mr. Y.R. Mishra a/w Ms.Anamika Malhotra for Respondent nos.1 and 3 Union of India

CORAM : SHANTANUS.KEMKAR AND G.S.KULKARNI, JJ

Date : 5 DECEMBER 2017

P.C.

1. By this Petition filed under Article 226 of the Constitution of India the petitioner is seeking a direction to allow her to terminate her pregnancy.
2. On 30.11.2017 we had taken a note of the fact that the petitioner had gone to 25 weeks pregnancy which is beyond 20 weeks a permissible cealing for abortion to be carried out, and having through the various medical reports submitted by the petitioner constituted a Medical Board of Sir J.J. Group of Hospitals, Mumbai consisting of the Dean of the said Hospital, Head of the Department (Gynaecology) Professors and Head of Department of Paediatric Cardiac Surgeon, Professors of Head of Department of Radiology and Psychology a

Cardiologist and any other expert in the field as the Dean may deem fit. The said Committee was directed to medically examine the petitioner and submit its report.

3. The learned AGP has stated that the petitioner had appeared before the Committee and she has been medically examined by the said Committee of the said hospital. The said Report has been filed by her which is taken on record and marked Exhibit X for identification. We find that each of the members of the said Committee have examined the petitioner and have given their separate opinions. A conclusion of the Expert Committee is as under:

COMMITTEE AFTER CAREFUL EXAMINATION AND AFTER CAREFULLY STUDYING THE SONOGRAPHY REPORT AND MRI REPORT.

IT IS CONFIRMED THAT THERE ARE SERIOUS NUROLOGICAL SKELETAL ABNORMALITIES HYUDROCEPHALUS AND LUMBOSACRAL SPINAL DEFECT SUGGESTIVE OF MYELOMENINGGOCELE AND HYDROCEPHALUS-SUGGESTIVE OF AN ARNOLD CHIARIMAL FORMATION. THIS IS A VERY SERIOUS ABNORMALITY.

THIS ABNORMALITIES HAVE VERY CHANCES OF MORBIDITY AND MORTALITY.

THUS THE CONDITION OF FETUS FULFILLS THE CRITERIA OF "SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP" IN THE FETUS.

THE PREGNANT WOMAN WANTS HER PREGNANCY TO BE TERMINATED AS SHE IS WELL AWARE OF NATURE OF HER CONDITIONS FETUS HAS AND ITS OUTCOME. SHE IS ANGUISHED WITH THE CONDITION OF THE FETUS IN UTERO.

THE WOMAN's PREGNANCY HAS ADVANCED TO 25 WEEKS AND IS BEYOND 20 WEEKS CUT OFF OF THE MEDICALTERMINATION OF PREGNANCY ACT. HENCE, SHE HAS APPROACHED HONOURABLE COURT FOR TERMINATION OF PREGNANCY.

AT THIS STAGE OF A PREGNANCY THE RISK OF TERMINATION REMAINS THE SAME AS THE NATURAL LABOUR AT TERM.

THUS IF THE COURT PERMITS THE PREGNANCY CAN BE TERMINATED AS DESIRED BYHER.

S/d
Dr. Maithili Kadam
Associate Professor
Dept of Psychiatry
GGMC,Mumbai

S/d
Dr. D.R. Kulkarni
Professor and Head
Dept of Paediatrics
Surg, GGMC, Mumbai

S/d Dr. Shilpa
Domkundwar Professor
and Head Dept of
Radiology
GGMC, Mumbai

S/d
Dr. N.C. Bansal
Professor & HOD
Dept of Cardiology
GGMC, Mumbai.

S/d Dr. Nita Sutay
Professor and Head
Dept of Pediatrics
GGMC,Mumbai

S/d Dr. Krishna rao
Bhosle Professor &
HOD, GGMC,Mumbai Dept of C.V.T.S
GGMC,Mumbai

S/d Dr.
Ashok Anand
Professor & HOD
Dept of OBGY
GGMC, Mumbai

1. Having gone through the aforesaid opinion, it is clear that there are serious neurological and skeletal abnormalities-Hydrocephalus and LumboSacral spinal defect suggestive of myelomeningocele and hydrocephalus suggestive of arnold chiarimal formation. This as per the experts opinion is a very serious abnormality. As per the Committee, these abnormalities have very high chances of morbidity and mortality. According to the Committee, the condition of fetus fulfills the criteria of "substantial risk of serious physical handicap" in the fetus."

2. Considering the aforesaid and the peculiar facts and circumstances of the case and various orders passed by the Supreme Court from time to time, we are of the opinion that the petitioner would suffer irreparable injury in case the relief as claimed for is not granted. In these circumstances, it is very difficult for us to refuse permission to the petitioner to undergo medical termination of pregnancy. If the petitioner's fetus is allowed to grow, there is risk that it would suffer life long serious abnormality which cannot be avoided. The baby will not certainly grow any further.

3. Having due regard to the fundamental rights conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, we deem it appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

4. The learned AGP as also learned counsel appearing for the Union of India have not opposed the petitioner's prayer on any ground legal or medical.

5. In the circumstances, we direct that the termination of petitioner's pregnancy is to be performed in the said hospital by Experts. The petitioner to remain present in the said hospital on 6.12.2017. We further direct that the termination of petitioner's pregnancy to be performed by the Doctors within a day or two as per the requirement, necessary arrangement bed one for the same.

6. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this Court which shall maintain the complete report of the procedure which would be performed on the petitioner at the time of termination of the pregnancy.

7. Petition is allowed in terms of a fore said order.

(G.S.KULKARNI, J) **(SHANTANUS.KEMKAR, J)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
APPELLATE CIVIL JURISDICTION

WRIT PETITION NO.13228 OF 2017

Gausiya Gulam Pathan ....Petitioner

Vs

Union of India & Ors. Respondents

Ms. Meenaz Kakalia for Petitioner

Mr. Y.R.Mishra a/w Mr. N.R. Prajapati for RespondentUnion of India Mr .S.L. Babar AGP for StateRespondent no.2

CORAM : SHANTANUS.KEMKARANDG.S.KULKARNI,JJ

Date :5 DECEMBER 2017

P.C.

Heard learned counsel for the parties. With consentm finally disposed of.

2. The Petitioner who is a 13 year old girl and a victim of alleged rape and sexual abuse has preferred this writ petition seeking direction for allowing her to terminate the pregnancy which is of more than 25weeks.

3. On 30.11.2017 while issuing notice to the respondents, this Court constituted a Committee of Experts of K.E.M. Hospital Mumbai to medically examine the petitioner and submit are port. As per directions of this Court the Expert Committee consisting of (1) Dr .Avinash N. Supe,

Director (Medical Education and Major Hospitals) and Dean (G&K)Chairman (2) Dr. Ajita Nayak, Professor, Psychiatry, K.E.M. Hospital (3) Dr. Amar Pazare, Professor and H.O.D. Medicine, K.E.M. Hospital (4) Dr. Indrani Hemantkumar Chincholi, Professor and H.O.D. Anesthesia K.E.M. Hospital (5) Dr.Y.S.Nandanwar, ExProfessor and H.O.D. Obstetrics & Gynecology, L.T.M.M.C and L.T.M.G. Hospital (6) Dr. Padmaja Samant, Addl. Professor, and Unit Head, Obstetrics & Gynecology,K.E.M .Hospital (7) Dr.Hemangini Thakkar, Addl. Professor, Radiology K.E.M .Hospital and(8) Dr. Ruchi Nanavati Prof & H.O.D. Neonatology, K.E.M. Hospital has been constituted by the said hospital. The Petitioner appeared before the said Medical Board. The Medical Board on examination has submitted its opinion. The salient features of the said opinion reads thus:

"(a) On the other hand, pregnancy at this stage (especially with this patient's challenges) is known to cause severe detrimental effects on the physical and psychological health and emotional well being of a young girl.

(b) Continuation of pregnancy may pose additional risk of conditions like pregnancy induced hypertension. (Known to occur in very young pregnant patients) It is the 2nd most common cause of maternal mortality.

(c) The patient has also been anaemic and was transfused blood to correct the same. Anemia is another important cause of maternal mortality.

Thus, we submit that continuation of pregnancy is likely to cause severe physical and mental consequences for the patient.

(d) The mental trauma of childbirth willbe the same regardless of whether the pregnancy is continued but the guilt of abandoning a fullygrown neonate will be additional in case of continuation of pregnancy."

4. The said opinion is taken on record and marked as **Exhibit 'X'** for identification. The said report/opinion is suggestive of the fact that the termination of the pregnancy at this stage of 25 weeks and three days or delivery at term will have equal risk to the mother. It also suggests that it would be in the interest of the (patient) petitioner that the pregnancy is to be terminated at it may pose danger to the risk on conditions like hypertension and cause of maternal mortality.

5. Considering the age of the petitioner which is only 13 years, the trauma she has suffered because of sexual abuse and the agony she is going through at present and above all the report of the Medical Board constituted by this Court, and also having due regard to the fundamental rights conferred under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act,

1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

6. Accordingly, we allow the petition and direct the petitioner to remain present in the said hospital tomorrow i.e. 6.12.2017 so that the termination of pregnancy can be carried out with in a day or two by the expert team.

7. The learned AGP is directed to apprise the Dean of the said Hospital so that appropriate arrangements for the termination of the pregnancy can be done.

8. In addition, we direct the Law Officer of the Municipal Corporation of Greater Mumbai to inform the said Hospital about passing of this order.

9. Parties to act on an authenticated copy of this order.

10. With aforesaid directions, petition is allowed in aforesaid terms.

We are passing this order keeping in view the law laid down by the Supreme Court in case of **MURUGAN NAYAKKARVSUNION OF INDIA & ORS** decided on 6.9.2017 in Writ Petition (s) Civil No. (s) 749 of2017.

(G.S.KULKARNI, J) **(SHANTANUS.KEMKAR, J)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 13728 OF 2017

Rajashri Nitesh Chadar …Petitioner

Versus

Union of India & Ors. …Respondents

…

Ms. Minal Kakalia a/w. Ms. Neha Phillip for the petitioner.

Mr. Rui A. Rodrigues a/w. N. R. Prajapati, Mr. Upendra Lokegaonkar for respondent nos.1 & 3.

Mr. Sandeep Babar, AGP for respondent no.2.

Dr. Pravin A. Bangar, AMO, KEM Hospital Parel present. Ms. Pooja Yadav for MCGM.

...

CORAM : SHANTANU S. KEMKAR &
R. G. KETKAR, JJ.

DATE : 18th DECEMBER,2017.

P.C. :

1. Heard parties through their counsel. With consent heard and finally disposed of.
2. In this petition, on 13th December, 2017 while issuing notice to the respondents, the Medical Board of expert Doctors of Seth G. S. Medical College & KEM Hospital, Parel, Bombay was

constituted by this Court to medically examine the petitioner as her pregnancy was stated to be of 22 weeks so as to form opinion whether it would be appropriate to direct respondent no.2 to allow the petitioner to carry out the medical termination of pregnancy in view of the various serious infirmities found in the certificate filed by the petitioner from Nanavati Super Specialty Hospital.

3. In pursuance of the order passed by this Court the Medical Board of G. S. Medical College & KEM Hospital, Parel, Bombay has submitted its report dated 15th December, 2017. On going through the report it appears that the Medical Board has examined the petitioner's physical condition and has given its opinion.

4. The relevant portion of the opinion of the Medical Board reads as under;

"7. Obstetric examination shows about 2224 weeks pregnancy, the petitioner herself is in fair health at present.

8. Ultrasonographic diagnosis is single live fetus with gestationalage of 23 weeks with Dandy Walker Malformation.

9. As per neurological review, with Dandy Walker Malformation. The fetus AFter birth may have mental retardation, seizures and ataxia. The possible severity of these disabilities cannot be quantified at present.

10. As per paediatric surgical review, there is no surgical cure for Dandy Walker Malformation.

11. Preanesthetic assessment the patient is fit for general/regional anesthesia."

5. Based upon the aforesaid findings, the Medial Board has stated as under;

"1. The child if born, viable, has possible risk of mental retardation, at axia and seizures which can not be quantified at present.

2. If the pregnancy is terminated now as per the patient's and her family's request:

(a) The most common complication of secondtrimester medical abortion is retained placenta, which is estimated to occur at a rate of 15% to 50%.

(b) Other complications of medical abortion include hemorrhage requiring transfusion (,1%), infection (2.6%), And failed abortion.

(c) In advanced gestational age cases induction time is longer and risk of hemorrhage is greater.

(d) The mortality rate with abortions performed at eight weeks or earlier was 0.1 deaths per 100000 legal terminationns, and rises to 8.9 Deaths per 100,000 abortions for those at 21 weeks or later. Mortality with abortions after 20 weeks is higher than that with natural live births.

(E) If induction fails, the patient may require hysterotomy for maternal indication; in that case, in future pregnancy there is small chance of rupture of scar (about 1%), the relative risk of morbidly adherent placenta is 3 to 5 (as per available statistics).

(f) At present there is no evidence of any physical risk to maternal health owing to the reported fetal malformations.

In view of the ABove, the MedicAL BoARd is of the opinion that termination of pregnancy MAY hAVe substantial physical risks for the pATIent. These risks Are STATEd bASEd on AVAIlABle scientific evidence."

6. We have also noticed that as directed by this Court, in regard to the pros and cons of proposed termination of pregnancy, counseling to the petitioner and her family members was done by the said Medical Board and the petitioner has expressed her willingness to take the risk.

7. Having regard to the aforesaid, in our considered view it would be appropriate to allow the petitioner to terminate the pregnancy as the fetus after birth will be of various serious infirmities as reflected in the opinion as aforesaid, in the circumstances, we allow this petition and direct the petitioner to remain present in the said hospital on 19thDecember, 2017 so that the termination of pregnancy can be carried out within a day or two as may be deemed fit by the Medical Board.

8. We also make it clear that the Medical Board which has examined the petitioner as per our directions will not held liable for submitting the report and they will not held liable for any litigation arising there from. We also make it clear that the petitioner has been made aware about the risk involved in carrying out the medical termination of pregnancy and she has taken the prompt decision to undertake the risk by carrying out the medical termination of pregnancy.

9. We direct learned AGP to appraise the Dean of the said hospital. We also direct Ms. Yadav, counsel who generally appears for Municipal Corporation to inform the said Hospital so that the appropriate arrangement of termination of pregnancy can be done.

10. Parties to act on an authenticated copy of this order.

11. Needless to say that the petitioner will bear the necessary expenses as per the norms of the hospital.

12. With a fore said directions, petition is disposed of.

(R.G.KETKAR, J.) **(SHANTANU S. KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

Writ Petition NO. 13848 OF 2017

Monisha Hironmoy Mazumder ...Petitioner

Versus

Union of India

And Ors. Respondents

....

Ms. Minaz Kakalia, Advocate for the Petitioner.

Mr. S.K. Halwasia a/w. Mr. N.D. Sharma, Advocate Respondent Nos. 1 & 3. Mr. Sandeep Babar, A.G.P. for Respondent No. 2 State.

....

CORAM : SHANTANU KEMKAR &

R. G. KETKAR, JJ.

DATE: DECEMBER 20, 2017

P.C.

1. The petitioner Monisha Hironmoy Mazumder has approached this Court under Article 226 of the Constitution of India seeking direction to the State to produce the report of the MTP Committee which may be constituted by this Court for examination and giving its opinion as to whether the petitioner can be allowed to get her pregnancy terminated.

The pregnancy of the petitioner has gone to 24 weeks which is beyond the ceiling of 20 weeks. In the circumstances, the aforesaid relief has been sought. On 15.12.2017 this Court after considering the orders passed by the Hon'ble Supreme Court from time to time as also the orders passed by this Court, constituted a Committee of B. J. Government Medical College / Hospital (Sasoon Hospital), Pune consisting of Dean of said Medical College/Hospital, Head of the Department (Gynecology), Head of the Department (Neurology), Professor and Head of Department of Paediatric Cardiac Surgeon, Professor and Head of Department of Radiology and Psychology of said College/Hospital. Said Medical Board/Committee has examined the petitioner and has submitted its opinion dated 18.12.2017, which reads as under:

> "Opinion of the Committee:
>
> The woman was examined thoroughly in the obstetrics OPD and necessary investigations were done example Hologram, ultrasonogaphy, fetal echocardiography etc. It was found that pregnancy is 23 weeks with live fetus with a complex cardiac anomaly like Truncus arterious, double outlet left/right ventricle with small pulmonary artery.
>
> The committee feels that the child if born alive at term may have to undergo multiple surgery which carry significant risk. The child has likelihood of severe physical and mental impairment and low chances of Survival in later life.
>
> In this condition it is advised to terminate this pregnancy with kind permission from Hon. High Court Mumbai."

2. Having considered the aforesaid opinion which clearly indicates that the child if born alive at term may have to undergo multiple surgery which carry significant risk and that the child has likelihood of severe physical and mental impairment and low chances of survival in later life. The Committee in clear terms has advised to terminate the pregnancy.

3. Considering aforesaid opinion, it is very difficult for us to refuse the permission to the petitioner to undergo medical termination of the pregnancy. It is certain that the petitioner's fetus if allowed to born, there is risk that it would suffer from lifelong serious physical handicap, which cannot be avoided.

4. In view of the aforesaid peculiar situation and having due regard to the fundamental rights conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971.

5. The learned A.G.P. as also the learned counsel for Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We record accordingly.

6. In the circumstances, we allow this Petition and direct that termination of the pregnancy of the petitioner would be performed within a day or two from the date of receipt of authenticated copy of this order by the expert doctors of said B.J. Government Medical College and Sasoon General Hospital, Pune. The termination of pregnancy will be supervised by the Committee/ Medical Board constituted by this Court which shall also maintain complete report of the procedure which would be performed on the petitioner at the time of termination of pregnancy. The expenses as may be chargeable shall be borne by the petitioner. Needless to say that we have not examined the petitioner's prayer for holding Section 3 of the Medical Termination of Pregnancy Act, 1971 to be unconstitutional and violative of Articles 14 and 21 of the Constitution of India.
7. With the aforesaid directions, Petition is disposed of.
8. Parties, including the Hospital in question, shall act on the authenticated copy of this order.

(R. G.KETKAR, J.) **(SHANTANU KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION

WRIT PETITION (L) NO. 3209 OF 2017

Priya Vijay Patel …Petitioner.

Versus

Union of India

& Ors. …Respondents.

….

Ms Meenaz Kakalia for the Petitioner.

Mr. D.P. Singh a/w Ms. Manisha Jagtap for Respondent Nos. 1 and 3. Ms. P.H. Kantharia, GP for Respondent No.2.

….

CORAM : R.M.BORDE &

R.G. KETKAR, JJ.

DATE: 04th JANUARY,2018

PER COURT:

Counsel for the petitioner, on instructions, states that the petitioner does not want to press the petition. It is also informed that the pregnancy carried by petitioner is at advance stage of 32 weeks. Considering this aspect, the petitioner is permitted to withdraw the petition.

Writ Petition, as such, stands disposed of as withdrawn.

(R.G. KETKAR) **(R.M. BORDE)**

JUDGE **JUDGE**

N THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

Writ Petition (ST) NO. 36727 OF 2017

Shaikh Ayesha Khatoon, Room No.112A, Millate Azad Welfare Society, Ambuj Wadi, Azad Nagar, Malwani,

1. Union of India, through the Secretary,
   Ministry of Law and Justice, Shastri Bhawan,
   "C" Wing, New Delhi110001.
2. State of Maharashtra,
   Through the Principal Secretary,
   Public Health Services, Mantralaya, Mumbai 23.
3. Ministry of Health and
   Family Welfare, through its Secretary,
   M.H. Division, New Delhi. ..Respondents

....

Ms. Meenaz Kakaliai/b.KrantiL.C., Advocate for the Petitioner. Mr. N.C. Walimbe, A.G.P., for Respondent No.2-State.

Ms. Shehnaz V. Bharucha a/ w. Ashok Verma, A.A. Ansari, Advocate for Respondent Nos.1 and3.

....

CORAM : R.M. BORDE &
R. G. KETKAR, JJ.

DATE: 09th JANUARY, 2018

ORAL JUDGMENT: [PER R.M. BORDE, J.]

Heard. Rule. With the consent of the parties, Rule made returnable forth with and the Petition is taken up for final disposal at the admission stage.

2. The petitioner is a lady undergoing 27th week of pregnancy and is praying for issuance of a direction to the respondents to allow her to undergo medical termination of pregnancy at medical facility of her choice and at her expenses. It is the contention of the petitioner that on Sonographical examination of the fetus it was revealed that it (fetus) suffers from several foetal anomalies including a congenital malformation. The report of Sonography dated 18.12.2017 is annexed at Exhibit 'A' to the petition. The Sonologist on examination reported several foetal anomalies as recorded below:

   (a) Inencephaly

   (b) Cerebellar hypoplasia

   (c) Hydranencephaly

   (d) Laryngeal Atresia

   (e) Atrium - Venticular septal defect

   (f) Double outlet single ventricle

   (g) Stomach not visible

3. It is reported that above congenital malformations increased the likelihood of an underlying genetic abnormality which could be ruled out with invasive testing and microarray. It is further reported that considering the number and severity of the malformations; chances of independent intact neonatal survival appear less. In view of the report of the Sonologist, the petitioner has approached this Court seeking relief, as sought above. The petitioner has also requested to refer her for further examination to Medical Committee in order to confirm the diagnosis of the Sonologist and to assist the Court in arriving at a decision as regards there quest made by the petitioner in the instant Petition.

4. Considering this, the learned Vacation Bench while directing issuance of notice to the respondents on 2.1.2018 directed respondent No.2 State of Maharashtra to get the petitioner examined by the Medical Board of Sir J.J. Groups of Hospitals, Mumbai consisting of Dean of the hospital, Head of Department (Gynecology), Professor and

Head of Department of Pediatric/Cardiac Surgeon, Professor and Head of Department of Radiology and Psychiatry and any other expert in the field.

5. The petitioner appeared before the Committee and she was medically and radiologically examined on 3.1.2018. The USG

Impressions recorded in the report are thus:

USG Impressions	Single live intrauterine gestation of mean gestational age 26weeks and 5days with gross polyhydramnios and multiple severe–cranial, complex cardiac and bowel anomalies as described above. Suggest cardiology opinion for the cardiac anomaly and genetic work up for underlying chromosomal anomalies as multiple fetal abnormalities are seen.

6. The observations of Associate Professor of Department of Pediatrics, Professor & Head of Department of Pediatric Surgery, Associate Professor of Department of Neurosurgery as well as the observations of Professor & Head of Department of Radiology and Professor & Head of Department of Psychiatry are as narrated below:

Observations of Dr. Subhash Walinjkar (Associate Professor of Department of Pediatrics):

USG report suggest single live intrauterine gestation of mean gestational age 26 weeks and 5 days with gross polyhydramnios and multiple severe - cranial, complex cardiac and bowel anomalies. In view of this grossly abnormal USG report is a high chance of fetal Morbidity and Mortality.

Observations of Dr. D.R. Kulkarni (Professor and Head of Department of Pediatric Surgery)::

USG report suggest single live intrauterine gestation of mean gestational age 26 weeks and 5 days with gross polyhydramnios and multiple severe - cranial, complex cardiac and bowel anomalies. In view of this grossly abnormal USG report is a high chance of fetal Morbidity and Mortality.

Observations of Dr. Sachin Giri (Associate Professor of Department of Neurosurgery):

USGf indingat SirJ.J.Hospital on 03/01/2018. USG at Sir. J.J. Hospital on 03/01/2018 shows Gross hydrocephalus with paper thin cortex. The lateral ventricles and the third ventricles are dilated. The posterior fossa is Hypoplastic. The head appears large due to excessive fluid. There are associated cardiac & intra-abdominal as well as thoracic anomalies. These findings suggest that there is high chance of morbidity & mortality.

Observations of Dr. Shilpa Domkundwar (Professor & Head of Department of Radiology):

OBSTETRICS

PRESENTATION	CEPHALIC A TPRESENT	UMBILICAL CORD	3 VESSEL NO CORD AROUND NECK,
CARDIAC ACTIVITY	SEEN 145/MIN	FETAL MOVEMENTS	PRESENT
PLACENTA	POSTERIOR	CERVICAL, LENGTH	ADEQUATE, 4 CM
PLACENTAL, THICKNESS	NORMAL, NO RETROPLACENTA L CLOTS	INTERNAL OS	CLOSED

FINDINGS :

Congenital Scan :

ENTITY	REMARK	ENTITY	REMARK
SKULL	ABNORMAL	B/LKIDNEYS	NORMAL
CVJ	NORMAL	GASTRIC BUBBLE	NOT SEEN
SPINE	NORMAL	BLADDER BUBBLE	PRESENT
BRAIN PARENCHYMA	THINNED OUT	LIMBS VISUALISSED	FOUR
HEART	COMPLEX ABNORMALITY	VESSELS IN CORD	THREE

Fetal Biometry: **AFI : 20CM, POLYHYDRAMNIOS**

BPD	77 mm	31 weeks	0 days
HC	284 mm	31 weeks	1 days
AC	220 mm	26 weeks	4 days
FL	48 mm	26 weeks	1 days
TIB	41 mm	26 weeks	6 days
FIB	39 mm	24 weeks	5 days
HUM	45 mm	26 weeks	5 days
RAD	36 mm	25 weeks	6 days
ULN	40 mm	26 weeks	1 days
MGA		26 weeks	5 days
EFW	1019+/- 149 gms		EDD 05/04/2018

Gross hydrocephalus is seen with paper thin cortex. The lateral ventricles and the third ventricles are dailated. The posterior fossa is Hypoplastic. The head appears large due to excessive fluid.

There is a small cystic structure with gut signature that shows repeated filling and emptying retro cardiac in location with infradiaphragmatic extension mostly suggestive of stomach herniation into the Mediastinum.

The bowel is not well seen ? Compressed ? Cause. Anal pit is appreciated.

Gross fetal hepatomegaly is seen with abnormal multiple intrahepatic venous channels.

The fetal heart shows complex abnormalities.

The LA is Hypoplastic. There is a fuctional single ventricle with RV configuration and a single atriventricular valve is appreciated. ASD is seen. The ventricle has double outlet with parallel outflow tracts with ? Fuctional transposition. The SVC is prominent. Abnormalvenous channel is seen to drain into the SVC from the contralateral side with pulmonary Venous drainage to it.

The infra diaphragmatic IVC is not appreciated.

Impression: Single live intrauterine gestation of mean gestational age 26 weeks and 5days with gross polyhydramnios and multiple severe – cranial, complex, cardiac and bowel anomalies as described above. Suggest cardiology opinion for the cardiac anomaly and genetic work up for underlying chromosomal anomalies as multiple fetal abnormalities are seen.

☐ **Observations of Dr. V. P. Kale (Professor & Head of Department of Psychiatry):**

No Evidence of any Psychopathology at present. She can take her own decision.

7. The Committee has recorded its opinion as narrated below:

COMMITTEE OPINION

UPON EXAMINATION & AFTER CAREFUL STUDY OF MULTIPLE SONOGRAPHY REPORTS, ITIS CONFIRMED THAT THE FETUS SUFFERS FROM SERIOUS NEUROLOGICAL, CARDIAC & BOWEL ABNORMALITIES WITH A VERY HIGH CHANCE OF MORBIDITY &MORTALITY.

THE WOMAN WAS BEEN EXPLAINEDABOUT THE OUTCOME IN THE LANGUAGE SHE UNDERSTANDS.

THE CONDITION OF THE FETUS FULFILLS THE CRITERIA OF "SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP" IN THEFETUS.

THE PREGNANT WOMAN HASVOLUNTARILY EXPRESSED HER DESIRE TO TERMINATE THE PREGNANCY AND IS WELL INFORMED ABOUT THE NATURE OF THE CONDITION OF FETUS AND ITS OUTCOME. SHE IS EXTREMELY ANGUISHED WITH THE CONDITION OF THE FETUS IN UTERO.

THE PREGNANCY HAS ADVANCED TO 27 WEEKS AND IS BEYOND 20 WEEKS CUT OF THE MEDICAL TERMINATION OF PREGNANCY ACT. HENCE SHE HAS APPROACHED HONOURABLE COURT FOR TERMINATION OF PREGNANCY.

AT THIS STAGE OF A PREGNANCY, THE RISK OF TERMINATION REMAINS THE SAME AS THAT OF NATURAL LABOUR AT TERM.

THUS IF THE COURT PERMITS THE PREGNANCY CAN BE TERMINATED AS DESIRED BY THE WOMAN."

8. There is a little doubt that there are foetal anomalies reported and the chances of survival of the fetus appear less and there is a substantial risk of severe physical handicap. The learned Counsel appearing on behalf of the petitioner, therefore, urges that this a fit case for according permission to the petitioner to undergo medical termination at the center of her choice.

9. The Medical Termination of Pregnancy Act, 1971 is enacted with a view to providing for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto. When the pregnancy is to be terminated by registered medical practitioners has been prescribed in Section 3ofthe Act. Subsection(2) of Section 3 provides that subject to the provisions of subsection (4), a pregnancy may be terminated by a registered medical practitioner, (a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or (b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion formed in good faith, that - (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (ii) there is a substantial risk that if the child were born, it would be suffer form such physical or mental abnormalities as to be seriously handicapped.

10. Section 3 (2) (b) (i) & (ii) as well as Section 5(1) of the Act of 1971 read thus:

"3. When pregnancies may be terminated by registered medical practitioners.

(1) xxxx

(2) Subject to the provisions of subsection (4), a pregnancy may be terminated by a registered medical practitioner,

(a) xxxx

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are,

of opinion formed in good faith, that

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer form such physical or mental abnormalities as to be seriously handicapped."

"5. Sections 3 and 4 when not to apply. (1) The provisions of section 4, and so much of the provisions of subsection(2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of

opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman."

Section3 of the Act of 1971thus prescribes the outer limit of 20 weeks in the matter of termination of pregnancy in certain circumstances enumerated in Clauses (i) & (ii) of subsection 2(b) of Section 3. Section 5 carves out an exception to Sections 3 & 4. It is provided that the provisions of section 4, and so much of the provisions of subsection(2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is contended relying on the provisions of subsection (1) of Section 5 by the petitioner that the bar contained in subsection (2) of Section 3 laying down the conditions for according permission to terminate the pregnancy is not absolute bar and inappropriate cases such permission can be accorded. Section 5 of the Act of 1971 carves out an exception in relation to the outer limit provided under subsection(2) of Section 3of the Act of 1971 i.e. 20 weeks in case where the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is the contention of the petitioner that firstly the trauma that the petitioner is likely to suffer is life threatening and it shall be construed that exercise of a choice in the event there are foetal abnormalities found and the chances of survives of the baby, if allowed to take birth, are minimum, is a matter to be considered within the parameters of Section 5 of the Act of 1971. Apart from this, the petitioner contends that the provisions of subsection (2) including clauses (i) & (ii) of subsection (2) (b) of Section 3 are required to be read in Section 5 except the outer limit of twenty weeks that has been provided in subsection (2) (b) of Section 3 of the Act of 1971.

11. The petitioner thus contends that if there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped, it will be open for the Court to accord permission to terminate the pregnancy by taking recourse to Section 5 of the Act of 1971.

12. It is further contended that theconcludingportionofSection5prescribingthelimitationin permitting such a choice or issuing direction in respect of termination of the pregnancy only in the event to save the life of the pregnant woman shall have to be interpreted harmoniously and looking to the object of the provision. It also needs to be considered that a pregnant woman has a right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India. In this context reliance can be placed on the observations of Hon'ble Supreme Court in the matter of Suchita Srivastavavs. Chandigarh Administration reported in 2009(9)SCC1.I n paragraph11 of said judgment, it is observed by the Hon'ble Supreme Court as narrated below:

"11. A plain reading of the abovequoted provision makes it clear that Indian law allows for abortion only if the specified conditions are met. When the MTP Act was first enacted in 1971 it was largely modelled on the Abortion Act of 1967 which had been passed in the United Kingdom. The legislative intent was to provide a qualified 'right to abortion' and the termination of pregnancy has never been recognised as a normal recourse for expecting mothers. There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birthcontrol methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a' compelling state interest' in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices."

13. It is further observed that ordinarily a pregnancy can be terminated only when a medical practitioner is satisfied that a 'continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health'[as per Section 3(2) (b) (i) of the Act of 1971]or when' there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped' [as per Section 3 (2) (b) (ii) of the Act of 1971]. It is true that Clauses (i) & (ii) of sub section 2(b) of Section 3 are attracted in the case where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks. However, as has been recorded above Section 5 5 permits termination of pregnancy by a registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It shall also have to be construed that Section 5 brings within its ambit the provisions of Section 4 and so much of the provisions of subsection

(2) of Section 3 of the Act of 1971 except the limitation in respect of length of the pregnancy of 20 weeks as provided in subsection (2) (b) of Section 3 of the Act of 1971. It would thus be logical to conclude that the contingencies referred in Clauses (i) & (ii) of subsection (2) (b) of Section3 will have to be read in Section 5 of the Act of 1971 and it would be relevant

to consider the threat perception and substantial risk involved if the child were to born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. The contingencies laid down in Clauses (i) & (ii) of subsection (2) (b) of Section 3 shall therefore equally apply to the request of a pregnant woman seeking permission to terminate the pregnancy beyond 20 weeksandaccordinglySection5 (1) will have to be construed, to meet the object and purpose of enactment and to promote cause of justice.

14. As has been recorded above, the freedom of a pregnant woman of making choice of reproduction which is integral part of "personal liberty", whether to continue with the pregnancy or otherwise cannot be taken away. It shall also be taken into consideration that besides physical injury, the legislature has widened the scope of the termination of pregnancy by including "a injury" to mental health of the pregnant woman. Thus, if continuance of pregnancy is harmful to the mental health of a pregnant woman, then that is a good and legal ground to allow termination of pregnancy if all the conditions incorporated in legal provision are met. In the instant matter the petitioner claims that it would be injurious to her mental health to continue with the pregnancy since there are severe foetal abnormalities noticed and it would also be violative of her "personal liberty" to deny her the choice to terminate the pregnancy. The provisions of Section5 of the Act of 1971 shall have to be interpreted in the manner for advancing the cause of justice. In this context it would be appropriate to refer to the judgment of Division Bench of this Court in the matter of High Court on its own motion vs. the State of Maharashtra, reported in 2017 CriL.J.218. In paragraph13 of the judgment, it is observed thus:

"13. A woman irrespective of her marital status can be pregnant either by choice or it can be an unwanted pregnancy. To be pregnant is a natural phenomenon for which woman and man both are responsible. Wanted pregnancy is shared equally, however, when it is an accident or unwanted, then the man may not be there to share the burden but it may only be the woman on whom the burden falls. Under such circumstances, a question arises why only a woman should suffer. There are social, financial and other aspects immediately attached to the pregnancy of the woman and if pregnancy is unwanted, it can have serious repercussions. It undoubtedly affects her mental health. The law makers have taken care of helpless plight of a woman and have enacted Section 3 (2) (b) (i) by incorporating the words" grave injury to her mental health". It is mandatory on the registered medical practitioner while forming opinion of necessity of termination of pregnancy to take into account whether it is injurious to her physical or mental health. While doing so, the woman's actual or reasonable foreseeable environment may be taken into account."

15. While interpreting the provisions of Section 5 of the Act of 1971, it must be borne in mind

the principle that the section must be construed as a whole whether or not one part is a saving clause and similarly elementary rule of construction of section is made of all The parts together and that it is not permissible too mit any part of it; the whole section must be read together. The words of Statute are first understood in their natural, ordinary and popular sense and phrases and sentences are construed according to their grammatical meaning unless there be something in the context, or in the object of the statute in which they occur or in the circumstances in which they are used, to show that they were used in special sense different from their ordinary grammatical meaning. The basic principle that while interpreting the provisions of a Statute one can neither add nor subtract even a single word, has to be kept in mind. A section is to be interpreted by reading all of its parts together, and it is not permissible too mit any part there of. The Court cannot proceed with the assumption that the legislature, while enacting the Statute has committed a mistake; it must proceed on the footing that the legislature intended what it has said; even if there is some defect in the phraseology used by it in framing the statute, it is not open to the Court to add and amend, or by construction, make up for the deficiencies, which has been left in the Act. The Court canonly iron out the creases but while doing so, it must not alter the fabric, of which an Act is woven. The Court, while interpreting statutory provisions, can not add words to a Statute, or read words in to it which are not part of it, especially when a literal reading of the same produces an intelligible result. [Vide Nalinakhya Bysack v. Shyam SunderHaldar andors., AIR1953SC148; Sri Ram Narain Medhiv. State of Bombay, AIR1959SC459; M. Pentiah and Ors. v. Muddala Veeramallappaand Ors., AIR1961SC1107; The Balasin or Nagrik Cooperative Bank Ltd.v. Babubhai Shankerlal Pandya and Ors., AIR 1987 SC 849; and Dadi Jagannadham v. Jammulu Ramulu and Ors., (2001) 7 SCC 71].

16. In the matter of New IndiA AssurAnce CompAny Ltd.v. Nusli Neville WAdiA And Another, (2008) 3SCC279, the Hon'ble Supreme Court while referring to the analysis of purposive construction has observed in paragraph52 as narrated below:

> "52. Barak in his exhaustive work on 'Purposive Construction' explains various meanings attributed to the term 'purpose'. It would be in the fitness of discussion to refer to Purposive Construction in Barak's words:
>
> > "Hart and Sachs also appear to treat 'purpose' as a subjective concept. I say 'appear' because, although Hart and Sachs claim that the interpreter should imagine himself or herself in the legislator's shoes, they introduce two elements of objectivity: First, the interpreter should assume that the legislature is composed of reasonable people seeking to achieve reasonable goals in a reasonable manner; and second, the interpreter should accept then onrebuttable presumption that members of the legislative body sought to fulfill their constitutional duties in good faith. This formulation allows the interpreter

> to inquire notin to the subjective intent of the author, but rather the intent the author would have had, had he or she acted reasonably."

(Aharon Barak, Purposive Interpretation in Law (2007) at pg. 87)

17. A statute must be interpreted having regard to the purport and object of the Act. The doctrine of purposive construction must be resorted to. It would not be permissible for the Court to construe the provisions in such a manner which would destroy the very purpose for which the same was enacted. The principles in regard to the approach of the Court in interpreting the provisions of a statute with the change in the societal condition must also be borne in mind. The rules of purposive construction have to be resorted to which would require the construction of the Act in such a manner so as to see that the object of the Act is fulfilled.
18. The two principles of construction one relating to cASus omissus and the other in regard to reading the statute as a whole appear to be well settled. In regard to the latter principle, the following statement of law appears in Max well at page47:

> "A statute is to be read as a whole "It was resolved in the case of Lincoln Colleges case (1595) 3 Co Rep. 58B, at page 59b that the good expositor of an Act of Parliament should make construction on all the parts together, and not of one part only by itself. Every clause of a statute is to be construed with reference to the context and other clauses of the act, so as, as far as possible, to make a consistent enactment of the whole statute.(Per Lord Davey in Canada Sugar Refining Co. Ltd. v. R. 1898 Act 735 (Canada)."

19. As has been observed by the Supreme Court in the matter of RBIVs. Peerless General Finance and Investment Co. Ltd. ,reported in (1987) 1 SCC 424, the textual interpretation that matches the contextual is known to be best interpretation. It is observed in paragraph 33 of the judgment, thus:

> "33. Interpretation must depend on the text and the context. They are the bases of interpretation. One may well say if the text is the texture, context is what gives the colour. Neither can be ignored. Both are important. That interpretation is best which makes the textual interpretation match the contextual. A statute is best interpreted when we know why it was enacted. With this knowledge, the statute must be read, first as a whole and then section by section, clause by clause, phrase by phrase and word by word. If a statute is looked at, in the context of its enactment, with the glasses of the statutemaker, provided by such context, its scheme, the sections, clauses, phrases and words may take colour and appear different than when the statute is looked at without the glasses provided by the context. With these glasses we must look at the Act as a whole and discover what each

section, each clause, each phrase and each word is meant and designed to sayast of it in to the scheme of the entire Act. No part of a statute and no word of a statute can be construed in isolation. Statutes have to be construed so that every word has a place and everything is in its place..."

20. Generally speaking, Statutes are classified in fourfold manner. Firstly, the statutes are remedial, secondly they are declaratory, thirdly they are procedural and lastly they are penal or disentitling. One has to find out the character of the statute as to whether it is penal or not, so as to apply principles of strict construction. In the instant matter it can not be said that the provisions of the enactment which are relevant for consideration are penal in character. In a way, the provision is remedial and procedural. The provision, therefore, cannot be applied the standards as regards interpretation of a Statute which is penal in character.

21. On analysis of the judgments and the narrations, as recorded above, one must while interpreting the provision so flaw, bear in mind that the provision as to be interpreted by reading all of its parts together and it is not permissible to omit any part there of.The golden rule of interpretation is that the provisions of law have to be read as it is without adding or subtracting anything therefrom. In an appropriate case, the Court can only iron out the creases but while doing so, it must not alter the fabric, of which an Act is woven.

22. In the instant matter, on reading of Section 5 of the Act of 1971, it does transpire that the contingencies and the parameters laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3 shall have to be read in Section 5 except the bar of limitation as provided in Section 3 (2) (b) of the Act of 1971. It would not be appropriate to over look the contingencies laid down in clauses (i) & (ii) of subsection(2) (b)of Section 3 while considering the request of a pregnant woman for termination of the pregnancy if the conditions laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3 are satisfied it would provide a good ground for exercise of jurisdiction under Section 5 of the Act of 1971.

23. The Ministry of Health and Family Welfare, Government of Maharashtra has prepared the MTP (Amendment) Bill and the notification in that regard was published on 29.10.2014. The State Government has proposed amendment to Section 3 of the Act of 1973 and clause(C) is proposed to be added which reads thus:

"(C) the provisions of subsection (2) of section 3as relate to the length of the pregnancy shall not apply to the termination of a pregnancy by a registered health care provider where the termination of such pregnancy is necessitated by the diagnosis of any of the substantial foetal abnormalities as may be prescribed."

24. Considering the above proposed amendment, according to us, the interpretation which we have put to Section 5 of the Act of 1971 appears to be a logical and same is in consonance

with the proposed changes as suggested by the State in the MTP (Amendment) Bill notified on 29.10.2014.

25. The petitioner has restricted the claim in the petition in respect of prayer clause (b) (ii) of paragraph56 of the Petition. The other prayers recorded by the petitioner in the instant petition are not pressed. Even otherwise, in view of the interpretation which we have put to Section 5 of the Act of 1971, prayer clause (a), as requested by the petitioner, does not need consideration.

26. For there as one recorded above, the Writ Petition is allowed.

    The petitioner is permitted to undergo medical termination of pregnancy at a medical facility of her choice. The petitioner undertake store port to the approved center for carrying out the procedure of medical termination of pregnancy with in two days from today.

27. The Counsel appearing for the petitioner states, on instructions ,that the petitioner will bear the medical expenses of the procedure of medical termination of pregnancy at a medical facility of her choice.

28. It is clarified at this stage that the petitioner has been sensitized by the Committee/Medical Board about the risk factors involved and it would be open for the petitioner to undergo the procedure of medical termination of pregnancy at her own risk and consequences. It is further made clear that the Doctors who have put their opinions on record shall have the immunity in the event of occurrence of any litigation arising out of the instant Petition.

29. Rule is accordingly made absolute. There shall be no order as to costs. The operative part of this judgment shall be uploaded today and all concerned parties, including concerned approved Medical Center, to act upon the authenticated copy of the operative order.

(R. G.KETKAR, J.) **(R.M. BORDE, J.)**

IN THE HIGH COURT OF JUDICATURE ATBOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 187 OF 2018

Misabah Umarfaruk Tamboli …Petitioner.

Versus Union of India

And others …Respondents.

….

Ms. Meenaz Kakalia a/w Kranti L.C. for the Petitioner. Mr. Sandeep Babar, AGP for respondent No.2

Ms. Shehnaz V. Bharucha i/b. P.S. Gujar for Respondent Nos. 1 and3.

….

CORAM : R.M.BORDE &

R.G. KETKAR, JJ.

DATE: 16th JANUARY,2018

PER COURT :

1. The petitioner seeks a declaration that section 3(2)(b) of the Medical Termination of Pregnancy Act, 1971 to the limited extent that it stipulates a ceiling of 20 weeks for termination of pregnancy is ultra virus to Article 14 and 21 of the Constitution of India. The issue raised in the instant petition need not be considered in view of the judgment delivered by us interpreting the provision of Section 5 of the Act of 1971 in the matter of ***Shaikh Ayesha Khatoon vs. Union of India and others, dated 09.01.2018 in Writ Petition (Stamp) No.36727 of 2017.*** The petitioner is also praying for issuance of directions in the nature of writ of mandamus to the respondents to constitute a Medical Committee for the examination for the petitioner to assist this Court in arriving at a decision on the plea and

to allow the petitioner to undergo Medical Termination of pregnancy at a medical facility of her choice.

2. The petitioner is undergone 32nd weeks of pregnancy. The petitioner was referred to the Medical Board consisting of seven experts from B.J. Government Medical College and Sassoon General Hospital, Pune. The committee consists of Dean, Professor and Head of Department of OBGY, Professor and Head of Department of Radiodiagnosis, Professor and Head of Department of Paediatrics, Professor and Head of Department of Medicine, Associate Professor and Head of Department of Cardiovascular surgery and Assistant Professor of Neurology from B.J. Government Medical College and Sassoon General Hospital, Pune. The committee has examined the petitioner in furtherance of the directions issued by this Court on 11.01.2018 and has submitted its report. The Committee has recorded its opinion as narrated below:

> ***"Opinion of the Committee:***
> *The committee examined these aid woman(Misabah) and necessary investigAtions were done. Ultrasonography and fetal MRI were suggestive of corpuscallosum agenesis.*
>
> *The pregnancy is 30weeks 5 days with breech presentation (today).*
>
> *The committee after discussion and studying similar case reports thinks that the Baby may not be born dead at birth but may have significant morbidities like mental retardation or epilepsy.*
>
> *In this condition, it may be advised to terminate the pregnancy with kind permission of Hon. High Court Mumbai.*
>
> *However, the pregnancy is 30 weeks 5 days to day and carries a significant risk to the mother for termination at this advanced stage of gestation. So the termination may be difficult at this gestation with a possibility of need of ceas areansection.*
> *The committee thinks that the pregnancy anbe terminated (induction of labour)at later date if there is either intrauterine death, prematurer up tureofmembranesorthere i sspontaneous on set of labour. In those events termination will be easy with less complications & morbidities."*

3. According to the committee, the petitioner is carrying pregnancy of 30 weeks and 5 days as on the date of the examination i.e on 11.01.2018. As on the date of issuance of this order, the petitioner is carrying 32nd week of the pregnancy. As reported by the committee, the termination may be difficult at this advance stage of gestation. The committee has further opined that the pregnancy can be terminated (induction of labour) at a later date if there is either intrauterine death, premature rupture of membranes of there is a spontaneous onset of labour and in such circumstances, the termination is easy with less complications and morbidities

4. Considering the report of the committee and considering advance gestation age i.e. 32 weeks, it would not be prudent to exercise extraordinary jurisdiction and grant permission as requested. It is reported by the committee that the procedure of the termination of the pregnancy may pose a threat to the life of the mother. In the circumstances, we do not deem it appropriate to exercise an extraordinary jurisdiction under Article 226 of the Constitution of India for the issuance of directions as requested by the petitioner.
5. The petition is devoid of substance and hence stands rejected.

(R.G. KETKAR) **(R.M. BORDE)**

JUDGE **JUDGE**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

Writ Petition NO. 766 OF 2018

Siddamma Golsar,

Shri Dattakrupa CHS Ltd.,

Through the Principal Secretary, Public Health Services, Mantralaya, Mumbai 23.

5thFloor, Building B/2, Flat No.511, S.V. Road,

Santacruz (W), Mumbai400054 ..Petitioner

Versus

1. Union of India, through
   the Secretary,
   Ministry of Law and Justice,
   Shastri Bhawan,
   "C"Wing, New Delhi110001.
2. State of Maharashtra,
   Through the Principal Secretary,
   Public Health Services,
   Mantralaya, Mumbai 23.
3. Ministry of Health and
   Family Welfare, through

its Secretary,

M.H. Division, New Delhi. ..Respondents

....

Ms. Meenaz Kakalia i/b. Kranti L.C. , Advocate for the Petitioner.

Ms. Purnima Awasthi a/w. Mr. Upendra Lokegaonkar i/b. A.A. Ansari, Advocate for Respondent Nos. 1 & 3.

Mr. Sandeep Babar, A.G.P. for Respondent No.2 - State.

....

CORAM : R.M. BORDE &

R. G. KETKAR, JJ.

DATE: 25th JANUARY,2018

ORAL JUDGMENT: [PER R.M. BORDE, J.]

Heard. Rule. With the consent of the parties, Rule made returnable forth with and the Petition is taken up for final disposal at the admission stage.

2. The petitioner is a pregnant lady who is praying for issuance of direction to the respondents to permit her to undergo the procedure of medical termination of pregnancy. It is reported that the petitioner is undergoing pregnancy at22nd week. On examination by the Sonologist initially on 5.1.2018, certain anomalies were noticed. The Sonologist on examination reported several foetal anomalies as recorded below:

> " Levocardia. Common AV canal defect with large primum ASD. B/LSVC. Single ventricle with no IVS seen. DOV with Dmalposed great arteries. Anterior aorta. Severe PS with confluent good sized branch pulmonary arteries. Normal function. Mildright AVVR. Detailed report attached.
> The baby will most likely require single ventricle palliation surgical pathway for the cardiac disease postnatally. I have explained to the parents that the baby will require 23 cardiac surgeries in its lifetime, the first 2 surgeries of which are done within the first 2 months of life. To reassess the cardiac echo soon after birth to confirm the treatment plan."

3. Considering the preliminary report of the Sonologist, this Court by order dated 19.1.2018 directed medical examination of the petitioner by a Medical Board of Sir J.J. Group of Hospitals, Mumbai consisting of Dean of the said Hospital, Head of the Department (Gynecology), Professors and Head of Department of Pediatrics /Cardiac Surgeon, Professors or Head of

Department of Radiology and Neurology and any other expert in the field to be inducted in the Board at the option of the Dean of Medical College. The petitioner accordingly appeared before the Medical Board on 20.1.2018 and was examined by the Board. The petitioner has also undergone the radiological examination. The observations of the Medical Board are quoted as below:

Observations of Dr. Vilas Kurude (Associate Prof. Dept. of Obstetrics & Gynecology):

- G.C. Fair TPR –Normal
- BP 110/70 mmHg
- PAUterus – 22weeks
- External ballotment+
- Diagnosis – Primigravida with 22weeks gestation with congenital anomalous baby (Multiple cardiac anomalies)

Observations of Dr. Shilpa Domkundwar (Prof. & Head, Dept. of Radiology):

OBSTETRICS

PRESENTATION	CEPHALIC	UMBILICAL CORD	3 VESSEL NO CORD AROUND NECK,
CARDIAC ACTIVITY	SEEN 136 beats /min	FETAL MOVEMENTS	PRESENT
PLACENTA	FUNDO POSTERIOR	CERVICAL, LENGTH	ADEQUATE
PLACENTAL, THICKNESS	NORMAL, NO RETROPLACENTAL CLOTS	INTERNAL OS	CLOSED

Fetal Biometry: **AFI : 67 cm, ADEQUATE**

BPD	54 mm	22 weeks	5 days
HC	200 mm	22 weeks	1 day
AC	160 mm	21 weeks	1 day
FL	38 mm	22 weeks	2 days
MGA		22 weeks	1 day
EFW		450 +/- 66 gms	EDD 25/05/2018

Fetal 2 D ECHO :

Situs solitus
Levocardia
3 Chamber view seen with single ventricle. Common AV canal defect is seen.
Double outlet single ventricle seen with transposed great arteries.
Aorta normal calibre.
Pulmonary artery : Valvular and infundibular stenosis seen.
RA and LA normal with ostium primum defect. Pulmonary veins can not be evaluated.
SVC and IVC draining RA PDA shows right to left flow. Brain:
Incidental borderline ventriculomegaly seen.

Impression : Single live intrauterine gestational sac of mean gestational age 22 weeks and 1 day with double outlet single ventricle, common AV canal defect, transposed great arteries, pulmonary valvular and infundibular stenosis and incidental ventriculomegaly.

Observations of Dr. K. N. Bhosle (Prof. & Head, Dept. of C.V.T.S.)

υFetal 2D Echo: Complex cyanotic congenital heart disease in the form of
1) Common AV canal defect.
2) Double outlet single ventricle.
3) Valvular and infundibular pulmonary stenosis.
4) Transposition of great arteries.

5) Obligatory patient Ductus arteriosus.

Opinion : Foetus, 22 weeks gestation with complex congenital cyanotic heart disease, having very high mortality outcome for multistage cardiac surgical management. Above complex cardiac anomalies endanger viability of foetus by virtue of their morphological complicated is position requiring multiple surgical interventions.

Observations of Dr. D. R. Kulkarni (Prof. & Head, Dept. of Pediatric Surgery):

On examining the patient and going through the report it appear that patient is having multiple cardiac anomalies for which expert cardiothoracic surgeon opinion is essential. As such no anomolies noticed in relation with pediatric surgical problems.

Observations of Dr. Kamlesh Jagyasi, (Prof. & Head, Dept. of Neurology):

Siddamma 25 years old married female with 22 weeks gestation referred with multiple cardiac anomalies in fetus detected by sonography. There is border line ventriculomegaly as per the sonography and no other nervous systems anomaly has been mentioned. There is no neurological indication for medical termination of pregnancy, refer to CVTS Surgeon for expert opinion.

4. The Committee has recorded its opinion as narrated below:

COMMITTEE OPINION

UPON EXAMINATION AND AFTER CAREFUL STUDY OF SONOGRAPHY REPORTS AND FETAL 2D ECHO REPORT, IT IS CONFIRM THAT FETUS SUFFERS FROM SERIOUS CARDIAC ANOMALIES, WITH VERY HIGH CHANCE OF MORBIDITY AND MORTALITY.

THE WOMAN HAS BEEN EXPLAINED ABOUT THE OUTCOME IN THE LANGUAGE SHE UNDERSTANDS.

THE CONDITION OF THE FETUS FULFILS THE CRITERIA OF "SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP" IN THEFETUS.

THE PREGNANT WOMAN HASVOLUNTARILY EXPRESS HER DESIRE TO TERMINATE THE PREGNANCY AND IS WELL INFORMED ABOUT THE NATURE OF THE CONDITION OF THE FETUS AND ITS OUTCOME. SHE IS EXTREMELY ANGUISHED WITH THE CONDITION OF FETUS IN UTERO.

THE PREGNANCY HAS ADVANCED TO 22 WEEKS AND IS BEYOND THE 20 WEEKS CUT OFF OF THE MEDICAL TERMINATION OF PREGNANCY ACT. HENCE SHE HAS BEEN APPROACHED TO HONORABLE COURT FOR TERMINATION OF PREGNANCY.

AT THIS STAGE OF A PREGNANCY, THE RISK OF TERMINATION REMAINS THE SAME AS THAT OF NATURAL LABOUR AT TERM.

THUS IF THE COURT PERMITS THE PREGNANCY CAN BE TERMINATED AS DESIRED BY THE WOMEN."

5. On consideration of the observations of each of the Member of the Medical Board, the Committee has opined that the "fetus fulfills the criteria of substantial risk of serious physical handicap "in the fetus. It is reported by the committee that the fetus suffers from serious cardiac anomalies with very high chance of morbidity and mortality. The petitioner was explained the diagnosis as well as the problems by the Committee. The petitioner is also made aware of the risks involved in the termination of the pregnancy. The Committee has reported that the risk of termination of pregnancy at 22nd week remains as the same as that of natural labour term. The Committee is of the opinion that if the Court grants permission the pregnancy can be terminated as desired by the petitioner.

6. This Court while dealing with an identical issue raised in Writ Petition (stamp) No. 36727/2017 and while considering the permissibility to exercise the powers after lapse of 20 weeks period pregnancy as provided under Section 3 of the Medical Termination of Pregnancy Act, 1971, has concluded that the provisions of Section 3(2)(b) clauses (i) & (ii) shall have to be read while interpreting Section 5(1) of the Act of 1971. This Court has opined that the only portion recorded in Section 3 which is referable to the length of the period of pregnancy shall have to be excluded. In paragraph22 of the judgment it is observed thus:

   "22. In the instant matter, on reading of Section 5 of the Act of 1971, it does transpire that the contingencies and the parameters laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3 shall have to be read in Section 5 except the bar of limitation as provided in Section 3(2) (b) of the Act of 1971. It would not be appropriate to over look the contingencies laid down in clauses (i) & (ii) of sub section (2) (b) of Section 3 while considering the request of a pregnant woman for termination of the pregnancy if the conditions laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3 are satisfied it would provide a good ground for exercise of jurisdiction under Section 5 of the Act of 1971."

7. In view of determination by this Court on interpretation of provisions of Section 5 of the Act of 1971, it would be permissible to direct termination of pregnancy carried by the pregnant woman in the event of noticing substantial risk of physical or mental abnormalities in case the child were to born or that it would suffer serious handicap. The parameters laid down under Clause (ii) of subsection 2(b) of Section 3 gets attracted while interpreting Section 5 of the Act of 1971 and in such circumstances as noticed in the instant matter so also as noticed by this Court in Writ Petition (St.) No. 36727/2017, it would be open for this Court to exercise the jurisdiction under Section 5 of the Act of 1971 and pass necessary orders as prayed for by the petitioner.

8. The provisions of Section 4 of the Act provides that no termination of pregnancy shall be made in accordance with this Act at any place other than a hospital established or maintained by the Government or a place for the time being approved for the purpose of the Act of 1971 by the Government or a District Level Committee constituted by that Government with the Chief Medical Officer or District Health Officer as the Chair person of the said Committee. (The District Level Committee consisting of not less than three and not more than five members including the Chair person, as the Government may specify from time to time.

9. For the reasons recorded above as also considering the view taken by us while disposing of Writ Petition (Stamp) No. 36727/2017, the instant Petition is allowed. The petitioner is permitted to undergo medical termination of pregnancy at a medical facility of her choice as provided under Section 4 of the Act of 1971. The petitioner undertakes to report to the approved center for carrying out the procedure of medical termination of pregnancy with in two days from today.

10. The Counsel appearing for the petitioner states ,on instructions, that the petitioner will be arthe medical expenses of the procedure of medical termination of pregnancy at a medical facility of her choice as specified in Section 4 of the Act of 197 It is clarified at this stage that the petitioner has been sensitized by the Committee/Medical Board about the risk factors involved and it would be open for the petitioner to undergo the procedure of medical termination of pregnancy at her own risk and consequences. It is further made clear that the Doctors who have put their opinions on record shall have the immunity in the event of occurrence of any litigation arising out of the instant Petition.

11. Rule is accordingly made absolute. There shall be no order as to costs. The operative part of this judgment shall be uploaded today and all concerned parties, including concerned approved Medical Center, to act upon the authenticated copy of the operative order.

(R. G.KETKAR, J.) **(R.M. BORDE, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 2020 OF 2018

Rupali Chetan Kumbhar ...Petitioner

Vs.

Union of India and Ors. Respondents

Ms. Minaz Kakalia for the Petitioner.

Mr. Sandeep Babar, AGP for respondent no. 2 State.

Mrs. Purnima Awasthi a/w Mr. Ashok Varma for respondent nos. 1 and 3 Union of India.

CORAM: SHANTANU KEMKAR&

M.S. KARNIK, JJ.

DATE: MARCH 01, 2018

P.C.:

Petitioner Rupali Chetan Kumbhar has approached this court under Article 226 of the Constitution of India seeking direction to the first respondent to produce a report of the appropriate committee which may be constituted by this court for examination of the petitioner and for submitting its report as to whether the petitioner can be allowed to get the pregnancy terminated.

2. According to the petitioner, pregnancy has gone up to 24 weeks which is beyond the permissible

period of 20 weeks, in the circumstances, petitioner has approached this court.

3. On 21.2.2018 while issuing notice to the respondents, this court has directed constitution of the committee consisting of various experts from Sir JJ Group of Hospitals, Mumbai. The said Committee after examining the medical reports submitted by the petitioner and after conducting various tests upon her, submitted its report. The relevant portion of the report of the said expert committee reads thus:

"THE COMMITTEE AFTER EXAMINATION AND CAREFUL STUDY OF MULTIPLE SONOGRAPHY REPORTS, HAS CONFIRMED THAT THE FETUS HAS A NELUROLOGICAL ABNORMALITY IN THE FORM OF:

1. ABSENCE OF CAVUM SEPTUM PALLUCIDUM

2. SQUARING OF FRONTAL HORNS OF BOTH LATERL VENTRICALS

3. AGENESIS OF CORPUS CALLOSUM

4. COLPOCEPHALY

5. SEPTO OPTIC DISPLASIA CANNOT BE RULED OUT. THIS CAN RESULT IN:

1. DELAYED DEVELOPMEMT.

2. RESISTANT EPILEPSY

3. INTELLECTUAL IMPAIRMENT

4. PHYSOCHOSIS

5. VISUAL DEFECTS

6. SPASTICITY /CEREBERAL PALSY

7. AUTISM/ ADHD/ DYSLEXIA

SUCH CASES ALSO MAY BE ASSOCIATED WITH:

1. MIGRATIONAL DISORDERS

2. PVL

3. INTRAAVENTRICULAR HAEMORRHAGE

4. MICROCFEPHALY OR HYDROCEPHALUS

5. VARIOUS SYNDROMES LIKE AIRCARDES SYNDROME AND OTHERS.

THUS THE CONDITION OF FETUS FULFIL THE CRITERIA OF "SUBSTANTIAL RISK OF SERIOUIS PHYSICAL HANDICAP." THE PREGNANCY HAS ADVACNED UPTO 24 WEEKS AND IS BEYOND 20 WEEKS CUT OFF OF MEDICAL TERMINATION OF PREGNANCY ACT. HENCE, SHE HAS APPROACHED THE HONOURABLE COURT FOR TERMINATION OF PREGNANCY.

IF THE HONORABLE COURT PERMITS PREGNANCY CANBE TERMINATED AS DESIRED BY PREGNANT WOMAN. THE RISK OF TERMINATION OF PREGNANCY IS NOT GOING TOBE MORE THAN THAT OF NORMAL LABOUR."

4. We have gone through the said opinion which includes opinion of the various expert doctors including Dr.Ashok Anand, Professor and Head, Dept. of OBGY, GGMC, Mumbai, Dr. V.P. Kale, Professor and Head, Dept of Psychiatry, GGMC, Mumbai, Dr. Shilpa Domkundwar, Professor and Head, Dept of Radiology, GGMC, Mumbai, Dr. Bela Varma, Professor and Head, Dept of Pediatric, GGMC, Mumbai, Dr. Kamlesh Jagyasi, Dr. Kamlesh Jagyasi, Professor and Head, Dept of Neurology, GGMC, Mumbai. It appears that the Committee has reached the conclusion that there would be substantial risk of serious physical handicap.
5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the petitioner to undergo the medical termination of the pregnancy. It is certain that if the petitioner is allowed to give birth to foetus, there is substantial risk of serious physical handicap.
6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medial termination of pregnancy under the provisions of the medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.
7. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.
8. We further direct that the termination of the petitioner's pregnancy to be performed within three days by the expert doctors of Sir, J.J. Group of Hospital, Mumbai where she has to undergo medical check up.
9. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this court which shall maintain the complete report of the procedure which would be performed on the petitioner at the time of termination of the pregnancy.

10. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.
11. Petitioner shall bear the cost of the operation and other expenses.
12. With the aforesaid directions, petition is disposed of.
13. Parties to act on authenticated copy of this order.

(M.S.KARNIK, J.) **(SHANTANU KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 3082 OF 2018

Rupali Rajkiran Chinde ...Petitioner

Vs.

Union of India and Ors. Respondents

Ms. Minaz Kakalia a/w Kranti L.C. for the Petitioner. Mr. C.P. Yadav, AGP for the Respondent-State.

CORAM: SHANTANU KEMKAR&

M.S. KARNIK, JJ.

DATE: MARCH 09, 2018

P.C.:

Heard learned counsel for the petitioner on the question of admission.

2. Issue notice to the respondents. Learned AGP waives service of notice on behalf of respondent nos. 2 and 3. Steps for service on respondent no.1 be taken within a week. In addition, petitioner is permitted to serve copy of the petition on the learned Additional Solicitor General.

3. According to the petitioner, she is pregnant and pregnancy has gone to 23 weeks which is beyond the ceiling of 20 weeks which is the permissible limit for abortion to be carried out. In the circumstances, Petitioner is seeking permission to get the pregnancy terminated by abortion as according to the petitioner, the foetus is having various complications and there is very likelihood that if born, the child would suffer severe physical and mental impairment and

there would be no chances of survival in the later life. In support of the claim, the petitioner has filed various medical certificates and sonography reports.

4. Having gone through the same, we are of the view that the petitioner requires to be referred for medical examination by constituting Medical Board/Committee of B.J. Government Medical College/Hospital (Sassoon Hospital), Pune. The Medical Board/Committee shall consist of Dean of the said Medical College/Hospital, Head of the Department (Gynaecology), Head of the Department (Neurology), Professor and Head of Department of Paediatric Cardiac Surgeon, Professor and Head of Department of Radiology and Psychology of the said College/Hospital and any other expert in the field.

5. The Petitioner be medically examined by the said Committee within four days from the date of receipt of the copy of this order. The report about her mental health and physical condition in regard to the relief prayed by her about termination of pregnancy be submitted by the said Committee through learned AGP on or before the next date of hearing. Proper counselling be also made to the petitioner by the said committee by explaining the petitioner about the pros and cons in regard to the termination of the pregnancy.

6. List the matter on 16th March, 2018 on supplementary board.

7. Parties as also the Committee so appointed to act on the authenticated copy of this order.

(M.S. KARNIK, J.) **(SHANTANU KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 4184 OF 2018

Fanta Rupesh Soni ...Petitioner

vs.

Union of India and Others ...Respondents

Ms. Meenaz Kakalia, for the Petitioner

Mrs. Purnima Awasthi a/w. Mr. Dhanesh Shah, for Respondent Nos. 1 and 3.

Mr. C.P. Yadav, AGP for the Respondent State.

CORAM: SHANTANU KEMKAR&
MAKARAND KARNIK, JJ.

DATE: APRIL 10, 2018

P.C.:

1. The Petitioner has approached this Court under Article 226 of the Constitution of India seeking direction to the first Respondent to produce a report of the appropriate Committee which may be constituted by this court for examination of the Petitioner and for submitting its report as to whether the Petitioner can be allowed to get the pregnancy terminated.
2. According to the Petitioner, pregnancy has gone up to 23 weeks which is beyond the permissible period of 20 weeks, in the circumstances, petitioner has approached this Court.

3. On 5th April, 2018 while issuing notice to the Respondents, this Court has directed constitution of the Committee consisting of various experts from Sir JJ Group of Hospitals, Mumbai. The said Committee after examining the medical reports submitted by the Petitioner and after conducting various tests upon her, submitted its report. The various experts of the Medical Board after examining the Petitioner had noted their observations in the said report. The observations consists of Dr. Ashok Anand, Dr. K.N. Bhosale, Dr. Shilpa Domkundwar, Dr. V.P. Kale and Dr. Bela Varma. The Committee examined the observations made by all the Doctors and has given its opinion which reads thus:

   "After caref*ully taking history, careful examination and after going through various Ultrasonography reports, opinion of Psychiatrist, Paediatrician as well as Head of the Cardiothoracic department, the Committee is of opinion that the fetus suffers from congenital abnormality where the limbs are short and there is hypoplasia of mandible as well.*

   This condition can also be associated with other congenital and chromosomal abnormalities. The mother is severely stressed because of status of the fetus and possible out come.

   She desires termination of pregnancy in the view fetal condition.

   The pregnancy is advanced to 23 weeks, well beyond permissible limit of 20 weeks of pregnancy. Hence, the permission for termination can only be granted by Hon'ble High Court.

   Hence, if the Hon'ble High Court decides to terminate the pregnancy in the view of fetal condition, pregnancy can be terminated with the due risk of termination of pregnancy to mother".

4. We have gone through the said opinion which includes opinion of the various expert doctors including Dr. Ashok Anand, Professor & Head, Department of Obstetrics & Gynaecology, Dr. V.P. Kale, Prof. & Head, Dept. of Psychiatry, Dr. K.N. Bhosale, Prof. & Head of C.V.T.S., Dr. Shilpa Domkundwar, Prof. & Head, Dept. of Radiology and Dr. Bela Varma, Prof. & Head, Dept. of Paediatrics of Sir J.J. Group of Hospital, Mumbai. It appears that the Committee has reached the conclusion that there would be substantial risk of serious physical handicap.

5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the Petitioner to undergo the medical termination of the pregnancy. It is certain that if the Petitioner is allowed to give birth to fetus, there is substantial risk of serious physical handicap.

6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the Petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the Petitioner to undergo the medial termination of pregnancy under the provisions of the medical Termination of Pregnancy Act,

1971. Such fundamental right as conferred on the Petitioner would not allow her to lead and live a life of misery.

7. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

8. We further direct that the termination of the Petitioner's pregnancy to be performed within three days by the expert doctors of Sir J.J. Group of Hospital, Mumbai where she has to undergo medical check up.

9. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this court which shall maintain the complete report of the procedure which would

10. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.

11. Petitioner shall bear the cost of the operation and other expenses.

12. With the aforesaid directions, Petition is disposed of.

13. Parties to act on authenticated copy of this order.

(MAKARAND KARNIK, J.) **(SHANTANU KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

<u>WRIT PETITION NO. 4738 OF 2018</u>

Reshma Govind Sahu ...Petitioner

Vs.

Union of India and Others ...Respondents

Ms. Minaz Kakalia i/b. Kranti L.C. for the Petitioner.

Mr. S.V. Bharucha a/w. Mr. D.H. Shah and Mr. A.A. Ansari, for Respondent Nos. 1 and 3.

Mr. Sandeep Babar, AGP for the Respondent No. 2State.

CORAM: SHANTANU KEMKAR &
MAKARAND KARNIK, JJ.

DATE: APRIL 20,2018

P.C.:

1. The Petitioner has approached this Court seeking direction against the Respondents to allow her to get her pregnancy terminated. The Petitioner has stated that her pregnancy has gone beyond the permissible limit of 20 weeks within which the pregnancy can be terminated under the Medical Termination of Pregnancy Act, 1971.
2. In view of various orders passed by the Supreme Court and thereafter by this Court from time to time, we had constituted a Committee of expert Doctors from Sir JJ Group of Hospitals, Mumbai vide order dated 16th April, 2018 to examine the Petitioner and give its opinion. The

Petitioner had appeared before the said constituted Committee of experts/Medical Board. The Medical Board after examining the Petitioner noticed as under:

> *"Mrs. Reshma is 25 week pregnant with Abnormal fetus, as per Neuroimging fetus has complete agencies of corpus callosum with colpocephaly with dilated ventricles and paucity of white matter. This fetus after birth has high possibility of having visual defects, seizures, intellectual impairment, hydrocephalus, cerebral palsy. Hence, Medical Termination of Pregnancy isadvisable"*

3. After going into the opinion of various experts including the aforesaid report, the Medical Board consisting of Dr. Ashok Anand, Dr. Shilpa Domkundwar, Dr. V.P. Kale, Dr. Bela Varma, Dr. Kamlesh Jagyasi, Dr. R.D. Kulkarni and Dr. N.O. Bansal has given its opinion which reads thus:

> *"The Committee after examination and careful study of multiple sonography reports, has confirmed that the fetus has a neurological abnormality, in the form of complete corpus callosal agencies with colopocephaly. After birth baby may have high possibility of visual defects, seizures, intellectual impairment, hydrocephalus, cerebral palsy.*
>
> *The condition of fetus fulfil the criteria of "substantial risk of serious physical handicap" which is non compatible with normal life. The pregnancy has advanced up to 26 weeks and is beyond 20 weeks cut off of medical termination of pregnancy act. Hence, she has approached the Hon'ble Court for termination of pregnancy.*
>
> *If the Court permits pregnancy can be terminated as desired by pregnant woman. The risk of termination of pregnancy is not going to be more than that of normal labour."*

4. We have gone through the said opinion which includes opinion of the various expert doctors including Dr. Ashok Anand, Professor & Head, Department of Obstetrics & Gynaecology, Dr. V.P. Kale, Prof. & Head, Dept. of Psychiatry, Dr. Shilpa Domkundwar, Prof. & Head, Dept. of Radiology, Dr. Bela Varma, Prof. & Head, Dept. of Paediatrics, Dr. D.R. Kulkarni, Prof. & Head, Dept. of Pediatric Surgry, Dr. Kamlesh Jagyasi, Prof. & Head, Dept. of Neurology and Dr. N.O. Bansal, Prof. & Head, Dept. of Cardiology of Sir J.J. Group of Hospital, Mumbai. It appears that the Committee has reached the conclusion that there would be substantial risk of serious physical handicap.

5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the Petitioner to undergo the medical termination of the pregnancy. It is certain that if the Petitioner is allowed to give birth to fetus, there is substantial risk of serious physical handicap.

6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the Petitioner under Article 21 of the Constitution of India to live life of dignity, it

will be appropriate and in the interest of justice to permit the Petitioner to undergo the medial termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the Petitioner would not allow her to lead and live a life of misery.

7. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

8. We further direct that the termination of the Petitioner's pregnancy to be performed within four days by the expert doctors of Sir J.J. Group of Hospital, Mumbai where she has to undergo medical check up.

9. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this court which shall maintain the complete report of the procedure which would be performed on the Petitioner at the time of termination of the pregnancy.

10. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.

11. Petitioner shall bear the cost of the operation and other expenses.

12. With the aforesaid directions, Petition is disposed of.

13. Parties to act on authenticated copy of this order.

(MAKARAND KARNIK, J.) **(SHANTANU KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 5332 OF 2018

Dhrupati Vitthal Waghmare ...Petitioner

Vs.

Union of India and Others ...Respondents

Ms. Meenaz Kakalia, for the Petitioner

Mr. D.R. Shah a/w. Ms. Nisha Valani, for Respondent Nos. 1 and 3. Mr. Sandeep Babar, for Respondent No. 2State.

CORAM: SHANTANU KEMKAR&
MAKARAND KARNIK, JJ.

DATE: MAY 04, 2018
(IN CHAMBER)

P.C.:

1. The Petitioner has approached this Court under Article 226 of the Constitution of India seeking direction to the first Respondent to produce a report of the appropriate Committee which may be constituted by this court for examination of the Petitioner and for submitting its report as to whether the Petitioner can be allowed to get the pregnancy terminated.
2. According to the Petitioner, pregnancy has gone up to 25 weeks which is beyond the permissible period of 20 weeks, in the circumstances, petitioner has approached this Court.

3. On 27th April, 2018 while issuing notice to the Respondents, this Court has directed constitution of the Committee consisting of various experts from Sir JJ Group of Hospitals, Mumbai. The said Committee after examining the medical reports submitted by the Petitioner and after conducting various tests upon her, submitted its report. The various experts of the Medical Board after examining the Petitioner on 27th April, 2018 had noted their observations in the said report. The observations consists of Dr. Ashok Anand, Dr. K.N. Bhosale, Dr. Shilpa Domkundwar, Dr. Subhash Walinjkar, Dr. N.O. Bansal, Dr. V.P. Kale and Dr. Pawan Ojha. The Committee examined the observations made by all the Doctors and has given its opinion which reads thus:

   "Upon examination & after careful study of multiples onography reports, it is confirmed that the fetus suffers from serious neurological abnormality in the form of Cisterna MAgnA with Vermian Hypoplasia with a small cervical meningocele. Fetal right kidney Also shows Pyelectasis.

   The condition of the fetus fulfills the criteria of "Substantial risk of serious physical handicap".

   The woman was been explained about the outcome in the language she understands.

   The pregnant woman has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the condition of fetus and its outcome. She is anguished with the condition of the fetus in utero. Hence, it is advisable to terminate the pregnancy.

   The pregnancy has advanced to 26 weeks and is beyond 20 weeks cut off of the medical termination of pregnancy act. Hence, she has approached Court for termination of pregnancy.

   At this stage of pregnancy, the risk of termination remains the same as that of natural labour at term.

   Thus if the Court permits the pregnancy can be terminated as desired by the woman."

4. We have gone through the said opinion which includes opinion of the various expert doctors including Dr. Ashok Anand, Professor & Head, Department of Obstetrics & Gynaecology, Dr. V.P. Kale, Prof. & Head, Dept. of Psychiatry, Dr. K.N. Bhosale, Prof. & Head of C.V.T.S., Dr. Shilpa Domkundwar, Prof. & Head, Dept. of Radiology, Dr. Subhash Walinjkar, Prof. & Head, Dept. of Paediatrics, Dr. N.O. Bansal, Prof. & Head, Dept. of Cardiology &Dr. Pawan Ojha, Asso. Prof., Dept. of Neurology of Sir J.J. Group of Hospital, Mumbai. It appears that Committee has reached the conclusion that there would be substantial risk of serious physical handicap.

5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the Petitioner to

undergo the medical termination of the pregnancy. It is certain that if the Petitioner is allowed to give birth to fetus, there is substantial risk of serious physical handicap.

6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the Petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the Petitioner to undergo the medial termination of pregnancy under the provisions of the medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the Petitioner would not allow her to lead and live a life of misery.
7. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.
8. We further direct that the termination of the Petitioner's pregnancy to be performed tomorrow on 5th May, 2018 by the expert doctors of Sir J.J. Group of Hospital, Mumbai where she has to undergo medical check up.
9. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this court which shall maintain the complete report of the procedure which would be performed on the Petitioner at the time of termination of the pregnancy.
10. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.
11. Petitioner shall bear the cost of the operation and other expenses.
12. With the aforesaid directions, Petition is disposed of.
13. Parties to act on authenticated copy of this order.

(MAKARAND KARNIK, J.) **(SHANTANU KEMKAR,J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION STAMP NO.14261 OF 2018

Savita Ravi Garud, through her mother and natural guardian

Sunita Ravi Garud ..Petitioner

Vs.

Union of India & Anr. ..Respondents

Ms. Meenaz Kakalia for the petitioner.

Ms. Purnima Awasthi with Mr. Anand Singh for the respondent nos.1 and 3. Mr. Sandip Babar AGP for the State.

Mr. G.S. Godbole with Ms. Vidya Gharpure, Sharmila Modale, Madhuri More for the Corporation.

Dr. Vidya Thakur, Dr. Meena Savjam, Dr. Hemangi Worke, Dr. Gaurav Desai, Dr. Durga Valvi, KEM Hospital present in Court.

Mrs. Sunit R. Garud, mother of the petitioner present in the Court.

P.C. :

CORAM : A.K. MENON &

SMT. BHARATI H. DANGRE, JJ. (VACATION COURT)

DATED : 9TH MAY,2018.

1. Heard. The respondents waive service. By consent of the parties the petition is taken up for final hearing.

2. By this petition, the petitioner, through her mother and natural legal guardian seeks permission to medically terminate the pregnancy which has passed the 20 weeks contemplated in the Medical Termination of Pregnancy Act, 1971 (Act). The petitioner is present stated to be of 16 years of age and a victim of sexual assault and rape. It is stated that the petitioner has suffered immense mental and physical anguish as a result and seeks directions of the Court to allow her terminate her pregnancy to protect her health.

3. On 4th May, 2018 a Division Bench of this Court constituted a Committee of Experts to form a Medical Board at Rajawadi Hospital under the Dean and experts in the field of Gynecology, Neurology, Paediatrics, Psychology, Radiology and other experts to examine the petitioner and give its opinion whether it would be safe to terminate pregnancy of the petitioner. The Dean Rajawadi Hospital has pursuant to the order passed by this Court on 4th May, 2018 constituted a Board consisting of eight doctors Dr. Vidya V. Thakur, Dr. Sumedha Tiwari, Dr. Kiran Mhatre, Dr. Kanchan Chaudhari, Dr. Prakash Trivedi, Dr. Soumil Trivedi, Dr. Manish Doshi and Dr. Maya Wankhede.

4. The Board has since submitted a report dated 7th May, 2018 where by the general medical condition of patient has been found to be conducive to carry out the procedure. She is able to go through the procedure of medical termination. The examination included General medical examination as also examination by Radiologist, Psychiatrist, Gynecologist, Pediatrician and Anesthetist. The opinion is taken on record and marked "X" for identification. The opinion of the doctors and conclusions reached by the Panel of doctors are as follows:

   1. *Current pregnancy is about 25 weeks by clinical and Sonographic evaluation.*

   2. *In our opinion of board, considering the age of the patient (16 years) continuation of pregnancy (24.1 weeks) can lead to complications including mortality and is detrimental to the overall health of the patient.*

   3. *The mental trauma of child birth will be the same regardless of whether the pregnancy is continued but the guilt of the abandoning a fully grown neonate will be additional in case of continuation of pregnancy.*

5. On 7th May, 2018 when this matter was listed before us, the petitioner's mother seemed hesitant at one stage and was unsure as to whether or not pregnancy is to be terminated. However, after consulting the panel of doctors and given the opinion that continuation of pregnancy can lead to complications including mortality and is detrimental to the overall health of the patient, she has since expressed the desire to proceed with termination of pregnancy. We have also interacted with the mother of victim during the course of hearing

and she has stated that her hesitation was only caused due to different reactions of other family members. However, she is today firmly of the opinion that the pregnancy is required to be terminated. The Board is clearly of the view that pregnancy can be terminated as per patient and family members' request.

6. Today, at the hearing Mr. Godbole, learned counsel appearing on behalf of respondent no.4-corporation, which manages the Rajawadi Hospital has stated that the investigation has also revealed that the consequences of the procedure could be that the foetus may not survive. It is further submitted on behalf of the corporation that rather than the procedure being carried out at Rajawadi Hospital, Ghatkopar it would be appropriate that procedure is conducted at K.E.M. Hospital, Parel, in view of the fact that K.E.M. Hospital has much better facilities including those that may be required in the event of any emergency. In addition, it is submitted that the team of doctors at K.E.M. Hospital is much larger and more accessible in case of emergency when compared to the Rajawadi Hospital.

7. In the circumstances, having considered all facts and in particular the fact that the petitioner is of a tender age of 16 years and likelihood of mental and physical anguish and trauma she continues to go through and her fundamental right under Article 21 of the Constitution of India to live a life with dignity and in the light of the opinion that continuation of the pregnancy at this tender age of 16 years may lead to maternal mortality, it is appropriate that this Court permits medical termination of pregnancy. In this behalf this Court has in Writ Petition 13228 of 2017 passed a similar order following the decision of the Supreme Court in cases of Murugan Nayakkar Vs. Union of India Writ Petition (Civil) No.749 of2017.

8. In the circumstances, we allow the petitioner to medically terminate her pregnancy. Considering the fact that time is of essence and any further delay would increase the risk to the petitioner, the Corporation will ensure that the petitioner is transferred from Rajawadi Hospital to K.E.M. Hospital at the earliest possible opportunity and preferably by the end of day today i.e. 9th May, 2018 so that K.E.M. Hospital could conduct all preliminary and precautionary tests required as is done in any normal case of medical termination of pregnancy.

9. The entire team of doctors comprising the Board of Rajawadi Hospital shall be available for consultation with the team at K.E.M. Hospital. In conclusion, we make it clear that all necessary precaution be followed in terms of the Act and Rules framed thereunder and shall be observed by the K.E.M. Hospital. The Dean of K.E.M. Hospital shall ensure that all necessary arrangements are made forthwith to avoid any procedure delay for commencement which in any case should commence preferably tomorrow i.e. by 10th May, 2018.

10. The Law Officer, Municipal Corporation shall also inform the hospitals in question about this order to ensure timely compliance.

11. All concerned to act on an authenticated copy of this order. Meanwhile Mr. Godbole states that he will ensure that all necessary action will be taken by the hospitals concerned, without awaiting an authenticated copy of this order.
12. The petition is allowed in the aforesaid terms and is disposed off accordingly.
13. The Report dated 7th May, 2018 shall be retained in the Registry in a sealed cover.

(SMT. BHARATI .H. DANGRE,J.) **(A.K.MENON,J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION STAMP NO.14941 OF 2018

Meenakshi Sumit Bhattarjee ..Petitioner

Vs.

Union of India & Ors. ..Respondents

Mr. Sangram Chinapai / b.L.C. Kranti for the petitioner.

Ms. Indrayani Deshmukh and Ms. Kavita Solunke for the respondent nos.1 and 2. Mr. Sandip Babar AGP for the State.

Mr. G.S. Godbole with Ms. Vidya Gharpure, Sharmila Modale, Madhuri More for the Corporation.

Dr. Vidya Thakur, Dr. Meena Savjam, Dr. Hemangi Worke, Dr. Gaurav Desai, Dr. Durga Valvi, KEM Hospital present in Court.

Mrs. Sunit R. Garud, mother of the petitioner present in the Court.

P.C. :

CORAM : S.J KATHAWALLA&
A.S GADKARI, JJ. (VACATION COURT)

DATED : 23RD MAY, 2018.

1. On 21st May, 2018, we had passed the following Order:

"1. The above Writ Petition is moved before this Court for urgent admission.

2. The learned Advocates appearing for Respondent Nos.1 and 2 waive service.

3. The Petitioner is 37 years old and is 25weeks pregnant. She has produced the report /certificate dated 10th May, 2018 of Dr. Krishna kumar N. Shah, Children Specialist and Pediatric Neurologist stating that he has gone through the antenatal sonography and Fetal MRI reports dated 8th May, 2018 and has etou the severe anomalies detected in the unborn foetus. It is also mentioned in the said report /certificate that the petitioner and her husband also have at two year old daughter who"has more or less similar brain anomalies and she has global development delay, she can't sewel, does not recognize parents and has uncontrollable epilepsy". In view there of, we pass the following order:

i. We direct that a Medical Board shall be constitute at Sir J.J. Group of Hospital, Mumbai comprising of the Dean of the said hospital, Head of the Department (Gynecology) Professor and Head of Department of Pediatric /Cardiac Surgeon, Professor and Head of Department of Radiology and Head of Psychiatry Department,

2. Pursuant to the above Order, the Dean of the Sir J.J. Group of Hospitals, Mumbai has constituted a Medical Board comprising of the following doctors:

i. Dr. Ashok Anand, Professer and Head, Department of Obstetrics and

Gynecology, Sir J.J. Group of Hospitals, Mumbai.

i. Dr. V.P. Kale, Professor and Head, Department of Psychiatry, Sir. J.J .Group of Hospitals, Mumbai.

i. Dr. Varsha Rathi, Professor, Department of Radiology, Sir. J.J. Group of Hospitals, Mumbai.

iv. Dr. K.N. Bhosale, Professor and Head, Department of C.V.T.S., Sir J.J. Group of Hospitals, Mumbai.

v. Dr. N.O. Bansal, Professor and Head, Department of Cardiology, Sri J.J. Group of Hospitals, Mumbai.

vi. Dr. Bela Verma , Professor and Head, Department of Pediatrics, Sir J.J.

Group of Hospitals, Mumbai

vi. Dr. D.R. Kulkarni, Professor and Head, Department of Paediatrics Surgery, Sir. J.J. Group of Hospitals, Mumbai

3. The Board has submitted its report to this Court today. We have gone through there port and the opinion of the Board is reproduced here under:

"Upon examination and after careful study of sonography reports and fetal MRI, it is confirmed that the fetus suffers from serious intracranial anomalies with very high chance of morbidity and mortality.

The woman has been explained about the outcome in the language she understands.

The condition of the fetus fulfils the criteria of" substantial risk of serious physical handicap such as global development delay, severe intellectual disability, porcontrolled resistant epilepsy visual /hearing defects, cerebral palsy, behavioural disorders".

The pregnant woman has voluntarily expressed her desire to terminate the pregnancy and is we informed about the nature of the condition of

The fetus and its outcome. She is extremely anguished with the condition of the fetus in-utero.

The pregnancy has advanced to 26 weeks and is beyond the 20 weeks cut of the Medical Termination of Pregnancy Act. Hence, she has approached the Court for termination of pregnancy.

At this stage of pregnancy, the risk of termination remains the same as that of natural about a term.

Thus if the Court permits the pregnancy can be terminated as desired by the woman."

4. In view there of, the above Writ Petition which is taken up for final hearing is allowed. The Petitioner is permitted to undergo medical termination of pregnancy at a medical facility of her choice.
5. The Petitioner undertakes to report other approved center for carrying out the procedure of medical termination of pregnancy tomorrow at 3.p.m.
6. The learned Advocate appearing for the Petitioner states on instructions that the Petitioner will bear the medical expenses of the procedure of medical termination of pregnancy at a medical facility of her choice.
7. It is clarified that the Petitioner has been sensitized by the Committee / Medical Board about the risk factors involved and it would be open for the Petitioner to undergo the procedure of medical termination of pregnancy at her own risk and consequence. It is further made clear that the doctors, who have put their opinions on record, shall have the immunity in the event of occurrence of any litigation arising

Out of the instance Petition.

8. Rule is accordingly made absolute.
9. There shall be no order as to costs.
9. Al concerned including the approved Medical Center , shall act upon the authenticated copy of this Order.

(A.S. GADKARI, J) **(S.J. KATHAWALLA, J)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY ORDINARY ORIGINAL CIVIL JURISDICTION

WRIT PETITION (L) NO. 1764 OF 2018

Kalyani Bansode ...Petitioner

Versus

Union of India and Ors. ...Respondents

Mr. Sangram Chinnappa i/b. L.C. Kranti for the Petitioner.

Ms. Indrayani Deshmukh for Respondent No. 1.

CORAM : S.J. KATHAWALLA AND A.S. GADKARI, JJ.

DATED : 24th MAY, 2018

(IN CHAMBER)

P.C.:

1. On 21st May, 2018 we passed the following order :-

"1. Not on board. Upon mentioning, taken on board.

2. The above Writ Petition is moved before this Court for urgent admission.

3. The learned Advocates appearing for Respondent Nos. 1 and 2 waives service.

4. The Petitioner is 25 years old and is 26 weeks pregnant. She has produced the report / certificate dated 15th May, 2018 before this Court issued by Dr. Pankaj Shroff, Pediatric Surgeon, Nanavati Super Specialty Hospital, Mumbai stating that "the reports of sonography and MRI

both confirm that the intrauterine fetus suffers from congenital diaphragmatic hernia on the left side. The MRI report suggests that there is Herniation of left lobe of Liver in addition to stomach and small bowel.

LHR 0.92 Ratio of observed / expected LV 18.7 %.

All above criteria indicate 'poor prognosis' . I have explained the following :

"i. This variety of diaphragmatic hernia has a poor prognosis of survival.

ii. There is a chance that the baby may not survive after birth in spite of best efforts.

iii. There could be other congenital or genetic abnormalities associated with this condition which may get revealed after the birth.

iv. In case the parents want to attempt treatment the baby will need immediate intervention after delivery. In case the treatment is attempted the baby is expected to need as under :

a. Early induction / LSCS for obstetric reason

b. Delivery in institution

c. Immediate intubation / RT / Ventilatory support / surfactant treatment.

d. Surgery after stabilization with all the risks explained and investigations such as ECHO.

5. Steroids can be tried now.

At this point of time, the anomaly appears to be substantial and serious in nature. The exact prognosis of the surgery shall depend on development of lungs / neurological development / associated malformations."

In view thereof, we pass the following order :

i. We direct that a Medical Board shall be constituted at Sir J.J. Group of Hospital, Mumbai comprising of the Dean of the said hospital, Head of the Department (Gynecology) Professor and Head of Department of Pediatric / Cardiac Surgeon, Professor and Head of Department of Radiology and Head of Psychiatry Department and any other expert in the field as the Dean may deem appropriate to be included.

ii. The Petitioner will appear before the Board on 22nd May, 2018 at 01.30 p.m. along with her husband.

iii. The Board shall submit their report before this Court on 23rd May, 2018 at 11.00 a.m. setting out whether in their view it will be advisable to terminate the pregnancy of the Petitioner.

iv. Stand over to 23rd May, 2018.

v. *All concerned shall forthwith act on an ordinary copy of this Order, duly authenticated by the Associate of this Court. "*

2. Pursuant to the above order, the Dean of Sir J.J. Group of Hospitals constituted the Medical Board comprising of the following members :-

   (i) Dr. Ashok Anand, Prof. & Head, Dept. of Obstetrics and Gynecology, Grant Govt. Medical College and Sir JJ Group of Hospitals, Mumbai

   (ii) Dr. V.P. Kale Prof & Head, Dept of Psychiatry, Grant Govt. Medical College and Sir JJ Group of Hospitals, Mumbai

   (iii) Dr. Varsha Rathi, Professor, Dept. of Radiology, Grant Govt. Medical College and Sir J.J. Group of Hospitals, Mumbai

   (iv) Dr. K.N. Bhosle, Professor and Head, Dept. of C.V.T.S., Grant Govt. Medical College and Sir J.J. Group of Hospitals, Mumbai

   (v) Dr. N.O. Bansal, Prof and Head, Dept. of Pediatrics, Grant Govt. Medical College and Sir J.J. Group of Hospitals, Mumbai

   (vi) Dr. Bela Verma, Prof & Head, Dept of Pediatrics, Grant Govt, Medical College and Sir J.J. Group of Hospitals, Mumbai

   (vii) Dr. D.R. Kulkarni, Professor and Head, Dept of Peadiatrics Surgery, Grant Govt. Medical College and Sir J.J. Group of Hospitals, Mumbai.

3. The Medical Board has submitted its report to this Court. We have gone through the report. We have perused the opinion expressed by all the Doctors more particularly opinion of Dr. Bela Verma (Prof & Head, Department of Pediatrics) which is reproduced here under :-

   " In view of the large defect with partial herniation of the liver, the anomaly is substantial and serious in nature with poor prognosis and high morbidity and mortality. Medical termination of pregnancy may be considered with due risk to the mother. "

4. The opinion of the Committee of Doctors is reproduced hereunder :-

   " Upon examination and after careful study of sonography reports and fetal MRI, it is confirmed that the fetus suffers from large left congenital diaphragmatic hernia with herniation of stomach, bowel, left lobe of liver, resultant dextro-cardia and reduced lung volume.

   The condition of the fetus although serious can be treated post-natally with surgery. but the morbidity and mortality of this condition is high.

   The pregnancy has advanced to 27 weeks, hence the fetus born will be alive and will require neonatal intensive care and also paediatric surgical care.

The pregnant woman has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the condition of the fetus and its outcome. she is extremely anguished with the condition of the fetus in-utero.

The pregnancy has advanced to 27 weeks and is beyond the 20 weeks out of the Medical Termination of Pregnancy Act. Hence she has approached the Honourable Court for termination of pregnancy.

At this stage of pregnancy, the risk of termination remains the same as that of natural labour at term.

Thus if the court permits the pregnancy can be terminated as desired by the woman. "

5. The above Writ Petition is taken up for final hearing. After giving a considerable thought to the above views expressed by the Doctors, the Petitioner is permitted to undergo medical termination of pregnancy. She has through her Advocate informed the Court that she will undergo medical termination of pregnancy at Nanavati Super Speciality Hospital.
6. The Petitioner undertakes to report to the Nanavati Super Speciality Hospital along with her husband for carrying out the procedure of medical termination of pregnancy on 25th May, 2018 at 12.00 noon.
7. The learned Advocate appearing for the Petitioner states on instructions that the Petitioner will bear the medical expenses of the procedure of medical termination of pregnancy at a medical facility of her choice.
8. It is clarified that the Petitioner has been sensitized by the Committee / Medical Board about the risk factors involved and it would be open for the Petitioner to undergo the procedure of medical termination of pregnancy at her own risk and consequence. It is further made clear that the doctors, who have put their opinions on record, shall have the immunity in the event of occurrence of any litigation arising out of the instance Petition.
9. Rule is accordingly made absolute.
10. There shall be no order as to costs.
11. All concerned including the Nanavati Super Speciality Hospital, shall act upon an authenticated copy of this Order.

(A.S. GADKARI, J.) **(S.J. KATHAWALLA, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

CIVIL WRIT PETITION NO. 5760 OF 2018

Ms. Anjali Amit Kadam . Petitioner.

V/s.

Union of India & Ors. ..Respondents.

Ms. Neha Philip i/b. Kranti L.C. for the petitioner.

Ms. Indrayani Deshmukh for respondent No.1.

Ms. A.I. Patel, AGP with Mr. S.L. Babar, AGP for respondent No.2.

CORAM:	SHANTANU S.KEMKAR AND
	NITIN W.SAMBRE, JJ.
DATE :	JUNE 4, 2018
P.C. :	Not on Board. Taken on Board

1. The petitioner has approached this Court under Article226 of the Constitution of India seeking direction to respondent No.2to produce a report of the appropriate Committee which may be constituted by this Court for examination of the petitioner and for submitting its report as to whether the petitioner, whose pregnancy is about 23 weeks, which is beyond the permissible period of 20 weeks, can be allowed to be teriminated.
2. On May 28, 2018 this Court after going through the Sonography and M.R.I. reports directed that the Medical Board shall be constituted at Sir J.J. Group of Hospital, Mumbai comprising of Dean of the said Hospital, Head of the Department (Gynaecology), Professor and Head of Department of Pediatric / Cardiac Surgeon, Professor and Head of Department, Professor and

Head of Department of Radiology and Head of Psychiatry Department, Professor and Head of Neurological Department and any other expert in the field, as may been demeed appropriate to be included. The petitioner was directed to appear before the Board and the Board was expected to submit its report on May 30, 2018. A request made on behalf of the Dean of Sir J.J. Medical College through AGP for extension of time to submit the report which was accepted by this Court and the report was directed to be submitted on June 4, 2018.In terms of the said direction, the learned AGP has submitted the report which he received from the said Committee / Board of Sir J.J. Group of Hospital. The opinion of the Committee / Board reads thus:-

3. "Committee Opinion"

   Upon examination and after careful study of multiple Sonography Reports, it is confirmed that the fetus suffers from serious nuerological abnormality in the form of ventriculomegaly, hypoplastic cerebullum and small posterior fossa. The condition of the fetus fulfills the criteria of ***"substantial risk of serious physical handicap".*** *The woman was been explained about the outcome in the language she understands.*

   The pregnant woman has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the condition of fetus and its outcome. She is anguished with the condition of the fetus in utero. Hence it is advisable to terminate the pregnancy.

   The pregnancy has advanced to 23 weeks and is beyond 20 weeks cut off of the Medical Termination of Pregnancy Act. Hence she has approached honourable Court for termination of pregnancy.

   At this stage of pregnancy, the risk of termination remains the same as that of natural labour at term. Thus if the Court permits the pregnancy can be terminated as desired by the women "

4. We have gone through the aforesaid opionion which includes the observations of various Professors and Heads of the Department as also observations of Dr. Vernon Velho (Prof. and Head of Neurosurgery which reads thus:

   > *"20 years married since 1 years / primigravida with amenorrhea since 5 month. Referred for MTP on medical ground. USG Report on 30/05/2018 suggestive of single live intrauterine gestational sac of mean gestational age 23 weeks and 5 days with normal interval growth. As compared with the previous USG dated 21st May 2018, the ventriculomegaly has increased in size. There is evidence of hypoplastic cerebullum and small posterior fossa. In view of documented congenitaal brain anomalies on USG, patient is permitted to undergo MTP with due explained risk. "*

5. From the report, it appears that the Committee has suggested for termination of pregnancy as according to the committee, the fetus suffers from serious neurological abnormality and fulfills

the criteria of "substantial risk of serious physical handicap". It is also seen from the report that the petitioner (pregnant woman) has voluntarily expressed her desire and she was well informed about the nature of the condition of fetus and its outcome.

6. The report of the Board is taken on record and is marked as Exhibit "X2" for identification. In view of the aforesaid report, it is very difficult for us to refuse permission to the petitioner to undergo the medical termination of pregnancy. It is certain that if the petitioner is allowed to give birth to the fetus, there is a substantial risk of serious physical handicap.

7. In view of the aforesaid peculiar circumstances and having due regard to the fundamental right conferred on the petitioner under Article 21 of the Constiutution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of Medical Termination of Pregnancy Act, 1971.Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery

8. In view of the aforesaid report, the learned APP for the State and the learned counsel for Union of India have not opposed the petitioner's prayer on any grounds legal or medical. We order accordingly.

9. We further direct that the termination of the petitioner's pregnancy to be performed within three days by the expert doctors of Sir J.J. Group of Hospital, Mumbai where she has to undergo medical checkup.

10. The termination of the pregnancy will be supervised by the Committee Medical Board constituted by this Court which shall maintain complete report of the procedure which would be performed on the petitioner at the time of termination of the pregnancy.

11. We also make it clear that in the event of any problem in connection with the medical termination of pregnancy, the doctors of the Medical Board shall have immunity in law.

12. The petitioner shall bear the cost of operation and other expenses, if any. With the aforesaid directions, the petition is disposed of.

13. Parties to act on an authenticated copy of this order.

(NITIN W.SAMBRE, J.) **(SHANTANU S.KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 6612 OF2018

Shrusti Purushottam Patankar ..Petitioner.

V/s.

Union of India & Ors. ..Respondents.

Ms. Minaz Kakalia I/b. Krantil L C for thepetitioner.

Mr. Anand Singh with Ms. Purnima Awasti for respondent Nos.1 & 2.

Mr. Sandeep Babar, AGP for respondent No.2.

CORAM: SHANTANU KEMKAR AND NITIN W. SAMBRE, JJ.

DATE: JUNE 29, 2018

P.C.:

Pursuant to our order dated June 21, 2018, the Medical Board constituted by this Court has submitted the report after examining the petitioner.

2. We have gone through the observations report of Dr. Ashok Anand, Dr. V.P. Kale, Dr. Shilpa Domkundwar, Dr. Bela Varma, Dr. K.N. Bhosale and Dr. V.A. Gitta. These doctors are experts in the various fields as described in the opinion of this Committee. The compound opinion of this Committee is that :

OBSERVATIONS

Observations of Dr. Ashok Anand (Prof and Head, Dept. Obstetrics & Gynecology)

GC	–	Fair Afeb
P	–	80/min
BP	–	110 / 70 mm hg

P/I/C/C/L/E/ABSENT

CVS, RS –NAD

P/AUT 22 WEEKS, FBPRESENT, RELAXED P/S

–WHITE DISCHARGE+

P/V –CERVIX OS CLOSED,PAROUS

Opinion of Dr. V.P. Kale (Prof & Head, Dept of Pscychiatry)

Impression – No active psychopathology seen at present or in past.

Conclusion – she is mentally sound and is fit to undergo the procedure (MTP) from Pscyhiatric point of view.

Opinion of Dr. Bela Varma (Prof & Head, Dept of* Pediatrics*)

MTP can be done with due risk of procedure as explained to the parents as the fetus has Arnold Chiari Malformation type2 with MMIC which can lead to considerable moribidity and mortality.

Opinion of Dr.N.M.Dhediya (Prof & Head, Dept of Nephrology)

Creat	–	*0.8 mg.%*
Urea	–	*18mg%*
Hb	–	*12.4mg%*
WBC	–	*4000/cm*
Platelets	–	*adq.*
URM – Albumin	–	*Absent*
Pus Cells, RBC	–	*Nil*

Patient is fit to undergo medical termination of pregnancy patient, Post operatively renal function of patient should be seen.

Opinion of Dr. K.N. Bhosale (Prof & Head, Dept of CVTS) *In the case of Mrs. Shrushti P.Patankar anomaly scan of Heard does not show cardiovascular anomaly. There is apparently no indication for advising termination of pregnancy on the basis of CardiaVascular Anomaly.*

However the foetus has anomaly of central Nervous system which needs opinion of Neurosurgeonto elaborate on the advice of termination of pregnancy.

Opinion of Dr. V.A. Gitte (Prof & Head, Dept of Urology)

22 weeks ANC

One male child – 7 years USG

noted–12/06/2018 Mild

Ventiriculomegaly

obliteration of cystema magna with hypoplasia of coreballum.

Spinal lumbar meningo myelocele. S/o. Abnord Cheori Sudfermotion.

Urologycaly – Kidneys & Bladder –Normal.

As no urology abnormality detected on USG Patient have so opinion regarding MTP should be given by Paediatrician & Obstetrician."

2. Having gone through the said opinion, we find that the Committee has unequivocally stated that the Committee upon examination and after careful study of multiple sonography reports, confirmed that that fetus suffers from serious neurological abnormality in the form of moderate hydrocephalus with small posterior fossa and lumbar meningomyelocoele suggestive of arnold chhari malformation type2. The condition of the fetus fulfills the criteria of substantial risk of serious physical handicap. It appears that the petitioner has been explained about the outcome in the language she understands. It also appears that the petitioner has voluntarily expressed her desire to terminate the pregnancy and is well informed about the nature of the fetus and its outcome.

3. Having regard to the aforesaid, it is very difficult for us to refuse the permission to the petitioner to undergo medical termination of the pregnancy. It is certain that if the petitioner's foetus is allowed to be born, there is risk that it would suffer lifelong serious physical handicap, which cannot be avoided. It appears that the baby will certainly not grow any further.

4. In view of the above peculiar situation and having due regard to the fundamental rights conferred on the petitioner under Article 21 of the Constitution of India to live life of dignity,

it will be appropriate and in the interest of justice to permit the petitioner to undergo the medical termination of pregnancy under the provisions of the Medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the petitioner would not allow her to lead and live a life of misery.

5. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

6. We further direct that the termination of the petitioner's pregnancy be performed within three days from today by the expert doctors of Sir J.J. Group of Hospital, Mumbai where she has to undergo medical checkup.

7. The termination of pregnancy will be supervised by the Committee / Medical Board constituted by this Court which shall maintain the complete report of the procedure which would be performed on the petitioner at the time of termination of pregnancy.

8. With the aforesaid directions, we allow the petition in terms of prayer clause (c)(ii) seeking direction to the respondents to allow the petitioner to undergo medical termination of pregnancy.

9. With the aforesaid directions, the petition stands disposed of.

Parties to act on an authenticated copy of this order.

(NITINW.SAMBRE, J.) **(SHANTANU KEMKAR, J.)**

CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 6430 OF 2018

Neelam Choudhary Petitioner

V/s.

Union of India

State of Maharashtra

Ministry of Health and Family

Welfare, through its Secretary Respondents

Ms. Gayatri Singh Senior Advocate a/w Ms. Neha Philip a/w. Mr. Kranti L. C. for the petitioner

Mr. S. L. Babar AGP for the State

CORAM: SHANTANU KEMKARAND NITIN W. SAMBRE, JJ.

DATE: JUNE 19, 2018.

ORAL ORDER: [PER: NITIN W. SAMBRE, J.]

Heard the learned senior counsel Ms. Gayatri Sing and the learned AGP for the respondent.

2. By way of present petition, the petitioner has sought following reliefs:

> *"a. For a writ of declaration or any other appropriate* writ, order or direction in the nature of declaration, declaring section 3 (2) (b) of The Medical Termination of Pregnancy Act,

1971 to the limited extent that it stipulates a ceiling of 20 weeks for an abortion to be done under Section 3, as ultra vires Article 14 and 21 of the Constitution of India;

b. For a writ of declaration or any other appropriate writ, order or direction in the nature of declaration, declaring that the case of the Petitioner is a fit case for exercising jurisdiction under Section 5 of the Medical Termination of Pregnancy Act,1971.

c. For a writ of mandamus or any other writ, order, or direction in the nature of mandamus directing the Respondents to

i. *Constitute a Medical Committee for the examination of the Petitioner to assist this Hon'ble court in arriving at a decision on the plea of the Petitioner;*

ii *allow the Petitioner to undergo Medical* Termination of Pregnancy at a medical facility of her choice.

d. *For a writ of mandamus or any other writ, order, or direction in the nature of mandamus directing the Respondents to set up appropriate Medical Committees in each district in the State of Maharashtra to assess the pregnancy and offer MTP to the Petitioner and other women in need of the procedure beyond the prescribed 20 weeks limit.*

e. *For an order directing Respondent No. 1 to produce the report of MTP Committee which included the Health Secretary, Mr. Naresh Dayal, former DirectorGeneral of the Indian Council of Medical Research and Dr. N K Ganguly as its members as stated in para 9 of the petition."*

3. It is urged by the learned counsel for the petitioner that section of the Medical Termination of Pregnancy Act, 1971 (Hereinafter shall be referred to as 'the Act' for the sake of brevity) provides for the circumstances in which pregnancy may be terminated by registered medical practitioner. According to her, the petitioner got married in 2012 and initially she was not staying with her husband. It is further claimed that petitioner was pursuing her studies and thrice attempted unsuccessfully to clear 12th standard examination. From 2016 onwards, the petitioner started residing with her husband and in laws, however, certain differences cropped up resulting into petitioner coming back and resided with her parents. In 2016, it is claimed by the petitioner that in view of the cruelty and violence practiced by her husband, an NC complaint for offence under section 323, 504 of the Indian Penal Code came to be registered.

4. It is the case of the petitioner that since the husband of the petitioner promised her of well being, she restored her relationship with her husband. According to her, the physical and mental harassment by her husband and in laws continued even thereafter. According to her, she is a patient of epilepsy and is under constant medication from K.E.M. Hospital, Bombay.

5. While conceiving her marriage, the petitioner was time and again instructed her husband to

have protective sex *qua* birth of a child. However, the husband of the petitioner does not pay any heed to the same. On the other hand, it is claimed that the petitioner being a patient of epilepsy is unable to consume oral contraceptives on account of potential reaction with the drugs that she has administered for treating her epilepsy.

4. In view of constant mental and physical cruelty, the petitioner came back to her parental house after having diagnosed of carrying pregnancy of about more than 20 weeks.

5. In the aforesaid factual background, the learned counsel for the petitioner submits that the petitioner does not intend to continue with the pregnancy as she intend to pursue her studies and apply for divorce. According to her, taking into account her health problem of epilepsy, it will not be advisable to continue with the pregnancy and also pursue her studies. A further submission is made that in the aforesaid background, the respondent be directed to constitute a Medical Board so as to ensure termination of pregnancy.

6. *Per contra* the learned AGP would oppose the claim and would urge that the petition is not maintainable as there is no medical advice to the petitioner to terminate her pregnancy of more than 20 weeks. According to him, there is no substance in the petition and the petition is liable to be dismissed.

7. A foremost question that is required to be addressed in factual background raised in the petition is whether the petitioner's prayer for constitution of Medical Board for considering her claim for termination of pregnancy is required to be ordered and if no, whether this Court is required to go into examining the validity / virus of the provisions of the Act in question, particularly section 3 (2) (b) of the Act.

8. From the record, it is *ex facie* clear that it is the case of the petitioner that she is carrying as on date pregnancy of about 23 weeks. The petitioner was got married in 2012 and started residing with her husband and in laws in 2016. The fact remains that she is educated up to 11th standard and pursuing further studies. It is also apparent that in 2016, an NC came to be registered for an offence under section 323, 504 of the Indian Penal Code in view of the complaint lodged by the petitioner against her husband and in laws. It is apparently clear that the said NC complaint was not further prosecuted by the petitioner. Rather, in categorical terms she has admitted that, she has started residing with her husband. Out of the said relationship, she conceived a child and presently carrying pregnancy of 23 weeks.

9. In the aforesaid factual background, if the claim of the petitioner is examined *qua* her prayer for issuance of directions for permission to terminate pregnancy, it is required to be noted that the none of the medical papers which are placed on record certifies that there is imminent danger to life of the petitioner nor the condition of the foetus is in compatible with the extra uterine life. It is even not the case of the petitioner that the foetus would not be able to survive.

The petitioner has also not demonstrated that continuation of pregnancy can gravely endanger the physical and mental health of the petitioner.

10. Apart from above, it is required to be noted that the petitioner is seeking termination of pregnancy based on the cause viz. her matrimonial discord with her husband, her intention to initiate divorce proceedings and to pursue her career and improve her education qualification. If the aforesaid cause as cited by the petitioner are examined in the light of the provisions of the Medical Termination of Pregnancy Act, 1971, same not at all recognized to form basis for accepting the prayer of the petitioner to terminate the pregnancy. If the scheme of the Act is appreciated, the medical practitioner is permitted to terminate the pregnancy where the length of the pregnancy does not exceed 12 weeks. In case it exceeds weeks but does not exceeds 20 weeks, two registered medical practitioners should be of the opinion, formed in good faith that the continuance of pregnancy would involve risk to the life of the pregnant woman or of grave injury to her physical and mental health or there is substantial risk, if the child were born, same would suffer from physical or mental abnormality, has to be seriously handicapped. The explanation 1 provides for termination of pregnancy which was caused by rape and such rape is presumed to constitute a grave injury to the mental health of the victim woman. Explanation 2 to section 3 provides for the grave injury to the mental health of the pregnant woman, in case if the pregnancy occurs as a result of failure of any device or method used by married woman or her husband for the purpose of limiting the number of children.

13. Section 5 of the Act provides for non attraction of provisions of section 3, in case the opinion of two registered medical practitioners which is formed in good faith that the termination of such pregnancy is immediately necessary to save the life of the woman.

14. In the aforesaid background, what is to be noticed is the Statute provides for the termination of pregnancy by registered medical practitioner in the circumstances prescribed under section3 of the Act.

15. It is not the case of the petitioner that she is of unsound mind or there is any physical or mental deformity which prompts her not to continue with the pregnancy. As observed herein before, there is no material whatsoever brought on record to substantiate the said claim.

16. If the case of the petitioner in its entirety is appreciated, what is to be noticed is the petitioner is seeking permission to terminate pregnancy by issuing appropriate directions merely for asking when the fact remains that she is carrying pregnancy out of her marital life and she is major and educated.

17. That being so, in our opinion, the prayer put forth by the petitioner does not warrant any indulgence at the hands of this Court.

18. The Apex Court in the matter of **Suchita Srivastava V/s. Chandigarh Administration**[1] has expressed that right of a woman to have reproduction, the choice is insegregable part of her personal liberty as envisaged under Article 21 of the Constitution. It is also observed by the Apex Court that such woman has sacrosanct right to have her bodily integrity.

    The Apex Court in the matter of **Suchita Srivastava** [*cited supra*] had an occasion to consider the provisions of the Act *qua* fundamental rights. While dealing with the said issue, the Apex Court in para 11 has observed thus:

    > "*11. A plain reading of the above quoted provision makes it* clear that Indian law allows for abortion only if the specified conditions are met. When the MTP Act was first enacted in 1971 it was largely modelled on the Abortion Act of 1967 which had been passed in the United Kingdom. The legislative intent was to provide a qualified 'right to abortion' and the termination of pregnancy has never been recognised as a normal recourse for expecting mothers. There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should beno *restriction whatsoever on the exercise of reproductive choices* such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a 'compelling state interest' in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices".

19. The Apex Court in the matter of Z ***V/s.*** State of Bihar and others[3] while dealing with the Statutory provisions of the aforesaid Statute has observed thus:

    > "***27.*** *Thus, the opinion has to be formed by the registered* practitioners as per the Act and they are required to form an opinion that continuance of pregnancy would involve a grave

[1] **[2009 (9) SCC 1]**

[3] **[AIR 2017 SC 3908]**

mental or physical harm to her. We have already referred to Explanation 1 which includes allegation of rape. As is perceivable, the Appellant had gone from a women rehabilitation centre, had given consent for termination of pregnancy and had alleged about rape committed on her, but the termination was not carried out. In such a circumstance, we are obliged to hold that there has been negligence in carrying out the statutory duty, as a result of which, the *Appellant has been constrained to suffer grave mental injury.*

30. *In that context, the Court adverted to the distinction* between the 'mental illness' and 'mental retardation'. It also noted that the expert body's findings were in favour of continuation of pregnancy and took note of the fact that the victim had clearly given her willingness to bear a child. In that context, the Court stated:

"The victim's reproductive choice should be respected in spite of other factors such as the lack of understanding of the sexual act as well as apprehensions about her capacity to carry the pregnancy to its full term and the assumption of maternal responsibilities thereafter. We have adopted this position since the applicable statute clearly contemplates that even a woman who is found to be "mentally retarded" should give her consent for the termination of a pregnancy."

And again:

"There is no doubt that a woman's right to make reproductive choices is also a dimension of "personal liberty" as understood Under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there *is also a "compelling State interest" in protecting the life of the* prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices."

31 *Explaining the provision of the Act, the Court opined that ordinarily a pregnancy can be terminated only when a medical practitioner is satisfied that a continuance of the pregnancy*

would involve risk to the life of the pregnant woman or of grave injury to her physical or mental health or when there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. While the satisfaction of one medical practitioner is required for terminating a pregnancy within twelve weeks of the gestation period, two medical practitioners must be satisfied about either of these grounds in order to terminate a pregnancy between twelve to twenty weeks of the gestation period.

*The Court in **Suchita Srivastava** also took note of the provision that termination of the pregnancy has been contemplated when the same is the result of a rape or a failure of birth control methods, since both of these eventualities have been equated with a grave injury to the mental health of a woman. The Court emphasized that in all such circumstances, the consent of the pregnant woman is an essential requirement for proceeding with the termination of pregnancy. The three Judge Bench referred to the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (for short, '1995 Act') and opined that in the said Act also "mental illness" has been defined as mental disorder other than mental retardation.*

***37** The Court referred to the United Nations Declaration on* the Rights of Mentally Retarded Persons, 1971 [GARes 2856 (XXVI) of 20121971 and relied on principle No.7 of the same. Principle No. 7 reads as follows:

> *"50 **7.** Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their* rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

61 The legislative intention of 1971 Act and the decision in **Suchita Srivastava** prominently emphasise on personal autonomy of a pregnant woman to terminate the pregnancy in terms of Section 3 of the Act. Recently, Parliament has passed the Mental Healthcare Act, 2017which has received the assent of the President on 7th April, 2017. The said Act shall come into force on the date of notification in the official gazette by the Central Government or on the date of completion of the period of nine months from 7th April, 2017. We are referring to the same only to highlight the legislative concern in this regard. It has to be borne in mind that element of time is extremely significant in a case of pregnancy as every day matters and, therefore, the hospitals should be absolutely careful and treating physicians should be well advised to conduct themselves with accentuated sensitivity so that the rights of a woman is not hindered. The fundamental concept relating to bodily integrity, personal

autonomy and sovereignty over her body have to be given requisite respect while taking the decision and the concept of consent by a guardian in the case of major should not be over emphasized."

20. Similar issue was considered by this Court in the matter of Shaikh Ayesha Khatoon [*cited supra*]. The Division Bench of this Court had an occasion to consider the provisions of section 3 & 5 of the Act. The Division Bench while dealing with same has observed as under:

> *"11. Section 3 of the Act of 1971 thus prescribes the outer limit* of 20 weeks in the matter of termination of pregnancy in certain circumstances enumerated in Clauses (i) & (ii) of sub **section 2(b) of Section 3. Section 5 carves out an exception to Sections 3 &4. It is provided that the provisions of section 4, and so much of the provisions of sub section (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is contended relying on the provisions of subsection (1) of Section 5 by the petitioner that the bar contained in sub section (2) of Section 3 laying down the conditions for according permission to terminate the pregnancy is not absolute bar and in appropriate cases such permission can be accorded.** Section 5 of the Act of 1971 carves out an exception *in relation to the outer limit provided under subsection (2) of* Section 3 of the Act of 1971 i.e. 20 weeks in case where the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is the contention of the petitioner that firstly the trauma that the petitioner is likely to suffer is life threatening and it shall be construed that exercise of a choice in the event there are foetal abnormalities found and the chances of survives of the baby, if allowed to take birth, are minimum, is a matter to be considered within the parameters of Section 5 of the Act of 1971. Apart from this, the petitioner contends that the provisions of subsection (2) including clauses (i) & (ii) of subsection (2) (b) of Section 3 are required to be read in Section 5 except the outer limit of twenty weeks that has been provided in subsection (2) (b) of Section 3 of the Act of 1971.
>
> *12. The petitioner thus contends that if there is a substantial* risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped, it will be open for the Court to accord permission to terminate the pregnancy by taking recourse to Section 5 of the Act of 1971. It is further contended that the concluding portion of Section 5 prescribing the limitation in permitting such a choice or issuing direction in respect of termination of the pregnancy only in the event to save the life of the pregnant woman shall have to be interpreted harmoniously and looking to the object of the provision.

It also needs to be considered that a pregnant woman has a right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India. In this context reliance can be placed on the observations of Hon'ble Supreme Court in the matter of Suchita Srivastava vs. Chandigarh Administration reported in 2009 (9) SCC 1. In paragraph11 of said judgment, it is observed by the Hon'ble Supreme Court as narrated below:

"11. A plain reading of the above quoted provision makes it clear that Indian law allows for abortion only if the specified *conditions are met. When the MTP Act was first enacted in* 1971 it was largely modelled on the Abortion Act of 1967 which had been passed in the United Kingdom. The legislative intent was to provide a qualified 'right to abortion' and the termination of pregnancy has never been recognised as a normal recourse for expecting mothers. There is no doubt that a woman's right to make reproductive choices is also a dimension of 'personal liberty' as understood under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman's entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a 'compelling state interest' in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices."

21. From the observations made by the Apex Court in the matter of ***Suchita Srivastava*** *and* Z ***V/s.*** State of Bihar and others [*cited supra*] it is abundantly clear that provisions of the 1971 Act were examined in the back drop of Article 21 of the Constitution of India. The Apex Court was sensitive to the women's right of reproduction choice *qua* operation as provided under the Statute. The right to terminate the pregnancy on the said grounds which were beyond the control of such victim women are dealt with in detail and the Apex Court observed that in case a grave injury to mental health of a pregnant woman, in case of a rape, aids, mental incapacity such as mental retardation will be prevailing circumstances in exercising powers under section 3 of the Act. It is also required to be noted that in the matter of **Suchita Srivastava** [*cited*

supra] the Apex Court has held that the provisions of 1971 Act can be viewed as putting reasonable restrictions on exercise of reproduction choice of a woman.

22. In the wake of law laid down and discussed herein before, the fact remains that the ground which is sought to be espoused by the petitioner seeking termination of pregnancy is no more germane to the requirement under section 3 of the Act. Her matrimonial discord can not be considered as areas on for permitting her to have termination of pregnancy by invoking provisions of the Medical Termination of Pregnancy Act, 1971. For the eventualities which are spelt out in the petition, it is really difficult to consider and grant the request of the petitioner for permitting her to have termination of pregnancy.

23. Apart from above, though the petitioner has raised a plea of challenge to provisions of Section 3 of the Act being violative of Article 14 & 21 of the Constitution of India, the petitioner has hardly tried to justify her claim as no arguments are canvassed on the said issue.

24. That being so, this Court has reached to a conclusion that there is no substance in the present petition and same deserves to be dismissed and accordingly dismissed.

[NITIN W.SAMBRE, J.] **[SHANTANU KEMKAR, J.]**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELALTE JURISDICTION

WRIT PETITION NO.6915 OF 2018

Vijay laxmi Seenu Kounder ...Petitioner

vs.

Union of India and Others ...Respondents

Ms. Minaz Kakalia I/b. Mr. Kranti L.C., for the Petitioner

Ms. Neeta Masurkar a/w. Ms. Nieyaati Masurkar, for Respondent Nos. 1 and 3.

Mr. Sandeep Babar, AGP for Respondent State.

CORAM: SHANTANU KEMKAR&
N. W. SAMBRE, JJ.

DATE: JULY 12, 2018

P.C.:

1. We find that in spite of the order being passed by this Court on 29th June, 2018 constituting a Committee at Sir J.J. Group of Hospitals, Mumbai and directing the Petitioner to appear before the said Committee on 5th July, 2018 the Petitioner did not appear before the said Committee. Again on 5th July, 2018 the matter was listed and the Petitioner was directed to appear before the Committee on 6th July, 2018 but she did not appear.

2. Thus, it is clear that the Petitioner is not interested in prosecuting this Petition.

3. In the circumstances, the Petition is dismissed.

(N.W.SAMBRE, J.) **(SHANTANU KEMKAR, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 7393 of 2018

'X'

since minor through her mother

and natural legal guardian, ...Petitioner

V/s.

Union of India & ors. ...Respondents

Mr. Sangram Chinnappa with Ms. Meenaz Kakalia i/b. Kranti L.C. for petitioner.

Mrs. Purnima Awasthi, advocate for respondents 1 and 3.

Mr. Ranjit Thorat with Mr. J.J. Xavier for respondent no.4 BMC. Mr. V.N. Sagare, AGP for respondent no.2.

CORAM: NARESH H. PATILAND

G.S. KULKARNI, JJ.

DATE: 13th July, 2018.

P.C.

1. The petitioner, a victim girl aged 16 years filed a petition through her mother for a direction to allow the medical termination of her pregnancy which is stated to be of 22 weeks.

2. Consequent to our order passed on 12th July, 2018 we have received report from Committee of expert members attached to KEM Hospital, Mumbai. The report is placed on record and marked 'X' for identification.

3. The learned Counsel appearing for the petitioner submits that in view of the report and instructions of parents of victim, the girl is ready and willing to undergo the procedure.

4. We have perused the report. We are of the view that necessary counselling is required to be provided to the victim girl. It is informed that at present the victim girl is admitted in Rajawadi Hospital, Ghatkopar. We permit the petitioner to admit the victim girl in KEM hospital after getting appropriate discharge from Rajawadi Hospital, Ghatkopar. On admission, the Expert's team would take necessary steps for carrying out the procedure of termination of pregnancy with the aid and assistance of the experts in the field. The Medical Superintendent of Rajawadi hospital is present in Court who would inform the administration for taking necessary steps in discharging the patient so that the victim girl can be admitted to KEM hospital. On oral instructions of learned Counsel appearing for the Corporation, the KEM hospital administration would take necessary steps.

5. All concerned to act on an authenticated copy of order.

6. The learned Counsel appearing for the petitioner submits that in view of order passed, petition may be disposed of. Accordingly Writ Petition stands disposed of.

(G.S.KULKARNI, J) **(NARESH H. PATIL, J.)**

L.S. Panjwani, P.S.

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO.7137 OF 2018

Sowmya Prakash Shetty ...Petitioner

vs.

Union of India and Others ...Respondents

Ms. Neha Philip I/b. Ms. Meenaz Kakalia, for the Petitioner Mr. Purnima Awasthi, for Respondent Nos. 1 and 3.

Mr. Sandeep Babar, AGP for Respondents State.

CORAM: SHANTANU KEMKAR&

N. W. SAMBRE, JJ.

DATE: JULY 13, 2018

P.C.:

1. The Petitioner has approached this Court under Article 226 of the Constitution of India seeking direction to the first Respondent to produce a report of the appropriate Committee which may be constituted by this court for examination of the Petitioner and for submitting its report as to whether the Petitioner can be allowed to get the pregnancy terminated.
2. According to the Petitioner, pregnancy has gone up to 21 weeks which is beyond the permissible period of 20 weeks, in the circumstances, Petitioner has approached this Court.

3. On 6th July, 2018 while issuing notice to the Respondents, this Court has directed to constitute medical Committee consisting of various experts from Sir JJ Group of Hospitals, Mumbai. The said Committee after examining the medical reports submitted by the Petitioner and after conducting various tests upon her, submitted its report. The various experts of the Medical Board after examining the Petitioner had noted their observations in the said report. The observations consists of Dr. Ashok Anand, Dr. K.N. Bhosale, Dr. Shilpa Domkundwar, Dr. V.P. Kale, Dr. N.O. Bansal, Dr. Bela Varma and Dr. D.R. Kulkarni. The Committee examined the observations made by all the Doctors and has given its opinion which reads thus:

"After careful examination of the patient and of the Ultrasonography reports, Committee conforms that the fetus has multiple cardiac abnormalities in the form of complex congenital anomaly having transposition of great artery with double outlet right ventiricles with pulmonry hypoplasia. Nature of this anomaly requires staged cardiac surgical procedure having high morbidity and mortility risk. This surgery will be required in neonatal and in fantile period.

The condition of the fetus fulfils the criteria of substantial risk of serious physical handicap requiring multiple surgeries with a very high morbidity and mortality.

The woman has expressed her desire to terminate the pregnancy and is well informed about the nature of the condition of the fetus and its outcome. She is anguished with the condition of the fetus in the utero. In the view of fetal cardiac abnormalities and the desire of the pregnant woman to terminate the pregnancy committee recommends termination of pregnancy with due risk.

Since the pregnancy has advanced to 23 weeks and is beyond 20 weeks cut of the medical termination of pregnancy act. She has approached Hon'ble Court for termination of pregnancy.

If the Court permits the pregnancy can be terminated as desired by the pregnant woman with due risk."

4. We have gone through the said opinion which includes opinion of the various expert doctors including Dr. Ashok Anand, Professor & Head, Department of Obstetrics & Gynaecology, Dr. V.P. Kale, Prof. & Head, Dept. of Psychiatry, Dr. K.N. Bhosale, Prof. & Head of C.V.T.S., Dr. Shilpa Domkundwar, Prof. & Head, Dept. of Radiology, Dr. N.O. Bansal, Prof. And Head, Dept. of Cardiology, Dr. Bela Varma, Prof. & Head, Dept. of Paediatrics and Dr. D.R. Kulkarni, Prof and Head, Dept. of Paediatrics of Sir J.J. Group of Hospital, Mumbai. It appears that the Committee has reached the conclusion that there would be substantial risk of serious physical handicap.

5. Having regard to the aforesaid, it is very difficult for us to refuse permission to the Petitioner to

undergo the medical termination of the pregnancy. It is certain that if the Petitioner is allowed to give birth to fetus, there is substantial risk of serious physical handicap.

6. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the Petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the Petitioner to undergo the medial termination of pregnancy under the provisions of the medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the Petitioner would not allow her to lead and live a life of misery.

7. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

8. We further direct that the termination of the Petitioner's pregnancy to be performed within three days by the expert doctors of Sir J.J. Group of Hospital, Mumbai where she has to undergo medical check up.

9. The termination of the pregnancy will be supervised by the Committee/Medical Board constituted by this court which shall maintain the complete report of the procedure which would be performed on the Petitioner at the time of termination of the pregnancy.

10. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.

11. Petitioner shall bear the cost of the operation and other expenses.

12. With the aforesaid directions, Petition is disposed of.

13. Parties to act on authenticated copy of this order.

14. In view of the above peculiar circumstances and having due regard to the fundamental right conferred on the Petitioner under Article 21 of the Constitution of India to live life of dignity, it will be appropriate and in the interest of justice to permit the Petitioner to undergo the medial termination of pregnancy under the provisions of the medical Termination of Pregnancy Act, 1971. Such fundamental right as conferred on the Petitioner would not allow her to lead and live a life of misery.

15. The learned AGP as also the learned counsel for the Union of India have not opposed the petitioner's prayer on any ground, legal or medical. We order accordingly.

16. We further direct that the termination of the Petitioner's pregnancy to be performed within three days by the expert doctors of Sir J.J. Group of Hospital, Mumbai where she has to undergo medical check up.

17. The termination of the pregnancy will be supervised by the Committee/Medical Board

constituted by this court which shall maintain the complete report of the procedure which would be performed on the Petitioner at the time of termination of the pregnancy.

18. We also make it clear that in the event of any problem in connection with the medical termination of the pregnancy, the doctors of the Medical Board shall have immunity in law.
19. Petitioner shall bear the cost of the operation and other expenses.
20. With the aforesaid directions, Petition is disposed of.
21. Parties to act on authenticated copy of this order.

(N.W.SAMBRE, J.) **(SHANTANU KEMKAR, J.)**

COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 7444 OF 2018

'X' Age 16, Minor through her brother and

Natural legal guardian Mumtaz Hussain Patel ...Petitioner

Vs.

Union of India through Secretary & Ors. Respondents

Ms. Neha Philip with Ms. Meenaz Kakalia i/b. Kranti L.C. for Petitioner. Mrs. Neeta Masurkar with Mr. S.G. Thakur, Ms. Nieyati Masurkar for Respondent No. 1UOI.

Mr. A.B. Vagyani, GP, with Mr. V.N. Sagare, AGP, for State.

P.C.:

CORAM: NARESH H. PATILAND

G.S. KULKARNI, JJ.

DATE: 20th JULY2018

1. We have perused the report of the experts of Sir J.J. Group of Hospitals, which is in a sealed cover. The said report is marked "X" for identification. The Committee of experts examined the minor girl who is reported to be 16 and ½ years old. Each of the member of the Committee has independently given their opinion. A final analysis of the opinion of the Committee has been signed by all the members. Last three paragraphs of the opinion are reproduced as under:

"Pregnant minor, her sister & her aunt have expressed desire to terminate the pregnancy and are made aware of the dangers of continuation of pregnancy, as well as termination of pregnancy.

Since the pregnancy has advanced to 24 weeks, well beyond legallimitofterminationofpreg nancyi.e.20weeks, the termination can only be done with Hon'ble High Court permission.

At 24 weeks of gestation, termination of pregnancy also carries risk to pregnant minor. However continuation of pregnancy will have physical & mental stress. Hence it is advisable to terminate the pregnancy."

2. The learned Counsel appearing for the petitioner informs that aunt/parents/guardian of the minor girl and them in or girl are willing to undergo the necessary procedure for termination of pregnancy.

3. Considering the facts and the report submitted before us, we allow the petitioner and the committee of experts for taking necessary steps for terminating pregnancy of the victim girl.

4. The learned Government Pleader to communicate the order.

5. Investigating Officer is present in the Court. The learned Government Pleader submits that basic investigation is over, except getting DNA report. The investigating officer would complete investigation at the earliest and submit a final report on its own merits. The learned Government Pleader also submits that Assistant Director, Forensic Science Laboratory, Home Department, Maharashtra State, Mumbai, has intimated the investigating officer on 18th July 2018 that DNA report would be submitted by 26th July2018. The communication dated 18th July 2018 is taken on record and marked X1 for identification.

6. Writ petition stands disposed of accordingly.

[G.S.KULKARNI, J.] [NARESHH.PATIL, J.]

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 7634 OF 2018

'X' Age 16, Minor through her father and
natural guardian Devidas Sonawane ...Petitioner

Vs.

Union of India through Secretary & Ors. Respondents

Ms. Meenaz Kakalia with Ms. Neha Philip i/b. Kranti L.C. for Petitioner. Mrs. Purnima Awasthi for Respondent Nos.1 & 3.

Mr. V.N. Sagare, AGP, Advocate, for Respondent No.2. Dr. Padmaja Samant, KEM Hospital, present.

Mr. V.B. Sawant, PSI, Meghwadi Police Station, present.

CORAM: NARESH H. PATILAND
G.S. KULKARNI, JJ.

DATE: 31st JULY2018

P.C.:

1. By this petition, father of the minor victim girl prays for termination of pregnancy of his daughter. We had called for a report from the Medical Board attached to KEM Hospital on the last occasion.

2. On the last occasion, are port was submitted before the Court. According to the last report dated 20th July 2018, patient was again examined. Today second report is submitted. Second report is taken on record and marked “X1” for identification. After examination of the minor victim girl, the Medical Board opined as under:

   “The board is of the opinion that at present the patient is medically fit with due inherent risks of failure, infection and rarely, requirement of surgical procedure in any such procedure. These risks have already been spelt out in detail in the past report.

   In view of stated sexual assault, due psychological support may be offered to the patient during and after the procedure.

   The procedure can be done in the hospital where the patient is admitted now.”

3. Dr. Padmaja Samant, Additional Professor and Unit Head, Obstetrics & Gynaecology, KEM Hospital, is present in the Court. We had a brief interaction on the subject issue with Dr. Padmaja Samant. She submits that the patient is now medically fit for undergoing necessary procedure of terminating pregnancy. At present, the minor victim girl is indoor patient in Cooper Hospital.

4. The learned Counsel appearing for the petitioner submits that the victim girl and her parents are ready to allow the medical experts to carry out necessary procedure of terminating pregnancy. As on today the pregnancy is of 22 weeks and 2 days.

5. We have perused the medical report. Taking into consideration the medical report as referred above, the submissions advanced and in view of the request made, we think it appropriate to allow the minor victim girl to opt for termination of pregnancy.

6. We direct the Dean of KEM Hospital to take necessary steps to terminate the pregnancy of the victim girl on her admission in KEM Hospital by carrying out necessary procedure.

7. Needless to mention that the Dean of KEM Hospital may constitute a team for the said purpose.

8. The learned Counsel appearing for the petitioner submits that the victim girl would be admitted in KEM Hospital, if possible by today or tomorrow.

9. Writ Petition stands disposed of accordingly.

[G.S.KULKARNI, J.] **[NARESHH.PATIL,J]**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

CIVIL WRIT PETITION NO. 8793 OF 2018

Komal Apurva Shah Petitioner

vs

Union of India & ors Respondents

Ms. Neha Philip I.b Ms. Kranti L.C. for Petitioner. Mr. A.B. Vagyani Government Pleader a/w Ms. Kavita Solunkhe Asst. Government Pleader for State

Ms. Prachi Tatake for Respondent nos.1 & 3¬ Union of India

Ms. Oorja Dhond for Respondent no.4/BMC Dr. Padmaja Samant K.E.M. Hospital present

P.C:

CORAM: NARESH

1. The petitioner ¬ Komal Apurva Shah age 34 years has filed this petition under Article 226 of the Constitution of India seeking directions to the respondents to permit her to undergo medical termination of pregnancy at the medical facility of her choice. It is also her prayer that a medical committee be constituted for her examination and assist this Court in arriving at a decision on the prayer as made in the petition.
2. The petitioner has prayed for the said reliefs on the basis of a diagnostic report obtained by her from Dr. Nikhil Patkar of Anand Diagnostic Centre which is a ultra¬sonography report recording that the petitioner is 27 weeks and 4 days pregnant. It is observed in this report that the kidneys of the fetus are not visualized and of suggestive of bilateral renal agenesis. The

report records as under:

> "A single live intrauterine gestation of 27 weeks 4 days is noted with total anhydramnious. Both fetal kidneys are not visualized suggestive of bilateral renal agenesis. Cardiothoracic ratio is increased with reduced chest circumference suggestive of poulmonary hyupoplasis. No fetal limp movements were seen with limbs in fixed flexion contractures. Screening doppler shows increased diastolic flow in MCA with reversed cerebroplacental ratio suggestive of fetoplacental insufficiency."

3. The petitioner was also examined by Dr. Divyani K.Patel Consulting Obstetrician and Gynaecologist of Vanita General Hospital, Malad (East) Mumbai who also records " *non¬viable pregnancy beyond 20 weeks of gestation, followed by termination of pregnancy."*

4. By an order dated 8thAugust, 2018 we directed the Dean K.E.M. Hospital, Mumbai to constitute a committee of experts to examine the petitioner, and place on record of this petition, a report as to whether termination of the pregnancy at this stage was possible.

5. The Medical Board constituted in pursuance of our order dated 10th August 2018 consisted of the following thirteen experts, who would examine the petitioner:

   1. "Dr. Avinash N.Supe, Director (Medical Education & Major Hospitals) & Dean (G &K)¬Chairman.
   2. Dr. Padmaja Samant, Addl.Professor and Unit Head, Obstetrics & Gynecology, Dr. Himangi S. Warke, Associate Professor, Obstetrics & Gynecology,
   3. Dr. Himangi S. Warke, Associate Professor, Obstetrics & Gynecology.
   4. Dr. Shubhangi Parkar, Professor & HOD, Psychiatry.
   5. Dr. Kavita Joshi, Associate Professor, Medicine.
   6. Dr. R.D. Patel, Professor and acting HOD, Anesthesia.
   7. Dr. Hemangini Thakkar, Additional Professor, Radiology.
   8. Dr. Nalini Shah, Professor and Head Endocrinology.
   9. Dr. Sridhar Sundaram, Assistant Professor, Department of Gastroenterology.
   10. Dr. Atul Dongre, Associate Professor Dermatology.
   11. Dr. Neeraj Jain, Associate Professor Neurology.
   12. Dr. Sandesh Parelkar H.O.D. pediatric surgery.
   13. Dr. Ruchi Nanavati H.O.D. neonatology."

6. The petitioner was examined by each of the above experts of the Medical Board who recorded

their individual findings. On the basis of the findings of the experts the Medical Board has reached the following conclusion:

1. “The patient's dates are uncertain due to irregular cycles and only late scan is available. She is about 28 weeks by clinical evaluation and about 27 weeks by sonography done in KEMH GSMC.

2. “The diagnosis of bilateral renal agenesis has been confirmed on ultrasonography.

3. Due to her epilepsy, very low weight, celiac disease and anemia, Mrs. Komal Shah is a high risk case for any intervention.

   The anomaly is lethal and affects development of lungs too. The near certain loss of the baby is a cause of great distress to the parents, but,it does not warrant termination of pregnancy now in a woman with multiple health issues as mentioned above.

   Uninduced natural labour is more likely to have smooth progress and **fewer complications like excessive contractions, need for surgical intervention, trauma, bleeding, future problems that ensue with scarred uterus.** Though the petitioner and her husband are at present distressed with the thought of the near certain perinatal fatality, they both have to clearly understand these maternal risks mentioned above.

4. It will be prudent to let the nature take its own course.

5. The Board does not advise medical termination of pregnancy for the petitioner on medical grounds.

   The Board also requests the Court to grant immunity from any medico legal liability due to giving opinion as asked by the honourable Court.” (Emphasis added)

7. We had also the valuable benefit of the presence of Dr. Padmaja Samant, Additional Professor and Unit Head, Obstetrics & Gynecology K.E.M. H.G.S.M.C. who has assisted us in explaining different facets of the report of the Medical Board. Dr. Padmaja Samant says that chance of intra uterine demise in such cases is very high. She says that if the child is born, it would perish within a day or two of the birth. She has emphasized that due to the weak clinical condition of the petitioner, medical termination of pregnancy is definitely not advisable for the petitioner as observed by the Medical Board. She says that this is a case where the nature should take its own course and the doctors would aid the nature.

8. Learned counsel for the petitioner however, is of the contrary opinion. Her submission is that when the ultimate consequence is that the child is not to survive, then medical termination ought to be permitted. The Court should there for grant relief to the petitioner.

9. We have heard learned counsel for the parties. We have perused the report of the Medical Board and the record. In the facts of the case, we are not persuaded to accept the plea as urged on behalf of the petitioner that the petitioner be permitted to undertake medical termination of her pregnancy. No doubt, that this is a case of an abnormal fetus and chances of survival of the fetus are nil, there is also a possibility of intrauterine demise of the child, however, the petitioner has a variety of problems. She suffers from epilepsy. She is of very low weight about 35 kg. She has celiac disease and anemia. In these circumstances, the Medical Board has observed that the petitioner's *"is a case of very high risk"* for any intervention of a medical termination of pregnancy. In our clear opinion, the findings and the conclusions as recorded by the Medical Board cannot be discarded in the fact situation so as to permit the petitioner to undertake medical termination of her pregnancy. Such permission if granted would be against the health and well being of the petitioner. For these reasons, we can not grant any relief to the petitioner.

10. The findings of the Medical Board including the portion which pertain to the medico legal immunity stand accepted in totality for all the members of the Medical Board as also for Dr. Padmaja Samant in her explanation and assistance to the Court.

11. We express our appreciation to the valuable assistance provided by Dr. Padmaja Samant.

12. Writ Petition is accordingly rejected. No costs.

(G.S.KULKARNI, J} **ACTING CHIEF JUSTICE**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

Writ Petition NO. 8313 OF 2018

Nandini Tushar Rawool ...Petitioner

Versus

The Union of India Thr. The Secretary and Ors. ...Respondents

Ms. Meenaz Kakalia i/b. Kranti L.C., for the Petitioner.

Mr. A.B. Vagyani, Government Pleader with Mr. V.N. Sagare, AGP for the State Respondent no.2.

Mrs. Poornima Awasthi, for Respondent Nos.1 and 3 Union of India. Dr. Padmaja Samant from KEM Hospital present.

CORAM: NARESHH.PATIL, ACTING CJ &
G.S. KULKARNI, JJ.

DATE: 14thAugust, 2018

P.C.:

1. The petitioner Nandini Tushar Rawool aged 29 years who has a twenty six weeks pregnancy, has approached this Court by this petition under Article 226 of the Constitution seeking direction to the respondents to allow her to undergo medical termination of her pregnancy.

The petitioner has annexed to the petition an ultrasound sonography report dated 6 July 2018 which makes the following remarks:

"Fetal RVOT and LVOT could not be seen optimally. Fetal right atrium appears dilated."

2. The petitioner was also examined by Dr. Shrirang Dokhale who had conducted 2D Echo examination recorded a finding which are suggestive of "complex congenital heart disease of the fetus."

3. By an order dated 8 August 2018 we directed the Dean of KEM Hospital to constitute a committee of experts to examine the petitioner and to submit a report to the Court. Accordingly, the learned Dean has constituted a Medical Board consisting of the following experts in the different faculties:

"1. Dr. Avinash N. Supe, Director (Medical Education & Major Hospitals) & Dean (G &K)Chairman.

2. Dr. Padmaja Samant, Addl.Professor and Unit Head, Obstetrics & Gynecology, Dr. Himangi S.Warke, Associate Professor, Obstetrics & Gynecology,

3. Dr. Shubhangi Parkar, Professor & HOD, Psychiatry,

4. Dr. Anjali Rajadhyaksha, Professor, Medicine,

5. Dr. R.D. Patel, Professor and acting HOD, Anesthesia,

6. Dr. Hemangini Thakkar, Additional Professor, Radiology,

7. Dr. Rucha Nanavati, Professor and Head Neonatology,

8. Dr. Dheeraj More, Assistant Professor Cardiology,

9. Dr. Dwarkanath Kulkarni, Professor, Cardiovascular Surgery."

4. In pursuance to our order, a report of the Medical Board dated 10 August 2018 is placed on record. The petitioner was examined by all the members of the board. The members of the board have recorded the following findings:

"4. Ultrasonographic and echocardiographic diagnosis: By ultrasound of 09/08/2018 Mrs. Nandini Rawool is 26 weeks pregnant. The fetus has tetralogy of Fallot with ventricular septal defect, small riht ventricular outflow tract, double superior vena cava and two vessel cord.

5. **Obstetric examination:** On clinical examination of Mrs. Nandini Rawool, the uterus is about 28 weeks size, and fetal heart sounds can be heard. Uterus is relaxed.

6. **Psychiatric evaluation:** Mrs. Nandini Rawool is emotionally stable at present and is psychiatrically fit to take her health related decisions. She is well supported by her husband.

7. **Medical examination:** Mrs. Nandini Rawool has no clinically significant medical problem.

8. **Pre anesthetic assessment:** Mrs. Nandini Rawool is fit for general/regional anesthesia.

9. **Cardiology opinion:** This fetal condition means that the baby may require early palliative surgery followed by definitive surgery. The long term survival of the baby is unlikely to be like an otherwise healthy baby, but the condition is not likely to be fatal if managed properly."

(emphasis supplied)

5. The medical board on the above findings has recorded the following conclusions:

"Based on the above findings, the board has concluded that:

1. Current pregnancy is about 26 weeks by patient's clinical & sonographic evaluation.

2. The diagnosis of tetralogy of Fallot with ventricular septal defect, small right ventricular outflow tract, double superior venacava and two vessel cord has been made based on ultrasonography and echocardiography.

3. The fetal condition indicates need for early palliative surgery followed by definitive surgery. The condition is not fatal but long term survival of the baby is not likely to be like that of an otherwise healthy baby.

4. A full term mature baby may survive the surgery better rather than a pretermone.

5. There is no physical risk to the mother, due to continuation or termination of pregnancy.

6. If the pregnancy is terminated at 26 weeks, the baby may be born alive. The neonatological guidelines allow non resuscitation in only 2 conditions, Anencephaly and Trisomy 13. This means that the preterm neonate will be resuscitated and may live for variable length of time;. The anomalies are at present seen in the intrauterine fetus and may be less or more on assessment after birth. The management may be modified accordingly. The doctors will face an ethical dilemma in deciding for or against intervention. If the neonate dies due to problems of prematurity, the death will have to be reported to the authorities as per current procedural guidelines.

This will amount to deliberate preterm induction of avoidable cause.

*7. **Maternal risks:***

* *The petitioner Mrs. Nandini Rawool is in a physically and mentally fit condition to undergo procedure of induction. But the couple has to know certain risks associate with deliberate medical interventions.*

- * *Uninduced natural labour is more likely to have smooth progress and* ***fewer complications like excessive contraction, need for surgical intervention, trauma, bleeding, future problems that ensue with scarred uterus.*** *Though the petitioner and her husband are at present distressed with the thought of the near certain perinatal fatality, they both have to clearly understand these maternal risks mentioned above.*
- * *Mental anguish due to natural causes is part of life. Pregnancy out of sexual assault (for which this board recommended termination in the past), causes the stigma and profound psychological effect on a growing adolescent. That is a unique situation.*
- * *Inconvenience of looking after one's own challenged child as an indication for termination beyond viability is akin to reproductive materialism. The board is concerned about promotion of such practice, outsidethelegalsanctionofthecountry'slaws.Importantlyonlys ympathyforthemothercannotbebasisoftheopinion.*
- * *Till the law is modified, the onus of such promotion/practice lies with one board of experts or a hospital and that is medicolegally inappropriate.*
- * *Hence weighing the maternal health and neonatal problems, the board is of the opinion that the pregnancy may be continued and may take its own course.*
- * *Psychological counseling is recommended. Emotional support and counselling has taken innumerable mothers through such testing times.*
- * *The board also requests the court to grant immunity from any medico legal liability due to giving opinion as asked by the honourable court."*

(emphasis added)

6. The learned Counsel for the petitioner would submit that the board has confirmed that the fetus has a complex congenital heart disease and if the child is born, it is unlikely to be a healthy baby. It is her submission that in such a situation, the petitioner is entitled for the relief of medical termination of pregnancy. Learned Counsel for the petitioner has placed reliance on the decision of the Supreme Court in ***"Tapasya Umesh Pisal vs. Union of India & Ors."***[1], to submit that the facts of the present case are similar to the facts in the said case where the Supreme Court permitted medical termination of pregnancy. The learned Counsel for the petitioner has also placed reliance on the decision of the Division Bench of this Court in ***Shaikh Ayesha Khatoon Vs. Union of India & Ors***[2] to submit that Section 3 (2) (b) (ii) if read in conjunction of Section 5(1) of the Medical Termination of Pregnancy Act, 1971, then the relief ought to be granted to the petitioner.

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[1]Writ Petition (Civil) No.635 of 2017 Orderdt.10.8.2017.

[2] Writ Petition (St) No.36727 of 2017 order dt.9.1.2018

7. On the other hand, the learned Government Pleader has supported the finding as contained in the report of the medical board. The learned Government Pleader contends that the report clearly observes that the condition of fetus is not likely to be fatal if managed properly if early palliative surgery followed by definitive surgery is undertaken. The learned Government Pleader would refer to the observations of the board in paragraphs 3 and 6 wherein the board has noted that the condition of the fetus is not fatal but long term survival of the baby is not likely to be like that of another wise healthy baby.

8. Dr. Padmaja Samant, Additional Professor and Unit Head, Obstetrics & Gynecology at the request of the Court has assisted the Court. Dr. Samant has appraised and explained to the Court the various findings as recorded in the report of the medical board. When we asked for a clarification as regards the findings as recorded in paragraph 9 of the report which pertains to the cardiology opinion and the conclusion in paragraph 3 of the report as noted by the us above, Dr. Samant has explained to us that even if the pregnancy is terminated at this stage, the baby would be born alive. She explained that there is no harm for the petitioner to have a regular delivery of the baby as explained in the report and on delivery, the baby would be required to undergo early palliative surgery followed by definite surgery. She explained to us the Cardiology opinion which records that *"long term survival of baby is unlikely to be like another wise healthy baby "*, would mean that the child after successful surgery would not be like a normal child in the sense, the child would not be in a position to undertake running or climbing and except for these restrictions the child may have a normal life on a successful surgery. Dr. Samant also highlighted the findings of the committee in paragraph 6 and the maternal risk which are pointed out in paragraph 7 of the report.

9. We have heard the learned Counsel for the parties. We have per used there cord and there port of the medical board.

10. The Medical Board has recorded findings that the condition of fetus is not fatal, and the child when born would require early palliative surgery followed by definite surgery. It is further recorded that the long term survival of the baby is unlikely to be like an otherwise healthy baby, but the condition is not likely to be fatal if managed properly. Thus, in our opinion, this is not a case where the medical opinion on the surgery is such that the surgery would definitely and conclusively lead to child mortality. The findings in paragraph 6 of the conclusion as noted by us above, also stare at us. In the circumstances, this is not a case where we can permit medical termination of pregnancy.

11. The reliance on behalf of the petitioner on the orders of the Supreme Court in Tapasya Umesh Pisal Vs. Union of India & Ors. (supra) would also not assist the petitioner. That was a case where the fetus was diagnosed as having hypoplastic right heart with tricuspid and pulmonary atresia with small size pulmonary arteries. The opinion of the medical board was that in such

situation surgeries on the fetus have been reported to carry high morbidity and mortality. It was also reported that inspite of the surgeries, such children do not achieve normal oxygen level and would remain physically incapacitated and the life span of these children even after corrective surgeries is limited as described in medical literature. It was also a case of isolated complex congenital heart disease with increased morbidity and mortality post delivery. The radiologist had also reported a complete absence of right ventricle and pulmonary and tricuspid valve atresia. The Supreme Court also recorded the opinion of an eminent surgeon who stated that most of these children do not live till the adult life, as also their life is precarious because of the problems resulting from low oxygenation in the body. It was also observed by one of the Cardiac Surgeon that there is a near certain chance of severe handicap or sudden death of the baby after birth. It is in these circumstances, the Supreme Court had permitted the medical termination of pregnancy. Definitely, the facts in the present case are not such.

12. In the facts of the present case, the observations of the Division Bench in *Shaikh Ayesha Khatoon Vs. Union of India & Ors* (supra) in paragraphs 10 and 11 of the decision would also not assist the petitioner. It is clear that there is no threat to the life of the petitioner as observed by the medical board.

13. For the above reasons, we cannot discard the opinion of the medical board. The findings of the medical board including the last two lines which pertain to the medico legal immunity stand accepted in totality for all the members of the board as also for Dr. Samant in her explanation and assistance to the Court.

14. We express our appreciation to the valuable assistance provided by Dr. Padmaja Samant.

15. The prayer of the petitioner to permit medical termination of pregnancy, thus cannot be granted. We find no merit in the petition. It is accordingly rejected. No costs.

G.S.KULKARNI, J. **ACTING CHIEF JUSTICE**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 9748 OF 2018

Snehal Mohite ... Petitioner.

V/s.

Union of India and others. ... Respondents.

Ms. Meenaz Kakalia i/b. Kranti LC and Neha Philip for the petitioner.

Mr. Prashant More, AGP for the respondent- State.

CORAM : A.S.OKA AND M.S. SONAK, JJ.

DATE : 4th September 2018.

1. Heard the learned counsel appearing for the petitioner and the learned AGP for the State. As stated in the order dated 31st August 2018, the petitioner is in 22nd week of pregnancy. The petitioner relied upon an opinion expressed by a Medical Practitioner which indicated that the foetus has no chances of survival. It is for this reason, the petitioner is seeking a writ of mandamus permitting her to undergo medical termination of pregnancy.
2. In terms of the order dated 31st August 2018, a Medical Board was constituted by the Dean of B.J. Government Medical College and Sassoon General Hospital, Pune which is a Government medical college and hospital at Pune. The report of the Board is tendered on record by the learned AGP. The Committee/ Medical Board was constituted consisting of the Dean himself and six other doctors who have specialization in different branches

such as Obstetrics and Gynaecology, Radiology, Medicine, Paediatrics, Psychiatry and Cardiovascular Surgery.

It appears that the Board examined the petitioner and conducted several tests including ultrasonographical examination. The report submitted by the Professor and Head of the Radiology Department who was a part of the Medical Board indicated that the petitioner has pregnancy of 24 weeks (plus or minus two weeks) and that the foetus has multiple congenital cardiac abnormalities. The Paediatrician and the Physician who are the members of the Committee/Medical Board opined that the baby, if born alive, will have high mortality and morbidity in view of multiple congenital cardiac abnormalities. The Physician also opined that it appears to be a high risk pregnancy due to multiple congenital cardiac anomalies in the baby. The anomalies are listed in the report. In the report, an opinion has been incorporated that the risk of termination of pregnancy at this stage including need for caesarean are explained to the patient and her relatives. It is further stated that taking in to consideration the poor chances of survival and associated morbidities, if the baby survives, it is advisable to terminate the pregnancy with explained consent from the patient and her relatives subject to obtaining permission of this Court.

3. Thus, the considered opinion of the Medical Board/Committee is that it is advisable to terminate the pregnancy with the explained consent from the patient.

4. As the Medical Board has opined that the petitioner has pregnancy of 24 weeks (plus or minus two weeks), the question is whether in the light of section 3 of the Medical Termination of Pregnancy Act, 1971 (for short "the said Act") it is lawful to terminate the pregnancy. Apart from the decision of the Apex Court dated 3rd July 2017 in Writ Petition (Civil) No.431/2017 (Sarmishtha Chakrabortty and another v. Union of India Secretary and others), there is a decision of a Division Bench of this Court dated 9th January 2018 in Writ Petition (ST) No.36727/2017 (Shaikh Ayesha Khatoon v. Union of India and others). The decision in the case of Shaikh Ayesha Khatoon lays down the law on the subject. The Division Bench was dealing with the case of the petitioner therein who was in 27th week of pregnancy. The contention of the petitioner was that sonographical examination of the foetus revealed that it suffers from several anomalies including a congenital malformation. In paragraph-10 of the judgment, the Division Bench considered the provisions of section 3 and section 5 of the said Act.

Paragraph-11 of the said judgment reads thus:

> "11. Section 3 of the Act of 1971 thus prescribes the outer limit of 20 weeks in the matter of termination of pregnancy in certain circumstances enumerated in Clauses (i) & (ii) of subsection 2(b) of Section 3. Section 5 carves out an exception to Sections 3 & 4. It is

provided that the provisions of section 4, and so much of the provisions of subsection (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is contended relying on the provisions of subsection (1) of Section 5 by the petitioner that the bar contained in subsection (2) of Section 3 laying down the conditions for according permission to terminate the pregnancy is not absolute bar and in appropriate cases such permission can be accorded.

Section 5 of the Act of 1971 carves out an exception in relation to the outer limit provided under subsection (2) of Section 3 of the Act of 1971 i.e. 20 weeks in case where the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is the contention of the petitioner that firstly the trauma that the petitioner is likely to suffer is life threatening and it shall be construed that exercise of a choice in the event there are foetal abnormalities found and the chances of survives of the baby, if allowed to take birth, are minimum, is a matter to be considered within the parameters of Section 5 of the Act of 1971. Apart from this, the petitioner contends that the provisions of subsection (2) including clauses (i) & (ii) of subsection (2) (b) of Section 3 are required to be read in Section 5 except the outer limit of twenty weeks that has been provided in subsection (2) (b) of Section 3 of the Act of 1971."

Thereafter, in paragraph- 13, the Division Bench held thus:

"13. It is further observed that ordinarily a pregnancy can be terminated only when a medical practitioner is satisfied that a 'continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health' [as per Section 3(2)(b) (i) of the Act of 1971] or when 'there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped' [as per Section 3(2) (b)(ii) of the Act of1971]. It is true that Clauses (i) & (ii) of subsection 2(b) of Section 3 are attracted in the case where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks. However, as has been recorded above Section 5 permit termination of pregnancy by a registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It shall also have to be construed that Section 5brings within its ambit the provisions of Section 4 and so much of the provisions of subsection (2) of Section 3 of the Act of 1971 except the limitation in respect of length

of the pregnancy of 20 weeks as provided in subsection (2) (b) of Section 3 of the Act of 1971. It would thus be logical to conclude that the contingencies referred in Clauses (i) &(ii) of subsection (2) (b) of Section 3 will have to be read in Section 5 of the Act of 1971 and it would be relevant to consider the threat perception and substantial risk involved if the child were to born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. The contingencies laid down in Clauses (i) & (ii) of subsection (2) (b) of Section 3 shall therefore equally apply to the request of a pregnant woman seeking permission to terminate the pregnancy beyond 20 weeks and accordingly Section 5(1) will have to be construed, to meet the object and purpose of enactment and to promote cause of justice."

(Underline supplied)

In paragraph-15, the Division Bench dealt with an elementary rule of construction of statutes and, ultimately, in paragraph-22, the Division Bench held thus:

"22. In the instant matter, on reading of Section 5 of the Act of 1971, it does transpire that the contingencies and the parameters laid down in clauses (i) & (ii) of subsection(2) (b) of Section 3 shall have to be read in Section 5 except the bar of limitation as provided in Section 3(2)(b) of the Act of 1971. It would not be appropriate to over look the contingencies laid down in clauses (i) & (ii) of subsection(2) (b) of Section 3 while considering the request of a pregnant woman for termination of the pregnancy if the conditions laid down in clauses (i) & (ii) of subsection (2)(b) of Section 3 are satisfied it would provide a good ground for exercise of jurisdiction under Section 5 of the Act of 1971."(Underline supplied)Therefore, in view of the said findings, the Division Bench allowed the petition and permitted medical termination of pregnancy. The Division Bench, therefore, observed that the challenge to the validity of section 3 of the said Act need not be gone into.

5. In view of what is held by the Division Bench, section 5 will have application in case the contingencies specified in clauses (i) and (ii)of sub-section (2)(b) of section 3 of the said Act exist. Considering the opinion of the Medical Board which records that baby has complex cardiac abnormalities and is not likely to survive, obviously, in the eventuality of the birth of the child, the petitioner will have to undergo a mental trauma which will have a result of causing a grave injury to the mental health of the petitioner. Therefore, in the facts of the case, the law laid down by the Division Bench in the case of Shaikh Ayesha Khatoon (supra) will squarely apply.

6. The learned AGP, after taking instructions from the authorities of the B.J. Government Medical College and Sassoon General Hospital stated that if the petitioner gets herself admitted

to the said hospital, the process of medical termination of pregnancy will be undertaken. As a Psychiatrist was a part of the Medical Board, it is obvious that the petitioner has been sensitized of the risk involved in the medical termination of the pregnancy and she will have to undergo the procedure at her own risk and consequences. The learned counsel appearing for the petitioner states that the petitioner has understood the risk factors involved and that she is willing to undergo the procedure at her own risk and consequences. The learned counsel appearing for the petitioner states that the petitioner is willing to bear the necessary expenses. We accept the said statement.

7. Perusal of the report of the Medical Board shows that the petitioner is made aware of the risks involved in undergoing the procedure. Therefore, as observed by the Division Bench in the aforesaid case of Shaikh Ayesha Khatoon (supra), the doctors attached to the hospital shall have the immunity in the event of occurrence of any litigation arising out of the medical termination of pregnancy.

8. We propose to direct the Dean of the B.J. Government Medical College and Sassoon General Hospital, Pune to submit a report of compliance (report regarding medical termination of pregnancy) in a sealed envelop through the office of the Government Pleader. We make it clear that the sealed envelop will not be opened without express permission of the Court. Hence, we pass the following order:

    (i) We direct that while uploading the orders passed in this petition, the real name of the petitioner shall be masked and that the petitioner shall be described as "XYZ".

    Accordingly, modification of the earlier orders shall be made by making necessary corrections in the orders uploaded on the server;

    (ii) Subject to what is observed above, we permit the petitioner to undergo medical termination of pregnancy;

    (iii) It will be open for the petitioner to report immediately to the Dean of the B.J. Government Medical College and Sassoon General Hospital, Pune. The hospital authorities shall make immediate arrangements to enable the petitioner to undergo medical termination of pregnancy. The petitioner shall pay necessary charges;

    (iv) The Dean of the Medical College will submit a report of compliance in a sealed envelop which shall be filed on record through the office of the Government Pleader. Such report shall be filed within a period of two weeks from today;

    (i) We direct the Dean of the B.J. Government Medical College and Sassoon General Hospital to act upon an authenticated copy of the operative part of this judgment and order;\

We direct the office of the Government Pleader to communicate this order to the Dean without waiting for the operative part of the order being uploaded on server;

(vii) The report of the Committee constituted by the Dean which is submitted by the learned AGP shall be kept in as ealed envelop on the record of this petition;

(viii) Place the petition under the caption of direction on 28th September 2018.

(M.S.SONAK, J.) (A.S.OKA, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 10584 OF 2018

"XYZ" … Petitioner.

V/s.

Union of India,

Through the Secretary, Ministry of Law
and Justice, Delhi and Ors. … Respondents.

Ms. Meenaz Kakalia for the Petitioner.
Mr. A.R. Varma a/w Mr. Anand Singh for the Respondent No.1.
Mr. Y.S. Khochare, AGP for the Respondent No.2.

CORAM : A.S.OKA AND M.S. SONAK, JJ.
DATE : 24th SEPTEMBER 2018.

P.C. :

1. Heard the learned counsel appearing for the petitioner. The order dated 18th September 2018 passed by this Bench reads thus :"Not on board. Taken on board.1. Heard the learned counsel for the petitioner. The petitioner is in 24th week of pregnancy. The petitioner is relying upon the reports which are at Exhibit A and Exhibit B. According to the reports, the foetus suffers

from congenital cardiac anomalies. Therefore, the petitioner is claiming declaration that she is entitled to undergo medical termination of pregnancy.

2. Accordingly, we pass the following order :

   (i) We direct the Dean of Sasoon General Hospital and B.J. Government Medical College, Pune to constitute a Medical Board of the experts in various fields for examination of the petitioner;

   (ii) The petitioner will report to the office of the Dean of Sasoon General Hospital and B.J. Government Medical College, Pune tomorrow 19th September at 3.00 p.m.;

   (iii) Considering the advanced stage of pregnancy, it will be appropriate if the Medical Board will submit a report on Friday 21st September 2018 at 3.00 p.m through the Office of the Government Pleader ;

   (iv) We direct that the name of the petitioner shall be masked and shall be printed as "XYZ";

   (v) All concerned to act upon an authenticated copy of this order;

   (vi) S.O. till 21st September 2018 at 3.00 pm." In terms of the said order, the Dean of the B.J. Medical College and Government Medical College, Pune constituted a Medical Board of 7 Doctors working in the same College and Hospital consisting of himself, Professor and Head of the Department of Gynecology, Professor of Medicine, Professor and Head of the Department of Radio diagnosis, Associate Professor of Department of Paediatrics, Associate Professor of the Psychiatry and Associate Professor of Cardiovascular Surgery. There is a detailed report submitted by the Medical Board. The detailed report incorporates separate opinions expressed by the members of the Medical Board. mination it is NOT advised."(underline supplied)

4. The ultimate report of the Board reads thus : "The committee examined the girl XYZ (10548/2018) on 19/09/2018 and necessary investigations were done .Clinical examination and investigations reveal that the pregnancy is advanced [2728weeks] and carries a significant risk in termination. Also, the baby if born maybe alive and will have high morbidity and mortality. The committee feels that the pregnancy should not be terminated at this advanced gestational age."(underline supplied)

5 Today, the learned counsel appearing for the petitioner tried to argue that the opinion submitted by the Medical Board is not complete. She submitted that the Medical Board has not considered the risk involved by continuing the pregnancy. When we made a query whether the petitioner desires to cha3 In the report, it is observed that the petitioner is pregnant 27weeks and sonography has confirmed gestational age. The head of the Department of Gynecology has expressed the following opinion:" This is a pregnancy of 2628weeks with a child having a

serious congenital heart lesion. The risks of termination of pregnancy at this advanced gestation are significant including bleeding, uterine rupture, embolism, failure of induction, need for caesarean, sepsis, postpartum breast abscess and death etc. Also the baby born at this gestation is likely to survive for some time requiring NICU care and may die subsequently. Considering the risks in termination in this woman at advanced gestation with previous caesarean section, pregnancy tellenge the report of the Medical Board, she answered in the negative. As stated earlier, the Medical Board consists of 7 senior Doctors attached to B.J. Government Medical College and Sasoon General Hospital, Pune. It is obvious that the Medical Board must have considered the aspect of risk involved in continuing the pregnancy. In fact, the Medical Board constituted by the same Hospital and Medical College consisting of some of the Doctors who are part of the Medical Board constituted in this case, in some other cases, have recommended medical termination of pregnancy post20weeks of pregnancy.

6 We have no manner of doubt that the Board of 7 Doctors after considering all the relevant aspects has come to a conclusion that there is a risk involved in terminating the pregnancy of the petitioner in advanced gestational age.

7. Considering the opinion of the Medical Board, we are unable to grant any relief in this petition under Article 226 of the Constitution of India. Hence, we reject the petition.

(M.S. SONAK, J.) (A.S.OKA, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO.10711 OF 2018

Sandhya Padhy ...Petitioner

Vs.

The State of Maharashtra
and others ...Respondents

Ms. Bhavana Mhatre a/w Ms. Meenaz Kakalia I/b
Mr. Kranti L.C. for the Petitioner
Mr. P.G. Sawant, AGP for the respondent No.2
Ms. Purnima Awasthi for respondednt No.1

CORAM : A.S.OKA, &
M.S. SONAK, JJ.
DATE : SEPTEMBER 26, 2018

P.C.:

1. Perused the order dated 21st September 2018.The petitioner has tendered additional affidavit to which a photo copy of her Aadhar Card is annexed. Affidavit is taken on record and marked `A1' for identification.

2. In terms of the order dated 21st September 2018,a medical board constituted by the Dean of Sir J.J. Group of Hospitals has submitted a report. The medical board consisted of seven Doctors attached to Grant Medical College, Mumbai. The Board consisted of 1) Professor and Head of Department of Obstetrics and Gynecology of Grant Medical College and Sir J.J. Group of Hospitals, 2) Professor and Head of the Department of Psychiatry, Sir J.J. Group of Hospitals, 3) Professor and Head of Department of Radiology, Sir J.J. Group of Hospitals, 4) Professor and Head of Department of Paediatrics, Sir J.J. Group of Hospitals, 5) Professor and Head of the Department of Cardiology, Sir J.J. Group of Hospitals, 6) Professor and Head of the Department of Pediatrics Surgery, Sir J.J. Group of Hospitals,7) Professor and Head of the Department of C.V.T.S., Sir J.J. Group of Hospitals and 8) Professor and Head of the Department of Neurosurgery, Sir J.J. Group of Hospitals. The report is taken on record and marked`R1'for identification. In the report, opinion of the Board is recorded. The opinion reads thus:

COMMITTEE OPINION

> UPON EXAMINATION AND AFTER CAREFUL STUDY OFMULTIPLE SONOGRAPHY REPORTS, IT ISCONFIRMED THAT THE FETUS SUFFERS FROMSERIOUS NEUROLOGICAL ABNORMALITY IN THEFORM OF UNILATERAL DILATATION OF LEFTLATERAL VENTRICLE MEASURING 24 MM, BRAIN PARENCHYMA IS THINNED OUT 7 CLEFT LIP.THIS CONDITION IS LIKELY TO WORSEN WITHINCREASING GESTATIONAL AGE.THE CONDITION OF THE FETUS FULFILLSTHE CRITERIA OF "SUBSTANTIAL RISK OFSERIOUS PHYSICAL HANDICAP".
>
> THE WOMAN HAS BEEN EXPLAIINED ABOUT THEOUTCOME IN HER LANGUAGE SHE UNDERSTANDS.THE PREGNANT WOMAN HAS VOLUNTARILYEXPRESSED HER DESIRE TO TERMINATE THEPREGNANCY AND IS WELL INFORMED ABOUT THENATURE OF THE CONDITION OF FETUS AND ITSOUTCOME. SHE IS ANGUISHED WITH THECONDITION OF THE FETUS IN UTERO. HENCE ITIS ADVISABLE TO TERMINATE THE PREGNANCY.THE PREGNANCY WAS WITHIN PERMISSIBLELIMITS FOR MTP, WHEN SHE CAME FOR MTP.HENCE TERMINATION OF PREGNANCY CAN BEALLOWED WITH DUE RISK I/V/O FETAL ANOMALIES."

3. We have heard the learned counsel for the petitioner. The learned AGP for the second respondent and the learned counsel for the first and third respondents.

4. Our attention is invited to the decision of the Division Bench of this Court dated 9th January 2018m in Writ Petition St.No.36727 of 2017 in the case of Shaikh Ayesha Khatoon vs. Union

of India and others. The Division Bench was dealing with the similar case where the petitioner lady was in the 27th weeks of pregnancy. In the present case, the petitioner is in 26th week of pregnancy. The Division Bench considered sections 3 and 5 of the Medical Termination of Pregnancy Act,1971 (for short `the said Act').

5. In paragraph 10, the Division Bench quoted sections 3 and 5 of the said Act. Paragraph 10 reads thus:

"10 Section 3(2) (b)(i) and (ii) as well as section 5 (1) of the Act of 1971 read thus:

"3. When pregnancies may be terminated by registered medical practitioners (1) xxxx (2) Subject to the provisions of subsection(4), a pregnancy may be terminated by a registered medical practitioner, (a) xxxx (b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion formed in good faith, that (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or(ii) there is a substantial risk that if the child were worn, it would suffer from such physical or mental abnormalities as to be seriously handicapped."

"5. Sections 3 and 4 when not to apply –

(1) The provisions of section 4, and so much of the provisions of subsection(2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman."

In paragraph 13, the Division Bench held thus:"13 It is further observed that ordinarily a pregnancy can be terminated only when a medical practitioner is satisfied that a continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health [as per section 3(2) (b)(i) of the Act of 1971] or when there is substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped [as per Section 3(2) (b)(ii) of the Act of 1971]. It is true that Clauses (I) and (ii) of subsection2 (b) of Section 3 are attracted in the case where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks. However, as has been recorded above, Section 5 permits termination of pregnancy by a registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It shall also have to be construed that Section5 brings within its ambit the provisions of Section 4 and so much of the provisions o subsection(2) of

Section 3 of the Act of1971 except the limitation in respect of length of the pregnancy of 20 weeks as provided in subsection(2)(b) of Section 3of the Act of 1971. It would thus be logical to conclude that the contingencies referred in Clauses (i) & (ii) of subsection(2) (b) of Section 3 will have to be read in Section 5 of the Act of 1971 and it would be relevant to consider the threat perception and substantial risk involved if the child were to born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. The contingencies laid down in Clauses (i) & (ii) of subsection(2) (b) of Section 3 shall therefore equally apply to the request of a pregnant woman seeking permission to terminate the pregnancy beyond 20 weeks and accordingly Section 5(1) will have to be construed, to meet the object and purpose of enactment and to promote cause of justice."

6. Even in paragraph 22, the Division Bench reiterated that if the conditions laid down in clauses (i) and (ii) of subsection2(b) of section3 of the said Act are satisfied, it would provide a good ground for exercising jurisdiction under section 5 of the said Act. In the present case, going by the opinion of the Medical Board, the contingencies provided in clauses (i) and (ii) of subsection 2(b) of section 3 of the said Act exist. The Medical Board has opinioned that there is a substantial risk of child being born with serious physical handicap. There is no reason to discard the opinion of the Medical Board.

7. The opinion of the Medical Board records that the petitioner is well informed about the nature and condition of the fetus and its outcome and she has voluntarily expressed her desire to terminate the pregnancy.

8. The averments made in the petition show that the petitioner wants to undergo medical termination of pregnancy in Nowrosjee Wadia Maternity Hospital, Parel, Mumbai which is admittedly, a hospital run by Brihan mumbai Mahanagar Palika.

9. This is a case where the petitioner is willing to undergo medical termination of pregnancy. The petitioner is aware about the risks involved and the petitioner has agreed to bear the expenses. As observed in the case case of Shaikh Ayesha Khatoon (supra), it is obvious that the Doctors who are apart of Medical Board and the Doctors who supervise the procedure of medical termination of pregnancy will enjoy immunity from any legal action arising out of this litigation.

10. Accordingly, we pass the following order:(i) We permit the petitioner to undergo medical termination of her pregnancy in Now rosjee Wadia Maternity Hospital, Parel, Mumbai. It will be open for the petitioner to report to the office of the Head of the Department of Gynecology of the said hospital on Friday i.e. 28th September 2018at 11.00 a.m. The petitioner will produce a copy of this writ petition along with annexures and documents of identity which shall be verified by the concerned officers of the said hospital;(ii)We direct the authorities of NowrosjeeWadia Maternity Hospital to admit the petitioner immediately on her reporting

on Friday 28th September 2018 and ensure that the procedure for medical termination of pregnancy will be undertaken;(iii) Needless to add that the medical termination of pregnancy will be at the risk of the petitioner and the doctors who are the members of the Medical Board and the doctors who will perform the procedure will enjoy immunity from any legal action arising out of this litigation;(iv) The petition is disposed of on the above terms; (vi) Hospital Authorities to act on an authenticated copy of this order.

(M.S.SONAK, J.) (A.S.OKA, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO.10835 OF 2018

Sudha Dev Girkar … Petitioner

V/s.

The Union of India and Ors. …Respondents

Ms. Gayatri Singh, Senior Advocate i/b. Mr. Kranti L.C. for Petitioner.

Ms. Anusha Pravin Amin for the Respondent Nos.1 and 3.

Mr. A.B. Vagyani, Government Pleader a/w Mr. Y.S. Khochare, AGP for the Respondent No.2.

Mr. D.J. Khambatta, Senior Counsel, Amicus Curiae.

CORAM : A.S.OKA AND M.S. SONAK, JJ.

DATE : 9th OCTOBER 2018.

P.C. :

1. Heard the learned senior counsel appearing for the petitioner, the learned Government Pleader for the second respondent and the learned counsel appearing for the first and third respondents. Perused the earlier order dated 28th September 2018. In terms of the said order, report of the Medical Board constituted by Sir J.J. Group of Hospitals is received by the Court which is already taken on record. Summary of the medical board reads thus: “After

Careful Examination of patient and study of ultrasnography and fetal MRI report, committee confirms that fetus has neurological abnormalities in the form of findings suggestive of Arnold Chiari II Malformation. The condition of fetus fulfills criteria of "substantial risk of serious physical handicap with very high morbidity and mortality. The woman has expressed her desire to terminate the pregnancy and is well informed about the nature of thec ondition of the fetus and its outcome. Since the pregnancy has advanced to 22 weeks of gestation, it is beyond 20 weeks which is the cut off ofMedical Termination of Pregnancy Act. The risk of termination of pregnancy is the same as that of her delivery. She has approached Honourable Court for temination of pregnancy. If the Court permits, the pregnancy can be terminated as desired by the pregnant woman with due risk. The Hon'ble Court is also requested to instruct the parents to take responsibility of the child if born alive."

2. As pointed out in the earlier order, the petitioner is seeking medical termination of pregnancy. Our attention is invited to various decisions of the Apex Court and this Court. The said decisions have been considered by the Division Bench of this Court in its judgment and order dated 9th January 2018 in Writ Petition (St) no.36727 of 2017 (Shaikh Ayesha Khatun Vs. Union of India). In paragraph 10 of the said decision, the Division Bench has referred to sections 3 and 5 of the Medical Termination of Pregnancy Act, 1971 (for short "the said Act"). Paragraph10 reads thus :"10. Section 3(2) (b)(i) & (ii) as well as Section 5(1) of the Act of 1971 read thus:

"3. When pregnancies may be terminated by registered medical practitioners.

(1) xxxx

(2) Subject to the provisions of subsection

(4), a pregnancy may be terminated by a registered medical practitioner,

(a) xxxx

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion formed in good faith, that

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer form such physical or mental abnormalities as to be seriously handicapped."

"5. Sections 3 and 4 when not to apply.(1) The provisions of section 4, and so much of the provisions of subsection (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman."

3. The Division Bench thereafter considered the decision of the\ Apex Court in the case of Suchitra Srivastava and Anr. Vs. Chandigarh Administration1.

4. In paragraph 13, the Division Bench held thus :13.It is further observed that ordinarily a pregnancy can be terminated only when a medical practitioner is satisfied that a 'continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health' [as per Section 3 (2) (b) (i) of the Act of 1971] or when 'there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped' [as per Section 3 (2) (b)(ii) of the Act of 1971]. It is true that Clauses (i) & (ii) of subsection 2(b) of Section 3 are attracted in the case where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks. However, as has been recorded above Section 5 permits termination of pregnancy by a registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It shall also have to be construed that Section 5 brings within its ambit the provisions of Section 4 and so much of the provisions of subsection (2) of Section 3 of the Act of 1971 except the limitation in respect of length of the pregnancy of 20 weeks as provided in subsection (2) (b) of Section 3 of the Act of 1971. It would thus be logical to conclude that the contingencies referred in Clauses (i) & (ii) of subsection (2) (b) of Section 3 will have to be read in Section 5 of the Act of 1971 and it would be relevant to consider the threat perception and substantial risk involved if the child were to born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. The contingencies laid down in Clauses (i) & (ii) of subsection (2) (b) of Section 3 shall therefore equally apply to the request of a pregnant woman seeking permission to terminate the pregnancy beyond 20 weeks and accordingly Section5(1) will have to be construed, to meet the object and purpose of enactment and to promote cause of justice."

5. Ultimately, in paragraph 22, the Division Bench held thus :"22. In the instant matter, on reading of Section 5 of the Act of 1971, it does transpire that the contingencies and the parameters laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3 shall have to be read in Section 5 except the bar of limitation as provided in Section 3 (2) (b) of the Act of 1971. It would not be appropriate to over look the contingencies laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3while considering the request of a pregnant woman for

termination of the pregnancy if the conditions laid down in clauses (i) & (ii) of subsection (2) (b) of Section 3 are satisfied it would provide a good ground for exercise of jurisdiction under Section 5 of the Act of1971."

6. Now, coming back to the facts of the present case, we have already quoted the opinion of the Medical Board constituted under the orders of this Court. The Medical Board has recorded an opinion that the condition of fetus is such that there is substantial risk of serious physical handicap with associated morbidity and mortality. It is observed that the fetus has neurological abnormalities as stated in the report. A copy of the report was supplied to the learned counsel appearing for the petitioner yesterday for dealing with the opinion expressed by the Medical Board. The petitioner has filed an affidavit which is taken on record and marked"A1"for identification. The said affidavit shall be kept in a sealed envelope on record of the petition. The sealed envelope shall not be opened without permission of the Court. We accept the statements and undertakings given in the said affidavit taken on record and marked "A1" for identification.

7. In view of the aforesaid decision of the Division Bench of this Court which holds that the contingencies laid down in the sub clause (i) and (ii) of clause (b) of subsection(2) of section 3 will have to be read into section 5 of the said Act, we find that section 5 will have application in the present case inasmuch as the contingency as specified in sub clause (ii) of clause (b) of subsection(2) of section 3 exists as is indicated by the report of the Medical Board. Hence, permission deserves to be granted to her to undergo medical termination of pregnancy.

8. The learned senior counsel states that the petitioner's parents are present in the Court. She states that the petitioner wants to undertake medical termination of pregnancy in R.N. Cooper Hospital at Vile Parle in Mumbai which is a Municipal Hospital which is approved Hospital in terms of clause (b) of section 4 of the said Act.

9. As observed by the Division Bench in the aforesaid decision, considering the opinion of the Medical Board, the Doctors who have put their opinions on record and the Doctors who will supervise the procedure of medical termination of pregnancy shall have immunity in the event of occurrence of any litigations arising from this petition. It is obvious that the petitioner will have to undergo the procedure of medical termination of pregnancy at her own risk and she is fully made aware of the contents of the opinion of the Medical Board as is clear from the affidavit taken on record and marked "A1"for identification.\

10. Considering the opinion of the Medical Board and considering several issues which arise in similar cases which are being filed in large numbers, we are of the view that those issues need to be gone into. We, therefore, requested Shri Khambatta, learned senior counsel to assist the Court and he has willingly agreed to do so. We propose to hear the matter on 19th October 2018 at 3.00 pm on wider issues. We request the learned senior counsel including the learned

senior counsel appearing for the petitioners to address the Court on wider issues. We also make it clear that the State Government represented by the Government Pleaders Ms. Kantharia and Shri Vagyani as well as the learned counsel for the Union of India will have to address the Court on legal issues. Accordingly, we pass the following order : ORDER

(i) It will be open for the petitioner to undergo medical termination of pregnancy in R.N. Cooper Hospital at Vile Parle, Mumbai which is a hospital set up by the Mumbai Municipal Corporation;

(ii) The petitioner will report to the Department of Gynecology of the same Hospital at 3.00 pm today;

(iii) The Hospital Authorities will take necessary steps after the petitioner reports to the Head of the Department of Gynecology;

(iv) The petitioner will produce a copy of this Writ Petition as well as authenticated copy of the operative part of this order and will also produce the documents of her identity before the concerned authorities of the said Hospital for necessary verification;

(v) The authorities of the R.N. Cooper Hospital which is a Municipal Hospital will act on the authenticated copy of the operative part of this order;

(vi) For further hearing, the petition will be listed on 19thOctober 2018 at 3.00 pm. Though the further hearing will take place in open Court, the hearing will be in camera.

(M.S. SONAK, J.) (A.S.OKA, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION

WRIT PETITION (L) NO.3420 OF 2018

XYZ ... Petitioner

Vs.

Union of India and Ors. ... Respondents

Ms. Meenaz Kakalia for the petitioner.

Ms. Poornima Awasthi for the Respondent – UOI.

Ms. P.H. Kntharia, Government Pleader and Ms. Deepali Patankar,

Assistant to G.P. for the Respondent – State.

CORAM : A.S. OKA AND M.S. SONAK, JJ.

DATE : 9th OCTOBER 2018

P.C.

1 For the reasons recorded separately, we pass the following order :

O R D E R

(i) It will be open for the petitioner to undergo medical termination of pregnancy in Now rosjee Wadia Maternity Hospital at Parel, Mumbai;

(ii) The petitioner will report to the in charge of the Gynecology Department of the said Hospital on 10th October 2018 at 11.00 am;

(iii) The petitioner will produce a copy of this Writ Petition, authenticated copy of the operative part of this order and the documents of her identity before the concerned authorities of the said Hospital for necessary verification;

(iv) The Hospital Authorities will take immediate steps to allow the petitioner to undergo medical termination of pregnancy at the earliest;

(v) The petition is disposed of with the above directions;

(vi) The Authorities of Now rosjee Wadia Maternity Hospital to act upon the authenticated copy of the operative part of this order.

(M.S. SONAK, J) (A.S. OKA, j

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
APPELLATE SIDE

WRIT PETITION NO. 11750 OF 2018

Tahira Jadav Qureshi ... Petitioner

Vs.

Union of India and Ors. ... Respondents

Mr. Shubham Kaushal for the Petitioner.

Mr. Ashok R. Varma for the Respondent Nos 1 and 3.

Mr. P.G. Sawant, AGP for the Respondent No.2.

Mr. Vinod Mahadik for the Respondent No.4.

CORAM : A.S.OKA AND M.S. SONAK, JJ.

DATE : 16th OCTOBER 2018.

P.C. :

1. In terms of the order dated 11th October 2018, the Medical Board of Sir J.J. Group of Hospitals has submitted a report in which it is stated that the pregnancy requires termination as the fetus is already dead. The learned counsel appearing for the petitioner states that the petitioner underwent miscarriage and hence, the present petition does not survive. The report be kept on record in a sealed envelope. We accept the statements made by the petitioner. Petition does not survive and the same is disposed of.

(M.S. SONAK, J.) (**(A.S.OKA, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 11867 OF 2018

Videshi Bhandari ... Petitioner.

V/s.

Union of India and others. ... Respondents.

Ms. Meenaz Kakalia i/b. Mr. Kranti L.C. for the petitioner.

Mrs. Purnima Awasthi for respondent Nos.1 to 3.

Mr. P.P. More, AGP for respondent No.3.

CORAM : A.S.OKA AND M.S.SONAK, JJ.

DATE : 23rd October 2018.

P.C.:

1. On the earlier date, the parties were put to notice that this petition will be taken up for final disposal at the admission stage. Paragraphs 1 and 2 of the order dated 16th October 2018 read thus:“1 Heard the learned counsel appearing for the petitioner and the learned AGP for the second respondent. The petitioner who has 21st week of pregnancy has prayed this Court seeking permission to undergo medical termination of pregnancy on the ground that the fetus has congenital complete heart block which would lead to poor quality of life and it would be fatal.

2. While issuing notice for final disposal at admission, we pass the following directions :

   ORDER

   (i) Name of the petitioner shall be masked in the uploaded orders and her name shall be mentioned as "XYZ";

   (ii) We direct the petitioner to report to the Dean of B.J. Medical College and Sasoon Hospital at Pune on 19thOctober 2018 at 11.00 am. The Dean shall constitute appropriate Medical Board of experts in various fields. While appearing before the Dean, the petitioner shall produce a true copy of the entire petition and documents of her identity;

   (iii) We request the Dean to ensure that report of the Medical Board is submitted to this Court on 22nd October 2018 at 4.30 pm;

   (iv) All concerned to act upon an authenticated copy of this order;"

   2. As per the order of this Court, a Medical Board was constituted consisting of the Dean, Professor and Head of the Department of Gynaecology, Professor and Head of Department of Medicine, Associate Professor and Head of Department of Radio diagnosis, Associate Professor and Head of Department of Paediatrics and a Cardiovascular Surgeon.

   The conclusion of the Medical Board reads thus: "The committee examined the woman [mrs VVB] 11867 of2018 on 019/10/18 and necessary investigations were done. Clinic a examination and investigations shows complex and multiple abnormalities in the baby. The baby if born alive will require multiple surgeries with high morbidity and mortality.

   The committee feels that the pregnancy may be terminated with explained risk of termination at 2022 weeks and need for caesarean with kind permission of Hon. High Court."(underline supplied)

3. Our attention is invited to a decision of the Division Bench of this Court dated 9th January 2018 in Writ Petition (St.) No. 36727/2017(Shaikh Ayesha Khatoon v. Union of India and others) wherein the Division Bench of this Court considered the provisions of sections 3 and 5 of the Medical Termination of Pregnancy Act, 1971 (for short "the said Act of 1971"). Section 5 permits medical termination beyond 20 weeks of pregnancy. Sub clause (ii) of clause (b) of subsection (2) of section 3 of the said Act of 1971 is applicable when there is a substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

4. Considering the report of the Medical Board, the baby, if born alive, will require multiple surgeries with high morbidity and mortality. Therefore, section 5 as interpreted in the case of Shaikh Ayesha Khatoon (supra) will apply in the present case. Hence, a case is made out to

permit the petitioner to undergo medical termination of pregnancy.

5. We make it clear that the petitioner will undergo medical termination of the pregnancy at her own risk. Needless to add that the doctors forming part of the Medical Board as well as the doctors why undertake the procedure of medical termination of pregnancy will been titled to claim immunity in the event of occurrence of any litigation arising out of this procedure.

6. We, accordingly, pass the following order:

   a] In view of the report of the Medical Board of B.J. Government Medical College and Sassoon General Hospital, Pune, we permit the petitioner to undergo medical termination of pregnancy. It will be open for the petitioner to report to the Office of the Dean of B.J. Government Medical College and Sassoon General Hospital, Pune on 25th October 2018 at 11.00 a.m. for undergoing medical termination of pregnancy;

   b] As the petitioner is examined by the Medical Board constituted by the same Medical College and Hospital, the authorities of the Hospital will not insist upon production of the documents on identity;

   c] The procedure for medical termination of pregnancy shall be undertaken by the Hospital Authorities at the earliest and preferably on the same day on which the petitioner reports;

   d] Needless to add that the petitioner will undertake the procedure at her own risk;

   e] The authorities of B.J. Government Medical College and Sassoon General Hospital, Pune will act upon an authenticated copy of this operative order;

   f] Place the petition under the caption of compliance on 2nd November 2018. Compliance report to be submitted by the Hospital Authority before the next date.

(M.S.SONAK, J.) (A.S.OKA, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
APPELLATE SIDE

WRIT PETITION NO. 10583 OF 2018

Deepika Gawde …Petitioner.

V/s.

Union of India and others. …Respondents.

Ms. Meenaz Kakalia for the petitioner.

Mr. A.R. Varma and Mr. Anand Singh for respondent No.1. Mr. Y.S. Khochare, AGP for respondent No.2.

CORAM: A.S.OKA AND A.S.GADKARI,JJ.

DATE 21st September2018.

OPERATIVE PART OF THE ORDER :

For the reasons separately recorded in the judgment and order delivered today, the following order is passed:

(i) We direct the petitioner to file on record of this petition within one week from today a true photocopy of Pan Card or Adhar Card of any other authentic photo identity document;

(ii) We permit the petitioner to undergo medical termination of her pregnancy in Sir J.J. Group of Hospitals, Mumbai. It will be open for the petitioner to report to the office of the Dean of the said hospital on Monday i.e. 24th Septemebr 2018 at 10.00 a.m. The petitioner will produce a copy of this writ petition along with annexure and documents of identity which shall be verified by the concerned officers of the said hospital;

(iii) The authorities of the Sir J.J. Group of Hospital will make all arrangements to enable the petitioner to undergo medical termination of pregnancy;

(iv) Needless to add that the medical termination of pregnancy will be at the risk of the petitioner and the doctors who are members of the Medical Board and the doctors who will perform the procedure will enjoy immunity from any legal action arising out of this litigation;

(v) The petition is disposed of on the above terms;

(vi) All concerned to act on an authenticated copy of this order.

(A.S.GADKARI, J.) **(A.S.OKA, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION

WRIT PETITION (L) NO. 3878 OF 2018

XYZ ... Petitioner

Vs

Union of India and Ors. ... Respondents

Ms. Aditi Saxena for the Petitioner.
Ms. P.H. Kantharia, Government Pleader with Ms.
Deepali Patankar Assistant to Government Pleader for
the RespondentState.
Ms. Poornima Awasthi for RespondentUnion of India.
Dr. Maithili S. Umate, Assistant Professor, Department
of Psychiatry, JJ Hospital is present.

CORAM : A.S.OKA &
SANDEEP K. SHINDE JJ.
DATE : 5 DECEMBER, 2018

P.C. :

1. In terms of the order dated 16th November, 2018, a Medical Board was constituted by the

Dean of Sir JJ Group of Hospitals, Mumbai. Opinion of the Medical Board was submitted on 22nd November, 2018.

2. The Petitioner is seeking a direction to permit her to undergo medical termination of the pregnancy by relying upon the provisions of Section 5 read with Section 3 of the Medical Termination of Pregnancy Act, 1971 (for short 'the said Act') as interpreted by the Division Bench of this Court in Writ Petition Stamp No.36727 of 2017 in the case of Shaikh Ayesha Khatoon v. Union of India and two others. Subsection (2) of Section 3 of the said Act reads thus.

"3. When pregnancies may be terminated by registered medical practitioners

(1) xxxx

(2) Subject to the provisions of sub section

(4), a pregnancy may be terminated by a registered medical practitioner,

(a) xxx

(b) whenever the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion formed in good faith, that

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped." (emphasis added)

Section 5 of the said Act reads thus:

"5. Sections 3 and 4 when not to apply.(1) provisions of section 4, and so much of the provisions of subsection (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman."

3. The Division Bench held that grounds incorporated in Subclauses (i) and (ii) of Clause (b) of Subsection (2) of Section 3 will have to be read into Section 5. From the opinion of the Medical Board, it appears that subclause (ii) of clause (b) of subsection (2) of Section 3 cannot be applied . The submission of the learned counsel appearing for the Petitioner is that

continuance of pregnancy would involve a risk of causing grave injury to the mental health of the Petitioner. The submission was that the Medical Board has not given any opinion on this aspect. On the basis of the said statement, assessment of the Petitioner was made by three experts in mental health attached to the same hospital. There are two reports placed on record by the said three experts. The first is 30th November, 2018 and the second is dated 5th December, 2018. It appears to us that both the reports do not contain a categorical opinion about the applicability of Subclause (i) of Clause (b) of Subsection (2) of Section 3 to the present case in the context of the contention of the learned counsel appearing for the Petitioner that the continuance of pregnancy would involve a risk of causing a grave injury to her mental health.

4. We request the Dean of Sir JJ Group of Hospitals to constitute a Medical Board for giving opinion on the aforesaid aspect. It will be appropriate if the expert in the field of mental health/paediatritian are a part of the Medical Board. The Dean is free to include such other experts as he may deem fit in the Medical Board.

5. The Petitioner will report to the Office of the Dean of Sir JJ Group of Hospital on Friday, 7th December, 2018 at 11.00 a.m. We request the Dean to submit a report by 11th December, 2019. Place the petition on 11th December, 2018 at 3 p.m.

(SANDEEP K. SHINDE, J.) (A.S.OKA, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 13083 OF2018

Shivani Chaudhary, Room No. E/2, Lig Second, Sector 01, Kalamboli,
Navi Mumbai-410218 ...Petitioner

VERSUS

1. Union of India through the
   Secretary,
   Ministry of Law and Justice Shastri Bhawan,
   "C" Wing, New Delhi-110001
2. State of Maharashtra through the
   Principal Secretary, Public Health Services,
   Mantralaya, Mumbai-23.
3. Ministry of Health and Family Welfare,
   through its Secretary,
   M.H. Division, New Delhi.
4. Municipal Commissioner of Greater Mumbai,
   through its Municipal Commissioner, Mahapalika
   Bhavan,
   Mahapalika Marg, Mumbai-400014 Respondents

*****

Ms. Aditi Saxena i/b ky. Mr. Kranti L.C. Advocate for the petitioner

Ms. Purnima Awasthi, Advocate for respondents no.1, Union of India and respondent no.3 -Ministry of Health and Family Welfare.

Mrs. R.A. Salunkhe, AGP for respondent no.2-State. Mr. Santosh Parad, Advocate for respondent no.4-BMC.

CORAM: A.S. Oka, &

Sandeep K. Shinde, JJ. Monday,

DATE: 26 November, 2018.

ORAL JUDGMENT (PER : A.S. OKA, J) :

1. Rule.
2. The Learned counsel appearing for the first and third respondents waives service. Learned AGP waives service of notice on behalf of second respondent. Learned Counsel for the fourth respondent also waives service.
3. In terms of the order dated 19th November, 2018 a Medical Board was constituted by the Dean of Sir J.J. Group of Hospitals. The Medical Board consisted of the Professor and Head of Department of Gynaecology, Professor and Head of Department of Psychiatry, Professor of Department of Radiology, Professor of Department of Paedetrics Surgery, Professor and Head Department of Cardiology and Professor and Head of Department of Paedetrics of Sir J.J. Group of Hospitals and Government Medical College.
4. The opinion of the Medical Board reads as under:

COMMITTEE OPINION

"UPON EXAMINATION AND AFTER CAREFUL STUDY OF MULTIPLE SONOGRAPHY REPORTS, IT IS CONFIRMED THAT THE FETUS SUFFERS FROM SERIOUS ABNORMALITY IN THE FORM OF ***NON-IMMUNE FETAL HYDROPS (ASCITES, SUBCUTANEOUS EDEMA) AS DESCRIBED ABOVE WITH FOLLOWING ANONALIES : 1-RIGHT SIDED CCAM. 2- CONGENITAL DIAPHRAGMATICHERNIA.***

THE CONDITION OF THE FETUS FULFILLS THE CRITERIA OF ***"SUBSTANTIAL RISK OFSERIOUS PHYSICAL HANDICAP".***

THE WOMAN HAS BEEN EXPLAINED ABOUT THE OUTCOME IN THE LANGUAGE SHE UNDERSTANDS.

THE PREGNANT WOMAN HAS VOLUNTARILY EXPRESSED HER DESIRE TO TERMINATE THE PREGNANCY AND IS WELL INFORMED ABOUT THE NATURE OF THE CONDITION OF FETUS AND ITS OUTCOME. SHE IS ANGUISHED WITH THE CONDITION OF THE FETUS IN THE UTERO. HENCEITIS ADVISABLE TO TERMINATE THE PREGNANCY.

THE PREGNANCY HAS ADVANCED TO 24 WEEKS AND IS BEYOND 20 WEEKS CUT OFF OF THE MEDICAL TERMINATION OF PREGNANCY ACT. HENCE SHE HAS APPROACHED HONOURABLE COURT FOR TERMINATION OF PREGNANCY.

THUS IF THE COURT PERMITS THE PREGNANCYCAN BE TERMINATED AS DESIRED BY THE WOMAN."

5. We have heard the Learned Counsel appearing for the parties. Our attention is invited to the judgment and order dated 9th January, 2018 of the Division Bench of this Court in the case of **Shaikh Ayesha Khatoon vs. Union of India and Ors.** (W.P. No. 628 of 2018). The Division Bench considered various provisions of the Medical Termination of Pregnancy Act, 1971 (for short "the said Act") and in particular Sections 3 and 5. In paras-11,15 and 22, the Division Bench held as under:

"11. Section 3 of the Act of 1971 thus prescribes the outer limit of 20 weeks in the matter of termination of pregnancy in certain circumstances enumerated in Clauses (i) & (ii) of sub-section 2(b) of Section 3. Section 5 carves out an exception to Sections 3 & 4. It is provided that the provisions of section 4, and so much of the provisions of sub - section (2) of section 3as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is contended relying on the provisions of sub- section (1) of Section 5 by the petitioner that the bar contained in sub section (2) of Section3 down the conditions for according permission to terminate the pregnancy is not absolute bar and in appropriate cases such permission can be accorded. Section 5 of the Act of 1971 carves out an exception in relation to the outer limit provided under sub-section (2) of Section 3 of the Act of 1971 i.e. 20 weeks in case where the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. It is the contention of the petitioner that firstly the trauma that the petitioner is likely to suffer is life threatening and it

shall be construed that exercise of a choice in the event there are foetal abnormalities found and the chances of survives of the baby, if allowed to take birth, are minimum, is a matter to be considered within the parameters of Section 5 of the Act of 1971. Apart from this, the petitioner contends that the provisions of sub-section (2) including clauses (i) & (ii) of sub-section (2)(b) of Section 3 are required to be read in Section 5 except the outer limit of twenty weeks that has been provided in sub-section (2)(b) of Section 3 of the Act of 1971.

15.While interpreting the provisions of Section 5 of the Act of 1971, it must be borne in mind the principle that the section must be construed as a whole whether or not one part is a saving clause and similarly elementary rule of construction of section is made of all the parts together and that it is not permissible to omit any part of it; the whole section must be read together. The words of Statute are first understood in their natural, ordinary and popular sense and phrases and sentences are construed according to their grammatical meaning unless there be something in the context, or in the object of the statute in which they occur or in the circumstances in which they are used, to show that they were used in special sense different from their ordinary grammatical meaning. The basic principle that while interpreting the provisions of a Statute one can neither add nor subtract even a single word, has to be kept in mind. A section is to be interpreted by reading all of its parts together, and it is not permissible to omit any part thereof. The Court cannot proceed with the assumption that the legislature, while enacting the Statute has committed a mistake; it must proceed on the footing that the legislature intended what it has said; even if there is some defect in the phraseology used by it in framing the statute, it is not open to the Court to add and amend, or by construction, make up for the deficiencies, which has been left in the Act. The Court can only iron out the creases but while doing so, it must not alter the fabric, of which an Act is woven. The Court, while interpreting statutory provisions, cannot add words to a Statute, or read words into it which are not part of it, especially when a literal reading of the same produces an intelligible result. [Vide Nalinakhya Bysack v. Shyam Sunder Haldar and ors., AIR 1953 SC 148; Sri Ram Narain Medhi v. State of Bombay, AIR 1959 SC 459; M. Pentiah and Ors.v. Muddala Veeramallappa and Ors., AIR 1961 SC 1107; The Balasinor Nagrik Co-operative Bank Ltd. v. Babubhai Shankerlal Pandya and Ors., AIR 1987 SC 849; and Dadi Jagannadham v.Jammulu Ramulu and Ors.,(2001) 7 SCC 71].

22. In the instant matter, on reading of Section 5 of the Act of 1971, it does transpire that the contingencies and the parameters laid down in clauses (i) &(ii) of sub-section (2)(b) of Section 3 shall have to be read in Section 5 except the bar of limitation as provided in Section 3(2)(b) of the Act of 1971. It would not be appropriate to over look the contingencies laid down in clauses (i) &(ii) of sub-section (2) (b) of Section 3 while considering the request of a pregnant woman for termination of the pregnancy if the conditions laid down in clauses (i) &(ii) of sub-section

(2)(b) of Section 3 are satisfied it would provide a good ground for exercise of jurisdiction under Section 5 of the Act of 1971." (emphasis added)

7. Thus, the Division Bench held that the contingencies specified in Clauses (i) and (ii) of sub-sections 2(b) of Section 3 of the said Act, will have to be read in to Section 5. In the present case, as noted above, the opinion of the Medical Board records that the condition of the fetus fulfils the criteria of "substantial risk of serious physical handicap ". Therefore,Clause-(ii) of Section 2(b) of Section 3 is squarely attracted. As laid down in the aforesaid decision in the case of Shaikh Ayesha Khatoon (supra), a permission will have to be granted to the petitioner to undergo medical termination of pregnancy. The learned Counsel for the petitioner states that the petitioner wants to undergo medical termination of pregnancy in KEM Hospital, Mumbai which is an hospital run by the fourth respondent.

8. The report of the Medical Board records that the consequences of allowing the termination of pregnancy have been explained to the petitioner. It is obvious that the petitioner has shown willingness to undergo medical termination of pregnancy at her own risk. Moreover, as observed in the decision of ***Shaikh Ayesha Khatoon*** (supra), the Medical Practioners who are associated with the Medical Board and with the process of conducting of medical termination of pregnancy will enjoy immunity. Accordingly, the petition must succeed and it will be open for the petitioner to undergo medical termination of pregnancy in KEM. Hospital, Mumbai.

9. Hence, we pass the following order:

    1. It shall be open for the petitioner to undergo medical termination of pregnancy entirely at her own risk;

    2. The petitioner shall report to the office of the Dean of KEM. Hospital at Mumbai on Wednesday, 28thNovember, 2018 at 11.00a.m;

    3. The petitioner shall produce an authenticated copy of this order along with a complete copy of this Writ Petition, as well as, documents of her identity;

    4. The petitioner shall also produce a copy of the opinion of the Medical Board constituted under the orders of this Court along with an authenticated copy of the operative part of this order;

    5. On the petitioner producing the aforesaid documents, the authorities of KEM. Hospital shall immediately admit the petitioner and shall make immediate arrangements to enable her to undergo medical termination of pregnancy;

    6. We may make it clear that, medical termination of pregnancy is subject to observations made in this judgment;

7. Rule is made absolute in above terms.
8. The Dean and other authorities of the KEM. Hospital shall act on authenticated copy of operative part of this order.
9. Though the petition is disposed off, the same shall be listed on 11th December, 2018 at 11.00 a.m. under the caption of “for reporting compliance”.

(SANDEEP K.SHINDE, J) **(A.S. OKA,J)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
ORDINARY ORIGINAL CIVIL JURISDICTION

WRIT PETITION NO. 3393 OF 2018

Leila Amit Parmar ... Petitioner.

V/s.

Union of India and others. ... Respondents

Ms. Aditi Saxena for the petitioner.

Ms. Poornima Awasthi for respondent No. 1 UOI.

Ms. P.H. Kantharia, GP with Ms. Deepali Patankar, Assistant to GP for the respondent State

CORAM : A.S.OKA & SANDEEP K. SHINDE, JJ.

DATE : 13th December 2018.

P.C.:

Heard the learned counsel appearing for the petitioner. The petitioner is seeking relief of undergoing medical termination of pregnancy. The report of the Medical Board dated 22nd November 2018 records that the petitioner was in 28th week of pregnancy. Paragraphs1to 5 of the order dated 5th December 2018 read thus:

> " In terms of the order dated 16th November, 2018, a Medical Board was constituted by the Dean of Sir JJ Group of Hospitals, Mumbai. Opinion of the Medical Board was

submitted on 22nd November, 2018. 2 The Petitioner is seeking a direction to permit her to undergo medical termination of the pregnancy by relying upon the provisions of Section 5 read with Section 3 of the Medical Termination of Pregnancy Act, 1971 (for short 'the said Act') as interpreted by the Division Bench of this Court in Writ Petition Stamp No. 36727 of 2017 in the case of Shaikh Ayesha Khatoon v. Union of India and two others. Subsection (2) of Section 3 of the said Act reads thus:

"3. When pregnancies may be terminated by registered medical practitioners

(1) xxxx

(2) Subject to the provisions of subsection (4), a pregnancy may be terminated by a registered medical practitioner,

(a) xxx

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion formed in good faith, that

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped."

(emphasis added)

Section 5 of the said Act reads thus:

"5. Sections 3 and 4 when not to apply. (1) provisions of section 4, and so much of the provisions of subsection (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman."

3. The Division Bench held that grounds incorporated in Sub clauses (i) and (ii) of Clause (b) of Subsection (2) of Section 3 will have to be read into Section 5. From the opinion of the Medical Board, it appears that subclause (ii) of clause (b) of subsection (2) of Section 3 cannot be applied. The submission of the learned counsel appearing for the Petitioner is that continuance of pregnancy would involve a risk of causing grave injury to the mental

health of the Petitioner. The submission was that the Medical Board has not given any opinion on this aspect. On the basis of the said statement, assessment of the Petitioner was made by three experts in mental health attached to the same hospital. There are two reports placed on record by the said three experts. The first is 30th November, 2018 and the second is dated 5th December, 2018. It appears to us that both the reports do not contain a categorical opinion about the applicability of Subclause (i) of Clause (b) of Sub- section (2) of Section 3 to the present case in the context of the contention of the learned counsel appearing for the Petitioner that the continuance of pregnancy would involve a risk of causing a grave injury to her mental health.

4. We request the Dean of Sir JJ Group of Hospitals to constitute a Medical Board for giving opinion on the aspect. It will be appropriate if the experts in the field of mental health/paediatritian are a part of the Medical Board. The Dean is free to include such other experts as he may deem fit in the Medical Board.

5. The Petitioner will report to the Office of the Dean of Sir JJ Group of Hospital on Friday, 7th December, 2018 at 11.00 a.m. We request the Dean to submit a report by 11thDecember, 2019. Place the petition on 11th December, 2018 at 3 p.m."

(Underline added)

On 11th December 2018 and 12th December 2018, the learned counsel appearing for the petitioner stated that the petitioner is not willing to appear in the office of the Dean, Sir J.J. Group of Hospitals in terms of

2. The submission of the learned counsel appearing for the petitioner is that two reports which are already on record clearly show that the contingency in subclause (i) of clause (b) of sub-section (2) of section 3 of the Medical Termination of Pregnancy Act, 1971 (for short "the said Act") is established in as much as the contention of the petitioner is that continuance of pregnancy will involve a risk of causing grave injury to her mental health. In fact, the order dated 5th December 2018 is passed after consideration of two reports and this Bench came to a conclusion which is recorded in paragraph3 of the order dated 5thDecember 2018 about the absence of categorical opinion on the applicability of subclause (i) of clause (b) of sub-section (2) of section 3 of the said Act. That is the reason why we directed constitution of a fresh medical board by the said order. However, the petitioner has not appeared before the said medical board. The order dated 5th December 2018 is not challenged by the petitioner.

3. After having perused the judgment and order dated 19thSeptember 2016 in Suo Motu PIL No.1/2016 (High Court on its Own Motion v. State of Maharashtra), we find that the same does not take a different view than the view taken by the Division Bench in the case of Shaikh Ayesha Khatoon v. Union of India1

4. Considering the reasons recorded in the order dated 5thDecember 2018 and the failure of the petitioner to appear before the 1WP(ST.) No.36727/2017 decided on 9th January 2018medical board ordered to be constituted under the said order, it is not possible for this Court to come to a conclusion that grounds for grant of permission to undergo medical termination of pregnancy in terms of the law laid down in Shaikh Ayesha Khatoon (supra) are established. Therefore, we are unable to grant permission to the petitioner to undergo medical termination of pregnancy.
5. The learned counsel appearing for the petitioner submits that she wants to press the petition as far as prayer (a) is concerned and she wants to add additional prayers considering the fact that larger issue needs to be gone into.
6. Though we are rejecting the prayer for undergoing medical termination of pregnancy, we permit amendment to the petition for incorporating additional grounds, additional prayers and also for annexing additional documents.
7. Amendment shall be carried out within a period of two weeks from the date this order is uploaded. After the amendment is carried out, the petition will have to be placed before the first Court as this a 2018 petition challenging validity of an enactment. Earlier, we had not directed the office to place the petition before the first Court as the prayer clause (a) was not pressed.

(SANDEEP K. SHINDE, J.) (A.S.OKA, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 14494 of 2018

Kiran Kailas Gavhande and Ors .. Petitioners

Versus

Union of India through the Secretary
and Ors. ..Respondents

… Ms. Neha Philip for the petitioners.

Ms. ShilpaKapilforrespondentnos.1and3. Mr. P.G. Sawant AGP for the State.

CORAM: SMT. BHARATI H.DANGRE, JJ.
(Vacation Court)

DATED: 28th DECEMBER, 2018

P.C:

1. In pursuance of the order dated 20th December 2018, the petitioner no.1 was subjected to a medical examination and on 26th December 2018, a report from the B.J. Government Medical College and Sassoon General Hospital, Pune was received. The medical team of experts has opined that the pregnancy be terminated since it poses a risk and if the baby is given birth to, it will require multiple surgeries with high morbidity and mortality rate.

2 .On 26th December 2018, the matter was directed to be placed today so that the intended parents are apprised of the said report and accord their consent. Shri Rajendra Jaywantrao

Pawar¬ the intending father ¬ is present in the Court. He categorically makes a statement that he has gone through the report from the Medical College and Sassoon General Hospital, Pune and in light of the said report, and the opinion of the expert team of doctors is giving consent to the pregnancy of the petitioner no.1 to be terminated.

3 In such circumstances, since the expert team of doctors comprising the Heads of various departments have opined that there are multiple cardiac complication in the baby and that the pregnancy be terminated, this Court grants permission to terminate the pregnancy of the petitioner no.1. The learned AGP, on instructions, makes a statement that the petitioner no.1 can be admitted to the B.J. Government College and Sassoon General Hospital, Pune tomorrow early in the morning and then the team of doctors would immediately commence the process of terminating the pregnancy since continuation of the said pregnancy even by a day would involve high risk to the petitioner no.1.

In such circumstances, the petitioner no.1 is directed to report to the Hospital tomorrow at 8.00 am and direction is issued to the Government Medical College and Sassoon Hospital to proceed with the termination of pregnancy of petitioner by completing the necessary formalities.

With the said direction, writ petition stand disposed of.

(SMT. BHARATI H. DANGRE, J.)

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 14546 OF 2018

Ashwini Suhas Machava …Petitioner

Versus

Union of India and Ors. …Respondents

Ms. Meenaz Kakalia for the Petitioner.

Ms. Shruti Vyas, "B" Panel for R. No. 1 and 3. Mr. B.V. Samant, AGP for R. No. 2.

Ms. Sheetal Mane for BMC.

CORAM: B.P. DHARMADHIKARI &
REVATI MOHITE DERE, JJ.

DATE: JANUARY 03, 2019

P.C.:

1. **Heard respective counsel for the parties. Perused the orders of this court dated 20/12/2018 and 01/01/2019.**
2. The report of the Committee received in a sealed envelope was made available for perusal of the respective counsel. The same is taken on record as Exh."X".
3. Petitioner adult seeks leave to terminate because of the alleged abnormality in the foetus. The opinion of the experts is as under:

"AFTER CAREFUL EXAMINATION OF PATIENT AND STUDY OF THE ULTRASONOGRAPHY REPORTS, COMMITTEE FEELS THAT THE FETUS HAS CLEFT LIP AND CLEFT PALATAE AND ALSO ABNORMAL MOSAIC LOSS OR CHR 4 LOSS AND Y CHROMOSOME.

THIS CONDITION IS COMPATIBLE WITH LIFE AND BABY BORN AFTER THE BIRTH CAN BE NORMAL AND CLEFT LIP AND PALATE CAN BE SURGICALLY CORRECTED.

THE CONDITION OF THE FETUS DOES NOT FULFILLS THE CRITERIA OF "SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP" WITH THE POSSIBILITY OF DEVELOPMENTAL DELAY AND INTELLECTUAL ABNORMALITY.

SINCE THE PREGNANCY IS ADVANCED TO 24 WEEKS WELL BEYOND THE LEGAL LIMITS OF TERMINATION OF PREGNANCY, THE COMMITTEE LEAVE IT TO THE DISCRETION OF HONOURABLE HIGH COURTFOR PERMISSION OF TERMINATION OF PREGNANCY.

Sd/¬
Dr. Ashok Anand
Professor & Head
Dept. of OBGY,
CGMC, Mumbai
Chairman

Sd/¬
Dr. V.P. Kale
Professor & Head
Dept of Psychiatry
CGMC, Mumbai
Member

Sd/¬
Dr. Dhilpa Domkundwar
Professor & Head
Dept of Radiology,
CGMC, Mumbai
Member

Sd/¬
Dr. N.O. Bansal
Professor & HOD
Dept of Cardiology
CGMC, Mumbai
Member

Sd/¬
Dr. Kamlesh Jagiasi
Asso.Professor & Head,
Dept. of Neurology
CGMC, Mumbai
Member

Sd/¬
Dr. Bela Varma,
Professor & Head
Dept. of Paediatrics
CGMC, Mumbai
Member

Sd/¬
Dr. D.R. Kulkarni,
Professor & Head
Dept. of Paediatrics
Surgery
CGMC, Mumbai
Member

4. In view of the findings of the Experts that the condition is compatible with life and baby born can be normal human being and the cleft lip and cleft palate can be treated surgically, we are not inclined to grant the permission. Petition is rejected.

(REVATI MOHITEDERE, J.) **(B.P. DHARMADHIKARI, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION (L) NO. 36895 OF 2018

"X" ,age 14, since minor, through

her mother and natural legal guardian

Manisha Hadale ...Petitioner

Versus

Union of India and Ors. ...Respondents

Ms. Meenaz Kakalia for the petitioner.

Mrs. Shruti Vyas "B" Panel counsel for respondent no. 2. Ms. Pournima Awasthi for R. nos. 1 and 3.

Ms. Sheetal Mane for respondent BMC.

CORAM: B.P. DHARMADHIKAKRI & REVATI MOHITE DERE, JJ.

DATE: JANUARY 03, 2019

P.C.:

1. Petitioner a minor victim of sexual abuse, is before this court through her mother seeking leave to terminate the pregnancy. This court has on 28/12/2018 received report from the JJ Hospital Mumbai in a sealed envelope. Report is taken on record as Exh. X. Respective counsel for the parties were permitted to go through the same.
2. The Experts have given their separate findings and jointly advised for termination of the

pregnancy which is about 24 weeks old. They have also pointed out that the termination carries risk as to the pregnant minor girl.

3. Counsel for the petitioner upon instructions states that the minor and her natural guardian (mother) are ready and willing to undergo the operation.

4. As such pregnancy itself is presumed to constitute grave injury to mental health, in these circumstances, we grant permission as requested.

5. Petitioner shall report at JJ Hospital by 5th January, 2019 where necessary procedure shall be carried out at the earliest.

6. Parties to act on authenticated copy of this order.

(REVATI MOHITEDERE, J.) **(B.P. DHARMADHIKARI, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 277 OF 2019

Afsana Anwar Khan ...Petitioner

Versus

Union of India, through

The Secretary, Ministry of Law & Justice

& Ors Respondents

Ms. Afreen Khan for the Petitioner

Ms. Anusha Amin for the Respondent Nos. 1 and 3 Ms. S. D. Vyas, `B' Panel for the Respondent-State

CORAM : B. P. DHARMADHIKARI & REVATI MOHITE DERE, JJ.

DATE: WEDNESDAY, 16th JANUARY 2019

P.C. :

1. In terms of order dated 9th January 2019, the Expert Committee has forwarded its opinion dated 15th January 2019 to this Court in sealed envelope.
2. We opened the envelope. We find that the fetus suffer from serious neurological abnormality and fulfills criteria of "substantial risk of serious physical handicap". Expert Committee has concluded that fetus will not survive after delivery.

3. Committee mentions that this position was pointed out to petitioner and she had volunteered for termination of pregnancy. The Committee states that if Court permits, pregnancy can be terminated.
4. The Committee has also informed Court that if the child is born alive, parents must undertake to bear responsibility and required neon-natal management.
5. The counsel for petitioner, upon instructions, states that if in the procedure for termination of pregnancy, child is born alive, petitioner/parents shall look after him and attempt to make necessary arrangements. She also adds that petitioner is hardly 19 years old and comes from a poor family.
6. Considering the totality of facts, accepting the undertaking as given, we permit petitioner to proceed for termination of pregnancy. Petition is disposed of accordingly.
7. Petitioner to report at J. J. Hospital, Mumbai on 18thJanuary 2019 by 12:00 p.m., where the procedure shall be carried out at the earliest.

REVATI MOHITEDERE, J B. P. DHARMADHIKARI, J.

WRIIININ THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

CIVIL WRIT PETITION NO. 358 OF 2019

Aisha Khatoon Irfan Khan ...Petitioner

Versus

Union of India and Ors. Respondents

Ms. Afreen Khan, for the Petitioner.

Ms. Purnima Awasthi, for the Respondent Nos.1 and 3. Ms. S.D. Vyas, 'B' Panel, for the Respondent – State.

CORAM : B.P. DHARMADHIKARI &

REVATI MOHITE DERE, JJ.

DATE: 18th JANUARY, 2019

P.C. :

1. The Report of Expert Committee is made available in a sealed envelope by the learned counsel for the Respondent – State. We had called for that report, as per order dated 11th January, 2019. The report shows that fetus of a female about 23 weeks old has got serious neurological abnormality in the form of Acrania – Anencephaly, Neural Tube Defects, and experts state that it fulfills the criteria of 'Substantial Risk of Serious Physical Handicap'. They have also mentioned that fetus will not survive after delivery. They have, therefore, permitted termination

of pregnancy, if this Court, so orders and clarify that it can be performed in any Tertiary Care Hospital.

2. The Petitioner informs through her Advocate that she wants to undergo the said procedure at K.E.M Hospital, Mumbai.

3. In view of these developments, we permit the Petitioner to terminate the pregnancy at K.E.M Hospital, Mumbai. She shall report there by 20th January, 2019, at 12.00 noon and the Doctor shall complete the necessary procedure, at the earliest there after.

4. Writ Petition is accordingly disposed of.

5. All concerned to act on the authenticated copy of this order.

REVATI MOHITEDERE, J. **B.P. DHARMADHIKARI, J.**

IN THE HIGH COURT OF JUDICATURE ATBOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO.882 OF 2019

Nirmadevi Narayan ...Petitioner

vs.

Union of India through the Secretary,
Ministry of Law and Justice and Ors. Respondents

Ms. Bhavana Mhatre for the Petitioner.

Mr. M. C. Walimbe, AGP for the RespondentState.

CORAM : B. P. DHARMADHIKARI & REVATI MOHITE DERE, JJ.

DATE: 29/01/2019.

P.C.:

1. Not on board. Taken on board.
2. The petitioner an adult married woman seeks leave to terminate pregnancy on the ground of abnormalities in the fetus in view of pleadings in paragraph No.4.
3. On 22/1/2019 we sought opinion of Expert Committee of B.J. Medical College, Pune. Report of that Committee is made available for our perusal today in a sealed envelope. Report shows conclusion that the petitioner 26 years old is having pregnancy of 22 weeks and foetus has fatal

cardiac abnormalities. If pregnancy is continued, it will have high morbidity and mortality and therefore the petitioner is advised termination thereof at this gestational age.

4. We therefore find that report of medical expert shows that the child cannot born alive and in any case will suffer from said physical or mental abnormalities as to seriously handicap the said child. It thereby satisfies the ingredients of section 3(2) (b)(ii) of the Medical Termination of Pregnancy Act, 1971. The provisions of section 5 of the said Act are also satisfied in the present matter. We therefore grant necessary permission to the petitioner.

5. Petitioner shall report B. J. Medical College and Sassoon General Hospital, Pune by 12.00 noon on 31/1/2019. Necessary procedure shall be performed by the Doctors at the earliest. Parties to act upon authenticated copy of this order.

(REVATIMOHITEDERE, J.) **(B. P. DHARMADHIKARI, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 1121 OF 2019

Ashwini Vishal Pimple … Petitioner

V/s.

Union of India & Ors. … Respondents

Ms. Neha Philip for the Petitioner.

Ms. Anusha Amin for the Respondent Nos. 1 & 3.

Mr. B.V. Samant, AGP for respondent/State.

CORAM : B.P. DHARMADHIKARI, &
REVATI MOHITE DERE, JJ.

DATE : 31st JANUARY, 2019

P.C.:

1. On 25.01.2019 this Court placed the matter before Experts Committee of B.J. Government Medical College, Pune. Today, copy of report dated 28.01.2019 submitted by Experts is produced in sealed label envelope for our perusal.
2. The Committee of Experts has opined as under: "The Committee examined the girl AVP [2565 of 2019] on 28/01/2019 and necessary investigations were done. Clinical examination and investigations reveals that the pregnancy is 22 weeks and baby has serious neurological

anomaly. Also if pregnancy is continued the baby will have high morbidity and mortality. The Committee feels that the pregnancy can be terminated at this gestational age with kind permission of Hon High Court."

3. In view of this report, accepting the recommendations of the Committee and request of Petitioner, we permit pregnancy to be terminated.

4. Petitioner to report at B.J. Medical College and Sassoon Hospital, Pune on 02.02.2019 by 12.00 noon, Doctors there shall carry out necessary procedure at the earliest.

(REVATI MOHITE DERE, J.) **(B.P.DHARMADHIKARI, J.)**

INTHEHIGHCOURTOFJUDICATUREATBOMBAY
CIVIL APPELLATEJURISDICTION

WRIT PETITION NO.1447OF 2019

Zarka Khan …Petitioner

V/s.

Union of India and Ors. …Respondents

Ms. Neha Philip for the Petitioner.

Ms. Anamika Malhotra for Respondent Nos. 1 and 3. Mr. N.C. Halimbe, AGP for the Respondent.

CORAM : B.P. DHARMADHIKARI, &

REVATI MOHITE DERE, JJ.

DATE: 06th FEBRUARY, 2019

P.C.:

1. Heard respective Counsel. Perused report received from Sir J.J. Hospital along with forwarded letter dated 06.02.2019.

2. Envelop containing the forwarding letter and Report has opened in the Court. Perusal of report shows that eight experts have examined Petitioner and fetus. They have found that fetus suffers very serious neurological and other abnormalities in the form of Acrania, Kyphoscoliosis, Omphaloceole and Congenital Diaphragmatic Hernia. The Experts therefore, certified that condition of fetus fulfills the criteria of **"Substantial risk of serious physical Handicap".**

They have taken note of fact that pregnancy has advanced to 26 weeks and hence, permission of Court is necessary.

Petitioner before committee had reiterated her desire to terminate it. Even today, learned Counsel for Petitioner communicates the same desire.

3. In this situation, accepting the report, we permit Petitioner to terminate the pregnancy. She shall report at Sir J.J. Hospital by 12.00 noon on 08.02.2019 where necessary procedure shall be undertaken at the earliest.

4. Parties to act upon an authenticated copy of this order.

(REVATI, J.MOHITEDERE, J.) **(B.P.DHARMADHIKARI,J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 2325 OF 2019

Aditi Sharma ...Petitioner

Versus

Union of India,

through the Secretary,

Ministry of Law & Justice & Ors. ... Respondents

Ms. Afreen Khan for the Petitioner

Ms. Purnima Awasthi for the Respondent Nos. 1 & 3

Mr. N. C. Walimbe, A.G.P for the Respondent No.2-State

CORAM : B. P. DHARMADHIKARI &

REVATI MOHITE DERE, JJ.

DATE: THURSDAY. 28 th FEBRUARY 2019

P.C. :

1. In furtherance of orders of this Court dated 20th February 2019, the J.J. Hospital, Mumbai has forwarded the report of experts to the office of Government Pleader. Copy of this report along with forwarding letter is taken on record as Exhibit `A'.
2. Committee has opined that the fetus suffers from serious neurological and other abnormalities

and after technically describing the same, point out that it fulfills criteria of "substantial risk of serious physical handicap".

3. Committee has, therefore, advised termination with the permission of this Court. Petitioner is seeking that leave only as pregnancy has advanced to 23 weeks.\
4. In this situation, we grant leave as prayed for.
5. Petitioner to report to Cloudnine Hospital, Siddhachal Arcade, CTS No. 1084C and 1186A, New Link Road, Malad (West),on 2nd March 2019 by 12 O'clock in the afternoon, where necessary procedures shall be performed at the earliest.
6. Petition disposed of.
7. All concerned to act on the authenticated copy of this order.

REVATI MOHITE DERE, J. B. P. DHARMADHIKARI, J.

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 2279 OF 2019

Pranita Jaykisan Pardhi ...Petitioner

vs.

Union of India through Secretary Ministry
of Law and Justice and Ors. Respondents

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Ms. Afreen Khan a/w Ms.Meenaz Kakalia and Ms. Neha Philip for the Petitioner.

Mr. B. V. Samant, AGP for the Respondent/State. Ms. Nisha Valani for Union of India.

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CORAM : B. P. DHARMADHIKARI &
REVATI MOHITE DERE, JJ.

DATE: 01/03/2019.

P.C.:

1. On 20/2/2019 we referred the case of petitioner to Expert Committee of JJ hospital, Mumbai to find out feasibility of termination of pregnancy which then was about 23 weeks old. Experts Committee sought one extension to submit report and the report was then submitted on 27/2/2019.

2. The Committee consists of 8 doctors whose designations are as under:

"1. Dr. Ashok Anand, Professor and Head Dept of Obstetric and Gynecology, Grant Government Medical College and Sir J.J. Group of Hospital, Mumbai.

2. Dr. V.P. Kale, Professor and Head, Department of Psychiatry, Sir J.J. Group of Hospitals, Mumbai

3. Dr. Shilpa Domkundwar, Professor and Head, Department of Radiology, Sir J.J. Group of Hospitals, Mumbai

4. Dr. N. O. Bansal, Professor and Head, Department of Cardiology, Sir J.J. Group of Hospitals, Mumbai.

5. Dr. Nita Sutay, Professor and Head, Department of Paediatrics, Sir J.J. Group of Hospitals, Mumbai.

6. Dr. D. R. Kulkarni, Professor and Head, Department of Paediatric surgery, Sir J.J. Group of Hospitals, Mumbai

7. Dr. K.N. Bhosle, Professor and Head, Department of C.V.T. S., Sir J.J. Group of Hospitals, Mumbai

8. Dr. Kamlesh Jagaisi, Associate Professor and Head, Department of Neurology, Sir J.J. Group of Hospitals, Mumbai"

3. The opinion of the Committee is as under:

> *"Upon examination and after careful study of multiple sonography reports, it is confirmed that the fetus suffers from interaparenchy malcalcifications in liver predominantly in the sub diaphragmatic region with dilated suprahepaticivc and intraabdominal unbilical vein with congenital absent/hyoplastic portal vein.*
>
> *The condition of the fetus does not fulfil the criteria of "substantial risk" to the fetus.*
>
> *The woman as been explained about the outcome in the language she understands.*
>
> *Since the pregnancy is advanced to28 weeks of gestation and baby weight is also more than 900 gms it will be advisable to continue pregnancy as the child born will be alive and can survive post natal period with morbidity and occasional mortality"*

4. Looking to the controversy a copy of report was made available to the learned counsel for petitioner and the matter was adjourned to today.

5. Today, learned counsel for the petitioner has attempted to advance the case of the petitioner by urging that report of Experts Committee does not contain any evaluation on mental health

of petitioner as required by section 3 (2) (b) (i) of the Medical Termination of Pregnancy Act, 1971. Support is being taken from Division Bench order of this Court dated 5/12/2018 in Writ Petition (L) No.3878/2018 where the Division Bench found that the said clauses (b) (c) and sub clauses (i) (ii) of sub¬ section (2) of section (3) should be read into section5.

6. Our attention is invited to the judgment of Division Bench of High Court of Calcutta dated 18/2/2019 to demonstrate that there in similar situation permission has been granted.

7. Learned AGP relies upon the Expert's report to urge that joint findings of all eight Doctors show that there cannot be any termination of pregnancy as such and exercise would result in the child being born alive. He pointed out that even said child born alive is expected by Experts to survive the post natal period but with morbidity and occasional mortality.

8. The report presented by 8 Doctors forming Experts Committee at Sir J.J. Group of hospital shows that the Professor and Head Department of Psychiatry has recorded his impression that there was no active psychopathology seen in past or then at the time when the petitioner was examined. He concluded that she was mentally sound and fit to undergo the procedure from Psychiatric point of view.

9. The opinion of the Expert Committee together after joint deliberations shows that the condition of fetus does not fulfill the norm of “substantial risk” to the fetus. Not only this after mentioning that pregnancy has advanced to 28 weeks with baby weighing more than 900 gms, the experts have advised to continue it. The reason given by them is the child would be alive and can survive.

10. In the facts before the Division Bench of this Court, in the order dated 5/12/2018 observations in paragraph No.3 shows that there were two reports placed on record by three experts. First report was dated 30/11/2018 while the latter one dated 5/12/2018. Division Bench found that there was no categorical opinion about applicability of sub clause (i) of clause (b) of sub¬section (2) of section3.Thus, Division Bench then found that there was no consideration whether continuation of pregnancy would involve a risk of causing grave injury to mother's mental health. The matter was therefore sent back to Experts and fresh report was sought. It is pertinent to note here that the very same hospital was involved in said matter.

11. Insofar as the case before the Division Bench of Calcutta High Court is concerned, the mother there was examined and all Doctors then suggested that she should terminate pregnancy. At that time pregnancy had crossed 20 weeks. Hence permission of High Court was sought. It appears that the report of medical board placed before learned single judge revealed that baby was likely to be born alive and with available postnatal care, likely to survive the early postnatal period. Report also reveals finding that prognosis of baby would be better if it be delivered near term. Learned Single Judge therefore did not permit termination of pregnancy.

12. The matter was taken before the Division Bench. The Division Bench has looked into the report of medical board minutely particularly in paragraph Nos.6 and 7 thereof. It found that baby to be born was to suffer from down syndrome, gastrointestinal malformation (esophageal artesia with or without trachea¬ esophageal fistula) cardiac abnormality and required surgical intervention, prolonged and complicated neonatal course, the outcome of which was unpredictable. In paragraph 19 the Division Bench also found that fetus in the matter before it can neither evolve or develop further naturally to reverse the abnormalities already detected by medical science and produce a quality life once the child is born. Thus, in this backdrop the Division Bench reversed the findings of learned Single Judge and granted the permission.

13. As we have already noted supra the Doctors here have clearly opined that premature termination will result in a live birth and the child can survive postnatal period with morbidity and occasional mortality. Thus they have not advised pre¬mature termination. They have advised continuation of pregnancy. It is apparent that in this situation continuation of pregnancy will help the fetus/baby.

14. In the light of the opinion of the experts which we do not find vitiated on any count, we find that request made by the petitioner/mother can not be allowed. Accordingly the petition is rejected. No costs

(REVATIMOHITEDERE, J.) **(B. P. DHARMADHIKARI, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 2420 OF 2019

Rupali Shivaji Yalamar Patil …Petitioner

Versus

Union of India and Ors. …Respondents

Adv Afreen Khan for the petitioner.

Mr. N.C. Walimbe, AGP for the State.

Ms. Anusha Amin for respondent nos. 1 and 3.

CORAM: B.P. DHARMADHIKARI & REVATI MOHITE DERE, JJ.

DATE: MARCH 05, 2019

P.C.:

1. As per order dated 22/2/2019 the Experts Committee at JJ Hospital Mumbai has forwarded its report today in a sealed envelope. We have opened the envelope.
2. The Experts have find serious neurological abnormality in the form of flattening of vertebral bodies? Planty spondyly. They have also certified that the condition of the fetus fulfills the criteria of "substantial risk of serious high chances of morquio a syndrome in child and physical handicap"

3. The Experts therefore, have given no objection for termination of pregnancy. However, as the pregnancy is 23 weeks old, petitioner has been advised to obtain orders from this Court.

4. The Expert report shows that anomalies are associated with :

   * Growth Retardation.
   * Spinal Deformity.
   * Abnormal Heart Development
   * Bones and Joints abnormalities.
   * Early Death.

5. In this situation, we grant permission as sought for by the petitioner. Petitioner to report at JJ Hospital at 12.00 noon on 07/03/2019 where necessary formalities shall be completed at the earliest.

(REVATI MOHITEDERE, J.) **(B.P. DHARMADHIKARI, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION

WRIT PETITION NO. 3104 OF 2019

Shanta Yogesh Jadhav

Age: 21 years

202 Near Jilha Parishad School

Nagale, Vasai East, Kaman

Palghar, Maharashtra401208..Petitioner

Versus

1. Union of India through
   the Secretary,
   Ministry of Law and Justice,
   Shastri Bhawan, "C" Wing,
   New Delhi 110 001.
2. State of Maharashtra
   Through the Principal Secretary,
   Public Health Services, Mantralaya,
   Mumbai 23.
3. Ministry of Health and
   Family Welfare, through its Secretary,
   M.H. Division, New Delhi.
4. Municipal Corporation of

Greater Mumbai
Head Quarters, C.S.T.,
Mumbai – 400001..Respondents

Ms. Afreen Khan for the Petitioner.
Ms. Anusha Amin for Respondent Nos. 1 & 3.
Ms. M.P. Thakur, Assistant Government Pleader,

for Respondent No.2.
Ms. Shital Mane for Respondent No.4.

CORAM: S.C. DHARMADHIKARI &
B.P. COLABAWALLA, JJ.
DATE: MARCH 18, 2019

ORAL JUDGMENT (Per Shri S.C. DHARMADHIKARI, J.):

1. Rule. The respondents waive service. By consent, Rule is made returnable forthwith and the petition is taken up for final disposal. Heard.
2. The petitioner has approached this Court urging that, in her case a Medical Committee should be constituted for her examination to assist this Court for arriving at a decision and then allow the petitioner to undergo medical termination of pregnancy at the medical facility of her choice.
3. The prayer clauses (c) and (d) are pressed and they read asunder:

"c For a writ of mandamus or any other writ, order, or direction in the nature of mandamus directing the Respondents to

i. constitute a Medical Committee for the examination of the Petitioner to assist this Hon'ble court in arriving at a decision on the plea of the Petitioner;

ii. allow the Petitioner to undergo Medical Termination of Pregnancy at a medical facility of her choice.

d.For a writ of mandamus or any other writ, order or direction in the nature of mandamus directing the Respondents to setup appropriate Medical Committees in each district in the State of Maharashtra to assess the pregnancy and offer MTP to the Petitioner and other women in need of the procedure beyond the prescribed 20 weeks limit."

4. We are not going into the larger question for the simple reason that the petitioner, aged 21 years, is a resident of Palghar, and on 2822019, during the 2/3rd Trimester Scan Report, it was detected for the first time that the foetus of the petitioner, with a gestational age corresponding to 22 weeks 1day, suffers from Ventriculomegaly. Reliance is placed in that behalf on ExhibitB to the writ petition, which is are port of such Scan.

5. In the light of the diagnosis, the petitioner was admitted to Nowrosjee Wadia Maternity Hospital on 432019 and underwent further tests which confirms that the foetus suffers as above.

6. Reliance is placed on ExhibitC and thereafter the petitioner was advised to go ahead for termination of this pregnancy. However, the law came in her way.

7. Our attention is invited to several orders which enable the Court to issue a declaration or a direction overriding the statutory prescription in order to save the life of the mother in the event the foetus suffers as above. Now the statutory prescription of 20 weeks can be overcome by approaching this Court.

8. Thereafter, this Court directs constitution of a Medical Committee, which was the prayer on the earlier occasion.

9. On that day (1232019), on hearing both the petitioner, the learned AGP and the Advocate for the Municipal Corporation of Greater Mumbai, we passed the following order:

"1.It is stated that the petitioner will visitthe J.J. Hospital tomorrow(1332019at11:30a.m.) and present herself before the Superintendent/Dean of the Sir J.J .Group of Hospitals and thereafter the procedure under the Act, namely, The Medical Termination of Pregnancy Act,1971 shall be complied with. Meaning thereby ,a Medical Board would be constituted so that the petitioner can be examined and all the tests conducted so as to certify as to whether the foetus is indeed suffering from an illness which the petitioner claims to be fatal and on that basis can permission be granted to the petitioner to terminate the pregnancy which is beyond 20 weeks.

2. Let the matter be placed on 1832019. First on board.

3. All concerned to act upon an authenticated copy of this order."

10. The matter was placed today and a Report of the Committee has been received which Report contains detailed observations of the individual doctors, their opinions and thereafter the

Committee's opinion. The Committee's opinion reads asunder:

"UPON EXAMINATION & AFTER CAREFUL STUDY OF MULTIPLE SONOGRAPHY REPORTS, IT IS CONFIRMED THAT THE FETUS SUFFERS FROM SERIOUS NEUROLOGICAL ABNORMALITY IN THE FORM OF ***ARNOLD CHIARI MALFORMATION TYPE 2.***

THE CONDITION OF THE FETUS FULFILS THE CRITERIA OF "SUBSTANTIAL RISK OF SERIOUS PHYSICAL HANDICAP".

THE WOMAN HAS BEEN EXPLAINED ABOUT THE OUTCOME IN THE LANGUAGE SHE UNDERSTANDS.

THE PREGNANT WOMAN HAS VOLUNTARILY EXPRESSED HER DESIRE TO TERMINATE THE PREGNANCY AND IS WELL INFORMED ABOUT THE NATURE OF THE CONDITION OF FETUS AND ITS OUTCOME. SHE IS ANGUISHED WITH THE CONDITION OF THE FETUS IN UTERO. HENCE IT IS ADVISABLE TO TERMINATE THEPREGNANCY.

THE PREGNANCY HAS ADVANCED TO 22 WEEKS AND IS BEYOND 20 WEEKS CUT OFF OF THE MEDICAL TERMINATION OF PREGNANCY ACT. HENCE SHE HAS APPROACHED HONOURABLE COURT FOR TERMINATION OFPREGNANCY.

THUS IF THE COURT PERMITS THE PREGNANCY CAN BE TERMINATED IN ANY TERTIARY HOSPITAL, AS DESIRED BY THE WOMAN. THE HON. HIGH COURT IS HOWEVER, REQUESTED TO INSTRUCT THE PARENTS TO BEAR RESPONSIBILITY OF THE CHILD AND THE REQUIRED NEONATAL MANAGEMENT IF BORNALIVE."

11. Based on that, the request is that the direction, as prayed, be issued to enable the petitioner to terminate the pregnancy.

12. Having perused this Report, the writ petition and all the annexures thereto, we brought to the notice of the petitioner's Advocate the opinion of the Committee. The experts feel that despite going for such a termination, it could be that in that process the foetus may be alive. In the event the foetus is alive and has a serious Neurological Abnormality, then the question that arises is, who will take the consequences and the responsibility of its survival.

13. The matter was called out today and kept back in order to enable the petitioner's Advocate to peruse this opinion carefully and thereafter to speak to the petitioner.

14. After speaking to the petitioner and taking her consent, the Advocate informs the Court that

the petitioner will take the responsibility in the event, as opined by the Committee, the foetus is alive. Then, she will also take all the necessary consequences as well.

15. We have brought to her attention that it is not just the law which the petitioner has invoked but there are other laws which would make such an act and as performed on the petitioner an offence and committed by somebody else along with her. That somebody else may not be necessarily acting at her be hest or on her advice but purely on the directions of this Court. Everybody including those issuing such directions and those implementing and abiding by them should not be exposed to unnecessary litigation much less prosecution, is our anxiety.

16. Having brought all this to the petitioner's notice through her Advocate and the petitioner saying that she has understood and considered every single aspect and is ready to take the consequences, that we make the Rule absolute in terms of prayer clauses (c) and (d). There shall be no order as to costs.

17. The petitioner has instructed her Advocate to make a request that when the procedure shall be undergone by her and it is her desire that it shall be carried out at the King Edward Memorial (KEM) Hospital of the Municipal Corporation of Greater Mumbai, at Mumbai. Let that be carried out and let the Advocate appearing for the Mumbai Municipal Corporation inform the Dean of that hospital to assist the petitioner by taking care of her as also enable her to undergo this process and procedure at the said hospital.

18. The petition stands disposed of in the above terms.

(B.P.COLABAWALLA, J.) **(S.C.DHARMADHIKARI, J.)**

IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATEJURISDICTION

WRIT PETITION NO. 3694 OF2019

Ms. Yashika Balkrishna Berde …Petitioner

Vs

Union of India through the Secretary
And Ors. …Respondents

Ms. Neha Philip for the Petitioner.

Ms. Anusha P. Amin for Respondent Nos.1 and 3.

Mrs. M.P. Thakur, AGP for State.

CORAM : S. C. DHARMADHIKARI &
B.P.COLABAWALLA, JJ.

DATE: MARCH 27,2019

P.C.:

1. The petitioner before us has filed this petition seeking a direction to allow her to terminate the pregnancy through the mechanism under the Medical Termination of Pregnancy Act, 1971.
2. It is claimed that Section 3 of this Act allows termination of pregnancy by registered medical practitioners even if the length thereof exceeds 20 weeks.

3. Presently the petitioner is in the 22nd week of her pregnancy and she says that the medical opinion is that the continuance of pregnancy would involve grave injury to the mental health of the petitioner..

4. The projection before us that the mental condition of the petitioner is not such as would enable her to continue with the pregnancy. Her mental health is not good and opinion of the private medical practitioner is relied upon in that behalf.

5. In the morning session, we indicated to the petitioner's advocate that given the nature of the opinion of the private medical practitioner, it cannot be said that her mental health is such that continuance of pregnancy would involve a risk to her mental condition. That is not a conclusive opinion. Yet, the petitioner's advocate, on instructions, maintains that the petitioner is not in a position to continue with the pregnancy as she would be required to be under medication throughout and it would also have some ill effect.

6. In the circumstances, strictly to examine her mental health, the request is to constitute a Medical Board.

7. In the above facts and circumstances and peculiar to this petitioner, we request the Dean, Sir J.J. Group of Hospitals, Mumbai to constitute a Medical Board so as to examine the petitioner with regard to her mental health and submit are port to this Court.

8. The learned AGP Mrs. Thakur says that she will communicate this order to the Superintendent/ Dean of the above hospital and ensure that report with regard to the mental health of the petitioner will be forwarded to this Court on next date.

9. We post this petitionon 1st April, 2019.

(B.P.COLABAWALLA, J.) **(S.C.DHARMADHIKARI, J.)**

HIGH COURT OF CHHATTISGARH, BILASPUR

Order Sheet

WPC No. 976 of 2016

Amita Kujur Versus State Of Chhattisgarh

13/04/2016

Ms. Rajni Soren, counsel for the petitioner. Mr. Ramakant Mishra, Dy. A.G. for the State. Heard.

The petitioner is a rape victim. She has lodged an FIR in P.S. Bagicha, District Jashpur (C.G.) on 21.03.2016 that she was subjected to rape between the period from 07.03.2015 to 13.03.2016. In view of facts disclosed, report was sent to P.S. Kansabel. It is stated in the petition that P.S. Kansabel has registered an offence against the accused alleging commission of offence under Section 376 IPC. The petitioner was subjected to Medical Legal Examination by Government Doctor in Government Hospital at Jashpur.

The petitioner has stated on affidavit in the petition that despite repeated representation and request made, she has not been taken to the hospital at Bilaspur for termination of pregnancy, despite willingness, as per the provision contained in Section 3 of the Medical Termination of Pregnancy Act, 1971 (for short "the Act of 1971").

Learned counsel for the petitioner submits that as in the Government Hospital at Jashpur, pregnancy could not be terminated, for want of expert doctors, request was made to the Station House Officer to take the petitioner to Chhattisgarh Institute of Medical Sciences at Bilaspur where experts are available but she was advised to proceed of her own. The petitioner contacted the doctors in Gynecology Department of Chhattisgarh

Institute of Medical Sciences at Bilaspur on 12.04.2016 but the doctors expressed their inability on the ground that unless copy of FIR, MLC report and referral order of Jashpur Government Hospital presented, no further steps can be taken.

Learned counsel for the petitioner submits that according to the MLC report prepared by Government doctor at Jashpur, the period of 20 weeks, beyond which ordinarily the Act does not permit termination of pregnancy is expiring in couple of days. Therefore, a prayer has been made for emergent orders in the matter. It is submitted that if the petitioner is not subjected to medical examination today itself, serious complication may arise and the petition, itself, may be rendered fruitless.

The petitioner states that she is victim of rape and report has also been lodged in the Police Station. I have gone through the report lodged in the Police Station.

Under Section 3 of the Act of 1971, termination of pregnancy is permissible subject to fulfillment of condition and the opinion found by the medical practitioner. However, for the purposes of formation of opinion, medical examination of the petitioner would be necessary by the doctor. As even according to the petitioner, period of pregnancy exceeded 12 weeks, law requires her examination and recording of opinion by atleast two doctors.

If an order is not given to the petitioner today itself, delay in termination of pregnancy may cause grave injury. By virtue of explanation (I) anguish caused by pregnancy in a case of rape victim is presumed to constitute a grave injury to the mental health of the pregnant woman.

In view of the above, a direction is issued to the Deen Chhattisgarh Institute of Medical Sciences Bilaspur to constitute immediately team of two doctors to perform medical examination of the petitioner form an opinion in terms of the provision contained in Section 3 of the Act of 1971 and takes suitable steps on the basis of such an opinion in the matter of termination of pregnancy.

Learned Deputy Advocate General shall directly inform the Dean Chhattisgarh Institute of Medical Sciences Bilaspur through the Collector of the District today itself.

On submission of copy of FIR before the Dean, the team of doctors shall proceed to medically examine the petitioner and such examination shall not be denied on the ground of non-production of referral letter or MLC.

The complete records of the case diary shall be brought by the Station House Officer, Kansabel before the CIMS authority forth with.

Learned State counsel shall inform Superintendent of Police, Jashpur that SHO Kansabel is required to immediately produce the case diary is concerning the case of the petitioner along with MLC report etc. before the CIMS authority at the earliest.

Certified copy to the petitioner today itself as also to the State counsel free of cost for necessary compliance.

List this case on **18.04.2016**.

Sd/-

(Manindra Mohan Shrivastava)

J U D G E

HIGH COURT OF CHHATTISGARH, BILASPUR

WPC No. 976 of 2016

Amita Kujur D/o Ignatius Kujur Aged About 23 Years R/o Badupara Mahadevdad P.S. Bagicha District Jashpur Chhattisgarh ---- Petitioner

Versus

1. State Of Chhattisgarh Through Chief Secretary Mantralaya Naya Raipur Chhattisgarh.
2. Secretary Department Of Home Mantralaya Naya Raipur Chhattisgarh.
3. Secretary Department Of Health Mantralaya Naya Raipur Chhattisgarh
4. Collector Jashpur District Jashpu rChhattisgarh.
5. Superintendent Of Police Jashpur, District Jashpur (Chhattisgarh)
6. Thana In Charge P.S. Kansabel District Jashpur Chhattisgarh.
7. Ashok Pandey Erstwhile Thana In Charge P.S. Kansabel District Jashpur Chhattisgarh.
8. Chief Medical Health Officer District Hospital Jashpur District Jashpur Chhattisgarh.
9. Chhattisgarh Institute Of Medical Sciences Through Its Medical Superintendent C I M S Bilaspur District Bilaspur (Chhattisgarh)

---- Respondents

For Petitioner	:	Ms. Rajni Soren, Advocate
For Respondents-State	:	Shri Ramakant Mishra, Dy. A.G.

S.B.: Hon'ble Shri Justice Manindra Mohan Shrivastava

Order On Board

20/04/2016

1. This petition has been filed by the petitioner, victim of a rape, for a direction to facilitate termination of her pregnancy, which according to her, is the result of commission of offence of rape on her.
2. On a petition filed before this Court by the petitioner, this Court directed medical examination of the petitioner to find out the gestational age. Pursuant to the direction issued by this Court on 13.4.2016, the petitioner was medically examined by a team of doctors. The case was directed to be listed on 18.4.2016. On 18.4.2016, learned counsel for the State made statement before this Court that the petitioner has been examined by a team of doctors. On this disclosure made, the report was directed to be filed on 18.4.2016 itself and the case was directed to be listed today. That is how the matter has come up for consideration before this Court.
3. Learned counsel for the petitioner argues that the petitioner is a tribal girl from Jashpur district who was abducted and taken to Alwar district of Rajasthan, where she was subjected to rape. After she was recovered, an FIR was lodged in Police Station-Bagicha on 21.3.2016, which was transferred to jurisdictional Police Station- Kansabel. A copy of the report has been placed on record as Annexure P-1. The petitioner having come to know that she had conceived as a result of rape, she represented to the Collector, Jashpur on 28.3.2016 to facilitate termination of her unwanted pregnancy. A representation was also made to the Superintendent of Police, Jashpur on 28.3.2016 itself. Those representations have been placed on record as Annexure P-2collectively.

   According to the pleadings, on 28.3.2016 itself, Additional Superintendent of Police & In-charge, Anti Human Trafficking Cell, assured immediate follow-up action and it is said that he telephonically instructed the police officers of Police Station- Kansabel to take necessary steps. It is the allegation of the petitioner that despite all steps taken by her informing the

State and Police Authorities to facilitate termination of pregnancy and an approach made to Chief Medical and Health Officer, Jashpur, steps were not taken and she was advised to approach Chhattisgarh Institute of Medical Science (CIMS) Bilaspur. When she approached doctors at CIMS, she was informed that she needs to bring the copy of FIR, MLC report and a referral letter from District Hospital, Jaspur. As the State Authority and Police Authority did not facilitate termination of pregnancy, though strongly desired by the petitioner, to prevent herself from severe mental agony of carrying unwanted pregnancy, the petitioner has now knocked the doors of justice by filing this petition.

4. Relying upon the judgment of the Supreme Court in the case of **Chandrakant Jayantilal Suthar & Anr. Vs. State of Gujarat**[1], **Suchita Srivastava & Anr. Vs. Chandigarh Administration**[2] and order dated 19.2.2016 passed by the High Court of Gujarat in the case of **Bhavikaben D/o. Rameshbhai Solanki Vs. State of Gujarat & Ors**.[3], prayer has been made to direct termination of pregnancy applying best interest theory and to prevent the petitioner from further mental agony which is a grave injury to the petitioner. Learned counsel for the petitioner has prayed for issuance of immediate direction in that regard.

5. Learned counsel for the respondents-State submits that as per the direction of this Court, the petitioner was examined on 13.4.2016 by a team of doctors and report has been placed on record.

6. As per the medical examination report dated 13.4.2016 given by a team of two doctors, following opinion has been formed:

> "Opinion: According to last menstrual period her gestational age is 20 weeks 4 days with P/A finding of pregnant uterus size 20-22 weeks and as per USG her mean gestational age is 20 weeks 4 days (copy enclosed). Hence according to MTP Act 1971 section 3 sub-section 2 b (copy enclosed), her pregnancy has exceeded the legal limit for MTP i.e. 20 weeks, therefore further direction is anticipated by the Hon'ble High Court, Chhattisgarh for further proceedings"

From the report, it is found that on 13.4.2016, the petitioner was found carrying pregnancy of more than 20 weeks.

7. At this stage, it is relevant to refer to the legal framework and the law of the land regulating the Medical Termination of Pregnancy Act, 1971 (here in after referred to as "the Act of 1971").The circumstances under which pregnancy may be terminated by registered medical

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1 Order dated 28.7.2015 passed in SLP (Criminal) No. 6013/2015

2 (2009) 9 SCC1

3 Special Criminal Application (Direction) No.1155 of 2016

practitioners has been provided under Section 3 of the aforesaid Act, which reads as follows:

> **"3.When pregnancies may be terminated by registered medical practitioners.**—(1) Not with standing anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.
>
> (2) Subject to the provisions of sub-section (4),a pregnancy may be terminated by a registered medical practitioner,—
>
> (a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or
>
> (b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are,
>
> **of opinion, formed in good faith, that—**
>
> (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or
>
> (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
>
> ***Explanation I***.—Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.
>
> ***Explanation II***.—Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.
>
> (3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.
>
> (4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a [mentally ill person], shall be terminated except with the consent in writing of her guardian
>
> (b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman."

The provision, as it reads, allows termination of pregnancy upon formation of opinion in

good-faith with regard to circumstances specified in clause (i) & clause (ii) of sub-section (2) of Section 3 of the Act of 1971, quoted herein -above.

"Explanation -I provides in no uncertain terms that where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman."

8. The petitioner, a victim of rape, has clearly expressed her strong desire to avoid giving birth to child which is a result of rape on her. It has been stated in her pleadings in additional memorandum filed on 18.4.2016 that the petitioner has studied only up to Class-XII and did not go to college because of financial reason. Her mother passed away when she was young, her father is old and infirm. Presently she is financially dependent on her brothers who are married. Thereafter, what has been stated by the petitioner requires special mention and reproduction also as here in-below:

   "The petitioner is under a lot of mental pressure and cannot bear stigma of being an unwed mother, she does not want to give birth to a child.

9. The situation which now stands as on today is that though the petitioner is not at all willing to carry pregnancy and seeks termination of her pregnancy so as to put an end to at least an agony of giving birth to an unwanted child, but the period of 20 weeks as provided in the Act has already elapsed. In fact, when the matter came up for consideration before this Court for the first time, the gestational period had crossed 20 weeks. As on today, the period of pregnancy is little more than 21weeks.

10. The course of action which is required to be taken has to be guided by the principles of best interest theory laid down by the Supreme Court in the case of Suchita Srivastava (supra). In the aforesaid decision, the Supreme Court evolved the test and held that the Court is required to ascertain the course of action which would serve the best interests of the person in question. It has also emphasized that the Court must undertake a careful inquiry of the medical opinion on the feasibility of pregnancy as well as social circumstances faced by the victim. The Court's decision should be guided by the interests of the victim alone and not those of stakeholders such as guardians or society in general. The observation made by the Supreme Court in para-37 of the judgment need attention, which reads thus:

   "37. As evident from its literal description, the "best interests" test requires the Court to ascertain the course of action which would serve the best interests of the person in question. In the present setting this means that the Court must undertake a careful inquiry of the medical opinion on the feasibility of the pregnancy as well as social circumstances faced by the victim. It is important to note that the Court's decision should be guided by the

interests of the victim alone and not those of the other stakeholders such as guardians or the society in general. It is evident that the woman in question will need care and assistance which will in turn entail some costs. However, that cannot be a ground for denying the exercise of reproductive rights.

11. A somewhat similar situation arose for consideration before the High Court of Gujarat in the case of **Bhavikaben** (supra). There the gestational age was of 24 weeks. That was also a case of rape victim. She tried to put an end to her life by consuming acid. She was ailing from medical problem also. Applying the best interest theory propounded by the Supreme Court in the case of **Suchita Srivastava** (supra) and the direction issued by the Supreme Court in another case of **Chandrakant Jayantilal Suthar** (supra), directions were issued for termination of medical pregnancy under supervision and care of doctors.

12. In the present case, the pregnancy has crossed 21 weeks of gestational age and unless there is judicial order as has been expressed in the opinion, it may not be possible for the doctors even to proceed with termination of pregnancy.

13. Taking into consideration the totality of the circumstances what has been stated by the victim, gestational age, judicial precedents, that as per Explanation -I appended to Section 3 of the Act of 1971 mental agony of a rape victim has to be treated as a case of grave injury, particularly taking into consideration that it is the interests of the victim alone which has to be kept in view, this Court is inclined to direct the treating doctors to terminate the pregnancy. Taking into consideration that period of 21 weeks has elapsed, in order to ensure the safety of life of the petitioner, it would be proper to direct that the team of five doctors including those who have already conducted medical examination shall consider the feasibility of termination of pregnancy at this gestational age.

    In view of the order of the Supreme Court in the case of Chandrakant (supra), it has to be left to the best opinion and judgment of medical experts in the matter. Once they find that at this stage, pregnancy can be terminated looking to the gestational age and overall condition of the petitioner, the same shall be carried out forthwith.

    A copy of this order shall be supplied to learned counsel for the petitioner and Shri Ramakant Mishra, Dy. A.G., today itself, for immediate onwards transmission to Dean, CIMS, Bilaspur for forthwith and immediate examination as per opinion, termination of pregnancy also.

14. This case is kept pending for the purposes of verifying the well-being of the petitioner after termination of pregnancy or for any other order which may be required to be passed in the matter including appropriate direction to be issued to the State Authority to avoid present situation.

15. The Hospital Authority shall take necessary tissues from fetus for DNA identification.

16. Respondent-State shall submit a report with regard to compliance of the Court direction on the next date of hearing.
17. List this matter on **25th April,2016.**

/-

(Manindra Mohan Shrivastava)

Judge

HIGH COURT OF CHHATTISGARH, BILASPUR

Order Sheet

WPC No. 976 of 2016

Amita Kujur Versus State of Chhattisgarh & Ors.

25/04/2016

Ms. Rajni Soren, counsel for the petitioner.S

Shri B. Gop Kumar, Dy. A.G. for the State.

1. Learned counsel for the State submits that vide submission memo which has been filed today, a report of termination of pregnancy carried out by a team of doctors in compliance of the order of this Court, has been placed on record. He informs that the pregnancy has been terminated in the matter.
2. Learned counsel for the petitioner submits that at present, the petitioner is admitted in the hospital and appropriate directions may be issued for discharge.
3. The discharge of the petitioner would depend upon her medical condition. It would be for the attending doctors to decide the condition of the petitioner and then discharge the petitioner.
4. Taking into consideration that the petition came to be filed by the petitioner in the Court because of delay in termination of pregnancy, appropriate guidelines are required to be issued in the matter.
5. Learned counsel for the State is granted a week's time to come out with suitable proposal in the

matter in order to ensure that the concerned police and medical authorities are enjoined with duty to deal with such matters expeditiously, without delay.

List it in the week after next.

Certified copy as per rules.

Sd/-

(Manindra Mohan Shrivastava)

Judge

Gopika Govindan v State of Kerala

WP (c) No. 23225 of 2017 (s)

Gopika Govindan, D/O. Govindan, Coordinator of the Child Rights Initiative, Human Rights Law Network, Amulya Street Kochi 18 -Petitioner

Versus

1. State of Kerala
   Represneted by the Principal Secretary.
   Deaprtment of Social Welfare,
   Ground Floor. Secretariat
   Trivandrum, 695001
2. Department of Health and Family Welfare.
   Represented by the Additional Chief Secretary.
   Secretariat, Thiruvanthapuram, 695001
3. The Child Welfare Committee
   Kakkanad P.O
   Ernakulam, Kochi 682030

-Respondents

For Petitoner : Adv. Smt. Sandhya Raju & Adv. Smt J.Sandhya

For Respondents : Adv. Mr, Aravinda Kumar Basu

S.B: The Hon'ble Chief Justice Mr. Navantiti Prasad Singh & The Hon'ble Mr. Justice Raja Navaniti Prasad Singh, C.J.

1. The facts of this case are disturbing. A girl of about 12 years has become pregnant and the foetus is about 28 weeks old. The person responsible is none other than her own brother, who is aged 14 years. The petitioner is a social worker who brought the plea of the mother of the children to this Court. She had sought for a direction from the court for medical termination of pregnancy. Twofold reasons are highlighted .Firstly, considering the age of the girl, she would suffer critical health issues not only at the time of delivery but in future as well not to mention the defects that may befall the infant. Secondly, the social stigma that the mother and the child would suffer would be life long and unbearable.
2. We called for a medical report from the Government T.D. Medical College Hospital, Alappuzha. A report has been submitted today in a sealed cover by the Medical Superintendent, which we have perused. The report clearly states that the girl is a well grown healthy adolescent girl. Considering the growth of the foetus, the opinion of the Medical Board was that termination of pregnancy at this stage would be more hazardous than going through a term delivery. Apprehension has also been raised that if there is a forced medical termination of pregnancy the girl may suffer permanent damages effecting her future life.
3. We have anxiously considered the report. In view of the report of the Medical Board, we cannot now accede to grant the relief in relation to medical termination of pregnancy.
4. The question now remains about the welfare of the girl and the child to be born. We are told that the girl is under the custody of the Child Welfare Committee, Kakkanad, Kochi. We would direct the committee to take all necessary steps to ensure the health and welfare of the mother and we would expect the State to extend all help and medical care for the safe and comfortable delivery of the child. Thereafter it would be the obligation of the State to ensure that the child and the mother, who herself is a child, are sufficiently provided for and looked after, which shall include educating the mother child so as to enable her to get employment. Apart from this, the Child Welfare Committee would ensure that she gets her due share under the Victim Compensation Scheme of the State Government, which amount if so received would be kept in fixed deposit as the victim is minor and the interest there from shall only be used for her benefit till she attains majority.
5. All these matter would be co-ordinated by the Child Welfare Committee, Kakkanad, Ernakulam, and their responsibility would be full and complete in this regard. The judgment may be communicated to the 1strespondent, the Child Welfare Committee and the Child

Welfare Officer, Kakkanad, Kochi. The report received from the Medical Superintendent shall be kept on record as part of records in this case.

This writ petition is disposed of as above.

Sd/-

NAVANITI PRASAD SINGH,

CHIEF JUSTICE

Sd/-

RAJA VIJAYARAGHAVAN V.,

JUDGE

CCPR

International covenant on civil and political rights

Distr. RESTRICTED*
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22 November 2005
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HUMAN RIGHTS COMMITTEE
Eighty-fifth session
17 October - 3 November2005

VIEWS

Communication No. 1153/2003

Submitted by:	K.L. (represented by the organizations DEMUS, CLADEM and Center for Reproductive Law and Policy)
Alleged victim:	The author
State party:	Peru
Date of communication:	13 November 2002 (initial submission)
Document reference:	Special Rapporteur's rule 91 decision, transmitted to the State party on 8 January 2003 (not issued in document form)
Date of adoption of Views:	24 October2005

* Made public by decision of the Human Rights Committee.

Subject matter: Refusal to provide medical services to the author in connection with a therapeutic abortion which is not a punishable offence and for which express provision has been made in the law.

Procedural issues: Substantiation of the alleged violation – unavailability of effective domestic remedies.

Substantive issues: Right to an effective remedy; right to equality between men and women; right to life, right not to be subjected to cruel, inhuman or degrading treatment; right not to be the victim of arbitrary or unlawful interference in one's privacy; right to such measures of protection as are required by the status of a minor and right to equality before the law.

Articles of the Covenant: 2, 3, 6, 7, 17, 24 and 26

Article of the Optional Protocol: 2

On 24 October 2005 the Human Rights Committee adopted the annexed draft as the Committee's Views under article 5, paragraph 4, of the Optional Protocol in respect of communication No. 1153/2003. The text is appended to the present document.

ANNEX

VIEWS OF THE HUMAN RIGHTS COMMITTEE UNDER ARTICLE 5, PARAGRAPH 4, OF THE OPTIONAL PROTOCOL TO THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

Eighty-fifth session concerning

Communication No. 1153/2003**

Submitted by: K.L. (represented by the organizations DEMUS, CLADEM and Center for Reproductive Law and Policy)

Alleged victim: The author

State party: Peru

Date of communication: 13 November 2002 (initial submission)

The Human Rights Committee, established under article 28 of the International Covenant on Civil and Political Rights,

Meeting on 24 October 2005,

Having concluded its consideration of communication No. 1153/2003, submitted on behalf of K.L. under the Optional Protocol to the International Covenant on Civil and Political Rights,

Having taken into account all written information made available to it by the author of the communication and the State party,

Adopts the following: The text of an individual opinion signed by Committee member Mr.

** The following members of the Committee participated in the examination of the present communication : Mr. Prafulla chandra Natwarlal Bhagwati, Ms. Christine Chanet, Mr. Maurice Glèlè Ahanhanzo, Mr. Edwin Johnson, Mr. Walter Kälin, Mr. Ahmed Tawfik Khalil, Mr. Rajsoomer Lallah, Mr. Michael O'Flaherty, Ms. Elisabeth Palm, Mr.Rafael Rivas Posada, Sir Nigel Rodley, Mr. Ivan Shearer, Mr. Hipólito Solari-Yrigoyen and Mr. Roman Wieruszewski.

Hipólito Solari-Yrigoyen is appended to the present document.

Views under article 5 paragraph 4 of the Optional Protocol

1. The author of the communication is K.L., born in 1984, who claims to be a victim of a violation by Peru of articles 2, 3, 6, 7, 17, 24 and 26 of the International Covenant on Civil and Political Rights. She is represented by the organizations DEMUS, CLADEM and Center for Reproductive Law and Policy. The Optional Protocol entered into force for Peru on 3 October1980.

Factual background

2.1 The author became pregnant in March 2001, when she was aged 17. On 27 June 2001 she was given a scan at the Archbishop Loayza National Hospital in Lima, part of the Ministry of Health. The scan showed that she was carrying an anencephalic foetus.

2.2 On 3 July 2001, Dr. Ygor Pérez Solf, a gynaecologist and obstetrician in the Archbishop Loayza National Hospital in Lima, informed the author of the foetal abnormality and the risks to her life if the pregnancy continued. Dr. Pérez said that she had two options: to continue the pregnancy or to terminate it. He advised termination by means of uterine curettage. The author decided to terminate the pregnancy, and the necessary clinical studies were carried out, confirming the foetal abnormality.

2.3 On 19 July 2001, when the author reported to the hospital together with her mother for admission preparatory to the operation, Dr. Pérez informed her that she needed to obtain written authorization from the hospital director. Since she was under age, her mother requested the authorization. On 24 July 2001, Dr. Maximiliano Cárdenas Díaz, the hospital director, replied in writing that the termination could not be carried out as to do so would be unlawful, since under article 120 of the Criminal Code, abortion was punishable by a prison term of no more than three months when it was likely that at birth the child would suffer serious physical or mental defects, while under article 119, therapeutic abortion was permitted only when termination of the pregnancy was the only way of saving the life of the pregnant woman or avoiding serious and permanent damage to her health.

2.4 On 16 August 2001, Ms. Amanda Gayoso, a social worker and member of the Peruvian association of social workers, carried out an assessment of the case and concluded that medical intervention to terminate the pregnancy was advisable "since its continuation would only prolong the distress and emotional instability of [K.L.] and her family". However, no intervention took place owing to the refusal of the Health Ministry medical personnel.

2.5 On 20 August 2001, Dr. Marta B. Rondón, a psychiatrist and member of the Peruvian

Medical Association, drew up a psychiatric report on the author, concluding that “the so- called principle of the welfare of the unborn child has caused serious harm to the mother, since she has unnecessarily been made to carry to term a pregnancy whose fatal outcome was known in advance, and this has substantially contributed to triggering the symptoms of depression, with its severe impact on the development of an adolescent and the patient’s future mental health”.

2.6 On 13 January 2002, three weeks late with respect to the anticipated date of birth, the author gave birth to an anencephalic baby girl, who survived for four days, during which the mother had to breastfeed her. Following her daughter’s death, the author fell into a state of deep depression. This was diagnosed by the psychiatrist Marta B. Rondón. Theauthor also states that she suffered from an inflammation of the vulva which required medical treatment.

2.7 The author has submitted to the Committee a statement made by Dr. Annibal Faúdesand Dr. Luis Tavara, who are specialists from the association called Center for Reproductive Rights, and who on 17 January 2003 studied the author’s clinical dossier and stated that anencephaly is a condition which is fatal to the foetus in all cases. Death immediately follows birth in most cases. It also endangers the mother’s life. In their opinion, in refusing to terminate the pregnancy, the medical personnel took a decision which was prejudicial to the author.

2.8 Regarding the exhaustion of domestic remedies, the author claims that this requirement is waived when judicial remedies available domestically are ineffective in the case in question, and she points out that the Committee has laid down on several occasions that the author has no obligation to exhaust a remedy which would prove ineffective. She adds that in Peru there is no administrative remedy which would enable a pregnancy to be terminated on therapeutic grounds, nor any judicial remedy functioning with the speed and efficiency required to enable a woman to require the authorities to guarantee her right to a lawful abortion within the limited period, by virtue of the special circumstances obtaining in such cases. She also states that her financial circumstances and those of her family prevented her from obtaining legal advice.

2.9 The author states that the complaint is not being considered under any other procedure of international settlement.

The complaint

3.1 The author claims a violation of article 2 of the Covenant, since the State party failed to comply with its obligation to guarantee the exercise of a right. The State should have taken steps to respond to the systematic reluctance of the medical community to comply with the legal provision authorizing therapeutic abortion, and its restrictive interpretation thereof. This restrictive interpretation was clear in the author’s case, in which a pregnancy involving an anencephalic foetus was considered not to endanger her life and health. The State should have

taken steps to ensure that an exception could be made to the rule criminalizing abortion, so that, in cases where the physical and mental health of the mother was at risk, she could undergo an abortion in safety.

3.2 The author claims to have suffered discrimination in breach of article 3 of the Covenant, in the following forms:

(a) In access to the health services, since her different and special needs were ignored because of her sex. In the view of the author, the fact that the State lacked any means to prevent a violation of her right to a legal abortion on therapeutic grounds, which is applicable only to women, together with the arbitrary conduct of the medical personnel, resulted in a discriminatory practice that violated her rights — a breach which was all the more serious since the victim was a minor.

(b) Discrimination in the exercise of her rights, since although the author was entitled to a therapeutic abortion, none was carried out because of social attitudes and prejudices, thus preventing her from enjoying her right to life, to health, to privacy and to freedom from cruel, inhuman and degrading treatment on an equal footing with men.

(c) Discrimination in access to the courts, bearing in mind the prejudices of officials in the health system and the judicial system where women are concerned and the lack of appropriate legal means of enforcing respect for the right to obtain a legal abortion when the temporal and other conditions laid down in the law are met.

3.3 The author claims a violation of article 6 of the Covenant. She states that her experience had a serious impact on her mental health from which she has still not recovered. She points out that the Committee has stated that the right to life cannot be interpreted in a restrictive manner, but requires States to take positive steps to protect it, including the measures necessary to ensure that women do not resort to clandestine abortions which endanger their life and health, especially in the case of poor women. She adds that the Committee has viewed lack of access for women to reproductive health services, including abortion, as a violation of women's right to life, and that this has been reiterated by other committees such as the Committee on the Elimination of Discrimination against Women and the Committee on Economic, Social and Cultural Rights. The author claims that in the present case, the violation of the right to life lay in the fact that Peru did not take steps to ensure that the author secured a safe termination of pregnancy on the grounds that the foetus was not viable. She states that the refusal to provide a legal abortion service left her with two options which posed an equal risk to her health and safety: to seek clandestine (and hence highly risky) abortion services, or to continue a dangerous and traumatic pregnancy which put her life at risk.

3.4 The author claims a violation of article 7 of the Covenant. The fact that she was obliged

to continue with the pregnancy amounts to cruel and inhuman treatment, in her view, since she had to endure the distress of seeing her daughter's marked deformities and knowing that her life expectancy was short. She states that this was an awful experience which added further pain and distress to that which she had already borne during the period when she was obliged to continue with the pregnancy, since she was subjected to an "extended funeral" for her daughter, and sank in to a deep depression after her death.

3.5 The author points out that the Committee has stated that the prohibition in article 7 of the Covenant relates not only to physical pain but also to mental suffering, and that this protection is particularly important in the case of minors. [1] She points out that, after considering Peru's report in 1996, the Committee expressed the view that restrictive provisions on abortion subjected women to inhumane treatment, in violation of article 7 of the Covenant, and that in 2000, the Committee reminded the State party that the criminalization of abortion was incompatible with articles 3, 6 and 7 of the Covenant.[2]

3.6 The author claims a violation of article 17, arguing that this article protects women from interference in decisions which affect their bodies and their lives, and offers them the opportunity to exercise their right to make independent decisions on their reproductive lives. The author points out that the State party interfered arbitrarily in her private life, taking on her behalf a decision relating to her life and reproductive health which obliged her to carry a pregnancy to term, and thereby breaching her right to privacy. She adds that the service was available, and that if it had not been for the interference of State officials in her decision, which enjoyed the protection of the law, she would have been able to terminate the pregnancy. She reminds the Committee that children and young people enjoy special protection by virtue of their status as minors, as recognized in article 24 of the Covenant and in the Convention on the Rights of the Child.

3.7 The author claims a violation of article 24, since she did not receive the special care she needed from the health authorities, as an adolescent girl. Neither her welfare nor her state of health were objectives pursued by the authorities which refused to carry out an abortion on her. The author points out that the Committee laid down in its General Comment No. 17, relating to article 24, that the State should also adopt economic, social and cultural measures to safeguard this right. For example, every possible economic and social measure should be taken to reduce infant mortality and to prevent children from being subjected to acts of violence or cruel or inhuman treatment, among other possible violations.

3.8 The author claims a violation of article 26, arguing that the Peruvian authorities' position

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[1] Human Rights Committee, General Comment No. 20, 10 March 1992 (HRI/GEN/1/Rev.7), paras. 2 and 5.

2 Concluding observations of the Human Rights Committee: Peru, 15 November 2000 (CCPR/CO/70/PER), para. 20.

that hers was not a case of therapeutic abortion, which is not punishable under the Criminal Code, left her in an unprotected state incompatible with the assurance of the protection of the law set out in article 26. The guarantee of the equal protection of the law implies that special protection will be given to certain categories of situation in which specific treatment is required. In the present case, as a result of a highly restrictive interpretation of the criminal law, the health authorities failed to protect the author and neglected the special protection which her situation required.

3.9 The author claims that the administration of the health centre left her without protection as a result of a restrictive interpretation of article 119 of the Criminal Code. She adds that the text of the law contains nothing to indicate that the exception relating to therapeutic abortion should apply only in cases of danger to physical health. But the hospital authorities had drawn a distinction and divided up the concept of health, and had thus violated the legal principle that no distinction should be drawn where there is none in the law. She points out that health is "a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity", so that when the Peruvian Criminal Code refers to health, it does so in the broad and all-embracing sense, protecting both the physical and the mental health of the mother.

State party's failure to cooperate under article 4 of the Optional Protocol

4. On 23 July 2003, 15 March 2004 and 25October 2004,reminderswere sent to the State party inviting it to submit information to the Committee concerning the admissibility and the merits of the complaint. The Committee notes that no such information has been received. It regrets that the State party has not supplied any information concerning the admissibility or the merits of the author's allegations. It points out that it is implicit in the Optional Protocol that States parties make available to the Committee all information at their disposal. In the absence of a reply from the State party, due weight must be given to the author's allegations, to the extent that these have been properly substantiated.[3]

Issues and proceedings before the Committee Consideration of admissibility

5.1 In accordance with rule 93 of the rules of procedure, before examining the claims made in a communication, the Human Rights Committee must decide whether the communication is admissible under the Optional Protocol to the Covenant.

5.2 The Committee notes that, according to the author, the same matter has not been submitted under any other procedure of international investigation. The Committee also takes note of

[3] See communication No. 760/1997, *J. G. A. Diergaart et al. v. Namibia*; Views adopted on 25 July 2000, para. 10.2, and Communication No. 1117/2002, *Saodat Khomidova v. Tajikistan*; Views adopted on 29July 2004, para.4.

her arguments to the effect that in Peru there is no administrative remedy which would enable a pregnancy to be terminated on therapeutic grounds, nor any judicial remedy functioning with the speed and efficiency required to enable a woman to require the authorities to guarantee her right to a lawful abortion within the limited period, by virtue of the special circumstances obtaining in such cases. The Committee recalls its jurisprudence to the effect that a remedy which had no chance of being successful could not count as such and did not need to be exhausted for the purposes of the Optional Protocol.[4]In the absence of a reply from the State party, due weight must be given to the author's allegations. Consequently, the Committee considers that the requirements of article 5, paragraph 2(a) and (b), have been met.

5.3 The Committee considers that the author's claims of alleged violations of articles 3and 26 of the Covenant have not been properly substantiated, since the author has not placed before the Committee any evidence relating to the events which might confirm any type of discrimination under the article in question. Consequently, the part of the complaint referring to articles 3 and 26 is declared inadmissible under article 2 of the Optional Protocol.

5.4 The Committee notes that the author has claimed a violation of article 2 of the Covenant. The Committee recalls its constant jurisprudence to the effect that article 2ofthe Covenant, which lays down general obligations for States, is accessory in nature and cannot be invoked in isolation by individuals under the Optional Protocol.[5] Consequently, the complaint under article 2 will be analysed together with the author's other allegations.

5.5 Concerning the allegations relating to articles 6, 7, 17 and 24 of the Covenant, the Committee considers that they are adequately substantiated for purposes of admissibility, and that they appear to raise issues in connection with those provisions. Consequently, it turns to consideration of the substance of the complaint.

Consideration of the merits

6.1 The Human Rights Committee has considered the present complaint in the light of all the information received, in accordance with article 5, paragraph 1, of the Optional Protocol.

6.2 The Committee notes that the author attached a doctor's statement confirming that her pregnancy exposed her to a life-threatening risk. She also suffered severe psychological consequences exacerbated by her status as a minor, as the psychiatric report of 20 August 2001 confirmed. The Committee notes that the State party has not provided any evidence to challenge the above. It notes that the authorities were aware of the risk to the author's life, since a gynaecologist and obstetrician in the same hospital had advised her to terminate the

[4] See Communication No. 701/1996, *Cesáreo Gómez Vázquez v. Spain*; Views adopted on 20 July 2000, para.6.2.

[5] See Communication No. 802/1998, *Andrew Rogerson v. Australia*; Views adopted on 3 April 2002, para. 7.9.

pregnancy, with the operation to be carried out in the same hospital. The subsequent refusal of the competent medical authorities to provide the service may have endangered the author's life. The author states that no effective remedy was available to her to oppose that decision. In the absence of any information from the State party, due weight must be given to the author's claims.

6.3 The author also claims that, owing to the refusal of the medical authorities to carryout the therapeutic abortion, she had to endure the distress of seeing her daughter's marked deformities and knowing that she would die very soon. This was an experience which added further pain and distress to that which she had already borne during the period when she was obliged to continue with the pregnancy. The author attaches a psychiatric certificate dated 20 August 2001, which confirms the state of deep depression into which she fell and the severe consequences this caused,taking her age into account. The Committee notes that this situation could have been foreseen, since a hospital doctor had diagnosed anencephaly in the foetus, yet the hospital director refused termination. The omission on the part of the State in not enabling the author to benefit from a therapeutic abortion was, in the Committee's view, the cause of the suffering she experienced. The Committee has pointed out in its General Comment No. 20 that the right set out in article 7 of the Covenant relates not only to physical pain but also to mental suffering, and that the protection is particularly important in the case of minors. [6] In the absence of any information from the State party in this regard, due weight must be given to the author's complaints. Consequently, the Committee considers that the facts before it reveal a violation of article 7 of the Covenant. In the light of this finding the Committee does not consider it necessary in the circumstances to made a finding on article 6 of the Covenant.

6.4 The author states that the State party, in denying her the opportunity to secure medical intervention to terminate the pregnancy, interfered arbitrarily in her private life. The Committee notes that a public-sector doctor told the author that she could either continue with the pregnancy or terminate it in accordance with domestic legislation allowing abortions in cases of risk to the life of the mother. In the absence of any information from the State party, due weight must be given to the author's claim that at the time of this information, the conditions for a lawful abortion as set out in the law were present. In the circumstances of the case, the refusal to act in accordance with the author's decision to terminate her pregnancy was not justified and amounted to a violation of article 17 of the Covenant.

6.5 The author claims a violation of article 24 of the Covenant, since she did not receive from the State party the special care she needed as a minor. The Committee notes the special vulnerability of the author as a minor girl. It further note that, in the absence of any information from the State party, due weight must be given to the author's claim that she did not receive,

[6] Human Rights Committee, General Comment No. 20: Prohibition of torture and other cruel, inhuman or degrading treatment or punishment (art. 7), 10 March 1992 (HRI/GEN/1/Rev.7, paras. 2 and5).

during and after her pregnancy, the medical and psychological support necessary in the specific circumstances of her case. Consequently, the Committee considers that the facts before it reveal a violation of article 24 of the Covenant.

6.6 The author claims to have been a victim of violation of articles 2 of the Covenant on the grounds that she lacked an adequate legal remedy. In the absence of information from the State party, the Committee considers that due weight must be given to the author's claims as regards lack of an adequate legal remedy and consequently concludes that the facts before it also reveal a violation of article 2 in conjunction with articles 7, 17 and24.

7 The Human Rights Committee, acting under article 5, paragraph 4, of the Optional Protocol to the Covenant, is of the view that the facts before it disclose a violation of articles 2, 7, 17 and 24 of the Covenant.

8. In accordance with article 2, paragraph 3 (a), of the Covenant, the State party is required to furnish the author with an effective remedy, including compensation. The State party has an obligation to take steps to ensure that similar violations do not occur in the future.

9. Bearing in mind that, as a party to the Optional Protocol, the State party recognizes the competence of the Committee to determine whether there has been a violation of the Covenant, and that, under article 2 of the Covenant, the State party has undertaken to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the Covenant and to offer an effective and enforceable remedy when a violation is found to have occurred, the Committee wishes to receive from the State party, within 90 days, information about the measures taken to give effect to the present Views. The State party is also requested to publish the Committee's Views.

[Adopted in English, French and Spanish, the Spanish text being the original version. Subsequently to be issued also in Arabic, Chinese and Russian as part of the Committee's annual report to the General Assembly.]

APPENDIX

DISSENTING OPINION BY COMMITTEE MEMBER HIPÓLITO SOLARI-YRIGOYEN

My dissenting opinion on this communication - the majority not considering that article 6 of the Covenant was violated-is based on the following grounds:

Consideration of the merits

The Committee notes that when the author was a minor, she and her mother were informed by the obstetric gynaecologist at Lima National Hospital, whom they had consulted because of the author's pregnancy, that the foetus suffered from anencephaly which would inevitably cause its death at birth. The doctor told the author that she had two options: (1) continue the pregnancy, which would endanger her own life; or(2)terminate the pregnancy by a therapeutic abortion. He recommended the second option. Given this conclusive advice from the specialist who had told her of the risks to her life if the pregnancy continued, the author decided to follow his professional advice and accepted the second option. As a result, all the clinical tests needed to confirm the doctor's statements about the risks to the mother's life of continuing the pregnancy and the inevitable death of the foetus at birth were performed.

The author substantiated with medical and psychological certificates all her claims about the fatal risk she ran if the pregnancy continued. In spite of the risk, the director of the public hospital would not authorize the therapeutic abortion which the law of the State party allowed, arguing that it would not be a therapeutic abortion but rather a voluntary and unfounded abortion punishable under the Criminal Code. The hospital director did not supply any legal ruling in support of his pronouncements outside his professional field or challenging the medical attestations to the serious risk to the mother's life. Furthermore, the Committee may note that the State party has not submitted any evidence contradicting the statements and evidence supplied by the author. Refusing a therapeutic abortion not only endangered the author's life but had grave consequences which the author has also substantiated to the Committee by means of valid supporting documents.

It is not only taking a person's life that violates article 6 of the Covenant but also placing a person's life in grave danger, as in this case. Consequently, I consider that the facts in the present case reveal a violation of article 6 of the Covenant.

[***Signed***]: Hipólito Solari-Yrigoyen

[Done in English, French and Spanish, the Spanish text being the original version. Subsequently to be issued in Arabic, Chinese and Russian as part of the Committee's annual report to the General Assembly.]

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One hundredth and first session
14 March - 1 April 2011

ANNEX

Views of the Human Rights Committee under article 5, paragraph 4,
of the Optional Protocol to the
International Covenant on Civil and Political rights
- One hundredth and first session- concerning
Communication No. 1608/2007

Submitted by: V.D.A. (represented by the organizations INSGENAR, CLADEM and ACDD) Alleged victim: L.M.R.

State party: Argentina

Date of communication: 25 May 2007 (initial submission)

The Human Rights Committee, established under article 28 of the International Covenant on Civil and Political Rights,

Meeting on 29 March 2011,

Having concluded its consideration of communication No. 1608/2007, submitted to the Human Rights Committee by V.D.A. under the Optional Protocol to the International Covenant on Civil and Political Rights,

Having taken into account all written information made available to it by the author of the communication and the State party,

Adopts the following:

Views under article 5, paragraph 4, of the Optional Protocol

1. The author of the communication, dated 25 May 2007, is V.D.A., an Argentine national, who submits this communication on behalf of her daughter, L.M.R., born on 4 May 1987. She claims that her daughter was the victim of violations by Argentina of articles 2, 3, 6, 7, 17 and 18 of the Covenant. The Optional Protocol entered into force for the State party on 8 November 1986. The author is represented by counsel.

The facts as submitted by the author

2.1 L.M.R. is a young woman living in Guernica, Buenos Aires province, who has a permanent mental impairment. She lives with her mother, V.D.A, attends a special school and receives neurological care. She has been diagnosed as having a mental age of between 8 and 10years.

2.2 In June 2006 the author took her daughter to Guernica Hospital because she said that she was feeling unwell. At the hospital she was found to be pregnant and the author requested a termination. The hospital staff refused to perform the procedure and referred the patient to San Martín Hospital in La Plata, which is a public hospital. They also informed her that she needed to file a complaint with the police. On 24 June 2006 a complaint was filed against an uncle of L.M.R. who was suspected of having raped her. The author claims that Guernica Hospital had the resources necessary to perform the procedure, without needing to refer the case elsewhere, and that its refusal forced the family to travel 100 kilometres to the provincial capital and to incur the related costs and inconvenience.

2.3 L.M.R. was approximately fourteen and a half weeks pregnant on her arrival at San Martín Hospital. She was admitted on 4 July 2006 and the hospital authorities requested an urgent meeting with the Bioethics Committee to solicit its opinion. Since this was a case of non-punishable abortion pursuant to article 86, paragraph 2 of the Criminal Code, [1] hospital staff began the pre-surgical

examinations necessary for the procedure. The aforementioned provision gives female rape victims with a mental disability the right to terminate a pregnancy but does not set deadlines and does not specify the type of medical procedure to be used. In addition, it establishes no requirement for judicial authorization of any form. The only requirements are that the disability should be diagnosed, that the victim's legal representative should give consent and that the termination should be performed by a licensed physician.

2.4 The hospital was issued with an injunction on all procedures and judicial proceedings were initiated to prevent the abortion. The juvenile court judge ruled that a termination should be prohibited because she did not find it acceptable to repair a wrongful assault (sexual abuse) "with another wrongful assault against a new innocent victim, i.e. the unborn child". 2.5 The decision was confirmed on appeal by the Civil Court, which instructed the juvenile court judge to perform regular checks on L.M.R., accompanied by her mother, regarding the progress of her pregnancy and to monitor the health of the girl and her unborn child directly, on an ongoing basis, through the intermediary of the Under- secretariat for Children.

2.6 The decision was contested before the Supreme Court of Justice of Buenos Aires province, which overturned the contested decision on 31 July 2006 and ruled that the termination could proceed. [2] Consequently, the Court informed San Martín Hospital that the surgical procedure its staff were to perform was legal and did not require judicial authorization. This ruling was issued almost a month and a half after the rape was reported and the termination of pregnancy was requested.

2.7 Despite the ruling, San Martín Hospital and the family came under enormous pressure from various sources opposed to the termination and the hospital refused to perform the procedure on the grounds that the pregnancy was too advanced (between 20 and 22 weeks). With help from women's organizations a new scan was performed in a private clinic on 10 August, revealing that the victim was 20.4 weeks pregnant.

2.8 With support from women's organizations, the family contacted various health centres and hospitals both in and outside the province, but none of them would agree to carry outa termination. However, the family managed to arrange an illegal termination on 26 August 2006.

2.9 Press reports indicate that both the Rector of the Catholic University and the spokesperson of the Corporation of Catholic Lawyers contributed to the pressure exerted on the family and the doctors. Threatening letters sent to the hospital were even made public without any authority taking action.

The complaint

3.1 The author maintains that, despite availing herself of a legal remedy that should have safeguarded her reproductive rights, L.M.R. was unable to obtain a legal abortion. She suffered discrimination in accessing reproductive health services and her reproductive autonomy, right to privacy and

confidentiality and right to access a safe termination through the public health system were violated. Both the victim and her family suffered mental and psychological injury and their daily lives were disrupted. The psychological injury suffered by L.M.R. took the form of post-traumatic stress disorder, with predominantly phobic symptoms. Although it is difficult to distinguish between the effects of the rape and those attributable to the State's failure to guarantee access to a safe abortion, there are sufficient grounds to maintain that if the termination had been performed in due time and form its damaging consequences could have been minimized.

3.2 The author claims that both she and her elder daughter lost their jobs because, for three months, they had to make themselves available for the administrative formalities imposed on them by the judicial and medical systems and to provide round-the-clock care for L.M.R., who was very upset by the situation. They also had to cover the material costs of these formalities.

3.3 The author claims that it is not only mentally-impaired rape victims who have difficulty accessing legal abortions. There are many cases in which continuing a pregnancy puts the mother's life and/or health at risk. Although such circumstances also constitute grounds for a legal abortion in Argentina, it is almost impossible to find health-care practitioners willing to carry out the procedure. There are numerous case law precedents in this area. Both in cases of non-punishable abortion and other medical interventions referred to the courts, and in applications for surgical methods of contraception, it has been ruled that judicial authorization is not necessary and that doctors should not request it.

3.4 Because it lacked the mechanisms that would have enabled L.M.R. to obtain a termination of pregnancy, the State party is responsible by omission for the violation of article 2 of the Covenant.

3.5 The author also maintains that the impossibility of obtaining a termination of pregnancy constituted a violation of the right to equality and non-discrimination established under article 3 of the Covenant. The State's failure to exercise due diligence in safeguarding a legal right to a procedure required solely by women, coupled with the arbitrary action of the medical staff, resulted in discriminatory conduct that violated L.M.R.'s rights. The victim's status as a poor, disabled woman adds to the seriousness of the violation since it heightened the State's obligation to protect her rights and eradicate the cultural and religious prejudices that were undermining her well-being.

3.6 The author recalls the Committee's concluding observations to the State party's periodic report, which state that "traditional attitudes towards women continue to exercise a negative influence on their enjoyment of Covenant rights". Since abortion is an issue that affects women only and is shrouded in all kinds of prejudices in the collective imagination, the attitude of the judicial officers and the medical staff at San Martín Hospital, and the authorities' failure to enforce the law, were discriminatory, depriving L.M.R. of her right to a safe, lawful abortion. Social attitudes and prejudices, and pressure from fundamentalist groups, also prevented L.M.R. from enjoying her right to life, health and privacy, and her right not to be subjected to cruel, inhuman and degrading

treatment, among others, on equal terms without discrimination, it being understood that for women these rights are sometimes of a different tenor than for men. Furthermore, the lack of hospital protocols to facilitate abortion in the two situations where it is permitted under Argentine law makes it more difficult for women finding themselves in these situations to exercise their right to a termination and gives the authorities leeway to apply the law in an arbitrary manner.

3.7 The author also maintains that the facts described constitute a violation of L.M.R.'s right to life. The State failed to adopt the measures and act with the due diligence necessary to ensure that L.M.R. could obtain a safe abortion and prevent the need for an unlawful, unsafe abortion. As the Committee itself has stated, in the case of women respect for the right to life implies a State duty to adopt measures that preclude the need for illegal abortions that put women's life and health at risk. She observes that illegal abortion is a public-health issue that continues to cost thousands of women's lives in Argentina and is the primary cause of maternal mortality. She recalls that when the Committee considered Argentina's third periodic report it expressed concern that "the criminalization of abortion deters medical professionals from providing this procedure without judicial order, even when they are permitted to do so by law, inter alia when there are clear health risks for the mother or when pregnancy results from the rape of mentally disabled women. The Committee also expresses concern over discriminatory aspects of the laws and policies in force, which result in disproportionate resort to illegal, unsafe abortions by poor and rural women".[3]

3.8 The author maintains that forcing her daughter to continue with her pregnancy constituted cruel and degrading treatment and, consequently, a violation of her personal well-being under article 7 of the Covenant. The refusal to terminate the pregnancy inflicted many days of mental and physical anguish and suffering on L.M.R. and her family, forcing them to resort to an illegal abortion that endangered her life and health while enduring opprobrium from numerous sources. The pressure to continue the pregnancy and give the baby up for adoption exposed the family to some very painful dilemmas. For the author this amounted to cruel and degrading treatment. She felt that people dared to make such offers only because she was poor, and found this deeply humiliating.

3.9 The author also alleges that the facts described constitute a violation of article 17 of the Covenant. The State party not only interfered in a decision concerning L.M.R.'s legally protected reproductive rights but also interfered arbitrarily in her private life, taking a decision concerning her life and reproductive health on her behalf.

3.10 There was also a violation of article 18 of the Covenant. Catholic groups made direct, public and continual threats of various kinds and subjected the family to pressure and coercion without the authorities stepping in to protect L.M.R.'s rights. In objecting to the procedure on the grounds of collective or institutional conscience, the Gynaecology Department of San Martín Hospital also failed to respect the right to freedom of religion and belief. Conscientious objection is inadmissible under the regulatory framework governing the duties of public servants and in application of the

obligation to safeguard patients' right to life and health that is incumbent on all medical professionals. Under the prevailing law, the hospital should have referred the case to another department.

3.11 The author requests that the Committee: (a) establish the State's international responsibility; (b) order the State to give full reparation to L.M.R. and her family, including compensation for material and mental injury and measures to prevent repetition; (c) order the State to implement hospital protocols that would facilitate access to legal, safe abortion and the mechanisms necessary to give effect to this right; (d) review the domestic legal framework for abortion, which establishes criminal penalties for women who terminate an unwanted or involuntary pregnancy, and forces them to undergo illegal abortions which seriously endanger their life and overall health.

State party's observations on admissibility and merits

4.1 In a note verbale dated 9 January 2008, the State party indicated that the communication was inadmissible on the grounds of failure to exhaust domestic remedies. The communication seeks to submit a simple application for compensation to international jurisdiction, even though the judicial remedies sought at the domestic level to ensure access to abortion were resolved in L.M.R.'s favour. The judicial proceedings which culminated in the Supreme Court ruling authorizing a termination of pregnancy lasted 37 days, which is not an excessive period based on the criteria of reasonableness consensually accepted in international human rights law. Consequently, since the case had been resolved favourably for the applicant under domestic jurisdiction, the application for full reparation submitted by the author is not substantiated.

4.2 Notwithstanding the foregoing, the State party observes that the author's claims for injury and damages should first be submitted to domestic jurisdiction. The Code of Civil and Commercial Procedure in effect in Buenos Aires province provides a specific, pertinent and effective procedure for claiming compensation for alleged physical and mental suffering.

4.3 On 9 May 2008 the State party reiterated that the judiciary acted with due promptitude in the case in point, since it was resolved in less than four weeks, despite having been referred from the court of first instance to the Civil Court and then to the Supreme Court of Justice of Buenos Aires province during a holiday period when the courts were in recess. However, the various circumstances of the case, the way in which the public took up the cause and the assessments of the medical staff involved made it impossible to carry out a surgical procedure permitted under criminal law. The author's subsequent decision to resort to an unsafe abortion was a decision she made of her own accord, and cannot be considered a direct consequence of the State's action. The State party also notes that the advocate for persons without legal capacity was never informed.

4.4 Should it be found that the author is entitled to reparation for damage and injury, mechanisms for lodging such claims are available under domestic legislation. With regard to her request that the State party take steps to prevent repetition and implement hospital protocols to facilitate access

to safe, legal abortion and mechanisms for exercising this right, on 29 January 2007, through Decree No. 304/2007, the Ministry of Health of Buenos Aires province approved a Provincial Health Programme for the Prevention of Domestic and Sexual Violence and for Victim Support, which contains a protocol for non-punishable abortion. Provincial criminal legislation and policy is restricted by the definitions of criminal offences established in Argentina's Criminal Code. It was for this reason that, within the limits of its jurisdiction, to prevent similar cases from arising in future the authorities of Buenos Aires province approved the afore mentioned programme.

Author's comments on the State party's observations

5.1 The author responded to the State party's observations on 14 June 2008. In relation to admissibility, she reiterated her request that the Committee should establish the State's international responsibility for the violation of L.M.R.'s rights, on the grounds that the State did not fulfil its obligation to safeguard and respect her right to a legal remedy, her right to life, her right to equal treatment, her right not to be subjected to cruel, inhuman and degrading treatment, her right to privacy and her right to freedom of thought and conscience. Establishing this responsibility is the main aim of the communication, and is fundamental to the satisfaction of the author's other requests. The application for full reparation and all other requests are a necessary consequence of the violation of L.M.R.'s human rights committed by the State.

5.2 L.M.R. sought a legal and safe abortion. She petitioned all possible courts to obtain one but the medical procedure sought was not performed. Accordingly, all domestic remedies were exhausted with regard to the main contention of the communication, which is that the refusal of a legal abortion was a violation of her rights. The applications for reparation and compensation that were prompted by the violation of these rights, and which the State contends should first have been filed in Buenos Aires province, would have done nothing to help guarantee her right to a legal abortion. In fact, they would have been ineffectual in helping L.M.R. access the medical procedure sought.

5.3 L.M.R. won a ruling in her favour before the highest provincial court, which was the court of last resort. However, the ruling was not enforced because the staff in the State hospital who should have executed it refused to do so. L.M.R. did not have the option of appealing against a favourable ruling that the State refused to enforce, in continuing violation of her rights. The author therefore maintains that the communication is admissible.

5.4 With regard to the State party's observations on the merits, the author notes that the State party prides itself on the speed of the judicial process. It fails to mention, however, that the process was unnecessary and the fact that it took place at all constitutes a violation of L.M.R.'s rights. Recourse to judicial proceedings was not required under the Criminal Code and was discouraged by numerous prior court decisions. The State party does not explain whether the juvenile court judge

who made the first-instance ruling was disciplined for failing to properly perform her duties as a public servant, a failing of which the hospital's employees and directors were also guilty.

5.5 The State party fails to recognize that it made no attempt to protect L.M.R. from press hounding, institutional harassment and the hospital inaction which ultimately prevented the termination of pregnancy from being carried out. The State party cites the "assessments of the medical staff" as justification. However, besides being arbitrary and subjective, these assessments were inaccurate in numerous respects. In one ultrasound report the length of the pregnancy was falsely recorded. In addition, a time limit for termination that has no legal basis was imposed. In acting this way, the health-care professionals showed contempt for the law and failed to exercise their duties as public servants. Despite constituting criminal offences, these failings were never subject to administrative or judicial investigation.

5.6 The fact that the author turned to the black market for an abortion that the State refused to perform was a direct consequence of the State's inaction and negligence. The author takes issue with the State party's observation that the advocate for persons without legal capacity was not informed. The State is effectively affirming that, in the midst of press persecution and relentless pressure from fundamentalist groups, she should have informed a judicial official of an illegal procedure performed under pressure of time in the face of inadequate resources and lack of access to effective justice.

5.7 The promulgation of the Ministerial Decree containing a protocol for non punishable abortion in Buenos Aires province was subsequent to the case. Furthermore, although the protocol is a positive development, it remains a partial solution only. The State party must ensure that protocols are in place in every province and every jurisdiction under its control in order to prevent violations of this kind from recurring. It must also ensure that such protocols are underpinned by laws of the highest level within the provincial jurisdiction and not, as in the case in point, by a Ministerial Decree.

Additional observations by the State party

6.1 On 21 August 2008 the State party observed that it could be concluded from the Supreme Court ruling that the lower instance courts of Buenos Aires province had interfered unlawfully since judicial authorization is not required for a termination of pregnancy under article 86.2 of the Criminal Code. The consequences of this interference made an abortion impossible due to the advanced stage of the pregnancy. This would appear to indicate that the claimant is right in invoking a possible violation of article 2 of the Covenant.

6.2 However, the hospital decided not to perform the termination because the advanced stage of the pregnancy meant that the procedure was no longer considered a termination from the medical point of view but was effectively an induced birth. This decision does not merit admonition, as there was no breach of any rule. It does, however, highlight the lack of rules to specify and clarify the point

in a pregnancy beyond which a termination ceases to be considered an abortion and becomes an induced birth.

6.3 The State party also observes that the State's unlawful interference, through the judiciary, in an issue that should have been resolved between the patient and her physician may be considered a violation of her right to privacy. Furthermore, forcing her to endure a pregnancy resulting from rape and undergo an illegal abortion may have been a contributing factor to the mental injury that the victim suffered, although it did not constitute torture within the meaning of article 1 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

6.4 The victim's freedom of thought, conscience and religion was not violated by the State, because the activities of specific groups are unconnected to the actions of its officials. The authorities of the hospital to which L.M.R. was admitted did not refuse to perform the termination for reasons of conscience but because they believed that the advanced stage of the pregnancy meant they were being asked to perform a different procedure, i.e. an induced birth.

6.5 On the basis of the above, the State party indicates that it would be ready to consider the possibility of initiating an amicable settlement procedure in which the applications made by the author would be examined.

Additional comments by the author

7.1 On 6 February 2010 the author rejected the contention that the hospital had decided not to perform the termination of pregnancy because the advanced stage of the pregnancy meant that the procedure was no longer considered a termination from the medical point of view but was effectively an induced birth. She recalls that the reason for the advanced state of the pregnancy was the unnecessary recourse to judicial proceedings. It was the State party that caused the delay. In addition, the hospital falsely recorded the length of the pregnancy in an ultrasound report and imposed a time limit for termination for which there is no legal basis either at national or international level.

7.2 Besides disregarding case law precedents which militate against recourse to judicial proceedings in such cases (i.e. against judicial responsibility), health-care professionals showed contempt for the law and failed to fulfil their duties as public servants. Despite constituting criminal offences, neither failing was subject to administrative or judicial investigation. The refusal to terminate the pregnancy was a tacit objection of institutional conscience on the part of the State hospital. The refusal was entirely arbitrary, because the Criminal Code sets no time limit beyond which the procedure cannot be performed. Furthermore, a precedent can be found in the case law of Buenos Aires Provincial Court, which last year gave authorization for a therapeutic termination to be performed in a State hospital in a pregnancy as advanced as L.M.R.'s.

7.3 The author does not accept the State party's contention that this is not a case of torture within the meaning of article 1 of the Convention against Torture and Other Cruel, Inhuman or Degrading

Treatment or Punishment. The State party gives no explanation to back up its position, which is contrary to the Committee's case law in the case of K.N.L.H. v. Peru.[4]

7.4 The author reiterates that the State party did not at any time take steps either to protect L.M.R. and her family or to prevent conservative groups within the Catholic Church from imposing their religious convictions on the victim, her family and the hospital staff, denying them the freedom to make their own decisions. For this reason, she disputes the assertion that freedom of thought, conscience and religion was not violated by the State since the acts in question were the acts of private individuals.

7.5 With regard to the possibility of an amicable settlement, the author informs the Committee that the parties met on three occasions between August and November 2008 to discuss reparation for the victim and her family and measures to prevent repetition. At the outset of the discussions, the State's representatives stated that restrictions imposed by the Public Prosecution Service of Buenos Aires province placed legal impediments on the payment of financial compensation. As a result, the parties failed to make progress on any aspect of the application for compensation. The only agreement reached was for a study grant of 5,000 pesos to be paid by the Ministry of Education of Buenos Aires at the end of 2008. Despite an undertaking that this grant would be payable annually, to date no further payment has been made.

7.6 There was a similar lack of progress on other aspects of the application, including the State's public acceptance of responsibility and the package of measures needed to prevent repetition. Aside from the adoption, in March 2009, of a comprehensive law to prevent, punish and eliminate violence against women, to date the only advance achieved in relation to the issues raised is an undertaking to address them.

7.7 The author reiterates her request to the Committee, dismisses the possibility of an amicable settlement and urges the Committee to issue its Views.

Issues and proceedings before the Committee

Consideration of admissibility

8.1 Before considering any claim contained in a communication, the Human Rights Committee must decide, in accordance with rule 93 of its rules of procedure, whether the communication is admissible under the Optional Protocol to the Covenant.

8.2 As required under article 5, paragraph 2 (a), of the Optional Protocol, the Committee has ascertained that the same matter is not being examined under another procedure of international investigation or settlement.

8.3 The Committee observes that, although the State party initially contended that the communication was inadmissible on the grounds of failure to exhaust domestic remedies, in

subsequent correspondence it agreed with the author that the injunction issued by the lower courts of Buenos Aires province in the case of L.M.R. constituted unlawful interference under article 86.2 of the Criminal Code. It also agreed with the author that several articles of the Covenant had been violated. Consequently, the Committee considers that there are no obstacles to consideration of the merits of the communication under article 5, paragraph2

(b) of the Optional Protocol.

8.4 The Committee takes note of the author's claims that, because it lacked the mechanisms that would have enabled L.M.R. to undergo a termination of pregnancy, the State party is responsible by omission for a violation of article 2 of the Covenant. The Committee recalls that, according to its established case law, article 2 of the Covenant constitutes a general undertaking on the part of the State and cannot be invoked in isolation by individuals under the Optional Protocol. Consequently, the complaint under article 2 will be considered together with the claims made by the author under other articles of the Covenant.[5]

8.5 The Committee also notes the author's claim that the impossibility of obtaining an abortion constituted a violation of the right to equality and non-discrimination established under article 3 of the Covenant. In her opinion, the State's failure to exercise due diligence in safeguarding a legal right to a procedure required solely by women resulted in discriminatory treatment of L.M.R. The Committee considers this allegation to be closely related to those made under other articles of the Covenant, and that they should therefore be considered together.

8.6 The Committee notes the author's claim that the facts described constitute a violation of L.M.R.'s right to life in that the State failed to adopt the measures and act with the due diligence necessary to ensure that L.M.R. could obtain a safe abortion and prevent the need for an unlawful, unsafe abortion. The Committee observes, however, that there is nothing in the case file to indicate that L.M.R.'s life was exposed to particular danger because of the nature of her pregnancy or the circumstances in which the termination was performed. Consequently, the Committee considers that this complaint is not substantiated and is therefore inadmissible under article 2 of the Optional Protocol.

8.7 The author maintains that her daughter was subject to a violation of article 18 as a result of State inaction in the face of pressure and threats from Catholic groups and the hospital doctors' conscientious objection. The State party denies that this article has been violated, on the grounds that the activities of specific groups are unconnected to the actions of its officials, and that the hospital's refusal to perform the procedure was guided by medical considerations. In the circumstances, the Committee considers that the author has not adequately substantiated her complaint for purposes of admissibility and that the complaint must therefore be declared inadmissible under article 2 of the Optional Protocol.

8.8 Concerning the allegations relating to articles 7 and 17 of the Covenant, the Committee considers that they were adequately substantiated for purposes of admissibility.

8.9 In the light of the above, the Committee declares the communication admissible in so far as it raises issues under articles 2, 3, 7 and 17 of the Covenant.

Consideration of the merits

9.1 The Human Rights Committee has considered the present communication in the light of all information made available to it by the parties, as provided in article 5, paragraph 1, of the Optional Protocol.

9.2 The Committee takes note of the author's allegation that forcing her daughter to continue her pregnancy, even though she should have enjoyed protection under article 86.2 of the Criminal Code, constituted cruel and inhuman treatment. The State party asserts that, while forcing her to endure a pregnancy resulting from rape and undergo an illegal abortion could have been a contributing factor to the mental injury that the victim suffered, it did not constitute torture. The Committee considers that the State party's omission, in failing to guarantee L.M.R.'s right to a termination of pregnancy, as provided under article 86.2 of the Criminal Code, when her family so requested, caused L.M.R. physical and mental suffering constituting a violation of article 7 of the Covenant that was made especially serious by the victim's status as a young girl with a disability. In this connection the Committee recalls its general comment No. 20 in which it states that the right protected in article 7 of the Covenant relates not only to acts that cause physical pain but also to acts that cause mental suffering. [6]

9.3 The Committee takes note of the author's allegation that the facts described constituted arbitrary interference in L.M.R.'s private life. It also notes the State party's acknowledgement that the State's unlawful interference, through the judiciary, in an issue that should have been resolved between the patient and her physician could be considered a violation of her right to privacy. In the circumstances, the Committee considers that the facts reveal a violation of article 17, paragraph 1 of the Covenant.[7]

9.4 The Committee takes note of the author's allegations to the effect that, because it lacked the mechanisms that would have enabled L.M.R. to undergo a termination of pregnancy, the State party is responsible by omission for the violation of article 2 of the Covenant. The Committee observes that the judicial remedies sought at the domestic level to guarantee access to a termination of pregnancy were resolved favourably for L.M.R.by the Supreme Court ruling. However, to achieve this result, the author had to appear before three separate courts, during which period the pregnancy was prolonged by several weeks, with attendant consequences for L.M.R.'s health that ultimately led the author to resort to illegal abortion. For these reasons, the Committee considers that the author did not have access to an effective remedy and the facts described constitute a violation of

article 2, paragraph 3 in relation to articles 3, 7 and 17 of the Covenant.

10. The Human Rights Committee, acting under article 5, paragraph 4, of the Optional Protocol to the International Covenant on Civil and Political Rights, is of the view that the information before it reveals a violation of article 7, article 17 and article 2, paragraph 3in relation to articles 3, 7 and 17 of the Covenant.

11. In accordance with article 2, paragraph 3 (a), of the Covenant, the State party is under an obligation to provide L.M.R. with avenues of redress that include adequate compensation. The State party is also under an obligation to take steps to prevent similar violations in the future.

12. Bearing in mind that, by becoming a party to the Optional Protocol, the State party has recognized the competence of the Committee to determine whether or not there has been a violation of the Covenant and that, pursuant to article 2 of the Covenant, the State party has undertaken to guarantee to all individuals within its territory or subject to its jurisdiction the rights recognized in the Covenant, the Committee wishes to receive from the State party, within 180 days, information about the measures adopted to give effect to the Committee's Views. The State party is also requested to publish the present Views.

[Adopted in English, French and Spanish, the Spanish text being the original version. Subsequently to be issued also in Arabic, Chinese and Russian as part of the Committee's annual report to the General Assembly.]

The following members of the Committee participated in the examination of the present communication: Mr. Lazhari Bouzid, Ms. Christine Chanet, Mr. Cornelis Flinterman, Mr. Yuji Iwasawa, Ms. Helen Keller, Ms. Zonke Zanele Majodina, Ms. Iulia Motoc, Mr. Gerald L. Neuman, Mr. Rafael Rivas Posada, Sir Nigel Rodley, Mr. Krister Thelin and Ms. Margo Waterval.

In accordance with article 90 of the Committee's rules of procedure, Mr. Fabian Omar Salvioli did not participate in the examination of the present communication.

1 This provision establishes the following: "Abortion performed by a licensed physician with the consent of the pregnant woman is not punishable: (1) if performed to avoid endangering the mother's life or health and if this danger cannot be prevented by other means; and (2) if the pregnancy results from the rape or indecent assault of a woman with a mental disability. In such cases, the consent of her legal representative must be obtained for the termination."

2 The Court ruled that: "(a) judicial authorization is not required for application of article

86.2 of the Criminal Code; (b) since the present case is not punishable under national legislation (...) no order prohibiting the surgical termination of the young girl's pregnancy can be issued (...), provided that the decision to perform the procedure has been taken by medical professionals in

accordance with best medical practice".

3 Communication No. 1153/2003, *K.N.L.H. v. Peru*, Views adopted on 24 October2005. 5 Communication No. 1153/2003, *K.N.L.H. v. Peru*, op. cit., paragraph5.4.

6 General comment No. 20: Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment (art. 7), 10 March 1992, paragraph 5. See also *K.N.L.H. v. Peru,* op. cit., paragraph6.3.

7 K.N.L.H. v. *Peru, op*. cit., paragraph 6.4.

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Fiftieth session
3 – 21 October 2011

Views

Communication No. 22/2009

Submitted by:	**T. P. F. (represented by the Centre for Reproductive Rights and the Centre for the Promotion and Protection of Sexual and Reproductive Rights)**
Alleged victim:	L.C.
State party:	Peru
Date of the communication:	18 June 2009 (initial communication)
References:	**Transmitted to the State party on 20 July 2009 (not issued in document form)**
Date of adoption decision:	17 October2011

Annex

Views of the Committee on the Elimination of Discrimination against Women under article 7, paragraph 3, of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women

At its fiftieth session concerning Communication No. 22/2009,

L. C. v. Peru[1]

Submitted by:	**T. P. F. (represented by the Centre for Reproductive Rights and the Centre for the Promotion and Protection of Sexual and Reproductive Rights)**
Alleged victim:	L.C.
State party:	Peru
Date of the communication:	18 June 2009 (initial communication)
References:	Transmitted to the State party on 20 July 2009 (not issued in document form)

The Committee on the Elimination of Discrimination against Women, established under article 17 of the Convention on the Elimination of All Forms of Discrimination against Women,

Meeting on 17 October 2011

Adopts the following:

Views under article 7, paragraph 3, of the Optional Protocol

1. The author of the communication, dated 18 June 2009, is T. P.F.. She is submitting the communication on behalf of her daughter, L. C., a Peruvian citizen born 2 April 1993. The author claims that her daughter has been a victim of violation by Peru of articles 1, 2 (c) and (f), 3, 5, 12 and 16 (e) of the Convention on the Elimination of All Forms of Discrimination against Women.

[1]The following members of the Committee participated in the adoption of the present communication: Ms. Ayse Feride Acar, Ms. Magalys Arocha Dominguez, Ms. Violet Tsisiga Awori, ,Ms. Barbara Evelyn Bailey, Ms. Olinda Bareiro-Bobadilla Ms. Meriem Belmihoub-Zerdani, Mr. Niklas Bruun, Ms. Naela Mohamed Gabr, Ms. Ruth Halperin-Kaddari, Ms. Yoko Hayashi, Ms. Ismat Jahan, Ms. Soledad Murillo de la Vega, Ms. Violeta Neubauer, Ms. Silvia Pimentel, Ms. Maria Helena Lopes de Jesus Pires, Ms. Victoria Popescu, Ms. Zohra Rasekh, Ms. Patricia Schulz and Ms. Dubravka Šimonović and Ms. Zou Xiaoqiao.

The author and her daughter are represented by the Centre for Reproductive Rights and the Centre for the Promotion and Protection of Sexual and Reproductive Rights.[2] The Convention entered into force in Peru on 13 October 1982 and the Optional Protocol on 10 July 2001.

The facts as presented by the author

2.1 L. C. lives in Ventanilla District, Callao Province. In 2006, when she was 13 years old, she began to be sexually abused by J. C. R., a man about 34 years old. As a result, she became pregnant and, in a state of depression, attempted suicide on 31 March 2007 by jumping from a building. She was taken to Daniel Alcides Carrion public hospital, where she was diagnosed with "vertebromedullar cervical trauma, cervical luxation and complete medullar section", with "a risk of permanent disability" and "risk of deterioration of cutaneous integrity resulting from physical immobility".

2.2 The damage to the spinal column, in addition to other medical problems, caused paraplegia of the lower and upper limbs requiring emergency surgery. The head of the Neurosurgery Department recommended surgery in order to prevent the injuries she suffered from worsening and leaving her disabled. As a result, the intervention was scheduled for 12 April2007.

2.3 On 4 April the hospital performed a psychological evaluation of L. C., in the course of which she revealed that the sexual abuse she had suffered and her fear of being pregnant were the causes of her suicide attempt. The following day a gynaecological examination was performed, confirming the pregnancy. The daily status reports on the health of L. C. from 2 to 12 April 2007 recorded the risk both of developing infections and of failing to avoid deterioration of her skin owing to the condition of total paralysis and deterioration of her physical mobility.

2.4 On the scheduled day of the surgery, the author was informed that it had been postponed and that the doctor wished to meet with her the following day, 13 April 2007. At that meeting, the author was informed that the surgery had been postponed because of L. C.'s pregnancy. The author also notes that L. C. was diagnosed with moderate anxiety-depression syndrome, for which she was given no treatment as it was contraindicated during pregnancy.

2.5 On 18 April 2007, the author, after consulting with her daughter, requested the hospital officials to carry out a legal termination of the pregnancy in accordance with article 119 of the Penal Code.[3] In her request the author referred to the conversation she had on 13 April 2007 with the

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[2] The Committee received an amicus brief from the International Commission of Jurists on the access to an effective remedy, as well as comments from the Health Equity and Law Clinic of the Faculty of Law, University of Toronto, on the concept of multiple discrimination.

[3] This provision states that "abortion shall not be punishable if performed by a doctor with the consent of the pregnant woman or her legal representative, if any, when it is the only way to save the life of the mother or to avoid serious and permanent harm to her health".

Head of the Neurosurgical Department in which he informed her that he could not operate L.C. due to her pregnancy. She alleged that the pregnancy seriously and permanently endangered the life, physical and psychological health and personal integrity of L.C. and the spinal surgery could not be performed if the pregnancy continued.[4]

2.6 Given the excessive delay by the hospital authorities in responding to the request, the author sought the assistance of the non-governmental organization "Centro de Promocion y Defense de los Derechos Sexuales y Reproductivos (PROMOSEX) (Centre for the Promotion and Protection of Sexual and Reproductive Rights) which, on 15 May 2007, brought the case to the attention of the office of the Deputy Defender for Women's Rights in the Public Defender's Office. On 30 May 2007, 42 days after having submitted the request for a therapeutic abortion, the medical board of the hospital denied the request because it considered that the life of the patient was not in danger.

2.7 The Deputy Defender requested a medical report from the High-Level Commission on Reproductive Health of the Medical College of Peru. After giving a description of the injuries that the girl had sustained the Commission, in a report dated 7 May 2007 indicated, inter alia, that due to L.C.'s age and neurological lesion a risk of complications during the delivery was to be expected. It concluded: "There are sufficient reasons to state that, if the pregnancy continues, there is grave risk to the girl's physical and mental health; a therapeutic abortion, if requested by the subject, would therefore be justified".

2.8 On 7 June 2007, when L. C. was 16 weeks pregnant, the author submitted an appeal for a reconsideration of its opinion regarding the termination of the pregnancy to the hospital medical board, attaching the report of the Medical College and stressing the serious and immediate risk to both the physical and mental health of the minor, the sole requirements established under the Penal Code to allow the legal termination of pregnancy.

2.9 On 16 June 2007, L. C. miscarried spontaneously. On 27 June 2007, the Director of the hospital responded to the request for reconsideration of the decision not to terminate the pregnancy submitted by the author, stating that "it was not subject to appeal since those were decisions taken by the various specialists who had evaluated the minor".

2.10 On 11 July 2007, L. C. was operated on for her spinal injuries, almost three and one half months after it had been decided that surgery was necessary. On 31July 2007 she was discharged from the hospital. The relevant medical report noted that L. C. required intensive physical therapy and rehabilitation at the National Physical Medicine and Rehabilitation Institute. However, that therapy did not start until 10 December 2007. Four months went by after the operation before the physical rehabilitation and psychological or psychiatric helps her required began.

2.11 L. C. remained in the National Rehabilitation Institute for two months, but had to abandon

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[4] Copy of the request is contained in the file.

her treatment for lack of means. Currently she is paralyzed from the neck down and has regained only partial movement in her hands. She depends on a wheelchair to get around and on others to meet all her needs. She has a catheter which must be changed five times a day under totally sterile conditions, which prevents her from attending school. The author states that the family's situation is disastrous. She cannot work because L. C. requires constant care, and the cost of the medicines and equipment she requires places a heavy burden on the family budget. The brothers of L.C. had to leave school in order to begin working.

2.12 According to the author, no administrative recourse exists in the State party to request the legal termination of a pregnancy. Nor is there a protocol for care that indicates the procedure for requesting a legal abortion or ensuring the availability of this medical service, resources that would be appropriate in demanding the right and guaranteeing access to an essential medical service required only by women.

2.13 The previous Peruvian Health Code established as a requirement in order to perform a therapeutic abortion that it must be performed by a doctor and be supported by two other doctors. However, the General Health Act currently in force (Act No. 26842 of 9 July 1997) repealed that standard and created a legal vacuum since it does not include any regulations on access to the medical procedure of therapeutic abortion. Since that time, the practice has been subject to the discretion of the officials on duty.

2.14 According to the author, there is no appropriate judicial mechanism allowing access to the courts to request termination of a pregnancy for therapeutic reasons, nor to provide full redress for a violation of this type. No remedy exists that operates with sufficient speed and effectiveness so that a woman can demand from the authorities the guarantee of her right to a legal abortion within the limited time period that circumstances require.

2.15 The remedy of amparo under the Constitution does not meet the necessary time frame to ensure effective action. Under the norms governing this proceeding, it takes somewhere between 62 and 102 days to reach a final decision, after all prior remedies have been exhausted. Furthermore, application for this remedy is subject to the exhaustion of all prior remedies, in this case the hospital's refusal to perform the abortion. In the case of L. C., that period exceeded the time period within which she could effectively enjoy that right without risking even more harm to her life and health. When the first refusal to perform the abortion was received she was already 16weeks pregnant and, had the appeal been heard, she would have been 20 weeks pregnant by that time. There would have been no sense in applying for amparo after that point, since by the time that a final and enforceable decision would have been likely to be taken L. C. would have been more than 28 weeks pregnant. Furthermore, although the norms establish a procedure that in theory should take somewhere between 62 and 102 days, in reality, amparo proceedings generally take years to resolve. In this regard, the author recalls the decision of the Human Rights Committee in the case of *K.N.L.H.*

v. Peru, also concerning the refusal to perform a therapeutic abortion on a woman pregnant with an anencephalic foetus, where the Committee did not consider the amparo proceeding to be an effective remedy that must be exhausted.[5]

The complaint

3.1 The author states that the refusal by the doctors at the hospital to perform the therapeutic abortion violated the rights of L. C. to health, a life of dignity and to be free from discrimination in access to such care. L. C. was deprived of the possibility of walking again by the unjustified withdrawal of a surgical intervention that was totally necessary. The failure of the health system in the State party to ensure access to essential services for women, such as abortion, compromises its obligations under the Convention. The State party has not met its obligations by failing to provide a legal medical service required only by women, and on which the victim's physical and mental health depended. This violation was aggravated by the fact that L. C. was a minor; in that respect the State had a double duty to protect her. Nor had the State party provided adequate and effective guarantees in its legislation to protect those rights.

3.2 The author maintains that the facts described constitute a violation of articles 1, 2, 3, 5, 12 and 16, paragraph 1 (e) of the Convention, as well as General Recommendation No.24.

3.3 With respect to article 5, the author states that placing conditions on timely access to a medical treatment on which the exercise of the right to health, life and a life of dignity depended by continuing an unwanted pregnancy resulted in discriminatory treatment based on the stereotype of imposing the reproductive function on L. C., above her welfare. As for article 12, the author claims that since L. C.'s pregnancy constituted a threat to her physical and mental health, therapeutic abortion was appropriate and necessary. The medical needs of L. C. and the due protection of her right of access to both physical and mental health without discrimination were totally ignored by those whose duty it was to guarantee those rights. The author also claims that the refusal to provide the legal health service of termination of pregnancy violates the right to decide the number and spacing of children provided in article 16 (e). Furthermore, the lack of administrative and judicial mechanisms protecting women from discrimination in providing legal termination of pregnancy violates articles 2 (c), 5 and 12 of the Convention and general recommendation No. 24. Also, the failure by the State to adopt legislative, administrative and judicial measures that protect, guarantee and ensure the right of access to health under conditions of equality in the context of therapeutic abortion violates articles 2 (f), 3, 5, 12 and 16 (e) of the Convention. The absence of such measures resulted in absolute discretion, allowing health professionals to deny timely medical services to L.C. in a disproportionate and illegal manner.

[5] See Communication No. 1153/2003, K.N.L.H. v. Peru, Views of 24 October 2005, para. 5.2.

3.4 According to the author, the facts as described also violate other fundamental rights, such as the right to life, dignity and freedom from cruel, inhuman and degrading treatment in the context of access to medical services without discrimination. She states that the interference of the doctors in L. C. 's decision to terminate her pregnancy shattered her life prospects. The process of requesting an abortion constituted a discretionary and arbitrary barrier to access to a legal service that had irreparable consequences for her life and health and in turn constituted suffering equivalent to torture. Forcing her to continue the pregnancy also constituted cruel and inhuman treatment and therefore a violation of her right to physical, psychological and moral integrity. Furthermore, the harm is of continuing duration, since it has repercussions in the form of her daily situation of disability, dependency and paralysis.

3.5 According to the author, the foregoing violations are aggravated by the fact that L. C. was a minor. The health-care professionals did not provide the special attention required by her status as an adolescent female, and furthermore, of limited economic resources.

3.6 The author requested that the Committee declare the violation of the author's rights under the Convention and request the State party to adopt measures of reparation, satisfaction and guarantees of non- repetition. The Committee should also urge the State party to adopt and implement legislative, administrative and judicial measures necessary to protect women's right to sexual and reproductive health without discrimination.

State party's observations on admissibility

4.1 By a submission of 18 September 2009 the State party maintains that the communication should be considered inadmissible under article 4, paragraph 1, of the Optional Protocol on the grounds of failure to exhaust all available domestic remedies.

4.2 The State party notes that the alleged victim could have filed a petition for *amparo* with the Constitutional Court. The author 's questioning of the effectiveness of that recourse is based on a prediction of future success, since she argues that the time frame for receiving a final decision varies between 62 and 102 days (according to the calculations she makes *motu proprio*, based on the rules of procedure of the Code of Constitutional Procedure). However, the author does not take into account that, although there are a first and second instances before the case can be submitted to the Constitutional Court, if the case is decided in those instances in favour of the applicant, that decision is final. Consequently, an application for amparo can be finalized by a ruling of the judge of first instance. Furthermore, in accordance with article 53 of the Code of Constitutional Procedure, the decision must be issued at the same hearing, or in exceptional cases, within not more than five days after the hearing has been completed. If a decision is appealed, the decision on the appeal must be issued with in five days after the case is heard.

4.3 The State party also invokes article 46 of the Code of Constitutional Procedure, under which

exceptions are made to the exhaustion of remedies before petitioning for amparo. Such exceptions are made when the exhaustion of remedies might render the harm irreparable, if there are no regulations governing prior remedies, or if the application has been initiated unnecessarily by the victim. Article 45 furthermore states that, in the event of doubt concerning the exhaustion of prior remedies, preference is given to the application for amparo.

4.4 Finally, the State party notes that, with regard to the implementation of article 1969 of the Civil Code, the author could have filed court proceedings to request compensation for damages and harm because the alleged victim did not receive timely medical treatment.

Author's comments on the State party's observations on admissibility

5.1 In her comments of 1 February 2010 the author referred to international jurisprudence in the area of exhaustion of domestic remedies and maintains that, in accordance with that jurisprudence, the effectiveness of a remedy rests on whether it can be adapted to the situation of vulnerability of the victim, the circumstances of a particular case and the objective to be attained according to the right violated.

5.2 In accordance with its regulations under article 53 of the Code of Constitutional Procedure, proceedings for the remedy of amparo should not exceed 10 working days from the acceptance of the request. However, there are various procedural problems that undermine the desired speed of this proceeding. First, the Code does not establish a deadline for the judge to accept the request. As a result, that time period is dependent on the subjective importance the judge attaches to the case, in addition to his caseload. Second, at the time the events took place, the existing system for service of documents was to designate a private individual or institution to carry out the personal delivery of any judicial order. This system turned out to be highly problematic, which led the State to adopt a reform programme beginning in 2008 to expedite service. This led to some progress but in general the problem persists. Third, article 53 provides for the possibility of holding an oral hearing, but does not establish a deadline for requesting such a hearing, nor for the judge to grant it, nor does it allow the judge to call a hearing on his own initiative.

5.3 According to the author, between May 2003 and August 2008, only six petitions for amparo concerning the protection of the right to health were reviewed by the Constitutional Court. The case that took the least amount of time to settle at first instance took two months and 16 days and the longest one year. Based on these precedents, a minimum of two months could be expected in order to obtain a decision at first instance. When L. C. finally received a response from the hospital refusing the termination of the pregnancy, 56 days had already gone by since her suicide attempt. Waiting another 60 to 90 days to obtain a court decision requiring the hospital to perform the termination of pregnancy and the subsequent spinal operation would only have worsened her clinical status and would have had no effect whatever on preventing or repairing

the harm already experienced. After L. C. miscarried (16 June 2007), the hospital did not schedule the surgery until almost a month later (11 July 2007). By then the violation of the right to have the operation had ceased but the damage was already irreversible. Therefore, it made even less sense to initiate a petition for amparo, since the request would have rightly been declared to be without merit. The author concludes that the remedy of amparo consequently is not an effective remedy in this type of case.

5.4 The author also notes that the prior methods used in the present case, the internal administrative proceedings within the hospital and the complaint to the Women's Rights Defender, also did not constitute an appropriate mechanism, since under the regulations they were not administrative proceedings intended, as part of due process, to address requests for legal termination of pregnancy.

5.5 *In the case K.N.L.H. v. Peru*[6], the Human Rights Committee had requested the State party to take measures to ensure that the situation was not repeated. According to the author, part of those measures should include both the issuance of guidelines for legal termination of pregnancy in circumstances established under the law and the establishment of an effective judicial remedy in the event that those guidelines are not followed in a satisfactory manner. The Committee on the Elimination of Discrimination against Women, in its 2007 concluding observations addressed to Peru, expressed its concern at the lack of measures to implement the recommendations made by the Human Rights Committee in that case. Those measures still do not exist.

5.6 The author also cites the decision of the European Court of Human Rights of 20 March 2007, in *Tysiac v. Poland*[7]. The Court determined that there had been a violation of the European Convention for the Protection of Human Rights and Fundamental Freedoms in arriving at the decision concerning a therapeutic abortion and noted that, once the legislature had decided to allow abortion, it must not structure its legal framework in such a way as to limit the use of that possibility. The Court added that disputes should be settled by an independent body, respecting guarantees of the right to be heard, and it should issue prompt and written grounds for its decision, since the time factor is crucial.

5.7 In Peru there is no administrative or judicial procedure that would have guaranteed the right of L. C. to be heard, allowing her to express her will and establish whether or not she wanted to terminate her pregnancy, the right to obtain a swift and objective response and the possibility of access to a judicial remedy that would guarantee enforcement of the duty to provide the medical services she needed.

5.8 With respect to civil action to seek compensation for damages mentioned by the State, it cannot be considered a sufficient remedy, since the damage suffered by L. C. to her health cannot

[6] Communication No. 1153/2003, K.N.L.H v. Peru, Views adopted on 24 October 2005.

[7] Tysiac v. Poland, (application No. 5410/03), judgment of 20 March 2007.

be repaired. Furthermore, it is retroactive in nature, since L. C. was unable to attain the objective of the termination of her pregnancy and the spinal surgery.

State party's observations on the merits

6.1 On 20 January 2010, the State party submitted observations on the merits of the communication in which it maintained that, in the present case, none of the alleged violations of the Convention had taken place.

6.2 The State party recalled that in the Peruvian legal system abortion is criminalized. As the only exception, it is not punishable in the event that the conditions established in article 119 of the Penal Code for therapeutic abortion are present.

6.3 The State party considers that article 1 of the Convention simply contains the definition of discrimination, but not a right in itself. Articles 2, 3, 5, 12 and 16 are invoked inasmuch as the State would not have guaranteed timely access without discrimination to health-care services in the form of a legal termination of pregnancy and spinal surgery in order to achieve the due rehabilitation of L.C.

6.4 From the documents made available by the Ministry of Health, it can be inferred that, on her admission to the hospital on 31 March 2007, L. C. received immediate medical attention and various medical examinations were performed on her, including psychiatric and neuropsychological examinations. The gravity of her condition was directly related to her own action (the suicide attempt), and not to the possible physiological effects that the pregnancy could have had on her.

6.5 L. C. arrived at the hospital with paraplegia from the fall she suffered, therefore it is inaccurate to state that her condition necessarily worsened because the abortion was not performed. What is more, according to the medical authorities, L. C. could not undergo the spinal operation until the wound adjoining the surgical incision site had improved.

6.6 The situation of L. C. was evaluated on three occasions by the hospital medical board (24 April, 7 May and 19 May 2007); there was no disinterest or lack of treatment.[8] On those occasions psychiatric and neuropsychological evaluations were recommended and the neurosurgeon believed that the surgery should be done when the occipito-cervical wound had improved, as that was the area where the surgical incision would be made.

6.7 At the third meeting of the medical board, held on 19 May 2007, the following was stated: "The operation required by the patient is not an emergency, it is elective ... The luxo-fracture

[8]The State party attached copies of the reports of the medical board. According to the first, of 24 April 2007, the doctors' views regarding the pregnancy were that "because of the patient's diagnosis, age, invasive nursing procedures, immobility in bed, it is considered high-risk, leading to elevated maternal morbidity, which could diminish with appropriate multidisciplinary medical management". The report also noted that there was no guarantee that the baby would not be affected by the spinal surgery.

C6 and C7 cannot undergo the planned surgical stabilization because there continues to be an infection in the area bordering the area of the surgical incision ... The Department of Obstetrics and Gynaecology maintains that, despite this being a high-risk pregnancy, the current condition of the patient is stabilizing in the neurological aspects and favourable in the psychological aspects ... In line with the laws in effect, the majority of us believe that the termination of pregnancy should not be performed". This decision was communicated to L. C.'s mother, who had requested the termination of pregnancy. She submitted an appeal, to which the response was the same. Therefore, she did have the possibility of appealing to the competent authorities to act on her request, independent of the fact that the result was not what she had hoped.

6.8 With respect to the right to decide the number and spacing of children, it should be evaluated based on existing family planning methods and programmes offered by the State. In the present case, however, the author attempts to link this right to therapeutic abortion, which the State party does not accept. Abortion is illegal as a general rule and is permitted only as an exception in cases of therapeutic abortion, and it is necessary to take domestic laws into account. It is not for the pregnant woman unilaterally to determine that the conditions for a therapeutic abortion have been met, but for the doctors. That is effectively what occurred in this case; they considered that the pregnancy did not represent a risk to L. C. and therefore deduced that her condition would have neither improved nor worsened if the abortion had been performed. As far as legal abortion is concerned, in reaching a decision that did not depend exclusively on the wishes of the pregnant woman, it is not possible, strictly speaking, to refer to the violation of a "right", as there is no link to reproductive freedom. Likewise, it would not be possible to link the fact that access to a therapeutic abortion was denied to the alleged existence of a certain stereotype against women.

6.9 According to the Technical Team of the General Directorate for the Promotion of Health of the Ministry of Health, in the present case it is important to consider the family environment, the risks to which L. C. had been exposed since the age of 11 (the age at which the sexual abuse began) and the way in which it gravely harmed her physical and mental health. These elements are a starting point for new initiatives for intervention with at-risk populations.

6.10 The Ministry of Health has models for comprehensive care for child abuse at the national level that offer care for children and families affected by violence, including sexual violence. If the family had sought help in a timely way that would have allowed treatment to be provided that would in some measure have helped to develop and reinforce the girl's social skills and emotional competence as protective factors against sexual and other forms of abuse, as well as diminishing the negative effects of the violence experienced and providing therapeutic monitoring of suicidal thoughts.

6.11 The State party mentions various programmes developed by the Ministry of Health to combat gender violence. Finally, with respect to the alleged violation of general recommendation No. 24,

the State party notes that it is not possible, as part of proceedings on individual communications, to rule on the direct violation or non-compliance with the general recommendations issued by the Committee.

Author's comments on the State party's observations on the merits

7.1 In her comments of 15 April 2010, the author rejected the observations of the State party that appeared to place the responsibility on L.C. and her family for not having sought help that would have provided treatment for the sexual abuse she was subjected to. The author did not hold the State responsible for the sexual abuse nor for the injury to L. C. as a result of her suicide attempt. Furthermore, those comments also carried a risk of gender discrimination.

7.2 In the view of the author, expecting a girl to have overcome her emotional trauma and sought assistance is a double victimization. It is cruel to create in a minor the idea that she was guilty for acts that were totally beyond her control, such as being sexually abused and consequently suffering a mental imbalance that worsened when she learned that she was pregnant. It further reveals a discriminatory attitude that responds to the gender stereotype tending to blame women who have been victims of violence for its consequences.

Reasons for the denial of the spinal surgery

7.3 The author recalls that L. C. was hospitalized on 31 March 2007. The following day she was given the diagnosis of "risk of permanent disability", as well as risk of deterioration of her skin due to physical immobility. As a result, surgery was scheduled for 12 April 2007. On 5 April 2007 her pregnancy was discovered, as well as the danger of miscarriage. The daily reports on her condition, from 2 to 11 April 2007, constantly reported the existing risk both of developing infections and of compromising the integrity of her skin due to her total paralysis, as well as the deterioration in her physical mobility.[9] Up to 12 April, the date on which the operation should have taken place, the hospital did not report that L. C. was suffering from any type of infection, nor any other circumstance that would have prevented it. Also on 12 April the author was informed that the operation was postponed and the following day she was informed that the reason was the pregnancy. In the condition report of 12 April it was clearly stated that the only reason for the postponement was prevention of harm to the foetus. Over the following five days the reports on her condition noted that there was no longer just a risk, but a deterioration in her cutaneous integrity and mobility, as well as her anxiety state. On the days following 18 April 2007, the date on which the author had requested the termination of pregnancy, the medical reports continued to note the same symptoms.

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[9]Copies of these reports are on file. The report of 11 April 2007 indicates a "deterioration of the cutaneous integrity" whereas the one of 12 April 2007 indicates an "alteration of the cutaneous integrity".

Finally, on 23 April, a note on the presence of an ulcer with infected skin in the occipital area appeared in her medical report.

7.4 Given the facts described, the author rejects the State's contention that it was the skin infection that caused the postponement of the surgery. She also rejects the statement that the surgery was not urgent but rather elective. Immediate surgery of this type offers the patient better chances of recovery. The doctors were aware of this, but only addressed it on 23 May, when the hospital issued a report recognizing that the operation was "essential in order to be able to begin rehabilitation therapy and to avoid compounding the problems and to avoid infections from prolonged hospitalization".[10] The infections would not have occurred if the surgery and recovery had been done in time. Therefore, it has been demonstrated that L. C. was deprived of the medical services she required with the utmost speed.

Denial of the therapeutic abortion as a necessary medical service in order to avoid serious and permanent harm

7.5 The possibility that the medical intervention might harm the foetus was placed above L. C.'s prospects for rehabilitation. This was confirmed by the express reason contained in the medical register which order the cancellation of the surgery and in the reports of the medical boards where what was to be discussed was whether forcing her to continue the pregnancy could bring about serious and permanent damage to the health of L. C. The first meeting of the board recommended postponement until the second trimester of gestation, when there would be less risk to the foetus, despite there cognition that the pregnancy would be high-risk.

7.6 The mental health of L. C. was completely overlooked in the evaluation concerning whether a therapeutic abortion was warranted. None of the medical evaluations concerning her mental health explored the consequences that would result from forcing L. C. to bring her pregnancy to term and become a mother. On 16 May 2007 a psychological evaluation took place. Only a brief paragraph in that report makes reference to the mental distress that the pregnancy caused L. C., stating that "when the topic of the pregnancy came up, she became unstable, rejected her pregnancy arguing that she could not raise a child because she was aware of her disability and that her mom was older and could not take care of her child". The report, rather than exploring whether there would be grave and permanent mental harm to L. C. if she were forced to continue the pregnancy, simply prescribed relaxation techniques and "reprogramming of healthier thoughts and beliefs". Similar conclusions can be obtained from the report of the third meeting of the medical board. The author recalls that mental health is an essential part of the right to health, as the Peruvian Constitutional Court itself has recognized. She insists that L. C. had the right to a therapeutic abortion on the

10 A copy of this report is contained in the file.

grounds of the grave and permanent harm to her mental health that would have resulted from forcing her to bring to term a pregnancy that had resulted from a rape and destabilized her to the point of attempting suicide.

Legal consequences of denying the provision of essential health services

7.7 L. C. was a victim of exclusions and restrictions in access to health services based on a gender stereotype that understands the exercise of a woman's reproductive capacity as a duty rather than a right. By failing to comply with the legal duty to provide health services to L. C. (including reproductive health services), and having done so for discriminatory reasons arising from her status as a woman, considering her reproductive capacity of greater importance than her human rights, the state party violated articles 1 and 12 of the Convention.

7.8 The author recalls the decision of the Human Rights Committee in the case *K. L. v. Peru* in which it concluded that there had been a violation of article 7 of the International Covenant on Civil and Political Rights.

Lack of an effective remedy to demand that legal termination of pregnancy be provided

7.9 The hospital director, who convened ex officio the first meeting of the medical board, asked it to say that the continuation of the pregnancy would not cause grave and permanent harm to the health of L. C., unless: (a) the spinal surgery could be performed without compromising the life of the child; (b) if the pregnancy of a patient with this medical diagnosis endangered the life of the mother; and (c) if the child, under these conditions, could be born with serious or permanent defects. Nevertheless, from the author's request and article 119 of the Penal Code it is clear that the request for an abortion was related to the serious and permanent harm involved in continuing the pregnancy. The questions, however, focused the discussion on harm to the foetus, which ensured an opinion that was practically a foregone conclusion and did not find a need to perform a therapeutic abortion. No one mentioned the effect that continuing to postpone the surgery would have on L.C.'s prospects for recovery, nor the harm to her mental health. Only the third meeting of the medical board, held on 19 May 2007, was convened for the purpose of determining whether, given the medical condition of L. C., the termination of pregnancy was warranted. However, it was not made explicit that this request should be evaluated in the light of the harm to her physical and mental health that the indefinite postponement of the surgery and the imposition of motherhood would have on the girl. Finally, despite not having discussed the causes for which the therapeutic abortion was requested, the board determined that the termination of pregnancy would not be performed. The author was only informed of this decision 11days later, that is, 42 days after her request.

7.10 The author reiterates her arguments with respect to the lack of effective judicial and administrative remedies in addressing requests for termination of pregnancy in the State party. This is relevant not only as a ground for admissibility in the present case, but also as grounds for the violation of articles 2 (c) and (f), 3 and 5 of the Convention.

7.11 In Peru there is no legislation or regulation on access to therapeutic abortion, with the result that each hospital determines arbitrarily what requirements are necessary, under what procedures cases requesting it will be decided, the time limits for making the decision and the level of importance placed on the views of the pregnant woman regarding the risks to her health that she is prepared to assume. The author recalls the Committee's general recommendation No. 24, which states that refusal by a State party to ensure the provision of certain reproductive health services to women under legal conditions is discriminatory, and when it occurs the State is obliged to establish a system that guarantees effective judicial measures.

7.12 The lack of legislative and administrative measures regulating access to therapeutic abortion condemns women to legal insecurity in so far as protection of their rights is completely at the mercy of gender prejudices and stereotypes, as occurred in the present case. The sociocultural pattern based on a stereotypical function of a woman and her reproductive capacity guided the medical decision on which the physical and mental integrity of L. C. depended, subjecting her to discrimination by placing her on an unequal footing with men with respect to the enjoyment of her human rights. The State's omissions and negligence in regulating access to therapeutic abortion created the conditions allowing agents of the State t o discriminate against L. C. and prevented her access to the medical treatment she required, which also constitutes a violation of articles 1 and 12 of the Convention.

Disregard for the right to decide and control reproductive capacity in cases of therapeutic abortion

7.13 The views and wishes of the woman regarding the continuation of the pregnancy are fundamental, since even though the medical diagnosis is what provides the technical elements to know whether the pregnancy is in any way incompatible with the health of the pregnant woman, the determination of the gravity of the harm that its continuation could cause has a subjective component that cannot be ignored, and represents the personal level of risk to her health that the woman is prepared to assume. Furthermore, as in any other instance in which the State intervenes in a personal decision, such intervention should be legal and regulated in such a way that, following due process, the person affected has the right to be heard. The contrary situation constitutes a violation of the right of protection from arbitrary interventions in decisions that, in general, are based in the intimacy and autonomy of each human being.

7.14 In the present case, there was illegal and irrational interference in the decision of L. C. to terminate her pregnancy. The lack of regulation surrounding access to therapeutic abortion subjected

L. C. to arbitrary action by agents of the State, which constituted a violation of her right to decide freely and responsibly the number of children she wished to have. Such interference therefore is a violation of the State party's obligations under article16, paragraph 1(e), of the Convention.

Relevance of the general recommendations issued by the Committee

7.15 The general recommendations issued by the Committee constitute the authorized interpretation of the Convention and the obligations it imposes on States, and are thus the best tool available to guide them in compliance with it. It is thus natural that, when a communication is submitted regarding violations of the obligations of States parties under the Convention, the standards of compliance used to evaluate the conduct of a State include not only the text of the Convention, but also the developments thereof made by the Committee responsible for its monitoring. For this reason, therefore, the author refers to the general recommendations, since they constitute a criterion for evaluation of compliance of States with the Convention, in this case Peru.

7.16 Based on the foregoing, the author requests the Committee to declare that there has been a violation of the articles of the Convention referred to; that measures to guarantee redress, satisfaction and non-repetition be established; that the State be urged to adopt and implement the necessary legislative, administrative and judicial measures to guarantee the obligation to ensure the right to sexual and reproductive health of women without discrimination; and to hold the agents of the State responsible as appropriate.

7.17 On 31 March 2011, the author transmitted to the Committee a legal opinion prepared by the International Commission of Jurists, a non-governmental organization. It addressed topics relating to the obligations of States parties under the Convention and international human rights law in general to provide an effective remedy and redress, in particular regarding the enjoyment by women, under equal conditions, of the right to life, health and not to be subjected to cruel, inhuman or degrading treatment or punishment. The opinion recalled the jurisprudence of the European Court of Human Rights in the cases *Tysiac v. Poland* and *A. B. and C. v. Ireland,* where the Court concluded that States should establish an effective and accessible procedure permitting access by women to legal abortion. In the absence of such a procedure, the Commission, in its opinion, concluded that the objection of failure to exhaust domestic remedies could not be raised against the author in the present case.

Issues and proceedings before the Committee

Consideration of admissibility

8.1 The Committee considered the admissibility of the communication, in accordance with articles 64 and 66 of its rules of procedure. In accordance with article 4, paragraph 2, of the Optional

Protocol, the Committee was satisfied that the same matter has not been nor is being examined under another procedure of international investigation or settlement.

8.2 The State party maintains that the communication should be considered inadmissible, in accordance with article 4, paragraph 1, of the Optional Protocol, on the grounds of failure to exhaust domestic remedies. It noted in particular that the author had not applied for amparo and expressed disagreement with her view that the time necessary to obtain a decision under that remedy was not in keeping with the need to act with the greatest possible speed required by the situation of L. C. It stated that the case could have been decided at first instance; that in this type of proceeding the decision can be issued at the same hearing or, exceptionally, within the five days following it; and that there are exceptions to the requirement of exhaustion of previous remedies, for example in the event of irreparable harm. The State party also notes that the author could have initiated judicial proceedings to request compensation for damages and harm.

8.3 In response to those arguments, the author states that in the State party there is no administrative or judicial procedure that would have allowed L. C. to enjoy her right to receive the urgent medical care that her condition required. Concerning the application for amparo, there are various procedural problems that undermine the desired speed of this proceeding, for instance, the lack of legal deadlines for the judge to accept the application or to hold the oral hearing; that the system of service of legal documents is defective in the State party; and that there are no precedents of similar cases that were resolved promptly using this recourse. She also states that when L. C. obtained a response from the hospital refusing the termination of pregnancy, 56 days had already gone by since the suicide attempt and that an additional wait to obtain a judicial decision obliging the hospital to perform the termination of pregnancy would have had the result of worsening her clinical condition. The author also rejects the idea that civil action could be considered an adequate remedy.

8.4 The Committee considers that, given the seriousness of L. C.'s condition, the avenues pursued by the author, that is, the proceedings before the hospital authorities, were the appropriate ones under domestic law. The Committee observes the following undisputed facts: that L.C. was hospitalized on 31 March 2007; that surgery was recommended by the Head of the Neurosurgical Department and scheduled to take place on 12 April 2007; that on the scheduled date the operation was cancelled; that on 13 April 2007, the author was informed by the Head of the Neurosurgical Department that L.C. could not be operated on account of her pregnancy; and that on 18 April 2007, the author addressed a written request to the medical authorities requesting the termination of the pregnancy. The medical board of the hospital decided on the request only on 30 May 2007. On 7 June 2007, based on the report of the Medical College of Peru dated 7 May 2007 stating that there was a grave risk to L.C.'s health if the pregnancy continued, the author submitted to the hospital authorities an appeal for reconsideration of their decision. This request was decided only on 27 June 2007, after L.C. miscarried on 16 June 2007. The decision indicated that it was not

subject to appeal. The Committee considers that this procedure was too long and unsatisfactory. Furthermore, the Committee does not find it reasonable to require that, in addition to the lengthy procedure before the medical authorities, the author should have gone to court to initiate a proceeding of an unpredictable duration. The unpredictability can be seen not only in the vagueness of the law itself regarding the deadlines established for *amparo*, but also by the fact that its speed cannot be demonstrated based on judicial precedent, as evident from the information provided by the parties.[11] The Committee considers that no appropriate legal procedure was available to the victim which would have allowed her access to a preventive, independent and enforceable decision. Consequently, the Committee concludes that the exception to the exhaustion of domestic remedies provided in article 4, paragraph 1, of the Optional Protocol, regarding the improbability that *amparo* would offer effective relief to the victim, is applicable in this case. In a similar manner, the Committee considers that civil action for compensation for damages and harm is also not a recourse that would offer the author an effective remedy, since in no case would it have been able to prevent or redress the irreparable harm to the health of L.C.

8.5 There being no other obstacles to admissibility, the Committee finds the communication admissible and shall proceed to consider it on the merits.

Consideration on the merits

8.6 The Committee has considered the present communication in the light of all the information made available by the parties, in accordance with article7,paragraph 1, of the Optional Protocol.

8.7 The Committee recalls that L.C. became pregnant at the age of 13 years as a result of repeated sexual abuse and thereafter attempted suicide in the State party, where abortion on the grounds of rape or sexual abuse is not legally available. The Committee must decide if the refusal by the hospital to perform a therapeutic abortion on L. C. as provided under article 119 of the Penal Code, and if the delayed scheduling of her operation on the spine gave rise to a violation of her rights under the Convention. The author invokes in particular articles 1, 2 (c) and (f), 3, 5, 12 and 16, paragraph 1(e) of the Convention.

8.8 The Committee takes note of the State party's observation that the reason for the delay in the spinal surgery was not the pregnancy, but the existence of an infection in the area where the surgical incision should be made, as can be seen from the evaluation reports issued by the three meetings of the medical board, the first of which was held on 24 April 2007. However, the Committee also notes the author 's assertion that the operation was initially scheduled for 12 April 2007, that the following day she was informed that the reason for the postponement was prevention of harm to the

11 See paragraph 5.3 above.

foetus and that the presence of an infection was noted for the first time only on 23 April 2007. The Committee considers that the State party has not disproved the author's allegations, therefore it starts from the assumption that there is a direct relationship between the withdrawal of the surgery, whose necessity cannot be questioned, and L. C.'s pregnancy.

8.9 The Committee will consider whether the facts, as established, constitute a violation of the rights of L. C. under articles 1, 2 (c) and (f), 3, 5, 12 and 16, paragraph 1(e) of the Convention.

8.10 The author alleges that the facts constitute a violation of article 12 because the continuation of the pregnancy represented a threat to the physical and mental health of L. C. She also alleges a violation of article 5 because timely access to necessary medical treatment was made conditional on carrying to term an unwanted pregnancy, which fulfils the stereotype of placing L. C.'s reproductive function above her right to health, life and a life of dignity. Article 16 , paragraph 1(e) was also allegedly violated because she was deprived of her right to decide on the desired number of children.

8.11 The Committee recalls the obligation of the State party under article 12, to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. It also recalls its general recommendation No. 24, which, as an authoritative interpretation tool in relation to article 12, states that "it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women" (para. 11). The recommendation also states that: "the duty of State parties to ensure, on a basis of equality between men and women, access to health-care services, information and education implies an obligation to respect, protect and fulfil women's rights to health care. States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations. They must also put in place a system which ensures effective judicial action. Failure to do so will constitute a violation of article12."(para.13).

8.12 The Committee observes that the day after her admission to the hospital L. C. was diagnosed as risking permanent disability and a deterioration of cutaneous integrity due to physical immobility. Accordingly, the doctors scheduled surgery on her spine for 12 April 2007. On that date the author was informed by the hospital authorities that the surgery would be postponed, and the next day she was informed orally that the reason was potential harm to the foetus. Up to 12 April 2007, the hospital did not report that L.C. was suffering from infection, nor any other circumstance that would have prevented the surgery. Over the following days, the medical condition of L. C. worsened and her cutaneous integrity, mobility and anxiety state deteriorated, until the presence of an ulcer with infected skin was noted in the medical report of 23 April 2007. From the information contained in the file it is unquestionable that the surgery was necessary; that it should have been performed as early as possible as demonstrated by the fact that initially it had been scheduled for

a few days after L. C.'s admission to the hospital; that after 12 April 2007 complications arose in L. C.'s medical condition that caused postponement of the operation, which was not done until 11 July 2007; and that the doctors considered the pregnancy to be "high risk, leading to elevated maternal morbidity".

8.13 The Committee notes that the Peruvian Health Act No. 26842 of 9 July 1997 repealed the procedure for therapeutic abortion and created a legal vacuum, since it does not provide for any procedure to request the therapeutic abortion allowed under article 119 of the Penal Code.

8.14 The Committee further notes that the reports of the medical board provided by the State party did not discuss the possible effects that the continuation of the pregnancy would have on the physical and mental health of the patient, despite the fact that, on the dates on which they were issued, the author 's request for a therapeutic abortion under article 119 of the Penal Code was pending. Under this provision, therapeutic abortion is allowed to avoid serious and permanent harm to the health of the mother. Furthermore, the refusal to terminate the pregnancy by the doctors at the hospital contrasted with the opinion of the Medical College, which, on 7 May 2007, concluded that there were sufficient reasons to state that continuing the pregnancy would put the girl's physical and mental health at serious risk, and therefore a therapeutic abortion was justified. The Committee further notes that the medical board of the hospital denied the termination of pregnancy because it considered that the life of L.C. was not in danger, but did not address the damage to her health, including her mental health, a right which is protected under the Peruvian Constitution.

8.15 In view of the foregoing, the Committee considers that, owing to her condition as a pregnant woman, L. C. did not have access to an effective and accessible procedure allowing her to establish her entitlement to the medical services that her physical and mental condition required. Those services included both the spinal surgery and the therapeutic abortion. This is even more serious considering that she was a minor and a victim of sexual abuse, as a result of which she attempted suicide. The suicide attempt is a demonstration of the amount of mental suffering she had experienced. The Committee therefore considers that the facts as described constitute a violation of the rights of L. C. under article 12 of the Convention. The Committee also considers that the facts reveal a violation of article 5 of the Convention, as the decision to postpone the surgery due to the pregnancy was influenced by the stereotype that protection of the foetus should prevail over the health of the mother. Having reached this conclusion, the Committee does not consider it necessary to rule on the possible violation of article 16 , paragraph 1 (e) of the Convention.

8.16 With regard to the allegations concerning the possible violation of articles 2 (c) and (f), the Committee recalls its jurisprudence, under which, although it recognizes that the Convention does not expressly refer to the right to a remedy, it considers that this right is implicit, in particular in article 2 (c), whereby States parties undertake to "establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public

institutions the effective protection of women against any act of discrimination ".[12] Furthermore, under article 2(f), and in conjunction with article 3, the State party is obliged to take all appropriate measures, including legislation, to modify or abolish existing laws which constitute discrimination against women. The Committee observes that the hospital medical board delayed taking a decision on the request for an abortion submitted by the author for 42 days and the hospital director waited 20 days longer to respond to the request for reconsideration. Furthermore, as indicated earlier, the remedy of amparo did not constitute an effective legal remedy to protect the author's right to appropriate medical care. The Committee also notes the author's allegations concerning the absence of laws and regulations in the State party governing access to therapeutic abortion, resulting in a situation where each hospital determines arbitrarily, inter alia, what requirements are necessary, the procedure to be followed, the time frame for a decision and the importance to be placed on the views of the mother. These allegations have not been disproved by the State party.

8.17 The Committee considers that, since the State party has legalized therapeutic abortion, it must establish an appropriate legal framework that allows women to exercise their right to it under conditions that guarantee the necessary legal security, both for those who have recourse to abortion and for the health professionals that must perform it. It is essential for this legal framework to include a mechanism for rapid decision-making, with a view to limiting to the extent possible risks to the health of the pregnant mother, that her opinion be taken into account, that the decision be well-founded and that there is a right to appeal.[13] In the present case the Committee considers that L. C. could not benefit from a procedure for requesting a therapeutic abortion that met these criteria. In the light of the information contained in the file, the Committee believes, in particular, that the delay by the hospital authorities in deciding on the request had detrimental effects on her physical and mental health. Consequently, the Committee considers that an effective remedy was not available to L.C. and that the facts described give rise to a violation of article 2 **(c) and (f) of the Convention.**

8.18 The Committee notes that the failure of the State party to protect women's reproductive rights and establish legislation to recognize abortion on the grounds of sexual abuse and rape are facts that contributed to L.C.'s situation. The Committee also notes that the State party bears responsibility for the failure to recognize the risk of permanent disability of L.C. coupled with her pregnancy as a serious physical and mental health risk, and to provide her with appropriate medical services, namely a timely spinal surgery and a therapeutic abortion allowed in such cases under the Penal Code. L.C. has suffered considerable physical and mental pain. Her family has also suffered both moral and material damages. After she miscarried on 16thJune 2007, she had the spinal surgery on

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[12] See Communication No. 18/2008, Vertido v. Philippines, Views of 16 July 2010, para. 8.3.

13 Along those lines, see the judgment of the European Court of Human Rights in the case *Tysiac v. Poland*, paras. 116 to 118.

11thJuly 2007, almost three and a half months after the Head of the Neurosurgery Department had recommended emergency surgery. Although the medical reports noted that she needed intensive physical therapy and rehabilitation after the surgery, L.C. was only provided with the necessary physical rehabilitation and psychological/psychiatric help, several months after the surgery, namely as from 10 December 2007. After spending two months in the National Rehabilitation Institute, due to lack of financial means, L.C. had to abandon the treatment. The Committee notes that L.C, a young girl of 16 (at the time of submission of the communication) is paralyzed from the neck down save for some partial movement in her hands. She is in a wheelchair and needs constant care. She cannot pursue her education and her family is also living in precarious conditions. Her mother (the author) who has to provide L.C. with constant care, cannot work. The cost of medicines and equipment required by L.C. has also placed a heavy undue financial burden on the family.

9. Acting under the provisions of article 7, paragraph 3, of the Optional Protocol, the Committee considers that the State party has not complied with its obligations and has therefore violated the rights of L. C. established in articles 2 (c) and (f), 3,5 and

12, together with article 1 of the Convention. The Committee therefore makes the following recommendations to the State party:

(a) Concerning L. C.: provide reparation that include adequate compensation for material and moral damages and measures of rehabilitation, commensurate with the gravity of the violation of her rights and the condition of her health, in order to ensure that she enjoys the best possible quality of life;

(b) General:

(i) Review its laws with a view to establish a mechanism for effective access to therapeutic abortion under conditions that protect women's physical and mental health and prevent further occurrences in the future of violations similar to the ones in the present case;

(ii) Take measures to ensure that the relevant provisions of the Convention and the Committee's general recommendation No. 24 with regard to reproductive rights are known and observed in all health-care facilities. Such measures should include education and training programmes to encourage health providers to change their attitudes and behaviour in relation to adolescent women seeking reproductive health services and respond to specific health needs related to sexual violence. They should also include guidelines or protocols to ensure health services are available and accessible in public facilities.

(iii) The State party should also review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse;

(iv) The Committee reiterates the recommendation it made to the State party during the consideration of its sixth periodic report (CEDAW/C/PER/CO/6, para. 25), urging it to review its restrictive interpretation of therapeutic abortion in line with the Committee's general recommendation No. 24 and the Beijing Declaration and Platform for Action.

10 In accordance with article 7, paragraph 4, of the Optional Protocol, the State party shall give due consideration to the views of the Committee, together with its recommendations, and shall submit to the Committee, within six months, a written response, including information on any action taken in the light of the views and recommendations of the Committee. The State party shall also publish the views and recommendations of the Committee, keeping the anonymity of the author and the victim, and circulate them widely in order to reach all the relevant sectors of the population.

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Human Rights Committee

Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication No. 2324/2013*, **

Submitted by:	**Amanda Jane Mellet (represented by the Center for Reproductive Rights)**
Alleged victim:	The author
State Party:	Ireland
Date of communication:	11 November2013
Document references:	***Decision taken pursuant to rule 97 of the Committee's rules of procedure, transmitted to the State party on 30 December 2013 (not issued in document form)***

*Adopted by the Committee at its 116th session (7-31 March2016).

** The following members of the Committee participated in the examination of the communication: Yadh Ben Achour, Lazhari Bouzid, Sarah Cleveland, Ahmed Amin Fathalla, Olivier de Frouville, Yuji Iwasawa, Ivana Jelic, Duncan Muhumuza Laki, Photini Pazartzis, Sir Nigel Rodley, Victor Manuel Rodríguez-Rescia, Fabián Omar Salvioli, Dheerujlall Seetul singh, Anja Seibert-Fohr, Yuval Shany, Konstantine Vardzelashvili and Margo Waterval Five opinions signed by seven Committee members are appended to the present Views.

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Date of adoption of Views:	31 March2016
Subject matter:	Termination of pregnancy in a foreign country
Procedural issues:	None
Substantive issues:	Cruel, inhuman and degrading treatment; right to privacy; right to obtain information; gender discrimination
Articles of the Covenant:	2(1), 3, 7, 17, 19 and 26 of the Covenant
Articles of the Optional Protocol:	None

1. The author of the communication is Amanda Jane Mellet, an Irish citizen born on 28 March 1974. She claims to be a victim of violations by Ireland of her rights under articles 2(1), 3, 7, 17, 19 and 26 of the Covenant. The Optional Protocol entered into force for Ireland on 8 March 1990. The author is represented by counsel.

The facts as presented by the author

2.1 The author lives in Dublin with her husband. They have no children. She became pregnant in 2011. On 11 and 14 November 2011, in her 21st week of pregnancy, she received scans at the Rotunda public hospital in Dublin. She was informed that her foetus had congenital heart defects, but that even if the impairment proved fatal she could not have a termination of her pregnancy in Ireland. The doctor at the hospital stated: "terminations are not available in this jurisdiction. Some people in your situation may choose to travel". The doctor did not explain what "travel" involved, but only that it had to be overseas. She did not recommend a suitable abortion provider in the UK.

2.2 On 17 November 2011, after further examination at the same hospital the author was informed that the foetus had trisomy 18 and would die in utero or shortly after birth. The midwife indicated to her that she could carry to term knowing that the foetus would most likely die inside of her, or she could "travel". The midwife did not explain what "travelling" would entail and did not give her any further information, but advised her to contact an Irish family planning organization for information and counselling. The author was not referred by the hospital to a provider abroad that could terminate her pregnancy, since health providers in Ireland are not permitted to make appointments for pregnancy terminations overseas for their patients. On 18 November the author informed the hospital of her decision to travel abroad for a termination and made an appointment with a family planning organization. This organization provided her with information about the procedure and gave her contact information of the Liverpool Women's Hospital. They also faxed her medical records to this hospital, which later contacted the author directly and gave her an appointment for about ten days later.

2.3 Ireland's laws permit qualified medical professionals to provide aftercare when a woman has

miscarried. Before travelling to Liverpool, the author therefore returned to the Irish hospital and visited her general practitioner (GP). The purpose was to obtain scans that would determine if the foetus had died, in which case her care would continue at the Irish hospital. After detecting a heartbeat, her GP tried to dissuade her from seeking an abortion abroad and insisted that even if she were to continue her pregnancy, "your child might not suffer". The author indicates that her main reason to seek abortion was to spare her child suffering.

2.4 On 28 November 2011, she flew with her husband to Liverpool and the following day she received medication at the Women's Hospital to begin the process of terminating her pregnancy. On 1 December she received further medication to induce labor. She was in labor for 36 hours and on 2 December she delivered a stillborn baby girl. Still feeling weak and bleeding, she had to travel back to Dublin, only 12 hours after the delivery, as they could not afford staying longer in the UK.[1] There is no financial assistance from the state or from private health insurers for women who terminate pregnancies abroad.

2.5 After her return to Dublin, the author did not receive any aftercare at the Rotunda Hospital. She felt that she needed bereavement counselling to cope with the loss of her pregnancy and the trauma of travelling abroad for pregnancy termination. While the hospital offers such counselling to couples who have suffered a spontaneous stillbirth, this service does not extend to those who choose to terminate the pregnancy as a result of fatal foetal impairments. Eventually she received post-abortion counselling at the family planning organization but not bereavement counselling. She still suffers from complicated grief and unresolved trauma, and says she would have been able to better accept her loss if she had not had to endure the pain and shame of travelling abroad.[2]

The complaint

Claims under article7

3.1 Ireland's abortion law subjected the author to cruel, inhuman and degrading treatment and encroached on her dignity and physical and mental integrity by: 1) Denying her the reproductive

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[1] The author says that they spent 3,000 EUR in total, including the 2,000 EUR fee they paid for the procedure in the UK.

[2]The author submits a Declaration by Joan Lalor, Associate Professor of Midwifery in Trinity College Dublin in which she concludes "that the current legal situation regarding the prohibition of termination of pregnancy for women with a diagnosis of fetal abnormality has led to intense suffering in Amanda's case and has severely impacted her ability to process her complicated grief. This situation will continue to cause additional unnecessary trauma leading to complicated grief for women in Ireland which is not experienced by women domiciled in countries where termination of pregnancy is legal". A Medico-legal report by Dr. Patel, Clinical Psychologist, was also submitted indicating the psychological difficulties suffered by the author as a result of the traumas surrounding the end of her pregnancy.

health care and bereavement support she needed; 2) forcing her to continue carrying a dying foetus; 3) compelling her to terminate her pregnancy abroad; and 4) subjecting her to intense stigma.

3.2 Once the author expressed her decision to terminate her pregnancy, the health personnel refused to provide her with the health care and support she needed. The expectation of care that she had formed as a patient of the Rotunda Hospital, her extreme vulnerability upon learning that her baby would die, and the prospect of then having to terminate a beloved pregnancy abroad with no support from the Irish health care system all illustrate that her mental anguish at being denied abortion services in Ireland rose to the level of cruel, inhuman and degrading treatment. The hospital's failure to offer her bereavement counselling, before and after the termination, hampered her ability to cope with her trauma. She was not offered acknowledgement or support to help her to adapt psychologically, grieve normally and rebuild her life. This failure was exacerbated by the fact that the hospital provides bereavement services to women who face fatal foetal impairments but choose to carry to term. The hospital thus makes a distinction and treats women who travel for termination as less deserving of support.

3.3 For the next 21 days, after learning that her foetus was dying, the author was tormented by the question of whether her foetus had died within her, and the fear that she would go into labor and give birth only to subject her child to suffering and watch it die. This added level of anxiety would have been spared had she had timely access to abortion services. The travel abroad was also a significant source of added anxiety and exposed her to obstacles which impinged on her physical and mental integrity and dignity. She had to make preparations for the travel; was deprived of the support of her family; had to stay in a foreign and uncomfortable environment while in Liverpool; and had to spend a sum of money which was difficult for her to raise. While waiting at the airport to fly home, only 12 hours following the termination, she was bleeding, weak and light-headed. The hospital in Liverpool did not offer any options regarding the baby's remains, and the author was compelled to leave them behind. She received the ashes, unexpectedly, three weeks later by courier, which deeply upset her. The travel abroad also interfered with her ability to mourn her loss.

3.4 Ireland's criminalization of the abortion services that she needed overwhelmed the author with shame and stigmatized her actions and person, which served as a separate source of severe emotional pain.

Claims under article 17

3.5 The author had to choose between, on one hand, letting the state make the deeply intimate reproductive decision for her to continue with a non-viable pregnancy under conditions of unimaginable suffering and, on the other hand, having to travel abroad for a termination. Neither of these options had the potential to preserve her reproductive autonomy and mental well-being. By denying the author the only option that would have respected her physical and psychological

integrity (allowing her to terminate her pregnancy in Ireland), the State interfered arbitrarily in her decision-making. Being abroad, she found herself in an unfamiliar setting and craved the privacy of her own home and the support of her family and friends. The abortion ban thus infringed upon her decision-making in regard to how and where she would best cope with the traumatic circumstances she faced.

3.6 The protection of the "right to life of the unborn", per the Irish Constitution, can be seen as a moral issue. Defining the moral interest in protecting foetal life as superior to the author's right to mental stability, psychological integrity and reproductive autonomy, goes against the principle of proportionality and, as such, constitutes a violation of the author's right to privacy under article17.

3.7 The interference with the author's rights was prescribed by law, since abortion is only legal if the woman's life is in danger. However, the interference was arbitrary. The aim sought by the Irish law (protection of the foetus) was not appropriate or relevant in her situation, and the interference with her right to privacy was therefore disproportionate. Even if the Committee would accept that the protection of the foetus can serve as a justification for interfering with a woman's right to privacy in certain situations, in the author's case this cannot apply. Limiting her right to privacy by denying her the right to terminate a pregnancy that would never result in a viable child cannot be considered a reasonable or proportionate measure to achieve the aim of protecting the foetus.

Claims under article 19

3.8 The right to freedom of information encompasses information concerning health issues, including critical information for making informed choices about one's sexual and reproductive health. In this respect, the author's right to access information was violated.

3.9 Ireland's Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995 ("Abortion Information Act") sets forth the circumstances in which information, advice and counselling about abortion services that are legal in another state can be made available in Ireland. It pertains in particular to information that is likely to be required by women who consider traveling abroad for an abortion and regulates the conduct of providers of such information, such as counsellors and health providers. It indicates that the provision of information, advice or counselling about abortion services overseas is not lawful unless, among other factors, the information, advice or counselling is truthful and objective, fully informs the woman of all courses of action open to her and does not advocate or promote the termination of pregnancy. The Act prohibits the distribution of written information to the public without solicitation by the recipient, and has been interpreted to require that a woman specifically request information, advice or counselling about termination

of pregnancy before she can receive it. Undersection10, a person who contravenes the relevant provisions of the Act shall be guilty of an offence and liable to a fine.

3.10 The Act does not prohibit health care providers from imparting information about abortion, including likely benefits and potential adverse effects and alternatives; the limited circumstances in which abortion is legal in Ireland; and information about legal abortion services abroad. Consequently, the author should have received such information. However, in practice, the existence of the Act effectively censored her health care providers from imparting even legal information, thereby exacerbating her mental distress and violating her right to information. While the Act prohibits health care providers from advocating or promoting the termination of pregnancy it lacks any definition of such conduct. This failure has a chilling effect on health care providers, who experience difficulty in distinguishing "supporting" a woman who has decided to terminate a pregnancy from "advocating" or "promoting" abortion.[3]

3.11 The author indicates that after receiving the information that her baby might not live the doctor "only stated when we asked what would happen if the condition was fatal … 'terminations are not available in this jurisdiction. Some people in your situation may choose to travel'". Some days later, upon receiving the amniocentesis results, the midwife confirmed that the foetus would die in utero or shortly after birth and provided the author with two options: she could continue with the pregnancy or she could "travel". Rather than providing the author with accurate, evidence-based information about abortion, the midwife avoided even accurately naming the abortion procedure, using the euphemism "travel" instead. She refused to discuss this option in any way, failing to provide the author with information about legal abortion services abroad. Instead, the midwife referred the author to a family planning organization. Thus, in the absence of clear guidelines in the Act about permissible or impermissible speech, the health care providers with whom the author interacted were hindered from imparting information to her about the medical aspects of abortion, its legal availability in Ireland and legal abortion services abroad.

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[3] The author provided a report of the IFPA, a non-governmental organisation that provides sexual and reproductive health consultations in 11 centers nationwide. The report indicates that "health care professionals are acutely aware of the possible repercussions, including damage to their reputation and career prospects, of a complaint alleging negligence, malpractice or breach of the law or of the Irish Medical Council's Guide to Professional Conduct and Ethics (…). They are also aware of the stigma and opprobrium that attaches to abortion in much political and media discourse. Doctors working in small and, especially, rural communities may fear that publicity linking them with abortion in any way will affect their livelihood and reputation (…) and lead to personal harassment. Many health care professionals evade the potential or perceived repercussions of falling foul of the law by declining to discuss abortion or to provide information to their patients. (…) In the absence of binding guidelines, protocols and processes of accountability (…) the attitudes of health care professionals are influenced by a complex set of factors. These include the personal values and beliefs of health care practitioners, their training, their understanding of the law, their level of knowledge about abortion and the ethos and culture of the institutions in which they train and work."] vulnerable, stigmatized and abandoned by the Irish health system, at a time when she most needed support.

3.12 The State's interference with the author's access to information is not a permissible limitation on her right to information under article 19 on the ground of protection of morals. The State's understanding of public morals, as enshrined in the Abortion Information Act and as clear from its application, effectively led to the denial of critical information to the author, was discriminatory and cannot withstand scrutiny under article 19 of the Covenant. Furthermore, the state's refusal to provide the author with information was irrelevant to the aim of protecting the "unborn", as the "unborn" in this case had no prospect of life.

3.13 The restrictions on the author's right to information were disproportionate because of their detrimental impact on her health and well-being. They caused her to feel extremely 3.14 Moreover, the Act's prohibition on publicly imparting information about abortion unless specifically requested was a disproportionate restriction on the author's right to access sexual and reproductive health information. She did not ask for written information about legal termination services abroad because she did not know what to ask. For instance, she did not know that the 24-week limit on legal abortion in the UK does not apply to pregnancies with fatal anomalies, and feared that she would be denied care even if she ventured abroad and would be forced to continue the pregnancy, continuously tormented by the question of whether the foetus had died inside of her. She failed to receive key information about the types of termination and the most appropriate service for her, given her advanced gestation. This process would not be acceptable or deemed to be good practice in other health systems.

Claims under articles 2(1), 3 and 26

3.15 Laws criminalizing abortion violate the rights to non-discrimination and equal enjoyment of other rights on the grounds of sex and gender. The rights to equality and non- discrimination compel states to ensure that health services accommodate the fundamental biological differences between men and women in reproduction. Such laws are discriminatory also because they deny women moral agency that is closely related to their reproductive autonomy. There are no similar restrictions on health services that only men need.

3.16 Criminalization of abortion on the grounds of fatal foetal impairment disproportionately affected the author because she was a woman who needed this medical procedure in order to preserve her dignity, physical and psychological integrity, and autonomy, in breach of articles 2(1), 3 and 26. The Irish abortion ban traumatizes and 'punishes' women who are in need of terminating their non-viable pregnancies. Male patients in Ireland are not subjected to such vulnerabilities as the author when seeking necessary medical care.

3.17 The author felt judged by her providers. Her general practitioner told her that even if she continued the pregnancy her child "might not suffer," thus showing disrespect for her decision

and autonomy and relegating her health needs to the provider's own personal beliefs about the paramount importance of the foetus's suffering. There are no situations in which men in Ireland are similarly expected to put their health needs and moral agency aside in relation to their reproductive functions.

3.18 The author's rights to equality and non-discrimination in the enjoyment of her rights under articles 7, 17 and 19, and her rights to be protected against discrimination under article 26 of the Covenant have been violated by the State's failure to provide her with information. The violation of her right to access sexual and reproductive health information was inflicted because she was a woman in need of terminating her pregnancy. Male patients in Ireland are not similarly denied critical health information and are not pushed out and abandoned by the health care system when requiring such information.

3.19 Ireland's criminalization of abortion reduced the author to her reproductive capacity by prioritizing the protection of the "unborn" over her health needs and decision to terminate her pregnancy. She was subjected to a gender-based stereotype that women should continue their pregnancies regardless of the circumstances, their needs and wishes, because their primary role is to be mothers and self-sacrificing caregivers. Stereotyping her as a reproductive instrument subjected her to discrimination, infringing her right to gender equality. Under the Irish health care system, women who terminate non-viable pregnancies are considered to not deserve or need counselling, whereas women whose foetuses die naturally do. This treatment illustrates that there is a stereotypical idea of what a woman should do when her pregnancy is non-viable, i.e. let nature run its course regardless of the suffering involved for her.

3.20 The violations to which the author was subjected should be understood in light of the structural and pervasive discrimination that characterizes the Irish abortion law and practice. The abortion regime discriminated both against the author as an individual woman and against women as a group. This regime fails to account for women's different reproductive health needs, thus reinforcing women's vulnerability and inferior social status. In conclusion, the author's rights to non-discrimination and to enjoy equally her rights to be free from cruel, inhuman and degrading treatment, to privacy, and to access information, guaranteed under articles 2(1) and 3 in conjunction with articles 7, 17 and 19 of the Covenant were violated, as was her right to equal protection under article26.

Exhaustion of domestic remedies

3.21 The author would not have had any reasonable prospect of success had she petitioned an Irish court for a termination of her pregnancy. While Ireland has a functioning and independent judiciary and domestic remedies would have been available to her, they would have been neither effective nor adequate.

3.22 At the time of the facts and until 2013, Section 58 of the Offences Against the Person Act (1861 Act) criminalized abortion for both women and abortion providers, even in cases where it was necessary to save the woman's life, and subjected to life imprisonment any woman who tried to terminate her pregnancy and any doctor who tried to help her. Furthermore, article 40.3.3 of the Constitution, introduced in 1983, reads: "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right". Section 22 of the Protection of Life during Pregnancy Act 2013, provides that "(1) It shall be an offence to intentionally destroy unborn human life; (2) A person who is guilty of an offence under this section shall be liable on indictment to a fine or imprisonment for a term not exceeding 14 years, or both."

3.23 In *Attorney General v. X and Others,* decided in 1992, the Supreme Court held that article 40.3.3 permits abortion only when "it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the mother, which can only be avoided by the termination of her pregnancy". In 2009, the Supreme Court further clarified the meaning of the constitutional protection of the "unborn". In *Roche v. Roche* the Court established that once an embryo has been implanted in the woman's womb its relevant attachment with the pregnant woman has been created and it enters a state of "unborn". This decision suggests that the constitutional protection of the "unborn" would extend to a foetus with a fatal anomaly as long as it is alive by being attached to the pregnant woman and having the potential to be born. This was the case for the author, who had received an implanted embryo and had thus entered the state of "unborn" that is explicitly protected by article40.3.3.

3.24 As long as the author's foetus was alive she did not have a reasonable prospect of convincing the High Court, only a year after the decision in *Roche v. Roche*, that her foetus was not protected under article 40.3.3, as it clearly had "the potential to be born, the capacity to be born" and its life was attached to hers. The *Roche v. Roche* decision also confirmed that article 40.3.3 is concerned with the balance between the lives of the pregnant woman and the foetus and not with the health or wellbeing of the woman. Furthermore, during the debate on the Protection of Life During Pregnancy Act (2013), the legislature opposed the inclusion of fatal foetal impairment as a legal ground for abortion.

3.25 Even in the improbable event that the Court would have found that the author's foetus did not constitute "unborn life" the Court would have been highly unlikely to conclude that the author thereby had a constitutional right to a termination of pregnancy. She would have had to invoke other constitutional provisions to claim such a right, most notably article 40.3, which protects unenumerated personal rights. However, such rights may also apply to, and be invoked on behalf of, the foetus. Furthermore, the author was 21 weeks pregnant when she learned that her foetus had a fatal condition. Even if the courts had prioritized her case, it is unlikely that they would have been able to render a decision as swiftly as required in the circumstances.

3.26 Regarding her right to information, the Supreme Court has affirmed that the regulation of the Abortion Information Act is constitutional and has thereby made it immune to future constitutional challenges. It follows that the author could not have had any reasonable prospect of challenging this Act.

3.27 A petition addressed to a court for a termination of her pregnancy would have been ineffective and inadequate. In the extremely unlikely event that a court found that she had a legal right to access abortion in Ireland, the author would have been unable to terminate her pregnancy there. In order to have an abortion the author would have had to obtain a mandamus order to compel the State to perform a legal duty of a public nature, which must be explicit and unambiguous. Furthermore, the courts would have been extremely reluctant to order the Executive to provide the author a termination of pregnancy, as this would be incompatible with the separation of powers doctrine. The available remedies would also have been inadequate in that they would have compounded the author's mental suffering by forcing her to undergo public litigation which would have exposed her to public hostility.

3.28 Finally, the author could have challenged the abortion ban by making an application under the European Convention on Human Rights Act. However, under this Act the author could only have sought a declaration of incompatibility and for an associated ex gratia award of damages. She would not have been able to seek a mandamus order ensuring her access to a termination, let alone in a timely manner.

3.29 No effective and adequate domestic remedies were available after the author terminated her pregnancy abroad. She would have had two hypothetical options for challenging the Irish abortion ban. First, she could have petitioned an Irish court to engage in an abstract review of the constitutionality of the ban. The court would most likely have declined to adjudicate her claim on the basis that it was moot since she no longer needed an abortion. Secondly, she could have complained under the Human Rights Act that the abortion violated her rights. As indicated above, this review could at most have resulted in a declaration of incompatibility and an ex gratia award of compensation, and would not be an effective or adequate remedy.

State party's observations on admissibility and merits

4.1 The State party submitted observations on 10 July 2014 and 21 July 2015. It indicated that it does not take issue with the admissibility of the author's complaint.

4.2 The State party asserts that article 40.3.3 of the Constitution represents the profound moral choices of the Irish people. Yet, at the same time, the Irish people have acknowledged the entitlement of citizens to travel to other jurisdictions for the purposes of obtaining terminations of pregnancy. The legislative framework guarantees the citizens' entitlement to information in relation to abortion

services provided abroad. Thus, the constitutional and legislative framework reflects the nuanced and proportionate approach to the considered views of the Irish Electorate on the profound moral question of the extent to which the right to life of the foetus should be protected and balanced against the rights of the woman.

4.3 The State party provided a detailed overview of the Irish legislative and regulatory framework in relation to abortion and termination of pregnancy. It also referred to the judgment of the European Court of Human Rights in the case *A, B and C v. Ireland*.[4] Having regard to the fact that Irish law permitted travel abroad for the purposes of abortion, and appropriate access to information and health care was provided, the European Court did not consider that the prohibition on abortion for reasons of health and/or wellbeing exceeded the margin of appreciation accorded to Member States. The Court struck a fair balance between the privacy rights of A and B and the rights invoked on behalf of the foetus, which were based upon profound moral views of the Irish people about the nature of life. The Court found that there had been a violation of the applicant's right to private and family life contrary to article 8 of the European Convention in the case of applicant C, in that there had been no accessible and effective procedure to enable her to establish whether she qualified for a lawful termination of pregnancy.

4.4 Following this judgment the Protection of Life During Pregnancy Act 2013 was adopted. The Act deals with situations, inter alia, where termination of the life of the foetus is permitted in cases of a threat to the life of the woman due to physical illness and in emergencies, as well as situations where there is a real and substantial risk of loss of the woman's life by way of suicide. It reaffirms an individual's right to travel to another state and the right to obtain and make available information relating to services lawfully available in another state. It makes it an offence to intentionally destroy unborn human life, which can attract a fine or imprisonment for a term not exceeding 14 years.

4.5 The Irish regime may reflect concerns of which account is taken by article 6 of the Covenant. This provision has the potential to afford the foetus a right to life, which is deserving of protection. It cannot be definitively concluded that no measure of protection in relation to the right to life is afforded to the foetus, as otherwise article 6(5) would lack sufficiency of meaning, reason and substance. Contrary to the author's opinion, no conclusion regarding the application of the Covenant to prenatal rights exists at this current time in circumstances where relevant and material facts and context have yet to present themselves for consideration by the Committee.

Claims under article 7

4.6 The author was not subjected to cruel, inhuman or degrading treatment. In *K.L. v. Peru*,[5] the

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[4]Application No. 25579/05, 16 December 2010.

[5]Communication No. 1153/2003, *K.L. v. Peru*, Views adopted on 22 November 2005.

specific actions of state agents were the direct causal action found to be arbitrary interferences with the rights of the author, which denied her access to a lawfully available therapeutic abortion. In the present case the author was not denied access to lawful abortion. She could not avail of such procedure and this was communicated to her clearly and properly by the relevant state agents. She was then appropriately referred to the family planning facility to exercise her existing legal options. Accordingly, and contrary to what occurred in *K.L. v. Peru*, there were no actions on the part of state agents that were or could be described as having been based on the personal prejudices of officials in the health system.[6] Thus, it cannot be stated that there was any arbitrary interference with any right of the author and which lead to or resulted in cruel, inhuman and degrading treatment.

4.7 If any finding were made in this case, in the absence of the actual actions of State agents, on the basis of evolved constitutional and legal principles, this would represent a significant difference in kind (as opposed to a difference in degree), in the jurisprudence of the Committee. This would be contrary to paragraph 2 of General Comment No 20 which stipulates that "it is the duty of the State party to afford everyone protection through legislative and other measures as may be necessary against the acts prohibited by article 7, whether inflicted by people acting in their official capacity, outside their official capacity or in a private capacity". There was no act of "infliction" by any person or State agent, and therefore, there was no cruel, inhuman or degrading treatment.

4.8 The State party has not engaged in cruel, inhuman or degrading treatment on the basis that: (i) the communication is actually and factually distinct from the cases relied on by the author; (ii) in circumstances where the author's life was not in danger, the procedure for obtaining a lawful abortion in Ireland was clear. The decision was made by a patient in consultation with her doctor. If the patient did not agree she was free to seek another medical opinion and, in the last resort, she could make an emergency application to the High Court. There is no factual evidence that State agents were responsible for any arbitrary interference with this decision-making process, or that they were responsible for any act of "infliction"; (iii) the grounds for lawful abortion were well known and applied by virtue of article 40.3.3 of the Constitution, the grounds as elucidated by the Supreme Court in the X case, the Medical Council Guidelines and the CPA Guidelines; (iv) whilst the author states that she was aware that abortion was not allowed but had no idea that a termination on medical grounds would fall into the same category, this was her subjective understanding of the law; (v); the hospital and its staff was clear in its views that a termination was not possible in Ireland, and therefore, no arbitrary decision-making processes or acts of infliction can be suggested which caused or contributed to cruel, inhuman or degrading treatment; (vi) the State party's position and stance in relation to its law sought to achieve a reasonable, careful and difficult balance of competing

[6] According to the State party, the same argument applies with respect to the Views of CEDAW in communication No. 22/2009, *L.C. v. Peru*, adopted on 17 October 2011 and the Human Rights Committee in communication No. 1608/2007, *LMR v. Argentina*, Views adopted on 29 March 2011.

rights as between the foetus and the woman; (vii) the State party sought that balance in accordance with article 25 of the Covenant.

Claims under article 17

4.9 The author's privacy rights under article 17 of the Covenant were not violated. If there was any interference with her privacy it was neither arbitrary nor unlawful. Rather, it was proportionate to the legitimate aims of the Covenant, taking into account a careful balance between the right to life of the foetus with due regard to that of the woman. The advice given to the author by the hospital was properly and lawfully given. The State party is permitted to create laws, in accordance with and in the spirit of article 25 of the Covenant, which allow for a balancing of competing rights.

4.10 In the A, B and C case the ECHR found the following: "having regard to the right to lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland, the Court does not consider that the prohibition in Ireland of abortion for health and well-being reasons, based as it is on the profound moral views of the Irish people as to the nature of life … and as to the consequent protection to be accorded to the right to life of the unborn, exceeds the margin of appreciation accorded in that respect to the Irish State. In such circumstances, the Court finds that the impugned prohibition in Ireland struck a fair balance between the right of the first and second applicants to respect for their private lives and the rights invoked on behalf of the unborn." The balance to be achieved has been considered by the Irish electorate on numerous occasions.

4.11 In *K.L. v. Peru and L.M.R. v. Argentina*, where the Committee found violations of article 17, legislation existed which allowed for the therapeutic termination of a pregnancy. The authors were initially told that they qualified for terminations, but which qualifications were then arbitrarily interfered with and not protected by the states in question. In the instant case, no such conflict arose, as the hospital gave its clear opinion that a termination of pregnancy would not be available in Ireland. Therefore, the arbitrary interference which occurred in those cases did not occur in the present communication.

Claims under article 19

4.12 Sufficient information has not been produced to substantiate the claims. Certain unsubstantiated allegations are made by the author, for example, in relation to the midwife. By claiming that the midwife "refused to discuss" options she suggests an intention on the part of the midwife, without any further information being put before the Committee. In referring the author to the appropriate organisation from where she could obtain the information she required, the midwife was not engaged in censoring. Nor was there a violation of article 19 in circumstances where the referral allowed the author to "receive information" of all information permissible, in fulfilment of article 19(2).

Therefore, in circumstances where the hospital gave advice to the author to see a counsellor, which referral led to a discussion of all the available options, there was no violation of article 19. Further, the Health Service Executive's crisis pregnancy program provides a rich resource of information available to the public at large in relation to crisis pregnancy and abortion. This resource is free of charge and was available to the author.

Claims under articles 2(1), 3 and 26

4.13 The State party contends that there has been no discrimination, but that if there has been any this should be regarded as a reasonable and objective differentiation to achieve a purpose which is legitimate under the Covenant. There can be no "invidious discrimination" in relation to a pregnant woman as her physical capacity/circumstances in a state of pregnancy are inherently different to that of a man. This differentiation is a matter of fact and can only be accepted as axiomatic.

4.14 There is no basis for considering that the legal framework complained of, being article 40.3.3 of the Constitution and the relevant provisions of the 1861 Offences against the Person Act, discriminate against women on grounds of sex. This framework is gender neutral. If a man procures or carries out an abortion in circumstances not contemplated by the Constitution he may be guilty of an offence. Even if the legal framework did discriminate on grounds of gender, any such discrimination would be in pursuit of the legitimate aim of protecting the foetus and be proportionate to that aim. The measures at issue are not disproportionate, as they strike a fair balance between the rights and freedoms of the individual and the general interest. Again in this area, in accordance with the ECHR, the State party enjoys a margin of appreciation. Therefore, the differentiation is reasonable and objective and achieves a legitimate end.

4.15 The State party disputes that its laws stereotyped the author as a reproductive instrument subjecting her to gender discrimination. Rather, the inherent differentiation between a man and a pregnant woman requires the careful balancing of rights of the foetus which is capable of being born alive, and the rights of the woman.

Author's comments on the State party's observations

5.1 The author submitted comments on the State party's observations on 12 December 2014. She contests the State party's portrayal of the Irish people's view on abortion and their "choice" as to when it should be available in Ireland. For many years, opinion polls have indicated that a significant majority of the Irish people support legalizing access to abortion in cases of non-viable pregnancies and fatal foetal impairments. A similarly high majority support legalizing abortion where the pregnancy results from sexual assault or where a woman's health is at risk. Moreover, the constitutional referenda do not support the State party's description of the Irish people's profound

"moral choice". The Irish electorate has never been provided with an opportunity to vote on a proposal to expand the situations in which access to abortion is legal. At no time has the Irish people been provided with the opportunity to express their view that abortion should be made available to women in circumstances other than where there is a risk to a woman's life. In fact, two proposals put to the electorate in 1992 and 2002 which would have further restricted access to abortion by making abortion illegal where a woman is at risk of suicide were rejected. Furthermore, in the three constitutional referenda on the matter of abortion the percentage of the eligible electorate voting in favour of restrictions was less than35%.

5.2 The 2013 Protection of Life During Pregnancy Act has no bearing on the author's complaint, as it applies only to the regulation of procedures to be followed when an abortion is sought by a woman in a situation where there is a real and substantial risk to her life.

Claims under article 7

5.3 As a result of the absolute nature of the right enshrined in article 7, a State party may not seek to justify its conduct with reference to a need to balance the rights protected under it with the "rights of others". Furthermore, requiring arbitrary action by state agents as a constituent element of ill treatment has no basis in the wording of article 7. Whether the State party's conduct caused ill treatment through arbitrary action or not is irrelevant to the protection afforded by article 7. When a claim is made that article 7 has been violated, the matter for enquiry is whether harm suffered amounted to ill treatment and whether the conduct from which the harm resulted was attributable to the state. Whether or not the conduct was arbitrary is immaterial.

5.4 By extension of its assertions regarding "arbitrary action" the State party implies that the domestic illegality of the abortion sought by the author is determinative and reason in and of itself for the dismissal of her claims under article 7. It suggests that because the abortion sought was illegal under domestic law the State party's denial of the medical procedure could not be considered to amount to ill-treatment. This reasoning undermines the principle that domestic law may never be invoked to justify a failure to discharge obligations under the Covenant and contradicts the absolute nature of the protection afforded by article 7. To accept it would be to tacitly accept the assertion that by criminalizing or legally prohibiting certain medical procedures a state may avoid responsibility under article 7 even where withholding such procedures causes individuals severe pain and suffering. When the author was denied an abortion her suffering was made no more tolerable to her in the knowledge that the denial conformed with domestic law. In fact, the criminalization of abortion increased, rather than diminished, her suffering.

5.5 The author rejects the State party's categorization of the facts as excluding state conduct that could contravene the prohibition of ill-treatment. Her medical team, who were public employees, failed to provide her with the abortion she sought. She was denied an abortion by agents of the state

acting in accordance with state laws and policies. This caused the author severe mental anguish. Her pain and suffering reached the threshold required by article7.

Claims under article 17

5.6 The State party's denial of access to abortion constitutes an arbitrary interference in the author's exercise of her right to privacy for the following reasons:

(i) The interference discriminated against her because she was woman, thereby contravening the prohibition of discrimination on the basis of sex enshrined in articles 2and 3 of the Covenant;

(ii) The interference was not necessary or proportionate to a legitimate aim. The State party has not presented arguments specific to the author's circumstances that would demonstrate the necessity and proportionality of its conduct towards her.

(iii) The State party failed to demonstrate that its interference with her right to privacy was necessary towards achieving the legitimate aim invoked. As indicated above, the State party's characterization of the Irish people's "profound moral choices" is misrepresentative of the views of a majority of Irish people.

(iv) The State party has failed to demonstrate that its interference in the author's right to privacy was appropriate or effective in achieving its aim. A criminal legal regime which prohibits women in all circumstances from obtaining an abortion in the jurisdiction, except where there is a real and substantial risk to their lives, and threatens them with significant prison terms in the name of protecting alleged moral choices concerning "the right to life of the unborn", yet simultaneously includes an explicit provision providing fora right to travel out of the state to obtain an abortion is not a means to its end. Rather, it is a contradiction in terms and calls into question the genuine nature of the State party's claims.

(v) The State party has failed to demonstrate that the interference was proportionate. The trauma and stigma she endured as a result of the attack on her physical and psychological integrity, dignity and autonomy combined to give rise to serious mental pain and suffering. In this context, the State party's laws cannot be described as proportionate or as achieving a careful "balance of competing rights as between the unborn child and its mother". Instead, the State party prioritized its interest in protecting "the unborn" and offered no protection to the author's right to privacy. Rather, the author could have faced a severe criminal sentence had she obtained an abortion in Ireland.

5.7 The margin of appreciation doctrine invoked by the State party applies exclusively to the European Court jurisprudence and has not been accepted by any other international or regional

human rights mechanisms. Furthermore, the European Court has never considered the application of the margin of appreciation doctrine to a set of facts similar to those experienced by the author.

Claims under article 19

5.8 The Abortion Information Act can be described as a "system of strict state control governing the manner in which information must be given". Doctors are barred from referring their patients to an abortion provider abroad and failure to comply with the Act's requirements is an offence and subject to a fine. As a result, the right to information is not treated as a positive right whose realisation is in the public good and requires action by the state to remove barriers to its exercise. The punitive framework in operation in the State party, resulting from the broad criminalization of abortion and the related lack of clarity as to what is permissible under the Act deterred both the author's doctor and midwife from providing the information she sought.

5.9 The author rebuts the assertion that through directing her to the IFPA the State party discharged its obligations under article 19. The euphemistic advice given by state employees to contact IFPA represented a breach in the continuum of doctor-patient care that was not based on her health needs but was the result of prevailing stigma and fears or uncertainty as to the consequences of providing the information directly.

5.10 As to the Crisis Pregnancy Programme, according to its own website "does not provide counselling or medical services directly to the public. Instead, it funds other organizations to provide counselling or medical services that are in line with its objectives. The Programme is mandated to work towards a "reduction in the number of women with crisis pregnancies who opt for abortion by offering services and support which make other options more attractive".

5.11 The restriction on the author's right to information did not comply with article 19(3). The State party has not justified the restrictions. The restrictions were not prescribed bylaw, since the Abortion Information Act does not meet the Covenant requirement that a restriction of article 19 must be "formulated with sufficient precision to enable an individual to regulate his or her conduct accordingly".[7] Furthermore, the restriction was neither necessary nor proportional to a legitimate aim. There was no purpose other than to impair the author's enjoyment of her right of information related to abortion services abroad; and was disproportionate in light of the detrimental impact on her dignity and well- being.

Claims under articles 2, 3 and 26

5.12 Article 40.3.3 of the Constitution does not "balance" the right to life of men, or their enjoyment

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[7] General Comment No. 34, paragraph 25.

of other rights. In this way, the State party's assertion that the provision is gender neutral cannot be supported. Furthermore, the first part of article 58 of the Offences against the Person Act applies to women only and is therefore not gender neutral. The legal framework has a distinct and specific impact on women and the consequences of the laws on the personal integrity, dignity, physical and mental health and well-being of women are severe.

5.13 State parties to the Covenant cannot invoke women's biological difference to men and their reproductive capacity as a basis to permissibly restrict their rights. Ireland has failed to discharge its burden to disprove a prima facie case of discrimination on sex and justify differential treatment as proportionate to a legitimate aim. It did not explain how the withholding of abortion services from the author in the circumstances of a fatal foetal impairment and the adverse impact this had on her was proportionate to the aim of protecting "the unborn". The aim of "protecting the rights of the unborn" was placed above the author's dignity and well-being. She was treated as inferior and subjected to wrongful gender stereotyping. The prohibition of abortion in cases of fatal foetal impairments and non-viable pregnancies cannot be considered proportionate to the aim of protecting the foetus.

Issues and proceedings before the Committee

Consideration of admissibility

6.1 Before considering any claim contained in a communication, the Human Rights Committee must, in accordance with rule 93 of its rules of procedure, decide whether or not the case is admissible under the Optional Protocol to the Covenant.

6.2 The Committee notes, as required by article 5, paragraph 2 (a), of the Optional Protocol, that the same matter is not being examined under any other international procedure of investigation or settlement. The Committee further notes that the State party does not dispute the admissibility of the communication. All admissibility criteria having been met, the Committee considers the communication admissible and proceeds to its examination on the merits.

Consideration of the merits

7.1 The Human Rights Committee has considered the communication in the light of all the information made available to it by the parties, as provided for under article 5, paragraph 1, of the Optional Protocol.

7.2 The author in the present communication was informed by public medical professionals, in the 21st week of her pregnancy, that her foetus had congenital defects and would die in utero or shortly

after birth. As a result of the prohibition of abortion in Irish law she was confronted with two options: carrying to term, knowing that the foetus would most likely die inside of her or having a voluntary termination of pregnancy in a foreign country. Article 40.3.3 of the Constitution stipulates in this respect that "the State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right". The State party argues that its constitutional and legislative framework[8] reflects the nuanced and proportionate approach to the considered views of the Irish Electorate on the profound moral question of the extent to which the interests of a foetus should be protected and balanced against the rights of the woman. The State party also indicates that article 40.3.3 of the Constitution, as interpreted by the Irish Supreme Court, provides that it is lawful to terminate a pregnancy in Ireland only if it is established as a matter of probability that there is a real and substantial risk to the life of the woman (as distinct from her health), which can only be avoided by a termination of the pregnancy.

7.3 The author claims to have been subjected to cruel, inhuman and degrading treatment as a result of the legal prohibition of abortion, as she was, inter alia, denied the health care and bereavement support she needed in Ireland; compelled to choose between continuing to carry a dying foetus and terminating her pregnancy abroad; and subjected to intense stigma. The State party rejects the author's claim by arguing, inter alia, that the prohibition seeks to achieve a balance of competing rights between the foetus and the woman; that her life was not in danger; and that there were no arbitrary decision-making processes or acts of "infliction" by any person or State agent that caused or contributed to cruel, inhuman or degrading treatment. The State party also states that the legislative framework guarantees the citizens' entitlement to information in relation to abortion services provided abroad.

7.4 The Committee considers that the fact that a particular conduct or action is legal under domestic law does not mean that it cannot infringe article 7 of the Covenant. By virtue of the existing legislative framework, the State party subjected the author to conditions of intense physical and mental suffering. The author, as a pregnant woman in a highly vulnerable position after learning that her wanted pregnancy was not viable, and as documented, inter alia, in the psychological reports submitted to the Committee, had her physical and mental anguish exacerbated by: not being able to continue receiving medical care and health insurance coverage for her treatment from the Irish health care system; the need to choose between continuing her non-viable pregnancy or traveling to another country while carrying a dying foetus, at personal expense and separated from the support of her family, and to return while not fully recovered; the shame and stigma associated with the criminalization of abortion of a fatally ill foetus; the fact of having to leave the baby's

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[8] At the time of the events at issue the Offences Against the Person Act imposed the criminal penalty of life imprisonment for a woman or a physician who attempted to terminate a pregnancy (see para. 3.22).

remains behind and later having them unexpectedly delivered to her by courier; and the State's refusal to provide her with necessary and appropriate post-abortion and bereavement care. Many of the described negative experiences she went through could have been avoided if the author had not been prohibited from terminating her pregnancy in the familiar environment of her own country and under the care of the health professionals whom she knew and trusted; and if she had been afforded needed health benefits that were available in Ireland, were enjoyed by others, and she could have enjoyed had she continued her non-viable pregnancy to deliver a stillborn child in Ireland.

7.5 The Committee considers that the author's suffering was further aggravated by the obstacles she faced in receiving needed information about her appropriate medical options from known and trusted medical providers. The Committee notes that the Abortion Information Act legally restricts the circumstances in which any individual may provide information about lawfully available abortion services in Ireland or overseas, and criminalizes advocating or promoting the termination of pregnancy. The Committee further notes the author's unrefuted statement that the health professionals did not deliver such information in her case, and that she did not receive key medically indicated information about the applicable restrictions on overseas abortions and the types of terminations most appropriate given her period of gestation, thereby disrupting the provision of medical care and advice that the author needed and exacerbating her distress.

7.6 The Committee additionally notes, as stated in General Comment No. 20, that the text of article 7 allows of no limitation, and no justification or extenuating circumstances may be invoked to excuse a violation of article 7 for any reasons.[9] Accordingly, the Committee considers that, taken together, the above facts amounted to cruel, inhuman or degrading treatment in violation of article 7 of the Covenant.

7.7 The author claims that by denying her the only option that would have respected her physical and psychological integrity and reproductive autonomy under the circumstances of this case (allowing her to terminate her pregnancy in Ireland), the State interfered arbitrarily in her right to privacy under article 17 of the Covenant. The Committee recalls its jurisprudence to the effect that a woman's decision to request termination of pregnancy is an issue which falls under the scope of this provision.[10] In the present case, the State party interfered with the author's decision not to continue her non-viable pregnancy. The interference in this case was provided for under article 40.3.3 of the Constitution and therefore was not unlawful under the State party's domestic law. However, the question before the Committee is whether such interference was unlawful or arbitrary under the Covenant. The State party argues that there was no arbitrariness, since the interference

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[9] General Comment No. 20, paragraph 3.

[10] Communications 1153/2003, *K.L. v. Peru*, Views adopted on 24 October 2005, para 6.4; and 1608/2007, *L.M.R. v. Argentina*, Views adopted on 29 March 2011, para 9.3. See also General Comment No.28, paragraph 10.

was proportionate to the legitimate aims of the Covenant, taking into account a carefully considered balance between protection of the foetus and the rights of the woman.

7.8 The Committee considers that the balance that the State party has chosen to strike between protection of the foetus and the rights of the woman in this case cannot be justified. The Committee recalls its General Comment No. 16 on article 17, according to which the concept of arbitrariness is intended to guarantee that even interference provided for by law should be in accordance with the provisions, aims and objectives of the Covenant and should be, in any event, reasonable in the particular circumstances. The Committee notes that the author's wanted pregnancy was not viable, that the options open to her were inevitably a source of intense suffering, and that her travel abroad to terminate her pregnancy had significant negative consequences for her, as described above, that could have been avoided if she had been allowed to terminate her pregnancy in Ireland, resulting in harm contrary to article 7. On this basis, the Committee considers that the interference in the author's decision as to how best cope with her non-viable pregnancy was unreasonable and arbitrary in violation of article 17 of the Covenant.

7.9 The author claims that criminalization of abortion on the grounds of fatal foetal impairment violated her rights to equality and non-discrimination under articles 2(1), 3 and 26. The State party rejects this claim and contends that its legal regime regarding termination of pregnancy is not discriminatory.

7.10 The Committee notes that under the legal regime in the State party, women pregnant with a foetus with a fatal impairment who nevertheless decide to carry the foetus to term continue to receive the full protection of the public health care system. Their medical needs continue to be covered by health insurance, and they continue to benefit from the care and advice of their public medical professionals throughout the pregnancy. After miscarriage or delivery of a stillborn child, they receive any needed post-natal medical attention as well as bereavement care. By contrast, women who choose to terminate a non-viable pregnancy must do so in reliance on their own financial resources, entirely outside of the public health care system. They are denied health insurance coverage for these purposes; they must travel abroad at their own expense to secure an abortion and incur the financial, psychological and physical burdens that such travel imposes, and they are denied needed post-termination medical care and bereavement counselling. The Committee further notes the author's uncontested allegations that in order to secure a termination of her non-viable pregnancy, the author was required to travel abroad, incurring financial costs that were difficult for her to raise. She also had to travel back to Dublin only 12 hours after the delivery, as she and her husband could no longer afford to stay in the UK.

7.11 In its General Comment No. 28 on non-discrimination the Committee states that "not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the

Covenant”[11]. The Committee notes the author’s claim that Ireland’s criminalization of abortion subjected her to a gender-based stereotype of the reproductive role of women primarily as mothers, and that stereotyping her as a reproductive instrument subjected her to discrimination. The Committee considers that the differential treatment to which the author was subjected in relation to other similarly situated women failed to adequately take into account her medical needs and socio-economic circumstances and did not meet the requirements of reasonableness, objectivity and legitimacy of purpose. Accordingly, the Committee concludes that the failure of the State party to provide services to the author that she required constituted discrimination and violated her rights under article 26 of the Covenant.

7.12 In the light of the above findings, the Committee will not examine separately the author’s allegations under articles 2(1), 3 and 19 of the Covenant.

8. The Human Rights Committee, acting under article 5(4), of the Optional Protocol, is of the view that the facts before it disclose a violation of the author’s rights under articles 7, 17 and 26 of the International Covenant on Civil and Political Rights.

9. Pursuant to article 2, paragraph 3(a), of the Covenant, the Committee considers that the State party is under an obligation to provide the author with an effective remedy. This requires it to make full reparation to individuals whose Covenant rights have been violated. Accordingly, the State party is obligated, inter alia, to provide the author with adequate compensation and to make available to her any needed psychological treatment. The State party is also under an obligation to take steps to prevent similar violations occurring in the future. To this end the State party should amend its law on voluntary termination of pregnancy, including if necessary its Constitution, to ensure compliance with the Covenant, including ensuring effective, timely and accessible procedures for pregnancy termination in Ireland, and take measures to ensure that health-care providers are in a position to supply full information on safe abortion services without fearing being subjected to criminal sanctions,[12] as indicated in these Views of the Committee.

10. Bearing in mind that, by becoming a party to the Optional Protocol, the State party has recognized the competence of the Committee to determine whether there has been a violation of the Covenant or not and that, pursuant to article 2 of the Covenant, the State party has undertaken to ensure to all individuals within its territory or subject to its jurisdiction the rights recognized in the Covenant and to provide an effective remedy when it has been determined that a violation has occurred, the Committee wishes to receive from the State party, within 180 days, information about the measures taken to give effect to the Committee's Views. In addition, it requests the State party to publish the Committee's Views.

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[11] General Comment No. 18: Non-discrimination, para. 13.

[12] See also CCPR/C/IRL/CO/4, concluding observations adopted by the Committee at its 111th session (7–25 July 2014), paragraph 9.

Appendix I

Individual opinion of Committee member Yadh Ben Achour (concurring

[Original: French]

1. I fully share the conclusions of the Human Rights Committee which find that the present case reveals a violation of articles 7, 17 and 26 of the Covenant. The Committee has, however, decided not to consider separately the author's allegations under articles 2(1) and 3 of the Covenant.

2. I consider that the Committee should have received and accepted on the merits the argument defended by the author of the communication (see paragraphs 3.15 to 3.19 of the Views) that the Irish law criminalizing abortion also violates articles 2(1) and 3 of the Convention.

3. By denying women their freedom in an area affecting their reproductive function, this type of legislation runs counter to the right not to be discriminated against on the basis of sex, because it denies women their freedom of choice in this domain. There is no similar restriction imposed on men.

4. The prohibition of abortion in Ireland, owing to its binding effect, which is indirectly punitive and stigmatizing, targets women *because they are women* and puts them in a specific situation of vulnerability, which is discriminatory in relation to men. Under this legislation, the author has in effect been the victim of the sexist stereotype, whereby women's pregnancy must, except where the life of the mother is at risk, continue, irrespective of the circumstances, as they are limited exclusively to their reproductive role as mothers. Reducing the author to a reproductive instrument constitutes discrimination and infringes her rights both to self-determination and to gender equality.

5. On the basis of the foregoing, I thereby consider that the fact that the State, under its domestic

law, does not permit the author to interrupt her pregnancy constitutes gender discrimination (which is one of the forms of discrimination on the basis of sex provided for by articles 2 (1) and 3 of the Convention).

6. The State party's law therefore infringes the rights of the author under articles 2(1) and 3 of the Convention, read together with article 26.

Appendix II

Individual opinion of Committee member Sarah Cleveland (concurring)

1. I concur in the Committee's Views in this case. I also agree with the separate opinion of my colleagues that the Committee should have found a violation of article 19 of the Covenant and articulated a comprehensive finding of gender discrimination under articles 2(1), 3 and 26. I write separately to set forth my views on the finding of a violation of article26.

2. In paragraphs 7.10 and 7.11, the Committee notes the disproportionate socio- economic burdens that the Irish legal system imposes on women who decide not to carry a fetus to term, including those imposed on the author in particular. It also notes the author's claim that Ireland's criminalization of abortion discriminatorily subjected her to gender- based stereotypes. The Committee concludes that the distinctions drawn by the State party "failed to adequately take into account her medical needs and socio-economic circumstances and did not meet the requirements of reasonableness, objectivity and legitimacy of purpose" under article 26. The Committee thus identifies two prohibited grounds for finding a violation of article 26: discrimination on grounds of socio-economic status and gender discrimination.

3. With respect to socio-economic status, the Committee previously has expressed specific concern in relation to article 26 regarding the highly restrictive Irish legal regime, which requires women to travel to a foreign jurisdiction to obtain a lawful termination of pregnancy in most contexts, and the resulting "discriminatory impact of the Protection of Life During Pregnancy Act on women who are unable to travel abroad to seek abortions"[a]. Article 26, of course, "guarantee[s] to all persons equal and effective protection against discrimination" on the grounds of both "property" and "other

[a] CCPR/C/IRL/CO/4, concluding observations adopted by the Committee at its 111th session (7–25 July 2014), para. 9. See also E/C.12/IRL/CO/3, CESCR, Concluding observations on the third periodic report of Ireland (July 2015), para. 30 (expressing concern at "the discriminatory impact on women who cannot afford to obtain an abortion abroad or access to the necessary information").

status."[b] It therefore prohibits the unequal access to reproductive health care for low-income and vulnerable populations that results from Ireland's legal restrictions on reproductive health services.

4. The author further contends that Ireland's criminalization of abortion stereotyped her as a reproductive instrument and thus subjected her to discrimination. She explains that by prioritizing protection of the "unborn" over a woman's health and personal autonomy, Ireland subjected her to a gender-based stereotype that women should continue their pregnancies regardless of circumstances, because their primary role is to be mothers and caregivers, thus infringing on her right to gender equality. In particular, the author contends that Ireland's differential treatment of women who decide to carry a pregnancy with a fatal impairment to term, versus women who terminate such pregnancies, reflects a stereotypical idea that a pregnant woman should let nature run its course, regardless of the suffering involved for her. (Para. 3.19).

5. The State party in turn contends that the criminalization of abortion cannot discriminate against women, per se, because any differential treatment is based on factual biological differences between men and women. It argues alternatively that any gender- based differential treatment of woman pursues the legitimate aim of protecting the foetus, is proportionate to that aim, and thus is not discrimination. (Paras. 4.13-4.15).

6. The view that differences in treatment that are based on biological differences unique to either men or women cannot be sex discrimination is inconsistent with contemporary international human rights law and the positions of this Committee. Under such an approach, apparently it would be perfectly acceptable for a State to deny healthcare coverage for essential medical care uniquely required by one sex, such as cervical cancer, even if all other forms of cancer (including prostate cancer for men) were covered. Such a distinction would not, under this view, treat men and women differently, because only women contract cervical cancer, as a result of biological differences unique to women. Thus there would be no comparable way in which men were treated differently.

7. Modern gender discrimination law is not so limited. The right to sex and gender equality and non-discrimination obligates States to ensure that State regulations, including with respect to access to health services, accommodate the fundamental biological differences between men and women in reproduction and do not directly or indirectly discriminate on the basis of sex. They thus require States to protect on an equal basis, in law and in practice, the unique needs of each sex. In particular,

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[b] Cf. Communication No. 1306/04, Haraldsson and Sveinsson v. Iceland (Views adopted 24 Oct. 2007), para. 10.3 (distinction between groups of fishermen was "based on grounds equivalent to property" under article 26); CESCR General Comment No. 20: Non-discrimination in economic, social and cultural rights (2009), para. 35 (recognizing "other status" as including differential treatment on grounds of economic and social situation, which can lead to unequal access to health care services). Cf. *Artavia Murillo, et al. v. Costa Rica*, IACHR (2012), paras. 303-304 (ban on *in vitro* fertilization discriminated against persons who lacked financial resources to seek IVF treatment abroad).

as this Committee has recognized, non discrimination on the basis of sex and gender obligates States to adopt measures to achieve the “effective and equal empowerment of women ”[c].

8. Article 26 requires “equal and effective” protection against discrimination on grounds of sex. The Committee has drawn upon the Race Convention and CEDAW to define discrimination as prohibiting “any distinction, exclusion, restriction or preference which is based on any ground such as … sex…, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms ”[d]. Article 26 prohibits discrimination in law or in fact in any field regulated and protected by public authorities[e], and does not require an intent to discriminate. Violations can “result from the discriminatory effect of a rule or measure that is neutral at face value or without intent to discriminate”[f]. Thus, “indirect discrimination” contravenes the Covenant “if the detrimental effects of a rule or decision exclusively or disproportionately affect persons” with a protected characteristic and the “rules or decisions with such an impact” are not “based on objective and reasonable grounds”[g].

9. State policies that treat or impact men and women differently as a result of biological differences are obviously “based on … sex”[h]. Such distinctions necessarily constitute discrimination unless they are supported by reasonable and objective criteria and a legitimate purpose[i].

10. This Committee has long recognized that the enjoyment of rights and freedoms on an equal footing does not mean identical treatment of men and women in every instance and may require differential treatment in order to overcome conditions that cause or help to perpetuate discrimination[j]. The Committee accordingly has recognized that interference with women’s access to reproductive health services can violate their rights to equality and non-discrimination[k]. Protection of sex and gender equality obligates States parties to respect women’s privacy in relation to their reproductive functions, including prohibiting States from imposing restrictions on women’s

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[c]General Comment No. 28, Equality of rights between men and women (article 3) (2000), para 8.

[d]General Comment No. 18, Nondiscrimination (1994), paras. 6-7 (emphasis added).

[e]Id., para. 12.

[f]Communication No. 998/2001, Althammer v. Austria (Views adopted 8 August 2003), para. 10.2; see also Communication No. 172/1984, *Broeks v. The Netherlands* (Views adopted 9 April 1987), paras. 15-16 (finding a violation of article 26 although the “the State party had not intended to discriminate against women”).

[g]Ibid.

[h]Cf. Dekker v. *Stichting Vorming scentrum voor Jong Volwassensen (VJV-Centrum) Plus*, [1990] 1 E.C.R. 3941, [1991] I.R.L.R. 27 (“[O]nly women can be refused employment on the grounds of pregnancy and such a refusal therefore constitutes direct discrimination on grounds of sex”); *Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219 (“Discrimination on the basis of pregnancy is discrimination on the basis of sex.”).

[i] General Comment No. 18, para. 13.

[j] General Comment No. 18, paras. 8, 10.

[k] General Comment No. 28, paras. 10, 11, 20.

access to sterilization and from requiring health personnel to report women who have undergone abortion. It also prohibits employers from requesting pregnancy tests before hiring women[l]. Gender equality requires that pregnant women in State custody receive appropriate care, obligates States to afford access to safe abortion services to women who have become pregnant as a result of rape, and obligates them to ensure that women are able to access information necessary for equal enjoyment of their rights[m].

11. This approach comports with that of the CEDAW Committee, which has emphasized that a State's failure or refusal to provide reproductive health services that only women need constitutes gender discrimination[n]. Even facially identical treatment of men and women may discriminate if it fails to take into account women's different needs[o].

12. Women's unique reproductive biology traditionally has been one of the primary grounds for *de jure and de facto* discrimination against women. This is true when women are treated differently from men based on stereotyped assumptions about their biology and social roles, such as the claim that women are less able to take full time or demanding jobs than men.[p] It is equally true when apparently gender-neutral laws disproportionately or exclusively burden women because they fail to take into account the unique circumstances of women. Both types of laws subject women to discrimination.

13. Ireland's near-comprehensive criminalization of abortion services denies access to reproductive medical services that only women need, and imposes no equivalent burden on men's access to reproductive health care. It thus clearly treats men and women differently on the basis of sex for purposes of article 26. Such differential treatment constitutes invidious sex and gender discrimination unless it reasonable and objective to a legitimate purpose under the Covenant – requirements that the Committee found were not satisfied here.

14. The author also articulates an alternative basis for a finding of gender discrimination – that

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[l]Id., para. 20.

[m]Id., paras. 11, 15, 22.

[n]CEDAW Committee, General Recommendation No. 24, *Article 12: Women and health* (1999), paras. 11-12. The CEDAW Committee has recognized that it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women, and that health care policies must addresses distinctive factors which differ for women in comparison to men, including biological factors and psychosocial factors such as post-partum depression. Ibid. See also CEDAW Communication No. 22/2009, *L.C. v. Peru* (Views adopted 17 Oct. 2011), para. 8.15 (State's failure to provide a minor rape victim with a therapeutic abortion denied her "access to medical services that her physical and mental condition required", in violation of her rights to non-discrimination and equal access to healthcare).

[o] CEDAW Committee, General Recommendation No. 28 on the core obligations of States parties under article 2 (2010), para. 5 ("[I]dentical or neutral treatment of women and men might constitute discrimination against women if such treatment resulted in or had the effect of women being denied the exercise of a right because there was no recognition of the pre-existing gender-based disadvantage and inequality that women face.").

[p] CESCR, General Comment No. 20, *supra*, para. 20. Cf. *Muller v. Oregon*, 208 U.S. 412 (1908) (upholding restrictions on working hours of women based on gender stereotypes).

Ireland's legal regime is based on traditional stereotypes regarding the reproductive role of women, by placing the woman's reproductive function above her physical and mental health and autonomy. The fact that the State party may have pointed to a facially nondiscriminatory purpose for its legal regime does not mean that its laws may not also be informed by such stereotypes. Indeed, the State's laws appear to take such stereotypes to an extreme degree where, as here, the author's pregnancy was nonviable and any claimed purpose of protecting a foetus could have no purchase. Requiring the author to carry a fatally impaired pregnancy to term only underscores the extent to which the State party has prioritized (whether intentionally or unintentionally) the reproductive role of women as mothers, and exposes its claimed justification in this context as a *reductio adabsurdum*.

15. The Committee has recognized that "[i]nequality in the enjoyment of rights by women throughout the world is deeply embedded in tradition, history and culture, including religious attitudes" and has admonished States parties to ensure that such attitudes are not used to justify violations of women's rights[q]. In numerous prior cases, the Committee has invalidated as discriminatory both legislation and practices that reflected gendered stereotypes of women's social and biological role. For example, the Committee found that a law that imposed greater obstacles to choosing the wife's name as the family name could not be justified based on arguments of "long-standing tradition" and violated article 26[r], as did a law that required married women, but not married men, to establish that they were the "breadwinner" to receive unemployment benefits[s]. More directly relevant here, in *L.N.P. v. Argentina*, the Committee found that the conduct of police, medical, and judicial personnel aimed at casting doubt on the morality of an indigenous minor rape victim based on stereotypes of virginity and sexual morality violated article 26[t]. And in *V.D.A (L.M.R.) v. Argentina*, the Committee concluded that failure to provide a legally available abortion to a mentally impaired minor constituted gender discrimination[u]. Similarly, in *L.C. v. Peru* the CEDAW Committee found that a hospital's decision to defer needed surgery in preference for preserving a rape victim's pregnancy "was influenced by the stereotype that protection of the foetus should prevail over the health of the mother"[v] and thus violated CEDAW. Recognition that

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q General Comment No. 28, para. 5.

r Communication No. 919/2000, *Müller and Engelhard v. Namibia* (Views adopted 26 March 2002), para. 6.8.

s Communication No. 172/1984, *Broeks v. The Netherlands* (Views adopted 9 April 1987), para. 15; *accord* Communication No. 182/1984, *F. H. Zwaan-de Vries v. The Netherlands* (Views adopted 9 April 1987), paras. 14-15 ("a differentiation which appears on one level to be one of status is in fact one of sex, placing married women at a disadvantage compared with married men"). See also Communication No. 415/1990, *Pauger v. Austria* (Views adopted 26 March 1992), para. 7.4 (pension law imposing an income requirement on widowers but not widows unreasonably differentiated on the basis of sex in violation of article 26).

t Communication No. 1610/2007 (Views adopted 18 July 2011), para. 13.3.

u Communication No. 1608/2007 (Views adopted 29 March 2011), para. 9.4 (finding a violation of article 2(3) in relation to articles 3, 7, and 17).

v *L.C. v. Peru, supra*, para. 8.15 (finding violations of CEDAW articles 5 and 12).

differential treatment of women based on gender stereotypes can give rise to gender discrimination is also in accord with the approach of other human rights bodies.[w]

16. The Committee's finding of a violation of article 26 in the author's case is consistent with these decisions and is fully justified on grounds of discrimination arising from gender stereotyping.

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[w] See CESCR, General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3) (2005), para. 5 (women often experience discrimination resulting from the subordinate status ascribed to them by tradition and custom). The ESCR Committee has further explained as follows:

the notion of the prohibited ground "sex" … cover[s] not only physiological characteristics but also the social construction of gender stereotypes, prejudices and expected roles, which have created obstacles to the equal fulfillment of … rights. Thus, the refusal to hire a woman, on the ground that she might become pregnant, or the allocation of low-level or part-time jobs to women based on the stereotypical assumption that, for example, they are unwilling to commit as much time to their work as men, constitutes discrimination. Refusal to grant paternity leave may also amount to discrimination against men.

CESCR, General Comment No. 20, supra, para. 20. *Cf. Artavia Murillo et al v. Costa Rica*, IACHR (2012), paras. 294-301 (ban on in vitro fertilization constituted gender discrimination as a result of stereotypes regarding fertility).

Appendix III

Individual opinion of Committee member Sir Nigel Rodley (concurring)

1. I entirely support the findings of the Committee in this sad case. I wish, however, to underline that the refusal of the State party to allow for terminations even in the case offatal foetal abnormality cannot even be justified as being for the protection of the (potential) life of the foetus. In addition, not only has article 7 been violated cumulatively (see paragraph 7.6), but by the very requirement that a pregnant woman carrying a doomed foetus is subjected to the anguish of having to carry the pregnancy to term.

Appendix IV

Individual opinion of Committee members Víctor Rodríguez Rescia, Olivier de Frouville and Fabián Salvioli (concurring)

[Original: Spanish]

1. Even though we concur with the Committee's findings regarding the admissibility and merits of communication No. 2324/2013 in relation to the violation of articles 7, 17 and 26 of the Covenant in respect of the author, we believe that the Committee should have determined whether or not there was also a separate violation of article 19, rather than sidestepping a discussion of that matter, as was done in paragraph 7.12 of the communication.

2. The author stated that, as a result of the legal regime in place, under which abortion is prohibited, the health professionals with whom she interacted at the Rotunda Hospital failed to provide her with critical information about the medical aspects of abortion and legal abortion services abroad, in violation of her right to seek and receive information under article 19 of the Covenant. The fact that the author was referred to a private counsellor who gave her partial information did not exempt the State from this positive obligation.

3. We believe that, when it comes to issues of health, including matters relating to sexual and reproductive rights, in which, moreover, people's lives and well-being may be at risk, information must be publicly available. Access to such information must figure as part of a public policy of the State that sets uniform guidelines for assisting users in taking personal decisions with regard to such a complex issue as abortion, which is, furthermore, prohibited in Ireland.

4. The health professionals with whom the author dealt provided her with meagre, imprecise information. When it was confirmed that the fetus had a fatal impairment, her doctor informed her that "terminations are not available in this jurisdiction. Some people in your situation may choose to travel." The midwife told the author that she could continue with the pregnancy and refused to discuss the second option("travelling").

5. It is clear to the undersigned that the Abortion Information Act places legal restrictions on

the circumstances under which public officials can provide information on legal abortion services available in Ireland or abroad and that it prohibits advocacy or promotion of the termination of pregnancy. This dissuades health-care providers from conduct which could be interpreted as being contrary to the law, or, even worse, leads them to fear that they might face criminal prosecution for "promoting" abortion.

6. In the light of the above, we believe that the existing legal framework encourages the withholding of clear and timely information that persons who might choose to undergo a legal abortion outside of Ireland could use in order to arrive at personal decisions regarding their reproductive health. This legislation and the lack of reliable, transparent information are not of a proportionate nature such as to be justified by any of the restrictions set out in article 19 (3) of the Covenant. Consequently, we believe that the communication should have also established that the State violated the author's right to seek and receive information in accordance with article 19 (2) of the Covenant.

7. *Violation of article 26 of the Covenant*. We share the Committee's conclusion as set out in paragraph 7.11 regarding the violation of article 26 based on the fact that there was discrimination vis-à-viso ther pregnant women in a better socio economic situation and in the light of the author's argument relating to gender stereotypes. However, in our view, a broader approach should have been adopted, given, among other things, the fact that there was discrimination vis-à-vis other pregnant women who, by virtue of their more favourable socioeconomic situation, are better placed to undergo an abortion abroad. We believe that there was also discrimination with regard to the author vis-à-vis men in terms of the way in which the issue of the criminalization of abortion is dealt with in law and in practice (discrimination on the basis of sex and gender). Consequently, we do not accept the reductionist argument put forward by the State to the effect that there is no discrimination because the biological difference between a man and a pregnant woman is a matter of fact.

8. The legal provision setting forth the prohibition of abortion in Irish law is, in itself, discriminatory because it places the burden of criminal liability primarily on the pregnant woman.

9. The fact that a man cannot conceive for biological reasons does not mean that a reasonable and objective differentiation can be made with regard to a pregnant woman who is left in a virtually isolated and defenceless position owing to the limited nature of the available information and services and who is forced to make a very difficult choice between committing an offence or having to travel abroad to have an abortion where it is legally permitted.

10. Furthermore, in paragraph 7.11 of its conclusions, the Committee notes the author's claim "that Ireland's criminalization of abortion subjected her to a gender-based stereotype of the reproductive role of women primarily as mothers, and that stereotyping her as a reproductive instrument subjected her to discrimination". On that basis, the Committee should also have found a clear violation of articles 2 (1) and 3, read in conjunction with articles 7, 17 and 19 of the Covenant. As pointed out by the author, these violations should be understood in the light of the structural and pervasive

discrimination that characterizes Irish abortion law and practice, in violation of the State party's obligation to respect and guarantee the rights recognized in the Covenant, without distinction of sex, and the right of women to the enjoyment of their civil and political rights on an equal basis with men.

11. In view of the above, our reasoning leads us to believe that the violation of article 26 should have been broader in scope, inasmuch as it also entailed structural discrimination against the author vis-à-vis men on the basis of sex and gender, and that there was also a violation of articles 2 (1) and 3, read in conjunction with articles 7, 17 and 19 of the Covenant.

Appendix V

Individual opinion of Committee member Anja Seibert-Fohr (partly dissenting)

1. I am writing separately because I do not agree with the finding of a violation of article 26 and the reasoning in paragraphs7.10-7.11.

2. I appreciate that the Views apply only to the particular facts of the present case in which the foetus according to the uncontested submission by the author was not viable. Accordingly the recommendation in paragraph 9 is confined to fatal foetal impairment.[a] But I fail to recognize why it was necessary and appropriate to find a violation of article 26 after the Committee concluded that articles 7 and 17 were violated.

3. The central issue in the present case resides in the prohibition on abortion in Irish lawinsituati onswhereafoetusisfatallyill.Thegroundswhichareoutlinedinparagraph 7.4 leading to the finding of an article 7 violation are substantially the same as those on which the Committee finds a violation of article 26 and which are again outlined in paragraph 7.4: the author's denial of health care and bereavement support which is available to women who carry the foetus to term and the need to travel abroad at personal expense. These claims were already absorbed by the wider issue decided under articles 7 and 17 and there was no useful legal purpose served in examining them under article26.[b]

4. Furthermore I cannot agree with the conclusion under article 26. According to the Committee's standing jurisprudence "the term 'discrimination' as used in the Covenant should be understood to imply any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition,

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[a] The reference "as indicated in these Views of the Committee" in para 9 applies to all aspects of the recommendations. See also the preceding reference to the "obligation to take steps to prevent *similar violations* occurring in the future".

[b] See mutatis mutandis ECtHR, Dudgeon v. United Kingdom (1981), paras 67-69.

enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.[c] Difference in treatment requires comparable situations in order to give rise to discrimination.[d] But the Committee has failed to explain in the present case where the difference in treatment resides and to what extent such difference was based on a ground which is impermissible under article 26.

5. With respect to the concrete medical treatment the medical needs of a woman pregnant with a foetus with a fatal impairment who undergoes abortion is substantially different in comparison to the situation of women who decide to carry a fatally-ill foetus to term. Therefore, in order to find a discrimination of a woman who undergoes abortion in comparison to those carrying the foetus to term it is insufficient to refer, as the Committee does in paragraph 7.10, to the denial of "health insurance coverage *for these purposes*". The subject of the treatment for which health insurance is sought in case of abortion is fundamentally different from obstetrics.

6. I recognize that the author also claims a difference in treatment with respect to subsequent medical care and bereavement counselling. Though such a difference constitutes a distinction which is relevant for an on-discrimination analysis, the author has neither submitted that local remedies have been exhausted in this respect nor that there is objectively no prospect of success to challenge the denial of bereavement support and needed post-abortion medical care in domestic proceedings.[e] Pursuant to article 5 2 (b) Optional Protocol the Committee is therefore prevented from finding a violation of article 26 on this ground.

7. There is another aspect in the Committee's reasoning which I cannot agree with. The Committee has failed to specify the grounds for the alleged discrimination. In order to support a finding of an article 26 violation a distinction must relate to one of the personal characteristics which are specified in article 26. That the author was adversely affected by the prohibition on abortion in Ireland by virtue of her financial situation is insufficient to ground a claim under article 26. Neither can the State party's prohibition on abortion be described as a discrimination based on gender. While it is true that it only affects women, the distinction is explained with a biological difference between women and men that objectively excludes men from the applicability of the law and does not amount to discrimination.

8. The author claims that the prohibition is based on a gender-based stereotype which considers women's "primary role … to be mothers and self-sacrificing caregivers" and stereotypes the author "as a reproductive instrument"(3.19). She also claims that the abortion regime was "reinforcing women's … inferior social status" (3.20'). But these allegations which are contested by the State

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[c] General Comment no. 18, para 7.

[d] Šmíde v. Czech Republic, Communication No. 1062/2002, para 11.5.

[e] The author only submitted that she would not have had any reasonable prospect of success had she petitioned an Irish court for a termination of her pregnancy.

party are not supported by any relevant facts. According to the State party the legal framework is the result of a balancing of the right to life of the unborn and the rights of the woman. Though the Committee disagrees in its findings under article 17 with the outcome of the balancing in the case of a fatally-ill foetus, this finding does not warrant the conclusion that the prohibition on abortion is based on gender stereotypes. It is rather grounded on moral views on the nature of life which are held by the Irish population.

9. I appreciate that the Committee does not rely on the allegation of gender stereotypes in its finding under article 26. Instead it refers only to "differential treatment to which the author was subjected *in relation to other similarly situated women*". Nevertheless, the Committee has failed to specify on which other status the distinction is grounded.

10. Unless the Committee wants to find a violation of article 26 every time it finds a violation of one of the rights and freedoms protected under the Covenant and deprive this provision of any autonomous meaning and value, the Committee would be well advised to engage with such claims in a more meaningful way giving due account to the notion of discrimination and the prohibited grounds in the future.

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International Covenant on Civil and Political Rights

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Human Rights Committee

Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication No.

2425/2014*, **, ***, ****

Communication submitted by:	Siobhán Whelan (represented by the Center for Reproductive Rights)
Alleged victim:	The author
State party:	Ireland
Date of communication:	9 April 2014 (initial submission)

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*Adopted by the Committee at its 119th session (6-29 March 2017).

** The following members of the Committee participated in the examination of the communication: Tania María Abdo Rocholl, Yadh Ben Achour, Ilze Brands Kehris, Sarah Cleveland, Ahmed Amin Fathalla, Olivier de Frouville, Christof Heyns, Yuji Iwasawa, Bamarian Koita, Marcia V.J. Kran, Duncan Laki Muhumuza, Photini Pazartzis, Mauro Politi, José Manuel Santos Pais, Anja Seibert-Fohr, Yuval Shany, and MargoWaterval.

***Individual opinions by Committee members Yadh Ben Achour, Sarah Cleveland (concurring), Olivier de Frouville (concurring) and Anja Seibert-Fohr (partly dissenting) are annexed to the present Views.

**** The footnotes are reproduced in the language of submission only.

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Document references:	**Decision taken pursuant to rule 97 of the Committee's rules of procedure, transmitted to the State party on 16 June 2014 (not issued in document form)**
Date of adoption of Views:	17 March 2017
Subject matter:	Access to termination of pregnancy
Procedural issue:	None
Substantive issues:	Denial of information; cruel, inhuman and degrading treatment; rights to equality and non- discrimination on the ground of sex; arbitrary interference in the right to privacy
Articles of the Covenant:	2 (1), 3, 7, 17, 19 and26
Article of the Optional Protocol:	None

1.1 The author of the communication is Siobhán Whelan, a national of Ireland born in 1970. She asserts that the State party violated her rights under articles 2 (1), 3, 7, 17, 19 and 26 of the Covenant. She is represented by counsel. The Optional Protocol entered into force for Ireland on 8 March1990.

Facts as presented by the author

2.1 On 4 January 2010, while in the twentieth week of her second pregnancy, the author underwent an ultrasound scan at Wexford General Hospital in Ireland. The obstetrician believed that the fetus was affected by holoprosencephaly, a congenital brain malformation occurring in approximately 1 in 250 pregnancies. Only 3 per cent of holoprosencephalic fetuses survive to delivery. The obstetrician informed the author and her husband that the baby would likely die in utero, and that if it were carried to term, it would probably die during labour or very soon after birth. Concerns were also raised about the formation of the heart, kidneys and other fetal organs. The obstetrician mentioned that "in another jurisdiction [they] would be offered a termination but obviously not in this country due to Irish law".[1] The author was not given further information and was not referred to anyone to discuss the diagnosis, the care she would be offered in Ireland or the possibility of travelling abroad to terminate the pregnancy. Instead, the obstetrician stated that the author "would continue with the pregnancy, attend ante-natal appointments 'as normal' and wait for nature to take its course".

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[1] In an affidavit dated 4 March 2014, the author stated: "Upon hearing that we would be offered a termination in another country we knew our baby's problem was very severe. On reflection this was probably the consultant's way of informally telling us that we could travel to terminate the pregnancy and that there was nothing they could do for us."

2.2 On 7 January 2010, the author underwent an additional scan and an amniocentesis in the National Maternity Hospital in Dublin. The diagnosis of fatal holoprosencephaly was confirmed by the hospital's doctors, who did not offer the author any information on counselling services, options available to her, or the risk that the condition would recur in a later pregnancy. The doctor gave her a report of the scan "in case [they] wanted to travel". When she asked where she could go if she wanted "to travel", she was simply told that there were good reports about Liverpool Women's Hospital. The author did not discuss with the doctor the possibility of terminating the pregnancy abroad, since the obstetrician in Wexford had told her that the procedure was illegal in Ireland. She indicates that she "felt it was illegal to even discuss this or ask too many questions for fear of having the door slammed in our faces or of not receiving any help whatsoever". On 12 January 2010, the author received the results of the amniocentesis over the phone, and was told that the baby also suffered from trisomy 13 (Patau's syndrome), a chromosomal condition associated with severe intellectual disability and physical abnormalities in many parts of the body. The author was told that this condition was "incompatible with life".

2.3 The author felt she could not continue with the pregnancy only to see her baby suffer and die, and that the continuation of the pregnancy would bring her terrible mental suffering. Thus, she and her husband decided to terminate the pregnancy. They contacted several crisis pregnancy agencies, including Cura and Positive Options, to seek information on traveling to the United Kingdom of Great Britain and Northern Ireland.[2] However, because most agencies were only able to assist women whose pregnancies were no further along than 13 weeks, the author did not receive any information on traveling to the United Kingdom, and "felt lost and totally on [her] own". Through a friend, the author obtained contact information for the Liverpool Women's Hospital and fixed an appointment there. The Hospital asked her to send relevant medical records by fax, and this was an additional hurdle for the author to overcome, as she did not have a fax machine. When the author returned to the hospital in Wexford in order to obtain the requested records, several staff members were insensitive towards her, with no regard for the devastating news she had received only a few days earlier. She finally managed to consult a locum doctor, who was very understanding. The author had to share the medical records with an acquaintance, who helped her to send them by fax. She feared the acquaintance would judge her for deciding to terminate the pregnancy.

2.4 The author was so consumed with arranging for the journey to England that she did not have time to process her grief. She and her husband had to leave their 20-month-old son with relatives for several days; this was the first time they had left him overnight. They also had to arrange for

[2] In her affidavit, the author states that she "began to ring around to some 'crisis' pregnancy agencies, including Cura and Positive Options …. None of them were able to help or provide the information we needed as most can only help if your pregnancy is 13 weeks or less. We did get the name of a private clinic in London whom we rang but it did not feel right to us to be going to one of these clinics at such a late stage in pregnancy."

leave from work and farm relief, as the author's husband is a farmer. The author's manager, whom she trusted, approved a sick note stating that the author had had a miscarriage. On 17 January 2010, feeling like "a criminal leaving [her] country", the author travelled to Liverpool and was joined shortly thereafter by her husband. On 18 January, she underwent scans and tests at Liverpool Women's Hospital, which reiterated the fatal diagnosis for the baby. The author was informed about the procedure for terminating a pregnancy and received an injection of intracardiac potassium chloride to stop the fetal heartbeat. On 20 January, she gave birth to her stillborn son at 21 weeks and 5 days. She and her husband spent the night in the hospital and were able to hold their son and say their goodbyes. On 21 January, a bereavement counsellor gave the author and her husband information about bereavement services in the United Kingdom, but did not have any information on similar services in Ireland.

2.5 The author had to leave the baby's remains at the Liverpool hospital, and was heartbroken to have to part with him in a foreign country. The baby was cremated in Liverpool three weeks later, and the author and her husband received the ashes by courier a few days later. The termination, cremation, travel and stay in Liverpool cost the author and her husband approximately 2,900euros.

2.6 It was only after returning home that the author had time to grieve. Her grief was mixed with feelings of anger, as the experience of being forced to leave her country in her situation had been truly demeaning. She returned to work one week after returning to Ireland, as she feared facing questions from colleagues and losing her job. She was not legally entitled to any paid maternity leave. The author attended a check-up with her general practitioner six weeks after the termination procedure, as suggested by the Liverpool hospital. Although the doctor was sympathetic and non-judgmental, and discussed the possibility of future pregnancies, the author was never offered any grief counselling. She felt very isolated during the subsequent months, and suffers from complicated grief due to the traumatic experience she endured and the forced delays in the grieving process.[3]

2.7 The author asserts that domestic remedies were neither effective nor adequate in her case. Under article 40.3.3 of the Constitution, as interpreted by the Supreme Court of Ireland in *Attorney General v. X and Others*,[4] abortion is a crime and is only permitted when it is established as a matter of probability that there is a real and substantial risk to the life, as distinct from the health, of the pregnant woman. At the time of the events in question, the Offences against the Person Act 1861

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[3] The author provides an undated affidavit from an associate professor of midwifery who interviewed the author on 12 December 2013. According to the affiant, the author suffers from complicated grief, "which has been compounded by a lack of supportive care around the diagnosis, ongoing frustration at being abandoned by the maternity services when she expressed a wish to terminate the pregnancy, and a sense of shame and feeling judged by society and her community for the decision she made, failure to follow up by maternity services and offer post termination care and a failure to offer appropriate grief counselling."

[4] [1992] 1 IR 1.

was the basis for criminal regulation of abortion in Ireland and defined any attempt to procure or perform an abortion as a felony punishable by life imprisonment.[5] The author states that the issues in the complaint are not being examined and have not been examined by any other international body.

The complaint Claims under article 7

3.1 The application of the State party's abortion law subjected the author to cruel, inhuman and degrading treatment and encroached on her dignity and physical and mental integrity by: (a) denying her there productive health care and information she needed and forcing her to continue carrying a dying fetus; (b) compelling her to terminate her pregnancy abroad; and (c) subjecting her to intense stigmatization for terminating her pregnancy.

3.2 The expectation of care that the author had formed as a patient, her extreme vulnerability upon learning that her baby would die, the complete denial of information from her health-care providers and the prospect of having to terminate a much-wanted pregnancy abroad with no support from the Irish health-care system illustrate the intense mental anguish suffered by the author. The health-care system's abandonment of its care for her, including through its failure to provide her with any counselling services or information about her options, made her feel as if she were entirely undeserving of care, and was not treated with respect for the dignity inherent in her person. Furthermore, no special arrangements were made to offer sensitive, supportive care to her should she have chosen to continue her pregnancy in Wexford, and she would have had to continue attending her medical appointments as if hers was a normal pregnancy.

3.3 Having to travel abroad and be forcibly separated from her family and far from home also exposed the author to certain obstacles to her recovery, which impinged on her physical and mental integrity and dignity. It also interfered with her ability to mourn the loss of her pregnancy. Her emotional distress was prolonged because she had to leave the baby's remains abroad and therefore was denied the rituals that normally accompany loss and grief.[6]

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[5] The Protection of Life During Pregnancy Act 2013 criminalized abortion, punishable with a prison

[6] The author provides an affidavit dated 4 November 2013 from a consultant psychiatrist who interviewed the author on 29 January 2014. The psychiatrist stated, inter alia, that the author "appears to have trusted the state, and that the betrayal of this trust was in itself a shock to her. She suffered unnecessary distress in relation to the absence of any response from the state services; the trauma of separating her son from his parents for the first time; being forced to travel abroad for the sole purpose of having a physically and psychologically difficult procedure; having to leave her baby's remains in a foreign country and finding the financial resources to fund the travel and the procedure." The psychiatrist was "of the opinion that through the process of deliberate neglect of her care in the Irish health service that she has suffered cruel and inhuman treatment and that this has had a permanent effect on her personality".

Claims under article 17

3.4 The prohibition on pregnancy termination constituted a breach of the author's right to privacy, as it compromised her reproductive autonomy and her right to integrity and mental well-being by denying her the support of her family during a moment of trauma and crisis. The Committee's Views in K.N.L.H. v. Peru indicate that women's reproductive autonomy is included in the right to privacy and may be at stake when the State interferes with a woman's reproductive decision-making.[7] By banning abortion and preventing the author from exercising the only option that would have respected her physical and psychological integrity (allowing her to terminate her pregnancy in Ireland), the State arbitrarily interfered in her decision-making. The ban on abortion, which prioritized fetal life over the author's right to mental well-being, psychological integrity and reproductive autonomy, constituted a clearly disproportionate interference with the author's right to privacy.

3.5 Furthermore, the physical distance from her well-known surroundings and family, as well as the emotional trauma of feeling abandoned by her own country, interfered with her private life, understood as the relationships and support framework she enjoyed in Ireland. By defining the moral interest in protecting fetal life as superior to the author's right to mental stability, psychological integrity and reproductive autonomy, Ireland breached the principle of proportionality and violated her right to privacy. Even if the Committee accepts that the protection of the life of the "unborn" can serve as a justification for interfering with a woman's right to privacy in certain situations, this cannot apply in the present case. Limiting her right to privacy by denying her the right to terminate a pregnancy that would never result in a viable child cannot be considered a reasonable measure to protect the life of the unborn. Thus the interference with her right to privacy was arbitrary.

Claims under article 19

3.6 The Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995 ("abortion information act") sets forth the circumstances in which information, advice and counselling about abortion services that are legal in another State can be made available in Ireland. It pertains in particular to information that is likely to be required by women who consider travelling abroad for an abortion and regulates the conduct of providers of such information, such as counsellors and health providers. The Act indicates that the provision of information, advice or counselling about abortion services overseas is unlawful if, inter alia, it advocates or promotes the termination of pregnancy. The Act also prohibits the distribution of written information to the public without solicitation by the recipient, and has been interpreted to require that information,

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[7] Communication No. 1153/2003, Views adopted on 24 October 2005.

advice or counselling about termination of pregnancy can only be provided in a face-to-face counselling session, and not over the phone.

3.7 While the Act prohibits health-care providers from advocating or promoting the termination of pregnancy, it lacks any definition of the types of speech that would constitute "advocacy" or "promotion." This deficiency has a chilling effect on health-care providers' speech. The author's treating physicians in Ireland denied her the information she needed. They did not offer her any leaflets or phone numbers that could have allowed her to obtain further information about the fetal diagnosis. Nor was she offered any information about termination or travel options. The doctor who treated her in Dublin handed her a report with the words, "in case [you] want to travel", but did not elaborate on what travelling for a pregnancy termination would entail. Believing that health-care providers were legally precluded from providing her with further information, the author felt abandoned and feared she would face judgment or legal repercussions if she requested relevant information.

3.8 The restrictions on sexual and reproductive health information that the author experienced cannot be characterized as being provided for by law for the purpose of the test under article 19 (3). The State's interference with her access to sexual and reproductive health information was also not a permissible limitation on her right to information under article 19 on the ground of protection of morals and was discriminatory. The restrictions were directly related to the perceived need to protect the right to life of the "unborn" in the Constitution. However, in the author's situation, the "unborn" had no prospect of life. The denial of information was therefore irrelevant to the aim of protecting the "unborn".[8]

[8] The author provides a report issued by the Irish Family Planning Association, a non-governmental organization that provides sexual and reproductive health consultations nationwide. The report addresses the experiences of Irish women who have received a diagnosis of fatal fetal anomaly and seek to terminate the pregnancy. The report states that the abortion information act, which is interpreted conservatively, has a chilling effect on information provision by health-care professionals, who assume or fear that they are precluded from discussing abortion with patients. While doctors are free to engage in the normal communication of information and advice with patients and other professionals, in reality most doctors do not discuss abortion with their patients, perhaps out of fear of possible repercussions, including damage to their reputation and career prospects, malpractice complaints or allegations of a breach of the law or of professional ethics guidelines. Women who receive diagnoses of fatal fetal anomaly need information on the process and the appropriate aftercare and associated procedural risks; on the post-abortion treatment of fetal remains; on issues such as post-mortem examination, chaplaincy services, cremation and funeral arrangements; and on costs and visa requirements, if applicable. Many women seeking to terminate pregnancy feel anger at the experience of being expelled and exiled from a health service they trust — and pay for through taxes. The author also provides a statement from a general practitioner physician and spokesperson for Doctors for Choice Ireland, an alliance of medical professionals advocating for comprehensive reproductive health services in Ireland. According to the statement, a scientific paper published in September 2012 noted that 87 per cent of the 500 physicians surveyed in Ireland are in favour of providing abortion services in cases of fatal fetal abnormalities. The study also indicated that the requirement to travel overseas for an abortion causes the patient physical, psychological and social ill- health, an impaired doctor-patient relationship and an impaired doctor-doctor relationship.

Claims under articles 2 (1), 3 and 26

3.9 The author suffered several violations of her rights to equality and non- discrimination. Under the country's highly restrictive abortion law, she was denied on the basis of her sex access to medical services that she needed in order to preserve her autonomy, dignity and physical and psychological integrity. In contrast, male patients and patients in other situations in Ireland are never expected to disregard their health needs and moral agency in relation to their reproductive functions, or to leave their family and country in order to receive health care. The rights to equality and non-discrimination require States to ensure that health services accommodate the fundamental biological differences between men and women in reproduction.

3.10 In addition, the author's rights to equality and non-discrimination under articles 2 (1) and 3 read in conjunction with articles 7, 17 and 19 of the Covenant were violated because, due to her sex, she was not fully informed by Irish health providers of the options available to her, including the use of legal abortion services abroad. In contrast, male patients and patients in other situations are not denied critical health information and are not abandoned by the health care system in this regard. The author received discriminatory treatment from the Irish health-care providers, who treated her as if her pregnancy were progressing normally, without offering the support and care that her particular circumstances required. This treatment was not based on objective or reasonable grounds.

3.11 The author was also subjected to gender-based discrimination insofar as she was stereotyped as a reproductive instrument whose needs were subordinate to those of her unborn, non-viable fetus. Restrictive abortion laws constitute a form of discrimination against women. Because the author's health was not endangered by the pregnancy, she was expected to sacrifice her own mental health and well-being for her dying fetus, and was not treated according to her particular medical needs. The rights to equality and non- discrimination require States parties to take affirmative measures to eliminate gender stereotypes in reproductive healthcare.

Remedies requested

3.12 The author requests that the State party: (a) provide her with appropriate compensation; (b) review relevant provisions of the Constitution, as necessary, to conform with articles 2, 3, 7, 17, 19 and 26 of the Covenant; (c) amend the Protection of Life During Pregnancy Act 2013 to conform with articles 2, 3, 7, 19 and 26 of the Covenant; (d) take measures necessary to ensure effective, timely and accessible procedures for legal pregnancy termination in Ireland; and (e) amend the abortion information act to bring it into line with article 19 of the Covenant, and ensure its proper implementation.

State party's observations on the admissibility and merits

4.1 In its observations dated 19 January 2015 and 14 October 2015, the State party does not contest

the admissibility of the communication. It explains in detail the country's laws and regulations concerning termination of pregnancy. The Supreme Court has interpreted article 40.3.3 of the Constitution as permitting termination of the life of the unborn where there is a real and substantial risk to the life, as distinct from the health, of the mother.[9] The article reflects the profound moral choices of the people, as expressed through several popular referenda. Yet the Irish people have acknowledged that citizens are entitled to travel to other jurisdictions in order to terminate pregnancies, and Irish law guarantees the right to information on abortion services provided abroad. Thus, the constitutional and legislative framework reflects a nuanced and proportionate approach to the views of the Irish electorate on the highly politicized and divisive question of the extent to which the right to life of the fetus should be protected and balanced against the rights of the woman. The people's choices, which are based on deeply held and considered views, should be respected.

4.2 The Committee's jurisprudence permits limitations and allowances with respect to the right to privacy (where limitations are proportional) and the right to non-discrimination (where limitations are based on reasonable and objective grounds.) The State party urges the Committee to follow the approach of the European Court of Human Rights, as set forth in *A, B and C v. Ireland*.[10] Noting that Irish law permits travel abroad for the purposes of abortion, and provides for appropriate access to information and health care, the Court considered that the prohibition on abortion for reasons of health and/or well-being did not exceed the margin of appreciation accorded to member States. The Court struck a fair balance between the applicants' privacy rights and the rights invoked on behalf of the fetus, which were based upon the profound moral views of the Irish people about the nature of life. The Court found a violation of applicant C's right to private and family life under article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights), in that no accessible and effective procedure enabled her to establish whether she qualified for lawful termination of pregnancy. Academic analyses and discussions indicate that many of the Committee's decisions reveal choices that are consistent with the doctrine of margin of appreciation.[11]

4.3 Following the above-mentioned judgment, the Protection of Life During Pregnancy Act 2013 was adopted in Ireland. Under the Act, abortion is permitted where there is a threat to the life of the woman due to physical illness and in emergencies. The Act also addresses situations where there is a real and substantial risk of loss of the woman's life by way of suicide. The Act reaffirms an individual's right to travel to another State and the right to obtain and make available information

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[9] The State party cites *Attorney General v. X and Others*.

[10] Application No. 25579/05, judgment of 16 December 2010.

[11] The State party cites, inter alia, Yuval Shany, "Toward a general margin of appreciation doctrine in international law?", *The European Journal of International Law*, vol. 16, No. 5 (2005), p. 929.

relating to services lawfully available in another country. Under the Act, intentional destruction of unborn human life is an offence punishable by a fine or imprisonment for a term not exceeding 14 years.

4.4 The gradual evolution of Irish law on abortion, produced by the democratic process of consultation, debate and direct action of inclusion, has at all times attempted to seek a careful balance between the constitutional right to life of the unborn with equal regard to that of the mother. Moreover, any measures the State party has taken have not been disproportionate to the legitimate aim pursued of protecting life. While the author argues that prenatal rights and life are excluded from protection under the Covenant, article 6 (5) prohibits imposition of the death penalty for pregnant women. Thus, it cannot be concluded that the Covenant does not afford any protection to the right to life of the unborn child.

Claims under article 7

4.5 In *K.N.L.H. v. Peru*, the State party had allegedly denied the author access to a lawfully available therapeutic abortion when she was pregnant with an anencephalic fetus. In the absence of observations from the State party, the Committee deemed that this constituted arbitrary interference with the author's right to privacy. However, in the present case, the State party did not deny the author access to lawful abortion procedures. Such a procedure was not available to the author, and she was clearly and properly informed of this by the relevant State agents. Accordingly, and contrary to what occurred in *K.N.L.H. v. Peru*, there were no actions on the part of State agents that were or could be described as having been based on the personal prejudices of officials in the health system.[12] Thus, in the present case, none of the author's rights was arbitrarily interfered with so as to result in cruel, inhuman and degrading treatment.

4.6 According to the State party: "If any findings were made in this case, in the absence of arbitrary actions of agents of the State, but on the basis of evolved constitutional and legal principles, this would represent a significant difference in kind (as opposed to a difference in degree) in the jurisprudence of the Committee." Such a finding would be contrary to paragraph 2 of general comment No. 20 (1992) on the prohibition of torture or other cruel, inhuman or degrading treatment or punishment, according to which it is the duty of the State party to afford everyone protection through legislative and other measures as may be necessary against the acts prohibited by article 7, whether inflicted by people acting in their official capacity, outside their official capacity or in a private capacity. In the present case, there was no act of

[12]According to the State party, the same argument applies with respect to the Views of the Committee on the Elimination of Discrimination against Women on communication No. 22/2009, L.C. v. Peru, adopted on 17 October 2011, and those of the Human Rights Committee on communication No. 1608/2007, L.M.R. v. Argentina, adopted on 29 March 2011.

“infliction” by any person or State agent; therefore, there was no cruel, inhuman or degrading treatment.

4.7 The State party has not engaged in cruel, inhuman or degrading treatment, given that:

(a) There are significant and material factual differences between the cases the author relies upon and her own situation;

(b) In circumstances where the author’s life was not in danger, the procedure for obtaining a lawful abortion in Ireland was clear. The decision was made by a patient in consultation with her doctor. If the patient did not agree, she was free to seek another medical opinion and, in the last resort, she could make an emergency application to the High Court. There is no factual evidence that State agents were responsible for any arbitrary interference with this decision-making process, or that they were responsible for any act of “infliction”;

(c) The grounds for lawful abortion were well-known in Ireland and were applied in accordance with 40.3.3 of the Constitution, the grounds as elucidated by the Supreme Court in the X case, the Medical Council guidelines and the Crisis Pregnancy Agency guidelines;

(d) While the author states that she was aware that abortion was not allowed but had no idea that a termination on medical grounds would fall into the same category, this was her subjective understanding of the law;

(e) The hospital staff were clear that a termination was not possible in Ireland, and therefore, no arbitrary decision-making processes or acts of infliction that caused or contributed to cruel, inhuman or degrading treatment can be suggested;

(f) The State party’s position and stance in relation to its law sought to achieve a reasonable, careful and difficult balance of competing rights as between the fetus and the woman;

(g) The State party sought that balance in accordance with article 25 of the Covenant.

Claims under article 17

4.8 The State party did not violate the author’s rights to privacy or integrity under article 17 of the Covenant. If there were any interference with her privacy, this was neither arbitrary nor unlawful. Rather, it was proportionate to the legitimate aims of the Covenant, taking into account a careful balance between the right to life of the fetus with due regard to that of the woman. The advice given to the author by the hospital was properly and lawfully given. The State party is permitted to create laws, in accordance with and in the spirit of article 25 of the Covenant, which allow for a balancing of competing rights.

4.9 In the aforementioned *A, B and C* case, the European Court of Human Rights considered that "the impugned prohibition in Ireland struck a fair balance between the right of the first and second applicants to respect for their private lives and the rights invoked on behalf of the unborn". The balance to be achieved has been considered by the Irish electorate on numerous occasions.

4.10 In *K.N.L.H. v. Peru and L.M.R. v. Argentina*, in which the Committee found violations of article 17, existing legislation allowed for therapeutic terminations of pregnancy. The authors in those cases were initially told that they qualified for lawful terminations, but these rights were then not protected by the States in question. In the instant case, no such conflict arose, as the hospital gave its clear opinion that a termination of pregnancy would not be available in Ireland. Therefore, the arbitrary interference that occurred in those cases did not occur in the present case.

Claims under article 19

4.11 The author has not substantiated her claim that her right to receive information under article 19 was violated. Non-directive information on termination services in other countries is available under Irish law, in accordance with the abortion information act. The author states that the consultant's remark at the hospital in Wexford (mentioning that in another country, she would be offered a termination of pregnancy, whereas this was not possible in Ireland) was an informal way of telling her and her husband that they could travel to terminate the pregnancy. Further, at the hospital in Dublin, the author was given the name of a hospital in the United Kingdom. The author also states that she felt she could not even raise the issue of terminating the pregnancy because it was illegal. She further states that she called several crisis pregnancy agencies, and that none was able to assist because her pregnancy was over 13 weeks along. She also states that she obtained the name of a private clinic in London, though she did not feel comfortable calling the clinic. The full nature and context of the discussions between the author and these services is not at all clear, and the Committee is not in a position to evaluate factual issues. The legislative framework in place entitled the author to certain information. The author does not specify how exactly this framework was not respected. Any failure to ascertain information she was clearly legally entitled to seems to have been based on misapprehensions on the author's part as to the effect of Irish law. In making available to the author, on a public basis, appropriate organizational information from where the author could ascertain all of the relevant information she required, no censorship can be said to exist. Further, the crisis pregnancy programme of the Health Service Executive provides to the public a rich resource of free online information concerning crisis pregnancies and abortion. At the website of Positive Options, for example, it is explained that it is legal under certain specified conditions for a woman to be given contact information on abortion services outside Ireland.[13] This information was available to the author at the relevant time.

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4.12 The affidavit provided by the representative of the Irish Family Planning Association refers to certain opinions that are not supported by empirical evidence. These include the statements that many health-care professionals assume or fear that they are precluded from discussing abortion; and that they avoid using the word "abortion" in favour of euphemisms that are entirely inappropriate and insensitive in doctor-patient communication concerning crisis pregnancies. Similarly, in the affidavit of the general practitioner, additional statements of personal opinion are made without reference to empirical evidence (concerning the alleged uncertainty of Irish doctors about how much information and support they can give to a patient who wants an abortion).

Claims under articles 2 (1), 3 and 26

4.13 The State party did not subject the author to discrimination. If there were any discrimination, it should be considered a reasonable and objective differentiation to achieve a purpose that is legitimate under the Covenant. There can be no "invidious discrimination" in relation to a pregnant woman, as her physical circumstances are inherently different from those of a man. This differentiation is a matter of fact and can only be accepted as axiomatic.

4.14 The challenged legal framework, namely article 40.3.3 of the Constitution and the relevant provisions of the Offences against the Person Act does not discriminate against women on the ground of sex. This framework is gender neutral. If a man procured or carried out an abortion in circumstances not contemplated by the Constitution, he may be guilty of an offence. Even if the legal framework did discriminate on the ground of gender, any such discrimination would be in pursuit of the legitimate aim of protecting the fetus and would be proportionate to that aim. The measures at issue are not disproportionate, as they strike a fair balance between the rights and freedoms of the individual and the general interest. Again in this area, in accordance with the European Court of Human Rights, the State party enjoys a margin of appreciation. Therefore, the differentiation is reasonable and objective and achieves a legitimate end.

4.15 The State party disputes that its laws stereotyped the author as a reproductive instrument subjecting her to gender discrimination. Rather, the inherent differentiation between a man and a pregnant woman requires the careful balancing of rights of the fetus, which is capable of being born alive, and the rights of the woman.

Author's comments on the State party's observations

5.1 In her comments dated 22 May 2015, the author contests the State party's portrayal of the Irish people's views on abortion. For many years, opinion polls have indicated that a significant majority of the Irish people support legalizing access to abortion in cases of non- viable pregnancies and fatal fetal impairments. A similarly high majority support legalizing abortion where the pregnancy results from sexual assault, or where a woman's health is at risk. The results of the country's constitutional

referenda do not confirm the State party's description of the Irish people's profound "moral choice", because the Irish electorate has never voted on a proposal to increase the number of situations in which access to abortion is legal. Indeed, the Irish people have never had the opportunity to express the view that abortion should be made available to women in circumstances other than where there is a risk to a woman's life. In fact, voters rejected two proposals that would have made abortion illegal where a woman is at risk of suicide. Furthermore, in the three constitutional referenda on abortion, the percentage of the eligible electorate voting in favour of restrictions was less than 35 per cent.

5.2 The Protection of Life During Pregnancy Act 2013 is irrelevant to the author's complaint, since it merely regulates procedures to be followed when a woman who faces a real and substantial risk to her life seeks an abortion.

Claims under article 7

5.3 Because the prohibition of cruel, inhuman or degrading treatment or punishment is absolute, no derogations are permitted, and a State party may not seek to justify its conduct by balancing an individual's rights under article 7 with the "rights of others". The notion of a margin of appreciation, which the Committee has explicitly rejected, is irrelevant in an appraisal of article 7 protections.[14] Also irrelevant is whether the State party's conduct caused ill-treatment through arbitrary action. Rather, the determinative issue under article 7 is whether harm suffered amounted to ill-treatment and whether the conduct from which the harm resulted was attributable to the state.

5.4 The State party suggests that because the abortion the author sought was illegal under domestic law, the State party's denial of this procedure cannot be considered to amount to ill-treatment. However, because the protections under article 7 are absolute, domestic law may never be invoked to justify a failure to discharge obligations under the Covenant. When the author was denied an abortion, her suffering was aggravated, not alleviated, by the knowledge that abortion is a crime in Ireland.

5.5 Omissions may constitute ill-treatment, and the public employees who provided the author's medical care omitted to administer the abortion she sought. Because she was denied an abortion by State agents acting in accordance with State laws and policies, the author endured severe pain and suffering reaching the threshold required by article 7. Although some health-care professionals were kind to her, on the whole she felt abandoned and ostracized by the Irish health-care system.

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Claims under article 17

5.6 By denying the author access to an abortion procedure, the State party arbitrarily interfered with her right to privacy in a manner that is not permissible under the Covenant for the following reasons:

(a) By criminalizing and prohibiting abortion, the State party discriminated against the author because she is a woman, thereby contravening the prohibition of discrimination on the basis of sex enshrined in articles 2 and 3 of the Covenant;

(b) The interference with the author's right to privacy was not necessary or proportionate to a legitimate aim. The State party has not presented arguments specific to the author's circumstances that would demonstrate the necessity and proportionality of its conduct towards her;

(c) The State party failed to demonstrate that its interference with the author's right to privacy was necessary towards achieving the legitimate aim invoked. As indicated above, the State party's characterization of the Irish people's "profound moral choices" is misrepresentative of the views of a majority of Irish people;

(d) The State party has failed to demonstrate that its interference in the author's right to privacy was appropriate or effective in achieving its aim. A criminal legal regime that prohibits women in all circumstances from obtaining an abortion in the jurisdiction, except where there is a real and substantial risk to their lives, and threatens them with significant prison terms in the name of protecting alleged moral choices concerning "the right to life of the unborn", yet simultaneously includes an explicit provision providing for a right to travel out of the state to obtain an abortion is not a means to its end. Rather, it is a contradiction in terms and calls into question the genuine nature of the State party's claims;

(e) The State party has failed to demonstrate that the interference was proportionate. The trauma and stigma the author endured as a result of the attack on her physical and psychological integrity, dignity and autonomy gave rise to serious mental pain and suffering. In this context, the State party's laws cannot be described as proportionate or as achieving a careful "balance of competing rights as between the unborn child and its mother". Instead, the State party prioritized its interest in protecting "the unborn" and offered no protection to the author's right to privacy. Rather, the author could have faced a severe criminal sentence had she obtained an abortion in Ireland.

5.7 The margin of appreciation doctrine invoked by the State party applies exclusively to the jurisprudence of the European Court of Human Rights and has not been accepted by any other international or regional human rights mechanisms. Furthermore, the Court has never considered

the application of the margin of appreciation doctrine to a set of facts similar to those encountered by the author.

Claims under article 19

5.8 The author rejects the State party's claim that it respected her right to information under article 19 by promulgating laws on abortion and establishing crisis pregnancy websites and agencies, and by making indirect and vague allusions to abortion services abroad during her medical consultations. The publicly employed medical professionals treating the author failed to provide her with clear evidence-based medical information on how to obtain a legal abortion in another jurisdiction. The State party is responsible for providing this information and may not shift this burden onto the author or fulfil its obligations in this regard by merely establishing websites with publicly available information.

5.9 The abortion information act represents a system of strict State control governing the manner in which information must be given. Under the Act, doctors may not refer patients to abortion providers abroad. Failure to comply with the Act is an offence subject to a fine. This punitive legal framework deterred the author's doctors from providing the information she sought, and made her feel like a criminal.

5.10 The author rejects the State party's claim that her allegations concerning the right to information are unsubstantiated. The author stated in a sworn affidavit that the medical staff at the hospitals in Ireland failed to provide her with the medical information she needed. Her testimony was corroborated by that of several other medical professionals, who noted the serious chilling effect of the abortion information act on health-care professionals in Ireland.

5.11 The State party has not justified its restrictions on the author's right to information. These restrictions were not prescribed by law and did not comply with article 19 (3) of the Covenant, since they were not formulated with sufficient precision to enable an individual to regulate his or her conduct accordingly.[15] The restrictions had no purpose other than to impair the author's enjoyment of her right to information on abortion services abroad. The restrictions were also disproportionate in the light of their detrimental impact on the author's dignity and well-being.

Claims under articles 2, 3 and 26

5.12 The State party incorrectly asserts that article 40.3.3 of the Constitution is gender neutral. However, this provision does not "balance" the right to life of men, or their enjoyment of other rights. Furthermore, the first part of article 58 of the Offences against the Person Act applies only

[15] Ibid., para. 25.

to women. The legal framework has a distinct and wholly disproportionate impact on women such as the author.

5.13 States parties may not invoke women's biological differences from men and their reproductive capacity as a basis for restricting their rights. The prohibition of abortion in cases of fatal fetal impairments and non-viable pregnancies is not proportionate to the aim of protecting the fetus. The author, who found herself in these circumstances, was treated as inferior to the fetus and was subjected to wrongful gender stereotyping.

Issues and proceedings before the Committee

Consideration of admissibility

6.1 Before considering any claims contained in a communication, the Human Rights Committee must decide, in accordance with rule 93 of its rules of procedure, whether the claim is admissible under the Optional Protocol.

6.2 Recalling article 5 (2) (a) of the Optional Protocol, the Committee notes that the same matter is not being examined and has not been examined under another procedure of international investigation or settlement.

6.3 The Committee takes note of the author's claim that she has exhausted all effective domestic remedies available to her. In the absence of any objection by the State party in this connection, the Committee considers that the requirements of article 5 (2) (b) of the Optional Protocol have been met. The Committee further notes that the State party does not dispute on any other grounds the admissibility of the communication. Because all admissibility criteria have been met, the Committee considers the communication admissible and proceeds to examine it on the merits.

Consideration of the merits

7.1 The Committee has considered the communication in the light of all the information made available to it by the parties, as provided for under article 5 (1) of the Optional Protocol.

7.2 The author of the present communication was informed by public medical professionals during the twentieth week of her pregnancy that her fetus had a fatal condition and would in all likelihood die in utero or shortly after birth. Because of the legal prohibition of abortion in Ireland, the author had to either carry the pregnancy to term, knowing that the fetus would most probably die inside of her, or voluntarily terminate the pregnancy abroad. Article 40.3.3 of the Constitution provides in this respect that "the State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right". The State party indicates that under article 40.3.3,

as interpreted by the Irish Supreme Court, it is lawful to terminate a pregnancy in Ireland if it is established as a matter of probability that there is a real and substantial risk to the life of the woman (as distinct from her health). The State party argues that its constitutional and legislative framework,[16] which contains a single exception to the legal prohibition against abortion (risk to life) and arrangements for provision of information about obtaining abortion outside the country in other circumstances, reflects the nuanced and proportionate approach to the deeply held views of the Irish electorate on the profound moral question of the extent to which the interests of a fetus should be protected and balanced against the rights of women.

7.3 The author claims that the legal prohibition of abortion caused her to suffer cruel, inhuman and degrading treatment, in that she was denied the health care and bereavement support she needed in Ireland; felt pressurized to carry to term a dying fetus; had to terminate her pregnancy abroad without emotional support from her family; and was subjected to intense stigmatization and loss of dignity. The State party contests the author's claims by arguing, inter alia, that the prohibition on abortion seeks to balance the competing rights between the fetus and the woman; and that there were no arbitrary decision-making processes or acts of "infliction" by any person or State agent that caused or contributed to cruel, inhuman or degrading treatment. The State party also maintains that its laws guarantee access to information about abortion services provided abroad and constitute part of the balance it struck between the competing rights.

7.4 The Committee recalls that the legality of a particular conduct or action under domestic law does not mean that it cannot infringe article 7 of the Covenant.[17] The Committee notes that in the present case, the author's claims appertain to her treatment in State health facilities, which was the direct result of the legislation in place in Ireland. The existence of such legislation engages the responsibility of the State party for the treatment of the author, and cannot be invoked to justify a failure to meet the requirements of article 7.

7.5 The Committee considers it well established that the author was in a highly vulnerable position after learning that her much-wanted pregnancy was not viable. As documented in the psychological reports submitted to the Committee, her physical and mental situation was exacerbated by the following circumstances arising from the prevailing legislative framework in Ireland and by the author's treatment by some of her health-care providers in Ireland: being unable to continue to receive medical care and health insurance coverage for her treatment from the Irish health-care system; feeling abandoned by the Irish health-care system and having to gather information on her medical options alone; being forced to choose between continuing her non-viable pregnancy or

[16] At the time of the events at issue, the Offences against the Person Act imposed the criminal penalty of life imprisonment for a woman or a physician who attempted to terminate a pregnancy. (See para. 2.7 above.)

[17] See communication No. 2324/2013, *Mellet v. Ireland*, Views adopted on 31 March 2016, para. 7.4. See also the Vienna Convention on the Law of Treaties, art. 27.

travelling to another country while carrying a dying fetus, at personal expense and separated from the support of her family; suffering the shame and stigma associated with the criminalization of abortion of a fatally ill fetus; having to leave the baby's remains in a foreign country; and failing to receive necessary and appropriate bereavement counselling in Ireland. Much of the suffering the author endured could have been mitigated if she had been allowed to terminate her pregnancy in the familiar environment of her own country and under the care of health professionals whom she knew and trusted, and if she had received necessary health benefits that were available in Ireland, which she would have enjoyed had she continued her non-viable pregnancy to deliver a stillborn child in Ireland.

7.6 The Committee considers that the author's suffering was further aggravated by the obstacles she faced in receiving information she needed about appropriate medical options from her known and trusted medical providers. The Committee notes that the abortion information act legally restricts the circumstances in which any individual may provide information about lawfully available abortion services in Ireland or overseas, and criminalizes advocating or promoting the termination of pregnancy. The Committee further notes the author's unrefuted statements that the health professionals in Ireland did not provide her with clear and detailed information on how to terminate her pregnancy in another jurisdiction or from which other health-care providers she could obtain such information, thereby disrupting the provision of medical care and advice that she needed and exacerbating her distress.

7.7 The Committee considers that, taken together, the facts described in paragraphs 7.5-7.6 above establish a high level of mental anguish that was caused to the author by a combination of acts and omissions attributable to the State party, which violates the prohibition against cruel, inhuman or degrading treatment found in article 7 of the Covenant. The Committee also notes in this regard, as stated in paragraph 3 of general comment No. 20, that the text of article 7 may not be limited, and no justification or extenuating circumstances may be invoked to excuse a violation of article 7 for any reason. Accordingly, it cannot accept as a justification or extenuating circumstances the State party's explanations concerning the balance between moral and political considerations that underlies the legal framework existing in Ireland.

7.8 The author further claims that by denying her the only option that would have respected her physical and psychological integrity and reproductive autonomy under the circumstances of this case (allowing her to terminate her pregnancy in Ireland), the State party interfered arbitrarily with her right to privacy under article 17 of the Covenant. The Committee recalls its jurisprudence according to which the scope of article 17 encompasses a woman's decision to request termination of pregnancy.[18] In the present case, the State party interfered with the author's decision not to continue

[18] See *Mellet v. Ireland*, para. 7.7; *K.N.L.H. v. Peru*, para 6.4; and 1608/2007, para 9.3. See also general comment No. 28 (2000) on the equality of rights between men and women, para. 10.

her non-viable pregnancy, pursuant to article 40.3.3 of the Constitution and the Offences against the Person Act. Under these circumstances, the question before the Committee is not whether such interference has a legal basis in domestic law, but rather whether or not the application of domestic law was arbitrary under the Covenant, as even interference provided for by law should be in accordance with the provisions, aims and objectives of the Covenant and should be, in any event, reasonable in the particular circumstances.[19] The State party argues, in this connection, that the interference was not arbitrary, since it was proportionate to the legitimate aims of the Covenant, taking into account a carefully considered balance between protection of the fetus and the rights of women.

7.9 The Committee considers that the balance that the State party has chosen to strike between protection of the fetus and the rights of the woman in the present case cannot be justified. The Committee refers in this regard to its Views in Mellet v. Ireland, which dealt with a similar refusal to allow for termination of pregnancy involving a fetus suffering from fatal impairment.[20] The Committee notes that, like in *Mellet v. Ireland*, preventing the author from terminating her pregnancy in Ireland caused her mental anguish and constituted an intrusive interference in her decision as to how best to cope with her pregnancy, notwithstanding the non-viability of the fetus. On this basis, the Committee considers that the State party's interference in the author's decision is unreasonable and that it thus constitutes an arbitrary interference in the author's right to privacy, in violation of article 17 of the Covenant.

7.10 The author claims that by criminalizing abortion on the ground of fatal fetal impairment through legislation that only restricts the rights of women, the State party violated her rights to equality and non-discrimination under articles 2 (1), 3 and 26. The State party maintains that its laws regarding termination of pregnancy are gender-neutral and non-discriminatory.

7.11 The Committee notes that under the laws of the State party, pregnant women who decide to carry to term their fatally impaired fetuses continue to receive the full protection of the public health-care system. Their medical needs continue to be covered by health insurance, and they continue to benefit from the care and advice of their public medical professionals throughout the pregnancy. After miscarriage or delivery of a stillborn child, they receive any needed post-natal medical attention as well as bereavement care. By contrast, women who choose to terminate a non-viable pregnancy must do so in reliance on their own financial resources, entirely outside of the public health-care system. They are denied health insurance coverage for these purposes; they must travel abroad at their own expense to secure an abortion and incur the financial, psychological and physical burdens that such travel imposes, and they are denied needed post-termination medical care

[19] See general comment No. 16 (1988) on the right to privacy, para. 4.

[20] See *Mellet v. Ireland*, para. 7.8.

and bereavement counselling. The Committee further notes the author's uncontested allegations that in order to terminate her non-viable pregnancy, she was required to travel abroad at her own expense.

7.12 The Committee recalls paragraph 13 of its general comment No. 18 (1989) on non-discrimination, in which it states that not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant. The Committee notes the author's claim that she was denied on the basis of her sex access to medical services that she needed in order to preserve her autonomy, dignity and physical and psychological integrity; that, in contrast, male patients and patients in other situations in Ireland are not expected to disregard their health needs and travel abroad in relation to their reproductive functions; and that the State party's criminalization of abortion subjected her to a gender- based stereotype according to which the primary role of women is reproductive and maternal. The Committee considers that the differential treatment to which the author was subjected in relation to other women who decided to carry to term their unviable pregnancy created a legal distinction between similarly situated women that failed to adequately take into account her medical needs and socioeconomic circumstances and did not meet the requirements of reasonableness, objectivity and legitimacy of purpose. Accordingly, the Committee concludes that the failure of the State party to provide the author with the services that she required constituted discrimination and violated her rights under article 26 of the Covenant.

7.13 In the light of the findings above, the Committee will not separately examine the author's allegations under articles 2 (1), 3 and 19 of the Covenant.

8. The Committee, acting under article 5 (4) of the Optional Protocol, is of the view that the facts before it disclose a violation of the author's rights under articles 7, 17 and 26 of the Covenant.

9. In accordance with article 2 (3) (a) of the Covenant, the Committee considers that the State party is under an obligation to provide the author with an effective remedy. This requires it to make full reparation to individuals whose Covenant rights have been violated. Accordingly, the State party is obligated to, inter alia, provide the author with adequate compensation and to make available to her any needed psychological treatment. The State party is also under an obligation to take steps to prevent similar violations occurring in the future. To this end, the State party should amend its law on voluntary termination of pregnancy, including, if necessary, its Constitution, to ensure compliance with the Covenant, including with respect to ensuring effective, timely and accessible procedures for pregnancy termination in Ireland, and take measures to ensure that health-care providers are in a position to supply full information on safe abortion

services without fearing being subjected to criminal sanctions,[21] as indicated in the present Views.

10. Bearing in mind that, by becoming a party to the Optional Protocol, the State party has recognized the competence of the Committee to determine whether there has been a violation of the Covenant and that, pursuant to article 2 of the Covenant, the State party has undertaken to ensure to all individuals within its territory or subject to its jurisdiction the rights recognized in the Covenant and to provide an effective remedy when it has been determined that a violation has occurred, the Committee wishes to receive from the State party, within 180 days, information about the measures taken to give effect to the Committee's Views. In addition, it requests the State party to publish the present Views.

[21] See also CCPR/C/IRL/CO/4, para. 9.

Annex I

[Original: French]

Separate opinion of Committee member Yadh Ben Achour

1. I agree with the findings of the Human Rights Committee that the facts in the present case (communication No. 2425/2014) disclose a violation of articles 7, 17 and 26 of the Covenant. In paragraph 7.13 of its Views, the Committee decided nevertheless not to examine separately the author's allegations under articles 2 (1) and 3 of the Covenant.

2. I am of the opinion that, in its consideration of the merits, the Committee should have upheld the author's claim that, in Ireland restrictive abortion laws constitute a form of discrimination against women. The author points out that, in contrast, male patients and patients in other situations in Ireland are never expected to disregard their health needs and moral agency in relation to their reproductive functions, or to leave their family and country in order to receive health care. The rights to equality and non-discrimination require States to ensure that health services accommodate the fundamental biological differences between men and women in reproduction (see paragraph 3.9). According to the author, the Irish legislation that makes abortion a criminal offence also violates articles 2 (1) and 3 of the Covenant.

3. In paragraph 7.12 of its Views, the Committee begins by referring to this problem in the same terms as the author, noting that male patients in Ireland are not expected to disregard their health needs and travel abroad in relation to their reproductive functions and that the State party's criminalization of abortion subjected the author to a gender-based stereotype according to which the primary role of women is reproductive and maternal.

4. But then, abandoning this logic and shifting its perspective, the Committee addresses the author's claim on the basis of another ground, taken from another sphere, that differs in nature from the ground invoked by the author. In fact, the type of discrimination to which the Committee refers is no longer that of gender-based discrimination between men and women but rather discrimination on the basis of economic factors among women. It considers that the differential treatment to which

the author was subjected created a legal distinction between similarly-situated women and that the existing legal situation in the State party, which allows women to seek, at their own expense, termination of pregnancy in foreign countries, imposes an exceptionally heavy burden on women of low socioeconomic status when compared to other women with superior economic means.

5. While I agree with this point of view, which is based on article 26, I nevertheless consider that the author was right to believe that, because of its effects, the Irish legislation in question also constituted a violation of articles 2 (1) and 3 of the Covenant. By denying women their freedom with regard to a matter concerning their reproductive functions, this type of legislation runs contrary to the right to non-discrimination on the basis of sex because it denies women the ability to exercise their free will in this area. No similar restrictions are imposed on men. This type of legislation imposes a disproportionate, abnormal and unjust existential burden on women, by virtue of being women.

6. Through its binding, indirectly punitive and stigmatizing effects, the prohibition of abortion in Ireland targets women, by virtue of being women, and places them in a specific situation of vulnerability that is discriminatory in comparison with men. As a result of the application of this legislation, the author was, in fact, subjected to a gender-based stereotype according to which a woman's pregnancy should be continued no matter what the circumstances, except where her life is endangered, since the role of women is limited exclusively to that of procreative motherhood. The act of reducing the author to an instrument of procreation constitutes discrimination and simultaneously infringes her freedom of self-determination and her right to gender equality and personal autonomy.

7. On the basis of these considerations, I am therefore of the opinion that the fact that the State, in applying its internal legislation, did not allow the author to terminate her pregnancy in accordance with her own, free assessment of the whole of her situation constitutes gender-based discrimination, which is one of the forms of discrimination on the grounds of sex referred to in articles 2 (1) and 3 of the Covenant.

8. The State party's legislation therefore violates the rights to which the author is entitled under articles 2 (1) and 3 of the Covenant, read in conjunction with article 26.

Annex II

Individual opinion of Committee member Sarah Cleveland (concurring)

I concur in the decision of the Committee, both for the reasons set forth by the Committee in its Views, and for the reasons stated in my separate opinion in *Mellet v. Ireland*, communication No. 2324/2013, Views adopted on 31 March 2016.

Annex IV

Individual opinion of Committee member Anja Seibert-Fohr (partly dissenting)

1. The Committee's Views are not about the prohibition of abortion in general but relate to the particular facts of this case. The holding and the recommendations therefore apply only to the case in which the fetus, according to the uncontested submission by the author, was not viable.[a]

2. The denial of postnatal medical attention, as well as the failure to provide the author with bereavement care that is available to women who carry their non-viable fetus to term, contributed, inter alia, to the author's suffering, which led the Committee to find a violation of article 7 in her case (see paras. 7.5-7.7 of the Views). While I agree with this holding, I fail to recognize why it was necessary and appropriate to find on the same grounds also a violation of article 26 after the Committee had already concluded that articles 7 and 17 had been violated. Not only are the claims on which the majority of the Committee based its findings under article 26 already absorbed by the wider issue decided under articles 7 and 17, such that there is no useful legal purpose served in examining them under article 26 (see paragraph 7.12 of the Views),[b] they are also insufficient to sustain a violation of article 26.

3. I recognize that the Committee limited its holding to the difference in treatment "in relation to other women who decided to carry to term their unviable pregnancy "(see para. 7.12 of the Views) and did not find a discrimination based on sex and gender. Nevertheless, I cannot agree with the majority's conclusion under article 26 for the following reasons.

4. According to the Committee's standing jurisprudence, the term "discrimination" as used in the Covenant should be understood to imply any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing,

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[a] See the references to "as indicated in present Views" and "similar violations" in paragraph 9 of the Views.

[b] See also European Court of Human Rights, *Dudgeon v. United Kingdom*, application No. 7525/76, judgment of 22 October 1981, paras. 67-69.

c See general comment No. 18 (1989) on non-discrimination, para. 7.

of all rights and freedoms.[c] Difference in treatment requires comparable situations in order to give rise to discrimination.[d]

5. With respect to abortion, the medical needs and services sought by the author are fundamentally different from obstetrics. Thus, in regard to termination of pregnancy, women are not in a comparable medical situation with respect to those who carry the pregnancy to term. For this reason, there are no grounds for finding the denial of abortion services to be discriminatory.

6. The situation is different with respect to post-partum care. I recognize that the post- pregnancy situation of women who have carried and lost a non-viable fetus is comparable irrespective of whether they carried the pregnancy to term. They suffer from the loss of a fatally ill fetus. It is cruel to deny bereavement support to women who, due to the non- viability of their fetus have undergone an abortion, whereas such support is available to women who have carried the pregnancy to term. But in the context of article 26 the issue remains whether this difference in treatment is based on any of the grounds specified therein, that is, race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. This is doubtful in the present case because the State party's regulatory framework does not have its origin in the status of a woman who undergoes an abortion but is based on moral views on the nature of life, which are held by the Irish population. One may disagree with the sustainability of protecting a fatally ill fetus. But this does not render moot the State party's intent to protect any fetal life until death. After all, we would never accept a death sentence carried out on a pregnant woman, irrespective of whether the pregnancy is viable or not. e Though the Committee in its findings under article 17 does not agree with the outcome of the State party's balancing of the right to life of the unborn and the rights of the woman because the fetus was fatally ill in the present case, this does not warrant the conclusion that the difference in treatment of women who undergo an abortion and those who carry to term is based on a personal characteristic of the woman concerned. The Committee thus has failed to explain why the difference in treatment was based on an impermissible ground.

7. Even if we assumed that the denial of bereavement support was based on an impermissible ground, the author has neither submitted that local remedies have been exhausted in this respect nor that there is objectively no prospect of success to challenge the denial of bereavement support and post-abortion medical care in domestic proceedings.fPursuant to article 5 (2) (b) of the Optional Protocol the Committee is therefore prevented from finding a violation of article 26 in this regard.

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[d] See communication No. 1062/2002, *Šmídek v. Czech Republic*, decision of inadmissibility adopted on 25 July 2006, para. 11.5.

8. Finally, for the reasons given in my separate opinion in *Mellet v. Ireland* I do not agree with those members who would have preferred if the Committee had found a violation on the basis of sex and gender. I refer to my previous opinion.[g] I also repeat that the Committee should preserve the autonomous meaning of article 26 by giving due account to the notion of discrimination and to the grounds prohibited there under rather than presuming a violation of this provision whenever a violation of one of the other rights protected under the Covenant are found. An overbroad reading is unnecessary under our Covenant[h] and would deprive article 26 of its particular value.

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