Committee on the Elimination of Discrimination against Women

Pre-sessional Working Group for the 94th session for Adoption of the List of Issues Prior to Reporting for India

Joint submission by Commonhealth India; Centre for Health Equity, Law and Policy; International Planned Parenthood Federation, South Asia Region (IPPF-SARO); and the Center for Reproductive Rights

CommonHealth India[1], Centre for Health Equity, Law and Policy[2], IPPF SARO[3] and the Center for Reproductive Rights[4] respectfully present this submission to the Committee on the Elimination of Discrimination against Women (the Committee) for its consideration with regard to the List of Issues Prior to Reporting (LOIPR) on India under the Convention on the Elimination of All Forms of Discrimination against Women (the Convention) .

A significant period has elapsed since the Committee's last periodic review of India in 2014.[5] During this time, the protection of sexual and reproductive health and rights (SRHR) has not made significant progressive strides. Enjoyment of the Convention's rights concerning access to sexual and reproductive health care in India continues to be restrained. The Human Rights Committee, last year, highlighted several legal and practical barriers to accessing abortion including: "*lack of clarity of the relevant legislation, including the Bharatiya Nyaya Sanhita, 2023, fear of reprisals against medical practitioners, very severe restrictions on abortion for medical reasons after the*

[1] CommonHealth - Coalition for Reproductive Health and Safe Abortion, constituted in 2006, is a rights-based, multi-state coalition of organisations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities in India. Within sexual and reproductive health and rights, CommonHealth concentrates its efforts largely on maternal health and safe abortion. The coalition draws its membership from diverse disciplines, thematic areas and geographies within the country.

[2] The Centre for Health Equity, Law and Policy (est. 2019) at the Indian Law Society, Pune, uses the law as a tool for health transformation. C-HELP's work is grounded in the belief that the right to health — rooted in the Constitutional framework and reinforced by international commitments — is central to social justice. Through research, dialogue, and advocacy, it seeks to shape policies and laws that enable equitable health outcomes for all. More info at https://www.c-help.org/

[3] IPPF South Asia Regional Office (SARO) is one of the six regional networks of International Planned Parenthood Federation.

[4] The Center for Reproductive Rights is a global legal advocacy non-governmental organization dedicated to the advancement of reproductive freedom as a fundamental human right that all governments are legally obliged to protect, respect, and fulfill; www.reproductiverights.org.

[5] Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding observations on the combined fourth and fifth periodic reports of India,* CEDAW/C/IND/CO/4-5.

twentieth week of pregnancy, the obligation to obtain an authorization from a third party in many cases and conscientious objections on the part of medical personnel."[6]

In its previous review of India[7], the Committee had raised concerns regarding the high maternal mortality rates in India, adverse impact of unsafe abortion access and services, post abortion care and lack of adequate care for management of complications arising from unsafe abortion. The Committee had recommended for India to make its maternal health policies inclusive, impart information around SRHR and ensure equitable and non-discriminatory access to safe abortion.[8]

This submission provides the Committee with updates following the publication of the 2014 review report, with a particular focus on access to abortion, adolescents' access to SRHR and access to inclusive and non-discriminatory maternal health for women and girls and persons with the capacity to gestate. While we use "women and girls" most often throughout this submission, we also variously use the terms "individual", "person", "pregnant person" and "adolescent".

I. Abortion - Barriers to access and Costs of Criminalization

Around 22 per cent of abortions in India occur in an unsafe environment.[9] In the case of adolescents, this figure reaches as high as 78 per cent[10]. Consequently, 8 cases of maternal mortality daily is attributed to unsafe abortion.[11] Despite being an essential healthcare need, abortion is criminalised in India, conditional and restricted, and based on third-party authorisation. Access to abortion is further limited by socio-economic, legal and systemic barriers enforced by gender-based discrimination, which violates Articles 2 and 12 of the Convention, amongst others.

A. Criminalization of Abortion

Section 88 of the newly amended Bhartiya Nyaya Sanhita (BNS), 2023 (formerly the Indian Penal Code, 1860) retains the old penal provisions on voluntarily causing miscarriage unless done in good faith to 'save the life of the woman'. This provision criminalises pregnant women themselves while completely ignoring their right to make reproductive choices, autonomy and privacy. Sections 89-92 of the BNS creates a chilling effect – being at the root of the medical service provider's fear of prosecution, and causing them to deny abortion services and care to pregnant

[6] Human Rights Comm., Concluding Observations on the Fourth Periodic Report of India, ¶ 23, U.N. Doc. CCPR/C/IND/CO/4 (Sept. 2, 2024)
[7] Ibid
[8] Ibid, 31.
[9] National Family Health Survey (NFHS-5), 2019-2021; Malik, M., Girotra, S., Zode, M., & Basu, S. (2023). Patterns and Predictors of Abortion Care-Seeking Practices in India: Evidence From a Nationally Representative Cross-Sectional Survey (2019-2021). Cureus, 15(7), e41263. https://doi. org/10.7759/cureus.41263
[10] United Nations Family Population Fund (UNFPA) State of the World Population Report.(2022).
[11] Ibid

person.[12] Abortion in India is premised on this carceral and penal approach that poses unique challenges to its access.

B. The Medical Termination of Pregnancy Act, 1971: Key Barriers to Access

The Medical Termination of Pregnancy Act, 1971, (MTP Act) exists as an exception to the criminal provisions. A key impetus behind this legislation was to address India's population growth, besides addressing high maternal mortality and incidence of unsafe abortions. The MTP Act consequently, does not centre the rights and bodily autonomy of women.

It allows conditional abortion based on the opinion of Registered Medical Practitioners or RMPs (up to 20 weeks on consent of one RMP, and between 20-24 weeks on consent of two RMPs) or the State-appointed Medical Board in cases of *significant foetal abnormality*. Beyond 24 weeks of gestation, abortion is permissible only under two circumstances: when it is necessary to save the woman's life— a ground available at any stage of pregnancy on the opinion of even a single registered medical practitioner—or when a substantial fetal abnormality is diagnosed by a duly constituted Medical Board. The MTP Act was amended in 2021 which notably expanded on the earlier gestational limits and eligibility criteria, but abortion access continued to be contingent upon the registered medical provider's advice.[13] Introduction of medical boards in the decision-making deepens the third-party authorization framework. The suggested structure with diverse medical professionals raises specific concerns of accessibility, delays in receiving urgent abortion care, and increased burden on the healthcare system. makes it unlikely to be formed in all states and consequently adding further access barriers for those seeking abortion from remote areas.

By imposing restrictions in terms of gestational limits and compliance with exclusive grounds listed in the MTP Act, access to abortion services is substantially curtailed for women who may otherwise have valid reasons for seeking termination, including late discovery of pregnancy, existing medical conditions, changes in relationship status, or systemic barriers that delay access within the permitted timeframe.

By mandating RMPs' approval for abortion, the Act reduces women's reproductive choice to a medical necessity, systematically disregarding material circumstances in their lives, social and cultural factors like stigma and shame, and their health and life choices. The law ignores the inherent dichotomy between exercise of bodily autonomy and that of mandatory requirement of

---

[12] Chandra, A., Satish, M., Shree, S., Saxena, M.(2021). Legal barriers to accessing safe abortion services in India: a fact finding study. Center for Reproductive Rights, Centre for Constitutional Law, Policy, and Governance, NLU Delhi, & National Law School of India University, Bengaluru. . https://www.nls.ac.in/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-AbortionServices-in-India.pdf

[13] Center for Reproductive Rights, 'Center's New Factsheet Explains Recent Changes to the Abortion Law in India' (Center for Reproductive Rights, 27 September 2022). https://reproductiverights.org/india-abortion-law-mtp-amendment-factsheet/. Accessed 11 July 2024.

third-party authorization. A fact-finding study demonstrated stigma related to abortion among service providers where abortion was misunderstood as unlawful and there was fear of the legal process. [14] Further that law which places RMPs as gatekeepers of providing abortion, their personal views on morality on abortion, adversely impacts a person's access to the same. These views are shaped by several factors including their religious beliefs and views on woman's societal role.[15] Third-party authorisation from doctors leads to unnecessary delay, increased chances of denial and public scrutiny, which violates women's autonomy, privacy, dignity and right to healthcare.[16] The third-party authorizations further increase access barriers to pregnant women and girls living in rural and tribal areas and those from marginalized socio-economic backgrounds.[17] Inadequate qualified medical practitioners within the public healthcare system in far flung and least served areas further increase access barriers.[18] The third-party mandate for abortion access is in direct infringement of women's equality and amounts to discrimination as recognised by CEDAW Committee among other international bodies.[19]

In the case of X v. The Principal Secretary, Health & Family Welfare Department, Govt. of NCT of Delhi, the Supreme Court stated that[20]:*"Reproductive autonomy requires that every pregnant woman has the intrinsic right to choose to undergo or not to undergo abortion without any consent or authorization from a third party….."[T]he decision to carry the pregnancy to its full term or terminate it is firmly rooted in the right to bodily autonomy and decisional autonomy of the pregnant woman."*

The Indian Supreme Court has recognised abortion as an exercise of a pregnant person's bodily autonomy which is missing in the legislative framework. Further the Court extended access to abortion under the MTP Act to unmarried women noting that marital status should not determine

---

[14] Center for Reproductive Rights. *Legal Barriers to Accessing Safe Abortion Services in India*. New Delhi: Center for Reproductive Rights, August 2021. https://reproductiverights.org/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-Abortion-Services-in-India_Final-for-upload.pdf.

[15] Ibid

[16] Anjuri, A., & Bargal, H. (2025). The Bench and the Body: An Analysis of Abortion Jurisprudence in India (2019-2024). C-HELP. https://www.c-help.org/post/the-bench-and-the-body-an-analysis-of-abortion-jurisprudence-in-india-2019-2024

[17] Center for Reproductive Rights, 'Center's New Factsheet Explains Recent Changes to the Abortion Law in India' (Center for Reproductive Rights, 27 September 2022). https://reproductiverights.org/india-abortion-law-mtp-amendment-factsheet/. Accessed 11 July 2024.

[18] DIPIKA JAIN ET AL, MEDICAL BOARDS FOR ACCESS TO ABORTION UNTENABLE: EVIDENCE FROM THE GROUND, (Jindal Global Law School, 2021) at 3, available at https://jgu.s3.ap-south1.amazonaws.com/cjls/CJLS_Medical_Boards_Report_Final.pdf/

[19] UN Doc. CEDAW/C/TLS/CO/2-3, para. 31(a)); UN SRRH report on criminalization, para. 23; K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, para. 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, para. 9.3, U.N. Doc. CCPR/ C/101/D/1608/2007 (2011); CRC Committee, Concluding Observations: India, para. 66(b), U.N. Doc. CRC/C/IND/CO/3-4 (2014)

[20] *X v. the Principal Secretary Health and Family Welfare Department & Another,* (2023) 9 SCC 433

abortion access.[21] The Court in *A (Mother of X) versus State of Maharashtra*[22], also expanded the interpretation of 'woman' to include persons other than cisgender women who may require abortion services, acknowledging the exclusion of transgender and gender non-conforming individuals from the legal framework[23].

A study done on the adjudication process in abortion cases between 2019 and 2024 revealed that out of 1126 cases that came to court seeking abortion, in approximately 958 cases, the court's decision either aligned with the opinion of the Medical Board or treated it as determinative. Even when the Board commented beyond the scope of the MTP Act for instance, by commenting on the implications for a woman's future pregnancies—courts adhered to such opinions without scrutiny. The judicial application of the MTP Act demonstrates access to abortion issue being inherent in India's lack of rights-based approach and one where medical opinion and stigmatised approached RMPs have precedes exercise of women's bodily autonomy.

The current legal framework demonstrably fails to provide enabling environment to allow for full exercise of SRHR. The failure to provide abortion on demand could lead to forced pregnancies which violates pregnant woman's fundamental human rights[24].The CEDAW Committee has interpreted Article 16 of the Convention to include the right to not experience forced pregnancy as this Article guarantees every woman the right to decide on the number and spacing of children[25]. More recently, CEDAW recognized abortion as a fundamental right and referred to WHO abortion guidelines to adopt evidence-based protocols on the provision of abortion.[26]

The MTP Act continues to remain a doctor-centric law that was envisioned to protect medical community from criminal prosecution for providing abortion without foregrounding the rights of pregnant women especially from marginalized communities. The law and its recent effort to amend missed an opportunity to recast abortion from rights-based perspective.[27]

---

[21] *X v. the Principal Secretary Health and Family Welfare Department & Another,* (2023) 9 SCC 433 [124]
[22] 2024 INSC 371.
[23] *A (Mother of X) versus State of Maharashtra*, 2024 INSC 371 [21].
[24] recent jurisprudence of the Human Rights Committee (El Golpe cases) setting standards on forced pregnancy and motherhood:
Human Rights Committee, Fatima vs Guatemala, comunicación núm. 3629/2019 (2025), UN. Doc. CCPR/C/143/D/3629/2019 ; Comité de Derechos Humanos, Susana vs. Nicaragua, comunicación núm. 3626/2019 (2025), UN. Doc. CCPR/C/142/D/3626/2019; Comité de Derechos Humanos Lucia vs Nicaragua comunicación núm. 3627/2019 (2025), UN. Doc. CCPR/C/142/D/3627/2019; Human Rights Committee Norma vs Ecuador Communication Num. 3628/2019 (2025), UN. Doc. CCPR/C/142/D/3628/2019, paras. 11.2, 11.21 and 13.
[25] Comm. on the Elimination of Discrimination Against Women, Gen. Recommendation No. 35, ¶ 18, U.N. Doc. CEDAW/C/GC/35 (July 26, 2017)
[26] Center for Reproductive Rights. "Fact Sheet: CEDAW Inquiry into Poland's Abortion Law." New York: Center for Reproductive Rights, October 11, 2024. https://reproductiverights.org/wp-content/uploads/2024/10/CEDAW-Poland-Factsheet-10-11-24.pdf.
[27] CJLS, CRR, Commonhealth and Rising Flame (2023). *Advocacy manual on legal regulation of abortion in India: Complexities and challenges*. https://reproductiverights.org/wp-content/uploads/2023/06/Advocacy-Manual-on-Legal-Regulation-of-Abortion-in-India-Complexities-and-Challenges.pdf

C. Judicial Inconsistencies

The 24-week gestation limit for abortion pushes women beyond this gestation period to seek permission for abortion from the courts. However, reportedly, women well within the gestational limit are also forced to approach courts because of a plethora of reasons like denial of abortion by registered medical providers, wrong understanding of the law and insistence on court order by the providers, highlighting deep systemic biases against women's access to reproductive healthcare.

Court involvement also amounts to third-party involvement and adds another layer to the barriers faced by women accessing abortion, especially given the high inconsistency that exists in the rulings. Some courts have expanded the scope of the MTP Act, which otherwise lacks rights-based language, to allow abortion even late in the gestation limit, holding that women's life and health take priority over potential life[28] while other courts have denied abortion simply because the limit given in the Act is over.[29] The confusion created by such contrasting rulings further undermines women's right to health and legal remedies.

D. Increasing Anti-Rights Movement challenging women's bodily autonomy and health

In India anti-rights actors are designing their strategies to oppose abortion, its legal framework and access to abortion. They are directly targeting the MTP, Act, 1971. Further their advocacy is garnered towards targeting and influencing women and youth. [30] The narratives being used online by these entities are rooted in "life from conception" principle and using the language of "right to life" of the "unborn" thereby aiming at extending the legal rights to a fetus.[31] Inter-American Court[32] and European Commission on Human Rights[33] have held that international human rights conventions and declarations do not protect the right to life prior to birth, and that any prenatal protections must be consistent with women's human rights. The CEDAW Committee has itself made it clear that the fundamental principles of non-discrimination and equality require that the rights of a pregnant woman be given priority over an interest in prenatal life.[34] Dangerously they are co-opting and misrepresenting scientific studies to make anti-choice argument seem as though

---

[28] XYZ v. Union of India, 2019 SCC OnLine Bom 560.
[29] ABC v. State of Gujarat, 2024 SCC OnLine Guj 1520,
[30] Ragini Bordoloi, *Unveiling the Resistance to Choice, A media monitoring report exploring anti-abortion entities and emerging anti-choice narratives in India*, CommonHealth India, January 2024.
[31] Ibid
[32] Artavia Murillo et al. ("In Vitro Fertilization") v. Costa Rica, Preliminary objections, Merits, Reparations and Costs, Judgment, Inter-Am. Ct. H.R., ¶¶ 224-244 (Nov. 28, 2012)
[33] Paton v. United Kingdom, App. No. 8416/79, ¶ 9, 19 Eur. Comm'n of H.R. Dec. & Rep. 244 (1980)
[34] L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, ¶ 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

it is one rooted in pro-science approach.[35] In India the prolife movement is predominantly led by religious institutions, with some indication of transnational influence.[36]

More recently on 9th August 2025, a "March for Life" in Bangalore, fourth edition of the march which was kickstarted after the reversal of Roe v. Wade judgment by the US Supreme Court was organized by the Family Commission, Archdiocese of Bangalore. It attracted a diverse crowd, including students, religious leaders from various faiths, pregnant women, adolescents and young couples[37]. This event echoed the pro-life messaging and dangerously co-opted the language of equality and anti-discrimination to challenge pro-abortion stances. The event directly targeted the Medical Termination of Pregnancy Act, 1971, by prioritizing the social and cultural aspects of the pro-life view over the legal guarantees of abortion in India. A march with diverse religious and inter-generational participation with a clear attack on the existing law would potentially lead to strengthened efforts to challenge legal guarantees and push more polarizing and prominent public discourse on abortion rights in India.

There is an increasing tension between the progressive foundation of the Supreme Court's constitutional rights jurisprudence and fetal interest narratives before the courts. It was observed in the analysis of court cases between 2019 and 2024 that concerns regarding a 'viable foetus' were frequently linked to pregnancies exceeding 24 weeks, with courts and Medical Boards invoking viability as a basis for denying abortion in 65 cases out of 1126 cases studied.[38] Additionally, in 19 cases, the discourse extended to the fundamental rights of the unborn child, including the foetus's right to life and claims of embryonic personhood in clear contradiction with international human rights law and standards.[39] . It was also observed that viability discussions stem from Medical Board opinions and are being picked up by the courts, despite not having any legal basis i.e. recognition/provision in the law.[40]

E. Pre-conception and Pre-natal Diagnostics Technique Act, and its interface with Abortion

[35] Id.
[36] "Unmasking 'Anti-Choice' Rhetoric." Commonhealth, Commonhealth, 18 Aug. 2023, commonhealth.in/unmasking-anti-choice-rhetoric/
[37] Megha Sethu & Kruthika R, Inside India's March for Life (2025): A March Against Choice, CommonHealth (Sept. 10, 2025), https://commonhealth.in/inside-indias-march-for-life-2025-a-march-against-choice/
[38] Anjuri, A., & Bargal, H. (2025). The Bench and the Body: An Analysis of Abortion Jurisprudence in India (2019-2024). C-HELP. https://www.c-help.org/post/the-bench-and-the-body-an-analysis-of-abortion-jurisprudence-in-india-2019-2024
[39] *Whose Right to Life? Women's Rights and Prenatal Protections Under Human Rights and Comparative Law*, Center for Reproductive Rights (2014), https://reproductiverights.org/wp-content/uploads/2020/12/GLP_RTL_ENG_Updated_8-14_Web.pdf
[40] Ibid

The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act,1994, was enacted in India to curb gender biased sex selection and address the declining sex ratio by banning prenatal sex determination and the misuse of diagnostic technologies for sex-selective abortions. The law criminalises conducting tests in unregistered units, using techniques that facilitates sex determination and selling or distributing equipment such as ultrasound machines for unlawful purposes.

Women's access to safe abortion in India is heavily restricted due to fear among service providers of legal consequences under the IPC, the MTP Act, and especially the PCPNDT Act. Providers often misunderstand abortion as broadly illegal, largely because sex-selection and determination is criminalised and widely conflated with abortion in general.[41] Medical associations have also reinforced caution, requiring additional permissions for second-trimester procedures.[42]Linking PCPNDT enforcement with the MTP Act has further intensified scrutiny of abortion services, under the presumption that most later term abortions are sex selective. Consequently, women are often denied abortions, forced to continue unwanted pregnancies, or pushed toward unsafe and illegal methods, which undermine reproductive rights and endanger women's health and life.

Another impediment is the growing surveillance by the state over women's reproductive lives. In March 2025, the Health Department of Haryana state made registration of all pregnant women mandatory during their first trimester. The registration was intended to enable better monitoring and reporting of reproductive, maternal, newborn, and child health (RMNCH). However, this directive represents a substantive intrusion into women's privacy and may lead women to seek unsafe abortion outside the formal healthcare system.[43] Another state, Uttar Pradhesh's Mukhbir Yojana, invites informers to let the state know about potential terminations, especially based on suspicion at the best. By inviting and incentivising informants to report on potential terminations, this policy creates a fearful and chilling environment for any person wanting to seek abortion. It undermines their bodily autonomy and reproductive choice and subjects them to public and state monitoring. This is a clear violation of the fundamental right to privacy, also violating Articles 2 and 12 of the Convention.

II. Adolescents' Access to SRHR - Laws, Policies and Ground Realities

[41] Chandra, A., Satish, M., Shree, S., Saxena, M.(2021). Legal barriers to accessing safe abortion services in India: a fact finding study. Center for Reproductive Rights, Centre for Constitutional Law, Policy, and Governance, NLU Delhi, & National Law School of India University, Bengaluru. . https://www.nls.ac.in/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-AbortionServices-in-India.pdf

[42] Potdar P, Barua A, Dalvie S, Pawar A. "If a woman has even one daughter, I refuse to perform the abortion": Sex determination and safe abortion in India. Reprod Health Matters. 2015 May;23(45):114-25. doi: 10.1016/j.rhm.2015.06.003. Epub 2015 Jul 26. PMID: 26278839./https://pubmed.ncbi.nlm.nih.gov/26278839/

[43]Kumar, A. (2025, March 28). Mandatory pregnancy registration sparks privacy concerns in Haryana. The Hindu. https://www.thehindu.com/news/national/haryana/mandatory-pregnancy-registration-sparks-privacy-concerns-in-haryana/article69383370.ece

The Protection of Children from Sexual Offences (POCSO) Act, 2012[44], was enacted "protect children from offences of sexual assault, sexual harassment and pornography" and has legal provisions to tackle sexual offence involving a child who is defined as under 18 years of age. Under this law, any sexual act with a person below 18 is treated as statutory rape, regardless of consent.

Section 19 of POCSO mandates any person who "has apprehension that an offence under this Act is likely to be committed or has knowledge that such an offence has been committed" must report the same to the special juvenile police or local police. Medical service providers are also required to following this strict mandatory reporting requirements. While the motivation for the POCSO Act was to protect and tackle sexual offences towards children, Section 19 of the Act when read with legal provisions of the MTP Act create significant barriers to adolescents' access to SRHR particularly abortion.

One of the barriers is the effective undermining of confidentiality of pregnant girls. The MTP Act ensures confidentiality of women seeking abortion which prohibits doctors from disclosing their identities except when required under the law.[45] Because of the mandatory reporting provision of the POCSO Act, abortion service providers will have to inform authorities if a pregnant person under the age of 18 is seeking abortion. This legal overlap directly compromises confidentiality, violates their human right to privacy, forcing doctors to reveal the identity of adolescents and criminalising their consensual relationships.

The mandatory reporting mandate under the law essentially criminalizes consensual sexual relationships among adolescents. The POCSO act along with the Indian penal law deems any sexual activity among adolescents as statutory rape. Compounded by this, the medical service provider is required to report any adolescent seeking abortion else they will risk fine or imprisonment. The current legal framework does not take consent of adolescents below 18 into account and criminalizes age-mate consensual sexual activity among adolescents. Cases where there is no prima facie evidence of exploitation or lack of consent are made to interact with the criminal justice system throughout the trial. The adolescent girls and their partners would have to endure the indignity of the process impacting their right to dignity and education.[46]

Non-compliance of mandatory reporting by providers carries risks of imprisonment or fines, creating a chilling effect that discourages medical practitioners from offering necessary care and deters adolescents from seeking timely and safe abortion services. Despite the Supreme Court's

---

[44] Protection of Children from Sexual Offences Act, 2012, No. 32 of 2012, Acts of Parliament, 2012 (India), https://www.indiacode.nic.in/bitstream/123456789/2079/1/AA2012-32.pdf
[45] S. 5A of the
[46] Enfold India. 2022. *Romantic cases under the POCSO Act: An Analysis of Judgments of Special Courts in Assam, Maharashtra & West Bengal*. https://enfoldindia.org/wp-content/uploads/2025/01/Romantic-cases-under-the-POCSO-Act.pdf

reading of provisions in 2022 to ensure that personal details of the adolescents' pregnant girls be kept confidential[47], its operationalization remains ineffective on the ground pending legislative changes. Despite seeking abortion within prescribed statutory limits, approximately 239 minor victims of rape have had to approach the courts between 2019 and 2024 , requiring judicial authorisation for seeking abortion [48]. Moreover, the MTP Act requires minors to be accompanied by a guardian, whose consent is mandatory for the procedure. A 'guardian' is legally defined as "a person having care of the minor." In the Indian socio-cultural context, where sexuality is heavily stigmatised, adolescents often attempt to seek abortion services discreetly, without parental involvement or interaction with authorities. In this context, adolescent girls who need to seek abortion services are afraid of their partner being imprisonment and are likely denied abortion service or seek abortion in unsafe conditions.[49]

Significantly adolescents from marginalized communities face additional barriers to accessing abortion owing to their intersecting caste, religion and gender identities.[50]

III. Maternal Health and Reproductive Health

India's overall maternal mortality rate (MMR) had a steady decline over the last decade from 130 per 100,000 live births in 2014-16 to 88 per 100,000 live births in 2021 to 2023[51]. However, when an examination is done from an equity lens, disparities become prominent. Based on a seven-state study and regional consultations undertaken by CommonHealth, the following findings emerged[52]:

A. Health status and outcomes

Marginalized communities such as Adivasi/tribal women, Dalits, Muslims, urban migrants, sex workers, and women living with HIV faced disproportionately high rates of anemia,

---

[47] *X v. the Principal Secretary Health and Family Welfare Department & Another,* (2023) 9 SCC 433
[48] Anjuri, A., & Bargal, H. (2025). The Bench and the Body: An Analysis of Abortion Jurisprudence in India (2019-2024). C-HELP. https://www.c-help.org/post/the-bench-and-the-body-an-analysis-of-abortion-jurisprudence-in-india-2019-2024
[49] Supra 32
[50] Centre for Reproductive Rights, Centre for Justice, Law and Society at Jindal Global Law School, Rising Flame, CommonHealth, and The YP Foundation. *Advocacy Manual on Legal Regulation of Abortion in India: Complexities and Challenges*, reproductiverights.org/wp-content/uploads/2023/06/Advocacy-Manual-on-Legal-Regulation-of-Abortion-in-India-Complexities-and-Challenges.pdf.
[51] Office of the Registrar General & Census Commissioner, India. (2023). *Special bulletin on maternal mortality in India 202–2023*. Government of India. Retrieved from https://censusindia.gov.in/nada/index.php/catalog/46177/download/50425/SRS_MMR_Bulletin_2021_2023.pdf
[52] Sri BS, Khanna R, Ravindran TKS, Gawri S, Shinde S. Woman-centred maternal Health care: What does it mean and how can it be achieved – A position paper based on women's voices. SAHAJ, CommonHealth; March 2025.

undernutrition, and pregnancy-related complications, including pregnancy-induced hypertension leading to morbidity and mortality during pregnancy. Mental health concerns, including depression and anxiety during pregnancy and the postpartum period, were also widespread among these groups, exacerbated by systemic discrimination, gender-based violence, and social isolation. Child marriage remained prevalent and due to fears of legal consequences, many adolescent pregnancies went unreported. In these cases, home births were preferred and were mostly in unsafe and unhygienic conditions.

B. Healthcare system level discriminatory practices

Many facilities demonstrated entrenched discriminatory practices, with Dalit women reporting refusal of physical examination, verbal abuse, and differential treatment. Muslim women faced increasing communal stereotyping and stigmatization by healthcare providers. Particularly Vulnerable Tribal Groups (PVTGs) and migrant communities encountered severe communication barriers with healthcare providers who lacked cultural sensitivity and linguistic competence.

Widespread non-consensual insertion of post-partum intrauterine devices (PPIUCD) across multiple states were reported, with women sharing coercion and lack of information about side effects from healthcare providers. Systematic coercive or non-consensual hysterectomies as well, often intersection with ethnic or socioeconomic discrimination.[53] The consistently disproportionate proportion of female sterilization and dismal proportion of male sterilization depicts a gendered angle of women predominantly bearing the responsibility of contraception.

C. Healthcare infrastructural gaps

Severe human resource shortages were glaring. There were critical gaps in specialists' availability, particularly gynaecologists in rural areas, with many Primary Health Centers non-functional or understaffed geographical remoteness, lack of transport pose additional barriers. Accredited Social Health Activist (ASHA workers) were often absent from tribal settlements.There are shortages of health workers, especially female doctors, and a lack of essential services like ultrasound machines and diagnostic tests.

[53] Megha Rajagopalan & Qadri Inzamam, *India's Sugar Cane Fields: Child Labor and Hysterectomies*, *The New York Times*, Mar. 24, 2024, https://www.nytimes.com/2024/03/24/world/asia/india-sugar-cane-fields-child-labor-hysterectomies.html

Despite 89% institutional birth rates nationally and integration of LaQshya guidelines[54], women from most marginalized communities reported being left alone during labor, denial of pain relief, unnecessary referrals, and lack of essential supplies including blood for emergencies.

Financial exploitation in the form of persistent informal payments was rampant. Hospital staff in public facilities who are supposed to provide free care made these demands which forced marginalized women into debt or reliance on unqualified providers.

D. Access barriers for vulnerable groups

Arbitrary documentation requirements exclude many from accessing health services. Though declared non-mandatory by the Supreme Court, in practice Aadhaar card[55] is routinely sought and it prevented women from accessing government maternity schemes, while sex workers faced barriers due to lack of identity documents such as Aadhaar card.

Remote tribal settlements lack assigned community health workers, while geographical remoteness, lack of transport, poor road connectivity and inadequate ambulance services all delay emergency care.

High out of pocket expenditure had often led people from marginalized communities to unsustainable borrowings and pushed them into debt traps and poverty cycles. Some chose to be reliant on untrained service providers and developed complications as well.

While the CEDAW Committee's concluding observations[56] on health from the last review focused on being inclusive, there has been greater push towards ensuring institutional deliveries without addressing underlying social determinants as well as systemic shortcomings including intimate partner violence, nutritional deficiencies, unsafe working conditions, and gender discrimination. Pregnant women in informal work - including sanitation, mining, and agriculture - lack adequate maternity protection, working until delivery and returning immediately postpartum without rest. Weak or absent grievance redressal systems leave women without recourse for discrimination or poor-quality care, while healthcare providers lack training on gender sensitivity and cultural competency.

---

[54] National Health Mission. *LaQshya: Labour Room Quality Improvement Initiative Guideline*. Ministry of Health & Family Welfare, Government of India, 2017, nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/LaQshya-Guidelines.pdf.

[55] A 12-digit unique identification number issued by the Unique Identification Authority of India (UIDAI) to all residents of India, serving as both proof of identity and address. It includes a range of demographic and biometric details of the individual.

[56] Committee on the Elimination of Discrimination against Women. (2014, July 24). *Concluding observations on the combined fourth and fifth periodic reports of India* (CEDAW/C/IND/CO/4-5, para. 31). United Nations. Retrieved from https://docs.un.org/en/CEDAW/C/IND/CO/4-5

IV. A set of recommended questions for the Committee's consideration as it formulates the LOIPR on India

Considering the above, we respectfully ask the Committee to consider addressing the following questions to the Government of India:

- What measures has the Government taken or is it envisaging to undertake legal reforms that would decriminalize abortion removing relevant penal provisions from the BNS, and guarantee its barrier-free access to women and girls?
- What measures has the Government taken or is envisaging to take to remove/address key legal barriers to effective access to abortion including provisions such as third-party authorization requirements through medical boards under the MTP Act, 1971 (as amended in 2021), in line with WHO abortion guidelines and human rights standards?
- What measures has the Government taken or is envisaging to take to ensure that existing legal provisions such as mandatory reporting under the POCSO Act, 2012 and parental consent requirements for abortion do not undermine effective access to sexual and reproductive health and rights (SRHR) for adolescent girls and exacerbate the stigma and social barriers they encounter?
- What measures has the State party taken or is envisaging to decriminalize factually consensual and non-exploitative sexual activity between adolescents of similar age group below 18 years (especially between 16-18 years) while continuing to implement existing strong legal mechanisms to protect adolescents from sexual violence?
- What measures has the Government taken or is envisaging to ensure equitable and inclusive access to maternal and reproductive health rights and services especially for women from marginalized communities, especially from rural areas and tribal communities? Specifically, what measures has the Government taken to ensure sensitization of medical personnel and implementing authorities, strengthen participation of women and girls from marginalized communities in the development and implementation of policies and programs and ensure accessibility, availability, quality of SRH information and services without discrimination.