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The Right to Privacy and Access to Abortion in a Post- *Puttaswamy* World

Severyna Magill*

Abstract

In August 2017 India's Supreme Court ruled that a Constitutional right to privacy exists in *KS Puttaswamy v Union of India*. Whilst considering how the right to privacy has evolved the Supreme Court referenced international case law charting the right to use contraception and to access abortion. Indian jurisprudence already has a wealth of case law on reproductive rights, often referencing the same principles of liberty, autonomy, and dignity that the *Puttaswamy* judgment refers to. After *Puttaswamy* there has been much talk about the scope of reproductive rights in India being broadened. This article contributes and builds upon this discourse as it seeks to predict how the Supreme Court will respond to future challenges using the new constitutional right to privacy. It maps the legal framework under the Medical Termination of Pregnancy Act, which regulates access to abortion within India and considers issues relating to access to abortion, the continuing practise of sex-determination and sex-preferred abortions, and debates surrounding access to abortion where foetuses have been diagnosed with medical conditions likely to affect their quality of life, and/or survival. This article examines liberty, autonomy, and dignity as they are articulated within the *Puttaswamy* decision and how they are represented within existing reproductive rights jurisprudence and academic debates with reference to access to abortion. This approach aims to predict how any future challenge to the Medical Termination of Pregnancy Act's provisions using the new constitutional right to privacy will be responded to by the Supreme Court of India.

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Keywords: *Puttaswamy*, Reproductive Rights, India, abortion, privacy, liberty, autonomy, dignity.

1. Introduction

In 2012, a retired Karnataka High Court judge, Justice KS Puttaswamy, became a key litigant challenging the government's introduction of a unique identification number scheme, known commonly as Aadhaar, across India. The unique identification number was based on individuals' biometric data and obtaining it gradually became a mandatory requirement in accessing public utilities and filing tax returns. Justice Puttaswamy's writ petition before the Supreme Court of India claimed that Aadhaar was an intrusion on the right to privacy.¹ As there was no right to privacy in the text of the Constitution, the Supreme Court first had to establish the constitutional status of privacy. Justice Puttaswamy's petition, together with twenty others, thus came to be decided first as a right to privacy claim, decided by a landmark nine-judge bench in *Puttaswamy v Union of India*.²

In the unanimous decision, the Supreme Court of India declared privacy to be a constitutionally protected right. It held that: '[t]he right to privacy is protected as an intrinsic part of the right to life and personal liberty under Article 21' of the Constitution of India. The right was deemed to include 'at its core the preservation of personal intimacies' including, but not limited to, 'procreation' and the 'right to be left alone.'³ The relevance and applicability of this decision to reproductive rights is clear. The exercise of a person's reproductive rights, including the right to access abortion, may now be said to be firmly grounded in the right to privacy, in turn, as the Supreme Court held in *Puttaswamy*, rooted in the values of liberty, autonomy, and dignity.⁴ The *Puttaswamy* judgment

¹ Akshatha Machina, 'Aadhaar petitioner Justice KS Puttaswamy hails verdict' *The Economic Times* (New Delhi, 27 September 2010) <<https://economictimes.indiatimes.com/news/politics-and-nation/aadhaar-petitioner-justice-ks-puttaswamy-hails-verdict/articleshow/65975395.cms>> accessed 1 October 2019.

² *KS Puttaswamy v Union of India* (2017) 10 SCC.

³ *ibid* Plurality Judgment, [3(f)] 263.

⁴ The author chooses to use the term 'pregnant person' in recognition of non-gender binary persons, including trans-men's ability to conceive and become pregnant. This is appropriate given the Supreme Court of India's recognition of transgender rights in *National Legal Services Authority v Union of India And Others* (2014) 5 SCC 438. She also uses the terms 'they' and 'their' as gender-neutral, singular pronouns throughout. As

cannot be read as a complete exploration of reproductive rights in India given the specific legal question it considered. However, the right to privacy, as declared in *Puttaswamy*, disrupts the constitutional basis of the current legal framework surrounding abortion, and reproductive rights more broadly, in India. While the Medical Termination of Pregnancy Act 1971 (MTPA) decriminalises access to abortion in limited circumstances, there is no legal right to abortion on demand. The creation of a constitutional right to privacy therefore potentially creates a privacy-based justification for a freestanding right to abortion.

The article explores such consistencies and inconsistencies between the privacy infused reading of reproductive rights in *Puttaswamy*, and pre-existing reproductive rights jurisprudence in India. In particular, the aim is to illustrate how the new constitutional right to privacy may shape future challenges to the MTPA and to consider how the right to reproductive health needs to evolve to align with the substantive basis of *Puttaswamy*. This article begins by mapping the legal framework regulating access to abortion in India. It then explores three principles of privacy: liberty, autonomy, and dignity, that emerged in *Puttaswamy* and applies them to three challenging areas of reproductive rights in India today: (i) access to abortion and the availability of health-infrastructure; (ii) the continuing practice of sex-determination and sex-preferred abortions; and (iii) debates surrounding access to abortion where foetuses have been diagnosed with medical conditions likely to affect their quality of life, and/or survival.

Section 1 agrees with Justice Chandrachud's assertion in the plurality opinion that without an individual's ability to exercise choices the inviolability of the human personality, and the right to liberty are in doubt.⁵ The section highlights the barriers women across India may encounter when trying to access reproductive healthcare due to economic, geographic, and social reasons. It questions how meaningful a right to liberty to make free choices is, if there is limited healthcare infrastructure that prevents the realisation of legal rights. It recommends adopting Martha Nussbaum's capabilities approach to more effectively question what resources and opportunities exist, and which need to be improved, for women to meaningfully be able to exercise their rights to privacy, liberty, and reproductive health. This approach highlights the weaknesses in the availability of health infrastructure and suggests a framework to structure the government's obligations to fulfil constitutional and human rights duties.

the petitioners in all of the cases referred to identified as women the author uses the terms pregnant person, they, their, and woman/women interchangeably.

⁵ *Puttaswamy* (n 2) [168] 242-243.

Section 2 examines how the right to privacy, and specifically autonomy as it is defined in *Puttaswamy*, may be used to seek legal sanction for the practice of sex-determination and sex-preferred abortions in India. The right to autonomy, at its core, supports the right of individuals to exercise choice free from interference by the State. An examination of existing jurisprudence challenging the validity of restrictions on sex-determination demonstrates how Indian courts have found co-existing constitutional and public policy interests that outweighed the rights petitioners used in seeking sex-determination. Applying the reasoning of the existing jurisprudence, this article argues that it is unlikely that any challenge to restrictions on sex-determination using the new constitutional right to privacy would be successful.

Within India, the MTPA's provisions currently allow the termination of a foetus with a diagnosed impairment up to twenty weeks into the pregnancy. Section 3 examines how dignity was referred to in the *Puttaswamy* decision and within existing reproductive rights jurisprudence within India. It also identifies the use of dignity both by anti-choice as well as disability rights activists, to ascribe rights to foetuses. It presents the similarities Kavana Ramaswamy identifies between commonly accepted justifications for terminating foetuses likely to be born disabled in the US, with reasons used to support the termination of female foetuses in India. It argues that while the disability rights discourse is still emerging in India, the concept of dignity, and to whom it is ascribed, is currently inconsistently applied within existing Indian jurisprudence. If a petition using the constitutional right to privacy goes to court seeking to broaden the MTPA's twenty week limit this article suggests it is likely this will be accepted but as disability rights arguments are continually developing this is uncertain.

Throughout this article the term reproductive rights will be used to refer to reproductive health rights, and specifically access to abortion. The UN's International Conference on Population and Development (1994) (ICPD) defined reproductive health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes'.⁶ Whilst the ICPD was foundational in declaring that women and girls have rights to sexual and reproductive health, it stopped short of recognising a right to abortion. Since then the UN's Committee for Economic, Social and Cultural Rights, in its 2016

⁶ UN International Conference on Population and Development (1994) [7.2] <www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf> accessed 15 May 2019. See Rebecca Cook and Bernard Dickens, 'From Reproductive Choice to Reproductive Justice' (2009) 106 *International Journal of Gynaecology and Obstetrics* 106.

General Comment on the Right to Sexual and Reproductive Health, has explicitly recognised the right to abortion as a human right.⁷ The right to reproductive health may therefore be understood to include access to the ‘*foundational*’ determinants of healthcare infrastructure to prevent and treat medical conditions.⁸ This includes upholding wellbeing, such as access to family planning education, contraception, and abortion. In 2010, Lance Gable defined rights to ‘privacy, liberty, equality, autonomy and dignity’ as ‘*decisional*’ reproductive rights.⁹ Gable argued these rights enable individuals, primarily in the West, to exercise autonomous decisions over their reproductive functioning. Recent jurisprudence could add freedom from cruel or degrading treatment to this list.¹⁰ When the right to health is blended with reproductive rights, Gable argues that the right to reproductive health rights is created.¹¹ It is this confluence of health with reproductive rights that forms the basis of the present discussion.

2. The Legal Framework Regulating Access to Abortion in India

‘Causing miscarriage’ (abortion) is criminalised under sections 312-16 of the Indian Penal Code 1860 (IPC). The IPC, a hangover of the British colonial rule, criminalises both causing abortions and accessing them.¹² A woman who ‘causes herself to miscarry’ is caught within these provisions.¹³ There are different consequences of breach depending on the number of weeks of gestation.¹⁴ This restrictive law forced many women to access illegal abortion services that were unregulated, unhygienic, and unsafe. As a direct consequence of the IPC’s restrictive provisions, the maternal mortality and morbidity rate was extremely

⁷ UN Committee on Economic, Social and Cultural Rights ‘General Comment No 22 on the Right to Sexual and Reproductive Health’ (2016) E/C.12/GC/22 [13], [18], [21], [28].

⁸ Lance Gable, ‘Reproductive Health as a Human Right’ (2009-2010) 60(4) Case Western Reserve University School of Law 957, 969.

⁹ *ibid* 969.

¹⁰ *VC v Slovakia*, (2014) 59 EHRR 29 (European Court of Human Rights); *Mellet v Ireland* (2016) CCPR/C/116/D/2324/2013 (UN Human Rights Committee).

¹¹ Gable (n 8) 970.

¹² The IPC’s provisions regulating abortion, enacted in 1860, closely resemble the UK’s Offences Against the Person Act 1861.

¹³ Explanation to Section 312 of Indian Penal Code.

¹⁴ Section 312 of Indian Penal Code.

high.¹⁵ In response, the Government of India constituted a committee to review the law relating to abortion in the 1960s.

The Report of the Committee to Study the Question of Legalisation of Abortion (1966), also referred to as the Shantilal Shah Committee Report, recommended the decriminalisation of abortion in specific compassionate circumstances.¹⁶ The MTPA was subsequently enacted in 1971 in line with the Report's recommendations. The MTPA does not introduce a right to abortion, which would have provided rights-holders access to abortion on demand. Instead, the MTPA's public health origins, to prevent the 'avoidable wastage of the mother's health, strength and, sometimes life',¹⁷ focus on enabling access to legal and regulated abortion services within government hospitals and decriminalises abortion in certain circumstances. It is useful to consider its provisions in some detail. To comply with the MTPA's provisions, abortions may only be performed in some circumstances and must be performed by registered medical practitioners. Further, they must be performed in hospitals/places established/maintained/approved by the government or district level committees.¹⁸ Section 3 of the MTPA allows abortion, up to twenty weeks of gestation, 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'¹⁹ or if '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'. If a pregnancy is caused by rape or a failure of contraception, then it is presumed that the continuation of pregnancy could constitute grave injury to a woman's mental health.²⁰

A woman's 'actual or reasonably foreseeable environment'²¹ may also be considered when considering the potential injury caused to a woman if the pregnancy is not terminated. This has been interpreted, though not consistently, to include the existing care responsibilities a woman may have, and her socio-economic position. Section 5 of the MTPA states that the length of the pregnancy does not apply when an abortion is 'immediately necessary to save the life of the pregnant woman.' Life here, as in similar legislation across the world, has not been defined and

¹⁵ World Health Organisation 'Health Statistics and Information Systems' <www.who.int/healthinfo/statistics/indmaternalmortality/en/> accessed 5 July 2019.

¹⁶ Amar Jesani, Aditi Iyer, 'Abortion - Who is Responsible for Our Rights?' (*CEHAT*; August 1995) 7 <www.cehat.org/go/uploads/Publications/A%2040.pdf> accessed 20 August 2019, Siddhi Hirve, 'Policy and Practice' (*India Seminar*, undated) <www.india-seminar.com/2003/532/532%20siddhi%20hirve.htm> accessed 20 August 2019.

¹⁷ Statement of Objects and Reasons of MTPA.

¹⁸ Sections 3 and 4 of MTPA.

¹⁹ Section 3(2)(ii) of MTPA.

²⁰ Section 3 (2), Explanation I and II of MTPA.

²¹ Section 3 (3) of MTPA.

is open to judicial interpretation.²² In all cases the consent of the pregnant person is required, and in the cases of minors or a ‘mentally ill person’,²³ the consent of their guardian is also required.²⁴

Whilst the MTPA is often praised for being liberal, especially considering how long ago it was drafted, it is not immune from criticism. Health activists and feminists have consistently highlighted the government’s failure to prioritise access to contraception to prevent unplanned pregnancies, something that has been promoted since the Shantilal Shah Committee Report first recommended it in 1966.²⁵ The 2002 Amendment to the MTPA included use of medical abortion medication as a legal form of abortion. Despite this its use in government hospitals is significantly lower than its use in private facilities, thus creating inequality in access.²⁶ Since the Amendment, abortion medication has become widely available informally, with sales increasing by 646 percent between 2002-2007.²⁷ The broad use of the medication informally, suggests low levels of formal access nationally or its use beyond the Act’s provisions. Easy informal access to abortion medication results in it being taken without medical guidance.²⁸ This has resulted in some medical practitioners experiencing a high number of cases of incomplete abortion, usually when the medication has been taken

²² Attorney General v X [1992] 1 IR 1.

²³ Section 2(i) of The Medical Termination of Pregnancy Amendment Act 2002.

²⁴ Section 3(4) of MTPA.

²⁵ Susheela Singh et al, ‘The Incidence of Abortion and Unintended Pregnancy in India, 2015’ (2018) 6 *Lancet Global Health* e111, e111-112; Meena Armo et al, ‘Maternal Morbidity Due to Unsafe Medical Abortion in Rural Practice Is Just the Tip of the Iceberg: Is It Really Preventable?’ (2015) 4(1) *International Journal of Reproduction, Contraception, Obstetrics and Gynaecology* 56; Ravi Duggal and Vimala Ramachandran, ‘The Abortion Assessment Project—India: Key Findings and Recommendations’ 2004 12 (24 Supplement) *Reproductive Health Matters* 122, 122-3, 126.

²⁶ Singh et al (n 25) 116; Pritam Potdar et al, ‘“If a Woman Has Even One Daughter, I Refuse to Perform the Abortion”: Sex Determination and Safe Abortion in India’ (2015) 23(45) *Reproductive Health Matters* 114.

²⁷ Beverly Winikoff and Wendy Sheldon, ‘Use of Medicines Changing the Face of Abortion’ (2012) 38(3) *International Perspectives on Sexual and Reproductive Health*, 164, 164.

²⁸ “[A]nnual 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”; Sarita Barpanda et al, ‘My Body My Choice—A Human Rights Perspective of Abortion Law in India’ (*Human Rights Law Network*, 5 July 2019) 15 <<http://reproductiverights.hrln.org/my-body-my-choice-a-human-rights-perspective-of-abortion-law-in-india/>> accessed 10 July 2019.

beyond the recommended gestational limit,²⁹ resulting in some doctors calling for a ban on its sale.³⁰

Another important development in the 2002 Amendment concerned the replacement of the term ‘lunatic’ with the term ‘mentally ill person’.³¹ Yet, the Amendment did not consider a person’s capacity to consent and this has caused delays in accessing abortion.³² It also failed to replace the outdated language which allows failure of contraception between a married couple to be a ground for abortion, thus leaving non-married pregnant persons vulnerable to being excluded.³³ Lastly, it did not extend the twenty week gestational limit to allow abortions if foetal conditions that affect quality of life/survival are diagnosed beyond the twenty week period.

In addition to these legal limitations of the MTPA, including the 2002 Amendment, there are also practical concerns surrounding its implementation. Across India there is a shortage of both access to formal healthcare offering reproductive health and abortion services, and a lack of legal literacy on women’s reproductive rights.³⁴ Neither the legal framework nor its implementation thus seem to be rights compliant. The constitutional right to privacy furnishes new ground to consider whether this scenario continues to be licit. The next section thus turns to consider what difference, if any, the right to privacy makes to the MTPA’s constitutional status.

3. Privacy: In and Post Puttaswamy

In considering whether a constitutional right to privacy exists the Supreme Court of India looked at several of the underlying principles of

²⁹ The Drug Controller India “approved the use of mifepristone in April 2002 and misoprostol in Dec 2006 for termination of pregnancy up to 49 days gestation period. In Dec 2008 this combi-pack was approved for the medical termination of pregnancy up to 63 days gestation”; see Armo et al (n 25) 56-7.

³⁰ *ibid* 59.

³¹ Section 2 of MTPA Amendment 2002.

³² See *Suchita Srivastava and Anr. v Chandigarh Administration*, AIR 2010 SC 235 [4], [10], [22], [31]; *Ms Z v State of Bihar and Others* (2017) SC Civil Appeal No. 10463 of 2017 [23], [39].

³³ Dipika Jain, ‘Time to Rethink Criminalisation of Abortion? Towards a Gender Justice Approach’ (2019) 12 (1) National University of Juridical Sciences Law Review; Barpanda et al (n 28) 8-9.

³⁴ UN Committee on the Elimination of Discrimination against Women, ‘Concluding Observations: India’ (2014) CEDAW/C/IND/CO/4-5 [30]; UN Committee on Economic, Social and Cultural Rights, ‘Concluding Observations: India’ (2008) E/C.12/IND/CO/5 8 [33].

privacy including liberty, autonomy, and dignity. These three principles are of relevance to the corpus of reproductive rights. This section will examine how the Supreme Court conceptually understood each of these principles in *Puttaswamy*, before examining to what extent the same principles already existed in Indian jurisprudence on women's reproductive rights.

A. Liberty and Access to Abortion

In *Puttaswamy*, a nine-judge bench of the Supreme Court unanimously agreed that the 'right to privacy is protected as an intrinsic part of the right to life and personal liberty under Article 21 and as part of the freedoms guaranteed by Part III of the Constitution.'³⁵ The six concurring judgments declared that a constitutional right to privacy exists and drew on the role liberty plays in underpinning the right to privacy. Four of the six judgments linked the right to privacy with pregnancy.

Justice Chandrachud, writing the plurality judgment, referred to the US's ground-breaking reproductive rights cases *Griswold v Connecticut* which struck down the prohibition on the possession, sale, and distribution of contraception to married couples;³⁶ and *Roe v Wade* that legalised abortion.³⁷ Justice Chandrachud traced how access to contraception and abortion are a part of a woman's rights to privacy and liberty as found under the Due Process Clause of the Fourteenth Amendment of the US Constitution.³⁸ Whilst examining the case of *Griswold*, Justice Chandrachud identified how the US Supreme Court had ruled that constitutional guarantees, created 'zones of privacy' within marital relationships and that these zones of privacy must be 'protected from abridgment by the Government'.³⁹ The ability to decide whether to use contraception free from State control marked the emergence of reproductive rights doctrine as it exists today, whereby individuals are able to exercise their liberty and decisional autonomy over their reproductive health.

Citing from Justice Blackmun's majority judgment in *Roe* Justice Chandrachud focused on how the US Supreme Court's concept of privacy extended personal privacy to decisional autonomy in accessing abortion

³⁵ *Puttaswamy* (n 2) Order of the Court, 2(iii).

³⁶ *Griswold v Connecticut* 381 US 479 (1965) (US Supreme Court).

³⁷ *Roe v Wade* 410 US 113 (1973) (US Supreme Court).

³⁸ *Puttaswamy* (n 2), [134 ii], 149.

³⁹ Excerpts from *Griswold* (n 36) as cited in *Puttaswamy* (n 2) [134(ii)], 145.

The Constitution does not explicitly mention any right of privacy. In a line of decisions, however, the Court has recognised that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution...This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon [S]tate action, as we feel it is... [is] broad enough to encompass a woman's decision whether or not to terminate her pregnancy.⁴⁰

This interpretation of privacy as liberty is consistent with Indian jurisprudence and *Puttaswamy* where the plurality opinion based the core aspect of liberty as an interest in being 'free from intrusion.'⁴¹ Citing Justice Subba Rao's dissenting opinion from the 1964 Supreme Court of India decision in *Kharak Singh v State of Uttar Pradesh*,⁴² the *Puttaswamy* judgment defined liberty as the 'right of an individual to be free from restrictions or encroachments on his person, whether those restrictions or encroachments are directly imposed or indirectly brought about by calculated measures.'⁴³ *Puttaswamy* also cited the Supreme Court from 1967 where it was decided that the State must demonstrate that any curtailment of liberty, to be constitutionally valid, 'must satisfy that both the fundamental rights are not infringed by showing that there is a law and that it does not amount to an unreasonable restriction within the meaning of Article 19(2) of the Constitution.'⁴⁴ By citing these cases, *Puttaswamy* reinforced the constitutional principle that no unreasonable infringement on the right to liberty is permissible and supported the recognition of a zone of privacy protected from State action rooted within the right to personal liberty.

Justice Chandrachud's focus on the development of the US constitutional right to privacy offers a comparative perspective on the right to privacy and access to abortion. However, as Justice Chandrachud identified, there are limits to this comparative approach. While India and the US may share common law legal systems with written constitutions vesting the final constitutional authority in a Supreme Court as the guardian and translator of ever-evolving fundamental rights, their culture, socio-economic status, and political approaches to offering government-

⁴⁰ *Roe* (n 37) as cited in *Puttaswamy* (n 2) [134 (ii)], 149-150, emphasis removed.

⁴¹ *Puttaswamy* (n 2) [34], 30.

⁴² *Kharak Singh v State of Uttar Pradesh* (1964) 1 SCR 332.

⁴³ *ibid* 358-359.

⁴⁴ *Puttaswamy* (n 2) [20], 19-20, citing *Satwant Singh Sawhney v D Ramarathnam*, (1967) 3 SCR 525, 554.

funded healthcare differ drastically.⁴⁵ Liberty, as a constitutional right, provides individuals in the US with the freedom to decide whether to terminate a pregnancy, thus enabling an individual to effectively exercise reproductive choices, free from arbitrary interference by the State if the procedure can be accessed and financed. In India, an absence of healthcare infrastructure in rural areas, and vast socio-economic deprivation and poverty often means that women are restricted from being able to physically access healthcare infrastructure, or from being able to access it due to financial or social constraints when it does exist. These barriers prevent women from being able to access reproductive healthcare services. Limited healthcare infrastructure, poverty, low literacy and barriers to access even if facilities exist also prevent women from being able to increase their knowledge of, and subsequent effective use of contraception.

In 2010 the Delhi High Court heard two combined petitions which demonstrate the failure of government funded schemes to ensure vulnerable women below the poverty line have access to reproductive healthcare.⁴⁶ Shanti Devi was a Dalit woman from Bihar who lived in a slum with her husband in Faridabad, Haryana, on the outskirts of Delhi. Their combined monthly income was less than £40 per month, which placed her below the poverty line. Shanti had tuberculosis, which she was not receiving treatment for, and severe anaemia. Due to Shanti's caste, pre-existing medical conditions, and economic status she was in a marginalised and vulnerable position.⁴⁷

Shanti had been pregnant four times before but only two of her children had survived. In the seventh month of her fifth pregnancy Shanti fell from a flight of stairs. Following the fall, Shanti saw a *dai*, a traditional midwife, as 'she could not afford to see a doctor.'⁴⁸ The *dai* advised her to see a doctor in the hospital but she could only afford to go after two weeks, by which time neither Shanti nor the *dai* could feel the baby moving. Shanti presented at the hospital on 19 November 2008 with signs of swelling, fever and severe anaemia. The doctors found that her pregnancy had stopped developing and there were no signs of foetal life. She was not given any medication or advice by the local hospital and

⁴⁵ Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (CUP 2000) 24; *NALSA* (n 4); *Obergefell v Hodges* 576 US (2015) (US Supreme Court); Khagesh Gautam, 'Obscenity, Internet, Free Press and Free Speech: Constitutions of India and the United States' (2013) 8 (1) *Journal of Comparative Law* Missing page number where journal starts.

⁴⁶ *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others* 172 (2010) DLT 9.

⁴⁷ *ibid* [28]; Jameen Kaur, 'The Role of Litigation in Ensuring Women's Reproductive Rights: An Analysis of the Shanti Devi Judgement in India' (2012) 20(39) *Reproductive Health Matters* 24.

⁴⁸ *Laxmi Mandal* (n 46) [28.1]-[28.7].

was told to attend a different hospital, 48-55 kilometres away, that might be able to treat her for free due to her economic status. No transport was offered. The second hospital treated her anaemia but was unable to remove the foetus due to a shortage of beds in the Intensive Care Unit and recommended she attend a different hospital. The third hospital refused to treat her without a payment of around £3,000. One reason she was denied free treatment was that her ration card, used to prove her Below the Poverty Line status, was issued in her home State of Bihar and not Delhi, where she was trying to access treatment. As she could not afford the treatment, she returned to the second hospital and was then referred to a fourth hospital. The fourth hospital removed the foetus at no cost and kept her admitted for 18 days following a court order.

On 28 January 2010 Shanti Devi lost her life after haemorrhaging whilst giving birth at home to a premature baby in the seventh month of her sixth pregnancy. The Delhi High Court found her preventable death was rooted in her inability to access free medical care that should have been assured to her.⁴⁹ Shanti's case illustrates the financial, geographic, and social barriers that exist, which may prevent a woman from being able to exercise legal rights to reproductive healthcare. Similar barriers were also demonstrated in the second petition.

Despite the socio-economic differences between India and the US, the notion of privacy as a form of liberty which respects an individual's 'free choices' was repeated in the *Puttaswamy* plurality opinion.⁵⁰ There is little recognition of how an individual's ability to exercise their liberty may fundamentally differ between the US and India due to cultural, economic, and geographical constraints.

The plurality opinion also relied on Western philosophy, specifically notions of liberty from JS Mill's theory. Mill claims that for liberty to exist within a society, a person must have 'absolute' independence '[o]ver himself, over his own body and mind, [for] the individual is sovereign.'⁵¹ This principle of 'sovereignty' over oneself was a core element of the privacy judgment. Justice Chandrachud agreed that: "The ability of an individual to make choices lies at the core of the human personality.... Without the ability to make choices, the inviolability of the personality would be in doubt."⁵²

Many women in India have a limited ability to make choices surrounding their reproductive rights. The UN Office of the High Commissioner for Human Rights (OHCHR) has identified 'that the defining feature of a poor person is that she has very restricted

⁴⁹ *ibid.*

⁵⁰ *Puttaswamy* (n 2) [3(c)], 262.

⁵¹ John Stuart Mill as reproduced in *Puttaswamy* (n 2) [31], 28.

⁵² *ibid* [168], 242-243.

opportunities to pursue her well-being.⁵³ The right to liberty, without pre-existing access to healthcare, may therefore be of limited use to the majority of women in India seeking access to abortion. An alternative framework of liberty could instead be Martha Nussbaum's capabilities approach which recognises both the need to have 'one's bodily autonomy treated as sovereign', and the importance of 'bodily health', including reproductive health.⁵⁴

If a future legal challenge seeks to expand access to abortion within India, Nussbaum's capabilities approach is a particularly useful framework to adopt to explore how India's emerging right to privacy could affect Indian women's right to reproductive rights, particularly access to abortion, considering existing local socio-economic conditions. Nussbaum's capabilities approach suggests that particular questions be asked that go beyond traditional ways of measuring development, to better identify gendered differences regarding access to, and control over, resources. Nussbaum suggests a series of questions worth asking: what resources exist? To what extent does *A* have access to *X*, and control over it? How satisfied is she with the choices available to her etc? We can then be able to understand to what extent a person is able to 'function in a fully human way.'⁵⁵ Nussbaum recognises that women globally are less privileged than men and that poverty is inherently gendered thus declaring that women 'lack essential support for leading lives that are fully human'.⁵⁶

Nussbaum's framework, which examines the opportunities available to individuals, thus provides a guide to identifying intersectional differences between women. This recognises that women typically have less control over and access to financial resources than men, and that their physical location, mobility and other factors will also affect a women's ability to access healthcare. Nussbaum's approach therefore encourages a structural legal and policy driven solution towards making rights realisable by focussing on what needs to be provided to make rights a reality.

Martha Nussbaum's approach resonates with Sandra Fredman's model of achieving substantive equality by adopting a transformative framework with four overlapping aims.⁵⁷ Within her framework, Fredman argues that it is important to break the historic cycle of disadvantage by identifying distributive inequalities and redressing the

⁵³ Office of the High Commissioner for Human Rights, 'Human Rights and Poverty Reduction: A Conceptual Framework' (2004) HR/PUB/04/1, 7.

⁵⁴ Nussbaum (n 45) 78.

⁵⁵ *ibid* 71.

⁵⁶ *ibid* 1-3, 4.

⁵⁷ Sandra Fredman, *Discrimination Law* (2nd ed, Clarendon 2012) 25-33.

'detrimental consequences attached to that status' which disproportionately affect identifiable groups. This approach, which targets 'disadvantage rather than aiming at neutrality' is better able to achieve substantive equality.⁵⁸ Fredman argues recognition of the need to increase standards of healthcare already exists in India: improvement of public health is amongst the State's 'primary duties' under Article 47 of the Constitution. Although it is not justiciable and no standalone right to health exists case law has relied on it when defining State obligations.⁵⁹

In 1996, the Supreme Court declared '[i]t is no doubt true that financial resources are needed for providing these facilities [emergency medical treatment]. But at the same time it cannot [be] ignored that it is the Constitutional obligation of the State to provide adequate medical services to the people.'⁶⁰ The Court further decided that the central government be a party to the proceedings and made it a joint obligation of the centre as well as the state governments to provide medical services and that a 'time-bound plan for providing these services should be chalked out'.⁶¹ This demonstrates a willingness within India to expand State duties regarding the allocation of funding for, and access to, increased healthcare provision. Fredman argues that the Supreme Court has therefore willingly identified the 'positive duties to provide healthcare, even if this involves requiring the State to provide resources or to improve the efficiency of its administration.'⁶² This proactive approach, rooted in India's Directive Principles, suggests the socio-economic right to health is increasingly becoming justiciable and legal challenges seeking the broadening of reproductive rights are likely to be successful.

Puttaswamy, despite considering how the right to liberty has been used to shape access to abortion in the US, failed to consider the implications of its judgment for the majority of women in India. Despite India's positive obligations, under the MTPA (to make access to termination of pregnancy services available in government hospitals and approved locations) and under article 47 (to improve public health) of the Constitution, access is not always guaranteed, especially given India's vast rural population and under-funded healthcare infrastructure.⁶³

⁵⁸ *ibid* 25-7.

⁵⁹ Articles 37 and 47 of the Constitution of India.

⁶⁰ *Paschim Banga Khet Mazdoor Samity and Others v State of West Bengal and Anr* AIR 1996 SC 2426, [16].

⁶¹ *ibid* [17], 16.

⁶² Sandra Fredman, *Comparative Human Rights Law* (OUP 2018) 237-8.

⁶³ See *Dunabai w/o Vesta Adivasi v State of Madhya Pradesh Through Principal Secretary & six Others*. Writ Petition No.5097/2011 High Court of Madhya Pradesh order 31/10/2012; *Sandesh Bansal v Union of India* W.P. No. 9061 of 2008, order 06/02/2012; *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others*. (n 50); *People's Union for*

Marginalised women, particularly religious minorities and Dalit and tribal women are often unable to pay the more expensive private fees, and/or travel the longer distances to access public clinics leaving them vulnerable to not being able to access formal medical care.⁶⁴ This makes economically marginalised and vulnerable women less likely to access formal methods of safe abortion. Estimates claim that for every legal abortion that is recorded between two and eleven illegal abortions take place.⁶⁵ As Siddhivinayak Hirve remarks, ‘although it may not be the case that abortions in unapproved facilities are all unsafe, it can still be assumed that safe abortion care is still not widely available.’⁶⁶

As a consequence of the above, many women in India today do not have the access to abortion services that the enactment of the MTPA intended and India has the same unsafe levels of abortion taking place as would be expected in a country where abortion is illegal.⁶⁷ The right to liberty with reference to access to abortion and ‘sovereignty’ over one’s body will therefore require more than a constitutional right to privacy to be meaningful for millions of women across India to have enhanced reproductive rights.

Health and rights activists have therefore been campaigning for improved service provision, especially in rural areas, amendments to legislation, and courts are regularly approached by petitioners seeking to enforce or broaden the MTPA’s provisions. The UN has repeatedly declared that for the right to health to be an accessible reality for all people, States must ensure public health and healthcare facilities, and goods and services, are available, accessible, acceptable and of good quality.⁶⁸ The UN has also repeatedly recognised the need for positive measures to ensure that individuals are ‘enabled and assisted’ in being able to access healthcare services.⁶⁹ These guidelines could be better adopted within India to enable a pregnant person’s right to liberty is actually protected.

Civil Liberties v Union of India AIR 2008 SC 495; *Paschim Banga Khet Mazdoor Samity and Others v State of West Bengal and Another*, AIR 1996 SC 2426.

⁶⁴ Duggal et al (n 25) 125.

⁶⁵ Siddhivinayak Hirve, ‘Abortion Law, Policy and Services in India: A Critical Review’ (2004) 12(24) *Reproductive Health Matters Supplement: Abortion Law, Policy and Practice in Transition* 114, 115.

⁶⁶ *ibid* 115.

⁶⁷ World Health Organization, ‘Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008’ (2011) <www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/> accessed 14 August 2019.

⁶⁸ CESCR, ‘General Comment 14 on The Right to the Highest Attainable Standard of Health’ (2000) E/C.12/2000/4 11; CESCR, ‘General Comment 22’ (n 7).

⁶⁹ CESCR, ‘General Comment No 14’ (n 68) [37]; CESCR, ‘General Comment 22’ (n 7) [45]-[48].

Applying the UN's Available, Accessible, Acceptable, and Quality framework to reproductive rights means access to abortion must physically exist within functioning public health and healthcare facilities, goods, services, and programmes; be of good quality, and that these facilities and programmes must have trained medical staff and essential drugs. Facilities must be within physical/geographic reach, including in rural areas and be accessible to all people regardless of their health or other status including disability. For health facilities to be accessible they must also be affordable. *Puttaswamy*'s recognition of the role of liberty in securing a right to reproductive privacy, though, does not develop what is required to enable women in India to be able to exercise the right to privacy with reference to their reproductive autonomy. It is useful to note the role of dignity here in developing the right to privacy in this context.

When claims for reproductive rights started approaching courts in other jurisdictions, the right to access/provide contraception and abortion services were typically granted under the ambit of a patient's rights to make decisions regarding their reproductive health within constitutional guarantees of privacy.⁷⁰ Increasingly, however, the role of a person's dignity to be able to access safe, legal, proximate, affordable, and non-discriminatory, services free from unjustified interference or restrictions has been relied upon in cases surrounding reproductive rights.

The UN Human Rights Committee, CEDAW Committee, and the Inter-American Court of Human Rights have all emphasised the importance of dignity in enabling women to fully exercise their reproductive rights.⁷¹ This shift in judicial thinking recognises the impact upon a pregnant person's wellbeing as a rights holder if access to quality medical care is either interfered with or not available.

The weight of these comparative and international decisions and the need to be able to exercise choices that Nussbaum's capabilities approach explores is reflected in *Puttaswamy*, where the judgment linked the ability of individuals to make 'essential' life choices with liberty and dignity:

Privacy recognises the autonomy of the individual and the right of every person to make essential choices which affect the course of life. In doing so privacy recognises that living a life of dignity is essential for a human being

⁷⁰ *Griswold* (n 36); *Roe* (n 37).

⁷¹ See *Mellet* (n 10); *AS v Hungary* (2006) CEDAW/C/36/D/4/2004 (CEDAW Committee); 'IACtHR Urges All States to Adopt Comprehensive, Immediate Measures to Respect and Protect Women's Sexual and Reproductive Rights' (2017) <www.oas.org/en/iachr/media_center/PReleases/2017/165.asp> accessed 26 July 2019.

*to fulfil the liberties and freedoms which are the cornerstone of the Constitution.*⁷²

Justice Chandrachud also asserted that '[w]ithout the ability to make choices, the inviolability of the personality would be in doubt... Hence privacy is a postulate of human dignity itself.'⁷³ Linking the right to privacy with rights to liberty and dignity makes it inevitable that future challenges to existing abortion legislation will rely on liberty and dignity based arguments to augment the right to health perspective which prioritises access and availability as much as decisional autonomy.⁷⁴ Without these improvements in access, the reaffirmation in *Puttaswamy* of the importance of liberty in exercising reproductive choices free from intrusion by the State, is unlikely to have any benefit for the majority of Indian women seeking to exercise their reproductive rights.

If the framework of the MTPA is challenged by petitioners seeking to increase rights to reproductive health and broader access to abortion within India, the new constitutional right to privacy provides a useful framework. *Puttaswamy*'s recognition of the co-existence and interdependence of privacy, liberty, dignity, and the positive obligations that are necessary to fulfil women's rights to reproductive healthcare set the foundations for a new right to reproductive healthcare model. Adopting Nussbaum's capabilities approach and using it to focus on what steps the government needs to take to make abortion and reproductive rights an accessible reality could effectively realise women's right to liberty to exercise choices within their zone of privacy are more effectively realisable.

B. Privacy, Autonomy and Sex-Determination

Puttaswamy repeatedly drew on domestic and comparative jurisprudence to define how privacy and autonomy are interlinked. The judgment repeated the South African Constitutional Court's holding that: '[p]rivacy recognises that we all have a right to a sphere of private intimacy and autonomy'.⁷⁵ It further added that autonomy 'must mean' individuals can act free 'from interference by the [S]tate.'⁷⁶ In India, the right to

⁷² *Puttaswamy* (n 2) [113], 109-110.

⁷³ *Puttaswamy* (n 2) [168], 243.

⁷⁴ The Delhi High Court in *Laxmi Mandal* (n 46) is an exemplary of how the right to nutrition and health-care services directly affected a woman's right to life with reference to her reproductive rights.

⁷⁵ *Puttaswamy* (n 2) [134(iii)], 167 citing Justice Ackermann in *National Coalition for Gay and Lesbian Equality v Minister of Justice* (1999) 1 SA 6.

⁷⁶ *Ibid* citing Justice Sachs in *National Coalition* (n 75).

autonomy can only be examined in light of the actual ability to exercise that autonomy within the social fabric of the society and the restrictions it places on women's agency.⁷⁷

There is growing recognition of the fact that poverty is inherently gendered, that women have less access to formal and higher education, less access to the formal workforce, and significantly less ownership of property and land, and subsequently less access to and control over resources.⁷⁸ Within family and marital structures women may not benefit from access to resources or have control over how resources are allocated.⁷⁹ This had lead Meghan Campbell to claim that poverty is a gendered phenomenon and 'being a woman both causes and contributes to poverty'.⁸⁰ Combined with a patriarchal social structure and a strong social preference for male children many women in India report living in coercive environments that force them to access abortions, especially if they are carrying a female foetus. In 2004, the Abortion Assessment Project conducted a comprehensive social study using community-based household surveys, qualitative studies and working papers to assess the prevalence of formal and informal abortion in India. The data gathered 'indicated the prevalence of the practice of sex determination and abortion of female foetuses.'⁸¹

The Abortion Assessment Project's findings also highlighted the lack of female agency within decision-making processes surrounding terminations and identified women's husbands and family members as the primary decision-makers surrounding women's reproductive choices. Women were reported to express their 'helplessness' at deciding whether to have a termination, that the decision was 'rarely their own'⁸² and that 'their status in the family and sometimes the very survival of their marriage depended on their ability to produce sons.'⁸³ The research demonstrated the low status, and low decision-making power women often have within their marriages. National Census records of the child sex-ratio indicate this is a real and continuing concern.⁸⁴ The Census of

⁷⁷ A similar argument was put forward by Fredman with reference to women's agency in choosing to wear religious attire. The author feels given the evident role of culture in both sex-selection and the manifestation of religious values the comparison is applicable. See Fredman, *Comparative Human Rights Law* (n 62) 452.

⁷⁸ Nussbaum (n 45) 1.

⁷⁹ CEDAW Committee, 'General Recommendation 29 on Economic Consequences of Marriage, Family Relations and their Dissolution' (2013) CEDAW/C/GC/29.

⁸⁰ Meghan Campbell, *Women, Poverty, Equality: The Role of CEDAW* (Hart 2018) 3.

⁸¹ Duggal et al (n 25) 126.

⁸² *ibid* 125.

⁸³ *ibid* 126.

⁸⁴ Child sex-ratio is calculated by the number of females per 1,000 males in the 0-6 year old group; 'Census of India 2011, Provisional Population Totals: Data on Rural and Urban Areas' (2011) Volume 1, Paper 2 Chhattisgarh Series 23, 22.

India reported the national child sex-ratio to be 945 in 1991, 927 in 2001, and 914 in 2011.⁸⁵ This suggests a continual increase in the number of sex-preference based abortions performed nationally between 1991-2011.⁸⁶

Autonomy was described in *Puttaswamy* as the ability to exercise free choice and the ability to have ‘control over the body’ by consenting to, or denying medical procedures you may be subjected to.⁸⁷ It has been argued that there is tension between the MTPA which creates a right for women to exercise autonomy over their bodies by allowing them to terminate pregnancies and the restrictions imposed by the Pre-Conception Pre-Natal Diagnostics Techniques (Prohibition of Sex Selection) Act, (PCPNDTA) that prohibits sex-determination.⁸⁸ Whilst the PCPNDTA prohibits all sex-determination and does not regulate abortion, it is accepted that India’s artificial sex-ratio is a result of abortions taking place after sex-determination has been performed based on the preference for a male child.⁸⁹

Despite the neat legal separation between sex-determination and access to abortion, the social reality is rather convoluted. In 1978, after AIIMS, one of India’s leading government hospitals, recognised a pattern between sex-determination and subsequent sex-preference based abortions, the Union Health Minister for India banned sex-determination tests in all government-run hospitals.⁹⁰ The ban failed to discourage their social demand, which came to be served in the private sector. From the late 1970s onwards ‘amniocentesis and other sex-selection tests...became the “bread and butter”...for many gynaecologists.’⁹¹ Private healthcare facilities were not prohibited from practising sex-determination until 1994 when the PCPNDTA came into

<http://censusindia.gov.in/2011-prov-results/paper2/data_files/chhattisgarh/chhattisgarh.pdf> accessed 5 August 2019.

⁸⁵ *ibid* 105.

⁸⁶ At the time of writing the 2011 is the most recent Census for which data is available.

⁸⁷ *Puttaswamy* (n 2) [2], 4; [71] 71.

⁸⁸ The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994 and the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act 2002.

⁸⁹ Alka Gupta, ‘Female Foeticide in India’ *UNICEF* <<https://unicef.in/PressReleases/227/Female-foeticide-in-India>> accessed 12 July 2019; *Vijay Sharma and Kirti Sharma v Union of India (Ministry of Law & Justice, Ministry of Health and Family Welfare)* AIR 2008 Bom 29 [9].

⁹⁰ Vibhuti Patel, ‘A Long Battle for the Girl Child’ (2011) 46(21) *Economic and Political Weekly* 18.

⁹¹ *ibid* 18-9.

force and applied to all healthcare institutions. Despite the complete ban, its implementation remains weak.⁹²

To decrease sex-selective abortions the State government in Punjab launched the 'Nawanshahr Model' in 2005 which used technology to collect data on pregnancies from the first trimester until birth and shared this information between government departments, NGOs, and outreach workers. Between the third and fifth month of a person's pregnancy, female employees within a local government office were tasked with calling pregnant women to enquire after the development of their pregnancies. According to the Office of the Deputy Commissioner of Nawanshahr, this measure was intended to 'leaves [sic] an invisible impact on the minds of the pregnant lady as well as on her in-laws that somebody is monitoring and watching them... [and it] discourages them not [sic] to go for [a] sex determination test and then abortion subsequently...'⁹³ The Chandigarh Administration and State of Maharashtra both attempted to implement data collection programmes to track pregnancies with the intention of decreasing the number of sex-selective abortions in 2008 and 2011 respectively.⁹⁴ Such programmes clearly infringe upon women's rights to privacy and bodily autonomy.

Feminists and government agencies in India are often at loggerheads within and between each other when trying to address these social concerns. Some claim the intent and substance of the programmes are autonomy-affirming as they protect women's rights.⁹⁵ Others, however, claim that the processes involved are utilised to police women's bodies and that the restrictions are anti-autonomous, and thus are a violation of women's right to life and the right to health.⁹⁶ Feminist academic Nivedita Menon has argued that 'there is a profound philosophical incoherence

⁹² *Federation of Obstetrics and Gynaecological Societies of India (FOGSI) v Union of India & Ors* AIR 2019 SC 2214 [61].

⁹³ Office of the Deputy Commissioner of Nawanshahr as cited in Navtej Purewal, 'Disciplining the Sex Ratio: Exploring the Governmentality of Female Foeticide in India' (2014) 21(5) *Identities: Global Studies in Culture and Power* 466.

⁹⁴ *ibid*; Pratibha Masand, 'Silent Observer' sonography model for state?' *Times of India* (Mumbai, 29 January 2011) <<https://timesofindia.indiatimes.com/city/mumbai/Silent-observer-sonography-model-for-state/articleshow/7387461.cms>> accessed 12 September 2019; Kanchan Srivastava, 'Exclusive: Maharashtra government's 'Silent Observer' can do little to save girl child' *DNA India* (Mumbai, 19 September 2011) <<https://www.dnaindia.com/mumbai/report-exclusive-maharashtra-government-s-silent-observer-can-do-little-to-save-girl-child-1588899>> accessed 12 September 2019.

⁹⁵ Sital Kalantry, *Women's Human Rights and Migration: Sex-Selective Abortion Laws in the United States and India* (UPP 2017) 47-51.

⁹⁶ World Health Organization et al, 'Preventing Gender-Biased Sex Selection' (2011) <https://apps.who.int/iris/bitstream/handle/10665/44577/9789241501460_eng.pdf> accessed 17 September 2019; Diya Uberoi and Maria de Bruyn, 'Human Rights Versus Legal Control Over Women's Reproductive Self-Determination' (2013) 15(1) *Health and Human Rights*.

involved in arguing for abortion in terms of the right of women to control their bodies and at the same time, demanding that women be restricted by law from choosing specifically to abort female foetuses.’⁹⁷ Menon argues that even within the coercive patriarchal structure of society that dictates a preference for male children, women should be allowed to exercise their autonomy and agency in making reproductive decisions. A UN inter-agency statement also stated that restrictions imposed to prevent an imbalanced sex-ratio ‘should not result in the curtailing of the human rights of women.’⁹⁸

Where women are blamed for giving birth to female children and fear being abandoned by their husbands and families, their choices are not free choices, but an expression of the limited agency women possess within their circumstances. This led Mallika Kaur Sarkaria to label sex-selective abortion as an ‘agent of patriarchy’.⁹⁹ Campbell has highlighted that women’s psychological insecurity, voicelessness, economic disadvantage, compromised autonomy, social exclusion and marginalisation are the result of ‘patriarchal power relationships between men and women.’¹⁰⁰ The UN has recognised that sex-preference ‘is a symptom of pervasive social, cultural, political and economic injustices against women, and a manifest violation of women’s human rights’.¹⁰¹ To uphold a woman’s right to autonomy, these inequalities must be resolved without denying women access to abortion. Prima facie, there seems to be a conflict between respecting a pregnant person’s autonomy and reducing the imbalanced sex-ratio.

Since the PCPNDTA’s enactment, several petitions have sought more effective implementation of the PCPNDTA.¹⁰² Similarly there have

⁹⁷ Nivedita Menon, *Recovering Subversion: Feminist Politics Beyond the Law* (Permanent Black 2004) 72.

⁹⁸ World Health Organization ‘Preventing Sex Selection’ (n 96) 4.

⁹⁹ Mallika Kaur Sarkaria, ‘Lessons from Punjab’s “Missing Girls”’: Toward a Global Feminist Perspective on “Choice” in Abortion’ (2009) 97 California Law Review 905.

¹⁰⁰ Campbell (n 84) 13; Caroline Sweetman, *Gender, Development and Poverty* (Oxfam 2002).

¹⁰¹ World Health Organization ‘Preventing Sex Selection’ (n 96) 4.

¹⁰² *Centre for Enquiry into Health and Allied Themes (CEHAT) v Union of India* (2001) 5 SCC 577, where the Court ordered the Central Government and State authorities to implement the PCNDTA ‘with all vigor and zeal’; *Centre for Enquiry Into Health and Allied Themes (CEHAT) and Ors. v Union of India and Ors.* (2003) 8 SCC 398, where the SC ordered ‘directions issued by this Court on 4th May, 2001, 7th November, 2001, 11th December, 2001 and 31st March, 2003 should be complied with.’; *Voluntary Health Association of Punjab v Union of India and Others.*, Writ Petition (Civil) No. 349 Of 2006 with Writ Petition (Civil) No. 575 Of 2014, which ruled ‘each of the High Courts in the country are requested to constitute a Committee of three Judges that can periodically oversee the progress of the cases’; *S.K. Gupta v Union of India & Ors.*, Civil Writ Petition (PIL) No.3270/2012, High Court of Rajasthan, Jaipur Bench, date of order: 15.4.2015,

also been challenges to the Act's reach and attempts made to carve out exceptions to the prohibition of sex-determination. Two notable cases are *Vinod Soni v Union of India*,¹⁰³ and *Vijay Sharma and Kirti Sharma v Union of India*.¹⁰⁴ Both of these cases came up before the High Court of Bombay in 2005. In *Vinod Soni*, the petitioners argued that their personal liberty, as guaranteed under Article 21 of the Constitution of India, should extend to being allowed to 'determine the nature of family' including the 'sex of that family which he or she may eventually decided [sic] to have and/or develop'.¹⁰⁵ They argued that the PCPNDTA was an unconstitutional infringement of that right. The Court held that as 'nature' decides whether a male or female foetus develops '[t]he right to life or personal liberty cannot be expanded to mean that [it includes] the right... to determine the sex of a child which may come into existence'¹⁰⁶ and dismissed the case.

Three months after deciding the *Vinod Soni* case, the same court gave its judgment in the *Vijay Sharma and Kirti Sharma* case. Here the Court dismissed the Article 21 claim citing the prior judgment but heard the claim that the PCPNDTA violated the petitioners' constitutional right to equality. The petitioners had argued that the Act was not intended to provide for a blanket ban on sex-determination, rather it was intended to prevent its 'misuse'. They argued that if a family already had one or two daughters then parents would not be misusing sex-determination to prevent the birth of daughters but instead could use sex-determination to 'balance' their family with a male child. They further argued that having a second or third daughter, if the child was not wanted, could constitute a 'grave mental injury to a woman' and therefore sex-preference abortions should be allowed under the MTPA.¹⁰⁷

The High Court acknowledged that the PCPNDTA restricts parents' ability to choose the sex of their children and considered whether this restriction was legally permissible by assessing whether the restriction was proportionate. The Court ruled that a woman who wants to terminate her pregnancy due to the sex of the foetus 'cannot be equated' to a woman who wants to terminate her foetus's development under the terms laid down by the MTPA.¹⁰⁸ It further argued that to permit being pregnant with a female foetus to be recognised as 'injury to mental

where the court recommended 'positive and purposeful implementation of the PCPNDT Act'.

¹⁰³ *Vinod Soni and Anr. v Union of India* (2005) Cri L.J 3408.

¹⁰⁴ *Vijay Sharma and Kirti Sharma* (n 39).

¹⁰⁵ *Vinod Soni* (n 103) [3].

¹⁰⁶ *ibid* [8].

¹⁰⁷ *Vijay Sharma and Kirti Sharma* (n 39) [5].

¹⁰⁸ *ibid* [17].

health' would be 'to encourage sex selection which is not permissible.'¹⁰⁹ It thus held that the blanket ban on sex-selective abortions was indeed constitutional.¹¹⁰ In considering whether the PCPNDTA was necessary, the High Court found that the State was 'duty bound to intervene in such matters to uphold the welfare of the [sic] society, especially of the [sic] women and children' and that 'regulation of medical technology [is] in the larger interests of the society.'¹¹¹ As the sex ratio disparity was not 'disputed by the petitioners'¹¹² the Act's existence, and its aim to prevent sex-determination, and thus subsequent sex-determined abortion, was considered to have a legitimate aim and to be necessary. This interpretation is consistent with comparative jurisprudence where a 'pressing social need' has been used to establish that which may be necessary.¹¹³

In deciding whether an act is proportionate a court may apply the 'balancing test'. This test balances 'the weight of the individual interest affected' with 'the importance of certain governmental aims and the need for the interference to achieve such aims'.¹¹⁴ In *Vijay Sharma and Kirti Sharma* the High Court found that, given 'the *frightening figures* which show the imbalance in male to female ratio' and 'that there is a *considerable decline* in the number of female children' it has 'no doubt that if the use of the said techniques for sex selection is not banned, there will be unprecedented imbalance in male to female ratio and that will have disastrous effect on the society.'¹¹⁵ It therefore found that the need to prevent such a 'disastrous effect on society' outweighed the impact on individual rights.

The High Court also declared that, should sex-selection prior to, or after conception be allowed, it would offend the 'dignity of women' and 'violate' their right to life.¹¹⁶ The High Court stated that sex-selection 'violates Article 39(e) of the Constitution' which creates a 'principle of [S]tate policy that the health and strength of women is not to be abused...[and] ignores Article 51A(e) of the Constitution which states that it shall be the duty of every citizen of India to renounce practices derogatory to the dignity of women.'¹¹⁷ The PCPNDTA was thus found to be proportionate. The creation of the new constitutional right to

¹⁰⁹ *ibid.*

¹¹⁰ *ibid* [25].

¹¹¹ *ibid* [9].

¹¹² *ibid* [20].

¹¹³ Janneke Gerards, *General Principles of the European Convention on Human Rights* (CUP 2019) 234.

¹¹⁴ *ibid* 242-243.

¹¹⁵ *Vijay Sharma and Kirti Sharma* (n 39) [19] emphasis added.

¹¹⁶ *ibid* [25].

¹¹⁷ *ibid.*

privacy may however mean that the PCPNDTA's legitimacy is again open to challenge.

In *Puttaswamy*, the Supreme Court had ruled that, '[p]rivacy recognises the autonomy of the individual and the right of every person to make essential choices which affect the course of life.'¹¹⁸ It defined privacy as 'the ultimate expression of the sanctity of the individual...a constitutional value which straddles across the spectrum of fundamental rights and protects for the individual a zone of choice and self-determination.'¹¹⁹ It also gave special recognition to the right of privacy within 'family life, marriage [and] procreation'¹²⁰. At first glance, it can seem that an individual may have the right to determine the sex of their foetus using the autonomy basis of the right to privacy. This, however, may be a misreading of the implications of *Puttaswamy*.

It is useful to recall that the Court in *Puttaswamy* had also held that, 'rights conferred on citizens and non-citizens are not merely individual or personal rights. They have a large social and political content' and autonomous acts are not absolute as they may be restricted to protect co-existing inalienable rights.¹²¹ Further, the Court had cited Craig Stern and Gregory Jones' work, which claims that any act, however autonomous, which violates an inalienable right is morally invalid and therefore 'pretend[s] to an autonomy that does not exist [and that] [i]nalienable rights are precisely directed against such false autonomy.'¹²² The Court had thus found that '[t]he right to privacy, which is an intrinsic part of the right to life and liberty' can only be restricted if there is 'a law in existence to justify an encroachment on privacy'; that such a law pursues 'a legitimate [S]tate aim' which 'falls within the zone of reasonableness' and that 'the means which are adopted by the legislature are proportional to the object and needs sought to be fulfilled by the law.'¹²³

In *Vijay Sharma and Kirti Sharma*, the Bombay High Court articulated how the PCPNDTA pursues a public health aim recognising the significant and irreparable consequences of sex-selective abortions that violate women's right to life and dignity. It successfully demonstrated that the PCPNDTA's restrictions were a necessary and proportionate restriction on the right to autonomy and privacy. The High Court's references to the dignity of women, and the subsequent interest

¹¹⁸ *Puttaswamy* (n 2) [113], 109-110.

¹¹⁹ *ibid* [169], 245.

¹²⁰ *ibid* [3F], 263.

¹²¹ *ibid* [101], 97; [45] 37.

¹²² Craig Stern and Gregory Jones, The Coherence of Natural Inalienable Rights, (2007-2008) 76(4) University of Missouri-Kansas City Law Review as cited in *Puttaswamy* (n 2) [45], 37-38.

¹²³ *Puttaswamy* (n 2) [180], 255.

in not allowing sex-determination are consistent with how *Puttaswamy* referred to the dignity of women and how one autonomous norm cannot be used to violate another. As such the restriction is in fact autonomy affirming. It is therefore unlikely that a constitutional challenge to the restriction on sex-determination using the new constitutional right to privacy would be successful as it would not outweigh the constitutional principles it will be measured against.

C. Dignity, Foetal Rights and the Right to Access Abortion after Twenty Weeks

Notions of dignity are threaded throughout *Puttaswamy*. Dignity is ‘recognised to be an essential part of the right to life and accrues to all persons on account of being humans.’¹²⁴ It was seen as both a ‘constitutional value and a constitutional goal’¹²⁵ and that ‘[i]t is the duty of the State not only to protect the [sic] human dignity but to facilitate it by taking positive steps in that direction.’¹²⁶ Dignity was also recognised as part of India’s ‘constitutional culture’¹²⁷ with ‘reflections of dignity’ found in the constitutional guarantee against arbitrariness and the protection of freedom and liberty.¹²⁸ Western references to dignity are also present where the Court referred to Ronald Dworkin’s theory that it is necessary that men ‘have fundamental rights against the government’ in order to protect their dignity,¹²⁹ and the US Supreme Court’s decision in *Roe* which declared that ‘choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.’¹³⁰

In India the judiciary has been inconsistent in defining when foetal rights to life begin and subsequently when they start to compete with a pregnant person’s rights. In particular, the absence of legislation on when abortions may take place if a foetus has been diagnosed with a condition that may affect its quality of life, contributes to this inconsistency.¹³¹ The

¹²⁴ *ibid* [84], 84, citing *NALSA* (n 4) [73], 490.

¹²⁵ *ibid* [105], 99, citing *Jeeja Ghosh v Union of India* (2016) 7 SCC 761 [37] 792.

¹²⁶ *ibid* [101], 97 citing *M Nagaraj v Union of India* (2006) 8 SCC 212 [26], 243-244.

¹²⁷ *ibid* [84], 84, citing *NALSA* (n 4) [73], 490.

¹²⁸ *ibid* [96], 94.

¹²⁹ *ibid* [46], 38-39 citing Ronald Dworkin *Taking Rights Seriously* (Duckworth 1977) 199 (emphasis removed from original).

¹³⁰ *ibid* [134 ii], 155 citing *Roe* (n 37).

¹³¹ Section 3, Medical Termination of Pregnancy (Amendment) Bill, proposed enabling abortions to take place up to twenty-four weeks under Section 3, and to not have any gestational limit on abortions if ‘substantial foetal abnormalities’ were diagnosed. In 2017, The Medical Termination of Pregnancy (Amendment) Bill again recognised the need to enable abortions to legally be able to take place up to twenty-four weeks, especially ‘if

constitutional right to privacy, linked to the right to dignity creates an opportunity for this to be revisited. Comparatively, some countries hold that the foetal right to life exists from the moment of conception thereby creating a legal framework where the right to life is equally held by the pregnant person and the foetus.¹³² In these cases abortion may be prohibited in all circumstances,¹³³ or only allowed when there's an immediate risk to the life of the pregnant person.¹³⁴ When this threshold is not met the pregnant person may be denied agency over their bodily autonomy regarding the termination of their pregnancy, thereby intrinsically affecting their right to life with dignity and non-discriminatory access to healthcare. The emerging global norm is that rights are afforded to a life when it is born, though some countries recognise a State interest in foetal rights from the point of viability.¹³⁵ In India, a woman may only have an abortion after twenty weeks if there is a risk to her life, indicating a balance between the pregnant person's rights, and foetal rights from this point forwards.¹³⁶

In 2016, the Supreme Court of India issued an order in response to a civil writ petition granting the petitioner, Ms X, permission to abort her pregnancy. Ms X was twenty-three and a half weeks pregnant. Her foetus was found to have 'severe multiple congenital anomalies, [meaning] the foetus is not compatible with extra-uterine life.'¹³⁷ Under the MTPA a termination of pregnancy is allowed if there exists 'a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.'¹³⁸ This provision is however only applicable to pregnancies up to twenty weeks of gestation. Ms X was beyond the twentieth week of gestation. The only provision that permits a termination beyond the twenty-week limit is section 5, which states abortion is permissible if: 'the termination of such pregnancy

doctors believe the pregnancy involves a substantial risk to the mother or the child or if there are substantial foetal abnormalities.' To date neither of the Bills have been passed.

¹³² Fredman, *Comparative Human Rights* (n 62) 206-17.

¹³³ Section 241-43 of the Criminal Code of Malta 1854.

¹³⁴ Article 40.3.3 of the Constitution of Ireland (1937) (now repealed); 'Malta needs to reform laws against abortion, Council of Europe's Rights Commission insists' *Times of Malta*, (Malta, 26 February 2018) <<https://timesofmalta.com/articles/view/malta-needs-to-reform-laws-against-abortion-council-of-europes-rights.671775>> accessed 13 July 2019; Marc Santora and Joanna Berendt, 'Polish Women Protest Proposed Abortion Ban (Again)' *The New York Times*, (New York, 23 March 2018) <<https://www.nytimes.com/2018/03/23/world/europe/poland-abortion-women-protest.html>> accessed 13 July 2019.

¹³⁵ *Vo v France* (2005) 40 EHRR 12 (European Court of Human Rights); *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276, 27 (UK High Court).

¹³⁶ See Section 3 of MTPA; *Suchita Srivastava* (n 52) [22], 15.

¹³⁷ *X v Union of India*, Writ Petition (C)No.593 of 2016, SC, 25.07.2016, the order 2.

¹³⁸ Section 3(2)(ii) of MTPA.

is immediately necessary to save the life of the pregnant woman.”¹³⁹ The pregnancy, however, presented no immediate risk to the petitioner’s life.

Despite the Medical Board’s opinion that the petitioner had no ‘active medical complaints’ the Board argued: ‘[The risk to the mother of continuation of pregnancy can gravely endanger her physical and mental health...Hence the Medical Board advises that the patient, Ms X should not continue with this pregnancy.’¹⁴⁰ The Supreme Court agreed with the Medical Board and granted the petitioner the liberty to terminate her pregnancy, arguably thus upholding her right to life with dignity by not imposing upon her significant and unwanted caring responsibilities.¹⁴¹ In 2018, the High Court of Bombay also granted a petitioner the right to terminate her pregnancy, ‘advanced of thirty weeks of gestation’, when the Medical Board claimed that her foetus ‘fulfils criteria of “substantial risk of serious physical handicap with very high morbidity and mortality.”’¹⁴² Here too there was no reference to the pregnant person’s life being at risk. Instead the Court said it had ‘no reason to doubt the opinion of the Medical Board’ and permitted the abortion.¹⁴³

These cases demonstrate that courts are granting access to abortion beyond the provisions of the MTPA when foetal conditions affect the foetus’ ability to survive to term or post birth, or are likely to impact the infant’s quality of life once it is born. Courts are also interpreting the psychological impact on a pregnant person of continuing with a pregnancy where the foetus will not be able to survive outside of the womb as grave enough to justify a termination of pregnancy beyond twenty weeks. This upholds the pregnant person’s right to choice and dignity.

The right to dignity has also been used to protect women from unwanted invasions of their reproductive choices. In the oft cited case of *Suchita Srivastava v Chandigarh Administration*, the Supreme Court overturned a lower court’s order that the petitioner should have a termination of pregnancy against her wishes.¹⁴⁴ The Court found that a woman’s ‘privacy, dignity and bodily integrity’ must be respected and ‘there should be no restriction whatsoever on the exercise of reproductive choices’ including the choice to ‘procreate as well as to

¹³⁹ *ibid*: the duration of the pregnancy ‘shall not apply to the termination of a pregnancy’ in such cases, see Section 5 of MTPA.

¹⁴⁰ *X v Union of India* (n 157) 4.4.

¹⁴¹ *ibid* [6].

¹⁴² *XYZ v Union of India and Another*, High Court of Bombay, Writ Petition No. 10527 of 2018, [3]-[4].

¹⁴³ *ibid* [4]-[5].

¹⁴⁴ *Suchita Srivastava* (n 52).

abstain from procreating.¹⁴⁵ Here again the Supreme Court prioritised women's rights to dignity by upholding a petitioner's wishes, in this case, by not allowing an unwanted medical procedure to be performed.

In other cases when a pregnant person's circumstances fulfil the grounds under which a termination of pregnancy can take place under the MTPA, extra-legal barriers have been created by the courts. Courts have sought an estranged husband's consent to terminate a pregnancy even when the petitioner was destitute and the pregnancy was the result of rape.¹⁴⁶ The creation of extra-legal barriers and the inconsistencies between judgments in the interpretation of the MTPA's provisions means that a person's ability to exercise their reproductive health rights, especially in cases where the pregnancy is beyond twenty weeks and there is no physical risk to their survival, is at the mercy of judges' inclinations more than the rule of law.

Judgments supporting a petitioner's plea to terminate or continue a pregnancy are often based on women's rights to privacy, bodily autonomy, and dignity, and not on the provisions of the MTPA. In some cases, the courts don't justify their decisions.¹⁴⁷ In other cases women's petitions to have their pregnancies terminated have been denied as the foetus's chances of survival are measured above their anticipated quality of life. In these cases, the pregnant person's well-being, and the impact of continuing with an unwanted pregnancy on their right to life is not considered at all.¹⁴⁸

Although India doesn't legally recognise foetal rights, the MTPA's restriction on access to abortion beyond twenty weeks, unless the pregnant person's life is at risk, does in effect create a duty on the State to defend the right of the foetus beyond twenty weeks of gestation. In Ireland, until recently, there was a constitutional obligation to protect the foetal right to life 'as far as it is practicable.'¹⁴⁹ Ireland's obligation to protect foetal life was interpreted to mean women's requests for abortions were denied, even when the foetus had been diagnosed with a condition incompatible with life. Fiona de Londras critiqued the law's implementation claiming that the foetal right to life was more akin to a 'right to be born'¹⁵⁰ regardless of the life-expectancy post-delivery. The denial of abortion in these circumstances resulted in the UN Human

¹⁴⁵ *ibid* [11].

¹⁴⁶ The consent of a guardian is only needed in the case of minors or a "mentally ill person"; see MTPA Amendment Act 2002.

¹⁴⁷ XYZ (n 143).

¹⁴⁸ *Savita Sachin Patil and Ors. v Union of India (UOI) and Ors.* 2017 (2) RCR (Civil) 326.

¹⁴⁹ Article 40.3.3 of the Constitution of Ireland (1937).

¹⁵⁰ Fiona de Londras, 'Fatal Foetal Abnormality, Irish Constitutional Law and *Mellet v Ireland*' (2016) 24(4) *Medical Law Review* 591.

Rights Committee's finding that women's rights to non-discrimination, privacy and freedom from cruel, inhuman, and degrading treatment were violated.¹⁵¹

Indian courts' inconsistent approach to deciding whether people can have abortions beyond twenty weeks regardless of whether their foetus has a condition not compatible with life or likely to have a disability that may affect its quality of life can have unintended consequences. The Centre for Reproductive Rights recently reported that a woman had an abortion at nineteen weeks before being able to confirm whether her foetus had a medical condition that would affect its quality of life as she feared she would not be able to have a termination after twenty weeks when the test results were due. Many accurate diagnostic tests can only take place after twenty weeks of gestation and this is beyond the limit imposed by the MTPA that permits abortion due to foetal conditions. A pregnant person should never have to decide whether to terminate a pregnancy before a medical diagnosis is confirmed. Subjecting a person to such a grave decision when they are not fully informed or denying access to abortion after the twenty week limit once they have the test results, undermines their rights to dignity, autonomy, liberty, privacy, equality, and non-discrimination.

The failure of the 2002 Amendment to extend the period within which abortions may legally take place if a foetus is likely to be disabled fails to recognise medical advancements in technology which are now better able to detect foetal conditions beyond twenty weeks of gestation that may affect a foetus's chance of fully developing in utero or of survival/quality of life post-delivery. Modern tests are better able to predict a foetus's quality of life and anticipated caring responsibilities. This has led some medical practitioners and courts within India to argue that if a condition has been diagnosed and the pregnant person does not want to continue with the pregnancy, then '[f]orced continuation of a pregnancy is an infringement of [the] right to privacy and dignity of a woman'.¹⁵² Now that a constitutional right to privacy exists, one component of which is dignity, it is possible that cases that meet Section 3's conditions may go to court challenging the 20 week gestational limit.

There are though, limits to these arguments. Disability rights are one set of limitations to an overly broad right to abortion. In the US, pro-choice advocates have argued that women should be allowed to access abortion services if: 'the termination of pregnancy spares the child a life

¹⁵¹ *Mellet* (n 10).

¹⁵² Somashekhar Nimbalkar and Dharti Patel, 'The Medical Termination of Pregnancy Act: Need to Keep Pace with Technology' (2019) 4(1) *Indian Journal of Medical Ethics* 60, 62; *XYZ* (n 143) [4].

of suffering',¹⁵³ or it 'spares parents innumerable hardships and allows them to plan their family around monetary concerns.'¹⁵⁴ In India parents-to-be are allowed to terminate pregnancies, up to twenty weeks, on 'eugenic grounds'¹⁵⁵ 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'.¹⁵⁶ Disability rights activists have argued the justifications used in the US and India to terminate foetuses likely to be born disabled 'manifests a bias against disability' and subsequently devalues disabled lives.¹⁵⁷

Kavana Ramaswamy argues while American justifications for abortion in the case of foetuses likely to have disabilities may seem benign, there are parallels with Indian justifications for sex-preferred abortions. Ramaswamy identifies three justifications used to terminate pregnancies where the foetus is likely to be born disabled as including: first, to spare 'the child a life of suffering'; second, to spare 'the parents innumerable hardships'; and third, to allow parents 'to raise a child with the best possible chance of success'.¹⁵⁸ She then draws parallels between these and justifications for aborting female foetuses, such as: first, females 'are likely to lead lives devoid of real opportunities'; second, 'parents are expected to take responsibility for defending a female child from patriarchal violence, arguably increasing the cost and labour for parents'; and third, by identifying the economic costs of female children, including the burden of dowry.¹⁵⁹

Research in the Indian context shows how some medical practitioners in the private sector, who were able to make large profits from practising sex-determination and subsequent abortions, openly proffered justifications and support for the practise of aborting female foetuses which echo Ramaswamy's claims: '...in developing countries like India, as the parents are encouraged to limit their family to two offspring, they will have a right to *quality* in these two as far as can be assured.

¹⁵³ Raanan Gillon, 'Is There a 'New Ethics of Abortion?'' (2001) 27 *Journal of Medical Ethics* ii5, ii8-ii9 as cited in Kavana Ramaswamy, 'Addressing Ableism: Lessons from the Problem of Female Feticide in India' (2017) 27(1) *Transnational Law & Contemporary Problems* 16.

¹⁵⁴ Janice McLaughlin, 'Screening Networks: Shared Agendas in Feminist and Disability Movement: Challenges to Antenatal Screening and Abortion' (2003) 18 *Disability & Society* 297.

¹⁵⁵ Statement of Objects and Reasons [3(3)] of MTPA.

¹⁵⁶ Section 3(2)(ii) of MTPA.

¹⁵⁷ Ramaswamy (n 153) 24.

¹⁵⁸ *ibid* 16.

¹⁵⁹ *ibid* 16; Sarkaria (n 99) 908 also cites dowry, social pressure and the fear of gender-based violence as factors that may motivate women to not want daughters. Note also the use of 'injury' that would be caused to parents if they had female children against their will, as argued in the *Vijay Sharma and Kirti Sharma* (n 39) [5(b)].

Amniocentesis provides help in this direction.¹⁶⁰ Motivations to perform sex-selective and disability-selective abortions are therefore interrelated. The Forum against Sex Determination and Sex Preselection claimed that doctors have interpreted, presumably with their patients' consent, that the 'mental health' provision within the MTPA includes 'trauma' that the woman would be subjected to if she had a female child, and on this basis have conducted abortions up to twenty weeks.¹⁶¹ Terms such as 'quality' and 'trauma' echo arguments where abortions have been campaigned for when a pregnant woman is carrying a foetus that is likely to be born disabled. As eugenic abortions reduce the number of people with disabilities from being born, Ramaswamy argues when sex-determination is practised it is 'akin to wiping out women to address the problem of patriarchy.'¹⁶²

Puttaswamy recognised how principles of autonomy, liberty, and dignity as constitutional provisions, have influenced reproductive rights in the US, but failed to consider how these should be balanced in cases of female fetuses or fetuses diagnosed with impairments. While *Puttaswamy* answered whether a constitutional right to privacy existed, the judgment also indicated a clear awareness of how the iteration of a self-standing right to privacy would affect other areas of law within India. This recognition of the potential impact of the judgment echoes the 'politics of rights' theory where Scheingold recognised that rights may be used to influence social change and that politics and governments often rely on law as a symbol of legitimacy to buttress their policies.¹⁶³ Scheingold also claims that American politics' capacity to 'adjust peacefully to changing conditions is attributable in large measure to a penchant for channelling serious conflict into legal procedures.'¹⁶⁴ The symbolic legitimacy of law as a tool to settle complex debates peacefully may then provide a framework to resolve competing claims to dignity and autonomy in pregnancies where a foetus is diagnosed with a life-limiting condition.

In cases where a foetus has a condition wholly incompatible with its survival it may be seen as futile to impose restrictions on a pregnant

¹⁶⁰ MH Patanki et al, 'Prenatal Sex-prediction by Amniocentesis - Our Experience of 600 Cases' (1979) First Asian Congress of Induced Abortion and Voluntary Sterilisation as cited in Patel (n 90) (emphasis added).

¹⁶¹ *ibid* 75 (emphasis added).

¹⁶² Ramaswamy (n 153) 22.

¹⁶³ Stuart Scheingold, *The Politics of Rights: Lawyers, Public Policy, and Political Change* (2nd ed, UMP 2004) 4-5. Scheingold also recognised the limitation of rights, and law generally, as a basis for change if it isn't able to address unequal distribution of resources within society.

¹⁶⁴ *ibid* 23.

person's autonomy by limiting their access to abortion.¹⁶⁵ In cases where a foetus has been diagnosed with an impairment, the extent of which is unknown or not fatal, there are more complicated rights arguments with a pregnant person's dignity and autonomy on one hand, and disability rights campaigners speaking on behalf of unborn foetuses and disabled lives on the other. The extent of terminations being performed on foetuses with Down Syndrome has reached such proportions that there have been claims the national governments in Denmark and Iceland have allowed for its eradication and extinction, as the birth rate of children with Down Syndrome reaches almost non-existent levels.¹⁶⁶ In these cases, campaigners are arguing that 'feminist choice' is being used to cloak ableism.¹⁶⁷ While the Danish Ambassador to Ireland denied allegations that 'Denmark has a eugenic policy to eradicate Down [S]yndrome',¹⁶⁸ Germany has witnessed emotive federal debates on whether public health insurers should fund prenatal Down Syndrome tests.¹⁶⁹ In the US, Ohio considered a Bill to prevent practitioners from performing abortions if the motivation was to terminate a pregnancy where the foetus was diagnosed with Down Syndrome.¹⁷⁰ These events demonstrate how politically charged access to abortion versus disability

¹⁶⁵ De Londras (n 150) 595.

¹⁶⁶ Dave Maclean, 'Iceland Close to Becoming First Country Where No Down's Syndrome Children Are Born' *The Independent* (London, 16 August 2017) <<https://www.independent.co.uk/life-style/health-and-families/iceland-downs-syndrome-no-children-born-first-country-world-screening-a7895996.html>> accessed 19 September; Renate Lindeman, 'Down Syndrome elimination in Denmark is "Just another day at the office"' *Huffpost* (Los Angeles, 8 December 2017) <www.huffpost.com/entry/down-syndrome-elimination-in-denmark-is-just-another_b_5a2a8e98e4b0d7c3f26221d0?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2x1LmNvbS8&guce_referrer_sig=AQAAAGQ38YvixVb2WXsx42eT6AC48vLzFRLPh2Mi6XYuE2LxLhINKRjdoa-0jONKRMc7sa8NyRojQQYqBmIqMyXAWb9z8pshOfQcg3fZUyuaaSsVpH7ndHF9n9AOV_jE41Ii4XYdFGDR5jdNv5To3nlE7CRZpcxtY_evroNTJYcRWnF> accessed 19 September 2019; Tim Stanlet, 'Down's Syndrome people risk 'extinction' at the hands of science, fear and ignorance.' *The Telegraph* (London, 18 January 2016) <www.telegraph.co.uk/news/2016/03/22/downs-syndrome-people-risk-extinction-at-the-hands-of-science-fe/> accessed 19 September 2019.

¹⁶⁷ Stuart Scheingold, 'Essay for the In-Print Symposium on the Myth of Moral Justice' (2006) 4 *Cardozo Public Law, Policy, and Ethics Journal* 47.

¹⁶⁸ Lindeman (n 166).

¹⁶⁹ Derek Scally, 'Germany mulls insurance cover for prenatal Down syndrome test' *The Irish Times*, (Dublin, 19 March 2019) <www.irishtimes.com/news/world/europe/germany-mulls-insurance-cover-for-prenatal-down-syndrome-test-1.3831801> accessed 19 September 2019.

¹⁷⁰ Tamar Lewin, 'Ohio Bill Would Ban Abortion if Down Syndrome is Reason' *The New York Times* (New York, 22 August 2015) <https://www.nytimes.com/2015/08/23/us/ohio-bill-would-ban-abortion-if-down-syndrome-is-reason.html?_r=0> accessed 19 September 2019.

campaigns can be. Recognising rights to dignity, autonomy, and liberty as reproductive rights, must therefore reflect the complex social context within which they operate.

Foetal protection laws that enable the prosecution of a pregnant person if they harm their foetus, for example due to drug use, do not also restrict women from accessing abortion.¹⁷¹ This demonstrates a conscious balancing of the restriction of one practice, but not another. Disability rights are still a nascent discourse in India, similar to, and perhaps reflective of its formal exclusion from international human rights law until relatively recently.¹⁷² The arguments it raises are powerful and any consideration of them will have to balance significant competing rights.

Puttaswamy built on how the right to privacy has shaped reproductive rights internationally without considering how the concept of dignity can be used to apply to both pregnant persons and foetuses or recognising that the global norm is that foetus' do not have rights. In 2014, the Government of India issued the Draft Medical Termination of Pregnancy Bill. The Bill suggested amending the MTPA to read that no limitation, based on the length of a pregnancy, should apply if there has been a diagnosis of "substantial foetal abnormalities".¹⁷³ This suggests support for a pregnant person to terminate their pregnancy if foetal conditions affecting quality of life post birth have been diagnosed. This interpretation is consistent with international human rights law approaches and has been followed in previous domestic jurisprudence.

Any future consideration of how the right to privacy influences the reproductive rights discourse in India must engage substantively with domestic peculiarities and show a nuanced appreciation of how competing rights and interests must be addressed within the privacy discourse. While balancing these competing rights it will be useful to remember that internationally foetuses are generally not recognised as rights holders and that any balancing or proportionality test that is applied will have to consider the significant consequences of restricting a

¹⁷¹ Kalantry (n 95) 60-1.

¹⁷² Disability was recognised in the (non-binding) Universal Declaration of Human Rights' (1948) provision on the right to health and security (Article 25) but was absent as a protected characteristic in its provision for non-discrimination (Article 2). When the UDHR was codified neither of the twin covenants recognised disability as a protected characteristic upon which discrimination was prohibited and disability remained absent as a protected characteristic until it was included with the UN Convention on the Rights of the Child in 1989. It was again absent in 1990 with the adoption of the UN's International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. It was only in 2006 that the UN Convention on the Rights of Persons with Disabilities was adopted, which came into force in 2008.

¹⁷³ Medical Termination of Pregnancy (Amendment) Bill 2014.

woman's rights to protect a foetus's rights. It is likely, considering existing domestic jurisprudence which has upheld women's rights to autonomy, liberty, and dignity, that future judgments will also uphold a woman's right to abortion over protecting foetal rights thus continuing the already existing sense of justice promoted in *Puttaswamy*.

4. Conclusion

In the 48 years since the MTPA was drafted, both judicial thinking and medical developments in technology have significantly evolved in India. The most recent attempts to reform the MTPA in 2014 and 2017 attempted to increase access to abortion up to twenty-four weeks. The 2014 Bill also attempted to allow abortions in the case of foetuses likely to be born disabled without a gestational limit and proposed including nurses and midwives as recognised 'healthcare providers'. This would have enabled them to prescribe abortion inducing medication in order to increase accessibility, especially in rural areas. However, neither of the Bills attempted to decriminalise abortion or create a standalone right to abortion, and neither was passed. The new constitutional right to privacy may help change this.

This article has explored how *Puttaswamy* defined privacy, particularly with reference to the constitutional values of liberty, autonomy, and dignity that were explored in the Supreme Court's decision. It then considered how the constitutional right to privacy could apply to reproductive rights in India and paid particular attention to three thematic areas: access to abortion; sex-determination; and the potential of competing rights considering developments in disability rights campaigns.

Section 1 focused on what liberty should be interpreted to mean with reference to reproductive rights. It agreed with the claims in *Puttaswamy*, that without the ability to exercise free choices the right to liberty would be in doubt. It referred to Shanti Devi's experiences that contributed to her preventable death and highlighted the economic, geographic, and social discrimination women in India are vulnerable to experiencing, thus preventing the effective realisation of their legal rights. The section recommended identifying what resources and opportunities have historically been denied to women and adopting Martha Nussbaum's capabilities approach to more effectively redress historic inequality. It also recommended drawing inspiration from Sandra Fredman's transformative equality framework in structuring India's positive duties towards effectively realising women's rights to reproductive health. This

approach would particularly focus on improving the availability of health-infrastructure in rural as well as urban areas to increase access and reducing financial or other barriers that prevent women from being able to freely exercise their rights.

Section 2 examined Nivedita Menon's assertion that there is a disconnect between claiming that women should have rights to autonomy and access to abortion and simultaneously prohibiting their access to sex-determination. It examined existing jurisprudence challenging the validity of restrictions on sex-determination and found co-existing constitutional and public policy interests that justify a ban on sex-selective practices. Section 3 illustrated how dignity may be used to support a wide right to abortion but that competing disability rights narratives caution against a move towards an overly broad right to abortion. Contrasting disability rights with a woman's right to abortion this section predicts the right to privacy, as found within *Puttaswamy*, will be used to outweigh competing foetal rights concerns.

To conclude, there are distinct similarities in how dignity, liberty, and autonomy are understood with reference to the reproductive right to health within pre-existing jurisprudence on reproductive rights within India and *Puttaswamy*. Despite these similarities, *Puttaswamy* explored the right to privacy with reference to the Adhaar card's constitutionality. If the new constitutional right to privacy is used in an effort to expand the MTPA's provisions a more nuanced consideration of the cultural and economic realities that exist within India which affect women's access to reproductive healthcare will have to be explored before reframing India's obligations to fulfil women's constitutional rights.

An examination of existing jurisprudence and academic debates suggests that improvements to India's healthcare infrastructure to improve women's access to reproductive healthcare services would fulfil women's right to privacy and liberty. Existing jurisprudence also suggests that any attempt to secure access to sex-determination, or to prevent abortion when a foetus is likely to be born disabled, using the new constitutional right to privacy would not succeed, due to co-existing constitutional and public policy interests. What is certain is that a revised rights-based legal framework to reproductive rights that focuses on combining rights with the State's positive duties is likely to emerge in this new '*post-Puttaswamy*' world.