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THE IMPACT OF CRIMINALISATION OF ABORTION AND THE NEED FOR LEGAL REFORMS IN TEN COUNTRIES IN ASIA

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Asian-Pacific Resource & Research Centre For Women (ARROW)
1 & 2 Jalan Scott, Brickfields
50470 Kuala Lumpur, Malaysia

Telephone	00 603 2273 9913/9914
Fax	00 603 2273 9916
E-mail	arrow@arrow.org.my
Web	arrow.org.my
Facebook	facebook.com/ARROW.Women
Instagram	arrow_women
Twitter	@ARROW_Women
Youtube	youtube.com/user/ARROWomen
LinkedIn	arrowomen

arrow.org.my

ABOUT ARROW

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

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

The Centre for Justice, Law and Society (CJLS) at Jindal Global Law School, India is a multi-disciplinary research centre that critically engages with contemporary issues at the intersection of law, justice, and marginalisation. It is a collaborative endeavour of scholars, activists and students engaged in high quality empirical and theoretical research. CJLS foregrounds the question of justice, especially intersectional justice, to respond to the changing relationship between law and society. Its approach combines research and education with activism and advocacy and recognises the importance of interdisciplinary critical engagement with the law. CJLS has also crafted judicial, legislative and policy interventions and facilitated consultations with grassroots social movements designed to address punitive laws, regressive policies that de-centre those most affected, and access to justice for marginalised groups. CJLS has been a thought leader on reproductive rights in India. Our advocacy efforts have facilitated systemic change in the domain of sexual and reproductive health and rights (SRHR). Our work in SRHR has focused on research and sustained advocacy on abortion and reproductive justice.

PRODUCTION TEAM

Author
Dipika Jain
Peer reviewers
Sai Jyothirmai Racherla, Sivananthi Thanenthiran, Garima Shrivastava, and Payal Shah
Covers/Section dividers/Country graphics
Nico Mallari
Layout
Ramani Mohanakrishnan

CONTENTS

ABBREVIATIONS

ANM	Auxiliary Nurse Midwives
BLAST	Bangladesh Legal Aid and Services Trust
BAPSA	Association for Prevention of Septic Abortion
BCW	Beijing Conference on Women
BPOM	Indonesian Drug & Food Authority
CAC	Comprehensive Abortion Care
CBCP	Catholic Bishops Conference of the Philippines
CDCP	Center for Disease Control and Prevention
CEDAW	United Nations Convention for Elimination of All Forms of Discrimination Against Women
CMRA	Child Marriage Restraint Act
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of Child
D&E	Dilatation and Evacuation
D&C	Dilatation and Curettage
DCC	Drug Control Committee
DGDA	Directorate General of Drug Administration
DHS	Demographic Health Survey
EPAU	Early Pregnancy Assessment Units
EVA	Electrical Vacuum Aspiration
FDA	Food and Drug Administration
FPAN	Family Planning Association of Nepal
FRHAM	Federation of Reproductive Health Associations Malaysia
FWLD	Forum for Women Law & Development
HCD	High Court Division of the Supreme Court of Bangladesh
HGM	His Majesty's Government
HRC	Human Rights Committee
IACHR	Inter-American Commission on Human Rights
ICC	Indonesian Criminal Code
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economics, Social and Cultural Rights
ICPD	International Conference on Population and Development Programme of Action
IPC	Indian Penal Code
IPV	Intimate Partner Violence
IUD	Intrauterine Device
JAG	Joint Action Group of Gender Equality
LGBTQIA+*	Lesbian Gay Bisexual Transgender Queer Intersex Asexual Plus
LMP	Last Menstrual Period
MCW	Magna Carta of Women
MMA	Medical Abortion Pills
MA	Medical Abortion
MMR	Maternal Mortality Rate
MoHFW	Ministry of Health & Family Welfare
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medicine
MRTSP	Menstrual Regulation Training and Services Programme
MTP	Medical Termination of Pregnancy Act, 1979
MVA	Manual Vacuum Aspiration
NCPFP	National Committee for Population and Family Planning
NGO	Non-Government Organisation
NWO	Nepal Women's Organisation
OB-GYN	Obstetrics and Gynaecology
OHCHR	Office of the High Commissioner for Human Rights
OT	Operation Theatre
PAC	Post-Abortion Care
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994
PHC	Primary Health Centre
PINSAN	Philippine Safe Abortion Network
PMAC	National Policy on Prevention and Management of Abortion Complications
POCSO	The Protection of Children from Sexual Offences Act, 2012
POGS	Philippine Obstetrical and Gynaecological Society Guidelines on "Ethical Issues in Fetomaternal Care"
PPC	Pakistan Penal Code
PPH	Postpartum Haemorrhage
RPC	Revised Penal Code
RPRHA	Responsible Parenthood and Reproductive Health Act
RRAAM	Reproductive Rights Advocacy Alliance Malaysia
RSA	Referral System for Safe Abortion
SAAF	Safe Abortion Action Fund
SC	Supreme Court
SMRHR	Safe Motherhood and Reproductive Health Rights Act, 2018
SONA	State of the Nation Address
SPC	Spanish Penal Code
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SMRHR Act	Safe Motherhood and Reproductive Health Rights Act
SMRHR Regulation	Safe Motherhood and Reproductive Health Rights Regulation
STD	Sexually Transmitted Diseases
TFR	Total Fertility Rate
TOP	Termination of Pregnancy
TSC	Technical Sub Committee
UNFPA	United Nations Population Fund
UNHRC	The United Nations Human Rights Council
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organisation

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EXECUTIVE SUMMARY

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

The Key questions this study seeks to answer are:

1. What is the legal status of abortion in each country?
2. What is the role played by the criminal legal framework in creating barriers to accessing abortion services?
3. How does criminalisation of abortion impact access to abortion services?

The study followed a qualitative research approach with semi-structured interviews as the primary method of data collection. These in-depth, semi-structured, online, as well as face-to-face (where possible) individual interviews were conducted with key stakeholders including feminists, academics, lawyers, healthcare providers, policy makers, service providers and activists working on the ground. The interviews were voluntary, audio-taped, transcribed verbatim and analysed for thematic contents by the standard content analysis framework. The interviews focused on self-perception of the participants with regard to the study questions, as the research conducted was exploratory in its approach. The analysis below primarily draws from the insights gained during interviews and is supplemented by the literature review.

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

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

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

The study highlights prosecution, harassment and intimidation of healthcare providers and abortion seekers in nine out of ten countries establishing an urgent need for legal reforms within an anti-carceral framework including decriminalisation of abortion.

CHAPTER 1

INTRODUCTION

A university student from Jakarta, Indonesia recalled her traumatic experience of getting an abortion from an unauthorised clinic. After she got pregnant, she was clear that *"keeping it was never an option."*[1] The experience was distressing for her because of the lack of compassion of the service providers. For a year after the procedure, she faced many complications but did not visit a doctor since abortion is criminalised in Indonesia, except under certain circumstances.[2]

In Malaysia, a qualitative study documenting women's experiences with abortion narrated unpleasant and disheartening experiences of people seeking abortion services.[3] One of the participants said:

> *"For me it is very difficult. If you get pregnant, if you want to do abortion, you cannot go to a government clinic or hospital. You can only come here [private clinic]."*[4]

She also spoke about the financial burden she had to incur because abortions are illegal, unless performed to save the life of the pregnant woman.[5]

> *"Yeah, money is a problem because my husband is the only one working. I am a housewife with three children and also, I have to support my father-in-law. I take pills because the first time I did washing [surgical abortion] it cost almost RM500 (approximately USD 112)."*[6]

In the Philippines, scholars argue that abortion services were provided and legally permitted prior to Spanish colonial rule and the imposition of Catholicism in the late nineteenth century.[7] Abortion was criminalised with the enactment of the Spanish Penal Code (SPC) of 1870, which remained in force from 1887 – 1931.[8] After the United States of America (USA) took control of the Philippines, the legal prohibition on abortion was retained in the Revised Penal Code (RPC) enacted in 1932.[9] Articles 256 – 259 of the RPC prohibit and criminalise abortion.[10] This framework of criminalisation makes Philippines' abortion laws the most restrictive in Southeast Asia, with a disproportionate impact of criminalisation on marginalised persons.[11]

In an incident documented in a study in the Philippines,[12] a young woman from Manila faced discrimination, pressure, and abuse by her healthcare providers.[13] Her experience as documented in the study has been quoted as follows:

> *"Terrified and haemorrhaging after taking an unregistered drug to induce an abortion, Kaye, a young woman from Manila, sought medical treatment at a government hospital. Instead of prompt and compassionate care, she was verbally abused by the staff and had to wait for almost 24 hours before receiving life-saving treatment for her complications. Hospital workers refused to provide treatment until Kaye admitted that she had self-induced an abortion. After the forced confession, she was immediately reported to the police by hospital staff. Police officers came to the hospital and brought Kaye to jail, where she was charged and detained for illegally inducing abortion."*[14]

A few doctors in Manila have reported that they have stopped providing abortion services because they were almost caught in entrapment operations.[15] Although there is a clandestine network of doctors that provide these services, they are kept extremely confidential owing to the fear of prosecution.[16]

In Nepal, Lakshmi Dhikta, a Dalit woman who lived in a rural area, was forced to give birth for the sixth time because she could not afford having an abortion in a government hospital.[17] The cost of obtaining an abortion was 1130 Nepalese rupees (approximately USD 8.75).[18] Her strenuous financial situation was worsened by the need to provide for a sixth child. In *Lakshmi Dhikta v. Nepal* (2009),[19] the Supreme Court of Nepal found that Lakshmi's reproductive rights were violated due to the structural barriers in accessing abortion services resulting from her class and caste positions.[20] The Court held that anything that prevents a person from exercising the right to abortion and forces them to continue their pregnancy is a violation of the rights guaranteed by the Nepalese Constitution and other laws.[21] However, despite this progressive jurisprudence, a recent 2023 study found that:

> *"Women with lower socioeconomic status, including young, non-married, less educated, less wealthy, and from the Dalit caste were more likely to present for an abortion beyond 10 weeks. Some logistical factors also increased the chance participants presented at or beyond 10 weeks, such as traveling more than 3 hours to get to the clinic, discovering pregnancy after six weeks gestation, and having previously attempted to terminate the pregnancy elsewhere."*[22]

In the Indian State of Tamil Nadu, as with much of the rest of India, poor and marginalised women overwhelmingly seek reproductive healthcare, including abortion services at public health facilities.[23] The anecdote quoted below details the experiences of a woman from Tamil Nadu who sought abortion services, and reveals that health facilities, government-run health facilities in particular, are hostile towards persons seeking termination of their pregnancies. This hostility is attributable to stigma and cultural vilification of abortion, even though abortion is conditionally legal under the Medical Termination of Pregnancy Act, 1971 (MTP Act):[24]

> *"I pleaded to the doctor to do an abortion. I cried, pleaded and begged. My husband had left me knowing I am pregnant… to get married to another woman… I do not have anyone else. Will you please do an abortion? I can't raise the children alone, and I am just a casual labourer, and there is no one else to support me. The doctor said that I have to stay there for ten days for observation. It [my pregnancy] was only 48 days then. They kept tablets in my vagina, and it did not come out. Then they gave oral pills every alternate day; it still did not happen. Each tablet cost Rs. 500 [US$ 6.7]. One day the senior lady doctor came for rounds and began to comment in a very rude manner, you would go and lie down to* evannukko *(some man), and is it our job to do abortion for you?"*[25]

The above quote is from a participant in a 2022 study by Bhuvaneswari Sunil, which offers insight into the on-ground realities of the abortion landscape in India.[26]

The criminalisation of abortion and the legal restrictions placed on access to sexual and reproductive healthcare services significantly impact the health and rights of persons with capacities for pregnancies and other reproductive health needs. Restrictive abortion laws coupled with the socio-cultural norms that further a stigmatised discourse on abortion are significant points of contestation for abortion rights advocates in these countries. The stories above highlight the fact that legal restrictions on abortion impede access to abortion on the ground. There is a significant difference between the legal permissibility of abortions and the realities in terms of on-ground accessibility of the service, especially for marginalised persons. Strict laws surrounding abortion like those in the Philippines, make it significantly more difficult to access safe abortion services, while also creating a culture of fear and stigma around abortion and post-abortion care. Notably, significant barriers to abortion access are also prevalent in countries where abortion is legalised under certain conditions. Indonesia, Malaysia, Nepal and India, all have laws that allow pregnant persons to avail abortion services, though the extent of permissibility varies in each context. However, as demonstrated in the cases and instances quoted above, pregnant persons who wish to access abortion services still face hostility and discrimination due to cultural stigma, also reflected in the continued criminalisation of abortion under the respective penal codes of these countries, abortion being legal only in specific circumstances.

Abortion has long been a controversial issue in the Global North as well as the Global South.[27] Historically, most countries have criminalised abortion, although recent legal reforms have led to liberalisation of laws in many parts of the world.[28] In 1920, Russia became the first country to legalise abortions during the first trimester, though abortion was subsequently banned and criminalised by the Stalin regime in 1936.[29] However, this ban was lifted in 1955 after the death of Stalin and abortion remains decriminalised in Russia.[30]

Notably, significant barriers to abortion access are also prevalent in countries where abortion is legalised under certain conditions.

Marge Berer, tracing the history of abortion laws, notes that abortion was legally restricted in almost every country by the end of the 19th century.[31] The most important sources of such laws were the legal systems of imperial European countries like Britain, France, Portugal, Spain and Italy,[32] which imposed their domestic laws forbidding abortion on their colonies.[33] Further, Berer argues that the reasons for restrictions on abortion are threefold:[34]

> 1. *"It was believed that abortion was dangerous, and abortionists were killing women. The laws therefore sought to protect women—who nevertheless sought abortions and risked their lives in doing so (as they still sometimes need to do today).*
> 2. *Abortion was considered a sin or a form of transgression of morality, and the laws were intended to deter and punish.*
> 3. *Abortion was restricted to protect foetal life in some or all circumstances."*

Bela Ganatra argues that in South Asia and Southeast Asia, abortion activism is largely centred on the issues of services and accessibility, rather than the legal barriers.[35] However, it is imperative to unpack the legal barriers to enable a more holistic understanding of challenges to accessing abortion services. Abortion laws in South Asian and Southeast Asian countries are situated within a paradigm of criminalisation.[36] The challenges that stem from such criminalisation are compounded by the social stigma and cultural unacceptability

of abortion. Such cultural inaccaptability is a social phenomenon rooted in the widespread and systemic need to control women's sexuality and bodies, and is perpetuated by unequal power structures and cis-heteronormative gender norms.[37]

Significantly, in many countries in the Global South, abortion is permitted by law, with a few exceptions due to political, economic, and social contexts. For instance, in Vietnam, there are very few legal restrictions on abortion services.[38] In 1954, Vietnam, newly liberated from French colonial rule, underwent significant reforms in it's sexual and reproductive health policy, beginning with law on marriage and family, which was adopted in 1960 and guaranteed the protection of the rights of women and children.[39] The trajectory continued with the implementation of Vietnam's first population policy in 1963.[40] To reduce the rate of population growth, this policy required each family to have fewer children spaced out over five or six years, promoted the use of intrauterine devices (IUDs) and condoms, and made abortion services available at some health facilities.[41] In 1977, Vietnam's family law aimed to promote women's rights by creating a favourable climate for contraception use.[42] Such policies continued in post-independence Vietnam, whose liberation from colonial rule was marked by policies that recognised women's autonomy.[43] The country now has one of the most liberal abortion policies in Southeast Asia. Vietnam's protection of abortion rights is a radical decriminalising stance.[44]

However, in other countries, abortion laws are more restrictive—such as in the Philippines, where the Catholic Church exercises immense power and extensively influences the politics to push for an anti-abortion agenda.[45] There is a consequent fear of seeking post-abortion care due to the strict criminalisation of abortion and threat of being reported. The next section gives a bird's eye view of the legal regulation of abortion in each of these countries, which is then elaborated upon in Chapter II.

CRIMINALISATION OF ABORTION IN SOUTH ASIA AND SOUTHEAST ASIA: AN OVERVIEW

It is essential to understand the colonial and postcolonial history of abortion to comprehend the legal framework on abortion in a few countries in Asia. This study focuses on ten countries, of which eight (i.e., the Philippines, Vietnam, Sri Lanka, Pakistan, Bangladesh, Malaysia, Indonesia, and India) have a colonial history. Therefore, colonial legal orders have significantly framed the current abortion laws in these countries. The other two countries of Nepal and Thailand do not have a colonial history but mirror the framework of criminalisation to some extent. In South Asia, restrictive abortion laws in India, Pakistan, Sri Lanka, Bangladesh and Malaysia are rooted in British colonial laws.[46]

In Southeast Asian countries such as the Philippines, access to abortion continues to be very restricted owing to the criminalisation of abortion, first under the SPC of 1870 and then under the RPC adopted after the USA took control of the country.[47] This criminal framework has remained in operation in the Philippines even after the formal recognition of its status as an independent country in 1946.[48] Criminalisation was mirrored in Indonesia, whose legal system is derived from the Dutch and the British systems, and Article 299 of the Penal Code of Indonesia currently criminalises abortion.[49]

In other countries where abortion laws are more restrictive, there is a consequent fear of seeking post-abortion care due to the strict criminalisation of abortion and threat of being reported.

Vietnam was a French colony, and when France saw a decline in fertility rates in the early 20th century, they passed more stringent measures to end the practice.[50] To this effect, in addition to the criminal status awarded to abortion, a 1920 law penalised acts that could "incite abortion" or act as propaganda for contraception,[51] which was changed to a civil liability in 1923. Legal reforms in France in1939 placed further sanctions on abortions. First, the 1923 prohibition of attempted abortion was confirmed; next, the punishment for "professional abortionists" was increased, and finally, the term "pregnant woman" was broadened to "whosoever procured an abortion or attempted to procure an abortion on a pregnant woman or a woman who is presumed to be pregnant."[52] This meant any woman who tried to seek an abortion could be charged, whether or not they succeeded, or were even actually pregnant.[53] Further, self-induced abortion was also penalised, albeit with lesser punishment and finally, formal authorisation was given to "therapeutic abortions" to save the life of a woman who could be in danger.[54] There is no explicit mention in any source that the 1920, 1923, and 1939 laws changed the status of abortion in Vietnam the same way they did in France. However, since most laws of the colonial rulers were imposed upon colonial subjects, it may be deduced that these laws did in fact bring about a similar change in the legal status of abortion in Vietnam.[55]

Further an analysis of the legal system in Malaysia reveals that abortion law was introduced under the colonial British Empire's Indian Penal Code of 1860.[56] According to Section 312 of the Penal Code of Malaysia, abortion is criminalised, but "is permissible to save the life of a woman or to preserve her physical and mental health."[57] Only general practitioners registered under the Medical Act, 1971 are allowed to provide abortion services.[58] Under the Syariah law, which is only

applicable to Muslims, the *Fatwa* (a ruling on a point of Islamic law given by a recognised authority) issued by the National Fatwa Council in 2002[59] allows for abortion to be carried out under 120 days of gestation if the pregnant woman's life is under threat, or in case of foetal anomalies. However, there have been two amendments to Section 312 of the Penal Code of Malaysia—one in 1971 to permit abortion to save a woman's life, and another in 1989 to permit provision of abortion services to preserve a "woman's physical and mental health".[60]

In pre-partitioned India, which constituted modern day India, Pakistan and Bangladesh, criminalisation of abortion can be traced to colonial times in 1803 when the prohibition against abortion (when a woman was "quick with child") carried a punishment of death in Great Britain and Ireland.[61] These laws continued to remain in force through their incorporation in the penal codes of each of these countries under colonial rule, which remained operative even after they gained independence.

For India, the Indian Penal Code, 1860 (IPC), which was imposed as a part of British colonial law, is the governing law that fully criminalises the act of "causing miscarriage."[62] In 1971, the Medical Termination of Pregnancy (MTP) Act was enacted as an exception to the criminal law, and effectively legalised abortion in a broad range of circumstances up to a gestation period of 20 weeks.[63] Recent amendments to the MTP Act, first in 2002 and then 2021, have further liberalised the law.[64] However, while abortion is legal under certain conditions, the criminal law framework continues to govern the circumstances that are not covered under the MTP Act.[65]

Similarly, in Pakistan, abortion law under the Pakistan Penal Code, 1860 (PPC) was amended in 1990 to *"conform better to Islamic teachings regarding offences against the human body."*[66] Therefore, the penalties for illegal abortion depend upon whether the organs of the foetus have fully developed. Before the organs are formed, abortion is permitted to save the life of the pregnant woman or to "provide necessary treatment."[67] If these conditions are not fulfilled, the termination of a pregnancy is penalised under *Tazir* by imprisonment for a period of three to ten years as per *Isqat–i–Haml* under Section 338A of the PPC.[68] After the organs are formed, abortion is only permitted to save the pregnant woman's life, and if the condition is not fulfilled, traditional Islamic penalties in the form of compensation and imprisonment for up to seven years are imposed as per Section 338C of the PPC.[69]

Further, abortion is criminalised in Bangladesh under Sections 312 – 318 in the Penal Code of 1860. The only exception is when abortion services are provided to save a woman's life.[70] However, Menstrual Regulation (MR) has been permitted by the government since 1979 as part of its family planning policy.[71] MR is used to *"regulate the menstrual cycle when menstruation is absent for a short duration"* through manual vacuum aspiration or a combination of mifepristone and misoprostol.[72] It can be performed by doctors up to 12 weeks from the last missed menstruation and up to ten weeks by paramedics and nurses.[73]

In Sri Lanka, pregnant persons do not have access to abortion except under life-saving circumstances.[74] It is one of the most restrictive laws in South Asia, and the criminalisation of abortion finds its roots in the colonial legal order of the British which sought to *"protect the sanctity of foetal life"* and deemed abortion to be a "sin."[75] Consequently, the Sri Lankan Penal Code of 1883 deemed abortion a crime, except when provided to save the life of the woman and the code continues to remain in operation.[76]

It is pertinent to note that while colonial legal order has played a significant role in eight of the ten countries, the two remaining countries, i.e., Nepal and Thailand have never been formally subject to colonial rule.[77] Therefore, it is imperative to understand the complexity of legal regulation of abortion beyond the colonial legal order.

Prior to the liberalisation of abortion laws, the *Muluki Ain* (Nepal's legal code that is based on ancient Hindu scriptures),[78] criminalised abortion by equating it to infanticide. This resulted in malicious incarceration of women undergoing induced or spontaneous abortions to ensure that they forfeited their right to property.[79] Nepal became a constitutional monarchy in 1990 and had a democratically elected government by 1991. Women's rights saw significant expansion during Nepal's political transition from an absolute monarchy to a parliamentary monarchy.[80] The Constitution of 1990 mandated the fundamental right to equality for both men and women. The movement towards liberalisation of abortion laws has spanned over three decades, with positive legal developments to this effect in 2002,[81] when access to abortion was made available on-request up to 12 weeks of gestation.[82] Subsequently, in 2018, the Safe Motherhood and Reproductive Health Rights (SMRHR) Act was passed to expand access to abortion services.[83] Even though Nepal currently has a very liberal abortion law, a parallel criminal law framework contimues to exist.

It is pertinent to note that while colonial legal order has played a significant role in eight of the ten countries, the two remaining countries, Nepal and Thailand have never been formally subject to colonial rule.

Notably, though Thailand was never under colonial rule, it does have a semi-colonial history, as argued by Singh,[84] who notes that semi-colonialism is where a metropolitan country exerts power and influence in an asymmetrical relationship, without such power being exerted as outright domination and formal sovereignty over the colonial state.[85] The semi-colonial status of Thailand was what prompted the establishment of international law and cemented its validity by means of unequal treaties between the colonial powers and the semi-colonial states like Siam. This also meant that the legal framework in these semi-colonial states was not free from the influence of colonial era laws. Consequently, similar to the colonial states, abortion has been historically criminalised under Sections 301 – 305 of the Thai Penal Code, or Criminal Code of 1908, and is punishable except under limited circumstances.[86] The criminalisation provision extends to consensual abortion by a pregnant woman, abortions provided without consent and attempted abortions.[87] The only exceptions are to save the life of the pregnant women in case of "indecent act" or a rape.[88] However, a Supreme Court ruling in 2020 held that the criminalisation of abortions was unconstitutional, pursuant to which abortion has been partially decriminalised in Thailand.[89]

Calls for decriminalisation of abortion arose only recently.[90] Initially, the global abortion rights movement was focussed on "safe legal abortion."[91] While legalising abortion refers to making abortion permissible under the law and identifying the grounds on which it is allowed, decriminalising abortion means removing all criminal sanctions against abortion. As of 2010, the statistics for legal abortion worldwide were as follows:[92]

Percentage of world's countries were abortion was legally permitted to save the life of the woman.	98%
The proportion of countries allowing abortion on other grounds:	
To preserve the woman's physical health	63%
To preserve the woman's physical health	63%
To preserve the woman's mental health	62%
In case of rape, sexual abuse, or incest	43%
Foetal anomaly or impairment	39%
Economic or social reasons	33%
On request	27%

Further, based on the data as recorded by the Center for Reproductive Rights up to September 27th, 2022, the global status of abortion laws is as follows:[93]

Number of countries worldwide that:	
Have completely prohibited abortion	23
Permit abortions to save the pregnant woman's life	42
Permit abortions to preserve the woman's health	47
Permit abortions for social or economic reasons	13
Permit abortions on request, subject to upper gestational limits	76

Several countries have recently decriminalised (partially or completely) abortion including Chile,[94] Argentina,[95] South Korea,[96] Thailand,[97] and Columbia[98] among others.

Stakeholders from across South Asia and Southeast Asia have been working towards legal reforms to centre access to safe abortion services.[99] Vietnam and Thailand have made some progress in the fight towards decriminalisation (partial in the case of Thailand), with the Constitutional Court of Thailand's recent decision in 2020, ruling the criminalisation of abortion to be unconstitutional. As of October 2022, the Ministry of Public Health issued a regulation that extended the 12-week period to 20 weeks for abortion on demand. Women seeking abortion services between 12 to 20 weeks of gestation need to get an approval of an authorised medical practitioner and abortion beyond 20 weeks is still not allowed.[100] Nepal[101] and Bangladesh[102] have witnessed recent constitutional challenges seeking decriminalisation of abortion, whereas Indonesian activists are working to increase the gestational limit up to which abortions are permitted. In the Philippines, we see a continued struggle for liberalisation of abortion laws as feminist movements fight to counter the religious stigma and opposition associated with abortion despite severe backlash and in some cases, penal consequences for advocating for expansion of safe abortion services. There is, therefore, a need to critically assess the legal regulation of abortions, the factors contributing to the same, and the manner in which a path towards decriminalisation may be paved.

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

RATIONALE AND OBJECTIVE OF THE STUDY

A review of abortion laws in the ten countries that form the subject of this study, and a comparative analysis thereof, especially in the context of colonialisation, demonstrate that the history of criminalisation of abortion is a direct result of colonial penal provisions from British, French, Dutch and Spanish laws in at least eight countries. In all of these postcolonial States except Vietnam, the original and unamended provisions of the penal laws that criminalise abortion services still exist today, only tempered by other specific laws that govern the exceptions for such punishment.

While much scholarship has focused on the abortion law framework in the Global North, there is limited literature and comparative analysis on abortion laws in the Global South, especially in South Asia and Southeast Asia. This study therefore seeks to critically examine the legal framework of abortion in ten countries in South Asia and Southeast Asia namely, the Philippines, Thailand, Indonesia, Vietnam, Malaysia, Nepal, Pakistan, India, Sri Lanka, and Bangladesh, and study the legal framework that regulates access to abortion services. The study further engages with the impact of a criminal law framework on access to abortion services in these countries and the subsequent need to decriminalise abortion. The study also reveals ongoing efforts towards decriminalisation of abortion in some jurisdictions and concludes with broad recommendations.

METHODOLOGY

This study seeks to comprehensively examine the legal framework on abortion in countries of South Asia and Southeast Asia and map the historical trajectories of these laws.

We have selected five countries from South Asia and five countries from Southeast Asia. In each of these regions, we looked at countries that have progressive legal frameworks, as well as the ones that have highly restrictive ones. We prioritised countries with recent legal developments around decriminalisation including Nepal, Thailand, India, and Bangladesh. There are several other important countries in Asia with significant legal developments on abortion including Cambodia, Bhutan, Laos, Myanmar, etc. that this report is unable to capture.

The study followed a qualitative research approach with semi-structured interviews as the primary method of data collection. These in-depth, semi-structured, online and in-person individual interviews were conducted with key stakeholders including feminists, academics, lawyers, healthcare providers, policy makers, service providers, and activists working on the ground. 81 persons were interviewed over the course of 14 months via Zoom, and, where possible, in person interviews were conducted. We only spoke to experts who had spent significant time working on gender and reproductive rights. We received approval to conduct the study from the Jindal Global University Research and Ethics Review Board on 9th September 2021. Six of the respondents requested that their details remain confidential. We have identified them as 'Respondent A, B, C, D, E and F.' The analysis in the following chapters. Chapter III in particular, primarily draws from the insights gained during interviews and is supplemented by the literature review for each of the countries.

While much scholarship has focused on the abortion law framework in the Global North, there is limited literature and comparative analysis on abortion laws in the Global South, especially in South Asia and Southeast Asia.

The interviews were voluntary, recorded, transcribed verbatim, and analysed for thematic contents by the standard content analysis framework. The interviews were primarily conducted in English, and professional interpreters were used for some respondents in Thailand, Indonesia, and Vietnam. The interviews focused on self-perception of the participants with regard to the research questions, as the research conducted was exploratory in its approach.

RESEARCH QUESTIONS

The Key questions this study seeks to answer are:

1. What is the legal status of abortion in each country?
2. What is the role played by the criminal legal framework in creating barriers to accessing abortion services?
3. How does criminalisation of abortion impact access to abortion services?

LIMITATIONS

This is a focused study that looks at the status of abortion in the ten countries identified above, tracing the legal history of abortion regulation, the legislative frameworks governing the same, and the status of criminalisation and its consequent impact on access to abortions in the respective jurisdictions. The author is cognisant of the heterogeneous contexts and their influence on the landscape of sexual and reproductive health and rights (SRHR) in the differing contexts. These include religious, social and cultural differences, as well as

other particularities that stem from historical legal constructs and doctrines, in addition to the political economy of sexual and reproductive health in each country. However, the scope of this study is restricted to understanding the repercussions of criminalisation of abortions and its impact on access to abortion services, and to propose broad recommendations for a rights-based framing of abortions. This study is unable to capture the complex and heterogeneous demographic nuances of each country.

The analysis documented in the shapters below primarily draws from the insights gained during interviews. Though information on each country's SRHR landscape was informed by at least five interviews, it was difficult to obtain as much information from Vietnam. Many of the laws in Vietnam are in Vietnamese with no English translation, leading to a language barrier which limits the scope of analysis for the country.

ROADMAP

This study has been divided into five chapters. This introductory chapter provides a brief background to the subject-matter of the study, while detailing the rationale and methodology adopted for the comparative research and analysis undertaken for the ten countries mentioned above. This chapter is followed by a detailed review and analysis of the historical evolution of abortion laws in each of the ten countries on the Philippines, Thailand, Indonesia, Vietnam, Malaysia, Nepal, Pakistan, India, Sri Lanka and Bangladesh. The second chapter also outlines the legal framework of abortion laws in each country, while tracing the significant judicial and legislative developments in every jurisdiction. The legal analysis in Chapter II forms the basis of the thematic analysis undertaken in the Chapter III, which is substantially informed by the findings and observations documented through the qualitative interviews with 81 respondents in the ten countries. This chapter alludes to the common thematic challenges and barriers to accessing abortions that persist in the ten countries of South Asia and Southeast Asia, each of which (except Vietnam) have an overarching framework of criminalisation as the most significant challenge in terms of access to abortions. It looks at the impact of religious and socio-cultural influences that further the stigma and taboos around abortions, the disproportionate impact of criminalisation on healthcare providers, and its lopsided consequences for marginalised persons, as evidenced through instances of prosecution in each country. The analysis in Chapter III lends itself to broad recommendations for decriminalisation of abortion services and other reforms that are listed in Chapter IV of the study. These broad recommendations identify some common overlapping concerns and challenges across the countries. The final chapter of the study records some concluding observations to the study.

ENDNOTES FOR ABBREVIATIONS, EXECUTIVE SUMMARY, AND CHAPTER 1

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

* The study also uses the term "transgender persons" to highlight the experiences of persons whose self-determined gender identity and expression does not subscribe to a binary framework of gender. However, we are mindful of the fact that the term 'transgender person' is not uniformly applicable in all the distinct contexts, where there are regional identifiers for gender-variant persons. The use of the term transgender persons in this report is also in view of the usage of the terminology by the Courts and other forums which have been referred to in this study.

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

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

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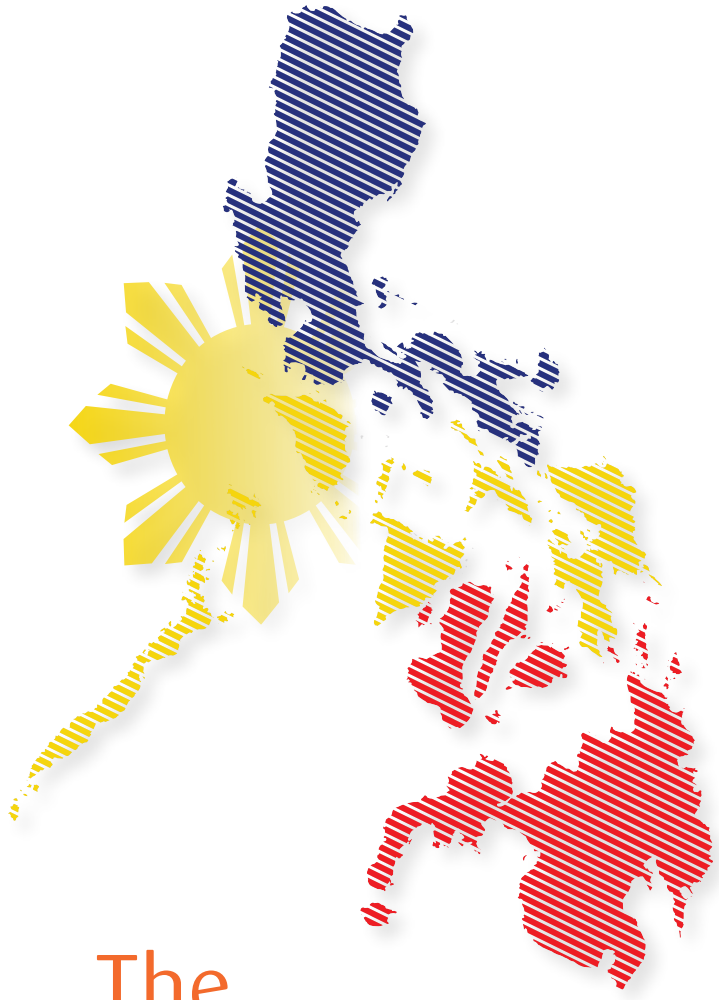
CHAPTER 2

LEGAL FRAMEWORK ON ABORTION IN ASIA: COUNTRY-WISE ANALYSIS

INTRODUCTION

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

It is imperative to critically assess the historical trajectory of abortion regulation and legal barriers to abortion access in order to comprehend the structural challenges. Accordingly, this section analyses the judicial and legislative developments that have contributed towards the current framework of abortion laws in each of these countries.



The Philippines

BACKGROUND

In the Philippines, access to abortion is restricted to cases of therapeutic abortion. Many Filipino women continue to experience unwanted pregnancies. The most significant challenge faced by Filipino women is the restrictive legal framework with respect to their reproductive rights.[1] They experience relatively low levels of contraceptive use, high levels of unintended pregnancies and frequent abortions. This is evident in the high levels of maternal mortality.[2] Further, given the fact that abortion services are not just restricted but highly stigmatised, many women, especially those from marginalised socioeconomic backgrounds, undergo unsafe abortions.[3] According to the Guttmacher Institute, there were a total of 3,770,000 pregnancies annually between 2015-2019, of which 1,930,000 were unintended and 973,000 ended in abortion.[4] Based on these figures, approximately 1 out of 2 pregnancies are unintended and 1 out of 4 pregnancies end in abortion. Data records from 2018 reveal that there were 560,000 induced abortions that took place that year, with 90,000 women having sought treatment for post-abortion complications. The data also reported 1,000 deaths, a direct result of the restrictive abortion laws in the country.[5] These were preventable deaths that could have also been avoided through availability of information and acces to modern contraceptives in the Philippines, especially in the city of Manila.[6] This is primarily attributable to the political power wielded by the Catholic Church Hierarchy, as well as its influence on society and government officials, which condemn abortion and forbid the use of modern contraceptives. However, religious factors alone are not the root cause of the scepticism around use of modern contraceptives. It is fuelled by myths associated with contraceptive use.[7]

The Philippines government first took note of unsafe abortions in 2000, when it introduced the Prevention and Management of Abortion Complications policy (PMAC) which clarified the legal status of medical treatment in cases of post-abortion complications.[8] This policy was an attempt at addressing the issue of unsafe abortion services. However, the lack of proper implementation of PMAC resulted in unsafe abortions being a persisting issue in the Philippines.[9]

International law establishes a broad range of obligations for national governments in relation to healthcare.[10] It requires governments to ensure the availability of healthcare services including reproductive healthcare services.[11] The Philippines ratified the United Nations Convention for Elimination of All Forms of Discrimination against Women (CEDAW) in 1981 and its optional protocol in 2003.[12] The International Conference on Population and Development Programme of Action (ICPD) was adopted by the Philippines in 1994.[13] In 2009, the government enacted a national law called the Magna Carta of Women (MCW) to codify the principles of CEDAW.[14]

The Philippines government first took note of unsafe abortions in 2000, when it introduced the Prevention and Management of Abortion Complications policy (PMAC) which clarified the legal status of medical treatment in cases of post-abortion complications. This policy was an attempt at addressing the issue of unsafe abortion services. However, the lack of proper implementation of PMAC resulted in unsafe abortions being a persisting issue in the Philippines.

In 2012, during a special inquiry, the CEDAW Committee *"reiterated its concern about the harmful consequences of the criminalisation of abortion" and further noted "the disproportionate and discriminatory impact of these laws and policies on vulnerable groups of women including adolescent girls, poor women and those in abusive relationships."*[15] The Philippines government did not formally accept the Committee's reccommendations, but instead introduced the Responsible Parenthood and Reproductive Health Act (RPRHA) in 2012.[16] The RPRHA provides for modern contraceptive services and counselling and sex education, especially to the rural Filipino women. It provides for treatment of post-abortion complications in a "humane, non-judgmental and compassionate manner in accordance with law and medical ethics."[17] The RPRHA intended to expand rights to contraceptive access and was unsuccessfully challenged in the Philippines' Supreme Court by anti-choice groups, claiming *"that certain registered contraceptives are abortifacients."*[18]

LEGISLATIVE AND JUDICIAL REFORMS

As a former Spanish colony, Philippines' RPC is deeply rooted in the SPC.[19] Notably, the Philippines continues to retain the framework of criminalisation that was adopted by the SPC, while Spain allows abortion up to 14 weeks of gestation period.[20] Under the RPC, abortion is a punishable offence.[21] Consequently, access to therapeutic or medically necessary abortions is not guaranteed even in cases where the life of a pregnant woman is at risk.[22] Further, the law also permits abortion even in cases of women or girls who become pregnant as a result of rape or incest.[23] The criminalisation of abortion has not only made abortion unsafe, but has also undermined the ability of pregnant persons to access lifesaving post-abortion care which is legal.[24] Abortion is highly stigmatised in the medical community owing to its criminal status under the law.[25]

> Laws under the Midwifery Act of 1992, Medical Act of 1959, and Pharmacy Act 2016 authorise *"the revocation or suspension of the licences of any practitioner who performs abortions or provides abortifacients."*[26]

The main opposition to abortion is rooted in religious factors. The Philippines is predominantly a Catholic country and the Catholic Church wields power in several spheres of Filipino society. The Church was an important actor in the 1986 Revolution that overthrew Ferdinand Marcos' authoritarian regime.[27] The President that followed, Cory Aquino, *"was much more pliant to the Church's wishes."*[28] The Constitution of 1987, which is currently in effect is also known as the "Cory Constitution."[29] Article 2, Section 12 of the Constitution provides that "[t]he State recognizes the sanctity of family life and shall protect and strengthen the family as a basic autonomous social institution. It shall *equally protect the life of the mother and the life of the unborn from conception*."[30]

Scholars have argued that the drafters of the Constitution did not intend to universally restrict abortion access.[31] The drafters specifically recognised *"the Roman Catholic principle of double-effect, according to which the termination of a pregnancy may be permitted when the intended effect is to preserve the life of a pregnant woman."*[32]

The 'catholic hierarchy' especially of the Catholic Bishops Conference of the Philippines (CBCP), exercises considerable influence over the legislative and political processes and actively opposes women's reproductive rights. During the drafting of the Philippine Constitution of 1987, the CBCP tried its best to push for a constitutional ban on contraceptive and abortion services but failed.[33] The eventual compromise reached on this issue allowed for equal protection to both the pregnant woman and the foetus.[34]

> **The most significant challenge faced by Filipino women is the restrictive legal framework with respect to their reproductive rights.**

Despite vehement opposition by the Church, there have been incremental legislative developments in support of reproductive health. The RPRHA extends universal access to fertility control, maternal care, contraceptive services and sexual education.[35] One of the most notable provisions of the RPRHA is the *"prevention of abortion and management of post-abortion complications."*[36] The CBCP has termed this legilstaion the 'DEATH' legislation that is likely to promote the evils of *"divorce, euthanasia, abortion, total reproductive contraception and homosexuality."*[37] This law was generally supported by the Filipino public received presidential assent in December 2012. The RPRHA was challenged before the Philippines Supreme Court in *James M. Imbong vs. Hon. Paquito N. Ochoa* (discussed in detail below). The Supreme Court ruled that the law was not unconstitutional but struck down eight provisions partially or in full.[38] In contrast to the liberalising trend in contraceptive policy, the Philippines' abortion law is among the strictest in the world.[39]

In 2016, a revised post-abortion care policy titled the National Policy on Prevention and Management of Abortion Complications (PMAC) was introduced by the Department of Health.[40] The policy considered recommendations by the CEDAW committee and clarified that there was no legal obligation to report women who received abortion services.[41]

In 2017, President Rodrigo Duterte signed an executive order for universal access to modern family planning methods and for an accelerated implementation of the RPRHA.[42] Human Rights Watch called Duterte's decision *"a bright spot in the administration's otherwise horrendous human rights record."*[43]

In 2018, a new policy for post-abortion care was introduced.[44] The policy has been critiqued by activists like Upreti and Jacobs who argue that amongst other shortcomings, the new policy fails to clarify that medical authorities are not legally obligated to report women who seek post-abortion care.[45] This lack of clarification creates barriers to accessing lifesaving post-abortion care.

The MCW adopted in 2009 is a "comprehensive women's human rights law that seeks to eliminate discrimination against women by recognizing, protecting fulfilling and promoting the rights of Filipino women, especially those in the marginalised sector."[46] It further guarantees access to post-abortion care and treatment for other pregnancy-related complications. The next section discusses the challenge to the RPRHA before the Supreme Court of Phillipines.

James M. Imbong vs. Hon. Paquito N. Ochoa [G.R. No. 204819, April 08, 2014]

The RPRHA was challenged before the Supreme Court of the Philippines shortly after its enactment, with approximately 14 petitions and 2 interventions being filed before the Court by conservative and religious groups. They challenged the constitutional validity of the RPRHA. [47]

The case was heard by a ten-judge bench of the Supreme Court.[48] The petitioners argued that abortion is constitutionally prohibited under Article 2, Section 12 of the Constitution. Therefore, allowing contraceptive services violates this constitutional provision.[49] Further, it is a violation of the right to health and protection against hazardous products because contraceptive devices are "cancerous and can cause myocardial infarction."[50] The petitioners also argued that because public funds are being used to procure contraceptives, the RPRHA violates the petitioners' right to religious freedom and the law fails to meet the "compelling state interest test."[51]

The respondents argued that the RPRHA does not violate the right to religious freedom and hence, is constituionally valid.[52] The respondents further argued that the petitioners were violating this right to religious freedom by asking the Court to "*recognise only the Catholic Church's sanctioned natural family planning methods and impose this on the entire citizenry*."[53]

The verdict was delivered by Justice Jose Mendoza with concurring opinions by Justices Carpio, Leonardo-De Castro, and Abad; a separate concurring opinion by Justice Brion; a concurring and dissenting opinion by Justices Sereno, Del Castillo, Reyes, Perlas-Bernabe; and a dissenting opinion by Justice Leonen. The Court upheld the constitutionality of RPRHA but struck down eight provisions that violated constitutional rights.[54] These provisions do not affect the RPRHA's implementation and include, for example, Section 7 which required private healthcare centres, general hospitals and hospitals owned by religious groups to transfer non-emergency patients to another facility.[55] Section 7 also allowed pregnant "minors" and "minors" who had a miscarriage to access reproductive health and family planning services.[54] Sections penalising health care service providers for failure to transfer non-emergency cases to another healthcare provider, denial of legal and safe reproductive health procedures to a minor in a non-emergmecy situation and failure to disseminate reproductive health services and programs were also struck down.[56] The third important provision struck down by the Court included provisions granting access to reproductive health services for a married person without spousal consent.[57]

In 2018, a new policy for post-abortion care was introduced. The policy has been critiqued by activists like Upreti and Jacobs who argue that amongst other shortcomings, the new policy fails to clarify that medical authorities are not legally obligated to report women who seek post-abortion care. This lack of clarification creates barriers to accessing lifesaving post-abortion care.

While the Court agreed not to make a legal determination with regard to the beginning of life, the majority verdict delivered by Justice Mendoza concluded that *a "zygote" is a human organism and life begins at conception."*[58] Further, Justice Brion agreed that life begins at conception and attributed personhood to a foetus.[59] He expressly rejected the legal rationale in *Roe v. Wade* arguing that the framers of the constitution did not want the Supreme Court to reach a similar decision.[60] Finally, the Court ruled that the obligations imposed by the RPRHA violate the right to religious freedom and "burdens the conscience of medical practitioners to provide information on reproductive health."[61] However, the Court made an exception in cases where the abortion

is required to save the life of the pregnant person. In the event that there is a disagreement between spouses on the medical procedure, the Court held that the decision of the pregnant person undergoing the procedure will previal.[62]

Therefore, the Court struck down several reproductive healthcare provisions, diluting the scope of the RPRHA. The disproportionate impact of this decision is on adolescent girls, whereby they are compelled to seek abortion services under unsafe conditions.[63]

The Philippine Obstetrical and Gynaecological Society (POGS) Guidelines on Ethical Issues in Fetomaternal Care guidelines published in 2011 provide some guidance for life-saving abortions.[64] These guidelines allow for termination of a pregnancy when it is in harmony with the principle of "double effect."[65] The principle of double effect states that "sometimes it is permissible to cause a harm as a side effect (or "double effect") of bringing about a good result even though it would not be permissible to cause such a harm as a means to bringing about the same good end."[66] However, these guidelines still prevent abortion in other situations where it would still be harmful to a woman's health.[67] However, these guidelines are extremely restrictive. For instance, they only permit surgical abortions. Further alternative methods including potassium chloride or methotrexate are prohibited because they have a direct effect on the foetus.[68]

There have been several efforts towards legalisation of abortion. For instance, the first Bill titled the House Bill 6343 introduced by Roy Padilla Jr. sought to exceptionalise abortion in cases of rape, incest, foetal anomalies and where the pregnant woman's life is in grave danger.[69] The Bill was opposed by several actors including the Commission on Human Rights on the grounds that it contradicts Article 2, Section 12 of the Constitution.[70]

A few months later, Padilla introduced another Bill titled the House Bill 7193.[71] The Bill allowed for termination of a pregnancy by a pregnant woman under the following conditions: a) where there is documented medical evidence of a threat to her life; b) in cases of foetal anomaly; and c) in cases of rape and incest which may cause a threat to her physical or mental health.[72]

The two Bills did not move beyond the stages of referral to the House Committees. However, these attempts indicate a "developing support for change in the status quo among health and human rights advocates and some political leaders."[73] This support is also evident in the change of stance of the Philippines Commission on Human Rights.[74] The Commission called for a review of the restrictive abortion laws and implications of criminalisation of abortions services and post-abortion care.[75] Following this, a Bill for decriminalisation of abortion was drafted by lawyer Clara Rita Padilla and members of Philippine Safe Abortion Advocacy Network (PINSAN). In 2022, the Human Rights Commission offered unwavering support for this Bill and endorsed decriminalisation of abortion.[76]

the Court struck down several reproductive healthcare provisions, diluting the scope of the RPRHA. The disproportionate impact of this decision is on adolescent girls, whereby they are compelled to seek abortion services under unsafe conditions.

Thailand

BACKGROUND

Thailand is a Constitutional Monarchy and was previously named Siam. It has no history of formal colonial rule.[77] However, Thailand has a shared history of semi-colonial rule with Japan and China.[78] Erstwhile Siam remained independent at a time when the British and French Empires had conquered the two bordering countries of Burma and Cambodia.[79]

It was after the promulgation of the Criminal Code of 1908 that abortion first became a subject of public discourse. This was during the reign of King Chulalongkorn.[80] Prior to this, there is limited evidence of any public discussion on abortion.[81] *Trai Phum Phra Ruang* (The Three Worlds according to King Ruang) is the first text mentions of abortion as a sinful act deserving of punishment.[82] As per this text, *pret*, a demon has incurred bad karma for committing several sinful acts, including causing a miscarraige.[83] *Prets* are therefore punished and suffer starvation. They are also cursed to birth seven babies every morning and evening.[84] Their starvation is aggravated and they devour the own babies. Despite this, *prets'* hunger remains unsatisfied.[85] This story is indicative of the sinful perception of abortions by Buddhists.

Feminist scholars argue that the lack of historical evidence of women seeking abortion services is attributable to the possibility of women having full rights to terminate unwanted pregnancies.[86] For instance, there is a record of a court case from 1905 where a man was accused of committing adultery and giving the woman "hot medicine" with the intention of terminating the pregnancy.[87] However, the judge aquitted the man due to insufficient evidence.[88] On the contrary, there was no evidence of knowledge of the pregnancy and evidence suggested that the "hot medicine" was given to help her menstruate.[89]

The lack of historical evidence about women seeking abortion in Thailand has been attributed to the possibility women may have had full rights to terminate unwanted pregnancies and such termination was considered a common practice.

Abortion was first criminalised under the Criminal Code of 1908.[90] The Code penalised abortions, infanticides and abandonment of new-born babies.[91] However, the Code was modified in 1957 and abortion was made permissible under Sections 301-305 in three circumstances: i) pregnancies caused by rape; ii) pregnancies of girls under the age of 15 years; and iii) pregnancies leading to the risk of women's health.[92]

LEGISLATIVE AND JUDICIAL REFORMS

Section 301 of the Code penalises any woman who causes herself to terminate a pregnancy or allows another person to provide abortion services to her.[93] The punishment imposed *is not more than three years of imprisonment or fine of not more than 6000 Baht, or both.*[94]

Section 305 makes exceptions in the case of medical practitioners who provide abortion services to women who are pregnant on account of *sexual assault or rape as defined in Section 276, Section 277, Section 282, Section 283, or Section 284 of the Penal Code.*[95] Medical providers are also exempted from criminal liability if the abortion services are provided in the interest of "women's health".[96] In 2005, the Medical Council of Thailand adopted a regulation that defines "women's health" under Section 305(1) to include both physical and mental health.[97]

Thailand ratified the CEDAW in 1985. The Constitution of Thailand came into effect on October 11, 1997.[98] The Constitutional Court of Thailand is the highest court in the country to adjudicate matters of constitutional law.[99] In a significant ruling, the Consitutional Court decriminalised (partially) abortion services. The case of Srisamai Chaeuchat and the verdict delivered by the Constitutional Court will be discussed next.

Abortion was first criminalised under the Criminal Code of 1908.

In 2018, Dr. Srisamai Chaeuchat, a government doctor and a member of the Referral System for Safe Abortion (RSA), was arrested for providing abortion services through the RSA.[100] Dr. Chaeuchat had provided abortion services to women with their consent. However, she was arrested by the police and charged under Section 302 of the Criminal Code. The women whose pregnancies were terminated were charged under Section 301 of the Criminal Code.[101] However, the police failed to invoke Section 305 of the Criminal Code which provides the exception in the case of medical practioners.[102]

The constitutionality of Sections 301 and 305 was challenged before the Constitutional Court. The petitioner argued that these provisions violated Sections 27, 28 and 77. Section 27 guarantees the right to equal protection of the law and equality before the law.[103] Section 28 guarantees the right to life and liberty.[104] Further, Section 77 provides for the repeal of laws that are inconsistent with constitutional values.[105]

The petitioner challenged Section 301 on the grounds of inequality, since it only punishes women for termination of a pregnancy. It was argued that pregnancy is not a 'unilateral action of a woman' therefore, a provision imposing sanctions only on women violates Sections 27 and 28 of the 2017 Constitution.[106]

The petitioner further argued that Section 305 fails to take into consideration technical and medical advancements. For instance, it only focuses on surgical abortion and does not factor medical methods of abortion (MMA).[107] Medical abortion (MA) is a procedure that uses medication to terminate a pregnancy. It does not require surgery or aneasthesia and is safe and most effective during the first trimester of pregnancy, i.e. up to 12 weeks of gestation, as per the World Health Organisation (WHO).[108] MA is provided using a combined regimen of the drugs mifepristone and misoprostol that can be used to terminate early pregnancies. Both mifepristone and misoprostol have been designated as 'essential medicines' by the World Health Organisation (WHO) since 2005. According to the WHO, *"medical abortion pills should be widely available and affordable, and do not need to be dispensed by highly trained specialists or in specialty facilities."*[109]

The petitioner sought an exemption from liability in case: (i) the pregnancy has not crossed 12 weeks of gestation, (ii) a pregnancy that was affecting the mental health of the pregnant person, or (iii) in cases of foetal anomalies.[110]

In February 19, 2020, one year after the petition was filed, the Constitutional Court ruled that the provisions under the Criminal Code were partially unconstitutional and directed the legislature to amend the Code.[111] The Court, while deliberating on the constitutionality of Section 301 held that giving preference to foetal rights over a pregnant woman's rights, is a violation of the rights of bodily autonomy and self-determination.[112] Therefore, Section 301 is violative of Section 28 of the Constitution.[113]

The Court acknowledged the limitations of the Criminal Code and the complexities around abortion services and how criminal provisions lead to unsafe abortion practices.[114] The Court therefore directed relevant state agencies to revise the Code in line with the Court's reasoning and decision as well as current practices and circumstances within 360 days.[115]

On January 25, 2021 the Thai National Assembly amended the Criminal Code to decriminalise abortion services up to 12 weeks of gestation. The amended Code was brought into effect on February 7, 2021.[116] The legislature also amended Section 305 of the Code and added a justification for medical practitioners. Under the amended Section, provision of abortion services is justified when: i) provided during the first 12 weeks of gestation; ii) the pregnancy poses a threat to the physical or mental health of the woman; iii) the pregnancy carries a high risk of foetal anomalies; or iv) the pregnancy results from a sexual assault.[117]

According to the WHO, "medical abortion pills should be widely available and affordable, and do not need to be dispensed by highly trained specialists or in specialty facilities

Therefore, abortion is now available on demand during the first 12 weeks. On September 26, 2022, the Ministry of Public Health issued a notification in the Royal Gazette that extended the 12-week period to 20 weeks for abortion on demand.[118] Pregnancies between 12-20 weeks can be terminated with prior consultation and approval from one authroised medical practitioner.[119] However, abortion beyond 20 weeks of gestation is still not allowed.[117] A more liberal draft that sought to permit abortion up to 24 weeks was rejected by the House of Representatives.[120]

As per the amendments brought into effect in February 2021, women receiving abortion services after the first trimester still face penalties, unless the termination is as per the conditions set by the Medical Council.[121] The penalties for seeking terminations in such instances have also been revised from a maximum of three years imprisonment to six months imprisonment, and reduction in the maximum fine imposed from 10,000 Thai Baht (approximately USD 290) to 6,000 Thai Baht (approximately USD 174).[122]

Many international organisations and women's rights groups in Thailand argue that the current abortion law is not adequate. Human Rights Watch issued a statement urging the government to completely decriminalise abortion.[123] Tamtang Group, an abortion rights group, and the Feminist for Freedom and Democracy Group issued a statement after the amendment to the Code was passed stating that the new law[124]:

> *"..violates human rights principles by continuing to punish people who get an abortion after the 12th week of pregnancy, even though in the past, and after the law comes into effect, there has as yet been no measures to communicate to the public so that the society has information and a correct understanding of safe abortion, or any clear measure about how the law will be enforced so that all state public health providers will provide safe abortion services or refer those who come to receive services according to the new law, which will guarantee that those who want to terminate a pregnancy will be able to receive comprehensive information and to access services within the time frame stated by the new law."*

Indonesia

BACKGROUND

Indonesia is the world's third largest democracy.[125] Its legal system is a derivative of the colonial Dutch and British systems. Due to its geographical terrain, the implementation of a single autocratic legal system has failed and given rise to legal pluralism with three legal system: (1) national law, derived from the Dutch colonial law; (2) Islamic/ Sharia Law; and (3) customary law or *Hukum Adat*.[126]

A Guttmacher Institute report from 2008 noted the relatively high rate of abortion in Indonesia, i.e., about 37 abortions for every 1,000 women of reproductive age. Most of these abortions were unsafe and conducted by traditional birth attendants, healers, or masseurs.[127]

After the fall of the Soeharto regime in 1998, the country was decentralised to ensure unity and peace. Surjadjaja, argues that the post 9/11 rhetoric polarised Islamic beliefs.[128] However, she notes that the feminist movement remained steadfast despite challenges. She concludes that *"despite these daunting challenges, the advocates of women's health in Indonesia have achieved stunning political success. Through their powerful networks of access to political decision-makers, they convinced parliament to put the health bill as a priority agenda item in the National Legislation Programme for 2005-2009."*[129]

The main opposition to abortion in Indonesia comes from conservative religious groups.[130] The Guttmacher Institute's report pointed to a survey of 105 religious leaders from 2008.[131] Though not nationally representative, the survey found that, *"the majority of religious leaders (82%) agreed that abortion is acceptable if a woman's life is in danger."*[132]

Most abortions in Indonesia occur outside the formal helathcare system. A study conducted in 2018 in Java estimated that 1.7 million abortion occurred in that year.

Barriers to access are amplified where information is limited or unavailable, the law is unclear, the cost of abortion is high, and unmet needs for contraception and obtaining the husband or family's consent remain necessary.[133] For example, the government discourages sex education, as they believe that people who disseminate information on SRHR are re-encouraging youths to have premarital sex.[134]

LEGISLATIVE AND JUDICIAL REFORMS

Abortion is criminalised under Articles 299 and 346-349 of the Indonesian Criminal Code (ICC).[135] Article 299 of the ICC imposes criminal penalties on any person who deliberately provides treatment to a pregnant woman with the intention of terminating her pregnancy.[136] A person who prompts a pregnant woman to undergo any treatment with the belief that such treatment will result in the termination of her pregnancy is also penalised under this provision and the maximum punishment imposed is four years of imprisonment.[137] Further, Articles 346-349 of the ICC penalise a woman with four of imprisonment in case she causes her own miscarriage (Article 346),[138] and any person who assists the pregnant woman will be sentenced to maximum five and a half years of imprisonment (Article 348(1))[139] which will extend to seven years if the act causes the death of the woman(Article 348(2)).[140] A person who causes the termination of a pregnancy without the consent of the woman is liable to be punished with 12 years of imprisonment (Article 347(1)).[141] If such an act results in the death of the pregnant woman, the person can be punished with a maximum of 15 years of imprisonment (Article 347(2)).[142] Finally, if a physician, midwife or pharmacist is an accomplice to the termination of pregnancy under Article 346, the punishment is enhanced by one-third of the maximum sentence and the medical license may be revoked (Article 349).[143]

An understanding was reached in the 1970s on the advice of the Chief Justice of the High Court that abortion services can be provided to save the life of a pregnant woman.

Since then, there have been continuous efforts by women's rights groups and the medical fraternity seeking legal reforms. As a result of the protracted protests and movements, the Health Law No. 23/1992 was enacted.[144] Article 15 of the Health Law states:[145]

> *"(1) Certain medical steps shall be taken in the state of emergency as part of an effort to save pregnant women and their fetus.*
> *(2) The medical steps as referred to in paragraph (1) shall be taken only:*
> *a. on the basis of medical indications which force health officers to take such steps;*
> *b. by health officers who have expertise and obligation to do so in accordance with theprofessional responsibility and consideration of a team of experts;*
> *c. with an approval from the pregnant woman concerned, or her husband or other family members;*
> *d. by the use of certain health facilities."*

It was only in 2009 that Health Law No.23/1992 was replaced by the Law No.36 of 2009 on Health (ILCH).[146] Article 75 of the Health Law of 2009 allows for the provision of abortion services up to 6 weeks of gestation period under the following conditions:[147]

i) medical emergency at early stages of pregnancy that threatens the life of the pregnant woman and/or the foetus and in the case of foetal anomalies; and
ii) if the pregnancy is the result of rape and may cause psychological trauma to the pregnant woman.

Article 76 states that abortion services as noted under Article 75 may be provided:[148]

"i) before pregnancy attains the age of six weeks counting from the first day of the last menstruation, except in the case of medical emergencies;
ii) by health workers with skill and authority with a certificate stipulated by Minister;
iii) with the consent from the pregnant mother concerned;
iv) with the permission from the husband, except rape victim; and
v) health service provider satisfying requirements stipulated by Minister."

Owing to legally restrictive setting, access to MMA pills is only through online channels.[149] Misoprostol is available under different brand names but is only registered for treating gastric ulcers in Indonesia.[150] Mifepristone is not registered and hence not accessible in the country.[151] Imports of misoprostol-containing drugs have surged in the past three years, although no precise data exists.[152] In 2015, the Ministry of Communications and Information blocked 300,000 sites selling illegal drugs "which were mostly used for abortion."[153] In 2018, the Indonesian Drug and Food Agency popularly known as BPOM reported that the Ministry of Communications and Information took down 2,217 websites selling drugs, including misoprostol for abortion.[154]

While this study was ongoing, there were two significant legislative developments. First, the House of Representatives passed the Sexual Violence Law on April 12, 2022.[155] The new law recognises nine distinct forms of sexual violence including forced contraception and sterilisation, forced marriages, among others.[156] Most significantly, the law recognises sexual violence within marital relationships.[157]

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More recently, in January 2023, Indonesia revised the Penal Code, a move that has received extensive criticism owing to the anti-rights framing of the Code.[158] Access to abortion is regulated under Sections 463 – 465 of the Code.[159] The law has expanded the category of persons who fall within the purview of "victims of rape and sexual violence experiencing pregnancy" to include instances of pregnancy that result from forced marriages, sexual slavery, sexual exploitation and sexual torture.[160] Prior to the amendment of the Penal Code in 2023, the 2009 Health Law only made abortions permissible for survivors of rape.[161] The revised Code has increased the gestational limit for the termination of pregnancies that are a result of sexual violence and rape to 14 weeks as opposed to the 6 week limit imposed by the 2009 Health Law.[162]

The enactment of the revised Penal Code in 2023 is the result of targeted advocacy and collaborative movement building by feminists, sustainable abortion advocacy groups and SRHR advocates. However, while the category of sexual violence has been expanded for the purpose of abortion access, the revisions to the Code have been critiqued extensively owing to the growing concerns around the threats to human rights posed by the law.[163]

BACKGROUND

One of the fastest growing economies of Southeast Asia, Vietnam is a socialist republic.[164] France first attempted to seize control of Vietnam in 1858 and the country was formally colonised by the French in 1885.[165]

Abortion was criminalised under Section 317 of the French Penal Code of 1810 that had a population control agenda in view of declining birth rates in France in the 19th century.[166] Abortion penalties were extremely harsh and rarely imposed, which triggered legal reform in terms of relaxation of penalties for abortion in 1923. However, the same did not alter the rates of abortion in the country, since women, especially from marginalised groups, chose to circumvent the law by carrying out unsafe unhygienic abortions at home as a method of birth control. The 1810 French Penal Code was implemented in Vietnam.[167]

After the withdrawal of Japanese troops in 1945, Vietnam declared independence and created the Democratic Republic of Vietnam.[168] However, French colonial rule continued until 1954.[169] The Constitution of Vietnam was formally adopted in 1946 and enshrined values of equality, liberty and social justice.[170]

Abortion is legal and widely available in Vietnam. In October 2014, it was reported that 40% of all pregnancies in Vietnam end in abortion.[171] According to this report, Vietnam has one of the highest rates of abortion in the world. "*Official statistics record that about 36% of Vietnamese adolescents aged betwwen 14 and 17 years have had sex, and arund 8.4 percent of females from 15 to 24 have had at least one abortion*.[172]"

Most abortions are available surgically using manual vacccum spiration (MVA) and dilation and cutterage (D&C), with the number of medical abortions being limited.[173] Medical abortions are available in tertiary and provincial hospitals and MMA pills are not widely available. A study found that the cost of MMA pills is higher than MVA and D&C in Vietnam.[174]

LEGISLATIVE AND JUDICIAL REFORMS

After its independence in 1954, Vietnam reconsidered its policy on SRH. The abortion policy in Vietnam underwent major reforms, and is now one of the most liberal framework for regulation of abortion in Southeast Asia.[175] This started with the Law on Marriage and Family adopted in 1960, which guaranteed the protection of women's and children's rights.[176] In 1963, North Vietnam adopted its first population policy.[177] The policy targeted reduction in the population rate in Vietnam. There were no formal attempts made to reach these goals. However, the use of condoms and IUDs was encouraged and abortion services were made available at some health facilities.[178]

The 1977 Family Law aimed at promoting contraceptive use and women's rights.[179] When a 1979 census revealed that the population (estimated at 54 million) was growing rapidly, concerns around family planning increased.[180] Thereafter, in 1984 the National Committee for Population and Family Planning (NCPFP) was formed as a formal attempt to coordinate the goals of family planning and limiting population growth.[181]

In 1986, the Government of Vietnam launched the *doi moi* reforms which led to significant changes as Vietnam transitioned from a centralised economy to a decentralised *"socialist-oriented market economy"*, and sparked the development of the private sector.[182] The *doi moi* reforms, the literal translation of the term being 'restoration', were

economic reforms initiated by the Sixth National Congress of the Communist Party of Vietnam in 1986.[183] Privatisation resulted in the introduction of fees for healthcare services.[184] Although these reforms improved the general quality of life in Vietnam, 28 million people were living below the poverty line as of 2003.[185] Furthermore, since the introduction of the *doi moi* reforms, use of public healthcare services declined significantly.[186] UNICEF reported that the general rate of abortion in 2020-2021 was approximately 4.7 per 1,000 women and the abortion ratio stood at 68 per 1,000 live births.[187] The capital, Hanoi, reported the highest abortion rate among all the cities at 196.9 per 1,000 live births. Almost 53.6% of the abortions were provided on account of contraceptive failure.[188]

The Council of Ministers in 1989 passed Decision No. 162.[189] Article 6 imposed an obligation on the State to provide birth control devices and abortion services to eligible persons for free.[190] This article reads:

> *"The state will supply, free of charge, birth control devices, such as intrauterine loops and condoms, birth control pills and public health services for the insertion of intrauterine loops and abortions to eligible persons who are cadres, manual workers, civil servants or members of the armed forces, persons to whom priority is given under policy and poor persons who register to practice family planning."*

The Medical Health Act of 1989 institutionalised the provision of free abortion services for married women of reproductive age if they registered with local family planning promoters.[191] The Law on Protection of Public Health was also enacted in 1989 and Article 44 of the Act provides:[192]

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

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

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

In 2001, the Ministry of Health formulated a National Strategy on Reproductive Health Care, which is the primary government policy on reproductive health.[193]

At present, abortion is legal until 22 weeks of pregnancy on demand at public and private facilities throughout the nation.[194] The two ways in which a pregnancy can be terminated are: 1) menstrual regulation *(hut thai)*—a suction procedure that is to be performed in the first five weeks of conception; and 2) Abortion *(nao thai)* - which refers to any other procedure including manual vacuum aspiration, or dilation and curettage that is performed beyond five weeks.[195] Abortion services must be provided by a certified health professional.[196] In case the services are not provided by a certified healthcare professional, the termination of a pregnancy amounts to an illegal abortion under Article 243 of Vietnam's 1999 Penal Code.

Vietnam has a robust healthcare system, with the public and private sector co-existing. With respect to SRH in particular, the social health insurance covers the cost of pregnancy and delivery care, and also provides financial coverage in the case of pregnancy related complications which may require treatment at higher-level facilities.[197] Reproductive healthcare is also provided to women free of charge at public healthcare facilities.[198] Pre-natal diagnostics and gender-biased sex selective abortions have been prohibited in Vietnam since 2003.[199]

At present, abortion is legal until 22 weeks of pregnancy on demand at public and private facilities throughout the nation.

BACKGROUND

Malaysia is a multi-ethnic and multicultural country. The Federal Constitution of Malaysia, enacted in 1957 and amended in 1963, identifies Islam as the religion of Malaysia, but states that other religions can also be practised.[200] As a Muslim majority country, Malaysia practises a dual system of law – common law and Islamic law.[201] The judicial system in Malaysia comes from the English model of common law. Syariah courts exist at the state level,[202] but Syariah law is not applicable to non-Muslims and orders from Syariah courts are not enforceable by civil courts.[203]

The family planning services in Malaysia operate in the context of maternal health care.[204] Prior to 2011, only married women could access contraceptive services from the public health sector.[205] Availability of contraceptives is restricted to persons from privileged economic backgrounds as they are likely to be more expensive and therefore inaccessible to marginalised persons.[206] Further, women who received abortion services reported that among the challenges associated with consistent use of contraception was the fear of side effects, contraceptive failure, partner's influence and a lack of confidence in contraception. In 2001, the Federal Constitution was amended and gender-based discrimination was included in the prohibited forms of discrimination.[207] Though Malaysia ratified CEDAW in 1995, the ratification was with reservations on the ground that articles of CEDAW conflicted with Syariah law and the Federal Constitution.[208] A ratified treaty cannot take precedence over national laws.[209]

The total fertility rate (TFR) in Malaysia plunged from 3.0 in 2000 to 2.3 in 2008 even though the contraceptive prevalence rate stagnated for the past 20 years.[210] This suggests that abortions occur widely in the country, yet no official statistics can be found for abortion rates in Malaysia. The estimated abortion rate in Malaysia has been found to be 16%.[211] Abortion is considered a taboo in Malaysia.[212]

In 2001, the Federal Constitution was amended and gender-based discrimination was included in the prohibited forms of discrimination.

It is permissible under Section 312 of the Penal Code if performed by a general practitioner registered under the Medical Act, 1971 to save a woman's life or to preserve her physical and mental health.[213] Under the Syariah law, which is only applicable to Muslims, the *Fatwa* (a ruling on a point of Islamic law given by a recognised authority) allows for abortion services to be provided under 120 days of gestation if there is a threat to the life of a pregnant woman or in the case of foetal anomalies.[214] The provision of services in the public health care sector is largely dependent on the discretion of individual practitioners given the absence of policy guidelines.

LEGISLATIVE AND JUDICIAL REFORMS

Abortion law was originally introduced in Malaysia under the British Empire's Indian Penal Code of 1871 which criminalised abortion in all circumstances.[215] However, the law brought forth by the British gained traction from Islamic jurisprudence as well. Based on the comparison between Islamic jurisprudence on abortion and Malaysian law, research has shown that abortion is prohibited under both, and abortion services may be provided under the Malaysian Penal Code in certain cases.[216]

There is no explicit text in Islamic jurisprudence from Qur'anic verses and hadiths that refers directly to abortion.[217] The debate around the permissibility of abortions sees a divergence of opinion between four schools of thought. For

Hanafi jurists, abortion is legal *"before soul is breathed into the foetus"* (i.e., before 4 months) as long as it is consented to by the husband or the wife.[218] Maliki jurists hold the most rigid views on abortion with a majority of them being in consensus on a complete prohibition of abortion. Some Maliki jurists are of the opinion that abortion is prohibited after 40 days of conception.[219] Jurists from the Shafi'i school see a divergence in opinion with some aligning with Hanafi scholars on the permissibility of abortion before four months. Others view abortion to be prohibited under all circumstances.[220] The fourth school of Hanbali jurists are in consensus on the prohibition of abortion after 120 days of pregnancy.[221]

Malaysian civil law on the other hand does not regulate abortion in the same manner as Islamic jurists.[222] Abortion in Malaysian law is prohibited under Articles 312-316 of the Malaysian Penal Code.[223] Section 312 states:

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

There have been two ground-breaking amendments to Section 312 of the Penal Code – one in 1971 to allow the termination of a pregnancy to save a woman's life and another in 1989 to allow termination of a pregnancy to preserve a woman's physical and mental health.[224] Pursuant to these reforms, Section 312 of the Penal Code states that apart from these grounds, those who cause an abortion with a woman's consent can be sentenced up to three years' imprisonment and/or fined.[225] If the woman is "quick with child," meaning she is beyond her fourth month of pregnancy, the woman and the healthcare provider can be sentenced to up to seven years imprisonment and a fine.[226] Section 313 states that those who cause an abortion without the woman's consent can be sentenced to up to 20 years' imprisonment and a fine.[227]

It is relevant to note that there is no gestational limit under Section 312 of the Malaysian Penal Code.[228] However, it must be read with Section 316 of the Code which criminalises acts that result in the death of a "quick unborn child."[229] Section 316 of the Malaysian Penal Code states:[230]

"Whoever does any act under such circumstances that if he thereby caused death he would be guilty of culpable homicide and does by such act cause the death of a quick unborn child, shall be punished with imprisonment for a term which may extend to ten years, and shall also be liable to fine."

Section 316 criminalises the act of causing death of a "quick unborn child", which is understood to mean a foetus of 22 weeks of gestation[231] or beyond. The understanding on ground is that termination of pregnancies is permissible by medical practitioners up to 22 weeks of gestation. Section 315 of the Penal Code states that an "act done with intent to prevent a child being born alive or to cause it to die after birth" is an offence "unless it is for the purpose of saving the life of the mother."[232] However, while cases of rape, incest or foetal anomalies are not mentioned in the Penal Code, in practice, these cases are often covered by the mental health exception, and there are instances of terminations in the third trimester, particularly in cases of foetal anomalies or to save the life of the pregnant person that are justified by clinical practice discretions.[233]

Separately, in order for an abortion to be legally permissible, the healthcare service provider must be a medical practitioner registered in Malaysia, and the decision to terminate the pregnancy must be made in good faith."[234] "Good faith" is defined under Section 52 of the Penal Code as an act done on the basis of due care and attention.[235] The pregnant woman must consent freely to such termination, and in case of a woman under the age of 18, the consent of the parent or the guardian must be obtained.[236] They must also be able to demonstrate with reason that they are not drunk, and should know the truth and consequences of their consent. [237]

Prior to 2011, only married women could access contraceptive services from the public health sector. Availability of contraceptives is restricted to persons from privileged economic backgrounds as they are likely to be more expensive and therefore inaccessible to marginalised persons.

In *Public Prosecutor v. Dr Nadason Kanalinga*, a gynaecologist was charged under Section 312 of the Penal Code.[238] The gynaecologist had injected a pregnant woman with saline as she had enlarged varicose veins when she was fourteen weeks pregnant.[239] Despite the gynaecologist's defence that he performed an operation of tubal ligation in good faith to save the life of the woman, the Malaysia High Court ruled that the "act of causing miscarriage was found to be done without good faith."[240]

To sum up, the circumstances under which a pregnancy may be terminated can be classified into four distinct categories- conditions related to: the foetus; the pregnant woman; the doctor; and the abortion process. The conditions for termination in each of these cases are as follows:

i. Conditions related to the foetus:
- *The age of the foetus should not be more than four months.*
- *The foetus must not have started moving in the pregnant person's womb.*

ii. Conditions related to the pregnant woman:
- *The woman must consent to the abortion; and there must not be coercion and must know the consequences of the abortion.*
- *The abortion must not put her health and life in danger.*
- *She must be more than twelve years of age.*

iii. Conditions related to the doctor:
- *They must be a specialist.*
- *They must get the consent of the pregnant woman.*
- *They must have a license to provide abortion services.*

iv. Conditions related to the abortion process:
- *A request from a specialist doctor.*
- *Not detrimental to the health of the pregnant person.*

In 2012, the Ministry of Health issued an official guideline on abortion in government hospitals. The guideline reinterpreted the provisions of the Penal Code, stating the requirement of two doctors for terminating a pregnancy. Of these, one should preferably be a gynaecologist or psychiatrist.[241] Requests for termination of pregnancies on grounds of mental health indications are seldom approved, and cases of serious life-threatening conditions resulting from a pregnancy are often the ones that receive an approval. [242]

The Medicines Advertisement and Sale Act, 1956 prohibited the publication of advertisements relating to abortion. This carries a sentence of up-to one year imprisonment in case of a first offence and/or a fine of 3,000 Ringgit (approximately USD 676.82) and in the case of a second offence, imprisonment for a period of up to two years, and/or a fine of 5000 Ringgit (approximately USD 1128.8).[243] Therefore, it can be said that abortion is prohibited unless there is a necessary reason, such as to save the pregnant person's life. Abortion is also permissible following the request of a specialist doctor in cases where it is not detrimental to the health of the pregnant woman and must be performed before the fourth month of pregnancy with the consent of the pregnant woman.

While abortion services are widely available in the private sector, they are generally discreet, often unregulated and providers charge exorbitant prices making abortion services inaccessible for pregnant persons from marginalised backgrounds.[244] Due to the lack of policy guidelines on abortion services by the Ministry of Health, access to abortion services depends on the views of individual practitioners at public health institutions. As a consequence, women are sometimes required to follow non-uniform procedures such as undergoing psychiatric tests, seeking second medical opinions, and even obtaining their husband's consent despite no such requirements in the law.[245] The imposition of these additional requirements as well as personal biases compound women's access to abortion services. This can cause unnecessary delays in women's access to abortion.[246]

The provision of services in the public health care sector is largely dependent on the discretion of individual practitioners given the absence of policy guidelines.

In 2012, the Ministry of Health published guidelines on termination of pregnancies in government hospitals that provide abortion services within the context of the law, including medical and surgical methods.[247] Surgical methods form the mainstay of abortion services in the public sector. D&C is the main method and is often used on an inpatient basis.[248] Ambulatory care methods of abortion provision have come into use with the establishment of early pregnancy assessment units (EPAU) in some major hospitals.[249] Mifepristone (RU486) is not registered for use in Malaysia. Previously, off-label use of misoprostol for medical abortion and softening the cervix before manual MVA, was common.[250] However, misoprostol has been discontinued and is not available.[251] MVAs are not currently used within Ministry of Health Malaysia (MOH) hospitals, although electrical vacuum aspiration (EVA) is provided. Vacuum Aspiration is performed in an operation theatre when indicated on a case-to-case basis. Traditional D&C is therefore still the method used in most cases and is primarily provided for medical reasons and never on demand.

There are indications that abortions in Malaysia occur clandestinely as suggested by stagnating contraceptive prevalence rate combined with the plunging fertility rate.[252] Due to government restrictions and unavailability of MMA pills, there is an increasing trend of unsafe abortion practices

via online sales of MMA pills through non-skilled, non-clinical companies and individuals.[253] It has been reported that the former Minister of Health, Datuk Seri S Subramaniam, stated that in Malaysia, these pills require a doctor's prescription and are for "specific purposes."[254] He stated that while domestic internet sales could be detected, leading to action against offenders, purchases from abroad are difficult to detect.[255] Mr. Subramaniam said that the Health Ministry was working with the Customs Department and police to detect packages containing such pills and inquire whether the pills were being sold locally.[256]

There have been two ground-breaking amendments to Section 312 of the Penal Code – one in 1971 to allow the termination of a pregnancy to save a woman's life and another in 1989 to allow termination of a pregnancy to preserve a woman's physical and mental health.

The inaccessibility of abortion services could be multifactorial, ranging from the clandestine nature of abortion to cultural, spiritual and social barriers and the lack of awareness around abortion laws. In addition, the Medicines (Advertisement & Sale) Act 1956 (revised in 1983) states that *"No person shall take any part in the publication of any advertisement referring to any article, or articles of any description, in terms which are calculated to lead to the use of that article or articles of that description for procure the miscarriage of women."*[257] *Therefore, obtaining information on abortion through the media is rare.*[258]

A study on access to abortion services concluded that the main barriers to abortion were the lack of abortion services and information.[259] These barriers caused women to not know where and who to go for abortion and they could only rely on information from friends or colleagues, which was often superficial and inadequate.[260] Difficulties in obtaining information caused anxiety in women seeking abortion services and also denied them the opportunity to search for detailed information to make informed decisions. In addition, discourse on abortion is rare and is viewed as a taboo,[261] which makes it difficult for people to seek legitimate information about abortion services and their availability.

Nepal

BACKGROUND

Much like Thailand, Nepal does not have a colonial history. Given its predominant Hindu population, Nepal was governed by the *Muluki Ain* 1959, a legal code based on ancient Hindu scriptures that criminalised abortion.[262] *Muluki Ain* was revised numerous times to ban abortion exempting circumstances where the pregnancy was a risk to the women's life.[263] About one-fourth of women were branded as "murderers" on the basis of pregnancy termination under charges of infanticide and homicide.[264] Most of these women belonged to marginalised communities and had no formal education. They were reported to police mostly by their relatives, while women from privileged backgrounds resorted to neighbouring countries like India for receiving abortion services.[265]

Although abortion was partially decriminalised in 2002, SRHR continues to be a taboo in Nepalese society.[266] The discourse on reproductive health of women differs based on region, ethnic backgrounds, class, and caste status i.e., people in the hilly regions are more accepting of abortion and other reproductive health services than people in the terai region.[267] Women in rural areas suffer the most, as traditions are more closely adhered to, and they are often forced into the hands of unscrupulous local quacks."[268] Bearing a son, irrespective of number of children, is culturally encouraged[269] and premarital pregnancies are considered culturally unacceptable[270] leading to unsafe abortion services. Preference for sons over daughters has led to practices of gender biased sex-selection despite it being an offence punishable with imprisonment for up to six months. Further, there are also a large number of unsafe terminations that are underreported.[271] The legal framework currently regulating abortion services in Nepal is discussed in detail in the section on judicial and legislative reforms.

Moreover, a qualitative study conducted in 2008 suggested that abortion can carry connotations of extra-marital relationships, which are strongly opposed by Nepalese socio-religious values.[272] Post-abortion, women are labelled as: "sinner *(papini)*, ill-luck *(alichhini)*, murderer *(jyanmaara)*, and foetus killer *(garbhaghati)*."[273] In some cases, women who have had an abortion are prohibited from taking part in religious activities.[274] In addition, abortion service providers and spouses of women who have received abortion services are also stigmatised and seen as bad persons.[275] Another qualitative study conducted in 2014 concluded that barriers to access to safe abortion take the form of geographic isolation, stigma from healthcare providers, poor implementation of the law and a lack of awareness about the law.[276] Furthermore, the study added that "several participants confirmed facing increased barriers in accessing safe abortion services due to adverse cultural attitudes towards pre-marital sex."[277]

About one-fourth of women were branded as "murderers" on the basis of pregnancy termination under charges of infanticide and homicide. Most of these women belonged to marginalised communities and had no formal education.

In 1990, Nepal became a constitutional monarchy with a democratically elected government in place by 1991, which led to greater freedom of speech and press, which were highly regulated before 1990.[278] Women's rights groups and activists were able to operate more freely and visibly.[279] Nepal was a signatory to the 1994 International Conference on Population and Development (ICPD) and the Beijing Conference on Women (BCW),1995.[280] Compounded by Nepal's involvement in the Safe Motherhood initiative by WHO in 1987, the discourse around abortion shifted focus to the framework of women's rights.[281] The Ministry of Health's involvement in initiative also led to increased administrative engagement with the right to safe abortion and consequent efforts towards legal reforms.[282]

MMA was introduced in Nepal in 2009 on a pilot basis.[283] The success of the pilot study encouraged the approval of MMA services on a country-wide scale, and the Family Division of the Ministry of Health and Population issued Guidelines in 2009 to permit auxiliary nurse midwives (ANMs) to administer MMA pills.[284] The safety, efficacy and acceptability of MMA provided by ANMs is now well established in Nepal.[285] The MMA brands (combined regime of mifepristone and misoprostol) registered by the Government of Nepal have been available only on prescription through Government accredited safe abortion providers since 2009.[286] Despite MMA access being solely permitted through government accredited safe abortion services, MMA pills are readily available for purchase at pharmacies throughout the country.[287] Arguably, Nepal has one of the most progressive laws on abortion, maternal health and overall SRHR in South Asia.

Women in rural areas suffer the most, as traditions are more closely adhered to, and they are often forced into the hands of unscrupulous local quacks. Bearing a son, irrespective of number of children, is culturally encouraged and premarital pregnancies are considered culturally unacceptable leading to unsafe abortion services.

LEGISLATIVE AND JUDICIAL REFORMS

The *Muluki Ain*, Nepal's legal code that is based on ancient Hindu scriptures, criminalised abortion by equating it to infanticide.[288] The punishment for terminating a pregnancy varied depending on the gestation age of the pregnancy at the time of such termination; imprisonment of one year in case of a pregnancy within 12 weeks of gestation, three years for a pregnancy between 12-25 weeks and 5 years for a pregnancy exceeding 25 weeks of gestation.[289] This resulted in incidents of malicious incarceration of women in order to ensure that they forfeited their right to property.[290] The movement towards liberalisation spanned over three decades and led to reforms in the abortion law in 2002.[291] The seeds of the movement can be traced back to a conference organised in 1975 by Family Planning Association of Nepal (FPAN), an affiliate of the World Planned Parenthood Federation. However, the discourse in the 1970s was largely situated within the framework of fertility and regulating population growth.[292]

In the 1980s, the Nepal Women's Organisation (NWO) convened a national forum which addressed abortion. Subsequently, the NWO worked with jurists to evaluate the abortion laws and made recommendations for reforms.[293] However, these recommendations were rejected as the Nepalese government was cautious in engaging with abortion reform in the light of the Mexico City Policy.[294] The policy was introduced by Reagan in 1984, repealed by Clinton during his presidency, reinstated by Bush, repealed again by Obama, then reinstated by the Trump administration and finally, repealed under Biden's administration in 2020.[295] The USA government was a key donor to the Nepalese government for health and family planning programmes.

Shyam Thapa notes the lack of organised and prominent opposition to abortion reform in the 1990s. Thapa also suggests that Nepal was able to have substantial legal reforms mostly *"because it has already been legalised for many years in neighbouring India, the world's largest democracy and undoubtedly a major source of influence for Nepal – culturally, politically and otherwise."*[296]

The movement for abortion reforms gained traction through the findings of various studies conducted in 1982, 1989, 2000 and 2002 examining the incidence of abortion among women in prisons. The findings of the studies revealed that "at least one-fifth of women in prison had been convicted for illegal abortion,", with other women serving time for crimes they had not committed and others being charged with "murder."[297] In 1997, the Ministry of Law, Justice and Parliamentary Affairs introduced the 11th Amendment Bill to the Parliament.[298] The Bill proposed an overhaul of many aspects of the Muluki Ain to dismantle the legal institutionalisation of gender-based discrimination.[299] The Bill included amendments to provisions on abortion and *"inheritance of property, citizenship, divorce and marriage"* and sought to increase *"the punishments for rape, particularly for rape of minors, pregnant and disabled women."*[300] The Bill was initially passed by the Lower House and rejected by the Upper House.[301] However, in March 2002, the House of

Representatives reconsidered the Bill, and it was eventually passed and came into effect on September 27, 2002.

The 11th Amendment introduced two additional clauses to the Muluki Ain- clauses 28A and Clause 28A prohibited anyone from terminating a pregnancy under coercion, threat, or negative influence. The punishment for committing an offence was three to six months of imprisonment for the individual responsible as well as the service provider, and if the termination was intended or procured for gender-biased sex-selective purposes, the Code imposed an additional punishment of one year of imprisonment.[302] Clause 28B nullifies Clause 28A to the extent that the qualified and authorised health workers accomplish pregnancy termination with the fulfilment of the abortion procedural process set by His Majesty's Government [HGM] under the following conditions:[303]

- *"Up to 12 weeks for any woman with the pregnant woman's consent.*
- *Up to 18 weeks of gestation if the pregnancy results from rape or incest with the pregnant woman's consent.*
- *At any time during pregnancy, with the advice- if the life, physical or mental health of the mother at risk or if the foetus is deformed- of a medical practitioner and the consent of the pregnant woman as well."*

> In 2008, the Supreme Court of Nepal upheld Clause 28B of the Muluki Ain and read it to be consistent with CEDAW.[304]

The amended *Muluki Ain* also safeguarded the rights of unmarried women to abortion and guarantees the privacy and confidentiality of the women receiving abortion services.[305] Moreover, the National Abortion Policy 2002 guarantees access to safe and affordable abortion services for every woman without discrimination and the Safe Abortion Service Procedure 2003 defines clinical procedures for safe pregnancy termination, service provision facilities, client consent and lays down criteria for approving a healthcare facility as a provider of Comprehensive Abortion Care (CAC).[306] The CAC program is a national initiative for provision of abortion services but is largely unsuccessful owing to the prohibitive cost of services in government hospitals, lack of awareness and concentration of CAC services in urban areas.[307] The maternal mortality ratio in Nepal between 1998-2008 witnessed a decline of 56% owing to the reforms of 2002.[308]

In 2006, further amendments were introduced to the Muluki Ain by an 'Act to Amend Some Nepal Acts for Maintaining Gender Equality (Gender Equality Act, 2006).[309] Pursuant to the Gender Equality Act, 2006, Clause 28A was amended and the punishment for causing termination of a pregnancy under threat, coercion or undue influence was based on the gestational age at which the pregnancy was terminated, akin to the provisions under the Muluki Ain, 1959. Such an act was punishable with imprisonment of one year in case of a pregnancy within 12 weeks of gestation, three years for a pregnancy between 12-25 weeks, and 5 years for a pregnancy exceeding 25 weeks of gestation.[310]

Clauses 28C and 28D were also introduced and these dealt with offences relating to gender-biased sex selective practices and terminations on account of such sex-selection.[311] Clause 28C penalised any act done to identify the sex of a foetus with the intention of terminating a pregnancy, imposing a punishment of three to six months of imprisonment committing such an act or causing it to be committed.[312] Clause 28D further penalised anyone "who carries out or causes to be carried out pregnancy termination having detected the sex of the foetus" and such person was liable to face imprisonment for a term of six months to two years.[313]

The Interim Constitution of Nepal of 2007 made ground-breaking changes in women's rights. Article 20(1) of the Constitution provides that no woman can be discriminated against on the grounds of sex and that all women have the right to reproductive health.[314] Article 20(2) provides all women the right to reproductive health and all such related rights. Similarly, the right to freedom from violence was also included in the Interim Constitution.[315]

In 2009, the Supreme Court issued a landmark judgement in *Lakshmi Dhikta v. Nepal*[316] and recognised abortion as a fundamental right under the Constitution. Lakshmi Dhikta, a Dalit woman and mother of five children from rural Nepal, was pregnant for the sixth time.[317] In light of Lakshmi's deteriorating health and their economic status, neither she nor her husband wanted to have another child.[318] The hospital that they approached asked for 1,130 rupees (approximately 8 USD) and they could not afford to pay this amount, Lakshmi was forced to continue her pregnancy.[319]

Lakshmi's case was taken up by the Court which held that reproductive rights include the right to protect or terminate a pregnancy and cannot be construed as an obligation to reproduce.[320] The Court recognised the right to abortion as an intrinsic part of reproductive rights and that the continuation of an unwanted pregnancy constitutes a violation of a woman's fundamental rights.[321] The Court also noted that there is no consensus on when life begins and the law does not recognise the foetus as a human or the rights of a foetus; any such recognition would violate the fundamental rights of the pregnant woman. The details of the verdict in this case have been discussed in detail in the succeeding paragraphs.

While efforts towards liberalising abortion laws in Nepal have been ongoing for decades, and these have resulted in significant reforms both on the legal and judicial front, abortion continues to be criminalised. In 2016, the Government of Nepal announced that they would provide free abortion services in public hospitals and clinics.[322] In 2018, the government enacted the Safe Motherhood and Reproductive Health Rights Act (SMRHR Act) and in 2020, adopted the Safe Motherhood and Reproductive Health Rights Regulation (SMRHR Regulation).[323] The SMRHR Act is a progressive legislation that prohibits discrimination in availability of healthcare services, provides that all reproductive health care services should be free of cost at government health facilities, and requires all levels of government to allocate a budget for reproductive health services.[324] The SMRHR Act recognises the right to obtain reproductive health services, counselling, information, and the right to determine the number and spacing of children[325] and mandates the confidentiality of reproductive health care services as well as its accessibility to adolescents and persons with disabilities.[326]

In 2017, the earlier penal code was replaced by the *Muluki Aparadh (Sangithan)* Act, which retains the legal provisions regulating abortion services.[327] The Centre for Reproductive Rights notes that the amended Muluki Ain adheres to the rights and principles codified in the Constitution and international human rights treaties ratified by Nepal.[328] The body of domestic and international law provides a strong framework of respect for the rights of autonomy, equality and self-determination, whereby women have decisional autonomy over their unplanned and unwanted pregnancies. The right to health care is also established in the ICESCR, which was ratified by Nepal in 1991.[329] Article 12 of the ICESCR guarantees "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[330] The Committee on Economic, Social and Cultural Rights, which monitors States parties' compliance with the ICESCR, has interpreted the right to health not as a right to be healthy, but as entailing freedoms and entitlements, including the right to control one's health and body in matters of reproductive and sexual health.[331] Entitlements include the right to a variety of conditions, facilities, goods and services that must be available as well as accessible. The Committee has urged States to provide access to a full range of SRH care and remove all barriers interfering with access to related health services.[332] Further, the CEDAW committee in 2018 urged Nepal to amend the SMRHR Act to fully decriminalise abortion.[333] In 2021, during the 37th session of the Universal Periodic Review, Nepal was specifically urged to "decriminalise abortion and concretely protect the rights and SRH of women and girls."[334]

Supreme Court of Nepal: Lakshmi Dhikta Decision

In *Lakshmi Dhikta v. Nepal*, abortion has been recognised as a constitutionally protected fundamental right. Prior to this case, the criminalised status of abortion in Nepal compelled many women to undergo unsafe abortion services which was also reflected in recent statistics. It may be noted that 50% of the maternal deaths in Nepal prior to 2002 were caused due to unsafe abortion services.[335] This was attributable to the prevailing notions on, *inter alia*, women in society, economic reasons. Lack of information, proximity to quality services and financial resources are the challenges that women face in the trials to access abortion services.

Even today, abortion remains the third most important cause of maternal mortality.[336] The government of Nepal has made efforts to ensure realisation of the right to health, but the structural constraints in the country have resulted in the benefits of these efforts not translating on ground, especially for women in rural areas. Further, various procedural requirements like the prohibitive cost of services in government hospitals, lack of awareness among women and concentration of service in urban areas are barriers faced by women.[337] The *Lakshmi Dhikta* petition cited many such findings to support its stance. The judgments pronounced in the Supreme Court paved way for the legalisation on abortion and introduction of the Equality Act in 2006.[338] The Court interrogated the government about its insufficient steps towards removing the practical barriers women face and ordered the State to facilitate increased access to safe abortion services, especially for marginalised women.[339]

The *Lakshmi Dhikta* decision, in recognising women as moral agents with their own decision-making authority, goes against the traditional institutionalised patriarchy. It makes the government accountable for any shortcomings in ensuring the implementation of rights of abortion in reality by addressing the unequal power dynamics and inequalities. The decision stands out because, not only does it grant women their rights, but also understands the importance of implementing the same. The Court paid attention to the necessity of change in the power dynamics of relationships and the institution of marriage. The Court in this decision reaffirmed women's dignity by giving women the right to be the master of their own bodies, sexual relations and procreation. The Court affirmed that pregnancy is more of a woman's right and less of an obligation. Therefore, denying the choice of women turns the respectful duty into slavery. [340]

Finally, the *Lakshmi Dhikta* decision also clarifies the country's position on the legality of foetus.[341] The court in this case observed that the pregnant woman's right always supersedes that of the foetus. Issues relating to pregnancy

are more tilted towards women than the foetus and every single development of the foetus in the womb cannot and must not be equated with human life as per the Court.[342] Before the introduction of the Interim Constitution, it was assumed that the foetus was recognised as equally alive, and that was the major reason why abortion was a crime.[343] Now, there is no provision or mention of the rights of the foetus in the constitution. Now, as per the Nepalese law, only a child that is born is granted with the status of human life. In cases where the foetus is capable of having life outside the womb, if it dies due to some unfortunate reason, it cannot be said that a human life is lost.[344] All such 'life' rights come with birth. A foetus is entirely dependent on the pregnant woman but is not a separate personality.

Despite this line of reasoning, the court did not completely ignore foetal interests. It does acknowledge them but only after women's rights. The Court rationalised the same by stating that the foetus's interests are important to the pregnant woman as well, so broadly they are a part of the 'mother's' interests. With such a view, there is a concern about the foetus in the later months of the pregnancy. Therefore, the Court believes that few restrictions are reasonable to be placed on pregnancy, but such restrictions have to exist only to a limited extent.

In another important case in 2005 of *Achyut Prasad Kharel v. Government of Nepal*,[345] a lawyer had challenged the law on the ground that because the law allows termination of pregnancy without spousal consent, it discriminatory towards men. The Court held that restriction on reproductive freedom can make pregnancy a responsibility that forces women to suffer in silence.[346] This not only leads to negative health outcomes, but also deprives women of basic dignity. The right to abortion acts as legal protection against forced continuation of pregnancy. If a woman is forced against her will to give birth to a baby, it creates irreparable harm to her, and her rights can never be reinstated.[347]

The Court in Lakshmi Dhikta decision was in line with the objectives of the CEDAW. It took a transformative approach and vouched for women's equality in a place where gender stratification exists. Going a step further than abortion rights, the Court also specified that state's duties include addressing substantive inequality by minimising nonidentical treatment of women and men, recognising different forms of discriminations ranging from socioeconomic status to age that intersect with sex and gender and by adopting measures to change this.[348] Transformative equality can be achieved when we start looking at the unintended pregnancy from the perspective of women affected and then, decide the resources for the disadvantages they face in seeking help. This can be achieved only when abortion is perceived as a 'positive right', provision of which is the state's duty.[349] The difference between the earlier approach and the one of transformative equality is that women have freedom to make decisions for themselves in the latter approach. The challenge there is to free women from the societal clutches and put them on an equal footing with men and let them have the liberty to manage their personal sexual affairs.[350]

Decriminalisation Petition, 2022

While efforts towards liberalising abortion laws in Nepal have been ongoing for decades, and these have resulted in significant reforms both on the legal and judicial front, abortion continues to be framed within a carceral framework of criminal laws. To counter the ill-effects of criminalisation of abortion and the disproportionate barriers it creates for marginalised persons in accessing safe abortion services, there have been more recent efforts towards seeking decriminalisation of abortion in the country. In February 2022, a Nepal-based organisation, the Forum for Women Law & Development (FWLD) approached the Supreme Court of Nepal seeking the complete decriminalisation of abortion in consonance with the constitutional protections and the recommendations by the United Nations.[351] The petition has been filed to move away from a restrictively permissible framework of abortion laws to allow for access to abortion services within a rights-based framework.

The petition relies heavily on the decision in the case of *Lakshmi Dhikta* and calls for the repeal of the criminal provisions pertaining to abortion in the Criminal Code of 2017 in order to protect rights guaranteed under the Constitution of Nepal and the legal entitlements under the SMRHR Act.[352] It further seeks amendments to the SMRHR Act which include changes to the provisions on gestational limits and the provision of conditional safe abortion beyond 28 weeks of gestation, the removal of regulatory mechanisms to facilitate safe abortion services through self-managed abortions and telemedicine, and drawing a clear distinction between miscarriages and induced abortion services to ensure the former is not criminalised.[353]

The petition relies heavily on the decision in the case of Lakshmi Dhikta and calls for the repeal of the criminal provisions pertaining to abortion in the Criminal Code of 2017 in order to protect rights guaranteed under the Constitution of Nepal and the legal entitlements under the SMRHR Act.

Pakistan

BACKGROUND

Pakistan established itself as an independent theocratic state after gaining independence from British colonial rule and the subsequent partition from India in 1947.[354] Abortion in pre-partitioned India, was only permissible to save a woman's life under the colonial Penal Code of 1860.[355] The criminalisation of abortion can be traced back to colonial times and the regressive policies of the West.[356] Further, religious traditions in 19th and 20th century in South Asia also generally disapproved of abortions. Hindu scriptures prohibited intentional abortions, except to save the life of the pregnant woman and with the permission of the King.[357] Islamic law only permitted abortions under certain circumstances before 120 days from conception and prohibited abortion thereafter, except to save the pregnant woman's life.[358]

Unsafe abortions are prevalent in Pakistan with one study reporting that over 85% of the 2.2. million abortions that took place in Pakistan in 2012 were provided by untrained persons, leading to life threatening complications in approximately 700,000 cases.[359] A report by the Guttmacher Institute stated that between 2015 – 2019, the rate of unintended pregnancies decreased by 21% but abortion rate increased by 64% with almost 61% of the unintended pregnancies ending in an abortion.[360] This is partly attributable to an unmet need for contraceptives: as per the Pakistan's Demographic Health Survey (DHS) for 2017 to 2018, only 34% of married women were using some method of contraception.[361]

Importantly, since 1965, the USA government has played a significant role in Pakistan's family planning program, "at times providing as much as 40 % of the program's supplies, including contraception."[362] The impact of the Mexico City policy, or the Global Gag Rule, and the Helms Amendment has been significant for organisations working on ground that are heavily reliant on financial support from the USA for their SRHR work.[363] Syed Kamal Shah, CEO of Rahnuma-Family Planning Association of Pakistan, one of the country's population welfare pioneers said, "*we were not willing to sign this certification, and our funding was closed right away.*"[364] Joles writes that "this seesaw effect [of the Mexico City Policy] can be jarring for aid recipients." [365] Asma Balal, Director for the Marie Stopes Society, Pakistan said that in the past, Marie Stopes could not use U.S. Agency for International Development (USAID) money to procure misoprostol or MVA kits for women seeking treatment for botched or incomplete abortions."[366]

Misoprostol is registered in Pakistan for both post-abortion care (PAC) and postpartum haemorrhage (PPH). Further, Zafa, a locally manufactured yet high quality product, is prescribed by pharmacists and obstetricians and gynaecologists as an abortifacient even though it is not registered for use for first

trimester abortions.[367] There have been efforts to introduce and expand menstrual regulation (MR) services, emulating Bangladesh's successful service delivery model. However, these efforts have not met the same success in Pakistan as in Bangladesh, which raises questions on whether registration of mifepristone for menstrual regulation would be possible or practical, given the potentially low demand for the service. MR is not well known or understood.[368] As per the Guttmacher Institute, the incidence rate of adolescents' pregnancies is high in Pakistan and many adolescents face the risk of poor reproductive health outcomes.[369] Data records as of 2019 indicate that adolescents women aged between 15 to 19 years experienced 617,000 pregnancies of which 36% were unintended and 58% of unintended pregnancies ended in abortion.[370]

LEGISLATIVE AND JUDICIAL REFORMS

Islamic law was replaced with the Indian Penal Code, 1860 (IPC) by the British during colonial rule, and two important constituents of Islamic criminal law: *ḥudūd* and *qiṣāṣ* were not incorporated in the IPC. *Ḥudūd* and *Qiṣāṣ* are offences against human body (prescribed in the *Qur'ān* and Sunnah).[371] *Ḥudūd* includes illicit sex *(zinā)*, slander *(qadhf)*, theft *(sariqa)*, and consumption of alcohol *(shurb al-khamr)*. *Qiṣāṣ* covers homicide and injury. The end of colonial rule also led to the establishment of Pakistan as an independent postcolonial State which adopted the provisions of the IPC under the Pakistan Penal Code, 1860 (PPC).

One of the earliest challenges to PPC was based on the Islamic law of qiṣāṣ.[372] *In Gul Hassan Khan v. Government of Pakistan,* the petitioners approached the Shariat Bench of the Court to challenge the provisions of the PPC.[373] The petitioners argued that the PPC did not consider "pardon" in murder cases to be in accordance with Islamic legal principles of *qiṣāṣ* and dīyah.[374] The petitioners had been pardoned by the legal heir of the deceased whose murder they had allegedly committed.[375] The Shariat Bench of the Peshawar High Court reviewed the relevant sections of the PPC with regards to the *Qur'ān* and Sunnah.[376] The Court declared several sections of the PPC and the Code of Criminal Procedure 1898 to be unacceptable as per Islamic laws and legal texts, as they failed to include the Islamic principles of *qiṣāṣ* and *dīyah*.[377]

Scholars argue that the decision in this case prompted an "Islamic Review" or an "Islamisation of Laws" pertaining to abortion as well in the 1990s. The concept of diyah and repayment was introduced under Section 338 in line with Qura'nic principles.[378]

Section 338 of the Pakistan Penal Code states:[379]

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

There is no clarity on what constitutes "necessary treatment," under Section 338, and this has allowed for a wide scope of interpretation of the term, leaving the provision of abortion services to the discretion of a healthcare provider.[380] The penalties imposed on the illegal termination of a pregnancy vary depending on the foetal development at the time of termination: before organs are formed (considered before and up to 4 months of gestation), the offence is penalised under *(tazir)*, by imprisonment for 3–10 years as per Section 338-A *(Isqat-i-Haml)*. After the organs are developed, traditional Islamic penalties are imposed in the form of diyaat and attract up to 7 years of imprisonment as per Section 338-C *(Isqat-i-janin)*. [381]

PAKISTAN CHILD MARRIAGE RESTRAINT ACT

Child marriage in Pakistan has been deeply rooted in various cultural, social and economic factors.[382] In view of the same, the Child Marriage Restraint Act (CMRA) was enacted in 1929. The intent of the CMRA was to restrain solemnisation of child marriages in Pakistan. A child is defined as a male under the age of 18 and a female under the age of 16.[383] The Act provides punishment for three types of offenders, (i) a male above the age of 18, marrying a child[384]; (ii) individual responsible for solemnising the marriage[385] and (iii) the parent or guardian of the child in such instances of marriage.[386] The punishment provided in all three cases is imprisonment up to one month which may also include a fine up to one thousand rupees. It may be noted that women who are the parent or guardian of the child are exempted from imprisonment under the Act.[387]

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In 2014, a Bill was introduced in the Provincial Assembly of Sindh[388] to amend the CMRA, which had been criticised for being toothless.[389] The Bill was passed by the assembly and provided for stricter punishment for already defined offences within the Act. It increased the term of imprisonment up to three years and the minimum punishment was revised to two years.[390] Notably, the amendment also altered the definition of a child to be a person less than 18 years of age, irrespective of gender.[391] Child marriages resulting in early conception, pregnancy and death of girls between 15 to 18 years were cited as the objective and reason behind introduction of the amendment, which could serve as a deterrent.[392]

There have been efforts to introduce and expand menstrual regulation (MR) services, emulating Bangladesh's successful service delivery model. However, these efforts have not met the same success in Pakistan

SINDH REPRODUCTIVE RIGHTS ACT, 2019

The lack of accessible, affordable and quality reproductive healthcare facilities has been a factor behind high MMR in Pakistan.[393] In an effort to addresses these concerns, the Sindh Reproductive Healthcare Rights Bill was introduced in the Provincial Assembly of Sindh in 2013 and eventually passed in 2019.[394] The Sindh Reproductive Healthcare Rights Act, 2019 recognises reproductive rights and acknowledges the need for better productive healthcare. The Act calls for the promotion of reproductive healthcare services, provision of professionalised obstetric care, emergency obstetric and neonatal care and improving existing reproductive healthcare systems to increase access to services among other things.[395]

BACKGROUND

While India has a long history of Arab, Turkish, and European invasion, it was the British that colonised India for over 200 years until its independence in 1947.[396] The country's colonial history has played a significant role in influencing it's present day economic policies and legal framework. The legal and political structures are also permeated by the class and caste divide.[397] Given its colonial past, abortion was criminalised in India under the IPC of 1860 first enacted by the British and subsequently adopted by the postcolonial State.

The Indian government introduced the first five-year plan in 1952 under which it allocated funds for "family planning" with the aim of stabilising the population at the level consistent with the requirements of a national economy.[398] In the 1960s and 1970s, family planning occupied more of the State's development agenda. Historically, advocates of family planning programs positioned their advocacy for contraception as being beneficial not only for women, but also for the "nation, which could meet its economic development by curbing population growth."[399] Family planning was posited as necessary for economic and social development, and women were called upon to curtail reproduction as their "duty" to the State. Scholars argue that instead of targeting and rectifying structural causes of inequality (such as unequal land distribution, caste-based injustices and patriarchal norms) "family planning" and "population control" were marketed as the 'magic cure' to inequality.[400] However, these policies took on increasingly coercive and violent measures, especially impacting historically marginalised communities and individuals including Dalit, Bahujan, Adivasi and Muslim persons.[401] Given the reliance of marginalised persons on the public healthcare system, they were frequent targets for birth control measures.[402] Further, cash incentives offered at mass vasectomy camps were effectively coercive, as the targets were landless and land-poor men (and thus more likely to have belonged to marginalised communities).[403] Family planning programs thus "left hierarchies of class, indigeneity, caste, and gender almost entirely unchallenged."[404]

It was in the backdrop of this family planning agenda that the Ministry of Health & Family Welfare (MoHFW) appointed a committee under Dr. Shantilal Shah to consider the legalisation of abortion in 1964.[405] The Shah Committee, comprehensively reviewed the socio-cultural, legal and medical aspects of abortion and made recommendations in 1966 to the effect that abortion be legalised to protect the lives and health of women on compassionate and medical grounds.[406] The Shah Committee's report was the impetus for the move towards the legal regulation of abortions which was looked upon by some states as a strategy for reducing population growth.[407] The Shah Committee however, categorically denied that this was the purpose behind the proposed legislation. The term ''Medical Termination of Pregnancy'' (MTP) was used to reduce opposition from socio-religious groups averse to liberalisation of abortion law.[408] The Committee's recommendations formed the basis of the Medical Termination of Pregnancy Bill, which was enacted as a law in 1971.[409]

The overarching framework of criminalisation of abortions in India has resulted in several structural constrains when it comes to abortion access. The latest data available from 2015 estimated the abortion rate to be 47 abortions per 1,000 women of reproductive age[410] and almost 3 in 4 women seeking illegal abortions.[411] Scholars and activists have argued that the lack of capacity in terms of numbers, and the disparate availability of obstetricians and gynaecologists in India,[412] coupled with the absence of adequate facilities providing abortion care, shortages in equipment, the inadequacy of public healthcare infrastructure, and the arbitrary authorisation requirements, all these factors could push abortion care out of reach for many throughout the country—especially for women living in poverty, women in

rural areas, and survivors of sexual assault.[413] According to the guidelines issued by the MoHFW, all public-sector facilities at the primary health centre (PHC) level and higher are allowed to provide induced abortion, as long as they have a certified provider on staff.[414] Public facilities are well positioned to be the principal healthcare provision centres for marginalised groups including women from weaker socio-economic backgrounds, for they offer free and affordable services and are more accessible than private sector establishments.[415]

Still, many public facilities do not offer abortion services.[416] Primary Healthcare Centres (PHCs) typically have limited capacity to offer the service, and across the six study states, only a small proportion do so (3–14%).[417] Studies also show that facilities offering abortion often use methods that are not in line with best practices for abortion care. WHO guidelines recommend the use of MMA or vacuum aspiration for most abortions; D&E is recommended in situations in which the other methods are not possible (typically in the second trimester); and D&C is no longer recommended as an abortion method at any gestation.[418]

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LEGISLATIVE AND JUDICIAL REFORMS

Abortion in India is criminalised under Sections 312 to 318 of IPC. In 1971, the MTP Act was enacted as an exception to the provisions under the IPC and the law allowed for termination of pregnancies under certain circumstances.[419] This law was dually situated in the context of population control discourse and to prevent unsafe abortions.[420] Under the MTP, abortion was legal up to 20 weeks "when it is necessary to save a woman's life or protect her physical or mental health, and in cases of economic or social necessity, rape, contraceptive failure among married couples and foetal anomaly."[421] The law required the authorisation of one registered medical practitioner (RMP) for terminating pregnancies up to 12 weeks of gestation and pregnancies between 12 to 20 weeks required the authorisation of two RMPs.[422] Abortion was also legalised beyond 20 weeks in the case of endangerment to the pregnant person's life.[423] Many activists, scholars and feminists have noted that such a requirement impedes the autonomy of women. For instance, Jesani and Iyer argue that a pregnancy that was wanted at the time of conception but may no longer be wanted cannot be terminate under these provisions. A pregnant person is "required to furnish explanations that fit into the broad liberal-and yet, restrictive conditions listed in the act."[424] The MTP Act also confers full protection to a RMPs against any legal or criminal proceedings for any injury caused to a woman seeking abortion, provided that the abortion services were provided in good faith.[425]

Under the MTP Act, abortion services can be provided at any hospital maintained by the government and any private facility providing abortion services must have the necessary approval and certification from the government. Any termination of pregnancy at a hospital or other facility that does not have prior approval of the government is deemed illegal and the onus is on the hospital to obtain prior approval.[426] The requirements under the MTP have been relaxed in certain exceptional cases where abortion services are provided to save the life of the pregnant woman. In such cases, the law permits a doctor without the stipulated experience or training to provide the services as long as they are registered practitioner. It further allows abortion services to be provided at a facility that does not have prior certification and pregnancies between 12-20 weeks of gestation may be terminated with the approval of one RMP.[427] The Medical Termination of Pregnancy Rules and Regulations,1975 (MTP Rules and Regulations) further list the criteria and procedures for approval of facility, procedures for consent, maintenance of records and reports and ensuring confidentiality.[428]

The MTP Act has been amended on two occasions since its enactment in 1971. The first was in 2002, after a long consultative process involving various governmental and non-governmental agencies, professional bodies and activists which resulted in the passing of the Medical Termination of Pregnancy (Amendment) Act 2002[429] and amended MTP Rules and Regulations, 2003.[430] In an effort to reduce the bureaucracy for obtaining approval of facilities, the amended Act decentralised regulation of abortion facilities from the State level to District Committees. It also introduced penalties for individual providers and owners of facilities not approved by or maintained by the government, who will face of 2–7 years imprisonment for providing abortion services at unauthorised facilities.[431] To reduce administrative delays, the amended MTP Rules define a time frame for registration and mandate the District Committee to inspect a facility within two months of receiving an application for registration and process the approval within the next two months if no deficiencies are found, or within two months after rectification of any noted deficiency.[432] However, the amended MTP Rules do not specify measures

to be taken if approval procedures are still not completed in the stipulated time frame. Most significantly, the amended MTP Rules recognise MMA and allow RMP to provide mifepristone and misoprostol in a clinic setting to terminate a pregnancy up to seven weeks, provided that the doctor has either on-site capability or access to a facility capable of providing surgical abortion services in the event of a failed or incomplete medical abortion.[433] However, the Drug Controller of India has approved mifepristone provision only by a gynaecologist, thus effectively restricting access. National consensus guidelines and protocols for medical abortions have been developed in this regard.[434]

The MTP Act was amended for a second time in 2021 with significant yet inadequate changes.[435] The key amendments include:

- *Requiring the opinion of one RMP for the termination of pregnancy up to 20 weeks of gestation period;*
- *Requiring the opinion of two RMPs for the termination of pregnancy between 20 - 24 weeks of gestation, thereby increasing the upper gestation limit from 20 to 24 weeks for "certain categories" of women, including survivors of rape or incest, minors and women with disabilities, among others; and*
- *Removing an upper gestational limit for termination in cases of substantial foetal anomalies after 24 weeks as diagnosed by a Medical Board.*

Notably, failure of contraception as a ground for terminating a pregnancy up to 20 weeks of gestation now covers "any woman or her partner" thereby doing away with the restrictive applicability of the MTP Act to "only married woman or her husband."[436]

Though the new amendment has been applauded by many, it has also been critiques for several reasons, the most significant of these being that the amendment has failed to undo the barriers to abortion access that have persisted despite the legalisation of abortion under the MTP. The amendment has increased the gestational limit for termination, but also entrenches practices requiring women to obtain authorisation by medical practitioners for all abortion care even in the earliest stages of pregnancy—despite broad calls for making the MTP Act a non-provider-centric, rights-based law. Further, while the amendment increases some gestational limits, it institutionalises third-party authorisation for abortion care by adding a requirement for approval from a three-person Medical Board in cases of severe foetal anomalies beyond 24 weeks.[437] The new amendment to the MTP Act could further exacerbate existing barriers and make it even more difficult for people to access safe abortion care in India. Further, abortion services when provided in circumstances not covered under the MTP Act are still penalised under Section 312 of the IPC.[438]

Notably, in addition to the MTP Act, there are several other legislations in India, that have some impact on access to abortion services. Of these, two legislations, the Pre-Conception Pre-Natal Diagnostics Techniques Act, 1994 (PCPNDT)[439] and the Protection of Children from Sexual Offences Act, 2012 (POCSO)[440] are key.

The PCPNDT Act is a legislation targeting the issue of gender-biased sex-selection which was contributing to the declining gender ratio in the country.[441] It must be noted that PCPNDT does not, in any way, regulate access to abortions. It outlaws pre-conception and prenatal sex determination. However, this ban on diagnostics is conflated with provision of abortion services.[442] Doctors are fearful of attracting penal consequences under the PCPNDT and the message that translates on ground is that any termination of a pregnancy will attract penal consequences under the PCPNDT.[443] POCSO, on the other hand, was enacted by the government to address the issue of child sexual abuse, sexual harassment, and pornography.[444] It criminalises all sexual activity with a person who is below the age of 18 years, and also imposes an obligation on any person, including healthcare service providers, who possesses the knowledge of such sexual activity, to mandatorily report it to the police. This mandatory reporting requirement has served as a deterrent for adolescents in consensual sexual relationships seeking abortions, owing to both the fear of criminalisation and disclosure of their private information.[445] Owing to the presence of these laws, the current legal framework in India provides conflicting guidance to healthcare providers and also leads to a conflation of these legal provisions owing to lack of clarity on-ground, thus hindering access to abortions.[446]

Here, it is also pertinent to take note of the legal complexity that results from the conflicting provisions under the Rights of Persons with Disabilities Act, 2016 (RPD Act).[447] Section 92(f) of the RPD Act penalises anyone that conducts a medical procedure when such procedure results in the termination of the pregnancy of a woman with disability without her consent. However, the provision carves out an exception for instances of "severe disability" where the pregnancy is terminated without the consent of the woman with disability, but such termination has the consent of her guardian.[448] This legal sanction for bypassing the informed consent requirement for persons with disabilities, when read with the provisions of the MTP Act which no longer imposes any upper gestational limit for termination of pregnancies owing to risk of foetal anomalies is reflective of the anti-disability, eugenics-based rationale embedded in the legal framework. The law thus fails to account for the

intersectional experience of marginalisation of pregnant persons with disabilities.[449]

Some of these conflicts have resulted in pregnant persons seeking judicial interventions in order to secure their reproductive rights. Courts have played a significant role in taking further the discourse on sexual and reproductive rights. Some important judicial decisions by the Supreme Court of India in this regard are discussed below.

Judicial Developments on Abortion

The 2009 decision of the Supreme Court in *Suchita Srivastava v. Chandigarh Administration*[450] is one of the first cases articulating reproductive rights within a fundamental rights framework.[451] The court held that a woman's right to make reproductive choices is a dimension of the guarantee of personal liberty under Article 21 of the Constitution. The Court stated that *"there is no doubt that a woman's right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India. It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating."*[453]

In 2016, the Supreme Court in *Devika Biswas v. Union of India* held that Article 21 of the Constitution included protection of "the reproductive rights of a person."[454] The Court recognised reproductive rights as an important part of the right to health and an aspect of personal liberty under Article 21 of the Constitution.[455] The Court defined such rights to include the right to *"access a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behaviour."*[456]

In the same year, another significant verdict was delivered by the High Court of Bombay in the case of *High Court on its Own Motion v. State of Maharashtra*.[457] In this case, the Court took suo motu cognisance of the issue of pregnant women prisoners in the state of Maharashtra. By way of a public interest litigation, the Court interrogated the situation where pregnant women prisoners were being referred to a committee to authorise the request for terminations of pregnancies.[458] Observing that such a practice was violative of the right to autonomy which undoubtedly rests with the pregnant woman, the Court held that women have absolute rights over their bodies and the well-being of the pregnant woman takes precedence over that of a foetus. The judgment of the Court was one of the first cases to recognise that barriers to accessing abortions are a unique manifestation of gendered discrimination.[459]

In 2017, in a landmark decision in *Justice K.S. Puttaswamy (Retd) & Anr. v. Union of India & Ors.*[460] the Supreme Court held that the right to privacy is a fundamental right under the Constitution, which includes within its scope the rights to bodily integrity, reproductive choice and decisional autonomy.[461] The Court examined the concept of 'decisional autonomy' linked to the rights to privacy and self-determination and observed that decisional autonomy encompasses the right of reproductive choice, including a person's right to decide whether to stay pregnant.[462] The Court further stated that *"family, marriage, procreation and sexual orientation are all integral to the dignity of the individual. Above all, the privacy of the individual recognises an inviolable right to determine how freedom shall be exercised."*[463]

In 2022, the Supreme Court delivered another landmark judgment in *X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT Of Delhi*.[464] The Court declared that the distinction between married and unmarried women provided under Rule 3B of the MTP Rules, which lists the categories of women who may terminate a pregnancy between 20-24 weeks of gestation, was unconstitutional. The Court gave an expansive interpretation to the provisions of the MTP Act and the Rules notified under the Act, observing that the law must take note of the change in material circumstances, which may result in the pregnant person not being in the same social, medical, financial of physical state to carry the pregnancy to term. Therefore, the categories of women under Rule 3B must not be read in a restrictive manner. *"If the law was to be interpreted such that its benefits extended only to married women, it would perpetuate the stereotype and socially held notion that only married women indulge in sexual intercourse, and that consequently, the benefits in law ought to extend only to them. This artificial distinction between married and single women is not constitutionally sustainable. The benefits in law extend equally to both single and married women."*[465]

The Court also recognised a married woman's right to abortion if the pregnancy was a result of forced or non-consensual sex. Reaffirming a woman's right to bodily autonomy, the Court condemned the widespread practice of imposing extra-legal conditions/requirements as done by RMPs for providing abortion services.[466] In regards to adolescent sexuality, the Court read down mandatory reporting requirements under Section 19 of the POCSO Act, stating that the identity and personal information of the minor need not be disclosed by the medical practitioner in their report under Section 19 or during any criminal proceedings that follow therefrom.

Most significantly, the Court took cognisance of the chilling-effect of a criminal framework on medical practitioners and the consequent barriers to safe abortions for pregnant persons, noting that access to abortions was not an issue restricted to cis-gender women alone, but one that also affected persons with capacities for pregnancies, which includes transgender and gender non-conforming persons.[467] It further noted the pressing need for decriminalisation to counter the social stigma as well as legal barriers that hamper access to abortions, especially for marginalised persons. The Court observed:[468]

"It is not only the factors mentioned above which hinder access to safe abortion but also a fear of prosecution under the country's criminal laws. Under the current legal framework, the MTP Act merely lays out exceptions to the provisions criminalizing abortion in Sections 312 to 318 of the IPC. Presently, under the MTP Act, the opinion of an RMP (in accordance with the restrictions and grounds laid down in the Act) is decisive. It is on the basis of the opinion formed by RMP(s), either under Section 3 or under Section 5, that a woman can terminate a pregnancy under the MTP Act. This makes the MTP Act a provider-centric law. Since women's right to access abortion is conditional on the approval by an RMP, the denial of services by an RMP compels women to approach courts or seek abortions in unsafe conditions. A fear of prosecution under this complex labyrinth of laws, including linking of the MTP Act with the IPC, acts as a major barrier to safe abortion access, by having a chilling effect on the behaviour of RMPs. The chilling effect historically associated with protection of freedom of speech and expression under Article 19 has an impact on the decision-making of medical professionals acting under the MTP Act and consequently impedes access to safe and legal abortions and the actualisation of women's fundamental right to reproductive autonomy."

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The comprehensive jurisprudence that has emerged from the Supreme Court of India in the last decade has paved way for a rights-based discourse on abortion in India. Through some significant rulings, the Court has reiterated that reproductive rights are essential facets of a pregnant persons' autonomy, dignity, and bodily integrity, as well as the right to health which is a fundamental component of the constitutionally protected right to life.[469] However, the discourse around reproductive rights has been increasingly couched within the language of privacy, and the judiciary is yet to articulate a clear link between the right of reproductive autonomy and gender equality.[470] The framing of reproductive autonomy within the language of equality and non-discrimination is critical for addressing the intersectional barriers to abortion access in India.[471]

The gaps and limitations of the law regulating abortions in India have also prompted challenges to the legislation, with Dr. Nikhil Datar, a gynaecologist from India approaching the Supreme Court of India seeking a clarification of the ambiguous provisions under the MTP (Amendment) Act, 2021 as well as the setting up of medical boards under the new law.[472] Notably, Dr. Datar had previously approached the Supreme Court of India in 2009, prior to the recent amendments to the MTP Act seeking the extension of the gestational limit within which a pregnancy may be terminated from 20 weeks to 24 weeks.[473] In addition to this case, there are prior challenges to the constitutional validity of the MTP Act currently pending before the Supreme Court of India. Three women, Swati Aggarwal, Garima Sekseria, and Prachi Vats have approached the Court in 2019 challenging the MTP Act for violating women's right to reproductive autonomy by making the decision to terminate a pregnancy contingent upon the approval of a RMP, among other grounds.[474] While these efforts before the Court are yet to see any results, it is also pertinent to take note of recent efforts on the legislative front that may have a significant impact on the status of criminalisation of abortions under the IPC. On June 26th, 2020. The Ministry of Home Affairs, Government of India, through a notification dated May 4th, 2020, has constituted a National Level Committee for Reform in Criminal Laws.[475] The Committee has been tasked with undertaking a comprehensive review of the criminal laws currently in operation in India, which includes the provisions under Sections 312 of the IPC.[476]

The framing of reproductive autonomy within the language of equality and non-discrimination is critical for addressing the intersectional barriers to abortion access in India.

Sri Lanka

BACKGROUND

Sri Lanka was colonised by three different European States over a period of 450 years: the Portuguese from 1505 to 1658, the Dutch from 1658 to 1796, and the British from 1796 to 1948.[477] Although Sri Lanka gained independence in 1948, it remained a dominion under the British Empire until 1972, when it was established as a Republic.[478] Sri Lanka is a multi-ethnic and multi-lingual country with the population primarily comprising six ethnic groups: Sinhalese, Tamils (Sri Lankan Tamils and Tamils of Indian origin), Muslims, Malays, Burghers (individuals of mixed European descent), and Veddhas (the aboriginal inhabitants).[479] Given its colonial past, the legal system in Sri Lanka is a complex mixture of common law, Roman-Dutch law, Muslim personal laws and customary laws. A republic Constitution was first adopted in 1972 and subsequently revised in 1978.[480]

Sri Lanka has made significant efforts towards developing a well-functioning health system. Progressive social policies, including universal health care and education, and a well-developed health infrastructure, have led to a decline in maternal mortality since the 1950s.[481] Sri Lanka has also been commended internationally for achieving one of the lowest MMRs in South Asia.[482] Between 2000 and 2010, the mortality ratio decreased from 58 to 35 deaths per 100,000 live births.483 This excludes the Northern Province, where 98% of births were attended by skilled personnel and took place in hospitals.[484]

Despite this progress and a robust and accessible system of healthcare, Sri Lanka has one of the most restrictive abortion laws in South Asia as abortion continues to be criminalised, the only exception to criminalisation being the termination of a pregnancy to save the life of the pregnant woman.[485] The criminal framework is rooted in colonial jurisprudence which considered abortion to be sin and sought to *"protect the sanctity of foetal life."*[486] This framework was consequently adopted into the Penal Code of Ceylon in 1883.[487]

Even in this highly restrictive climate, women continue to seek abortion services under unregulated and clandestine conditions.[488] Access to abortion is also impeded owing to structural inequalities as pregnant persons from privileged socio-economic backgrounds have access to safe abortion services available in private clinics.[489] In contrast. pregnant persons from marginalised socio-economic backgrounds are disproportionately disadvantaged due to the lack of affordable safe abortion services.[490] The cultural discourse around abortion is also heavily punctuated by sensationalism, as evidenced by 'raids' conducted by the media to 'expose' abortion clinics.[491]

Abortion was criminalised by the Penal Code of Ceylon in 1883 under Sections 303-306. There have been no amendments to these sections since the adoption of the Code in 1883. These provisions have continued to remain in operation under the postcolonial law and the termination of pregnancies in exceptional circumstances to save the life of the woman also requires authorisation by three doctors.

LEGISLATIVE AND JUDICIAL REFORMS

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In 1995, Professor G. L. Peiris, then Minister of Justice, introduced a Bill in parliament that proposed multiple amendments to the Penal Code.[495] The Bill originally proposed a relaxation of the restriction on abortions and the decriminalisation of abortion in instances of rape, incest and foetal anomalies. However, these clauses were subsequently deleted by Professor Peiris for being "too controversial."[496] Nonetheless, abortion law reform was discussed extensively by Members of Parliament over the course of two days. The record of debates from the session provide important insight into the differing positions held by Members of Parliament,[497] which were largely framed by patriarchal attitudes towards women.[498] Numerous concerns were raised across the table on the relaxation of abortion laws as it would "lead to promiscuity, especially among the young and open the floodgates."[499]

The discussion was also dominated by paternalistic attitudes that categorised women as vulnerable persons in need of protection.[500] There were, however, some exceptions with some members speaking in support of recognising women's right to abortion and noting how "new and profound changes in contemporary mores and values relating to gender equality, must be reflected in the law."[501] Although these debates did not result in any legislative reforms at the time, there have been subsequent developments and efforts on the legislative front with respect to the legal regulation of abortion in Sri Lanka.

In December 2010, the Ministry of Health was scheduled to deliberate on the registration of misoprostol for use in Sri Lanka, but this decision was postponed indefinitely.[502] Misoprostol was finally registered in 2015, following which the Ministry of Health introduced guidelines to regulate its distribution and usage.[503] These guidelines, last updated in 2021, prohibit the use of misoprostol during the first and second trimesters, unless it is confirmed that the pregnancy is non-viable and recommend its use during the third trimester for in-utero deaths.[504]

In 2011, the Minister of Child Development and Women's Affairs raised the issue of abortion law reform in the parliament.[505] The National Action Plan for Human Rights, 2011 also listed the decriminalisation of abortion in instances of rape and major foetal anomalies as one of the goals of the plan. In 2013, a draft Bill was prepared by the Law Commission that permitted abortion in case the pregnancy was a result of rape, incest or if there were significant foetal anomalies.[506] However, the Bill was opposed by the Catholic Church of Sri Lanka and also faced opposition from Buddhist clergymen and was not enacted as law.[507] In 2015, the Ministry of Health released National Guidelines on Post-Abortion Care that permitted any woman who had received abortion services through illegal means to seek care for any complications resulting from the termination without facing criminal consequences.[508]

In 2017, Justice Aluvihare of the Special Committee on amending the Penal Code and the Code of Criminal Procedure Act recommended that the Cabinet should *"allow [sic] abortions in the cases of rape and incest, pregnancy in women below the age of 16 years and pregnancies with serious foetal impairments."*[509] The Cabinet in 2017 approved a draft Bill that permitted the termination of pregnancies in "cases of lethal congenital impairments of the foetus and in cases of rape", however it drew strong opposition from religious groups, following which the Bill has been put on hold.[510]

> The draft Bill was extensively criticised by feminist activists and scholars, who found it to be 'problematic' and doctor-centric.[511] They also asserted that the proposed reforms did not go far enough and emphasised the need to adopt a rights-based approach that centres women's autonomy.[512] In this backdrop of criminalisation and restricted access to abortions, organisations like the Family Planning Association of Sri Lanka continue to advocate for abortion law reform.

Bangaldesh

BACKGROUND

Bangladesh is the youngest nation-state in South Asia.[513] On April 10, 1971, the 'People's Republic of Bangladesh Government' (a provisional Government) was formed after experiencing a genocide that claimed millions of lives. Thereafter, a new constitution was drafted and four basic principles of *Awami* League – nationalism, socialism, secularism and democracy – were adopted as the State policy.[514] In 2008, the caretaker government finally held elections in which Sheikh Hasina (Awami League) won a landslide victory.[515] In 2011, Sheikh Hasina abolished the caretaker system and adopted secularism.[516] Presently, Bangladesh is a parliamentary democracy largely influenced by the British parliamentary system. Executive power is in the hands of the Prime Minister, who is the head of the cabinet, and who must be a member of the 350-seat Jatiya Sangsad (unicameral parliament).[517]

Similar to Pakistan and India, the colonial era penal laws have significantly informed the legal framework of Bangladesh. The Penal Code of Bangladesh is adopted from the British penal code and abortion is criminalised leading to significant issues concerning SRH. To elucidate, some of the key problems that persist in Bangladesh include high MMR, unmet needs for contraception, high incidence rates of unsafe abortions. The MMR which has declined dramatically, it was still high at 176 per 100,000 live births in 2015.[518] The high MMR reflects poor availability and low utilisation of obstetric services as well as lack of access to information. Women marry at a young age, a median of 14.2 years and have 3.3 children on average.[519] The contraceptive prevalence rate (CPR), as of 2022 is 64% among currently married women aged 15–49; 55% of women are using modern methods of contraception, while 9% rely on traditional methods.[520]

Although the Bangladesh Family Planning Programme has met with success, there are problems such as low contraceptive continuation rates, method failure and high unmet need for contraceptives leading to unwanted pregnancies. One quarter of all maternal deaths were due to induced abortion.[521] While the rate of abortions has been consistently increasing, TFR for the last ten years remains stagnant, and CPR has been increasing.

Several studies have tried to estimate the number of abortions annually in Bangladesh. A study examining intimate partner violence (IPV) and MR found that, out of 457 women, "over 25% of women seeking abortion care reported experiencing IPV in 2012.[522] This was associated with other potential constraints to reproductive autonomy and reproductive health outcomes."[523] The study also found that IPV may manifest as controlling women's fertility and the denial of contraception.[524] Hence, women may access MR alone or in clandestine ways.[525] The study concluded that *"seeking abortion care unaccompanied and accessing induced medication abortions could be strategies used to control fertility covertly in the context of violence, and facilities should ensure that the full range of procedures, including medication abortion, are available to women."*[526]

LEGISLATIVE AND JUDICIAL REFORMS

Abortion is criminalised in Bangladesh under Sections 312-318 in the Penal Code of 1860. The only exception is when abortion is provided to save a woman's life.[527] However, MR has been permitted by the government since 1979 as part of its family planning policy.[528]

In 1972, criminal liability was waived for termination of pregnancies by women who had been raped during the war of liberation.[529] As early as 1976, the Bangladesh National Population Policy attempted to legalise first trimester abortion on broad medical and social grounds, but there was no legislation to this effect.[530] However, due to the increasing rates of unsafe abortions, the government encouraged the introduction of MR services in a few isolated family planning clinics.[531] Bangladesh is unique in South Asia in making MR

services available to women at the community level. In 1978, the Pathfinder Fund initiated and funded the MR Training and Service Programme (MRTSP) in seven government medical colleges, two district hospitals and one family planning clinic in Bangladesh.[532] In 1979, MR was legalised and incorporated into the National Family Planning Programme which stated that MR services should be available in all government hospitals and health and family planning complexes at the district and *upazila* levels.[533] A study conducted in 1990 recorded that more than 52,000 women sought MR, but 17.2% were turned away – in all cases but one because the pregnancies were over ten weeks of gestation.[534]

MR can be provided by doctors up to 12 weeks of gestation and by paramedics and nurses for up to ten weeks, in each case from the last missed menstruation.[535] In an environment where abortion is illegal, MR is accepted and widely practised with no opposition from religious groups.[536] According to the Guttmacher Institute, approximately 48% of all pregnancies were unintended, approximately 1,194,000 induced abortions were provided and approximately 430,000 MR procedures were performed in health facilities in 2014.[537] MR procedures accounted for termination of close to three-fifths of unintended pregnancies.[538]

Notably, women are often required to seek their husband's permission in cases of MR even though such permission is not mandated by law.[539] Research indicates that men have multiple roles in decision-making and actions.[540] Usually, this is positive, as they help their wives make the decision and then proactively seek information and services.[541] Studies also suggest that, in most cases, men are also responsible for providing the financial resources required for termination of a pregnancy and any post-abortion care required owing to complications.[542] Additionally, severe economic hardship, debilitated health and completed family size are principal reasons for termination of pregnancies and also carry some inherent legitimacy as valid grounds.

Despite the availability of safe and legal MR services, unsafe abortions still occur and are associated with high complication rates, resulting in women seeking post-abortion care.[543] Studies note significant barriers that impede access to MR procedures, including clinics being too far away, people not knowing where clinics are situated, negative attitudes of healthcare providers, and stigma against abortions.[544] One study found that there was a discrepancy in healthcare providers' knowledge of the gestational limit or the date from the last menstruation when MR can be provided. This may cause healthcare providers to turn pregnant women away, despite them being within the 10-12 weeks' limit prescribed by the law.[545] The same study also found an alarming incidence of "brokers" – third party individuals that waited outside hospitals/clinics or operated within hospital premises to "facilitate" abortions. Such brokers received a fee from the clinics to which clients were directed and these clinics were often unsafe with providers being unregulated and untrained.[546] Some providers refused to provide MR or post-abortion care services.[547] Another troubling dimension was that given the relatively private and easier access to medical termination through MMA pills, some women bought the pills directly without adequate guidance on administration.[548]

On September 13, 2012, mifepristone was approved by the Drug Control Committee (DCC) to be manufactured, sold and administered locally. After receiving approval of mifepristone only, the Menstrual Regulation with Medicine working group initiated the process of approval of local manufacturing of mifepristone-misoprostol combination pack for MR.[549] The combination pack was identified as a way to prevent indiscriminate or incorrect use of the medicines when used separately. The apprehension was that if mifepristone and misoprostol were dispensed in separate packets, users may use only one of them which would decrease the effectiveness and eventually lead to increased instances of incomplete MR, posing a health risk for women.[550] This concern was already aggravated by over the counter sale of MMA pills.[551] It was not an easy task for the relevant stakeholders to get approval of the mifepristone-misoprostol combination pack from the technical subcommittee (TSC) of the Directorate General of Drug Administration (DGDA).[552] However, in February 2013, the pharmaceutical company received approval of the mifepristone-misoprostol combination for MR to manufacture, sell and administer the pack locally. MMA pills may be prescribed up to 9 weeks of gestation and pregnancies can be terminated through MVA until 10-12 weeks since LMP.[553]

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There have been recent calls to reform the law on abortion.[554] Dr. Syeda Nasrin, a Supreme Court lawyer, filed a petition arguing that Sections 312-316 of the Penal Code violate Articles 27, 29, 31, 32, 38, and 42 of the constitution of Bangladesh.[555] Dr. Nasrin had previously sent a legal notice to the government pertaining to the legality of the provisions criminalising abortion and filed the writ petition

after she did not receive a response to this notice.[556] The petition stated that "sections of the British colonial-era Penal Code contradict articles of Bangladesh's Constitution and the Penal Code violated constitutional rights to life, body, privacy, liberty and freedom of choice, and giving birth to a child and accepting motherhood constitute essential parts of these rights."[557] The petition also highlighted the prevalence of abortions in clandestine conditions which lead to health complications. In response, a bench of the High Court Division of the Supreme Court (HCD, popularly known as the High Court), composed of judges Tariq-ul-Hakim and S.M. Kuddus Zaman issue a show-cause notice to the Secretary of the Ministry of Law and the Supreme Court's Registrar General and the two other respondents in the case asking them to file submissions within a period of four weeks explaining why Sections 312-316 should not be revoked and declared illegal."[558] The petition has received mixed reactions and also faced some backlash from feminists who have critiqued the privacy framework that the petition relies on and the case is currently pending before the Court.

An overview of the legislative frameworks and judicial developments, or lack thereof, of abortion regulation in the ten countries noted above reveals the systemic and structural barriers impeding pregnant persons' access to safe and legal abortion services in the respective jurisdictions. Out of the ten countries that inform this study, Vietnam's laws are the most liberal, and the Philippines the most restrictive. Nepal and Thailand permit abortion up to 12 weeks on demand, though criminalisation persists. Bangladesh is unique in its use of (MR) which is functionally a euphemism for abortion. MR policies allow for leeway in the operation of abortion in otherwise harshly criminalised procedures. India, Pakistan, Indonesia, and Malaysia all criminalise abortion with the exception of certain conditions, although India has legislation that regulates abortion services. Meanwhile, Sri Lanka criminalises abortion unless it is performed to save the life of the woman. The next section takes a closer look at factors that aid in the stigmatisation of abortion, the on-ground impact and repercussions of criminalisation of abortion, as well as the resultant challenges to abortion access.

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CHAPTER 3

FINDINGS AND ANALYSIS

INTRODUCTION

This chapter presents an understanding of access to abortion services through on-ground perspectives on how such access is facilitated or hindered by the legal framework of the ten countries. The chapter also engages with the findings and reflections obtained through qualitative interviews, which form the basis of thematic analysis on the criminalisation of abortion and the impact thereof in South Asia and Southeast Asia.

The interviews reveal that the historical criminalisation of abortions is rooted in colonisation, religious, cultural, and social values about gender roles, which in turn restrict the exploration of women's sexuality beyond monogamous, heteronormative familial structures. Such criminalisation has furthered social stigma against abortion, which plays out differently in the distinct socio-cultural contexts, particularly with reference to religious opposition in some countries. The decision-making power in relation to reproductive rights and reproductive health does not vest in the pregnant person. This results in cultures of misinformation, which associate abortion services with promiscuity, extra-marital affairs and 'bad' behaviour.

It is well established that criminalisation does not reduce the rate of abortions. Instead, it significantly hinders on-ground access to abortion services. Healthcare providers are highly concerned about the penal consequences they may face for providing abortion services. Evidence from some countries also indicates active prosecution, imprisonment and harassment of healthcare providers and abortion seekers. As a result, the framework of criminalisation compels pregnant persons to seek clandestine and unsafe abortion services which is often detrimental to their health.

The role (or lack of) of social movements in facilitating legal reforms, as well as the constitution of such movements, informs some of the analysis. Many countries have strong feminist movements that address and give direction to abortion-related reforms. However, the extent to which these conversations are mindful of intersectional experiences of barriers to abortion services varies across countries and contexts, making some movements more inclusive than others. For instance, the feminist movements in the Philippines, Indonesia and Thailand are reasonably inclusive, with expansive approaches towards gender diversity and persons with disabilities among others. Additionally, Bangladesh's feminist movement has been aiming to increase diversity and inclusion over the past few years, making space for women with disabilities and persons from LGBTQIA+ communities. Meanwhile, the lack of intersectionality in the feminist movement is a persisting challenge in India, with social hierarchies of caste, gender and disability often remaining unaddressed in mainstream conversations. The mainstream feminist movement in Nepal is inclusive of LGBTQIA+ persons but lacks adequate focus on the concerns of persons with disabilities and Dalit persons. It fails to recognise the need for the heterogeneity of experiences in the discourse on equality.

Evidence from some countries also indicates active prosecution, imprisonment and harassment of healthcare providers and abortion seekers. As a result, the framework of criminalisation compels pregnant persons to seek clandestine and unsafe abortion services which is often detrimental to their health.

Experts have outlined extra-legal factors such as religion and culture that support and reinforce the criminalisation of abortion. The primary opposition to abortion reform is the overarching socio-cultural landscape influenced by patriarchal, cultural and religious beliefs. Even in the absence of religious influences, people are anti-abortion – a sentiment based in a culture where they do not believe in 'destroying' a foetus, as in the case in Nepal. However, respondents from some countries reveal that abortion access is affected by bureaucratic inactions and complacency amongst stakeholders. In addition, several respondents from Pakistan, Vietnam, Sri Lanka and Nepal reported undue sensationalisation by media resulting in persistent stigma.

Further, this chapter analyses the challenges and impediments to adolescents' access to abortion services based on the differential ages of consent, child protection laws, stigma and socio-cultural perspectives on adolescent sexuality among others. For example, the focus of family planning policies on married adult women in several countries has created an atmosphere where doctors refuse to provide contraception and abortion services to adolescents. Penal provisions in child protection laws (such as the criminalisation of consensual sexual activity below the

age of 16 under the Penal Code of Sri Lanka and mandatory reporting provisions under the POCSO in India) coupled with requirements for parental or guardian's consent deter adolescents from seeking abortions.

Finally, the interviews provide an insight into the unique challenges and opportunities that each country is experiencing in realising abortion rights. The interviews also provide insights into legal reforms and legal strategies pursued by various stakeholders. As detailed below, these strategies include extensive coalition-building among groups that focus on gender equality and healthcare, as well as legal reforms through judicial activism and other legislative interventions.

RELIGION, CULTURE, SOCIAL STIGMA, AND THEIR RELATIONSHIP WITH CRIMINALISATION OF ABORTION

Abortion laws in South Asian and Southeast Asian countries are situated within a paradigm of criminalisation. However, given the enormous diversity in these regions in terms of religion, gender and sexuality norms, colonial and postcolonial histories, political systems and legal cultures, it is impossible to have a homogeneous understanding of the factors that impact access to abortion services. Varying socio-cultural and religious views amongst diverse populations have historically had a significant impact on law. Criminalisation often reflects the moral code held by the dominant culture in a nation, which both imbibes and exacerbates stigma.

In South Asia and Southeast Asia abortion is a stigmatised service.[1] The stigma around abortion is "multifaceted and multi-dimensional" and a "compounded stigma that builds on other forms of discrimination and structural injustices,"[2] including discrimination on account of gender, ethnicity, race and caste inequality, among other intersecting forms of oppression. The construction and production of abortion stigma is also local in some contexts and affected by the social structures prevailing in the concerned region or locality.

Stigmatised Status of Abortions

Across South Asia and Southeast Asia, the status of abortion follows a long history of shifting cultural norms and attitudes.[3] Abortion stigma refers to the shared understanding that abortion is morally wrong and socially unacceptable.[4] Attitudes towards sexual and reproductive healthcare and rights are particularly relevant to legal conversations surrounding abortion. Although the act of abortion is broadly considered a sin, it is particularly sinful when framed as a vehicle for premarital sex and sexual promiscuity in women. As seen in Nepal and Indonesia, abortion is often framed as a quick solution for promiscuity among young people and not as something sought out by respectable married couples.[5] Similarly, laws surrounding family planning and access to contraceptives in countries like Indonesia have a strong focus on married couples, failing to address the needs of unmarried persons and adolescents.[6]

In Nepal and Vietnam, stories of young women seeking abortion services are often sensationalised with a focus on "morality" of young women who are unmarried.[7] According to Anand Tamang, Director of the Centre for Research on Environment, Health and Population Activities (CREHPA), the media in Nepal exacerbates the stigma surrounding adolescent girls engaging in sex through sensationalised descriptions of young girls in their school uniforms visiting abortion clinics.[8]

Dr. Phan Bich Thuy, an activist and freelance consultant from Vietnam, argued that barriers to access are amplified by the proliferation of *"inaccurate information about health consequences of having an abortion in mainstream media and on the internet."*[9] She further noted that the public discourse on abortion was rare until the new draft of the Population Law was issued by the government in 2015.[10]

The draft law stated, *"[w]omen are entitled to end a pregnancy by abortion as requested before 12 weeks, unless the purpose of abortion is gender-related or might cause serious health consequences to the mother."*[11] This proposed law inspired a new movement where diverse stakeholders were seen engaging in advocacy.[12]

Stigma is a complex issue because it is both a cause and a consequence of reproductive inequality[13] which persists at individual, societal, legal and cultural levels thereby muddling clarity on the legal status of abortion services. Therefore, people often underestimate the extent to which abortion is legal. In many countries, even if abortion is legal, social stigma often results in a large section of the people being completely unaware of availability of legal and safe abortion services.

> For example, in Bangladesh, MR services for terminating a pregnancy are available without utilising the divisive term 'abortion.' Despite the introduction of MR in 1979, a study in 2014 found that over half of ever-married women in Bangladesh had never heard of MR.[14]

Similarly, in Nepal abortion is legal since 2002 and the government has provided comprehensive abortion services since 2004. However, as per the Nepal Demographic Health Survey (NDHS) 2016, only 41% of women (a mere 3% increase from 2011) were aware that abortion is legal in Nepal.[15] This accounts for less than half the women of reproductive age in Nepal.[16] There is also a disparity

between urban and rural women in Nepal: only 36% of rural women (versus 43% of urban women) were aware of the legality of abortion services. This can be attributed to the lack of rural abortion providers and poor public healthcare infrastructure.[17]

The confusion around the legal status of abortion in turn fuels unsafe back-alley abortions. It is evident that the criminalisation of abortion forces people to resort to desperate and unsafe measures to terminate their pregnancies.[18] The fear of criminalisation does not dissuade people from receiving abortions, but instead compels them to undergo unsafe and unregulated medical procedures. This increases the risk of maternal mortality and other forms of medical harm.[19] The stigma against abortion also exacerbates the common misconception that decriminalisation of abortion will not make a difference in access to abortion services, and therefore, the framework of criminalisation of abortions persists.[20]

Joanna Erdman argues that while the debate on abortions has been historically dominated by the understanding that legalising abortions is the end goal of decriminalisation efforts, the growing worldwide practice of self-managed abortions, which receives support from feminist groups, has challenged this paradigm.[21] The consequences of criminalisation are evident in the challenges to accessing MMA pills for self-managed abortions, which were highlighted by several respondents in their respective countries.

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MMA is the safest method of abortion. The combination regimen of mifepristone and misoprostol is the most effective in early stages of pregnancy.[22] However, many respondents cited the unavailability of MMA pills for abortions in their respective countries. For example, Marevic Parcon, an SRHR activist in the Philippines, noted that misoprostol is not listed as an essential drug.[23] As per the advisory No. 2021-2299 dated September 14, 2021 issued by the Food and Drug Administration (FDA), "Misoprostol (CYTOTEC) 200 mg tablet is not registered with the FDA. Authentic Misoprostol 200 mcg tablet "CYTOTEC" is indicated for the treatment of duodenal and gastric ulcers."[24] Similarly, in Thailand, Respondent E reported that *"MMA pills are not readily available over the counter or with a prescription and can only be acquired from a clinic affiliated with the Ministry of Public Health."*[25] Correspondingly, Thuy Mai, a SRHR activist from Vietnam, noted that MMA pills are not available over the counter. They require a doctor's prescription and can only be purchased and administered at a clinic or hospital.[26] In Malaysia, misoprostol is banned. According to Dr. S.P. Choong, an activist and the founder of RAAM, *"the ban was implemented not for safety reasons, but as a knee-jerk reaction to moral policing to a few cases of overdose."*[27] Further, Tunggal Pawestri, an activist from Indonesia, also pointed to difficulties in accessing misoprostol since *"doctors are unwilling to provide prescriptions for abortions. As a result, individuals resort to the black-market for misoprostol and often receive fake medications."*[28] In Sri Lanka, Respondent C noted that *"criminalisation affects access to MMA pills which are sold under the counter at exorbitant prices due to fear of prosecution. This also means that pregnant women with resources can access abortions, but those who cannot afford these pills are unable to access abortion services."*[30]

While stigma creates the sense of taboo and assumptions about people who seek abortion services, cultural norms determine how one's sexuality and relationship with their body is regulated.[31] The following section discusses the cultural barriers which prevent the mainstreaming of safe and accessible abortion services across different groups in South Asia and Southeast Asia.

Cultural Norms, Abortion and Regulation of Women's Sexuality

The stigma and cultural taboo against abortion has roots in the widespread desire to control women's sexuality and deny them bodily and decisional autonomy. It is perpetuated by unequal power structures and gender roles.[32] The association of abortion with rampant and uncontrolled women's sexuality has led to the perpetuation of widespread social stigma seen in several countries. For example, Dr. Alka Barua, a doctor and researcher in India, noted that *"the cultural association of abortion with sexuality (considered clandestine) creates a significant stigma surrounding abortion, regardless of the pregnant person's reasons for seeking one."*[33] Respondent A from India also alluded to this, noting that *"in order to uphold hegemonic structures of power, it is necessary to control women's sexuality, which is considered their 'innate nature' to serve the new social and political arrangements organised by cis-men of the dominant sections of society."*[34]

These attitudes also persist in Thailand; Nisa, a researcher from the Tamtang Group, stated that women who need abortions are seen as having an "inappropriate sexual life."[35] In Indonesia, activist Nanda Dwinta highlighted that *"abortion is seen as a consequence of premarital sex and the*

criminalisation of abortion is equivalent to the criminalisation of sexual behaviour."[36] Further, Dr. Irwin Hidayana, an Associate Professor at the Department of Anthropology, University of Indonesia, revealed that *"women's sexuality always becomes the target."*[37]

The stigma and cultural taboo against abortion has roots in the widespread desire to control women's sexuality and deny them bodily and decisional autonomy.

Dr. Ghullam Shabbir, doctor and activist in Pakistan, noted that *"abortion is a highly taboo and sensitive issue that is complex and challenging to broach."*[38] Dr. Xaher Gul, also a doctor and activist in Pakistan, expressed that, *"abortion is erroneously viewed as a means to hide extra-marital affairs or adultery."*[39] Dr. Sana Durvesh, a doctor and reproductive health activist in Pakistan, highlighted how the *"level of stigma attached to an abortion depends on the pregnant person's marital status."*[40] The negative perception around abortion therefore arises from the desire to restrict women from exercising their autonomy and freedom.

A similar situation is prevalent in Sri Lanka, where scholar and activist Subha Wijesiriwardena noted that the Sri Lankan society is *"patriarchal and ethnocentric, dominated by singular Buddhist, upper-caste male interests,"* leading to a very conservative domain on sexual and reproductive health.[41] Similarly, Sonali Gunasakera, head of the Family Planning Association in Sri Lanka, agreed that *"the patriarchal nature of society ensures that such decisions are made by men, which in turn further entrench the continued criminalisation of abortion services."*[42]

The role of caste in social relations cannot be understated in South Asia. Kiruba Munusamy argues that the root of violence against Dalit, Bahujan and Adivasi women in India stems from Brahminical patriarchy and that "Brahmin-dominant caste men" are protected by the caste system.[43] Manjula Pradeep has also spoken of the undeniable intersection between caste and gender, asserting that the annihilation of caste and dismantling of patriarchy are correlated.[44] Srujana Bej, Nikita Sonavane, and Ameya Bokil further argue that *"[w]hile upper-caste women in independent India have been able to reconfigure their identities and sexuality as being honourable due to the dictates of Brahminical patriarchy, Vimukta and Adivasi women who lie outside the caste system have not been offered the same "redemption"*. The historical oppression of these communities through colonial practices and the free reign of the caste system have continued their oppression.[45] Sunaina Arya argues that *"all the castes have been made exclusive and separate from each other through the institution of 'endogamy' i.e. marriage within the same caste. To preserve endogamy it was necessary to put restrictions on women with regard to marriage (and individual rights) and penalisation for violation of the same. A unique feature of this system is that women, irrespective of their caste, have very less individual rights—economic, social and religious, since women were the gatekeepers of 'caste purity.'"*[46] There was also a fear that Dalit men, whose sexuality was perceived as a threat to 'upper caste purity', would have sexual access to upper caste women, resulting in the requirement for institutional prevention through the careful guarding of women.[47] It became necessary to control women's sexuality, which has been viewed as their 'innate nature' to "serve the new social and political arrangements organised by men of the dominant sections of society."[48] Based on her work with Dalit women in the Indian state of Tamil Nadu, Sundari Ravindran discovered that younger people in the community are reluctant to discuss abortions and characterise them as a sin, although they admit that they would get abortions if necessary.[49] Interestingly, Ravindran attributed this to the association between abortion and "modernisation" (i.e., adoption of the values of upper caste women in the area).[50]

The implications of caste on access to healthcare rights was also highlighted by Shanta Laxmi, a SRHR activist from Nepal. She noted that while "there is an active Dalit rights movement in Nepal, the issues of Dalit women are not taken up by the mainstream women's rights movement and this lack of intersectionality remains a pressing concern."[51]

The distrust of women's sexuality is indicative of the belief that women cannot make decisions about their own health. This belief is supported by the doctor-centric framework of abortion laws including the MTP Act in India, which prioritise safeguards for abortion service providers and frequently call for the opinion of medical boards.[52] Respondent B from India also noted that "*there is an attempt to control the reproductive choices of women with disabilities under both the MTP Act and the RPD Act, 2016."*[53]

Hasanah Cegu, a lawyer and activist in Sri Lanka, confirmed that the Sri Lankan public attitude is that only "loose women" receive abortion services.[54] Cegu further revealed that *"the role of media is very critical in fuelling such attitudes and there have been instances where media persons have sent women along with a team with cameras to doctors' clinics under the pretext of seeking abortion services.*[55] *These interactions have been filmed and reported to the police, leading to further harassment, intimidation and stigmatisation."*[56] In Bangladesh, Dr Sanjib Ahmed, a medical practitioner and the Executive Director of Family Planning Association of

Bangladesh (FPAB) also pointed to *"the patriarchal values, owing to which the decision-making power does not rest with women and there is lack of information about sexuality and reproduction.*[57] *Simultaneously, women who have undergone abortion services are subject to allegations of promiscuity and subsequently ostracised."*[58] Anand Tamang further elaborated that *"women in Nepal went to prison for illegal abortions due to petty complaints from family, or because of false accusations or jealousy and that most of the complaints did not support the person undergoing the abortion – making it a tool of control and subjugation."*[59]

The cultural attitudes around abortion are heavily informed by religious traditions and conceptions of morality within communities, which in turn impact the legality of abortion services and access thereto.

Law and Religion

The criminalisation of abortion exists in tandem with various extra-legal factors, including religious beliefs.[60] As argued by legal scholar Sarah Purgh, the capacity of people to access and realise their SRHR has long been influenced by the shifting tides of politics and various configurations of political power that hold sway in specific times[61] including religion. She further argues that political decisions and associated policies that undermine or intentionally attack SRHR are often driven by the political priorities of those in power and the desire of politicians and decision-makers to gain or retain political power.[62] Historically, religious leaders exercised a great deal of power over politics and religious institutions have played a significant role in dictating how people live.[63] These forces make religious morality highly influential in the law, although the influence over policy remains contested.[64]

The cultural attitudes around abortion are heavily informed by religious traditions and conceptions of morality within communities, which in turn impact the legality of abortion services and access thereto.

Religion utilises many modes of moral reasoning to oppose abortion. For example, Christianity uses three arguments against abortion.[65] The first argument is that ''abortion violates the sanctity of life and is a rebellion against God's design."[66] This view is also held by other religious sects and not just Christianity.[67] Secondly, religion is employed to control promiscuous sexual activity, thereby confining women's activities to traditional gender roles. In essence, religion is a tool to enforce traditional views of morality.[68] The final argument is that religion is used as a method of promulgating religious groups' ideologies and views.[69] These rationales are quite common in religious opposition to abortion.[70]

Additionally, even where the laws regulating abortion are liberal, religious and social barriers can complicate access to abortion services. For instance, while abortion has been legal in Vietnam and is available on broad grounds since 1960s, studies reveal that the opinion on abortion is heavily influenced by religion, especially the belief in reincarnation.[71] Further, one study has shown that pre-marital abortion is an experience rife with stress and conflict among youth who feel conflicted about their non-observance of traditions.[72] Apart from this friction, it is important to note that abortion services have long been widely available through Vietnam's extensive healthcare system and since the introduction of the *doi moi* reforms,[73] there has been substantial growth in unregulated private sector (often by public-sector employees at their private residences or clinics).

However, in the Philippines, restrictive laws have long been rooted in the conservative political environment and the adamant pro-life movement led by the Catholic Church.[74] Data records reveal that the estimated numbers of Catholic Filipinos is 81%.[75] The Catholic Church's influence is immense and is reflected in the incessant negotiations on the 1987 Constitution, political and legislative actions against access to modern contraceptives by adolescents and the continuing blanket ban on abortion.[76] Dr. Sylvia, an academic based in the Philippines, noted that "most of the Filipinos views abortion as a sin."[77] Lawyer and activist Clara Rita Padilla confirmed the "resistance of the Catholic Church as well as presidential candidates to pro-abortion advocacy."[78]

However, Catholicism is not the only religious institution that characterises abortion as a sin. In Thailand, 95% of the population practices Theravada Buddhism, which acts a force of opposition against reproductive rights since it preaches non-violence.[79] Abortion is specifically considered a sin under this sect of Buddhism.[80] The prohibition against abortion exists in the code of discipline for monks.[81] In the context of contemporary Thailand, the dominant abortion discourses are based on Buddhist morality and mystical beliefs.[82] It believes that new life begins at conception and therefore, abortion is 'murder'.[83] The belief that the smallest form of life is created at the moment of conception leads to abortion being interpreted as a life-destroying act.[84] This discourse also evokes fear of the karmic consequences and negative attitudes towards abortion. Karma, a key Buddhist concept, is a major component of the Thai abortion rhetoric.[85] Nyanasobhano Bhikku argues that the question of the beginning of life is misleading since the cycle of life

is continuous: the last moment of one's life is immediately succeeded by the first consciousness of another life.[86]

Several interdisciplinary studies on abortion in non-western ethical traditions have been undertaken on Buddhism.[87] These studies establish the conceptual background to comprehend attitudes towards abortion, which differs from its "western" and predominantly Christian counterparts.[88] In Thai Buddhist texts, abortion is constructed as a product of corrupt "western" materialism and its ascendance over spirituality.[89] This equating of Buddhism with Thai-ness is based on the designation of Buddhism as one of the "Three Pillars" of Thai nationalism: the Nation, Religion *[satsana]*, and the King.[90] Satsana is usually understood to mean the Buddhist religion. In addition, a few sections in the Three Seals Laws (the *Ayutthayan* laws collected and revised in the early Bangkok period in 1804) identify penalties for termination of a pregnancy either intentionally (e.g., by giving them abortion pills) and accidentally (e.g., during a fight).[91]

Similarly, in the case of Nepal, which was officially a Hindu Kingdom until 2008, abortion was a criminal offence under the Criminal and Civil Country Code,1854. Informal punishments for terminating pregnancies existed even prior to this Code.[92] According to Bishal Khanal, the legal history of Nepal reveals a strong influence of religious-moral principles, especially Hinduism.[93] Abortion is deemed a sin in Hindu religious texts and women who have an abortion are often ostracised.[94] As a result "abortion was previously legally prohibited in Nepal on account of the country's strong religious beliefs and established customs. Terminating a pregnancy was considered sinful. A husband found involved in helping his wife's abortion was compelled to abandon her."[95] Modern Nepal's first legal document *Muluki Ain* 1910 BS (General Code 1854) is based on Hindu principles and practices.[96] Even after legalisation of abortion in Nepal, people with religious beliefs continue to view abortion as a sin.[97]

In Indonesia as well, the main opposition to safe abortion arises from many conservative religious groups. Similar to the confluence of religion and politics in the Philippines, Dr. Marcia Suomokil, the Director of Yayasan Ipas Indonesia[98] agreed that *"religious groups are backed by political groups in Indonesia"* and activist Tunggal Pawestri further noted *"the primary opposition to abortion rights comes from political parties with religious beliefs."*[99]

As noted in Chapter 2, Indonesia is not an Islamic State.[100] There are several religions that are practised in the country, six of which have been given legal recognition: Islam, Christianity, Catholicism, Buddhism, Hinduism and Confucianism. It is their collective influence on the political and cultural landscape that informs and influences social beliefs and laws, particularly in the context of abortion.[101]

Pertinently, in the case of Indonesia, although the prevalence of Islam is typically viewed as a major barrier to abortion access, Dr. Maria Ulfah Anshor, a doctor from Indonesia, explained that *"Syariah Law is more liberal than civil law with regard to abortion.*[102] *In Syariah Law, abortion is allowed before the foetus develops a soul, which is 120 days of gestation. Scholars agree that it is prohibited after 120 days of gestation."*[103] However, it must be noted that the Syariah Law is applicable only in the city of Aceh in Indonesia.[104] In her pioneering work titled, *"Fiqh on Abortion: Discourse in Reinforcing Woman Reproduction Right"*, Dr Maria argues that fiqh is an instrument to solve human problems including the high MMR due to unsafe abortions.[105] The paradigm of social *fiqh* ideally has five primary characteristics: *first*, interpretation of texts of *fiqh* contextually; *second*, initiating change of thinking style from understanding fiqh literally *(madzhab quali)* to viewing madzhab methodologically *(madzhab manhaji)*; *third*, a need to verify which is the main teaching *(ushul)* and which is supplementary *(furu)*; the fourth *fiqh* is presented as social ethic, not a positive state law; the *fifth*, effort in understanding philosophical thinking by taking social and cultural aspects into account.[106] The formulation of an alternative for safe abortions that does not contradict Islam can be developed by the application of the rational rules in *fiqh*, under which abortions may be classified as spontaneous abortions *(al-isqath al-dzaty)* where the foetus is destroyed by itself, emergency or in-treatment abortions *(al-isqath al-dha-rury al'ilajiy)* and erroneous abortions.[107]

Kasturi Puvaneswaran, a lawyer from Malaysia, noted that *"the opposition in the country is based purely on misconceptions about abortion, social stigma, and religious judgement."*[108] While Puvaneswaran highlighted that Malaysia has more liberal abortion laws than other Muslim majority countries, she also noted that *"religious factors, the lack of sex education and information on reproductive rights contribute to significant stigma against abortions."*[109] In the Indian context, religion has not been a driving factor in the debate on abortion, with the exception of states like Kerala, where the dominance of the Catholic Church plays a marginal role in the anti-abortion discourse.[110] This was evident in the opposition by the Catholic groups to the recent ruling of the Supreme Court of India in the case of *X v. Principal Secretary, Department of Healthcare, Government of NCT of Delhi.*[111] This ruling centred decisional autonomy of pregnant persons and has paved the way for progressive reforms to abortion laws in India.[112] Advocate Anubha Rastogi, a practicing lawyer from India also noted that *"religion is not a significant concern with respect to abortions in India and the primary concern for SRHR activists has always been access to safe and legal abortion services."*[113]

The terms 'religion' and 'culture' overlap significantly and are frequently used interchangeably; they may also be linked to notions of nationalism and nation-building.[114] Abortion, with its implied rejection of motherhood, undermines national ideals and, as such, can be considered to be in conflict with, or a rejection of, national identity.[115] The desire to adhere to a conservative national identity may be observed even more strongly in countries that have experienced recent violent conflict, with nationalist ideologies and conventional gender norms. As Bloomer argues, gender identities become established and essentialised, while cultural groups become homogenised, leaving little opportunity for variation in national and cultural identity debate.[116] These identities are frequently formed in connection to the societal "other," including ethnic groups.[117] Women face the burden of such nation-building, notably in terms of SRHR and the slightest contravention can be severely punished.[118] This is perhaps reflected in the fear of prosecution that accompanies the criminalisation of abortion, which disproportionately impacts marginalised persons.[119]

Religious and socio-cultural beliefs that have significant influence in shaping public opinions on abortion are often backed by a legislative framework that restricts abortion access through criminal provisions.[120] Such criminalisation significantly impedes access, especially for marginalised groups and individuals, in addition to battling the existing social hierarchies of caste, class, ethnicity, gender, age, and disability, among others.[121] Further, such criminalisation discourages healthcare providers from offering abortion services to pregnant persons owing to the fear of criminal consequences. The next section discusses the impact of criminalisation on access to abortions, highlighting the disproportionate impact thereof on marginalised persons especially adolescents.

IMPACT OF CRIMINALISATION ON ACCESS TO ABORTION

The State has the power and ability to label a conduct as harmful and impose criminal sanctions if the conduct is not constitutionally protected.[122] The stigmatisation of abortion can also be traced to provisions under criminal law that make abortion a punishable offence. As argued earlier, abortion stigma is a "compound stigma," which builds on other forms of discrimination and structural inequities.[123] For instance, in the Philippines, criminalisation has deepened the stigma associated with abortion.[124] Consequently, Filipino women are forced to carry unwanted pregnancies to term or undergo unsafe abortion services, which is a leading cause of maternal mortality in the country.[125] In 2008, there were approximately 560,000 induced abortions in the Philippines of which 190,000 women sought treatment for complications and 1,000 women died.[126] Judy Ann Miranda, an activist in the Philippines, highlighted:

> *"The general public does not have any access to safe abortion services which forces them to resort to unsafe means like going to underground clinics or administering self-managed abortions using unscientific means based on hearsay. Criminalisation has led to the creation of an unregulated and underground industry where the sale of abortifacients and other herbal supplements happens without any information or options for aftercare. This is also fuelled by capitalist needs to commodify these goods and sell them at high prices. These are often low quality and in unsafe packaging."*[127]

Similarly, it is widely known that most abortions in Indonesia occur outside the legal framework and are resultantly unsafe. A study from 2018 found that 73% of persons had self-managed abortions[128] and only 21% reported seeking abortion services from a doctor or midwife.[129] The remaining 6% opted for either a traditional provider or a pharmacist.[130] A measly 6% reported obtaining a surgical procedure, 16% used MMA pills or other medication and 39% used other methods, including a massage performed by a traditional healthcare provider.[131] Clearly, restrictive conditions have not reduced the number of persons seeking abortion in Indonesia, very much in line with observations world-over. An estimated 1.7 million abortions took place in Java in 2018 (where 57% of people in Indonesia reside).[132] This translates to 43 abortions per 1,000 women aged 15–49. By comparison, the regional abortion rate for Southeast Asia is 34 abortions per 1,000 women.[133]

- **73%** of persons who had an abortion self-managed it.
- Only **21%** reported undergoing abortion with a doctor or midwife.
- The remaining **6%** opted for either a traditional provider or a pharmacist.
- **16%** used MMA pills or other medication.
- **39%** used other methods, such as a massage performed by a traditional provider.
- **Restrictive conditions for abortion**, in line with observations world-over, **have not reduced the number of persons seeking abortion in Indonesia**.
- An estimated 1.7 million abortions took place in Java in 2018 (where 57% of people in Indonesia reside).
- This translates to 43 abortions per 1,000 women aged 15–49. By comparison, the regional abortion rate for Southeast Asia is 34 abortions per 1,000 women.

While the history and impact of criminalisation of abortion varies by country, it universally makes safe abortion services less accessible for pregnant persons[134] and dissuades service providers from offering legal and safe abortion services.[135] Criminalisation of abortion is a violation of the reproductive and decisional autonomy of all pregnant persons.[136] The principle of autonomy, when defined within a rights-based framework, is understood as the right of an individual to make free and autonomous decisions about their bodies, sexual and reproductive capacities, functions and choices free from coercion or violence.[137] The right of autonomy is at the very core of the fundamental rights to equality and dignity and is one of the core human rights principles that must be accounted for in ensuring the realisation of SRHR without discrimination.

Findings from a study conducted in 2016 suggested "a strong and persistent relationship between having an unwanted pregnancy resulting in a live birth and poorer later-life mental health outcomes."[138] It has been established that criminalisation of abortion does not eliminate the demand for abortions, but instead results in denial of access to safe abortion services.[139] It is apparent from the interviews that criminalisation of abortion is a major barrier and forces pregnant persons to seek unsafe abortion which often come with significant health risks. One of the reasons for the restriction of abortion is the notion of foetal personhood, as exemplified by the polarised American debates around abortion.[140] This argument is not always determinative in Asian context, though some cases mirror the foetal rights versus women's rights sentiments in the Philippines.[141] Although countries have "overarchingly different" lenses through which abortion is viewed, there is significant overlap in the justification of restrictive laws—including future regret, 'murder' and foetal heartbeat.[142]

Additionally, criminalising abortion allows stigma and taboos surrounding abortion to continue relentlessly, feeding into gender stereotypes[143] that characterise all women as 'mothers' and 'caregivers' to restrict their access to abortion services.[144] The conceptualisation of motherhood as a hegemonic ideology is reinforced by core beliefs such as the need to regulate and control 'mothers' who pit their interests before those of their children, and criminalisation then becomes a consequence of deviation from such hegemonic ideals.[145] Pregnant persons are expected to be completely self-sacrificing and these stereotypes compound the discriminatory effect of restrictive abortion laws and factor into pregnant persons' decision-making processes on whether to opt for a safe and legal abortion in a healthcare facility or undergo an 'illegal' abortion outside these facilities.[146] The criminalisation of abortion, coupled with the stigma and lack of adequate public healthcare facilities providing these services, has a disproportionate impact on marginalised persons.

The stigmatisation of abortion is very similar to the stigmatisation of sex work, in the way both shame sexuality and primarily attempt to police the bodies of women. The way that seeking abortion services makes pregnant persons a target for stigma is similar to the way sex workers are a target of stigma because they transgress deeply held cultural beliefs about women's sexuality, the connections between love and sex, and heterosexual (private) monogamy as the proper location of sexual relations.[147] The criminalisation of sex work, subversive sexuality such as that of queer and trans persons and abortion have roots in a conservative moral order.

Decriminalisation may either follow de-stigmatisation or precede it. Social stigma theory has two widely accepted fundamental components: difference and devaluation. Link and Phelan propose that stigma is defined by social exclusion, arguing that it arises in four distinct steps; (i) labelling of human difference; (ii) negative stereotypes; (iii) a distinct category marking the person as 'other'; and (iv) the stigmatised person experiencing a loss of status and discrimination leading to unequal outcomes.[148] Link and Phelan's model of stigma production is useful in understanding the definition of abortion stigma put forth by Kumar et al.:

> *"[abortion stigma is] a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood. While definitions of womanhood vary depending on local cultures and histories, a woman who seeks an abortion is inadvertently challenging widely held assumptions about the 'essential nature' of women."*[149]

The idea that abortion is a subversion of gender comes from deeply held conservative beliefs about women's sexuality, motherhood and the nurturing role of women. However, the essentialisation of abortion within womanhood is also harmful for trans and gender-variant persons who seek abortions, creating stigma and barriers to access.[150]

The creation of a criminal offence could be understood as attaching a criminalising label to individuals who are thought of as deviant. For example, a person who commits murder is thought of as a "murderer" and a person who is prosecuted for committing rape is a "rapist."[151] Decriminalisation often seek to detach the previously criminalised conduct from its criminal label.[152] "Prostitutes" seek to become sex workers and "abortionists" to become abortion service providers.[153] The goal of abortion decriminalisation is to de-stigmatise abortion services and facilitate access to safe abortions as an essential healthcare service and not a transgression from the normative structures.

In her overview of abortion law and policy, Marge Berer states that "*what makes abortion safe is simple and irrefutable—when it is available on the woman's request and is universally affordable and accessible.*"[154] The WHO has also noted that restricting access to safe abortion services results in both unsafe abortions and unwanted births – noting that most deaths from unsafe abortion occur in countries where abortion is legally and/or practically restricted.[155] Moreover, within a reproductive justice framework, the discourse around the decriminalisation of abortion must endeavour to frame abortion as equal to any other form of healthcare service.

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As recognised nationally and internationally, criminalisation is not supported within a rights-based framework. International human rights bodies have intervened in cases to argue that restrictive abortion laws rely on patriarchal stereotypes that "assume and reinforce the 'naturalness' of women as child-rearers" and protect the foetus over the life of the pregnant woman.[156] For instance, the CEDAW Committee argued that banning access to contraceptive services constituted "grave and systemic violations" of women's rights and that the denial of abortion services is a violation of human rights that interferes with a woman's right to health.[157] The United Nations Human Rights Council (UNHRC) and the Inter-American Commission on Human Rights (IACHR) echoed these arguments against gender stereotyping and the patriarchal mindsets that result in violations of equality rights and infringe upon decisional autonomy.[158]

The criminalisation of abortion may also be influenced by global policies.[159] The USA government particularly has influence on accessible abortion worldwide.[160] This is evident from the imposition of policies such as the Global Gag Rule, which is forced upon low and middle-income countries that borrow money from the USA to fund their healthcare systems.[161] It required "foreign non-governmental organisations (NGOs) to certify that they would not perform or promote abortion as a method of family planning using funds from any source as a condition for receiving U.S. funding."[162] The Global Gag rule is typically repealed during the terms of Democratic presidents and reinstated when Republican presidents come into power, making funding for safe abortion inconsistent and unsustainable.[163] Thus, the project of decriminalising abortion must consider the way global policies impact the reproductive landscape in the Global South, advocating for national as well as individual autonomy.

The challenges that confront decriminalisation efforts must therefore be accounted for. The movement for decriminalisation of homosexuality in some postcolonial countries serve as an important case study. In India, for example, Section 377 of the Indian Penal Code (IPC), an import of colonial era laws, broadly penalises sexual acts that are "against the order of nature."[164] Section 377 was used to outlaw all sexual activity other than heterosexual peno-vaginal sex and thus became a tool for policing various kinds of political actions surrounding non heteronormative acts, including those that relate to the lives of hijras, gay people, lesbians, bisexuals, transgender persons and other queer persons.[165] New activism around these groups emerged in the 1990s as part of the increasing visibility of sexuality through the media and the HIV/AIDS epidemic.[166] Section 377 was often justified on the ground that it is aimed at prosecuting paedophiles, much like the anti-abortion movement that argues for the protection of children.[167] In 2018, Section 377 was read down by the Supreme Court of India in the case of *Navtej Singh Johar Singh v. Union of India,*[168] which decriminalised adult consensual same-sex relationships.[169] However, the reading down of the provision failed to acknowledge the public nature of various queer identities, including transgender persons and hijras. The judgment also did not question the category of "natural" (the phrase "against the order of nature" in Section 377) and only included within its scope a socially acceptable expression of sexuality, thereby juxtaposing "natural" and acceptable identities with stigmatised and "unnatural" identities.[170] Gee Semmalar in his critique of the decision in *Navtej Johar* through an alternative writing of the judgment, centres the question of caste to argue the myriad ways in which caste structures construct identities of gender and sexuality and is determinative of the experience of discrimination and legal exclusion by transgender persons.[171] Semmalar's critique of *Navtej Johar* alludes to the limitations of judicial discourses on rights that remain oblivious to the distinct social hierarchies and therefore fall short of addressing the intersectional experience of oppression by marginalised persons.[172] In another critique offered by Saptarshi Mandal, it is argued that the *Navtej Johar* decision suffers from the limitations of a weak foundation for "the recognition of the rights of those marginalised on account of their sexual orientation and gender identity."[173] This case is illustrative of why decriminalisation must therefore be strategically thought through to comprehensively respond to the distinct challenges in each context. The adoption of an equality and non-discrimination rationale for decriminalising consensual as well as self-induced abortions would ensure that all persons have more comprehensive access to safe and legal abortion services.[174]

In simple terms, the decriminalisation of abortion refers to the removal of criminal sanctions against abortion in the law, indicating that there will be no punishments for providing or availing abortion services and that law enforcement agencies will not be involved in prosecuting the procurement or delivery of safe abortion services. Additionally, the decriminalisation of abortion means that courts will not be the institutions authorising or denying requests for abortions.[175] When it is decriminalised, abortion must be treated in the same way as other forms of healthcare. It is imperative to understand that decriminalisation of abortion treats pregnant persons as full citizens, noting the *"inseparable nature of reproductive rights and women's right to bodily autonomy, even in countries where legislative intent may not necessarily be along those lines."*[176] It is also important to clarify that the decriminalisation of abortion does not extend to persons who provide abortion services without requisite qualifications to the detriment of the pregnant person's health. It also does not extend to the legal consequences of providing abortion services without a pregnant person's consent. A reproductive justice framework for abortion should not require a justification from the pregnant person that they are undergoing an abortion for moral and necessary reasons.[177] It facilitates the realisation of the right to reproductive autonomy while being mindful of the graded barriers to abortion access for pregnant persons and counters the adverse impacts of criminalisation, which are discussed in detail in the next section.

CRIMINALISATION CREATES FEAR OF PROSECUTION

Despite widespread stigma around abortions, legal bans or restrictions on abortions do not eliminate demand, but merely limit access to safe abortions.[178] As a result of the criminalisation of abortion, pregnant persons are fearful of prosecution under such laws and are compelled to access unsafe and illegal abortion services.[179] Criminalisation also often creates a "chilling effect" amongst healthcare providers, where they are reluctant to provide abortions because of the fear of prosecution.[180]

Unsafe abortion remains one of the major causes of maternal mortality on a global level.[181] This is particularly true for marginalised persons due to the heightened fear of prosecution. As of 2015, unsafe abortions accounted for 14.5% of all maternal deaths globally and nearly all these deaths occurred in countries with restrictive abortion laws.[182] Parallels can be drawn with the argument that the decriminalisation of sex work fosters a safe working environment since in the absence of legal recourse, sex workers are more susceptible to exploitation.[183]

There have been several instances of prosecution, intimidation and harassment in the nine out of ten countries that were analysed for the purpose of this study. These were also highlighted by several respondents and are discussed in greater detail below.

Evidence of Prosecution and Intimidation in Southeast Asia

> *"We take on huge risks when we agree to perform an abortion, no procedure in the Philippines is as complicated or as dangerous."* [184]
>
> *– Dr. Miriam (Name changed)*

The above statement from Dr. Miriam, a veteran doctor from Philippines who has provided four abortion services (all clandestine ones), will resonate with many practitioners in the Asian region, where the criminalisation of abortions has led to a heightened fear of prosecution and the consequent denial of services to pregnant persons. The penal legislations and ambiguous legal frameworks limit the extent to which legal abortions are accessible, with several instances of prosecutions documented in Thailand, Indonesia, Philippines and Malaysia, further restricting the availability and accessibility of abortion services in the countries.

It is imperative to understand that decriminalisation of abortion treats pregnant persons as full citizens, noting the "inseparable nature of reproductive rights and women's right to bodily autonomy, even in countries where legislative intent may not necessarily be along those lines.

THAILAND

In Thailand, for instance, though the Constitution guarantees the right to public health services, these services are not fully realised by pregnant persons. Most qualified physicians refuse to provide abortions services and in cases where they agree to conduct the procedure, they interpret the law as narrowly as possible to safeguard themselves.[185] This 'chilling effect' has far-reaching consequences for the health outcomes of pregnant persons, who resort to clandestine abortion services and are reluctant to approach hospitals for post-abortion care.[186]

There have been several instances in the recent years where prosecution under the penal provisions criminalising abortions has led to an amplified fear and chilling effect on both abortion seekers and providers.

In 2015

A raid was conducted by the police in the Muang district in Thailand in a drug store and a beauty salon that were providing abortion services to adolescents. The arrested individuals had previously been convicted under the law and had served one year in jail.[187] In another case in 2017, a trained nurse was arrested and charged under provisions of the Criminal Code for running an illegal abortion clinic. The nurse admitted to providing abortion services to university students and was charged with offences including operating an unauthorised clinic, operating a medical institute without proper registration or a licence and selling medication without a permit.[188]

In the same year, in a case involving a 17-year-old who had terminated her 8-month pregnancy, the police arrested the adolescent, later stating that they had been charged with illegal abortion and might face charges for murder as well.[189] In 2018, a doctor and their trained assistants were arrested for providing abortion services in Prachuap Khiri Khan.[190] Similarly, another doctor was accused of providing illegal abortion services in Hua Hin municipality in context of some discarded foetuses found in the municipality in February 2018 and was arrested after the court approved their arrest warrant.[191]

INDONESIA

In Indonesia, Tunggal Pawestri highlighted the common occurrence for doctors to induce abortions and be prosecuted thereafter.[192] Dr. Marcia Suomokil also spoke of frequent raids on abortion clinics in Indonesia, adding that *"when women or healthcare providers are arrested, only a few of these cases are prosecuted, and the raids are primarily used as a tool of harassment and extortion by law enforcement."*[193] Mitra, a midwife in Indonesia, noted that "*many midwives with private clinics are targeted and prosecuted by the law enforcement because they believe midwives will provide access to abortion service."*[194] Several respondents recalled an incident involving a doctor, who was also a board member of the Women's Health Foundation and offered safe abortion services. The raid of his clinic resulted in the subsequent raids of abortion clinics across the country, and led his imprisonment in 2020. The doctor is said to have died of COVID-19 in prison in 2021.[195] Further, Tunggal Pawestri noted that *"due to the criminalisation in the law, it is difficult to find doctors and healthcare assistants to help pregnant women. Service providers who are capable of providing abortion services are very reluctant as they fear being trapped, harassed, criminalised and punished under the law."*[196] Further, Pawestri noted that this is a common occurrence in Indonesia with several doctors getting prosecuted for providing abortion services to their patients. For example, in July 2018, the imprisonment of a 15-year-old generated national and international attention.[197]

In 2018

An adolescent, raped by her brother, was by assisted by her mother to terminate her pregnancy. She and her mother were arrested immediately. Women's rights activists expressed outrage and frustration at the situation. Pawestri explained that "the abortion law in Indonesia makes it almost impossible to protect women. The requirement for women to get an abortion does not make sense."[198] Kate Walton, a Jakarta based development professional working on women's rights, has argued that:

"Even in cases where a pregnancy is a result of rape, the abortion process is incredibly complicated and time consuming, especially if the victim does not understand her rights under the law. The article allowing abortion in cases of rape is not widely known by the average citizen – it's very unlikely that the girl in Jambi and her family even knew about it."[199] The 15-year-old was sentenced to six months of imprisonment by a district court for procuring an abortion service after the prescribed limit of six weeks. She was later acquitted by a higher court.[200]

In another incident in 2020, the police arrested six medical workers, including three doctors, one midwife and two nurses, for providing allegedly illegal abortion services in Jakarta.[201] The police also arrested two couples who were at the clinic to seek an abortion.[202]

Even though criminal actions against practitioners and clients are rare, there is substantial threat, harassment and intimidation.[203] Terence H. Hull and Ninuk Widyantoro, a SRHR activist and psychologist, argue that the law is seldom enforced in a way that seeks to identify and punish all instances of the 'crime' and is instead applied in rare cases where individuals have become "bothersome" to

officials, or where they represent political minorities with little power to avoid legal sanction.[204] During the interview, Ninuk Widyantoro stated that *"recently in Indonesia, LGBTQIA+ persons have been under attack by law makers, reflecting a conservative pattern which can also be seen in the anti-women's rights sentiments in Indonesia's abortion law, as maternal death rates are very high owing to the criminalisation of abortion in the country."*[205] Widyantoro further noted that "there are many LGBTQIA+ feminist activists in Indonesia and the movement is quite divers. The new strategies of young activists should be prioritised.[206] Therefore, in this regard, feminist organisations have for decades called for reform of the legal provisions that are used to harass doctors but fail to protect women."[207]

THE PHILIPPINES

In the Philippines, Clara Rita Padilla noted that the criminalisation under the RPC is a direct translation from Spanish to English of the 1870 SPC,[208] which in turn was based on the 1822 SPC. She argues that "such criminalisation affects access to abortion services. The stigma in existing policy around abortion is exacerbated by a national policy and post-abortion care framework that mentions illegality of abortion about eight times in the document and removes provisions of confidentiality and reporting of abuses etc., that are intended to protect women."[209]

Given the restrictive abortion laws, cases of women being arrested, investigated and prosecuted are frequently reported by the local media in the Philippines. Activist Florence Tadiar noted that there have been attempts to prosecute abortion service providers, but none have been imprisoned.[210] They also stated that *"it is very common for police officers to bring their girlfriends to the clinic and they are helped despite the threat of the law,"* indicating that criminalisation exists as an intimidation tactic for the marginalised while those with power can navigate the law with ease.[211]

In 2013

In another incident, a couple was arrested under the RPC after they approached a hospital to deal with post-abortion complications.[212] They had induced abortion using 16 Cytotec pills which they had retrieved from a roadside vendor.[213] A separate incident involved a young woman from Manila who faced discrimination, pressure and abuse by healthcare providers.[214] She was haemorrhaging after having taken an unregistered drug to induce an abortion but was tormented by the service providers, who denied her treatment unless she confessed to the induced abortion. After she confessed, she was immediately reported to the police who arrested her, charged her under the relevant provision and detained her.[215]

In another instance, an 88-year-old midwife and her aide were arrested in Caloocan City after a 18-year-old student died two days after having visited them seeking abortion services.[216] They were arrested after a policewoman posing as a patient approached them for abortion services.[217] Few doctors have reported in a study that they no longer provide abortion services because they were almost caught in an entrapment operation.[218] Although there is a clandestine system and network of doctors that provide these services, they keep it extremely confidential for fear of prosecution.[219]

The abortion restrictions in Philippines have led to severe physical and mental health consequences for women and adolescent girls who have experienced unplanned or unwanted pregnancies and resorted to unsafe abortion, regardless of whether their abortion was motivated by an inability to provide for more children, satisfaction with family size, concerns about their health, lack of support from a partner, or because the pregnancy is a result of non-consensual sex.[220] The complications most frequently seen among women include incomplete abortion, blood loss and infection; severe complications include septic shock and intestinal perforation.[221] A study found that over 80% of women who have experienced unsafe abortions have also suffered from at least one complication from the procedure and nearly half have experienced severe complications.[222] The chilling effect on medical practitioners has far reaching consequences for the health outcomes of pregnant persons. Jihan Jacob, Legal Advisor for the Centre for Reproductive Rights, noted that individuals who resort to clandestine abortion services are reluctant to approach hospitals for post-abortion care.[223] Jacob also highlighted that doctors are hesitant to provide post-abortion care due to a fear of prosecution for providing medical assistance with incomplete abortions and consequent allegations of aiding and supporting abortions.[224] Marevic Parcon contextualised this by noting that three women die every day due to unsafe abortion, which is a direct impact of criminalisation.[225] Despite widespread use of criminal law to harass and intimidate healthcare providers and abortion seekers, there are not many cases of women serving time in prison for seeking abortion services, since a guilty plea can lead to provisional release with supervision or even the

eventual dismissal of the case due to the failure of witnesses to appear and testify.[226]

MALAYSIA

The adverse effects of criminalisation that feed into the fear of prosecution both for medical professionals and abortion seekers are visible in the context of Malaysia. Aminah R, a lawyer from Malaysia, stated that *"the Penal Code permits abortions up to 22 weeks to safeguard the mental and physical health of the pregnant woman and is a secular law applicable to everyone. Syariah law, on the other hand is only applicable to Muslim women."*[227] The understanding that a pregnancy may be terminated up to 22 weeks of gestation stems from a reading of Section 316 of the Penal Code which penalises the act of causing the death of a "quick unborn child."[228] The result of criminalisation, similar to other countries, is that doctors are hesitant to disclose that they provide safe abortions.[229] Aminah R. also noted heightened fear of prosecution among healthcare service providers. She stated:

"There is a heightened sense of fear among the service providers. There was one doctor that we spoke to who had multiple visits from authorities. In fact, he mentioned how there were two people who came in just to cause trouble and these interventions by authorities were often just disruptive stunts to drive fear among the community. Sometimes, they even bring a woman that is known to them under the pretext of getting an abortion, a deceptive operation to harass healthcare workers. These are also the same people who bring in women they know to get an abortion at the same clinic."[230]

However, Dr. Choong had a different view: he noted abortion is legal under some circumstances in Malaysia and stated that *"there is a tendency among bureaucrats to not recognise these exceptions that allow doctors to provide abortions services. This results in confusion among public about the legality of abortion."*[231] Dr. Ravindran further emphasised on the *"lack of legal awareness and confusion among doctors which results in their unwillingness to provide abortion services. This is further aggravated by sensational headlines on prosecution of doctors for providing abortion services."*[232]

Despite the amendments to the Penal Code in 1971 and 1989, which opened more grounds for abortion, access to safe and legal abortion remains largely restricted in Malaysia. Before these changes, several medical professionals were prosecuted. In *Munah Binti Ali v. Public Prosecutor* (1958), the defendant was charged and convicted by a lower court under Section 312 of the Penal Code for voluntarily causing a Chinese woman to miscarry and sentenced to imprisonment for three months.[233] While there was evidence to show that an instrument was inserted into her vagina that caused her to haemorrhage, it was eventually proved that the woman was not pregnant at the time that this insertion was done.[234] Therefore, the requirements of Section 312 of the Penal Code were not fulfilled and a new charge of attempt to miscarry was framed against the defendant.[235] In an appeal to the High court of the Federation of Malaya, while dismissing the appeal, the court held that it is not necessary for the woman to be pregnant to attract an offence under 'attempt to cause miscarriage'.[236]

In another case, *Public Prosecutor v. Dr Nadason Kanalinga*,[237] an obstetrician and gynaecologist was charged under Section 312 of the Penal Code. The defendant was accused of voluntarily causing miscarriage without good faith or an intention to save the life of the pregnant woman. He injected the pregnant woman with saline as she had enlarged varicose veins.[238] She was in labour within 48 hours and the pregnancy was terminated.[239] Despite the defence that he performed the operation of tubal ligation in good faith to save her life, the court ruled that the *"act of causing miscarriage was found to be done without good faith"* and that abortions should always be the last resort.[240]

Abortion seekers, in addition to doctors and healthcare providers, have also been prosecuted in Malaysia. Nirmala Thapa, a Nepalese migrant worker, was prosecuted and spent four months in prison.[241]

In 2014

In 2014, Nirmala was arrested and sentenced to twelve months of imprisonment for having an abortion.[242] When she was six weeks pregnant, she went to a local clinic to get an abortion. She feared that her employment status as a legal migrant worker would be put at risk if her pregnancy came to light.[243] Her doctor, who terminated her pregnancy argued that he had acted in good faith given the risks associated with her job and her migrant status.[244] Nirmala was convicted by the trial court and served four months in prison. Finally, before the High Court, Nirmala's lawyer argued that continuing the pregnancy posed a risk to her life and Nirmala was acquitted.[245]

As per Dr. Choong:

"the criminal prosecution of Nirmala Thapa for terminating a pregnancy that was at six weeks of

gestation through a registered medical practitioner, is the only case where there was a prosecution, despite the termination not contravening the Penal Code. However, the Attorney General still proceeded with the charge. Thus, the case demonstrates the vulnerability of migrants and other marginalised groups, and the State's failure to protect marginalised persons which translates into their inability to receive adequate reproductive health care services."[246]

As marginalised groups are most susceptible to criminalisation, they are most likely to be criminalised for abortion related reasons. The evidence of prosecution and the adverse impact of criminalisation of abortions as documented in the Southeast Asian countries also finds parallels in the South Asian counterparts, where access to abortions continues to be challenging. This is discussed in the next section.

Evidence of Prosecution and Intimidation in South Asia

Instances of prosecution that result from the criminalisation of abortions and further restrict access to safe abortions are also rampant in South Asia. The paradigm of criminalisation, a colonial legacy that continues to plague many postcolonial States in the region, coupled with the absence of a rights-based framing of abortion laws has led to the penalisation of abortion service delivery in India, Bangladesh, Pakistan, and Sri Lanka. Nepal has a rights-based legislative framework but continues to criminalise abortion in some forms. The evidence of prosecution, as it emerges from each of these countries, is discussed below.

NEPAL

Nepal, despite having witnessed some radical reforms to liberalise abortion laws, continues to witness the adverse impact of criminalisation and this can be evidenced through the instances of prosecution for illegal abortions documented in the country. In an incident in Sirhana district, a woman, her partner and the abortion service provider were prosecuted on the suspicion of an illegal abortion.[247] They were convicted by the court of first instance. However, at the stage of appeal, the Court in Rajbiraj dismissed the case on the grounds that the State had failed to furnish substantial evidence, especially given that it was a serious and sensitive case.[248]

In 2015

A separate incident involving a 15-year-old adolescent also points to the dire consequences of criminalisation.[249] In this case, an adolescent girl who had become pregnant as a result of rape had terminated her pregnancy at around 20 weeks by consuming MMA pills purchased from a local pharmacist.[250] The adolescent along with her father and the pharmacist were all charged for illegal abortion. The court convicted the adolescent who had admitted to consuming the pills to protect the reputation of her family.[251] However, her father and the pharmacist were acquitted as the father had discouraged the adolescent from consuming the pills and there was no satisfactory evidence to prove the culpability of the pharmacist.[252]

Further, a fact-finding study conducted in 16 districts of Nepal documented the impact of criminalisation on pregnant persons, noting that 53 abortion cases were registered in the District Courts and High Courts from 2011-2016.[253] 13 of these cases were against women who had terminated their pregnancies and five of these women were convicted.[254] The study noted that *"criminalisation of women for undertaking abortion beyond the legal conditions is aggravated by the lack of clarity in the law, biased mindset of law enforcement agencies against abortion as a crime, stigma of women obtaining abortion, and lack of family support and legal representation, resulting in the prosecution of women."*[255] It further showed that women were vulnerable to prosecution on the suspicion of an illegal abortion without a proper investigation.[256] A lack of clarity in law enforcement on definitions of abortion, miscarriage, infanticide and stillbirth has led to instances where women have been prosecuted for "intentional homicide where the cause of a new-born's death was undetermined, or for illegal abortion for experiencing a miscarriage."[257]

INDIA

Scholars argue that the laws on abortion in England and India are unsurprisingly similar: in both countries, abortion is a criminal offence subject to permitted circumstances under a statute (the Abortion Act, 1967 and the MTP Act, 1971 respectively).[258] The relationship between colonisation and reproductive rights has a long and fraught history. Colonised subjects were not on the receiving end of what Herring refers to as "care ethics," which describes the State and the law's duty to ensure that the basic needs of its citizens are met.[259]

However, multiple scholars argue that criminalising laws were laxly enforced during colonial times. Sharafi argues that "the ineffectiveness of statutory provision may have offered symbolic value *vis-à-vis* particular audiences (including missionary and metropolitan ones) but that was impracticable in the colonial setting."[260] Prior to colonisation, abortion was not regulated in South Asia.[261] However, once the British established dominance over the South Asian subcontinent (modern-day India, Pakistan and Bangladesh) they brought with them Victorian morals based on Christian ideology. Chitnis and Wright argue that those morals, in conjunction with a white-saviour complex most notable in white women of the colonial era, resulted in the criminalisation of abortion within the IPC—in a way similar to British law, which regulated abortion through laws of murder and infanticide.[262]

As noted in Chapter 2, the British criminalised abortion or "causing miscarriage," within the IPC.[263] This Code impacted India, Pakistan and Bangladesh. Choudhury notes that the three countries were governed by substantially the same law and shared the same legal history.[264] Under this law, anyone who induced a miscarriage with the intention to terminate a pregnancy was criminally liable for punishment, including the pregnant woman herself.[265] The IPC only permitted a single exception where a pregnancy was terminated "in good faith to save the life of the pregnant woman."[266] A study conducted in Vellore, India revealed that out of 46 women who sought abortion services, only 13 went to 'qualified' doctors, 65% of which were not actually qualified to provide abortions.[267] The fear of doctors regarding criminal prosecutions under Sections 312-318 of the IPC is a contributing factor to the millions of unsafe abortions in the country every year.[268] The study also notes that, Community Health and Development Program doctors discouraged women from seeking abortions,[269] forcing them to continue the pregnancy.

Several incidents in different states of India demonstrate that medical providers continue to be prosecuted for providing abortion services.

In 2021

A doctor in Meghalaya was arrested, detained for a month and prosecuted for providing abortion services to an adolescent girl who claimed to be 19 years old when she approached him.[270] The doctor was a registered medical practitioner authorised to provide termination of pregnancies. In this case, the pregnant person decided not to go ahead with the abortion after the doctor had made some preliminary preparations. Although later he was released on bail, it is imperative to note that the doctor was arrested despite not having actually provided an abortion to the adolescent.[271] In Maharashtra, another state in India, a group of 20 people were arrested for providing abortion services after the police found a sonography machine in a raid.[272] Further, in the state of Tamil Nadu, a hospital was cordoned off by the police based on the allegation that the healthcare providers in the hospital were not authorised to provide abortion services.[273] The hospital was reopened only after the High Court's intervention, which noted that such actions were not permitted under the law.

These incidents contribute to the general atmosphere of fear of prosecution that persists due to continued criminalisation. Several respondents from India including Dr. Alka Barua, Nikita Sonavane, lawyer and co-founder of the Criminal Justice & Police Accountability Project in India and Dr. Jaydeep Tank highlighted the adverse impact of the criminalisation of abortion in India.[274] Dr. Barua stated that: *"although pregnant women will find ways to undergo abortions regardless of criminalisation, it results in more women going to unsafe places to obtain clandestine abortions."*[275]

This is further complicated by other legislations like the POCSO and the PCPNDT, which criminalise adolescent sexuality and diagnostic practices for gender-biased sex selection respectively. The former contributes to the carceral framework around abortion for adolescents and the latter creates a prohibitive environment for safe and legal abortion services.[276] As a result of these legal barriers, medical practitioners often deny abortion services beyond 12 weeks, even when such abortion is permitted under the MTP Act.[277] Scholars argue that *"misinformation and unawareness of the law amongst health care providers acts as a barrier to providing safe abortion services."* For example, Nikita Sonavane also noted the adverse impact of criminal law and criminal prosecution on marginalised persons.[278]

BANGLADESH

Likewise, in Bangladesh, lawyer Abdullah Titir noted the chilling effects of criminalisation on the healthcare workers:[279] *"Most doctors who agree to provide abortions often impose extra-legal conditions to safeguard themselves from prosecution. For example, they often require spousal and/or parental consent; even though spousal or parental consent is not a requirement in law."*[280]

In 2022

A nurse providing abortion services at a clinic in Gazipur, Bangladesh was arrested and sentenced to imprisonment.[281] The lawyer argued that the word "miscarriage", and not "abortion" is mentioned in the Penal Code. He further argued that the prohibition under the Penal Code is for the protection of pregnant women from abuse but it has been misused to interdict women from accessing abortion services.[282]

PAKISTAN

In Pakistan, Sara Malkani highlighted that "while there have not been incidents of actual prosecution, there is still significant fear of prosecution among abortion service providers."[283] Sara Malkani also stated that *"law enforcement officials harass people who are working in NGOs and other organisations that offer reproductive justice information and counselling services."*[284]

SRI LANKA

Instances of prosecution are rampant in Sri Lanka as well. For example, in 2010, an abortion centre in Ekala was raided and the doctor was arrested for providing abortion services.[285] The police also took two pregnant persons into custody before sending them to a hospital for medical check-ups.[286] There have been two instances of raids of abortion clinics, which have resulted in the arrest of the doctors who were running the clinics.[287] A medical officer in Maskeliya was arrested for providing an illegal abortion services to an 18-year-old.[288]

Laws do not exist in a vacuum and their implementation depends in large part on institutional structures. Several respondents spoke about the structural barriers to abortions, in addition to restrictive laws. Respondents noted that selective availability of abortions in private healthcare facilities at high costs pose a barrier to abortion access. For example, significant barriers were highlighted in Malaysia where Aminah R. noted that *"abortions are obtained easily at private facilities, but access is restricted for people who cannot afford private healthcare."*[289]

Dr. Subatra Jayraj a doctor from Sri Lanka also explained that *"the majority of abortions, typically to protect the woman's mental and physical health, are conducted in private hospitals and abortions at public facilities are typically undertaken to only save the pregnant woman's life in dire situations."*[290] Therefore, what is needed instead is the immediate decriminalisation of abortion to reverse the "chilling effect" on medical practitioners and abortion seekers, thus making access to abortion much wider and significantly reducing legal barriers for marginalised persons. The next section will discuss this.

DISPROPORTIONATE IMPACT OF CRIMINALISATION ON MARGINALISED PERSONS

In 2017

Rara (pseudonym), an Indonesian student studying in Jakarta sought the termination of a pregnancy that was the result of a consensual relationship with her unmarried partner.[291] Since Rara's partner had another girlfriend at the time of the pregnancy, Rara chose to proceed with termination to not disappoint her devout Muslim parents.[292] Given the restrictive laws on abortion, Rara approached a small clinic in Jakarta that was known to provide illegal abortion services. She described a complete lack of care and compassion from the doctor and nurse who treated her.[293] Following her abortion, Rara suffered throbbing pain every time she had her period and given the stigmatisation of abortions and her previous trauma in medical settings, she approached a doctor after one year of pain.[294] Rara's story is one of many where criminalisation of abortions has compelled pregnant persons, especially from marginalised backgrounds, to be far removed from access to safe and legal abortions.

The WHO has found that safe abortion services become a luxury for the rich in countries where abortions are restricted in legal or structural ways, while pregnant persons from marginalised backgrounds are constrained to seek and undergo unsafe abortions.[295] This results in a large number of unnecessary deaths and morbidities, creating a strain on the public health systems.[296] Public healthcare facilities continue to remain inaccessible to marginalised persons like immigrants, Indigenous persons, gender and sexual minorities, who are therefore more likely to self-induce abortions at home without proper information.[297] However, this increases the risk of user error complications and most people are hesitant to seek post-abortion care due to the heightened fear of criminalisation.[298] Dr. Irwan Hidayana, an academic from Indonesia argued that most legal and policy frameworks are not inclusive. While citing the example of the universal health coverage in the country, he noted that, *"even though it is supposed to cover all citizens, many groups, like the trans and gender-variant persons are not able to access the same due to the lack of identification cards."*[299]

The denial of abortion services means that pregnant persons are either forced to continue with their unwanted pregnancies or resort to clandestine abortions, which may increase the risk of post-abortion complications and add to any physical and mental trauma. This is further complicated by inadequate public healthcare facilities and prohibitive costs of the private healthcare sector. For example, while the public healthcare sector in India is widely distrusted, Nandi et al. note that *"women, rural residents, persons belonging to Scheduled Tribes, and poorer groups were more likely to use the public sector for hospitalisations."*[300] The reliance of marginalised persons on public sector facilities that are underfunded indicates the State's negligence towards the well-being of the marginalised persons in their refusal to adequately equip the public healthcare sector.[301]

Public healthcare facilities continue to remain inaccessible to marginalised persons like immigrants, Indigenous persons, gender and sexual minorities, who are therefore more likely to self-induce abortions at home without proper information.

Persons with disabilities also find it difficult to access safe abortion services in India mostly due to inaccessible infrastructure at healthcare facilities.[303] The barriers are not solely physical, but also extend to the societal perception of persons with disabilities and the lack of empathy among service providers.[304] In Bangladesh as well, healthcare providers' perception and biases often impact access to SRHR services for persons with disability. Numerous ethnic minority groups and tea workers across Bangladesh often opt for traditional methods of abortion owing to factors like financial incapacity, lack of education, cultural and societal stigma and geographical challenges.[305]

In addition to impacting access to safe abortions, evidence from 16 studies demonstrates that criminalisation also contributes to opportunity costs.[306] Opportunity costs can be broadly understood as financial and health harms[307] and include travel burdens incurred to access abortion services, delayed and poor-quality post-abortion care, distress, financial burdens, stigma and exploitation.[308] These costs are exacerbated when the person seeking to terminate their pregnancy is already marginalised and is more susceptible to criminalisation.[309] They disproportionately affect single persons, socioeconomically disadvantaged persons and those accessing care in public rather than private facilities.[310] Often, these demographics overlap. Research conducted in 18 countries in South Asia and Southeast Asia reveals the disproportionate barriers encountered by specific groups,[311] including undocumented Burmese migrants working on the Thai side of the Thai-Burma border and adolescents in the urban slums of Dhaka, Bangladesh.[312] In both cases, research reveals that these women, who suffer extremely precarious economic, legal and social conditions, face amplified barriers and are compelled to seek abortion services from unlicensed and untrained providers or self-induced abortions.[313] A closer look at the domestic situation of marginalised persons in the jurisdictions that inform this study reveal the structural inequalities that are further compounded within a paradigm of criminalisation.

Many Burmese women migrate to Thailand in search of a more stable economic, social and political environment[314] and are primarily located in the Tak province of Thailand at the Thai-Burma border. The experiences of these Burmese women are often marked by unintended pregnancies due to lack of access to contraceptive services. The are then compelled to undergo self-induced abortion without adequate information.[315] While reasons for termination remain ubiquitous ranging from domestic violence, poverty to lack of employment opportunities and resources.[316] Professor Suzanne Belton, one of the respondents for this study, noted that:

> *"The Burmese refugee women in Thailand were stigmatised by the healthcare system. Some healthcare providers labelled these abortions as septic abortions, but most often these were labelled as criminal abortions. Often, doctors and nurses took pleasure in labelling the women as criminals. These were poorest of poor and extremely vulnerable."*[317]

Adverse psychological outcomes are more prevalent among marginalised persons, who are more susceptible to mental distress.[318] The stigmatised nature of abortion services, coupled with the restrictive laws that are often confined to a binary understanding of gender, have led to the exclusion of transgender and gender-variant persons from the scope of access.

In Thailand in 2020, a pro-democracy television host publicly argued that when common people are unable to attain rights, the rights of the LGBTQIA+ community were unlikely. This led to backlash from feminist and LGBTQIA+ movements on the basis that the host suggested a hegemonic hierarchy of concerns.[319] This reasoning extends to marginalised persons who seek reproductive care; their needs are neglected and those of the dominant population are prioritised, viewing the former as less consequential and an afterthought.[320] In the USA alone, an estimated 462 to 530 trans and non-binary people received abortion care in 2017.[321] By erasing

trans persons from the narrative and framing abortion as a cisgender women's issue, their barriers to access safe abortion are aggravated and their voices are excluded from mainstream activism.[322]

From the construction of laws and policies to sentencing practices and prison conditions, the criminal justice system is based on individualising harms committed by "offenders" and suffered by "victims".[323] This system disregards the complexities of harm and justice by paying little attention to existing social hierarchies, structural inequalities, and systemic violence. Preeti Dash, one of the respondents from India, noted:[324]

"The popular perception is that criminal law is the only effective and powerful means to address an issue given its deterrent effect. It is the criminal legal frameworks that influence the perception of what is acceptable and not acceptable. What it fails to account for is a critical understanding of such a deterrent effect and how that manifests on ground. Criminal law, at the end of the day, is a tool of State power and its implementation is not uniform. There are many ways in which the State uses and abuses this power of criminal law to ensnare groups and individuals."

The use of a carceral framework[326] was also critiqued by Respondent D from Bangladesh who questioned the role of criminal law in regulating human conduct and dictating morality in an arbitrary manner, especially when notions and beliefs vary across context and communities.[325]

Thus, an anti-carceral framework is needed to recognise the harms of retributive justice and to reject a system that is "primarily responsible for the violent oppression of marginalised communities."[327] Criminalisation of abortion does not lead to the absence of abortions but results in unsafe abortions; a non-penal framework would improve access to abortion services, particularly for marginalised persons. As care tends to be ignored and undervalued in public policy, marginalised persons are failed by their relationship with the State, which is marked by physical and emotional exploitation and abuse of their bodies.[328] A reproductive justice approach that aligns itself with the care ethics of moral philosophy would focus on reducing the subjectivity of marginalised persons to criminalisation.[329] This includes removing legal and other barriers to accessing safe abortion services, regardless of reasons for terminating the pregnancy and divorcing the legality of abortion from religious, cultural,and social stigma. Respondent F from Nepal observed how persons from marginalised communities like Dalit persons and persons with disabilities face difficulties in accessing abortion services due to the stigma prevalent around their identities and services providers' perception of them.[330] Most respondents highlighted the issue of adolescent access to abortion as being the most complex. Adolescent sexuality, its associated taboos and the devolvement of these perspectives into law and policy has a rich history. Therefore, it is imperative to delineate these issues when discussing decriminalisation of abortion and its adverse impact on adolescents. The next section examines the impact of criminal law on adolescents' access to abortion services.

DISPROPORTIONATE IMPACT ON ADOLESCENTS

In 1999, an infamous abortion 'scandal' spread throughout Nepal:[331] a 16-year-old was serving a prison sentence for an abortion. At 14, was raped by a relative and consequently became pregnant.[332] When she communicated this to her step-sister-in-law, she did not believe her and gave her a drug which induced an abortion.[333] The sister-in-law later reported her to the police and lied to them about her age. The 16-year-old was sentenced to 12 years in prison.[334] It was only after she had served 2 years in prison that the case was reviewed by another court and she was released.[335]

The criminalisation of abortion has significant impact on adolescents who need to access SRHR services including abortion. In case of adolescents, unplanned or unwanted pregnancies can be a complex situation and the criminalisation of abortion services can have a disproportionate impact on them, especially where such criminalisation is also coupled with restrictive laws on age of consent and legal age of marriage. Unintended pregnancy, particularly if it occurs outside of marriage, can have substantial consequences for young people including stigma, social isolation, school expulsion, forced marriage and in some cases violence and suicide.[336]

The popular perception is that criminal law is the only effective and powerful means to address an issue given its deterrent effect. It is the criminal legal frameworks that influence the perception of what is acceptable and not acceptable.

Gayle Rubin in her seminal work argues that the "primary mechanism for insuring the separation of sexual generations" is formalised in age of consent laws that fail to distinguish between sexual assault and consensual sexual interaction.[337] Michael Foucault further notes that law is utilised to "enforce hierarchical social norms, discipline "wayward" behaviour, and establish parental controls" over adolescents, under the guise of protecting adolescents from

sexual assault.[338] Age of consent laws are clearly based on the colonial characterisation of women as chattel, first of their fathers and after marriage, of their husbands, whose position is reinforced by the existence of legal exceptions to marital rape.[339] For instance, in 19th century England and the USA, it was commonly believed that 'premature' interest in sex, sexual excitement, and above all, sexual release, would impair the health a child.[340] This, compounded with the notion that sex was harmful to young people, resulted in social and legal structures designed to 'protect' minors from sexual knowledge and experience.[341]

Globally, United Nations Children's Fund (UNICEF) projected in a study that 10–12% of adolescents in low-and middle-income countries have had sex before the age of 15 years.[342] However, as suggested by Gayle Rubin, there is erotic hysteria when it comes to child sexuality.[343] Enacting criminal laws to criminalise adolescent sexuality is justified as a societal attempt to "condemn to protect" a vulnerable section of society.[344] These laws have significant consequences in the regulation of sexual behaviour, violating sexual civil liberties of persons. However, this is rarely taken up considering the 'protective' agenda of the law.[345] In addition, these laws seriously impact access to abortion services, as well as SRH services for adolescents, as further evidenced in the interviews.

As per the latest comprehensive data available, of the 11 million unsafe abortions conducted in Asia in 2008, 65% were in Southeast Asia leading to 17,000 deaths and 2.3 million hospitalisations due to complications.[346] Of these, 11% of abortions were provided to adolescents between the ages of 15-19 years and 23% among women aged 20-24 years.[347] According to a report published by the United Nations Population Fund (UNFPA) in 2015, 63% of adolescent pregnancies in Asia are unintended, contributing to a significant and underreported burden on unsafe abortions.[348] According to this report, globally, approximately 50% of all unintended pregnancies end in induced abortions, with instances of unsafe abortions. Consequent adolescent mortality rates are higher in countries where the law regulating abortions is restrictive.

For instance, studies in Indonesia[349] and the Philippines,[350] two countries with restrictive abortion laws have documented that most young women have resorted to the use of traditional or unsafe methods of abortion such as ingesting herbs, uterine massage, or insertion of foreign objects into the uterus. These young women are forced to seek care in cases of medical complications.[351] Adolescent sexuality is criminalised in other countries as well, which have implemented laws that characterise all adolescent sexual conduct as assault, thereby desexualising adolescents in the eyes of the state.[352] In some countries, such as Indonesia and Malaysia, the first solution to adolescent pregnancy is to marry the consenting sexual partners. In the Philippines for example, activist Dr. Junice Melgar noted that *"adolescents are considered to have no agency in the Philippines and therefore, even sexuality education is a challenge.[353] Sexual education in the curriculum was claimed by the church to violate the sanctity of the family, as well as parents' rights to make decisions for their children."*[354] This was taken to the Supreme Court in 2012. The Court noted that there was no existing sexual education curriculum thereby labelling the legal stance of the church as premature:[355]

Judy Ann Miranda noted that adolescent sexuality figures within the reproductive health law, however the Catholic Church has stymied any progress on sexuality education and awareness training in school.[356] At the time of their interview, Clara Rita Padilla noted that "the problem with the Philippine law is that there is a low age of consent, which is 12 years, and there is a push to raise the age of consent to 16 years."[357] After this interview, adolescent sexuality was decriminalised in the Philippines in 2022 by amending Section 266-A of the RPC.[358] The amendment to the penal code raised the age of consent from 12 years to 16 years, while also creating an exception in cases of close-in-age exceptions.[359] As a result, there will be no criminal consequences in cases of consensual adolescent sexual activity where the age difference is not more than three years and it is proved that sexual activity is consensual, non-abusive and non-exploitative.[360] This exemption from criminal liability does not apply in instances where an adolescent is below 13 years of age.[361]

In Malaysia, sexual relations between adolescents are criminalised within the legal framework of child protection that characterises adolescent sexual activity as assault.[362] Dr. Subatra Jayraj notes that *"the boy engaging in these acts is typically accused of sexual assault and criminalised by the girl's family to maintain a respectable appearance."*[363] Further, Aminah R. stated that *"there has been a call to include comprehensive sexuality education within the school curriculum for about ten years."*[364] However, this has still not been implemented in Malaysia and consequently there is lack of information on safe sex practices. The Government has set up a health clinic for SRH but, in practice, they do not support adolescent sexual health.[365] To the contrary, they discourage sex and promote abstinence; they provide information on sexually transmitted diseases (STDs), but not contraceptives which can prevent the transmission of STDs.[366]

Similarly, in Indonesia, family planning retains a strong focus on married couples, discounting unmarried persons and adolescents. Indonesia's National Family Planning Board 2015-2019 Strategic Plan focused on contraception services and safe abortion only for married couples.[367] As

per the Ministry of Health Regulations introduced in 2014, married women can access contraceptive services with the consent of their husbands.[368] This indicates a misogynistic and paternalistic outlook in the law towards reproductive autonomy of adolescent and single women.[369] Dr. Marcia Suomokil of Yayasan Ipas attributed the criminalisation of contraceptives to the framing of adolescent sexuality as taboo and a failure to acknowledge sexual activity among adolescents and unmarried people.[370] She also highlighted the gendered impact on adolescents noting that *"a pregnant student could not study at school, so they will automatically be kicked out of school, regardless of race, consensual sexual action with the partner and regardless of child marriage, but it does not happen to the men who impregnate the student."*[371] The situation is further complicated by the child protection law in the country. Mitra, a midwife from Indonesia, and Amalia, a youth volunteer, noted:

"The Child Protection Law grants rights to the foetus. This has had consequences for the debate on abortions, as once the foetus is given legal status, abortion cannot be performed."[372]

Requirements for parental or spousal consent further complicate the situation and can prevent adolescent from seeking access to abortion services.[373] In Vietnam, for example, SRHR activist Thuy Mai noted that *"the requirement to obtain guardian consent for an abortion is a major barrier to accessing healthcare."*[374] Similarly in Malaysia, Aminah R. stated *"while some doctors will provide teenagers with abortion services without parental consent or provide them with contraceptive services based on their needs, most doctors require parental or spousal consent for abortions involving a person below eighteen years of age. There is no movement to educate young people. Young people are basically taught to abstain."*[375] In Bangladesh, activist Samia Afrin agreed that *"unmarried persons and youth are not included in the government's family planning methods."*[376] As a result, adolescent girls require the consent of guardians to access SRH services, including abortions.

Adolescents in countries with permissive abortion laws also face acute restrictions and barriers in accessing safe abortion services. For example, the Right to Safe Motherhood and Reproductive Health Act, 2075 (2018) in Nepal provides that teenagers shall have the right to obtain SRH services, including safe abortion, but mandates the consent of a parent or guardian for adolescents under the age of 18 to ensure that the course of action is in the "best interests" of adolescents.[377] There are many reasons such as stigma, fear, or an abusive household, because of which an adolescent may not want to tell their legal guardian about their pregnancy. This compromises adolescents' right to privacy and confidentiality as well as their access to safe and legal abortion regardless of their circumstances.[378] In Singapore, for example, adolescents are more likely to delay seeking abortion, resort to unsafe providers or unsafe methods, and delay seeking help in case of medical complications.[379] In Nepal, lawyer Shreekrishna Mulmi, also noted that *"while sexual relations between individuals under the age of 18 years is considered rape, marriages in some remote villages often take place between individuals under the age of 18 years."*[380] This, according to Shreekrishna Mulmi, *"creates ambiguity on the legality of adolescent sexuality and adversely impacts access to SRH services by adolescents."*[381] In Pakistan, Dr. Sadiah Ahsan noted that *"there is a legal prescription for the minimum age of marriage and marriages involving individuals under the age of 18 years continue to occur."*[382] Dr. Xaher Gul further explained that *"sex outside a marital framework is criminalised and that unmarried adolescents are therefore not covered by the legal framework."*[383] Dr. Ghullam Shabbir added that *"most discourse around sexuality is focused on married adult women, which in turn results in them being the primary users of the healthcare system and abortion services."*[384]

In the Indian context, POCSO is a legislation on child sexual abuse that also inadvertently regulates adolescent sexuality.[385] The law designates all persons below 18 years of age as children, bringing them within the ambit of the law and its restrictive provisions.[386] Scholars argue that the POCSO conflates adolescent sexuality with the sexual assault and hampers contraceptive access for adolescents.[387] A study of unmarried adolescents seeking abortions in a tertiary hospital in India found that 75% had delayed seeking abortion until the second trimester because of fear of disclosure, lack of support and limited resources.[388] Consequently, adolescent and unmarried young women are also at higher risk of abortion-related mortality in some settings.[389]

Jasmine George, one of the respondents from India, alluded to the on-ground implications of stringent criminal laws for adolescents:

> *"Hidden Pockets Collective gets a lot of cases of adolescents through the helpline. We get a lot of cases where girls are pregnant and most of the time, nobody wants to pick up these cases. Doctors do not want to help because they are below 18 years of age and the provisions of mandatory reporting under POCSO deter them from providing services. Most of our laws are not protective in nature and are not empowering.....the only laws that are there for women and girls are the ones making it more difficult for them to access abortion services."*[390]

In India, another study in Jharkhand and Bihar found that unmarried young women are in a more disadvantageous position in terms of access to abortion services and reproductive health care as compared to married young women.[391] Young women stated that fear of confidentiality was one of the major reasons for not approaching the doctor earlier. A girl confessed that because her family thought of her as a 'good girl', she did not want to tell them about her pregnancy.[392] The study also found that women often resort to unsuccessful methods of abortion due to absence of any support and fear of judgement by the society, which ultimately resulted in delay in abortion and unsafe abortions.[393]

A similar legal conundrum is visible in Sri Lanka. Under Section 363 of the Penal Code of Sri Lanka, the legal age of consent for a girl is 16 years.[394] While there are cases against adolescents boys for getting other adolescent girls pregnant, Respondent C from Sri Lanka stated that *"there were instances where public facilities would provide abortions to adolescents in a safe manner, under the radar."*[395] Sonali Gunasekar noted that *"95% of abortions are done for women over the age of 35, who have over three children already. There are very few abortions done for adolescents."*[396] Subha Wijesiriwardena further noted that *"parents of minors in consensual relationships, especially girls, complain to the police, filing charges of kidnapping against the consensual partner of their daughters, effectively criminalising consensual adolescent relationships."*[397]

In a study conducted in Thailand, data was collected using in-depth interviews with 30 adolescent participants with lived experiences of undergoing legal abortion services under the Prevention and Solution of Adolescent Pregnancy Problem Act.[398] The study documented the experiences of adolescents between 15-19 years who had terminated pregnancies ranging in the gestational ages of 5 weeks to 22 weeks. The findings revealed that the adolescents wanted to keep their abortions confidential, especially from their families, given the stigma.[399] It also revealed that access to adolescent friendly services and information, as well as the availability of legal abortions, were important factors in helping adolescents terminate their pregnancies through safe methods.[400]

The stigma associated with adolescent sexuality and the legal frameworks restricting abortions to the exclusion of sexually aware and active adolescents do not actually affect the incidence of abortions, but only compel adolescents to seek unsafe and unregulated options that could be detrimental to their health and well-being. The social norms in many countries analysed in this study have led to non-recognition of adolescent sexual capacities, with strict penal laws governing consensual sexual interactions. The threat of prosecution or procedural complications caused by child sexual abuse laws conflict with abortion laws in several countries. Therefore, there is a need to move away from this stigmatising framework to one where the availability and accessibility of information as well as adolescent friendly services can facilitate the promotion and protection of the SRH and rights of adolescents.

Globally, there has been discourse on moving away from a framework of blanket criminalisation and developing legal frameworks that recognise the evolving capacities of adolescents to enter into consensual sexual relations.[401] The Convention on the Rights of the Child 1991 (CRC) explicitly calls on States to *"avoid criminalising adolescents of similar ages for factually consensual and non-exploitative sexual activity."*[402] An illustrative example of this can be seen in South Africa where the law has recognised consensual sex among adolescents between the ages of 12 years and 15 years as well as between a person who is 12 – 15 years old and a person who is 16 –17 years old, as long as they are no more than two years apart in age.[403]

The next section discusses the status of legal reforms undertaken to move towards a rights-based framing of abortion in several countries.

STATUS OF LEGAL REFORMS

Feminist groups have the potential to spearhead successful movements for decriminalisation of abortion as was witnessed in the case of Colombia where decriminalisation was the result of decades of grassroots organising on streets and in meeting rooms.[404] A constitutional case filed by Women's Link Worldwide represented by Colombian lawyer Monica Roa led to decriminalisation of abortion under certain circumstances.[405] Even after decriminalisation, challenges in implementation led to feminist organisations using creative litigation strategies that challenged barriers to accessing abortions due to limitations in State infrastructure.[406]

In discussing the strategies and interventions towards legal reforms on abortion and examining the role of social movements in such advocacy, some respondents reported interim strategies and steps taken towards the decriminalisation of abortion while also pointing to the factors that have limited the scope for radical reforms. For example, given the historical context within which the MR policy was introduced in Bangladesh, Altaf Hossain of Bangladesh Association for Prevention of Septic Abortion (BAPSA) stated that *"activists are fearful of backlash and revocation of the MR policy."*[407] According to Altaf Hossain, activists are therefore "working in small steps: in the next two years, activists in Bangladesh will advocate for increasing the gestational limit up to which MR is permitted as a precursor to complete decriminalisation."[408]

In 2020, Dr. Syeda Nasrin filed a petition before the HCD of the Supreme Court of Bangladesh seeking declaration that Sections 312 – 316 of the Penal Code are unconstitutional. Dr. Nasrin explained that she aimed for *"complete, and not partial decriminalisation of abortion and the Court has issued a show-cause notice to the government on the constitutionality of the provisions under the Penal Code."*[409] Dr. Nasrin has received mixed feedback on her petition from the movement, explaining that the petition may wake the sleeping lion on the abortion issue and cause activists to lose the progress that they have made so far.[410] Some respondents were sceptical about this petition; Respondent D noted that judgments from the Courts have not translated on the ground.[411]

In Indonesia, lawyer and activist Syafirah Hardani believed that *"while most activists in the country are currently advocating for universal access to abortion services, however as lawyers they want to focus on legal reforms within health law, especially increasing of the gestational period."*[412] Respondents from Yayasan Ipas, Indonesia also stated that *"there is a debate around whether feminists should advocate for universal access to abortion or incremental policy changes, making sure the government fully implements what they legislate."*[413] Dr. Marcia Soumokil added that, at this time, the movement for legal reform in Indonesia is looking to ensure synchronicity in all national laws, including the health law, the Penal Code and Child Protection Law.[414] However, the current focus of the feminist movement in Indonesia is the Bill on gender violence which aims at providing a legal framework for survivors of sexual and gender-based violence. The Bill was initiated in 2012 pursuant to the increase in cases of sexual and sex crime in the country.[415] It was passed on 12th April 2022 and aims to increase awareness on the issue of sexual violence while also working towards eliminating the problem.[416] Here it must also be noted that gender-based violence (GBV) has been a national priority for women's political groups in Indonesia. The mass sexual violence committed against women of Chinese ethnicity during the 1988 riots in the country triggered by economic issues and corruption, as noted by scholars, served as the impetus for mobilisation of women's political groups. This facilitated the establishment of the National Commission on Violence against Women (Komnas Prempuan).[417]

Social movements for decriminalisation vary in strength and are not necessarily dependent on the level of criminalisation. Though the Philippines strictly criminalises abortion, the conservative stigma created by the Catholic Church and government policies is countered by a very strong feminist movement. Organisations such as PINSAN (Philippine Safe Abortion Network)[418] and Likhaan Center for Women's Health[419] have been working towards abortion law reform in the country for decades. In 2018, women's rights activists organised a protest against the government to challenge the normalisation of patriarchy perpetuated by Duterte's comments.[420] Duterte had ordered soldiers to shoot female rebels "in the vagina", made inappropriate comments about his female Vice President's legs, joked about raping Miss Universe and equated having a second wife to keeping a "spare tire" in the trunk of a car.[421] Similar to the Thai pro-democracy protests, the Philippines' feminists protest was ensconced within a wider protest against Duterte's regime when he was delivering his third State of the Nation Address (SONA) in 2018.[422] Judy Ann Miranda noted that *"since 2022 is the national election, progressive women's groups are actively campaigning for a candidate who would be more open to women's rights and would defeat the current authoritarian regime, which is misogynistic and unsupportive of women's rights."*[423] Recently, Clara Rita Padilla drafted and presented a Bill on decriminalisation of abortion titled, *"To Decriminalise Abortion to Save the Lives of Women, Girls and Persons with Diverse Gender Identities"*.[424] Judy Ann Miranda referred to this Bill and noted that *"one of the biggest challenges is that the majority of the Senate and the House of Representatives is anti-women and anti-human rights."* The Bill has very few supporters in the Parliament.[425]

Equivalently, there is a strong movement in Malaysia advocating for abortion law reform. For instance, upon Nirmala's acquittal, the Joint Action Group of Gender Equality (JAG) an umbrella body of 11 women's rights groups in Malaysia, issued a statement urging the government to take responsibility for what had happened to Nirmala and to ensure that "no other woman will be hauled to court in the future over their decision to undergo an abortion."[426] The Federation of Reproductive Health Associations Malaysia (FRHAM)[427] and Reproductive Rights Advocacy Alliance Malaysia (RRAAM)[428] are other organisations that are working towards abortion access. In 2016, RRAAM and JAG organised a policy discussion on abortion law that involved various stakeholders, including Ministry of Health officials.[429] The discussion touched upon the criminalisation of abortion in the penal code and the lack of legal clarity caused by the inclusion of abortion in the penal code. The discussion also referenced India's approach of introducing a new law as an exception instead of deleting the relevant sections of the penal code.[430]

However, several respondents also highlighted that the feminist movements in their respective countries were not actively engaged in abortion advocacy. For instance, Dr. Kritaya noted that though abortion is mostly a feminist issue, in some cases, like in Thailand, the movement for decriminalisation of abortion is unaffiliated with the feminist

movement, and women's rights groups are burdened by issued that are considered higher priorities.[431] In this context, Whittaker notes that, *"women's groups are faced with many issues which are seen to hold a higher priority for women, such as marriage and inheritance laws, trafficking of women and children, and violence against women,"*[432] which relegates abortion rights to a non-priority. In 2021, the pro-democracy movement in Thailand prioritised issues relating to queer rights and abortion law reforms.[433] The movement included groups such as the Tamtang Group, the Feminist for Freedom and Democracy Group and the Safe Abortion Action Fund (SAAF) and organised a protest in front of the Parliament with the placing of funeral wreaths as a symbolic protest.[434] A Thai version of the Chilean feminist anthem "A Rapist in Your Path" was rewritten with a focus on abortion rights and performed by the group.[435] In 2021, Teerantanabodee evaluated the pro-democracy movement and feminist demands that are ensconced within certain factions of the pro-democracy movement.[436] Such factions argue that hetero-patriarchy and authoritarianism are interlinked in a way that the demand for democracy must include demands for queer and women's liberation.[437] Furthermore, the passing of legislation that legalised abortion on demand up to 12 weeks and revised penalties that criminalised abortion led to protests from feminists who visibly articulated their displeasure with a law that did not go far enough.[438] Feminists also highlighted that the law was not inclusive of trans, non-binary and intersex persons.[439] Scholars argue that while the early advocacy on abortion reform was conceptualised through the lens of maternal mortality and health, the abortion reform discourse has now expanded to rights-based approach.[440] The trajectory of abortion rights, advocacy and subsequent legal reform in Thailand indicates the various shifts and progress of the movement.

Respondents from Yayasan Ipas, Indonesia also stated that "there is a debate around whether feminists should advocate for universal access to abortion or incremental policy changes, making sure the government fully implements what they legislate.

There are other countries where abortion is not a priority for feminist or other movements. For instance, feminist movements in Sri Lanka and Bangladesh are currently focussed on sexual and gender violence. Marge Berer in her analysis of abortion laws also points to the feminist movement's preoccupation with gender-based violence as a priority agenda in most countries.[441] Sonali Gunasekara noted that *"due to strong patriarchal norms and Sri Lanka's historically conservative stance on abortion, there has never been a push towards the decriminalisation of abortion."*[442] Respondent C from Sri Lanka shed further light and noted that *"the mainstream feminist movement is not focused on SRHR, but a few activists and grassroots groups are demanding access to abortions."*[443] Similarly, in Bangladesh, Abdullah Titir noted that *"the feminist movement has historically focused on sexual and gender violence legal reform and not the right to abortion."*[444] Incidentally, the feminist movement in India is also focusing on gender and sexual violence.

Respondents in several countries highlighted unique challenges and backlash in abortion law reform. For example, in Pakistan, Dr. Sana Durvesh highlighted that *"conversations around abortion have taken a backseat within feminist movements and organisations due to backlash, funding constraints and the impact of the COVID-19 pandemic."*[445] For instance, due to fear of backlash, Dr. Sana was discouraged from engaging in conversations on abortion pursuant to the introduction of the Sindh Reproductive Healthcare and Rights Bill in 2013.[446] The Bill was unanimously passed and the Reproductive Healthcare and Rights Act came into force in 2019.[447] There is additional fear among activists in Pakistan that conversations around decriminalisation may result in backlash from religious groups, which can then lead to the implementation of regressive abortion laws. Sara Malkani highlighted that *"the fear is that if they draw attention to the criminalisation, opposing religious movements will push back and the law will become more conservative and restrictive. Thus, the movement made a deliberate choice not to advocate for legal reform."*[448]

In the Indian context, Manisha Gupte, Founder and Co-Convenor at Mahila Sarvangeen Utkarsh Mandal (MASUM), noted that the feminist movement was focused on addressing issues of violence and state enabled sexual abuse of women and not so much on abortion. This is possibly because the MTP Act was already in place.[449] Nikita Sonavane also pointed to the lack of an intersectional movement, noting that there needs to be a shared and nuanced understanding of distinct experiences of pregnant persons encountering barriers to abortions.[450] In particular, Nikita pointed to the need for building consensus such that issues of caste and class based discrimination, the experiences of persons with disabilities and queer and trans persons are adequately accounted for in the conversation on abortion.[451] Further, Dr. Jaydeep Tank cautioned "*I am a little worried that anti-choice conversation will strengthen, and that sometimes can have the potential to steamroll all of the progress that is done."*[452] Respondents from India also highlighted ambiguities within legal frameworks that present as barriers to abortion access. In India, the flawed conflation of the MTP Act with other laws

like PCPDNT (which prohibits gender-based determinations) and POCSO has led to 'chilling effect' on healthcare providers, who deny abortion services to pregnant persons due to fear of criminal prosecution.[453]

For instance, adult women have to repeatedly approach courts seeking permission for (often legal) abortions mostly because doctors deny services due to fear of prosecution under the IPC and PCPNDT, especially in the second trimester.[454] Doctors are fearful of treating adolescents in the reproductive health space as they may potentially face criminal sanctions under POCSO.[455] It is also important to take stock of recent developments that have prompted a stronger discourse around interrogating the criminal status of abortions under the IPC. In a recent judgement of the Supreme Court in India, *X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT Of Delhi*,[456] the Court took cognisance of adverse impact chilling effect of the criminal provisions on medical practitioners and the consequent barriers to safe abortions for pregnant persons, noting that criminalisation impedes access to safe abortion for pregnant persons.[457]

Doctors are fearful of treating adolescents in the reproductive health space as they may potentially face criminal sanctions under POCSO.

The consequences of criminalisation of abortions for pregnant persons have also prompted efforts towards radical reforms in Nepal, the most significant of these being the petition filed for decriminalisation of abortion by the Forum for Women Law & Development (FWLD) in the Supreme Court. The petition draws on the jurisprudence developed in the case of *Lakshmi Dhikta* and the Safe Motherhood and Reproductive Health Rights Act. It seeks the repeal of the criminal provisions on abortions in the Criminal Code.[458]

In the case of Vietnam as well, respondents highlighted the unique challenges surrounding abortion advocacy. Dr. Phan Bich Thuy noted that *"Vietnam has a strong women's rights movement, but they never had to really fight for abortion rights was it was already legal."*[459] With international assistance, Vietnam has made tremendous progress. In 2001, the Ministry of Health and Ipas launched an initiative known as the Comprehensive Abortion Care (CAC) project to revamp delivery of abortion services.[460] This led to standardising clinical abortion practice and centring women's need in service delivery articulated in the National Standards and Guidelines for Reproductive Health.[461] Dr. Phan Bich Thuy argued that *"at the end of 2015, the Vietnam National Assembly delayed the approval of the new Population Law. The public perception towards abortion was negative, and the policymakers were still concerned about the high number of abortions and the imbalance in sex ratio at birth."*[462] During the Women Day event in 2016, multiple stakeholders led by ASAP wrote an advocacy letter explaining the need for second-trimester abortion and the negative consequences of restricting this service. The letter also provided suggestions for policies supporting safe abortion.[463] Efforts towards expanding abortion access have thus been ongoing despite the distinct socio-political constraints in each of the countries.

A perusal of these developments reveals that while efforts towards expanding access to abortions have been underway in many countries and legal measures to this effect have also been introduced, there continues to be a lack of consensus on the issue of abortion to be framed within a rights-based language. This is also reflected in the fragmented nature of feminist movements in some countries and the lack of emphasis on abortion as a priority concern for these movements. This is not to take away from the successes that have been achieved in countries like Nepal, Vietnam, Thailand and ongoing efforts in several other jurisdictions. One of the key challenges that confronts these efforts is the lack of an intersectional understanding of the barriers to accessing abortion services. As noted in countries like India, Pakistan, and Sri Lanka, among others, there is an absence of a discourse around the right to abortion that takes note of the barriers faced by persons other than married, cis-gender, able-bodied women. This works to the exclusion of the SRHR needs of marginalised persons including ethnic and religious minorities, queer, trans and gender-variant persons, persons with disabilities and adolescents. The next section discusses the need for an intersectional approach[464] towards decriminalising abortions, one that adopts a reproductive justice framework thus taking note of the distinct systems of oppression that hinder access to abortions, more so for marginalised persons.

TOWARDS INTERSECTIONALITY AND REPRODUCTIVE JUSTICE

Historically, the abortion movement in the Global North divides itself into two factions, "pro-choice"[465] and "pro-life." The primary distimguishing factor between the two is that the pro-life position maintains that the foetus is a child that should retain all the rights of a living person and in some instances, more rights than that of a living person.[466] Therefore, it relies on the moral claim that abortion is 'murder' and should be illegal.[467] Meanwhile, the pro-choice position accords highest value to the life and autonomy of the pregnant person.[468] However, this context is not

universal, even within the West, where Indigenous persons and people of colour face different political circumstances.[469] The current political paradigm in most Asian countries does not support either life or choice for marginalised persons[470] and thus, the restrictive binary approach in the abortion context must be dismantled to achieve reproductive and gender justice that accounts for the distinct experiences of marginalised identities.

The term "reproductive justice" was coined in the USA in 1994 by a caucus of Black feminists at a pro-choice conference,[471] the International Conference on Population and Development (ICPD), which was sponsored by the United Nations known as "the Cairo Conference."[472] The group realised, as Loretta Ross later wrote, that "[o]ur ability to control what happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia, and injustice."[473] This framework views reproductive rights in light of intersecting marginalisation: *"[t]he reproductive justice framework recognises the importance of linking reproductive health and rights to other social justice issues such as poverty, economic injustice, welfare reform, housing, prisoner's rights, environmental justice, immigration policy, drugs policies, and violence."*[474] Reproductive injustice is demonstrated by the strong connections between structural and socio-economic oppression, and a lack of reproductive autonomy. For example, access to contraception is often reliant on insurance coverage, marital status, and employment.[475] Structural racism, gender discrimination and classism work in tandem as intersecting factors that limit access to reproductive healthcare and services.

The reproductive justice framework centres the reproductive health outcomes of marginalised persons and is critical for legal reform. For instance, in the USA, according to the Center for Disease Control and Prevention (CDC), Indigenous persons are two times more likely to die during pregnancy than white persons.[476] Indigenous women in Latin America also have poorer reproductive health outcomes than the general population.[477] As Indigenous women in Latin America face higher rates of unintended adolescent pregnancy, unsafe abortion plays a role in increasing their risk of maternal mortality. Similarly, in Brazil the population that is most likely to die or suffer from complications from unsafe abortions are low-income women of African descent.[478] These women have little access to institutional support, including SRHR education and family-planning services.[479] In 2009, the United Nations Committee on Economic, Social and Cultural Rights (ESCR) expressed concern about the high maternal mortality rate in Brazil, noting that death during pregnancy and childbirth disproportionately impacted Afro-Brazilian, Indigenous and rural women.[480] In many parts of Brazil, marginalised women seeking abortion-related care fear stigmatisation and criminal investigation.[481]

While traditional forms of discourse focus on women's right to abortion, access to reproductive services is essential for all persons.[482] One of the key problems addressed by the reproductive justice framework is the isolation of abortion from other social justice issues that concern communities of colour: issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race, gender, sexual orientation and a host of other concerns.[483] For instance, reproductive oppression is not just the domain of biologically defined women, buy also experienced by other groups including transmen, transwomen, gender queer and gender-variant individuals.[484] Queer abortion rights advocacy has surfaced in recent years[485] adopting the approach of queer theory that questions the construction of the gender binary and the consequently the stable categories of 'woman' and 'man.'486

Further, the framework of reproductive justice responds to the heterogeneity of experiences of pregnant persons, given the distinct role of one's caste, class, race, gender, indigeneity and religion, amongst other factors, in determining access to reproductive healthcare. Studies conducted in India, for instance, have revealed that caste and economic status are significant social determinants on access to healthcare.[487] Research also alludes to the "triple discrimination" faced by Dalit and Adivasi women due the extent to which caste is deeply embedded in the public healthcare infrastructure in the country. The cases of Shanti Devi,[489] a Scheduled Caste landless migrant from the Indian state of Bihar and Amita Kujur,[490] an Adivasi girl who was a survivor of rape, are both instances where this triple discrimination has impeded access to safe abortion services for marginalised persons.[491]

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According to Srinivasan,[492] concepts of reproductive justice expand the political terrain of abortion access beyond the mainstream with a focus on social and political factors that curtailed reproductive freedom.[493] She argues that the reproductive justice framework is a constant reminder that reproduction is always about gender as well as gendered forms of oppression and liberation, but it is never limited to only the politics of gender.[494] Reproductive justice compels

an investigation of intersecting axes of difference, but also demonstrates how reproductive oppression is implicated in a wider history of the nation state.[495]

The framework of reproductive justice offers a more comprehensive understanding of structural and systemic oppression beyond the choice argument.[496] Feminist scholars have demonstrated that the choice rationale is not inclusive of the realities of marginalised communities and does not account for the structural limitations imposed on the ability to make a choice. Smith advocates for a framework that does not hold "choice" above all else when considering reproductive justice to be inclusive of marginalised persons.[497]

The individualist approach of a choice-based framework cannot be applied to most people, as only a select few who have capacity for pregnancy are viewed as "legitimate decision makers."[498] Smith argues that a "legitimate decision maker" is determined by class and race.[499] Meanwhile, pregnant people of colour, indigenous pregnant persons, pregnant persons for marginalised socio-economic backgrounds, pregnant trans persons and pregnant persons with disability are not represented in this binary mode of thinking.[500] The language of choice has proved inaqequate for claiming public resources that most pregnant persons need to exercise autonomy over their bodies and lives.[501] In fact, giving women "choices" has eroded the argument for State support, because women without sufficient resources, who need aid from the state, are simply held responsible for making "bad choices."[502] Roberts states that, *"[r]eproductive justice activists treat abortion and other reproductive health services as akin to the resources all human beings are entitled to—such as health care, education, housing, and food—in an equitable, democratic society."*[503]

Respondents from Bangladesh, Nepal, Vietnam, Sri Lanka, India, and Pakistan highlighted the lack of intersectional framing of SRHR. For example, Thuy Mai touched upon the lack of an intersectional framing of reproductive rights in Vietnam, where *"a trans person was refused abortion services by a doctor on the ground they did not know how to perform the procedure and were fearful of losing their medical licence. As a result, the pregnant person self induced abortion at home."*[504] Speaking of a similar incident in Sri Lanka, Hasanah Cegu highlighted an instance where a trans man who was unable to get an abortion service was forced to carry on with his pregnancy.[505] However, Abdullah Titir noted that *"the feminist movement in Bangladesh has been aiming to increase diversity and inclusion over the past few years, making space for women with disabilities and persons from the LGBTQIA+ communities."* However, she further elaborated that *"MR remains constrained to a gender binary framework and is unavailable to transgender and gender-variant persons."*[506] Supecha, activist and Founder of Tamang Group from Thailand also spoke about increasing diversity of voices within the feminist movement and the new wave of youth leadership within the movements. Several respondents highlighted the importance of youth advocacy.[507] Ninuk Widyantoro, a veteran in the Indonesian feminist movement, is hopeful to see a new wave of young activists with new strategies. She noted that *"we are the old activists, we cannot always be there at the front line. We must empower young people to continue our struggle."*[508]

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In Nepal, Shanta Laxmi also highlighted the limitations of the feminist movement, noting that *"the movement does not focus enough on Dalit women and women with disabilities and instead focuses on 'gender equality and women's empowerment' without realising the heterogeneity within the category of women."*[509] Bali Sruti in Indonesia similarly explained that *"while Indigenous persons were able to access healthcare services in Bali, however, persons with disability continue to face stigma and discrimination."*[510] However, interviews in Jakarta reveal a more inclusive feminist approach in Indonesia. Anindya, an activist in Indonesia alluded to the intersections between feminist activism and disability activism in Indonesia, noting that there is a growing effort towards inclusive advocacy on SRHR rights especially on disability rights.[511] As argued by Srinivasan, the regulation and control of reproduction sustains hierarchies where some people's reproduction is valued while others is devalued. Privileged categories of people are encouraged to nurture and reproduce, whereas poor, oppressed caste, racially marginalised, and queer people are disempowered from doing so.[512]

In India, Nikita Sonavane highlighted the need to build an intersectional understanding on these issues and how the same can only be forged through cross movement conversations.[513] Further, Respondent B from India also noted the lack of an intersectional approach, *"the right to safe abortions is not seen as a priority agenda of PWD movements either at the national or global level and discussions around the right to safe abortions do not include the disability perspective on issues like accessibility and the obtaining of full and informed consent."*[514]

The above analysis clearly highlights the adverse impact of criminalisation and persistent stigma against abortion. In Bangladesh for instance, abortion is highly stigmatised across the board in both rural and urban spaces. Even in countries where abortion is partially decriminalised, cultural stigma still hampers accessibility. Existing studies establish that the criminalisation of abortion care does not reduce the number of abortions that people receive, but only heightens maternal mortality due to a higher number of unregulated and unsafe abortions, as well as the fear created around seeking post-abortion care after botched procedures. The consensus in international human rights law is that the criminalisation of abortion jeopardises the health and life of pregnant persons.[515] Thus, human rights institutions and activists are increasingly supporting decriminalisation of abortion law and the adoption of a reproductive justice framework for access to SRHR.

Abortion was criminalised because of colonial legal provisions in eight countries and the interviews revealed that there was some indirect impact of British influence on local laws in Thailand and Nepal, as well as religious considerations in the countries, and respondents clearly stated that such criminalisation has a significant impact on actual access to abortion. As is evident from the above analysis, healthcare workers are nervous about being trapped, criminalised and punished for providing abortion services.

With respect to the roles of feminist and social movements in decriminalisation strategies, it is seen that feminist movements in several countries have priorities like gender and sexual violence while in a few countries, these movements also address abortion-related concerns. For instance, India and Pakistan do not have a united movement on abortion yet. The feminist movement in Nepal is not inclusive, with inadequate focus on experiences of Dalit persons and persons with disability.

Throughout this study, it was discovered that laws, academic sources, news articles failed to use gender neutral language when discussing abortion, which speaks to a larger limitation of feminist movements and abortion activism throughout South Asia and Southeast Asia. Largely, respondents in some countries agreed that one of the biggest extra-legal factors that influences the criminalisation of abortion is religion. However, in India, rather than religious considerations, the primary opposition to abortion rights comes from the lack of understanding of the healthcare systems and the bureaucracy. In addition, it is important to note that although religious fundamentalism is cited as a reason for the negative public perception of abortion in Indonesia, *Syariah* Law is more liberal than civil law on abortion. As noted above, the Syariah Law is applicable only in Aceh in Indonesia, but is universally applicable in Malaysia and Pakistan. The highly sensationalist approach of the media towards abortion also forms a large source of opposition to abortion rights in Pakistan, Sri Lanka, Vietnam among others.

Further, as highlighted above, the issue of adolescent access to abortion is complex in many countries. This is on account of differential ages of consent, the criminalisation of consensual adolescent relationships, and a legal framework that may not grant adolescents ready access to sex education, information on safe sex practices and reproductive health, all in the backdrop of cultural and social stigmas that deter them from availing of SRH services. The focus of family planning policies on married adult women in several countries creates an atmosphere where doctors may refuse to provide contraception and abortion services to adolescents and penal provisions mentioned in child protection laws create an additional deterrent effect on adolescents seeking abortions without having to disclose their pregnancies to their guardians.

The issue of adolescent access to abortion is complex in many countries. This is on account of differential ages of consent, the criminalisation of consensual adolescent relationships, and a legal framework that may not grant adolescents ready access to sex education, information on safe sex practices and reproductive health, all in the backdrop of cultural and social stigmas that deter them from availing of SRH services.

Although Nepal has partially decriminalised abortion, the criminalisation of abortion continues to affect access to abortion services and now organisations are lobbying for complete decriminalisation. At this time, there are also significant lobbying efforts to improve access to abortion

while complying with the safe motherhood and reproductive regulations adopted by the government. As evidenced by Nepal, an expansion of democratic freedom is associated with greater gender equality. In Thailand, feminist coalitions and protests have cast a spotlight on abortion rights, moving towards partial decriminalisation.

CONCLUSION

The research and on ground realities in terms of barriers to accessing safe abortion services as revealed from the qualitative interviews clearly demonstrate that there is persistent cultural stigma against abortion. This is further complicated by an overarching framework of criminalisation which is a colonial legacy, or in some countries stems from religious opposition. The criminalisation of abortion, as recounted by many of the respondents, continues to be among the most significant hurdles for access to safe abortion services. It particularly deters healthcare providers from providing abortion services given the looming fear of prosecution. This, when compounded with the socio-economic and cultural barriers, absence of comprehensive legal frameworks that take note of the intersectional barriers, as well as the lack of public healthcare infrastructure to provide free and affordable SRHR services, has led to abortion services being significantly stigmatised and inaccessible, particularly for marginalised groups and individuals. Therefore, there is an imminent need for radical reforms that centre access to safe, legal and free abortion services. It is imperative that the legal framework centres the autonomy of the pregnant person within a rights-based framework. According to Loretta Ross, one of the activists who theorised reproductive justice, the criminalisation of abortion is a gendered and racial phenomenon that exists as part of the racist prison industrial complex. She argues that anti-abortionists seek to criminalise women and physicians to deny pregnant persons human rights: *"[t]he increasing prosecution of pregnant persons and physicians occurs in the context of a bloated and racist prison industrial complex eagerly gorging on people ensnared in its traps, producing more wealth for economic elites."*[516] With this baseline in mind, the criminalisation of abortion globally denies pregnant persons their rights, particularly when they are marginalised.

According to Loretta Ross, one of the activists who theorised reproductive justice, the criminalisation of abortion is a gendered and racial phenomenon that exists as part of the racist prison industrial complex. She argues that anti-abortionists seek to criminalise women and physicians to deny pregnant persons human rights: "[t]he increasing prosecution of pregnant persons and physicians occurs in the context of a bloated and racist prison industrial complex eagerly gorging on people ensnared in its traps, producing more wealth for economic elites." With this baseline in mind, the criminalisation of abortion globally denies pregnant persons their rights, particularly when they are marginalised.

The next chapter of this study puts forth some recommendations that can facilitate the shift to a more rights-based discourse on abortion and result in the elimination of barriers to access, while taking note of the distinct intersectional experiences of persons seeking abortion services.

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CHAPTER 4

RECOMMENDATIONS

Access to abortion is an issue that effects every person with the capacity for pregnancy. The criminalisation of abortion, as recounted by many of the respondents, continues to be one of the most significant hurdles to accessing safe abortions. As established in Chapter 3, fear of prosecution discourages medical professionals from providing abortion services, and fuels social stigma towards abortion. This, along with structural, socio-economic, and cultural barriers, the absence of comprehensive legal frameworks that address intersectional barriers, and the lack of public healthcare facilities that have free and affordable SRHR services, has led to abortions being significantly stigmatised and inaccessible, particularly for marginalised groups.

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

1. DECRIMINALISATION OF ABORTION

Abortion continues to be criminalised in nine out of ten countries. As established in the study, healthcare workers are very concerned about being trapped, criminalised, harassed and punished for providing abortion services. Different countries show varied incidents of prosecution under the criminal law framework. Indonesia, India, Malaysia, Philippines, and Sri Lanka demonstrate that healthcare providers and pregnant persons are prosecuted and harassed by the law enforced agency. It is therefore imperative to decriminalise abortion and encapsulate it within a rights-based framework of reproductive justice (rather than a criminal law framework) by centring access and the decision-making capacity of pregnant persons. Pregnant persons can therefore avail abortion services without fear or intimidation.

The laws criminalising abortion do not operate in silos but are significantly influenced by extra-legal factors and have long-term repercussions for SRH access. Where the criminalisation of abortion exacerbates the structural inequalities that impede pregnant persons access to SRH services, the decriminalisation of abortion can provide pathways for addressing such systemic violence and oppression that is the result of compounding inequalities of caste, class, race, gender, religion, age and disability among others. Efforts towards decriminalisation of abortion must be informed by a comprehensive understanding of the structural barriers and inequalities and therefore must address concerns beyond the legal terrain including lack of adequate public healthcare infrastructure, economic empowerment and lack of awareness among medical professionals on legality of abortion among other factors. The framework of choice is therefore limiting because it fails to account for these structural barriers.

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2. LEGAL REFORMS AROUND CHILD PROTECTION LAWS AND ADOLESCENT SEXUALITY

There is an urgent need to revisit the way adolescent sexual capacities and desires are regulated under the law. As this study reveals, the issue of adolescent access to abortion becomes complicated in many countries with differential age of consent. The focus on married adult women in family planning policies in several countries creates an atmosphere where doctors may refuse to provide contraception and abortion services to adolescents, and

penal provisions mentioned in Child Protection Laws (such as the mandatory reporting provision in the Indian POCSO law and the Section 363 of the Sri Lankan Penal Code) create an additional deterrent effect on adolescents seeking abortions without having to tell their guardians about their unplanned pregnancies. The criminalisation of consensual adolescent relationships, as well as legal frameworks that do not grant adolescents easy access to comprehensive sexuality education and reproductive health care, result in the perpetuation of existing cultural and social stigmas that deter them from availing of SRH services.

As opposed to blanket criminalisation, legal recognition of evolving sexual capacity of adolescents would better respond to the challenges that plague adolescent access to SRHR services, including abortion. This move, though complex given the legitimate concerns of child sexual abuse, can be navigated legally in a manner that recognises adolescents' ability to have consensual sexual relationships. An illustrative example of this is South Africa, where the law recognises that adolescents have a right to engage in sexual activity without incurring criminal sanctions. Sexual behaviour amongst adolescents who are between 12 and 15 years old are legal as long as it is consensual and with others within this age group, as well as with persons who are 16 or 17 years old, as long as they are no more than two years apart in age.[1]

3. COMPREHENSIVE SEXUALITY EDUCATION

The criminalisation of abortion suggests that sexuality and reproduction are considered a taboo and permit the dominance of religious (primarily Islamic, Hindu, Buddhist, and Catholic religions, dependent upon the country) and cultural restrictions. Socio-cultural barriers that are rooted in cis-heteropatriarchal gender roles further the stigma surrounding abortions and strip pregnant persons of their decision-making power. In most countries, the decision-making power in relation to reproductive rights and reproductive health decisions does not vest with wohe pregnant person. Even in countries where abortion is partially decriminalised, cultural stigma continues to hamper accessibility. Typically, the lack of adequate SRHR education is indicative of limited contraception services, reproductive health services and abortion.

One way of countering this stigma is through the proliferation of the discourse around gender and sexuality from an early stage. It is thus important that countries take steps towards incorporating comprehensive sexuality education within school and educational curricula and equip young persons with the requisite knowledge to better comprehend their sexual and reproductive health needs and rights.

The criminalisation of consensual adolescent relationships, as well as legal frameworks that do not grant adolescents easy access to comprehensive sexuality education and reproductive health care, result in the perpetuation of existing cultural and social stigmas that deter them from availing of SRH services.

4. INCLUSIVE FRAMEWORK FOR ACTIVISM AND REFORMS

In the move towards decriminalisation of abortions, it is imperative to be mindful of the intersectional discrimination faced by pregnant persons in accessing abortion services. Most legal reforms on abortion continue to be framed within cis-heteronormative, gender-binary modulations that restrict abortion services to married, cisgender women and do not account for the experiences of queer, trans, and gender-variant individuals. This speaks to a larger drawback of feminist movements and abortion activism throughout South Asia and Southeast Asia, emphasising the need for inclusive politics by adopting the language of reproductive justice. For instance, in Bangladesh, the movement has been aiming to increase diversity and inclusion over the past few years, making space for persons with disabilities, persons from the LGBTQIA+ communities and gender diverse persons. This can be done through building cross-movement solidarity with other social movements including Indigenous movements, LGBTQIA+ persons, persons with disabilities, anti-caste groups, anti-race groups and youth and adolescent coalitions.

5. RESPECTING INTERNATIONAL OBLIGATIONS

There must be an effort towards legal reforms that conform to the rights and obligations imposed by international treaties and policies. SRH rights have been addressed comprehensively within a rights-based framework, for example, in the Beijing Declaration and Platform for Action adopted by 189 countries in 1995. The international legal framework on abortion calls for the removal of any barriers, including laws that criminalise abortion seekers and health care providers. The framework encourages recognition of the evolving capacity of adolescents and removal of restrictive age of consent laws that criminalise consensual adolescent

sexual activities. The countries that have informed this study are signatories to many of the international treaties and conventions, including the CEDAW, the Convention of the Rights of the Child and the United Nations Human Rights Declaration, which impose international human rights obligations that must be complied with at the domestic level. Therefore, it is imperative that SRHR is framed within a rights-based framework that is culturally sensitive and respectful of domestic and customary rights.

6. STRUCTURAL AND SYSTEMIC CHANGES

Liberalising the law on abortion by itself will not be sufficient to improve abortion access, as law does not exist in a vacuum. The current system of healthcare in many countries across South Asia and Southeast Asia makes abortion inaccessible to most persons due to biases held by doctors (as is the case in Vietnam, India and Thailand), widespread distrust in underfunded public hospitals due to doctors who are not sensitised (as is the case in India), as well as a general lack of affordable, quality care.

Comprehensive reproductive healthcare for marginalised persons is essential to achieve reproductive justice. Medical providers must be trained in gender affirming care, so that trans gender and gender-variant persons do not undergo physical and emotional trauma related to being misgendered. Discrimination based on ethnicity, religion, caste and class are also a significant barrier to abortion healthcare. Marginalised persons often cannot afford reproductive healthcare services. There is evidence to suggest that free, affordable and quality access to healthcare services is often not provided in the public hospitals. Subsequently, they are either forced to give birth by carrying the abortion to term or seek out unsafe methods. Thus, systemic changes in the healthcare sector are needed to facilitate abortion access.

Such changes will ensure availability of trained and empathic healthcare providers who are willing to provide healthcare services to persons with marginalised identity. Further, comprehensive and free healthcare services should be universally available. Finally, the healthcare sector should be well-funded to support a robust infrastructure in rural locations.

Liberalising the law on abortion by itself will not be sufficient to improve abortion access, as law does not exist in a vacuum.

7. HARMONISATION OF CONFLICTING LAWS

One of the key barriers to accessing safe abortions is the presence of conflicting laws that lead to ambiguities around the legal status of abortions, resulting in the refusal of services by doctors and medical professionals and lack of awareness among people. Vietnam, Thailand, and India are illustrative examples of these challenges.

In India for instance, the PCPNDT Act which was enacted to regulate gender determination, has had an adverse impact on access to abortion services. Though the law makes no mention of abortions, the stringent criminal framework on gender-determination has led to crackdown on abortion service providers. A similar situation is evident in Vietnam, owing to the gender-determination law in the country. As a result, the fear of prosecution that stems from a criminal framework is heightened. In the case of Nepal, pre-natal sex-determination is punishable under the National Safe Abortion Policy of 2003. Here too, the endeavour is to counter the increasing instances of gender-biased sex-selective terminations. There is, therefore, no real legal conflict with law on abortion in each of these contexts except Nepal. However, the conflation of these laws on ground given the lack of awareness and heightened fear of criminal consequences experienced by medical professionals has reduced access to abortion services.

As noted in the recommendation No. 2, the issue of conflicting laws also impacts adolescent access to abortions. With conflicting provisions on age of consent and stringent child protection laws in operation, the issue of consensual adolescent sexuality and rights goes unaddressed. The penal laws on child sexual activity in Sri Lanka, India and Indonesia serve as illustrative examples of these challenges. To address this issue, there must be a concerted effort to harmonise all laws, ensuring that access to abortions is not compromised owing to legal ambiguities and conflicts. This must also be coupled with capacity building efforts to clarify the legal position and facilitate access to safe and legal abortions.

8. SENSITISATION AND TRAINING TO ADDRESS STIGMA

Although legal reforms can respond to some of the barriers to accessing abortion services by promulgating rights-based legislations, social stigma that continues to be a persistent, deep-rooted challenge for SRHR must be addressed beyond the law. The literature review and qualitative interviews revealed a significant prevalence of stigma around abortions, particularly in the perceptions of healthcare service providers and other key stakeholders such as public functionaries and religious leaders. The experiences of pregnant persons in countries with liberal laws and radical legal reforms like

Nepal and Vietnam reveal that the presence of permissive laws alone does not necessarily facilitate access to safe abortions as the implementation of these laws remains poor, which is partly attributable to cultural and social stigma.

This stigma is also fuelled by media reporting that sensationalises the issue of abortions and furthers a restrictive and binary understanding of gender. Media narratives play a crucial role in influencing the way abortion is perceived in the larger public domain. Abortion in popular media, is inextricably linked to 'murder', 'foeticide' and societal evils like skewed sex ratios, without any nuance in discussions pertaining to other circumstances, outside gender-biased sex determination, where abortions are necessary. Communication and awareness materials are seen to be highly moralistic, using violent imagery and slogans that serve to equate abortion with sin, directly targeting both abortion seekers as well as abortion providers.

Finally, is imperative that persons seeking abortion services are provided with all the relevant and correct information regarding available methods, as well as information on the latest available technologies by service providers, who need to spend adequate time and effort to enable pregnant persons to make an informed decision. Information around contraception to prevent unplanned and unwanted pregnancies should be made available. Therefore, there is a need to supplement efforts towards legal reforms with parallel engagement through dialogue and advocacy with key stakeholders including medical healthcare professionals including doctors and ancillary staff, religious leaders, judiciary, lawyers, public functionaries and members of Parliament, journalists and media personnel who can help proliferate a de-stigmatised understanding of abortion.

9. DE-STIGMATISING MEDICAL ABORTIONS

According to the WHO guidelines, medical abortion can be used safely and effectively up to and beyond 12 weeks' gestation period. Additionally, the WHO states that abortion can be self-managed up to 12 weeks when the patient has access to accurate information, a qualified health care provider and post-abortion care facilities.[2] Research and interviews that informed this study have demonstrated that self-managed abortions, though recommended by the WHO, are rarely available to pregnant persons either because of lack of awareness or lack of availability of MMA pills, which is in turn influenced by the global political economy of SRHR. For example, the Global Gag Rule's repercussions for SRHR access in Pakistan is a direct consequence of such politics.

Self-managed abortion can be a safe and viable option for women seeking abortion as well, if systems are put in place that ensure their safety and access to healthcare systems/ providers in case of any emergency or complications. There must be campaigns and widespread awareness drives to educate both healthcare providers and persons who can become pregnant on self-managed abortions. This must also be supplemented by efforts to make MMA pills widely available at free and affordable prices so as to enable persons, especially marginalised individuals to be able to access safe abortion services.

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ENDNOTES FOR CHAPTER 4

1 Strode, A. and Essack, Z., *Facilitating access to adolescent sexual and reproductive health services through legislative reform: Lessons from the South African experience* 107(9) SAMJ: Medicine and the Law (2017).

2 World Health Organization, *WHO recommendations on self-care interventions: self-management of medical abortion*. No. WHO/SRH/22.1. World Health Organization, (2022).

CHAPTER 5

CONCLUDING OBSERVATIONS

The ten countries that form the subject matter of this study have a contentious history on sexual and reproductive healthcare and rights, particularly abortion. The colonisation of eight out of ten of these countries is important in tracing the origins of abortion laws; the status of these countries as former British, Spanish and French colonies belie the significant legal and judicial developments in these countries, which have, in many cases, led to large scale reforms around abortion legal frameworks.

The origins of colonial criminalisation of abortion rested on Victorian morals based in Christian ideology, which emphasised the sanctity of life as well as the notion that life begins at the time of conception. This, compounded by a white saviour complex resulted in criminalisation of abortion or "causing miscarriage." This is evident in pre-partitioned India, Sri Lanka and Malaysia where the colonial rule criminalised abortion under the Penal Code. Nepal and Thailand are the only countries in the study that did not face colonial occupation (and to a large extent), faced other religious and cultural elements that resulted in widespread stigma against abortions.

The stigma against abortion stems, firstly, from societal attitudes towards women and their rights, labelling abortions as a 'sin' and framing them as a tool for premarital sex and sexual promiscuity in girls and women. Such stigma is facilitated by laws that criminalise abortion in many countries and stymies the availability of essential information on the legality and availability of abortions, even in countries where abortion is legal. For instance, in Vietnam and Nepal, abortion is considered immoral in nature, resulting in a significant amount of inaccurate information being proliferated about health consequences of abortion—and amplifying barriers to accessing safe abortions. Stigma against abortions influences policies around medical abortions, with several countries experiencing shortages of medical abortion pills and lack of state approvals around distributing essential medical abortion drugs—such as in Malaysia, Thailand, Indonesia, Sri Lanka and the Philippines. Restrictive policies around medical abortion further dissuades healthcare providers from writing prescriptions for pregnant people to avail these procedures.

Further, cultural norms largely dictate rules around bodily autonomy and the ways in which people's sexuality and relationships with their bodies are formally regulated. Cultural taboos against abortion stem, in part, from the systematic desire to control women's sexuality and deny women bodily autonomy. These taboos culturally associate abortion with sexuality, deeming it a sinful and clandestine activity. The situations in Thailand, Pakistan and Sri Lanka reveal the taboo and sensitive nature of abortion, with cis-heteropatriarchy, and ethnocentrisms furthering purist stances on sexuality and SRHR. India's situation is further complicated by caste, which directly impacts access to rights of caste-marginalised persons.

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Cultural attitudes around abortion are also affected by religious traditions within communities, with most religions viewing abortion as a sin. Individual and social opinions on abortion, morality and legality are strongly influenced by religious norms—to the extent that even in countries with liberal abortion laws like Vietnam, religious barriers can curtail access to abortion services. The wide availability of abortions in Vietnam is affected by religious views on reincarnation and restrictive laws in the Philippines are rooted in the pro-life movement of the Catholic church. In Thailand, Buddhism opposes reproductive rights and in Nepal, Hindu religious texts deem abortion a sin. In Malaysia, Christian and Muslim faiths equate abortion with 'murder', with the primary opposition to abortion coming from religious groups. Indonesia recognises several religions including Islam, Christianity, Buddhism, and Hinduism whose collective influence also informs social beliefs and laws in the context of abortion.

Cultural norms largely dictate rules around bodily autonomy and the ways in which people's sexuality and relationships with their bodies are formally regulated. Cultural taboos against abortions stem, in part, from the systematic desire to control women's sexuality and deny women bodily autonomy.

Beyond religious, social and cultural factors, the criminalisation of abortion under the legal frameworks of different countries significantly impacts access to abortions. Criminalisation can deepen the stigma against abortions, such as in the Philippines, where pregnant women are forced to carry unwanted pregnancies to term. The furtherance of taboos against abortion perpetuates gender stereotypes that ascribe 'motherhood' to women and label them as 'caregivers' – which, in turn, restrict their access to abortion. Further, the criminalisation of abortion does not affect actual incidence of abortion, as pregnant persons just avail of more unsafe, back-alley abortion services, as pointed out by the WHO in their 'Safe abortion: Technical and Policy Guidance for Health Systems' – which can significantly contribute to maternal mortality. Criminalisation of abortion also creates the fear of prosecution amongst healthcare providers and persons seeking abortion services themselves, in places like India, Pakistan, Sri Lanka, Indonesia, Malaysia and the Philippines. Prosecution rates vary between countries, but even in countries with liberal laws and paralegal criminal legal framework, fear of prosecution can gravely affect access to even legal abortions.

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In countries where strict laws or other factors curtail access to abortion services or render them unavailable, safe abortion services become a luxury that only the rich can afford. Poor and marginalised persons are forced to avail of abortion services that are often unsafe in nature, as several countries do not have adequate public and rural health infrastructure to uphold their SRH. In such a scenario, it becomes imperative to adopt an anti-carceral framework to decriminalise abortion and consequently improve access for marginalised communities. Further, restrictive laws around adolescent sexuality and abortion also impede access to abortions by adolescents. In countries like India, Sri Lanka, Indonesia, and Malaysia, criminalisation of adolescent sexuality manifests in many adolescents resorting to unsafe abortion methods. In the Philippines, the lack of legal agency also impedes the provision of essential sexual education to adolescents. In many countries like Nepal, Vietnam, Bangladesh, and Indonesia, abortion is also framed within a strong 'family planning' discourse, excluding adolescents and unmarried pregnant persons from its purview.

Several countries are witnessing legal reforms on abortion spearheaded by social movements. In some countries abortion rights movements are associated with feminist groups, such as in Indonesia and Philippines. In countries like Thailand, Sri Lanka, India and Bangladesh feminist movements have prioritised issues of sexual and gender violence. Activists in countries such as Pakistan and Malaysia have experienced backlash on abortion law reform, resulting in incremental progress. Further, Indonesia, Bangladesh and India's ambiguities in their legal frameworks have created additional barriers to abortion access. While countries like Vietnam have decriminalised abortion, there continue to be structural challenges around access to abortion services. To undertake meaningful, politically sensitive and compressive legal reform within a reproductive justice framework, it is imperative to view abortion rights within the larger SRHR framework, through an intersectional lens. Finally, it is crucial to address the intersectional barriers to access safe abortion faced by marginalised persons, who tend to face the disproportionate consequences of carceral and criminal frameworks and policies. As Angela Davis reminds us: *"An attempt to create a new conceptual terrain for imagining alternatives to imprisonment involves the ideological work of questioning why "criminals" have been constituted as a class and, indeed, a class of human beings undeserving of the civil and human rights accorded to others."*[1]

To undertake meaningful, politically sensitive and compressive legal reform within a reproductive justice framework, it is imperative to view abortion rights within the larger SRHR framework, through an intersectional lens. Finally, it is crucial to address the intersectional barriers to access safe abortion faced by marginalised persons, who tend to face the disproportionate consequences of carceral and criminal frameworks and policies.

ENDNOTE FOR CHAPTER 5

1 Angela Davis, Are Prisons Obsolete? (Seven Stories Press, 2003).

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asian-pacific resource & research centre for women

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

Asian-Pacific Resource & Research Centre for Women (ARROW)
1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

Telephone	(603) 2273 9913/9914/9915
Fax	(603) 2273 9916
E-mail	arrow@arrow.org.my
Web	www.arrow.org.my
Facebook	facebook.com/ARROW.Women
Instagram	arrow_women
Twitter	@ARROW_Women
Youtube	@ARROWomen
LinkedIn	arrowomen