COMPARATIVE ANALYSIS OF ABORTION LAWS: A STUDY OF EVOLVING LAWS, IMPLEMENTATION CHALLENGES, AND REPRODUCTIVE RIGHTS

A Dissertation submitted to the National University of Advanced Legal Studies, Kochi in partial fulfilment of the requirements for the award of Degree of Master of Laws in Constitutional and Administrative Law

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CERTIFICATE

This is to certify that **Ms. Neha Shajan, REG NO: LM0124013** has submitted her Dissertation titled '**Comparative Analysis of Abortion Laws: A Study of Evolving Laws, Implementation Challenges, and Reproductive Rights**' in partial fulfilment of the requirement for the award of the Degree in Master of Laws in Constitutional and Administrative Law, to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the dissertation submitted by her is original, bona fide and genuine.

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DECLARATION

I, Neha Shajan, do hereby declare that this LL.M. Dissertation titled **"Comparative Analysis of Abortion Laws: A Study of Evolving Laws, Implementation Challenges, and Reproductive Rights",** researched and submitted by me to the National University of Advanced Legal Studies, Kochi in partial fulfilment of the requirement for the award of Degree "Master of Laws in Constitutional and Administrative Law", under the guidance and supervision of Dr. Nandita Narayan, is an original, bona-fide and legitimate research work. It has been pursued for an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University.

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PREFACE

The right to reproductive choice remains one of the most contested issues in legal and political discourse, often caught at the intersection of individual autonomy, state interest, and evolving societal values. This dissertation undertakes a comprehensive comparative analysis of abortion laws across jurisdictions, focusing on the conflict between state interests and women's reproductive rights. Through a critical examination of legal frameworks, judicial interpretations, and policy implications in the United States, India, Germany, and France, the study seeks to highlight how legal systems navigate the tension between protecting foetal life and upholding reproductive autonomy.

The work begins with an introductory chapter that outlines the background and context of the study, the central research questions, and the theoretical framework guiding the inquiry. It also includes a detailed literature review and articulates the rationale, objectives, and methodology employed.

Subsequent chapters delve into the legal positions and judicial reasoning surrounding the state's interest in regulating abortion, the recognition of foetal rights and legal personality, and the specific challenges surrounding minors' access to abortion services across jurisdictions. The study also evaluates the impact of these legal frameworks on the actual accessibility of safe and legal abortion, offering a comparative perspective on how law influences public health outcomes and individual rights.

The final chapter consolidates the findings, offering reasoned conclusions and forward-looking recommendations aimed at enhancing reproductive rights while balancing legitimate state concerns.

This dissertation aspires to contribute meaningfully to the academic discourse on reproductive justice, comparative constitutionalism, and human rights law. It is intended for scholars, legal practitioners, policymakers, and all those interested in the evolving landscape of reproductive rights in a global context.

LIST OF ABBREVIATIONS

AIR	All India Report.
Anr.	Another.
BNS	Bharatiya Nyaya Sanhita, 2023
CAT	Convention Against Torture
CEDAW	Convention on Elimination of all forms of discrimination against women
CRC	Convention on the Rights of the Child
e.g.	Example.
ECHR	European Court of Human Rights
etc.	Et cetera.
HC	High Court.
Ker	Kerala
MTP Act	Medical Termination of Pregnancy Act
Ors.	Others.
PCPNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994.
POCSO Act	Protection of Children from Sexual Offences Act, 2012
Raj	Rajasthan
SC	Supreme Court.
SCC	Supreme Court Cases.
UN	United Nations.
v.	versus.
ICCPR	International Covenant on Civil and Political Rights.
ICESCR	International Covenant on Economic, Social and Cultural Rights
IPC	Indian Penal Code, 1860.
UDHR	Universal Declaration of Human Rights.
UN	United Nations
UNPF	United Nations Population Fund

U.S.	United States of America
Veil Act	Voluntary Interruption of Pregnancy Act
WHO	World Health Organisation
WP	Writ Petition

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1. V. Krishnan v. G. Rajan, 1993 SCC OnLine Mad 374
2. Jacob George v. State of Kerala, (1994) 3 SCC 430
3. Nand Kishore Sharma v. Union of India, AIR 2006 Raj 166
4. Vijay Sharma & Anr. v. Union of India, AIR 2008 Bom 29
5. Suchita Srivastava and Ors. v. Chandigarh Administration, AIR 2010 SC 235
6. Bashir Khan v. State of Punjab & Another, Civil Writ Petition No.14058 of 2014
7. Kamla Devi v. State of Haryana & Others, CWP No.2007 of 2015
8. High Court on its Own Motion v. State of Maharashtra, 2017 Cri LJ 218
9. Justice K.S. Puttaswamy v. Union of India, AIR 2018 SC (SUPP) 1841
10. XYZ (Minor) through her father v State of Maharashtra, Civil Writ Petition LD-VC-82 OF 2020
11. Pramod A. Solanke v. Dean of B.J. Govt. Medical College & Sasoon Hospital, 2020 SCC OnLine Bom 639
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14. Indulekha Sreejith Vs. Union of India and Ors., AIRONLINE 2021 KER 1285
15. X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT of Delhi, Civil Appeal No 5802 of 2022
16. XYZ Through her Natural Gurdian I.E. Mother Hirkani Sonu Bhoi v. State of Maharashtra and Others, WP No.792 of 2022
17. Shahistha v. State of Karnataka, (2022) 1 HCC (Kar) 20
18. X V. Union of India, Miscellaneous Application No. 2157 of 2023 in Writ Petition (Civil) No. 1137 of 2023
19. Victim A v. The State of Madhya Pradesh and Others, WP No. 5009 of 2023
20. N Vs. State of NCT of Delhi and Ors., W.P. (Crl.) 2728/2024
21. X (Minor Victim) Vs. State of Uttar Pradesh and others, WRIT C No. 21956 of 2024
22. Najila B and Ors. Vs. Union of India and Ors., WP (C) No. 44297 of 2024
23. A (Mother Of X) vs State of Maharashtra, Petition(s) for Special Leave to Appeal (C) No(s).9163/2024

24. Mrs. C Vs. The Principal Secretary Health and Family Welfare Department, Government of NCT of Delhi and others, W.P. (C) 11206/2024
25. Jegatha D. vs. The Inspector of Police, Ranipet and Ors., W.P. No. 2237 of 2025
26. XXX Vs. Union of India and Ors., WP (C) No. 8514 of 2025

United States of America

1. Roe v. Wade, 410 US 113 (1973)
2. Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)
3. Anders v. Floyd, 440 F. Supp. 535 (D.S.C. 1977)
4. Colautti v. Franklin, 439 U.S. 379 (1979)
5. Bellotti v Baird, 443 U.S. 622 (1979)
6. H.L. v. Matheson, 450 U.S. 398 (1981)
7. Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (1992)
8. Washington v. Glucksberg, 521 U.S. 702 (1997)
9. Stenberg v. Carhart, 530 U.S. 914 (2000)
10. Gonzales v. Carhart, 550 U.S. 124 (2007)
11. Whole Woman's Health v. Hellerstedt, 579 U.S. ___ (2016)
12. Dobbs v. Jackson Women's Health Organization, 597 U.S. (2022)

Germany

1. BVerfG, Judgment of the First Senate of 25 Feb. 1975, 1 BvF 1/74, ¶¶ 1–209
2. BVerfG, Order of the Second Senate of 28 May 1993, 2 BvF 2/90, ¶¶ 1–434

France

1. Constitutional Council [CC] [Conseil constitutionnel], Jan. 15, 1975, No. 74-54 DC, Rec. 19
2. Cour de cassation [Cass. crim.] [Court of Cassation, Criminal Division], Paris, June 25, 2002, No. 00-81.359, Bull. crim. 2002, No. 153

ECHR

1. Vo v. France, App. No. 53924/00, 2004-VIII Eur. Ct. H.R. 67

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Chapter 1: Introduction

1.1 Background and context

Abortion as a medical procedure has been present since a very long time and has been regulated in all states across the world on the grounds of religion, morals and/or protecting the life of the unborn child. Though many states have legalised abortions subject to fulfilling certain conditions, recent trends have seen a push back on the liberalisation of abortion laws by countries, the most prominent example being that of the United States who very recently ruled that abortion is no longer a constitutional right in a landmark judgment.[1]

India's approach to abortion is shaped by public health concerns and a constitutional emphasis on bodily autonomy. In India the bill for enacting the very first abortion law was introduced by Dr. Chandrasekhar, who sought for abortion to be liberalised for the following reasons:

- it can prevent the birth of deformed children,
- as a humanitarian ground with respect to victims of sex crimes, and
- mentally ill women, and as a health measure.[2]

Thus, India legalised abortion in 1971 with the Medical Termination of Pregnancy Act, (hereinafter MTP Act),[3] which allowed women to abort the foetus till 12 weeks with one medical practitioner and till 20 weeks with two medical practitioners, beyond which the same was illegal, provided that abortion could be performed if the pregnant women's life was in danger.

In 2002[4] an amendment was made to the Act, which provided for stricter conditions for conducting abortion to ensure the number of unsafe abortions reduces and those providing such abortion are restricted.

Though India progressively brought forth an enactment to provide women with the chance to undergo abortion without penal action the same was for a limited time

[1] Kareem Crayton, Ruby Edlin & Jennifer Ahearn, *Roe v. Wade and Supreme Court abortion cases Brennan Center for Justice* (2024), https://www.brennancenter.org/our-work/research-reports/roe-v-wade-and-supreme-court-abortion-cases (last visited Nov 18, 2024).
[2] Raj Pal Mohan and Raj Pa Mohan, Abortion in India, 50 Soc. Sci. 141, 141-143 (1975).
[3] Medical Termination of Pregnancy, 1971.
[4] Medical Termination of Pregnancy (Amendment) Act, 2002.

period and required the approval of one or two medical practitioners according to the stage of pregnancy. The amendment to the Act in 2021,[5] has sought to liberalise the abortion law by increasing the time limit for seeking abortion services till 20 weeks with the consent of one medical practitioner and till 24 weeks with the consent of two medical practitioners.[6]

Despite the 2021 amendment to the Medical Termination of Pregnancy Act and progressive court judgments, unsafe abortions remain a leading cause of maternal mortality in India. Unsafe abortions are the third leading cause of maternal mortality in India, and close to 8 women die from causes related to unsafe abortions each day, according to the United Nations Population Fund (UNFPA)'s State of the World Population Report 2022.[7]

While the law expanded access by increasing gestational limits and recognizing the rights of unmarried women, gaps persist in implementation. Stigma, lack of awareness, and inadequate access to safe abortion services force many women to resort to unsafe procedures. These challenges highlight the need for stronger enforcement, public health initiatives, and societal change to ensure the law's intended impact is realized.

The abortion law in India is compared with those of United States of America (hereinafter U.S.), Germany and France, to determine the difference in state interest in abortion and how each country deals with unsafe abortions. In the past few years U.S. has regressively changed its abortion jurisprudence from strict scrutiny of abortion laws to rational basis for enacting abortion laws, thereby reducing women's right in abortion in quite a few of the states.[8] Germany has always prioritised foetal rights over women's rights in abortion laws, providing for proactive state action in protecting the foetus.[9] Contrary to both U.S. and Germany,

[5] Medical Termination of Pregnancy (Amendment) Act, 2021.
[6] India's amended law makes abortion safer and more accessible. World Health Organization (WHO), 13 April 2021. Available at: https://www.who.int/india/news-room/detail/13-04-2021-india-s-amended-law-makes-abortion-safer-and-more-accessible.
[7] United Nations Population Fund, *State of the World Population 2022: Seeing the Unseen-The Case for Action in the Neglected Crisis of Unintended Pregnancy* (2022), https://www.unfpa.org/sowp-2022.
[8] *Tracking Abortion Laws by State After Roe v. Wade*, N.Y. Times (2024), https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html.
[9] D.A. Jeremy Telman, Abortion and Women's Legal Personhood in Germany: A Contribution to the Feminist Theory of the State, 24 N.Y.U. Rev. L. & Soc. Change 91 (1998).

France recently amended its Constitution to provide for right to make reproductive choice to women, making it the very first country to do so.

1.2 Research questions

i. How does the state's interest in protecting the rights of the unborn child compare across different countries, particularly in contrast to the lack of equivalent protections for women's reproductive rights?
ii. How have judicial decisions across different jurisdictions established tests to determine the commencement of foetal rights and legal personality, and how do these tests account for ethical and medical considerations in shaping abortion laws?
iii. How does the protection of minors' reproductive rights vary across different countries?
iv. How do abortion laws, along with related legal frameworks, impact access to safe abortion services, and how does this compare across different countries?

1.3 Statement of Problem

Despite progressive reforms such as the 2021 amendment to the Medical Termination of Pregnancy (MTP) Act and judicial recognition of reproductive rights, access to safe and legal abortion in India remains limited in practice. Legal provisions still require medical approvals and are bound by gestational limits, which can delay or deny care. As a result, unsafe abortions continue to be a leading cause of maternal mortality, pointing to a significant gap between legal intent and on-ground implementation.

This problem is not unique to India. Globally, there is an ongoing conflict between the state's interest in protecting foetal life and the individual's right to bodily autonomy. The absence of a consistent framework for determining the commencement of foetal rights and legal personality has led to wide disparities in abortion laws. While some jurisdictions, like Germany and France, adopt a balanced approach incorporating both ethical concerns and women's rights, others, such as parts of the United States after *Dobbs v. Jackson Women's Health Organization*

(2022), have shifted toward more restrictive models, undermining established reproductive freedoms.

Another critical issue is the inadequate protection of minors' reproductive rights. Legal systems vary widely some mandate parental or judicial consent, while others offer more autonomy without adequate support structures. These inconsistencies leave minors especially vulnerable to stigma, misinformation, and unsafe procedures.

The increasing complexity surrounding post-viability abortions further complicates legal regulation. Advances in medical technology continue to lower the threshold of foetal viability, raising ethical questions that laws often fail to adequately address, particularly in cases involving foetal abnormalities or the pregnant individual's mental health.

Beyond legal texts, stigma, lack of awareness, limited provider availability, and inconsistent enforcement contribute to a system where many, especially marginalized individuals, are forced to seek unsafe abortions. This reveals that legal reform alone is insufficient without parallel social, medical, and administrative support.

1.4 Rational and significance of study

This study is crucial for understanding how diverse legal systems navigate the complex interplay between reproductive rights, foetal rights, and public health imperatives. By examining the state's interest in protecting the unborn against the backdrop of limited equivalent protections for women, the research highlights disparities in prioritizing reproductive autonomy across countries. The focus on minors' reproductive rights reveals significant variations in the legal frameworks and societal attitudes shaping access to abortion, underscoring the vulnerability of young individuals.

Exploring medical, legal, and ethical considerations surrounding post-viability abortions brings into focus the tensions between advancing medical technologies, evolving legal doctrines, and ethical dilemmas. Similarly, examining the impact of legal restrictions on access to safe abortion services sheds light on how these

barriers disproportionately affect marginalized groups, creating a public health challenge. Comparing these issues across countries provides valuable insights into best practices and gaps in existing frameworks.

The study contributes to the global discourse on reproductive justice, offering recommendations for reform and ensuring that legal frameworks are inclusive, equitable, and responsive to individual rights and public health needs.

1.5 Scope and delimitation

This research examines abortion laws through a comparative analysis of India, Germany, the United States, and France. It explores how these countries balance the state's interest in protecting the rights of the unborn with women's reproductive autonomy, highlighting differences in priorities and protections. The research delves into the legal frameworks governing minors' reproductive rights, offering insights into how these nations address access and restrictions for young individuals. Additionally, it analyses the medical, legal, and ethical considerations surrounding abortions after foetal viability, comparing approaches across jurisdictions. The research also investigates how legal restrictions and broader frameworks influence access to safe abortion services, emphasizing their public health and socio-legal implications. By comparing these diverse legal systems, the study aims to uncover best practices and gaps, contributing to a nuanced understanding of global approaches to reproductive rights.

1.6 Citation style

The citation style used for the dissertation is Bluebook 21st edition.

1.7 Theoretical framework and literature review

1.7.1 Theoretical framework

The legal frameworks surrounding abortion in India, as analysed by the Jindal Report and other literature, reveal deep-seated doctrinal debates. One of the central issues lies in the interpretation of abortion as a constitutional right under Article 21 of the Indian Constitution, with courts divided between affirming women's reproductive autonomy as an extension of personal liberty and prioritizing foetal

rights. This tension underscores a broader clash between individual rights and state interest, a debate that echoes globally across jurisdictions like Germany, France, and the United States, which balance foetal protection and women's autonomy differently.

Judicial interpretations in India have also highlighted inconsistencies, particularly in cases involving vulnerable groups such as minors and survivors of sexual violence. While the law guarantees access to safe abortion services, systemic barriers like stigma, lack of medical training, and restrictive gestational limits continue to hinder their realization. The literature further points to the challenges posed by laws such as the PCPNDT Act, which aims to curb sex-selective abortions but inadvertently exacerbates access barriers due to over-regulation.

1.7.2 Literature Review

i. DIPIKA JAIN, UPASANA GARNAIK, KERRY MCBROOM, SWATI MALIK AND BRIAN TRONIC ABORTION LAWS IN INDIA: A REVIEW OF COURT CASES, JINDAL GLOBAL LAW SCHOOL 1–84 (2016)

The report by the Centre for Health, Law, Ethics and Technology at Jindal Global Law School provides a comprehensive analysis of legal judgments and orders related to the Medical Termination of Pregnancy (MTP) Act in India. the report analyses various decisions of the Courts in India to ascertain their interpretation of the Act and the implication of the judicial language utilised in the abortion cases. The report covers mainly Supreme Court and High Court judgements, along with District Court and Consumer Court cases. The report includes international obligations India has with respect to providing safe abortion services to the women and providing access for all women to these services. The report provides that there is a need for clarity in legal interpretation and for improved access to the abortion services especially in the case of vulnerable groups.

The report puts forth that the interpretation of the Courts with respect to abortion laws have been conflicting with some Courts stating that the reproductive right of a women is part of personal liberty under Article 21 of the Constitution and is a constitutional right while few other Courts have restricted the same rights with more and more Courts raising concern for the life of the foetus.

The report provides for the need for comprehensive data to be provided with respect to the abortion rate so as to understand the problem better and it also provides that an in-depth analysis of the challenges faced by the act on a ground level. Additionally, it calls for studies on public awareness of abortion laws, the impact of judicial interpretations, and the role of technology in improving access to services. Addressing these gaps could significantly enhance the understanding of abortion laws and their implications for women's health and rights in India.

ii. Rahaman, M., Das, P., Chouhan, P. et al. Examining the rural-urban divide in predisposing, enabling, and need factors of unsafe abortion in India using Andersen's behavioral model. BMC Public Health 22, 1497 (2022). https://doi.org/10.1186/s12889-022-13912-4

Unsafe abortion is a pressing public health issue globally, with India accounting for a significant share of the burden. Studies indicate that socio-economic vulnerabilities, unmet family planning needs, and inadequate access to healthcare are primary drivers of unsafe abortions, particularly in rural settings. The National Family Health Survey (NFHS-4) underscores pronounced rural-urban disparities, showing that rural women, younger age groups, and socio-economically marginalized populations are disproportionately affected. These risks are further compounded by a lack of awareness and insufficient healthcare infrastructure. Previous research also highlights the association of unsafe abortions with sex-selective practices and unmet contraceptive needs, particularly in rural India, where poverty and illiteracy exacerbate the problem.

Despite progress in understanding unsafe abortion practices, critical gaps persist. Rural-urban disparities in unsafe abortions have not been comprehensively analysed using national-level data. While socio-economic and geographical determinants are well-recognized, the impact of gendered power dynamics, societal stigma, and cultural pressures remains under-researched. Additionally, the

high prevalence of unsafe abortions among urban adolescents presents a significant challenge, demanding targeted and nuanced interventions. This study seeks to bridge these gaps by exploring socio-economic determinants of unsafe abortion across rural and urban India, aiming to inform the development of region-specific strategies and strengthen reproductive health services.

iii. Potdar, Pritam, Alka Barua, Suchitra Dalvie, and Anand Pawar. "If a Woman Has Even One Daughter, I Refuse to Perform the Abortion': Sex Determination and Safe Abortion in India." *Reproductive Health Matters* 23, no. 45 (2015): 114–25. https://www.jstor.org/stable/26495849.

The article examines the complexities surrounding sex-selective abortions in India, emphasizing the interplay between cultural norms, legal frameworks, and medical practices. The authors highlight the persistent societal preference for male children, which drives families to seek sex determination services, often leading to illegal abortions. Despite the implementation of the PCPNDT Act to curb these practices, healthcare providers report significant challenges, including bureaucratic hurdles, fear of legal repercussions, and pressure from local authorities and families.

A notable gap in the literature is the lack of effective strategies to change deep-rooted societal attitudes towards gender, which perpetuate the demand for male children. Additionally, the review reveals unresolved issues regarding the enforcement of existing laws and the need for comprehensive training for medical practitioners to navigate legal complexities while ensuring patient confidentiality. Controversies arise around the balance between regulatory oversight and the rights of healthcare providers, as well as the effectiveness of current interventions in addressing the underlying socio-economic factors that contribute to gender bias. Overall, the review calls for a multifaceted approach that includes legal, educational, and societal reforms to promote gender equality and protect women's reproductive rights.

iv. BHATE-DEOSTHALI, PADMA, and SANGEETA REGE. "Denial of Safe Abortion to Survivors of Rape in India." *Health and Human Rights* 21, no. 2 (2019): 189–98. https://www.jstor.org/stable/26915388.

The literature on abortion access for survivors of rape in India reveals significant gaps and unresolved issues, particularly regarding the legal and medical

frameworks governing abortion services. The authors emphasize that the medical profession in India has not kept pace with international standards for safe abortion, particularly for pregnancies beyond 20 weeks, leading to a denial of services for many women and girls. This situation is exacerbated by a lack of awareness among healthcare providers about their legal obligations to offer timely care to rape survivors, as mandated by Indian law.

Moreover, the psychological impact of forced continuation of pregnancies resulting from rape is often overlooked, with many doctors lacking the necessary training to address these complex cases. The authors also highlight the misinterpretation of laws surrounding abortion and rape, which contributes to the stigma and barriers faced by survivors seeking care.

Despite existing legal frameworks, the enforcement remains inconsistent, and the criminalization of marital rape further complicates access to abortion services. This literature underscores the urgent need for comprehensive training for healthcare providers and legal reforms to ensure that survivors receive the care they are entitled to, thereby addressing the ongoing controversies and gaps in the current system.

v. Purewal, Navtej. "Sex Selective Abortion, Neoliberal Patriarchy and Structural Violence in India." Feminist Review, no. 119 (2018): 20–38. https://www.jstor.org/stable/26776499

The literature surrounding abortion laws highlights diverse approaches across countries, examining legal, ethical, and medical implications. Studies indicate that while countries like Germany and France focus on balancing foetal rights and women's autonomy through gestational limits and regulated access, the United States exhibits significant state-level variations, reflecting polarized ideological and political divides. India, despite progressive legal amendments, continues to face challenges in implementation, exacerbated by socio-cultural stigma and systemic barriers.

Notably, gaps persist in addressing the global inequities in minors' reproductive rights, as legal protections and healthcare access vary widely. Controversies remain unresolved around post-viability abortions, with ethical debates centring on medical advancements and foetal survival probabilities. Additionally, the impact

of restrictive abortion laws on access to safe procedures highlights disparities in public health outcomes across regions.

While existing literature comprehensively examines individual country approaches, there is limited comparative analysis integrating medical, legal, and cultural dimensions, particularly focusing on minors and post-viability considerations. Moreover, the role of socio-economic and cultural factors in exacerbating inequities in access to safe abortion services remains underexplored, signalling the need for further cross-jurisdictional research. This study seeks to bridge these gaps, contributing a nuanced understanding of reproductive justice globally.

vi. Samantha Halliday. "Protecting Human Dignity: Reframing the Abortion Debate to Respect the Dignity of Choice and Life."

The article offers a comparative analysis of how the United States and Germany recognize the rights of the unborn, especially within the context of abortion laws. It contrasts the U.S.'s evolving and fragmented approach shaped by landmark rulings like Roe, and its recent reversal in Dobbs case with Germany's more consistent constitutional framework that grants the unborn child rights from conception.

In Germany, the Federal Constitutional Court emphasizes human dignity, requiring the state to protect prenatal life while allowing limited abortion access with counselling. This reflects a balanced approach that accommodates both foetal rights and women's autonomy. The U.S., on the other hand, lacks a unified position post-Dobbs, leading to divergent state laws and heightened political polarization.

The article effectively highlights how different constitutional values privacy in the U.S. versus dignity in Germany lead to contrasting outcomes. However, it could have addressed critiques of both systems, such as potential paternalism in Germany or social inequality in the U.S.

Overall, the article contributes to comparative legal scholarship by illustrating how constitutional traditions shape the legal status of the unborn across jurisdictions.

1.7.3 Contribution to the literature

This research aims to address gaps in the current understanding of abortion laws by comparing India's approach with Germany, the United States, and France. It will explore how these countries balance women's reproductive rights with state interest in foetal protection, offering insights to improve legal clarity and access in India. While existing literature highlights judicial inconsistencies and barriers faced by vulnerable groups, this study will examine how recognizing reproductive choice as a constitutional right could transform access to safe abortion services.

By integrating comparative legal analysis with a focus on ethical, medical and legal grounds this study will provide fresh perspectives on ensuring reproductive justice and propose actionable reforms to strengthen rights-based approaches in abortion laws.

1.8 Research objectives and hypothesis

1.8.1 Research objectives

i. To examine and compare the legal frameworks that protect the rights of the unborn child across various countries.
ii. To examine judicial tests for foetal rights and legal personality, considering ethical and medical implications in comparative abortion laws.
iii. To explore legal provisions and policies that govern minors' reproductive rights across different countries.
iv. To understand how abortion laws and related legal framework affect access to safe abortion services worldwide, examining cross-country differences.

1.8.2 Hypothesis

Recognizing abortion as a constitutional right will reduce unsafe abortions and enhance women's autonomy by prioritizing reproductive rights over restrictive state interests.

1.9 Research methodology

This study adopts a combined doctrinal and comparative legal analysis approach. The doctrinal method will critically examine statutory provisions, constitutional principles, and judicial interpretations of abortion laws in India, Germany, the United States, and France. Primary sources, including case law and legal texts, will be analysed to understand the theoretical underpinnings and judicial reasoning.

The comparative study will evaluate how these countries balance reproductive rights and state interests, identifying best practices and contrasting them with India's framework. Secondary sources, such as scholarly articles and reports, will supplement the analysis to provide a broader context.

The limitation of the study is that the research is focussing on four countries that is India, United States, France and Germany and will thus provide a limited global analysis on the topic. The limitations of this study further include challenges in obtaining comprehensive, up-to-date legal data across diverse countries, as legal frameworks may differ significantly in interpretation, accessibility, and transparency. The variability in cultural, ethical, and medical factors influencing abortion laws poses difficulties in making direct comparisons, particularly concerning post-foetal viability regulations.

1.10 Structure of dissertation

Chapter 1: Introduction

This chapter sets the foundation by outlining the background, research questions, problem statement, objectives, methodology, theoretical framework, and literature review. It also defines the scope, significance, and limitations of the study.

Chapter 2: State Interests vs. Women's Reproductive Rights

This chapter explores how the U.S., India, Germany, and France balance state interests with women's reproductive rights, highlighting constitutional and policy-based justifications for abortion regulations.

Chapter 3: Judicial Test for Foetal Right and Legal Personality

Focusing on judicial perspectives, this chapter examines how courts in the selected jurisdictions interpret foetal rights and legal personality, and how these affect the balance with maternal rights.

Chapter 4: Protection of Minor's Reproductive Rights

This chapter analyses legal provisions and judicial approaches to minors' access to abortion across the four jurisdictions, comparing consent requirements, procedural safeguards, and rights protection.

Chapter 5: Impact of Legal Frameworks on Access to Safe Abortion

This chapter evaluates how the legal frameworks in each country affect actual access to safe abortion, identifying barriers and implementation challenges.

Chapter 6: Conclusion and Recommendations

The final chapter summarises findings and offers recommendations for legal and policy reforms to better balance state interests with reproductive rights.

1.11 Limitation of study

The limitation of the study is that the research is focussing on four countries that is India, United States, France and Germany and will thus provide a limited global analysis on the topic. The limitations of this study further include challenges in obtaining comprehensive, up-to-date legal data across diverse countries, as legal frameworks may differ significantly in interpretation, accessibility, and transparency. The variability in cultural, ethical, and medical factors influencing abortion laws poses difficulties in making direct comparisons, particularly concerning post-foetal viability regulations.

Chapter 2: State Interests vs. Women's Reproductive Rights across different countries

2.1 Introduction

State interest in abortion differs country to country, sometimes focusing on the life of the foetus over the women, sometimes focusing only on the life of the women and other times trying to balance both these interests.

Beckwith in his article talks about how abortion is the intentional killing of a member of the society and is immoral. He further states that the unborn possess full moral status since conception and they are not potential humans but rather human beings with the capacity for rational development which is inherent.[10] According to him the distinction of when the life of the unborn is valued and when it is not, on certain grounds like viability, consciousness and dependency, are morally arbitrary and contrary to the principles of equal human dignity.[11] He argues that abortion is immoral and that there is an obligation on the society, more so on the pregnant women, to protect the most vulnerable member of the human family.[12]

On the contrary, John Stuart Mill posed a question of whether we have a moral right to bring into the world a child whom we cannot morally and properly bring up.[13] He further states that in a country that is over populated or on the verge of becoming over populated, to produce more than a small number of children, having an effect on increasing competition and reducing the amount of wage a person were to get due to the increasing competition, then it would be a serious offence against all those who live by the wages they get from their work. He further states it is valid for a state to impose a law restricting marriage unless the people prove they have means to support a family.[14]

Mill focused on the obligation on the parents to provide for the children and the immorality of bringing a child into a world where they are not capable of providing for

[10] Francis J. Beckwith, Defending Life: A Moral and Legal Case Against Abortion Choice 23-25 (2007).
[11] Id. at 132–34.
[12] Id. at 174–77.
[13] John Stuart Mill, On Liberty 206 (2011).
[14] Id. at 207.

them. On the other-hand Beckwith talked about the obligation on the mother to continue with the pregnancy.

The morality question could be posed in two ways: whether it is morally correct to terminate a pregnancy, thereby killing the foetus, or whether it is moral to bring a child into a world where one does not have the capacity to bring it up, as pointed out by Mill. Other than moral ground, there is the religious ground which opposes the termination of pregnancy at most stages if not all, primarily focussing on the right of the foetus or unborn child to life, and finally individual right to bodily autonomy, which primarily focuses on the women's right to be able to make reproductive choice. The state has the responsibility to balance these rights and provide for a law that provides a solution with minimum friction between the rights.

Roscoe Pound in his 'Theory of Interests' talks about conflicting interests and how these interests should be balanced. Pound states that the conflicting interest should be balanced by those making the law such that there is maximum satisfaction and minimum friction between the rights.[15]

The concept of abortion deals with two conflicting interest that is the women's interest and the foetus's interest. The state interest lies in in ensuring the health of the women while balancing the right of the foetus to live, in accordance with roscoe pounds theory with respect to abortion. The state interest with respect to abortion depends on each country while some try to balance both the interests, some explicitly focus on the foetal life over the women's rights and few others prioritise women's right to bodily autonomy over foetal rights.

The grounds for state interest in either the women's reproductive right or the foetal right to life is on the basis of religious, moral and autonomy grounds. This chapter will analyse the State interest in abortion in the four countries and the grounds for such interest and compare the same, to formulate a conclusion.

2.2 State Interest in United States Abortion Law

Over nearly four centuries, abortion practices in America have undergone a dramatic transformation, shaped by evolving legal landscapes, shifting social attitudes, and

[15] Linus J. McManaman, Social Engineering: The Legal Philosophy of Roscoe Pound, 33 St. John's L. Rev. 1, 1–17 (1958).

technological advancements. By exploring the distinct periods, a deeper understanding of the complexities and nuances of this issue emerges.[16]

From 1652 to 1842, abortion was unsafe, illegal, and rare, existing primarily within the realm of common law. Societal norms often condemned the practice, and midwives, bound by oaths to protect life, played a central role in reproductive health. However, early laws were insufficient to protect women from coercion or unsafe practices. During this era, abortion existed primarily in the shadows, governed by common law and societal norms that largely condemned the practice.[17]

Abortion regulation in America influenced by Common law, played a significant role. Abortion was not legal after quickening that is the period when the pregnant women for the very first time felt the foetus in the womb. Beyond legal aspects, strong social pressures and moral views shaped abortion practices. Unmarried pregnancies often brought shame, and societal expectations strongly encouraged men to take responsibility.[18]

At that point midwives were central figures in women's healthcare, attending births and providing reproductive guidance. Oaths taken by midwives emphasized protecting life, extending to unborn children.[19]

Early laws were rudimentary and offered minimal protection for women. Coercion, unsafe procedures, and lack of medical expertise made abortions dangerous. There were cases where women faced severe health consequences or even death due to botched abortions. Historical accounts reveal infanticide cases, with some classified as murder of a man child. Pressuring the father was common, and bitter execrations followed abortion. The era's anecdotes highlight the moral and social complexities surrounding abortion.[20]

The period between 1838 and 1878 witnessed the rise of professional abortion providers and increasing medical opposition. Figures like Madame Restell symbolized the commercialization of abortion services, while physicians began organizing against

[16] Marvin Olasky & Leah Savas, The Story of Abortion in America: A Street-Level History 1652-2022, 51 (Crossway 2023).
[17] Id. at 51-55.
[18] Id. at 29-34.
[19] Id. at 54.
[20] Id. at 35-45.

abortion, emphasizing the welfare of both mother and child. This era saw the emergence of moral and ethical debates surrounding abortion.[21]

From 1871 to 1940, abortion became more commercialized, but enforcement remained inconsistent. Abortion services expanded, often exploiting vulnerable women, while laws against abortion were poorly enforced. Efforts to provide alternatives to abortion, such as shelters for pregnant women, emerged.[22]

The years 1930 to 1995 brought technological advancements and cultural shifts that influenced perceptions of abortion. In the U.S. the Courts have utilised the concept of parens patriae to protect the interest of those who cannot protect their own interest including but not limited to minors. The state protects the foetus through its parens patriae authority though the same is not absolute and this authority is limited by the fourteenth amendment.[23]

One of the most landmark judgments on abortion was given by the Supreme Court in Roe v Wade, 1973.[24] The Court in this case held that the Texan abortion law that criminalised abortion with very limited exceptions, is violative of the fourteenth amendment to the Constitution.

The Court established that there is two state interest:

- Protecting maternal health
- Protecting potential human life

The Court further stated that the aforementioned interest varies on the stages of pregnancy, leading to the trimester framework. The Court if it has to infringe on a women's right to bodily autonomy does the same through a balancing test wherein the states interest in protecting the life of the foetus is weighed against the state interest in protecting the right to privacy of a pregnant women.

According to the trimester framework, in the first trimester that is till the 12th week of pregnancy the abortion decision is one which mainly between the women and the doctor, and at this particular stage abortion cannot be regulated or prohibited by the State. There is no compelling state interest in the life of the foetus. The state interest

[21] Id. at 90-95.
[22] Id. at 142 to 201.
[23] Id. at 202 to 267.
[24] 410 US 113 (1973).

here is leaning more towards protecting maternal health, considering that abortion at this stage is safer than childbirth.

In the second trimester that is from 13th to 24th week, the state may regulate abortion on the ground of maternal health (e.g. requiring abortion procedures to be provided in a safe environment). Prior to the viability stage that is prior to the third trimester, the primary state interest is in protecting the health of the women.

In the third trimester post 24 weeks, the state can prohibit abortion provided exceptions are put forth where it is necessary to save the life or health of the pregnant women. Thus, in the third trimester the state has a compelling interest in protecting potential human life.

The Roe judgment provided for a strict scrutiny test such that it allowed for regulation of abortion but did not provide for prohibiting abortion absolutely at any stage thereby making it difficult for the states to prohibit abortion, ensuring that the same was protective of the women's right to privacy and health. There was a shift to restricting state interest in solely protecting right to life of potential life and provided for protection of maternal health as well.

Thereafter came the case of Planned Parenthood v. Casey, (1992)[25] reaffirmed the core holding of Roe but replaced the trimester framework with a viability analysis and introduced the undue burden standard. A state regulation could not place a "substantial obstacle in the path of a woman seeking an abortion before the foetus attains viability."

Casey recognized that the state has legitimate interests throughout pregnancy:

- A profound interest in potential life from the outset of pregnancy, not just after viability
- An interest in protecting the health and safety of the woman

The Court allowed various state regulations such as informed consent, a 24-hour waiting period, and parental consent for minors so long as they did not impose an undue burden.

[25] 505 U.S. 833 (1992).

By giving importance to state interests throughout pregnancy and not only post-viability, Casey marked a shift toward greater state regulatory authority while still upholding the constitutional right to abortion.

Further, in Stenberg v. Carhart, (2000)[26] the Supreme Court struck down a Nebraska law that banned partial-birth abortion (a non-medical term for certain late-term abortion procedures), holding it unconstitutional because:

- It lacked an exception for the health of the mother
- It imposed an undue burden by banning a method commonly used for second-trimester abortions

The decision reaffirmed the necessity of protecting women's health even while recognizing the state's interest in preserving foetal life, emphasizing that laws regulating abortion procedures must still meet constitutional standards.

Post Stenberg the law which was set aside, was brought forth after making requisite changes. The aforementioned law was challenged in Gonzales v. Carhart, (2007)[27] which upheld the federal Partial-Birth Abortion Ban Act of 2003,[28] distinguishing it from Stenberg by noting that the federal law was more precise in its language and had congressional findings asserting that the procedure was never medically necessary.

For the first time since Roe, the Court upheld a restriction on abortion without a health exception, reasoning that:

- The state had a legitimate interest in promoting respect for life, including foetal life
- The law did not impose an undue burden on women seeking abortions

This decision signalled a shift in judicial deference to legislative judgment and reflected a broader recognition of moral and ethical dimensions of abortion as a legitimate part of state interest.

Thereafter, Dobbs v. Jackson Women's Health Organization, (2022),[29] marked a historic reversal of Roe and Casey. The case involved a Mississippi law banning most abortions

[26] 530 U.S. 914 (2000).
[27] 550 U.S. 124 (2007).
[28] Partial-Birth Abortion Ban Act of 2003.
[29] 597 U.S. (2022).

after 15 weeks well before foetal viability and provided exceptions only in the case of medical emergency or severe foetal abnormality.

The Supreme Court held that:

- The Constitution does not confer a right to abortion
- Roe and Casey were overruled
- The authority to regulate abortion is returned to the states

The majority opinion emphasized that abortion is a moral issue best resolved through the democratic process. The state's interest in protecting unborn life, maternal health, and the medical profession's integrity were found to be sufficient grounds for restricting abortion, even before viability. Here, the Court replaced the Undue Burden Test to a Rational Basis Review test which essentially means that that states can ban or restrict abortion at any stage of pregnancy if there is a rational legislative purpose.

The Court held that the U.S. Constitution did not provide for right to abortion and rejected the ruling in Roe that abortion rights were part of right to privacy under the constitution. The Court further noted that in Washington v Glucksberg (1997),[30] it was stipulated that substantive due process rights must be those that are deeply rooted in the nation's history and tradition. On the contrary abortion has been illegal in most states when the 14th amendment came into force and as such the same could not be considered as something that has been deeply rooted in the nation's history or tradition.

The ruling shifted the constitutional framework entirely, removing judicially recognized abortion rights and allowing states full authority to regulate or ban abortion as they see fit. Consequently, several states have enacted near-total bans, while others have moved to protect access.

Over the last five decades, the U.S. Supreme Court has moved from recognizing abortion as a fundamental right to dismantling that protection entirely. At every stage, the state's interest in protecting potential life has served as a counterweight to individual autonomy. From Roe's trimester-based restrictions, through Casey's viability and undue burden test, to Dobbs' full deference to state legislatures, the pendulum of constitutional interpretation has swung dramatically. The standard of judicial review has now become

[30] 521 U.S. 702 (1997).

very low such that the state interest is given more prevalence over fundamental right, shifting the burden of proof from the state to the individual, for challenging a law.

Under Roe and Casey, state interest in protecting foetal life became compelling only after viability, and any regulation had to avoid creating an undue burden. Under Dobbs, state interest is presumed legitimate at all stages of pregnancy, including pre-viability. There is no constitutional ceiling on how early a state can ban abortion, and no obligation to consider a woman's autonomy in the legal analysis. States now have nearly unrestricted authority to legislate based on moral, ethical, religious, or health-related grounds, without having to balance those interests against a woman's right to choose, as long as they have rational purpose. States had enacted trigger laws, such that if Roe were to be overruled these laws would limit or ban abortion.[31]

As of April 2025, there have been nineteen states including Texas, Idaho, and Tennessee have brought forth laws that prohibit abortion in almost all circumstances and only provide for limited conditions where abortion is allowed. Quite a few other states including Florida, Georgia, and South Carolina, though have not banned it completely but have restricted abortion post six weeks of pregnancy, a period where many women are aware of their pregnancies. In other States, like California, Maryland, Virginia, and New Jersey, liberal abortion laws have been enacted which provide for abortion till the point of viability or throughout the pregnancy and protect the providers and patients from out of state legal consequence. In few States, like Wyoming, and North Dakota, abortion laws have been blocked or are still in challenge, by the Courts wherein challenge was raised.[32]

Thus, post the reversal of Roe many of the State's interest lean towards the right to life of the foetus, some other States interest lies in providing a balance between the rights of the pregnant women and the foetus, restricting the same on ground of viability and few other States interest focus on the rights of the pregnant women. The states bring about restriction on the reproductive rights of the women utilising *parens patriae doctrine*, stating that they have duty to protect the interests of the unborn.[33]

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[31] Virginia Museum of History & Culture, *American Abortion Rights and Judicial Review*, https://virginiahistory.org/learn/american-abortion-rights-and-judicial-review (last visited January 19, 2025).
[32] Allison McCann and Amy Schoenfeld Walker, *Tracking Abortion Bans Across the Country*, N.Y. TIMES (April 28, 2025), https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html.
[33] Heather M. White, Unborn Child: Can You Be Protected?, 22 U. RICH. L. REV. 285, 289 (1988).

2.3 State Interest in Indian Abortion Law

Abortion in India presents a compelling intersection of ancient traditions, evolving legal norms, and pressing population concerns. The history of abortion in the country is as old as its civilization, shaped by moral codes, religious injunctions, and social customs that have long attempted to regulate the practice. Although deeply rooted in cultural and religious traditions that condemn abortion, Indian society has gradually accommodated changing socio-demographic needs, culminating in a more liberal legal framework.

Traditional Hindu philosophy has consistently emphasized the sanctity of life. Ancient Indian scriptures such as the Rig Veda, Dharma Sutras, and Smritis explicitly condemn induced abortion, categorizing it as a moral and religious transgression. Later epics like the Mahabharata and Ramayana also reflect similar themes. These condemnations, however, were closely tied to the high status accorded to women in Hindu thought, where honouring women was considered divine. Yet, religious and philosophical schools differed on a crucial question, when does life begin? Some believed life commenced at conception, others with foetal movement, and some only with the infant's first breath. These differing interpretations suggest that the condemnation of abortion was not universally rigid and left room for varying perspectives.[34]

Importantly, Hindu philosophy offered a dichotomy between the ideal and the permissible. While the saintly few were expected to adhere to strict codes, practical allowances were made for the general population. This flexibility allowed for nuanced understandings of abortion, especially in difficult or exceptional circumstances, reflecting a dynamic tradition rather than a static dogma.[35]

Despite this flexibility, abortion remained a criminal offense under Sections 312[36] and 313[37] of the Indian Penal Code enacted in 1860, which punished both the woman and the abortion provider unless the mother's life was at risk, these sections have been reiterated verbatim in Bhartiya Nyaya Sanhita under Sections 88 and 89.[38] However, by the mid-20th century, demographic pressures and rising awareness about women's

[34] Raj Pal Mohan, *supra* note 2, at 5.
[35] Id. at 141.
[36] Indian Penal Code, 1860, §312.
[37] Indian Penal Code, 1860, §313.
[38] Bharatiya Nyaya Sanhita, 2023, §88 & §89.

health prompted the state to reconsider its approach. Estimates revealed a significant number of abortions, both spontaneous and induced, particularly in rural areas. These statistics, although imprecise due to poor data collection, pointed to the widespread and often unsafe practice of abortion, highlighting the need for reform.[39]

In response, the government established a committee in 1964 to study the issue, called as the Shantilal Shah Committee.[40] After years of deliberation, a bill was introduced and eventually passed in 1971, resulting in the Medical Termination of Pregnancy (MTP) Act. This law marked a significant liberalization of abortion in India. It allowed abortions up to 12 weeks by a registered medical practitioner and up to 20 weeks with the approval of two practitioners, under specific conditions: threats to the mother's physical or mental health, foetal abnormalities, pregnancies resulting from rape, or failure of contraceptive methods.[41] The inclusion of mental health and contraceptive failure as grounds for abortion was particularly progressive, placing India's law on par with some of the more liberal abortion laws globally.

This legislative shift was largely driven by demographic concerns. With overpopulation becoming an urgent issue, the state recognized the need for accessible reproductive healthcare, including safe abortion services. The move also reflected a broader transformation in human consciousness, where demographic realities began to shape social and legal norms. In a country steeped in religious tradition and moral orthodoxy, such liberalization was significant, signalling a pragmatic balance between heritage and the imperatives of modern governance.[42]

The 1971 Act was also brought forth to decrease the maternal mortality rate, one of the main causes of which was unsafe abortions. The Act intended to legalise abortion till a certain time period to ensure women are able to seek safe abortion, and primarily focused on women being able to choose to terminate their pregnancy legally, after consultation with a doctor.[43] The parliamentary debates for the 1971 Act primarily focused to ensure that the rate of unsafe abortions decrease and time and again stated

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[39] Id. at 141-143.
[40] All India Institute of Medical Sciences, *Medical Abortion in India*, https://aiims.edu/aiims/events/Gynaewebsite/ma_finalsite/report/1_1_4.htm (last visited January 6, 2025).
[41] Medical Termination of Pregnancy Act, §3.
[42] Sarosh Framroz E. Jalnawalla, Medical Termination of Pregnancy Act: A Preliminary Report of the First Twenty Months of Implementation, 24 J. Obstet. & Gynaecol. India 588, 588–92 (1974).
[43] Rajya Sabha Debates, Medical Termination of Pregnancy Bill, Aug. 2, 1971, at 160–204.

that abortion is not to be included under family planning schemes, to control population, this Act is also not a measure to introduce abortion as such.[44] The time stipulations for both the 1971 Act and 2021 Amendment Act, was to provide women to be able to seek abortion services till the time it was safe for them to seek the same.

The 2021 Amendment Act provided for increasing the time limit to seek abortion till 20 weeks, requiring opinion of one medical practitioner and from 20 to 24 weeks requiring opinion of two medical practitioners.[45] In India the state interest is there in both the right of the women to make reproductive choices and in the right of the foetus to live, it tries to balance both the interest by restricting abortion post 24 weeks.

Indian courts, in interpreting the Constitution, have affirmed a woman's right to make reproductive choices as an essential facet of personal liberty. They have also actively intervened to ensure the effective implementation of the Medical Termination of Pregnancy Act. The Supreme Court in the case of Jacob George v. State of Kerala,[46] clarified that the provisions of IPC relating to miscarriage are subservient to the provisions of the MTP Act.

A landmark case in relation to abortion in India is the Supreme Court's three judge bench, case of Suchita Srivastava and Ors. v. Chandigarh Administration,[47] held that the women's right to make reproductive choice comes within the ambit of personal liberty under Article 21 of the Indian Constitution.[48] The Court further stated that though the right to make reproductive choice is protected under the Constitution, the same is subject to compelling state interest in the protecting life of the prospective child, moreover the Medical Termination of Pregnancy Act, acts as reasonable restrictions on the right to make reproductive choice. The court in this case recognised not only a women's right to make reproductive choices but also that a women's privacy, dignity and bodily integrity should be respected.

The Court in this case further differentiated between mental retardation and mentally ill stating that the former is still capable of making decision for themselves if retardation is mild, unlike the latter who are not capable of making decisions for themselves. The

[44] Id. at 202-204.
[45] Medical Termination of Pregnancy (Amendment) Act, 2021, §3.
[46] Jacob George v. State of Kerala, (1994) 3 SCC 430.
[47] Suchita Srivastava and Ors. v. Chandigarh Administration, AIR 2010 SC 235.
[48] India Const. art. 21.

Court held that Courts can only use the parens patriae jurisdiction in case of mentally ill people and minors. The Court held that the pregnant women in the present case suffering from mild mental retardation, is capable of making the decision to continue with her pregnancy and as such the Court cannot step in under parens patriae to make that decision for her. The Court respected and promoted a women's decisional autonomy with respect to their own reproductive health.

Over time, however, the discourse has evolved to situate abortion within the ambit of the right to privacy. This evolution was most clearly articulated in the landmark Supreme Court judgment in Justice K.S. Puttaswamy v. Union of India (2017),[49] where the right to privacy was declared a fundamental right under Article 21 of the Constitution. The Court held that privacy encompasses personal autonomy, bodily integrity, and decisional freedom in matters of intimate concern, including reproduction. This judgment significantly altered the legal terrain by strengthening the argument that a woman's choice to terminate a pregnancy is not merely a statutory right under the MTP Act but a constitutional right rooted in privacy and liberty.

In the case of X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT of Delhi, (2022),[50] the Court stated that the choice to terminate pregnancy comes within the ambit of bodily autonomy, considering the foetus relies on the women's body to survive and that if the state were to force a women to carry out the pregnancy to term it would be considered as an affront to the dignity of the women. The Supreme Court allowed a petitioner to end her 22-week pregnancy. In a ruling widely applauded by activists of reproductive rights, the Court determined that it is unlawful to differentiate between an individual's rights based only on their marital status.

The recognition of privacy as a fundamental right has therefore restructured the conversation around abortion. It acknowledges that decisions regarding pregnancy are deeply personal and must lie within the sphere of individual control rather than state authority. This shift challenges the state's historical tendency to treat abortion as a tool for demographic control or public health policy. Instead, it underscores the idea that the woman's body is not a site for state interest but a domain of personal choice and dignity.

[49] Justice K.S. Puttaswamy v. Union of India, AIR 2018 SC (SUPP) 1841.
[50] X v. Principal Secretary, Health and Family Welfare Department, Govt of NCT of Delhi, Civil Appeal No 5802 of 2022.

Nonetheless, tensions remain between individual privacy and state interest. The MTP Act, even after its amendment in 2021, does not grant absolute autonomy to the pregnant person. It continues to condition abortion on medical approval, especially beyond 20 weeks, and introduces categories of permissible abortions that often do not account for the complexity of individual lived experiences. Furthermore, judicial decisions have sometimes undermined privacy by requiring women especially minors and rape survivors to seek court approval even when the law supports their right to terminate the pregnancy. Such practices dilute the essence of privacy by subjecting personal choices to external scrutiny.[51]

Against this backdrop, the Indian judiciary has played a critical role in redefining the contours of both state and individual interest. In *Suchita Srivastava*, the Court acknowledged reproductive autonomy as a fundamental aspect of personal liberty, marking an early effort to limit state interference. *Justice K.S. Puttaswamy* elevated this understanding by grounding reproductive choice firmly in the right to privacy. Most recently, in *X v. Principal Secretary, Health and Family Welfare Department* (2022), the Court reaffirmed that compelling a woman to carry an unwanted pregnancy is an affront to her dignity, thus reinforcing individual autonomy over state interest.

Yet, despite this jurisprudential progress, the law does not confer absolute autonomy on the pregnant person. Even after the 2021 amendment, the MTP Act continues to require medical approval for termination, particularly beyond 20 weeks of gestation. The decision to abort is not left solely to the pregnant individual, but instead must be validated by one or more medical practitioners, depending on the gestational stage. This reinforces the state's gatekeeping role and limits the full realization of privacy and decisional autonomy.

As such, while the courts have moved toward recognizing abortion as a matter of personal choice rooted in dignity and privacy, the statutory framework still reflects a paternalistic approach where the individual's agency is mediated through institutional and medical authority. The state's interest in India continues to walk a careful line attempting to balance the pregnant person's right to autonomy with its perceived obligation to protect foetal life.

[51] Surabhi Singh, The Puttaswamy Effect: Exploring the Right to Abortion in India (Ctr. for Commc'n Governance at Nat'l L. Univ. Delhi 2021).

2.4 State Interest in German Abortion Law

The German Federal Constitutional Court has firmly recognized the embryo's right to life as a constitutionally protected interest, rooted in Article 2(2) of the Basic Law[52] and intrinsically linked to the guarantee of human dignity under Article 1(1).[53]

Germany's abortion jurisprudence is defined by two seminal rulings of the Federal Constitutional Court the 1975 judgment[54] and its reconsideration in 1993.[55] While both cases affirm the constitutional protection of unborn life under Article 2(2) of the Basic Law, they differ significantly in how the state's interest in protecting foetal life is balanced against a woman's right to self-determination and dignity.

In Germany, abortion is primarily governed by Sections 218 to 219b of the German Criminal Code (Strafgesetzbuch StGB).[56] According to these provisions:

Section 218 StGB criminalizes abortion in principle. However, it outlines specific exceptions under which abortion is not punishable.

Section 218a StGB provides the main exceptions:

Within the first 12 weeks of pregnancy, abortion is not punishable if:

- The pregnant woman undergoes mandatory counselling at least three days prior to the procedure.
- The procedure is performed by a licensed physician.

Abortion is also permitted and not punishable if:

- It is necessary to avert a danger to the life or physical or mental health of the pregnant woman, even after 12 weeks.
- The pregnancy results from sexual assault, coercion, or rape.

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[52] Grundgesetz [GG] [Basic Law], art. 2(2),
translation at http://www.gesetze -im-internet.de/englisch_gg/index.html.
[53] Grundgesetz [GG] [Basic Law], art. 1(1),
translation at http://www.gesetze -im-internet.de/englisch_gg/index.html.
[54]BVerfG, Judgment of the First Senate of 25 Feb. 1975, 1 BvF 1/74, ¶¶ 1–209,
https://www.bverfg.de/e/fs19750225_1bvf000174en.
[55] BVerfG, Order of the Second Senate of 28 May 1993, 2 BvF 2/90, ¶¶ 1–434,
https://www.bverfg.de/e/fs19930528_2bvf000290en.
[56]Strafgesetzbuch [StGB] [Penal Code], § 218 and § 219, https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html.

Although abortions meeting these conditions are not punished, the act remains technically unlawful under criminal law, and only exempted from punishment.

Due to the classification of abortion as unlawful (though not punishable), the procedure is not covered by public health insurance in most cases, except under medical or criminological indications. These regulations reflect the 1993 decision of the Federal Constitutional Court (BVerfG), which held that the unborn child has a right to life under the Basic Law (Grundgesetz), and thus the state has a duty to protect it. The Court, however, accepted that this protection could be achieved through a system of counselling rather than criminal punishment in the early stages of pregnancy.[57]

1975 Judgment: Primacy of the State's Duty to Protect Foetal Life

In abortion judgment 1 (1975), the Court reviewed the Fifth Act to Reform Criminal Law (1974), which had introduced a time-limit system, permitting abortion within the first 12 weeks without requiring any medical, ethical, or social justification. The legislation was challenged for violating the foetus's constitutional right to life.

The Court held that the unborn child is a legal person entitled to the full protection of Article 2(2) GG, which guarantees the right to life and physical integrity. It declared that the state bears a positive constitutional obligation to protect human life, including prenatal life from the moment of conception.

According to the Court, this duty could not be satisfied merely through social policy or counselling. Instead, the legal order must express this protection clearly typically through criminal law sanctions. The 1974 law was held unconstitutional because it permitted abortions without sufficient justification and failed to manifest the state's duty to protect unborn life through effective legal safeguards.

The Court acknowledged that pregnancy imposes a heavy burden on women, but held that this cannot override the foetus's right to life except in extreme cases, such as when the pregnancy poses a grave threat to the woman's life or health. Thus, the state interest in foetal life was considered paramount, and women's autonomy was secondary and derivative of the constitutional framework.

[57] Hanna Welte, *Germany's Abortion Regulation: A Relic of the Past?*, VÖLKERRECHTSBLOG (Oct. 15, 2024), https://voelkerrechtsblog.org/germanys-abortion-regulation-a-relic-of-the-past/ (last visited December 30, 2024).

1993 Judgment: Reaffirmation with Greater Emphasis on Women's Rights

In abortion judgment 2 (1993), the Court was again asked to rule on abortion law this time after German reunification. The Unified German legislature sought to introduce a reformed time-limit model similar to the one struck down in 1975. Under this model, abortion was to remain unpunished within the first 12 weeks provided the woman received mandatory state-regulated counselling aimed at encouraging continuation of the pregnancy.

While reaffirming that unborn life is protected by Article 2(2) GG, the 1993 Court took a more nuanced approach. It upheld the constitutionality of the time-limit system, not because the foetus lacks protection, but because the state may choose different methods beyond criminal punishment to fulfil its protective duty.

The Court acknowledged that criminal sanctions are not always the most effective means to protect life and that counselling and social support can also satisfy constitutional duties if they are genuinely oriented toward protecting life. Crucially, the Court emphasized the importance of respecting a woman's dignity and right to self-determination under Article 1(1) and Article 2(1) GG.

Thus, the state interest in protecting foetal life was still central, but it was now seen as reconcilable with women's rights through a framework of counselling, support, and moral persuasion. The key shift was from coercive legal enforcement to a life-affirming but choice-sensitive regulatory model.

Both rulings agree that foetal life is constitutionally protected and that the state has a positive obligation to safeguard it. However, they differ sharply in how this duty is to be executed:

- In 1975, the state's interest in foetal life dominated, and criminal law was seen as essential to expressing this interest. The woman's autonomy was viewed as constitutionally subordinate.
- In 1993, while reaffirming the protection of foetal life, the Court opened space for reconciling this with women's rights. It accepted a system of state regulated counselling and informed choice, even if it allowed abortion in some cases and could still meet constitutional requirements, provided it clearly affirms the value of unborn life and seeks to dissuade abortion.

The 1993 judgment thus represents a constitutional evolution not a retreat from protecting life, but a shift toward balancing competing interests with greater sensitivity to the woman's situation, especially in light of historical, social, and gender justice concerns post-reunification.

2.5 State Interest in French Abortion Law

The evolution of abortion law in France is a testament to the dynamic interplay between state interest, public morality, and women's rights. From an era of strict prohibition and moral condemnation to one of legal access and reproductive autonomy, France's legislative journey reflects broader societal transformations. Two key milestones in this trajectory are the Voluntary Interruption of Pregnancy Act (hereinafter the "Veil Act") of 1975[58] and the 2001 Amendment,[59] which together illustrate a significant shift in the French state's approach to balancing the protection of foetal life with the rights and dignity of women.

The Veil Act of 1975, named after Health Minister Simone Veil, marked a historic departure from centuries of repression and criminalization of abortion. Prior to its enactment, abortion in France was strictly prohibited under the Penal Code, with laws dating back to 1810 and intensified during the Vichy regime, which treated abortion as a crime against the state. The Veil Act introduced a conditional form of legalization: abortion was permitted within the first ten weeks of pregnancy, provided the woman declared herself to be in a state of distress, and underwent a mandatory period of counselling and reflection. Procedures had to be carried out in licensed medical facilities.

The passage of this law did not come without resistance. Deep divisions emerged within Parliament and society at large, with conservative and religious factions warning of a moral decline. Yet, Simone Veil's impassioned advocacy grounded in a concern for the dignity, health, and suffering of women paved the way for its eventual adoption.[60] The law represented a delicate compromise: it acknowledged the state's symbolic interest in protecting unborn life, yet recognized the practical and ethical necessity of providing

[58] Voluntary Interruption of Pregnancy Act, 1975.
[59] Law No. 2001-588 of July 4, 2001 relating to voluntary termination of pregnancy and contraception (1).
[60] de La Hougue, C. (2017, June 30). The Deconstruction of the Veil Law on Abortion. *European Centre for Law and Justice*. Retrieved from https://eclj.org/la-dconstruction-de-la-loi-veil/french-institutions/la-dconstruction-de-la-loi-veil (last visited January 14, 2025)

safe and legal abortion. In doing so, it reframed the state's role no longer as a rigid enforcer of morality, but as a mediator between conflicting values: life and liberty, tradition and modernity.

While the 1975 law was significant, it maintained a posture of controlled tolerance. Abortion was still not considered a fully autonomous right; it was granted as an exception, under distress, and with procedural safeguards. This framework allowed the state to express its continuing valuation of foetal life while avoiding the harsh consequences of criminalization.

Over time, however, the social and political landscape evolved. Feminist movements, international human rights norms, and changing public opinion contributed to a more progressive understanding of reproductive freedom. This culminated in the 2001 Amendment, which reformed the Veil law in several critical ways. First, it extended the legal time limit for abortion from 10 to 12 weeks of gestation, recognizing advances in medical science and the need for greater flexibility. Second, it eliminated the requirement for women to declare themselves in a state of distress, thus normalizing abortion as a matter of choice rather than crisis. Third, it empowered minors to access abortion without parental consent, provided they were accompanied by an adult of their choosing. This provision underscored the state's commitment to ensuring access to reproductive healthcare for all, irrespective of age or family dynamics.[61]

The 2001 reforms reflected a paradigm shift in the state's interest. No longer primarily concerned with the symbolic preservation of foetal life, the state prioritized women's autonomy, equality, and public health. Abortion was increasingly seen not as a moral or demographic issue, but as a right embedded in a broader framework of democratic citizenship. The French Republic's commitment to secularism, personal freedom, and gender equality found new expression in its approach to reproductive law.

While the French state did not entirely relinquish its concern for the unborn, it reinterpreted that interest in a way that respected the individual conscience and medical judgment. The state's role evolved from that of a guardian of morality to a protector of access, safety, and dignity. Importantly, this transformation did not occur in a vacuum

[61] Ollia Horton, *France's Veil Abortion Law Leaves Positive but Fragile Legacy, 50 Years On*, RFI (Jan. 17, 2025), https://www.rfi.fr/en/france/20250117-veil-abortion-law-leaves-positive-but-fragile-legacy-50-years-on (last visited February 6, 2025).

it was shaped by decades of feminist advocacy, public debate, and shifts in legal philosophy regarding bodily integrity and human rights.

In sum, the Veil Act and the 2001 Amendment together represent a progressive reconfiguration of state interest in French abortion law. The journey from conditional tolerance to reproductive empowerment encapsulates a broader societal reckoning with questions of life, liberty, and gender justice. By embedding abortion rights within the framework of public health and personal autonomy, France has shown how democratic states can uphold complex moral values while affirming the fundamental rights of women as equal citizens.

The Veil Act, initially adopted in 1975 for a five-year period, was made permanent by the Pelletier Act in 1979.[62] It originally permitted elective abortion up to 10 weeks of pregnancy, later extended to 12 weeks in 2001 and 14 weeks in 2022. Initially not reimbursed, abortion became partially state-funded in 1982 through the Roudy Act,[63] and completely free in 2013, including all related procedures by 2016.[64]

Procedural reforms included abolishing the waiting period and making the psychosocial interview voluntary for adults since 2001. Minors no longer require parental consent but must be accompanied by an adult. The Act also established a conscience clause for physicians, allowing them to refuse to perform abortions, a provision still in force. Therapeutic abortion was formally legalized earlier in 1939 under the French Family and Natality Code. The 1975 Act further allowed it throughout pregnancy for maternal or foetal health reasons, though the authorization process remains highly regulated and complex.[65]

Procedural safeguards have also evolved. The mandatory reflection period originally intended to ensure informed decision-making was abolished in 2016, following critiques that it caused unnecessary delays and stigmatized women. In terms of provider access, France has expanded the scope of practitioners permitted to perform abortions, allowing midwives to conduct medical abortions and, under the 2022 reform, some surgical abortions as well.

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[62] Pelletier Act, 1979.
[63] Roudy Act, 1982.
[64] Justine Chaput, Élodie Baril & Magali Mazuy, Abortion in France 50 Years After the Veil Act: Rates and Methods That Vary Across the Country, 627 Population & Sociétés 1 (2024).
[65] Id. at 1.

At a special joint session held at the Palace of Versailles on March 4, 2024 the amendment which calls abortion a guaranteed freedom was passed 780-72. France is now the only nation that has chosen to provide a constitutional right to abortion after lawmakers there passed a historic bill enshrining the right in the country's constitution with an overwhelming majority.[66]

The 2024 constitutional amendment is therefore not only a legal milestone but a symbolic culmination of France's decades long journey from repression to recognition. It represents a formal repositioning of the state's interest: from acting as a moral guardian of potential life to becoming an active protector of women's liberty, bodily autonomy, and equality.

2.6 Conclusion

The legal regulation of abortion across jurisdictions is a reflection of how societies negotiate the tension between state interest in protecting potential life, public morality, or medical ethics and individual interest, particularly a woman's autonomy, dignity, and bodily integrity.

In France, the journey from criminalisation to constitutional protection reflects an emphatic shift in Favor of individual rights. With the 2024 constitutional amendment declaring abortion a "guaranteed freedom," France has fully embraced reproductive autonomy as a constitutional identity. This marks a remarkable transition from the state's earlier role as moral arbiter to a facilitator of women's liberty, even while preserving a bioethical framework that tempers autonomy with medical oversight. The state's interest has evolved to ensure access and equality, no longer acting as a gatekeeper but rather a guardian of rights.

In contrast, Germany upholds a more complex compromise, grounded in its Basic Law's protection of human dignity and the right to life. Abortion remains technically unlawful but non-punishable within the first 12 weeks, provided mandatory counselling is completed. This reflects a responsible parenthood model, where the state interest in

[66] Hillary Margolis, France Protects Abortion as a 'Guaranteed Freedom' in Constitution, Human Rights Watch (Mar. 5, 2024), https://www.hrw.org/news/2024/03/05/france-protects-abortion-guaranteed-freedom-constitution (last visited February 16, 2025); see also Mariama Darame, France, First to Protect Abortion in Constitution, Sends Message to 'Women of the World', Le Monde (Mar. 5, 2024, 10:54 AM, updated Mar. 5, 2024, 2:51 PM), https://www.lemonde.fr/en/politics/article/2024/03/05/france-protecting-abortion-in-its-constitution-sends-message-to-women-of-the-world_6586538_5.html (last visited February 16, 2025).

protecting unborn life is constitutionally strong, yet is balanced through supportive structures rather than coercion. The German Constitutional Court has consistently reaffirmed this protective role, giving weight to the foetus while allowing room for the woman's personal circumstances.

India, meanwhile, presents an example where statutory reform has advanced significantly, but judicial inconsistency and societal norms continue to complicate access. The Medical Termination of Pregnancy (MTP) Act of 1971 recently amended in 2021 extends access to abortion on broad medical and social grounds. Indian courts have recognised abortion as a facet of the right to privacy and bodily autonomy under Article 21 of the Constitution. However, the state's interest often manifests through judicial discretion, medical gatekeeping, and concern for foetal viability, sometimes leading to conflicts between reproductive choice and patriarchal social constructs, especially in marital or minor pregnancies.

The United States, by stark contrast, has undergone a regressive shift. The 2022 decision in Dobbs v. Jackson Women's Health Organization overturned Roe v. Wade, erasing the federal constitutional protection for abortion. The state interest in protecting "potential life" has now devolved to individual states, many of which have enacted strict bans, some without exceptions for rape or incest. This represents an inversion of the autonomy model: state sovereignty has overridden individual liberty, often with disproportionate effects on vulnerable women. While states like California or New York protect abortion, others have criminalised it almost entirely making geography determinative of fundamental rights.

In sum, France and India demonstrate a growing judicial and legislative tilt toward individual reproductive freedom, albeit through different pathways, France through its constitutional symbolism, and India through its statutory evolution. Germany maintains a delicate moral equilibrium, upholding both foetal protection and women's welfare. The United States, however, illustrates the fragility of liberty when it lacks constitutional entrenchment, with state interest now prevailing in many regions at the expense of bodily autonomy. These comparisons reveal that while abortion law is deeply context-specific, the core tension between state control and individual agency remains universally resonant.

Chapter 3: Judicial test for Foetal right and legal personality

3.1 Introduction

The basic concept of where state interest lies as opposed to individual interest in different countries have been dealt with in the previous chapter. This chapter would specifically deal with the concept of legal personality of the foetus and the rights of a foetus as interpreted by the judiciary in US, India, Germany and France.

Many countries like India and France, across the world do not recognise the right of the foetus to be the same as the right of a person who is born already, that is foetus is not recognised as a legal personality. These jurisdictions do recognise the right of the foetus in later stages of pregnancy but at the same time do not provide for a right equivalent to the pregnant women's or right as a distinct person and if there were to be a choice made to save either one life, the life of the women would be prioritised.

In contrast in other countries, like Germany, where the right to life of foetus is recognised to be the same as of a born person, the right of abortion is highly restricted and the foetus is recognised as a legal personality whose death would be equivalent to killing of a person.

In international context, in the year 1994, the International Conference on Population and Development took place wherein on the one hand the Vatican delegation pushed for the right to life of a foetus to be recognised and on the other hand the women's Caucus at the Conference pushed for recognition of women's right to life, and against foetus's right to life from being recognised, as it would affect women's reproductive right and health detrimentally.[67]

This debate was finally addressed in the Universal Declaration of Human Rights, wherein Article 1 states "All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Everyone has the right to life, liberty and security of person."[68] This Article

[67] Rhonda Copelon, Christina Zampas, Elizabeth Brusie, & Jacqueline deVore, Human Rights Begin at Birth: International Law and the Claim of Fetal Rights, 13 SRHM 120, 120 (2005).
[68] Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810, at 71 (Dec. 10, 1948).

provides that that human rights are applicable from birth and not before birth, evident from when the proposal to delete the term born from the Article was rejected.[69]

Similarly the International Covenant on Civil and Political Rights (hereinafter "ICCPR") rejected the proposal that intended to provide right to life to all since conception[70] and stated that right to life provided under Article 6(1) includes only post-natal life.[71] The Human Rights Committee further provided that, the aforementioned Article would be violated if women are subject to unsafe abortion procedures, detrimental to the life of women, due to restrictive abortion laws in the States.[72]

This chapter will critically examine how different judicial systems have interpreted the legal status and rights of the foetus in light of national constitutional values and international human rights principles. By analysing key judicial decisions from the United States, India, Germany, and France, it will highlight the extent to which courts have recognised or rejected the notion of foetal legal personality and how such recognition affects the legality and accessibility of abortion.

3.2 Judiciary in United States on foetal right and personality

The right to make reproductive choice in the U.S. was initially established, slowly eroded and then removed entirely through judicial pronouncement over the decades. The evolution of foetal rights and the legal status of foetal personhood in American constitutional jurisprudence has been shaped by a series of landmark Supreme Court and federal court decisions, beginning with *Roe v. Wade* (1973).

In *Roe*, the Court definitively rejected the proposition that the foetus is a "person" within the meaning of the Fourteenth Amendment. Justice Blackmun, writing for the majority, clarified that the word 'person,' as used in the Fourteenth Amendment, does

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[69] U.N. GAOR 3rd Comm. 99th mtg., para. 110-124, U.N. Doc. A/PV/99 (1948).
[70] U.N. GAOR Annex, 12th Session, Agenda Item 33, para. 96, 113, 119, U.N. Doc. A/C.3/L.654 (1957).
[71] International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, art. 6.1, G.A. Res. 2200A (XXI),
U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force Mar. 23,
1976).
[72] Center for Reproductive Rights, *Submission to U.S. State Department Commission on Unalienable Rights* (Apr. 2, 2020),
https://reproductiverights.org/sites/default/files/2020-05/Center%20for%20Reproductive%20Rights%20-%20submission%20to%20US%20State%20Dept%20Commission%20on%20Unalienable%20Rights.pdf (last visited February 26, 2025).

not include the unborn." This holding was central to the Court's framework, which grounded abortion rights in a woman's right to privacy and bodily autonomy. While recognizing state interest in protecting potential life, the Court defined viability as the stage at which the foetus can potentially survive outside the womb and as the point at which that state interest becomes compelling. Before viability, the State could not prohibit abortion, although it could regulate the procedure to protect maternal health.

This framework was further developed in *Planned Parenthood of Central Missouri v. Danforth* (1976),[73] where the Court evaluated Missouri's definition of viability as "that stage of foetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems." The Court found this definition compatible with *Roe*, noting that viability is a flexible medical concept that may vary with each pregnancy. Significantly, the Court upheld the state's use of viability as the dividing line for permissible regulation but reiterated that viability remains a medical determination and rejected any fixed legislative cutoff based on gestational age alone. The decision continued to affirm that the state's interest in foetal life becomes compelling only at viability and not before.

In *Anders v. Floyd* (1977),[74] a three-judge district court in South Carolina struck down portions of the state's criminal abortion statute that presumed viability at twenty-four weeks. The court held that a state cannot arbitrarily designate a fixed point for viability and must instead defer to the flexible medical standard articulated in *Roe*. Although the foetus in that case lived for twenty days after a late-term abortion, the court found the statute unconstitutional and dismissed criminal indictments against the physician. The U.S. Supreme Court later vacated and remanded the decision in light of *Colautti v. Franklin* (1979),[75] suggesting that the district court may have relied on an imprecise definition of viability focused on potential rather than actual survival. Nevertheless, *Anders* reaffirmed the principle that viability cannot be legislatively predetermined and must be assessed on a case-specific basis by medical professionals.

The Court's reasoning in *Colautti v. Franklin* (1979), reinforced the centrality of viability while also revealing the complexities in its application. The case concerned a Pennsylvania statute requiring physicians to determine whether a foetus "may be

[73] 428 U.S. 52 (1976).
[74] 440 F. Supp. 535 (D.S.C. 1977).
[75] 439 U.S. 379 (1979).

viable" before performing certain abortions and to act with the same care they would in delivering a live birth. The Court struck down the statute as unconstitutionally vague, emphasizing that terms such as may be viable lacked clear standards and imposed an uncertain burden on physicians, potentially deterring the exercise of constitutionally protected rights. Importantly, the Court reiterated that the viability determination must rest on the professional judgment of the attending physician based on the specific circumstances of each case.

Together, these decisions illustrate the judiciary's consistent refusal to confer constitutional personhood on the foetus and its reliance on the concept of viability as the legal fulcrum for balancing state interests against a woman's right to choose. While the Court's language evolved from describing the foetus as having potential life in *Roe* to later references in Colautti to sustained survival outside the womb, no decision during this period accepted foetal personhood as a constitutional basis for banning abortion. Viability, not personhood, remained the threshold at which states could assert a compelling interest, and even then, only to the extent that such regulations preserved the life or health of the pregnant woman.[76]

The *Human Life Bill* was introduced in January 1981 by Senator Jesse Helms. It declared that life begins at conception and that foetuses are "persons" under the Fourteenth Amendment, thereby entitled to constitutional protection. It sought to bypass the need for a constitutional amendment by asserting Congress's power to define constitutional terms and by removing jurisdiction from lower federal courts over abortion cases, thus compelling the Supreme Court to confront foetal personhood directly. This approach was grounded in the belief that the Court had erred in *Roe v. Wade*, and that Congress could act to reverse that interpretation without a formal amendment.[77]

The proposal was met with immediate criticism, both from legal scholars and within the anti-abortion movement. Many constitutional experts questioned whether Congress had the authority to define the scope of the Fourteenth Amendment, noting that interpretation of constitutional provisions has traditionally been a judicial function.

[76] Eugene Griffin, Viability and Fetal Life in State Criminal Abortion Laws, 72 J. Crim. L. & Criminology 324, 329–33 (1981); see also Grover Rees III, State Protection of the Viable Unborn Child After Roe v. Wade: How Little, How Late?, 37 L. Rev. 270, 270-282 (1976).
[77] Mary Ziegler, *After Roe: The Lost History of the Abortion Debate* (2015).

While supporters cited Congress's enforcement power under Section 5 of the Fourteenth Amendment, critics argued that such power extended only to enforcing established rights, not creating or redefining them.[78]

In response to internal criticisms of the Human Life Bill, anti-abortion strategists like David O'Steen proposed a two-step constitutional strategy. The first step was to amend the Constitution to return abortion policy to the states, and the second step, later on, would involve securing foetal personhood protections. This incremental approach was seen as more legally and politically viable. Senator Orrin Hatch endorsed the idea, introducing a constitutional amendment, that came to be known as the *Hatch amendment*, that sought only to overturn *Roe* by restoring state's authority to regulate or prohibit abortion.[79]

The Hatch Amendment was immediately controversial within the movement. Activists like Judie Brown and Charles Rice opposed it, fearing it legitimized abortion in some states and would undercut momentum for a stronger amendment recognizing foetal rights. Brown described it as a political betrayal, arguing that it allowed politicians to appear pro-life while abandoning the unborn to state discretion. These critics viewed the Hatch proposal as a dangerous compromise that would fracture the movement and dilute its core message.[80]

The Hatch Amendment gained moderate support as a strategic compromise, but its endorsement by the NRLC in December 1981 deepened internal fractures within the anti-abortion movement. While key leaders and institutions backed it as a realistic step forward, absolutists saw it as a betrayal, leading to calls for resignations and exposing fundamental ideological rifts. These internal divisions weakened the movement's cohesion and complicated unified action.[81]

Although the Hatch amendment passed the Senate judiciary committee by a 10 to 7 vote but it was later defeated in the Senate wherein a vote of 47 to 46 led the amendment to be withdrawn. Thus, an attempt to introduce foetus under 14th amendment failed.[82]

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[78] Id. at 85-86.
[79] Id. at 86-87.
[80] Id. at 87-88.
[81] Id. at 88-89.
[82] Id. at 89.

Thereafter the Roe's trimester framework was replaced by the undue burden standard in *Planned Parenthood v. Casey*, (1992). Under Casey's test, a state law is invalid if it has the purpose or effect of placing a substantial obstacle in the path of any woman who wanted to avail an abortion, before the foetus gained viability. In other words, any significant barrier to pre-viability abortion was ruled unconstitutional, but moderate restrictions (informed consent, waiting periods, etc.) survived review if they did not impose an undue burden.

Over time, the Court's focus has remained on the viability threshold as the turning point for foetal interests. For example, Casey reiterated that no law may prohibit a woman from choosing abortion before viability, reinforcing Roe's core holding.

More recently, however, the U.S. Supreme Court shifted course. In *Dobbs v. Jackson Women's Health Org.*, (2022), a majority of the Court overruled *Roe* and *Casey*. The Court held that the Constitution contains no reference to abortion, and no such right is implicitly protected by the Due Process Clause. *Dobbs* thus eliminated the federal constitutional right to abortion entirely. This radical change returned abortion regulation to the states, effectively nullifying Roe-era viability and undue-burden tests at the national level. In sum, U.S. jurisprudence moved from a privacy-based individual-rights approach (pre-*Dobbs*) to a post-*Dobbs* regime where foetal rights (or the lack thereof) are determined by state law rather than federal constitutional command.

The U.S. Supreme Court has left regulation of abortion to state parties, and as the dissent in the Dobbs case states, the majority has allowed for a state to restrict abortion from the moment of fertilisation and force a woman to carry a pregnancy to term no matter the cost. The Court brought forth rational basis review test which is the lowest standard of review, such that on the ground of protecting foetal rights the states can now restrict abortion in any manner.

Thus, though the judiciary has not interpreted the 14th amendment to include foetus, thereby not recognising foetus as a person under the Constitution but it has allowed for protection of foetal rights by respective states by restricting abortion.

3.3 Judiciary in India on foetal right and personality

Similar to the Roe decision in US, in India the right to make reproductive choice has been recognised by the Courts as part of Article 21 of the Constitution. The Courts

further state that such a right is not absolute and is reasonably restricted by the provisions of the MTP Act. The right of a foetus under Article 21 has been brought forth in various cases. The very first case being that of Nand Kishore Sharma v. Union of India,[83] wherein the Rajasthan High Court rejected a petition which challenged the MTP Act on the ground that it violates the right to life of the unborn.

In the landmark case of *Suchita Srivastava*, the Supreme Court provided that the right to make reproductive choice is part of article 21 of the Constitution. It referred to the Roe decision, to apply strict scrutiny test, though not to its entirety since certain conditions are to be fulfilled to get abortion before viability stage other than a mandatory physician's opinion, but the Court recognised compelling state interest in the life of the foetus after a certain period and held that MTP Act is valid to the extent that it protects women's right to make reproductive choice but is also restricted after a certain period on reasonable grounds. The right to make reproductive choice as part of Article 21 was also recognised in the *Puttaswamy* judgment.

Thereafter in the case of High Court on its Own Motion v. State of Maharashtra,[84] the division bench of the Bombay High Court held that, while reiterating the position taken in the Suchita Srivastava case, it referred to international human rights law to stipulate that a person is only vested with human rights at birth and that an unborn foetus cannot be considered as a human with rights. The Court further stated that the right to control their own bodies and fertility and motherhood choices should be left to the women and no one else. The Court recognised the right to autonomy, and to decide what to do with one's own body i.e. whether to continue with the pregnancy or discontinue with it, as a basic right of women.

The cases listed till now recognise the right to make reproductive choice of the women under Article 21. The following judgments have talked about whether right to life includes right to life of the foetus, under Article 21.

The very first case on the rights of the unborn, is the case of Indulekha Sreejith Vs. Union of India and Ors., (2021),[85] wherein a single bench of the Kerala High Court,

[83] Nand Kishore Sharma v. Union of India, AIR 2006 Raj 166.
[84] High Court on its Own Motion v. State of Maharashtra, 2017 Cri LJ 218.
[85] Indulekha Sreejith Vs. Union of India and Ors., AIRONLINE 2021 KER 1285; see also Najila B and Ors. Vs. Union of India and Ors., WP (C) No. 44297 of 2024; see also XXX Vs. Union of India and Ors., WP (C) No. 8514 of 2025.

held that an unborn child had a life and rights of its own and such rights are recognised by the law. The Court notes that after six weeks, when life is infused into the embryo, it converts to a foetus, at which point the heartbeat starts and states that the unborn has life from the stage it transforms into a foetus. The Court states that though the unborn is not a natural person, it can be considered as a person within the ambit of Article 21, since there is no reason to treat unborn children differently from born children. Thus, the right of life of an unborn is covered under the Constitution.

In Shahistha v. State of Karnataka, (2022),[86] the division judge bench of Karnataka High Court held that an unborn child, particularly at the foetal stage, is entitled to the right to life under Article 21 of the Constitution, equating its constitutional protection with that of a born child. The Court reasoned that since life begins at the foetal stage, an unborn child qualifies as a "person" under Article 21, thereby granting it an equal and competing right to life vis-à-vis the mother.

These approaches mark a regressive departure from a well-established constitutional jurisprudence where the Supreme Court has consistently upheld a woman's right to reproductive autonomy as integral to her right to life and personal liberty.

In the case of X V. Union of India, (2023),[87] the three Judge Bench of the Supreme Court shifted its focus from the pregnant woman's health and rights to the method of abortion specifically, the act of stopping the foetal heartbeat. While earlier rulings allowed late-term abortions without emphasizing on procedural concerns, the Court here denied termination because at this point as the doctors would be faced with a viable foetus with significant disabilities, and stopping its heart raised ethical discomfort. This marks a move toward prioritizing foetal considerations over the woman's autonomy after a foetus becomes viable, though the Court continued to focus on balancing the rights of the unborn child with that of the women's reproductive right.

In *Suchita Srivastava*, (2009), the apex court reaffirmed that a woman's right to make reproductive choices is a dimension of personal liberty under Article 21. The aforementioned Kerala and Karnataka High Court's blanket recognition of foetal personhood not only lacks statutory basis under the Medical Termination of Pregnancy

[86] Shahistha v. State of Karnataka, (2022) 1 HCC (Kar) 20.
[87] X V. Union of India, Miscellaneous Application No. 2157 of 2023 in Writ Petition (Civil) No. 1137 of 2023.

Act, 1971 but also undermines the Court's duty to prioritize the dignity, autonomy, and bodily integrity of women. By elevating the foetus to the status of a constitutional person, the judgment inadvertently creates a false parity between a dependent, unborn life and an autonomous, rights-bearing individual, leading to the subordination of the pregnant woman's agency in a manner inconsistent with constitutional principles.

The Supreme Court decision in 2023 provides for maintaining a balance between the two conflicting interest and does not state that the foetus has a right under article 21 thus, the two High Courts have erred in reaching a conclusion wherein the right of the foetus and pregnant women is equated at all stages of pregnancy. The Courts in India do not recognise foetus as a person under Article 21, but it does provide for balancing of foetal rights with women's reproductive rights after a certain period of time in the pregnancy as provided in the MTP Act, i.e. 24 weeks.

3.4 Judiciary in Germany on foetal right and personality

The German Federal Constitutional Court has firmly recognized the embryo's right to life as a constitutionally protected interest, rooted in Article 2(2) of the Basic Law and intrinsically linked to the guarantee of human dignity under Article 1(1). In its landmark abortion decisions of 1975 (BVerfGE 39, 1) and 1993 (BVerfGE 88, 203), the Court emphasized that human life begins no later than the 14th day after conception and must be protected by the state from that point onward. While the Court stopped short of granting embryos full personhood, it adopted a continuity thesis, viewing embryos not as potential human beings but as human beings in early developmental stages. Accordingly, it held that allowing abortion by mere choice of the women through a liberal model fails to fulfil the constitutional duty to protect foetal life.

These decisions reflected a post-Holocaust ethical stance, interpreting the Basic Law as a repudiation of the Nazi-era devaluation of life and a commitment to safeguarding even the earliest forms of human existence. Nevertheless, this jurisprudence has been criticized for failing to adequately balance foetal rights with the pregnant woman's right to bodily integrity and self-determination, ultimately subordinating women's autonomy to a concept of state-imposed foetal protection.[88]

[88] Anja J. Karnein, A Theory of Unborn Life: From Abortion to Genetic Manipulation 44-47 (Oxford Univ. Press 2012).

In its landmark 1975 abortion decision (BVerfGE 39, 1), the German Federal Constitutional Court held that unborn life is protected under Article 2(2) of the Basic Law, which guarantees the right to life, in conjunction with the guarantee of human dignity under Article 1(1). Though the Court did not explicitly declare the foetus a full rights-holder, it established that the state bears a constitutional duty to protect prenatal life from the moment of conception. The Court framed the Basic Law as an objective value system that imposes obligations on the state not only to refrain from infringing rights, but to actively safeguard constitutionally protected interests, including unborn life.[89]

The Court emphasized that criminal law is one of the necessary instruments the state must use to fulfil this duty and struck down a 1974 law that had permitted abortions during the first trimester after consultation. It reasoned that allowing abortion on request even without penal consequences would undermine the constitutional status of foetal life by signalling that its destruction was legally and morally neutral.[90]

The decision rejected liberal constitutional theories focused solely on individual autonomy and recognized a structural power imbalance between the foetus and the pregnant woman, casting the state as the necessary guardian of the weaker party.[91]

Despite acknowledging the tension between a woman's right to personal autonomy and the foetus's right to life, the Court prioritized foetal protection, asserting that criminalization of abortion was constitutionally required except in narrowly defined exceptions (such as serious threats to the mother's life or health).[92]

Two dissenting justices opposed this approach, arguing for judicial restraint and emphasizing that mandatory criminal sanctions were neither effective nor the only constitutionally permissible means of protecting foetal life. Nevertheless, the majority's decision established a high constitutional value for foetal life, laying the foundation for Germany's highly restrictive abortion framework, and continues to influence German abortion law today.[93]

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[89] Vanessa MacDonnell & Jula Hughes, The German Abortion Decisions and the Protective Function in German and Canadian Constitutional Law, 50 Osgoode Hall L.J. 989, 1008-09 (2013).
[90] Id. at 1010-11.
[91] Id. at 1010.
[92] Id. at 1011-12.
[93] Id. at 1011-12.

The 1993 decision of the Constitutional Federal Court set aside a legislation that provided for abortion on demand. In its 1993 decision, the German Federal Constitutional Court reaffirmed and expanded the constitutional protection of foetal life established in its 1975 ruling. The Court struck down provisions of the Pregnant Women and Family Aid Law of 1992, which had legalized first-trimester abortions following mandatory counselling, and held that the unborn possess a constitutionally protected right to life under Article 2(2), in conjunction with the human dignity clause of Article 1(1) of the Basic Law.

While not granting full legal personhood, the Court emphasized that foetal life must be protected by the state and cannot be subordinated to other constitutional values through balancing. It declared that abortion remains fundamentally unlawful, even in the absence of criminal penalties, in order to affirm the moral and legal status of the unborn.

The Court required that counselling be structured to actively promote continuation of pregnancy, and emphasized that public funds, such as compulsory health insurance, should not be used to finance abortions, except in narrowly defined cases like rape or medical necessity. Dissenting justices criticized the decision for undermining women's rights and for asserting a duty to carry pregnancies to term without adequate regard for personal autonomy or the practical impact of declaring abortions unlawful yet non-punishable. Overall, the ruling reinforced the Court's stance that unborn life constitutes a legal interest of the highest constitutional rank deserving active state protection.[94]

In Germany, the legal recognition of foetal rights has evolved through constitutional and family law interpretations. While the German Civil Code grants legal personality only from birth, the Federal Constitutional Court has affirmed that the embryo constitutes human life and is entitled to constitutional protection, particularly the right to life under Article 2(2) of the Basic Law. This recognition has allowed wardship courts to intervene in exceptional cases such as when a father seeks to prevent an abortion to protect foetal interests. However, courts have generally maintained that abortions lawful under criminal law cannot be reframed as parental neglect under family law, thus precluding state intervention unless the abortion is demonstrably illegal. Consequently,

[94] Edith Palmer, German Abortion Law After the 1993 Constitutional Decision (Law Libr. of Cong., Eur. L. Div., Aug. 1993).

family law serves a complementary role, reinforcing but not overriding the criminal law's balance between maternal autonomy and foetal rights.[95]

3.5 Judiciary in France on foetal right and personality

In the French legal system, the foetus does not have juridical personality. The principle established is that legal personality begins at birth. Therefore, the foetus is not recognized as a legal subject independently capable of rights, including the right to life.

In its review of France's 1975 Voluntary Interruption of Pregnancy Act under Article 61 of the 1958 Constitution, the Constitutional Council clarified that its sole role is to assess statutes' constitutionality, not their conformity with international treaties (Art. 55), which have a different, reciprocity-based regime. [96] The Court therefore did not examine any alleged conflict between the abortion law and France's treaty obligations.

Turning to fundamental rights issues, the Council held that the Act fully respects individual's freedom including the pregnant woman's freedom to choose or participate in abortion on grounds of distress or medical necessity and so does not breach Article 2 of the 1789 Declaration of the Rights of Man and of the Citizen (freedom). At the same time, the Council reaffirmed the preamble's principle of respect for all human beings from the inception of life, as inserted into the Civil Code in 1994, but found that the statutory exceptions that is, distress and therapeutic terminations, are narrow, strictly conditioned by law, and do not infringe any higher constitutional principle including the Republic's guarantee of children's health under the 1946 preamble.

By upholding the law, the Council effectively ruled that French constitutional order does not recognize the foetus as a full person with an inviolable right to life from conception; rather, it permits limited derogations from prenatal life-protection to safeguard the pregnant woman's autonomy and health, so long as those derogations are tightly circumscribed by statute.

The position that foetus is not a legal person, was reinforced in French jurisprudence, particularly in the landmark decisions of the Cour de cassation, where it was held that

[95] Michael Coester, The Protection of the Embryo in German Family Law, 5 J. Child L. 88, 88-94 (1993).
[96] Constitutional Council [CC] [Conseil constitutionnel], Jan. 15, 1975, No. 74-54 DC, Rec. 19.

unintentional killing of a foetus could not be considered homicide, as the foetus was not regarded as a person under criminal law.[97]

In Cass. crim., 25 June 2002, No. 00-81359,[98] the French Court of Cassation reaffirmed its jurisprudence that Article 221-6 of the French Criminal Code, which criminalizes involuntary manslaughter, does not extend to the death of a foetus. This decision, which followed earlier rulings from 3 June 1999 and 29 June 2001 (Plenary Assembly), cemented the principle that the foetus is not regarded as a criminally protected person under French law. The Court ruled that the phrase another person used in Article 221-6 does not include the unborn, thereby precluding criminal liability for prenatal death even when caused by negligence and irrespective of the foetus's viability or gestational maturity.

The case arose when a pregnant woman reported abnormal foetal heart rhythms to a midwife, who negligently failed to consult a doctor. The foetus, later found to be viable and otherwise healthy, died in utero from anoxia. The Versailles Court of Appeal convicted the midwife of involuntary manslaughter, emphasizing the foetus's viability and attributing direct causality between the negligence and the death. However, the Court of Cassation quashed the conviction, applying the principle of strict interpretation of criminal statutes as codified in Article 111-4 of the Penal Code. It held that the criminal law could not be analogically extended to foetuses, and that only Parliament could address the legal vacuum regarding unintentional foetal death.

In reaching this conclusion, the Court notably rejected viability as a relevant legal threshold. Whereas several lower courts had considered viability an indicator of personhood for criminal purposes, the Court of Cassation clarified that legal personality in French criminal law begins only with live birth. The viability of the foetus, however medically or ethically significant, does not confer criminal personhood. This position distinguishes criminal from civil law, the latter of which conditionally recognizes the foetus in contexts such as inheritance, provided the child is born alive and viable. Accordingly, while civil law may retroactively protect the foetus in certain domains, this does not translate into criminal protection.

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[97] Aurora Plomer, A Foetal Right to Life? The Case of Vo v. France, 5 Hum. Rts. L. Rev. 311, 312 (2005).

[98] Cour de cassation [Cass. crim.] [Court of Cassation, Criminal Division], Paris, June 25, 2002, No. 00-81.359, Bull. crim. 2002, No. 153.

The ruling has provoked significant legal and ethical debate. Critics have noted the inconsistency in criminal law whereby the death of a foetus moments before birth is not punishable, whereas a death moments after birth constitutes homicide. Furthermore, the decision underscores a legislative gap: despite the availability of civil remedies, the absence of criminal sanctions for negligent foetal death arguably undermines the principle of equal protection. The Court of Cassation acknowledged this inconsistency but maintained that it is not for the judiciary to create new offenses through interpretation. Instead, the Court called upon the legislature to act should it wish to extend criminal protections to foetal life.

In sum, this case highlights the French judiciary's strict adherence to the principle of legality in criminal law, even at the expense of substantive justice in tragic cases involving medical negligence. The foetus, regardless of developmental stage or viability, remains outside the scope of criminal personhood in French law. The *Cass. crim., 25 June 2002* ruling illustrates a broader legal commitment to separating biological development from legal status, and reiterates that any change to this regime must come from the legislature, not the courts.[99]

In the Vo v. France case (2004), the European Court of Human Rights addressed the issue indirectly in the context of French law, affirming the margin of appreciation enjoyed by states in defining the beginning of life. It concluded that the lack of criminal penalties for unintentional termination of a pregnancy did not violate Article 2 of the European Convention on Human Rights (right to life). The Court emphasized that, in France, the foetus does not enjoy the same legal protections as a person under civil and criminal law.[100]

French civil law allows for certain protection of the foetus in a contingent way, such as inheritance rights, provided the child is born alive and viable. However, this does not equate to recognizing the foetus as a legal person. The French criminal law, by contrast, does not consider the foetus as a victim of homicide, as was affirmed in *Vo v. France*,

[99] Brigitte Daille-Duclos, *En droit pénal le fœtus n'est pas une personne*, Actu-Juridique (Feb. 9, 2021), https://www.actu-juridique.fr/civil/personnes-famille/en-droit-penal-le-foetus-nest-pas-une-personne/ (last visited March 16, 2025).
[100] Vo v. France, App. No. 53924/00, 2004-VIII Eur. Ct. H.R. 67; see also Aurora Plomer, A Foetal Right to Life? The Case of Vo v. France, 5 Hum. Rts. L. Rev. 311, 322-24 (2005).

and reiterated in French national court decisions that denied charges of involuntary homicide in cases involving foetal death.[101]

The French judiciary's approach reflects a legal and ethical framework that prioritizes the rights of the pregnant woman over the foetus, particularly in medical negligence cases. This is indicative of a broader legal culture that refrains from equating foetal existence with personhood, maintaining a clear line between prenatal life and juridical personality.[102]

France in 2024 made an amendment to their Constitution, adding an explicit right to terminate pregnancy, being the first country to do so in the world.[103] The judgment of Vo v. France, effectively empowers countries like France to regulate abortion autonomously, including enshrining it as a constitutional right, without breaching their obligations under the Convention.

3.6 Conclusion

The concept of foetal right and personality is dealt with by different states differently. In the US, prior to the Dobbs ruling the right of the foetus was only acknowledged post viability i.e. in the third trimester, even with the trimester framework being replaced by the undue burden test in Casey, the courts continued to focus on maternal health prior to viability and post viability trying to balance foetal rights with maternal health and life.

The environment surrounding abortion changed post Dobbs, to now focus on foetal rights at all stages of pregnancy doing away with the viability standard altogether. The Dobbs judgment left it to the states to legislate on the matter of abortion while clarifying that the constitution does not provide for a right to make reproductive choice like termination of pregnancy and that foetal rights should be protected, thus the Courts now shifted to primarily focus on foetal life with respect to abortion. The decision is Roe explicitly states that foetus is not recognised as a person in the Constitution of U.S., and

[101] Aurora Plomer, *supra* note 97, at 50.
[102] Id. at 331-32.
[103] Associated Press, *France Becomes the Only Country to Explicitly Guarantee Abortion as a Constitutional Right*, The Hindu (Mar. 5, 2024), https://www.thehindu.com/news/international/france-becomes-the-only-country-to-explicitly-guarantee-abortion-as-a-constitutional-right/article67914799.ece (last visited March 16, 2025)

the same has not been refuted by Dobbs. In the US, though foetal rights were emphasised in the Dobbs judgment, foetus does not come under the Constitution.

In contrast in India, the primary focus in abortion by the Courts while interpreting statutory, penal, and constitutional provisions has been on maternal health and liberty. The Courts have time and again emphasised on the importance of autonomy of women with respect to making reproductive choices, and that the Constitution provides for a right to make reproductive choice to the women. Though such a right is restricted by the MTP Act, while trying to balance foetal interest and women's right to make reproductive choice. The primary aim of the MTP Act, was to ensure that the rate of unsafe abortion reduces and was not enacted on the ground of protecting foetal life. Though interest of foetus is protected after twenty-four weeks, the Court does allow for abortion in very limited cases. The Court has also stated time and again that the foetus is not a person under Article 21 and as such the constitution of India does not recognise foetus as a person.

The German Federal Constitutional Court has consistently held that unborn life is constitutionally protected under Article 2(2) of the Basic Law, tied closely to the guarantee of human dignity in Article 1(1). While stopping short of recognizing full legal personhood, the Court views the embryo as a human being from conception and imposes a strong state duty to protect foetal life. Abortion is deemed fundamentally unlawful and only permissible under narrow exceptions, with the Court rejecting models that allow abortion purely on the basis of a woman's choice. This position reflects a post-Holocaust constitutional ethos emphasizing the sanctity of life, but has drawn criticism for subordinating women's autonomy to state-enforced foetal protection, resulting in one of the most restrictive abortion frameworks in Europe

In stark contrast, French jurisprudence does not recognize the foetus as a legal person. Legal personality begins at birth, and the foetus is excluded from criminal protections, even in cases of medical negligence leading to its death. The Constitutional Council has upheld the legality of abortion laws grounded in a woman's autonomy, and the courts have refused to extend criminal liability to foetal deaths, emphasizing strict adherence to the principle of legality. This position was reinforced in *Vo v. France* and culminated in the 2024 constitutional amendment explicitly guaranteeing the right to abortion. The

French approach prioritizes the rights and freedoms of the pregnant woman, firmly separating biological existence from legal personhood.

While Germany and the U.S. (post-*Dobbs*) emphasize state interest in protecting foetal life, with Germany offering constitutional recognition and the U.S. delegating the issue to states, India and France place greater weight on women's rights, with both countries affirming that the foetus does not enjoy constitutional personhood. This comparative analysis reveals the tension between foetal protection and women's autonomy, reflecting deeper constitutional, cultural, and historical values unique to each jurisdiction.

Chapter 4: Protection of Minor's Reproductive Rights across Jurisdictions

4.1 Introduction

When a minor girl gets pregnant, her future prospects become bleak, a pregnancy effect's her education, her job prospects and makes her more vulnerable to economic issues. Around 19% of girls in developing countries become pregnant before they attain the age of 18. Most births i.e. 95% of births, to adolescents occurs in developing countries, the data specifically talks about births since national data on pregnancies are scarce or underreported.[104]

Some developed countries have extremely low rates of adolescent pregnancies and consequently abortions, one such country is the Netherlands, wherein the National Public Health Insurance System provides for free contraceptives, moreover the country also provides for comprehensive sex education, preventing unwanted pregnancies among the adolescences. Similar decrease in abortion rates has been found in other countries which have pushed for providing minors with sex education and contraceptives.[105]

Many girls are faced with social, geographical and economic obstacles when wanting to access contraceptives and reproductive care services. Lack of sex education and access to healthcare, creates an environment for increased unsafe abortions being conducted, especially on adolescence who face more stigma as opposed to adults.[106] One of the main reasons for data being provided for older adolescents is due to scare data availability on girls aged 14 and below and any pregnancies they may face.[107]

International law emphasises on the importance of adolescents right to reproductive health and autonomy. In developing countries 70,000 girls die each year due to complications during pregnancy or childbirth, the leading cause of death among girls aged 15 to 19. Due to the stigma, lack of confidentiality, cost, lack of information, and lack of accessible reproductive health services, girls face much hardship while continuing with pregnancies, especially unplanned ones. Some other barriers for adolescents to access reproductive health services include restrictive legal and policy

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[104] United Nations Population Fund, *Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy*, State of World Population 2013 (2013), https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf.
[105] Id. at 65-72.
[106] Id. at 90.
[107] Id. at 5.

framework, parental authorisation requirement and judicial authorisation (wherein the judges exercise significant discretion deciding on when an abortion request can be given).[108]

Committee on the Rights of the Child urges states to ensure that the adolescents in their countries receive safe abortion services and post abortion care among other reproductive health services. The committee has also urged the states to decriminalise abortion to ensure that adolescent girls are able to access safe abortion services and requisite post abortion care. The committee has further called on the states to ensure that the girls are provided autonomy and are able to make informed decisions on their reproductive health.[109]

The Special Rapporteur on the Right to Health's Report on Adolescents and Committee on the Rights of the Child general comment on adolescents, recognise and state that parental consent to access reproductive health services act as barriers and deter adolescence from availing such services. The committee general comment further provides that legal presumption should be there that the adolescents are capable enough to seek and access reproductive health services and that adolescents should not be forced or coerced into availing reproductive services.[110]

The convention on elimination of all forms of discrimination against women (hereinafter "CEDAW"), established the committee on the elimination of discrimination against women, under Article 17 of CEDAW.[111] This Committee in L.C. v Peru, stated that Peru had violated an adolescent right to health, by forcing her to continue her pregnancy which had detrimental effect on the mental and physical health of the women.[112]

The Human Rights Committee, in KL v. Peru, stated that not providing adolescents access to abortion services on the ground of foetal impairment which is fatal is a violation of her rights and constitutes as cruel, inhumane, and degrading treatment. The

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[108] Center for Reproductive Rights, *Capacity and Consent: Empowering Adolescents to Exercise Their Reproductive Rights*, at 5 to 10 (2017), https://reproductiverights.org/wp-content/uploads/2020/12/GA-Adolescents-FINAL.pdf.
[109] Id. at 14-15.
[110] Id. at 14-16.
[111] Convention on the Elimination of All Forms of Discrimination Against Women art. 17, Dec. 18, 1979, 1249 U.N.T.S. 13.
[112] Comm. on the Elimination of Discrimination Against Women, Views, Communication No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (Oct. 17, 2011).

Committee held that by not providing access to abortion services to a minor, domestic laws, as well as provisions of International Covenant on Civil and Political Rights, (ICCPR), has been violated.[113]

Various international instruments and committee emphasise the importance of providing safe abortion services to adolescence as part of their right to make reproductive choices. The specific laws of United States, India, Germany and France with respect to adolescent abortion will be dealt with in this chapter.

4.2 Minor's reproductive right in US

In the US, the Supreme Court has stated that minors like adults have constitutional rights, but these rights are restricted by states interest in protecting minors from their immaturity. In *Danforth* case, 1976, the Court set aside a Missouri law which required minors to obtain parents' consent for abortion during first trimester, stating that the parents cannot have absolute veto over their minor child's decision which may possibly be arbitrary. Further, in Bellotti v Baird, (1979),[114] the Court upheld parental consent laws so long as they were accompanied by a judicial bypass mechanism. A mechanism wherein the minor is provided with an opportunity before the Court to prove the maturity of her decision and that an abortion would be in her best interest. Though this decision provides minors with an alternative if parents do not give consent but it still imposes a burden since minor will have to get either parental or judicial permission to gain access to reproductive services.[115]

The judicial bypass, though brought forth to protect a minor's autonomy and decision-making capacity regarding her own reproductive rights, often ends up creating a barrier. Courts have wide discretionary powers to grant or reject a case requesting abortion, with no uniform standard, such that judges may rely on one's own biases or societal norms, creating a process which is arbitrary.[116]

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[113] Human Rights Comm., Views, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (Oct. 24, 2005).
[114] 443 U.S. 622 (1979).
[115] Martin Guggenheim, Minor Rights: The Adolescent Abortion Cases, 30 HOFSTRA L. REV. 589, 591–93 (2002).
[116] Id. at 638-642.

Though judicial bypass was introduced to advance a minor's constitutional right to autonomy but the same has merely shifted the control from the parents to the state, which undermines the minor's autonomy.[117]

In U.S. laws, a differentiation is made out between parental consent and notification, while the former requires explicit consent from the parents the latter only requires the minor to notify the parents. Both parental consent and notification are prevalently used across many states to restrict minor's access to abortion, provided a judicial bypass is provided.[118]

In *Bellotti* the Supreme Court explained the reasoning behind using *parens patriae*, stating that during childhood and adolescence, minors often lack the insight, experience and judgment in making a decision about choices that may have detrimental effect on them. The minor's freedom is restricted by the state using *parens patriae* for preserving her welfare, and it further permits laws which restrict abortion even in cases of sexual assault and incest, in the interest of protecting the foetus, at the cost of the victims in such cases.[119]

Even in cases where Court accepts the maturity of the minor, the delays caused due to this process causes restrictions in accessing abortion services. In *Bellotti* Justice Powell has provided that the Court views minor's rights as privilege based on fulfilling certain conditions rather than inherent rights.[120]

Thereafter, in the case of H.L. v. Matheson, (1981),[121] the Supreme Court held that the law requiring doctors in the state of Utah, to inform a pregnant minor's parents before performing an abortion, is valid, holding that the law did not impose an undue burden on the girls ability to be able to access abortion services and that though the minor has constitutional right to privacy but the state has a legitimate interest in protecting the well-being of the minor.

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[117] Id. at 643-644.
[118] Amanda M. Lanham, Parental Notification Under the Undue Burden Standard: Is a Bypass Mechanism Required?, 37 RUTGERS L.J. 551, 553–55 (2006).
[119] Adina Abrahami, Comment, The Abortion Paradox: How States Fail to Reconcile Their Parens Patriae Duty
to Protect Minors with the Lack of Sexual Assault and Incest Exceptions in Stringent Abortion Regulations, 10 Ind. J.L. & Soc. Equal. 257, 260 (2022).
[120] Martin Guggenheim, *supra* note 115, at 57.
[121] 450 U.S. 398 (1981).

Casey, 1992, reaffirmed the rule that parental notification or consent laws are constitutional under the undue burden test, provided expediated judicial review is provided to the minor to obtain abortion without parents being involved.

As *Dobbs*, overruled *Roe,* it held that women do not have a right to make reproductive choices, like termination of pregnancy under the U.S. Constitution and thus, states are now free to make laws restricting abortion for protecting foetal rights. As a result, many minors stay in states where either abortion is banned or highly regulated and require parental consent or in some states where abortion is not banned or with fewer restrictions, but still require parental consent. Though there are few states like New Jersey, which allows for minors to seek abortion services without requiring parental consent.[122]

Access to abortion for minor's even prior to *Dobbs* was more legally restricted then an adult's access, which has become worse after *Dobbs*. Minors face great barriers preventing pregnancies due to limited access to contraception and comprehensive sex education, and these barriers become exacerbated if these minors get pregnant, since accessing abortion services by minors is prevented by barriers including but not limited to information, consent of third parties and economic barriers. One such example is of Indiana where a minor is supposed to submit a notarised parent consent form, thereafter undergo counselling, receive an ultrasound and then wait for 18 hours before the procedure, creating a frightening and unsupportive environment for minors seeking abortion access.[123]

In U.S. 19 states have now prohibited abortion at all stages of pregnancy with little to no exceptions and as of October, 2022 29 state laws require mandatory wating period for obtaining an abortion. In addition to the various restrictions imposed on adults for obtaining an abortion, minors face restriction through abortion trafficking laws that prohibit minors from that particular state to travel to another state for abortion and

[122] Patti Zielinski, *Two-Thirds of U.S. Adolescent Minors Are Impacted by State Abortion Restrictions*, RUTGERS UNIV. (Apr. 7, 2025), https://www.rutgers.edu/news/two-thirds-us-adolescent-minors-are-impacted-state-abortion-restrictions#:~:text=%E2%80%9CAs%20a%20result%20of%20Dobbs%2C,%E2%80%9CMinors%20are%20often%20targeted%20by (last visited March 18, 2025).

[123] Tracey Wilkinson, Julie Maslowsky & Laura Lindberg, *A Major Problem for Minors: Post-Roe Access to Abortion*, STAT (June 26, 2022), https://www.statnews.com/2022/06/26/a-major-problem-for-minors-post-roe-access-to-abortion/ (last visited March 20, 2025).

penalise any who help such minors, one such state having imposed such restriction is Idaho.[124]

On the contrary, as of December 2023, 9 states in their Constitution provide for protection of reproductive freedom and for abortion. Further, some states provide for protection of access to reproductive health services including abortion to all women, irrespective of their age, applying equally to minors.[125]

Quite a few states have consent-based restrictions on abortion services for individuals under guardianship or conservatorship, irrespective of the individuals age or capacity. As of 2022, 36 states require parental involvement in abortion decisions of minors and 31 states provide for judicial bypass mechanism. 6 states allow for minors to obtain abortion if other adult relative is involved. Few states allow for minors to consent to their own reproductive health care, also in the case where minors no longer live with their parents and do not require parental notification and consent.[126]

Further restricting minor's reproductive rights, 6 states as of 2022, prohibit schools from discussing about abortion as a possible outcome of pregnancy in their sex education classes and 1 other state requires that schools dissuade students from viewing abortions as acceptable.[127]

Currently in the U.S. various states impose certain forms of restrictions on minors, which they face in addition to the restrictions imposed on adults for accessing abortion services.

Internationally, U.S. has not ratified Committee on Rights of Children or CEDAW, and thus has no treaty obligation under these conventions but it has ratified ICCPR and other huma rights treatises, which push for providing minors with autonomy and protection of their reproductive health rights. The Human Rights Committee provides that State parties should not adopt anti-abortion measures and must endeavour to provide safe, legal and effective access to abortion. By bringing about restrictive abortion legislation in many states in the U.S. these states have violated various

[124] Julie Maslowsky et al., *Adolescence Post-Dobbs: A Policy-Driven Research Agenda for Minor Adolescents and Abortion* (Youth Reproductive Equity 2024), https://dx.doi.org/10.7302/22808 (last visited April 28, 2025)
[125] Id. at 28.
[126] Id. at 33.
[127] Id. at 31.

provisions of the ICCPR, provisions they are obligated to follow as parties to the treaty.[128]

Many States in the U.S. have quite restrictive laws with respect to abortion and accessing abortion care has become difficult for many women. These restrictions disproportionately effect minors since they face much more stigma, and face more economic restrictions, as compared to adult women, and this is in addition to the additional restrictions placed by laws on minors for accessing abortion services.

Though in some States parental consent requirement is provided with an alternative like judicial bypass, but even such alternatives are not consistent and sometimes impose even more restrictions than what the law imposes, like in the case of a 17-year-old in Florida, who was denied parental consent waiver for abortion on the ground that her grades were bad.[129]

Such cases in the U.S. show that minor's reproductive rights are not only restricted by legislation but also restricted by arbitrary judicial decisions that undermine their decisions-making capacity and circumstances. In essence these regulations undermine the very rights that they claim to protect placing disproportionate burden on minors, contrary to their international obligations.

4.3 Minor's reproductive right in India

The Medical Termination of Pregnancy Act, in India regulates abortion. The MTP Act provides that women can seek abortion services subject to fulfilling the conditions of the Act till twenty weeks with the opinion of one medical practitioner and till twenty-four weeks with the opinion of two medical practitioner.[130]

The Medical Termination of Pregnancy (Amendment) Rules, 2021, post the amendment to the MTP Act, added minors under the categories of women eligible for termination

[128] Human Rights Watch, *Human Rights Crisis: Abortion in the United States After Dobbs* (Apr. 18, 2023), https://www.hrw.org/news/2023/04/18/human-rights-crisis-abortion-united-states-after-dobbs#_ftnref190.
[129] Tevah Platt, *Abortion Policy Is Changing Every Day. Minors Are the Most Vulnerable and the Least Understood*, U. MICH. POPULATION STUD. CTR. (May 8, 2024), https://psc.isr.umich.edu/news/abortion-policy-is-changing-every-day-minors-are-the-most-vulnerable-and-the-least-understood/.
[130] Medical Termination of Pregnancy (Amendment) Act, 2021, §3(2)(a) & §3(2)(b).

of pregnancy till twenty-four weeks.[131] The new rules intend to make abortion more accessible to minors and recognise them as a vulnerable category.[132]

Further the aforementioned restriction of seeking abortion services based on length of pregnancy will not apply if substantial foetal abnormalities are diagnosed by the medical board[133] or if the life of the women is in danger.[134]

With respect to minors an additional condition or restriction is applied wherein those who are below the age of eighteen, their pregnancies shall be terminated subject to the consent of their guardian in writing.[135]

The MTP Act, provides for protection of privacy of women, that is medical practitioner is restricted from revealing the name of the women whose pregnancy was terminated, except when asked by an authority of law.[136] Though this law provides for confidentiality but it conflicted with mandatory reporting provision in the Protection of Children from Sexual Offences Act, (POCSO),[137]which required mandatory reporting of any adolescent sexual activity consensual or otherwise, since under this Act, sex with a person below the age of 18 is considered as statutory rape.[138]

This issue was addressed by the Supreme Court in *X v. Principal Secretary, Health & Family Welfare Department, 2002*, wherein it observed how the mandatory reporting under POCSO deterred many minors from obtaining abortion services especially minors from marginalised communities, putting them in a risky position of either seeking a doctor and subsequently have police involved or seek the services of an unsafe abortion centre where reporting would not take place. The Court taking note of how this provision of POCSO Act created a barrier for accessing abortion services by minors, held that the doctors are not required to reveal the identity and personal details

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[131] Medical Termination of Pregnancy (Amendment) Rules, 2021, r. 3B.
[132] Jagriti Chandra, *New Abortion Rules Recognise Minors as Vulnerable, Seek to Make Services More Accessible to Them*, THE HINDU (Oct. 30, 2021, 7:02 PM IST), https://www.thehindu.com/news/national/new-abortion-rules-recognise-minors-as-vulnerable-seek-to-make-services-more-accessible-to-them/article37253176.ece (last visited May 16, 2025)
[133] Medical Termination of Pregnancy (Amendment) Act, 2021, §2B.
[134] Medical Termination of Pregnancy Act, 1971, §5.
[135] Medical Termination of Pregnancy Act, 1971, §4(a).
[136] Medical Termination of Pregnancy (Amendment) Act, 2021, §5A.
[137] Protection of Children from Sexual Offences Act, 2012, § 19.
[138] Center for Reproductive Rights, *The POCSO Act & Adolescents' Access to Abortion in India: Heightened Vulnerabilities, Health Risks, and Impact on Their Rights* (2024), https://reproductiverights.org/wp-content/uploads/2024/07/POCSO-Act-Adolescents-Access-to-Abortion-in-India-fact-sheet.pdf.

of the minor, seeking abortion services under MTP Act, when reporting under POCSO Act. Thus, creating an environment where in the minor is able to seek abortion services without fearing repercussions or possible confidential breach.[139]

The Ministry of Health and Family Welfare Guidelines and Protocols provided for medico-legal care for victims or survivors of sexual violence in 2013, which stated that the examining doctor's primary responsibility is to administer treatment and conduct necessary medical investigations. Further it stated that for providing treatment to the victim, it is not mandatory for examining doctor to do admission, evidence collection or file a police complaint. This guideline's means that the doctor should first focus on conducting the abortion and can thereafter inform the authorities.[140]

The double bench of the Madras High Court, in the case of V Krishnan v. G. Rajan, 1993,[141]dealt with the issue of whether the guardian can seek abortion services for the minor child when, the girl is against the termination. The Court held that the right to life under Article 21 of the Constitution includes a right to continue with the pregnancy and give birth and that such right equally applies to minors as well as adults.

The Court in this case held that the MTP Act does not allow for abortion on demand to either the women or the guardian. The Court held that the guardian's consent is only required for abortion when the minor seeks an abortion and not when she opposes it. The Court in this case upheld the decisional autonomy of the minor with respect to her reproduction. The Court made its decision observing at that period how abortion in minor's was dangerous as opposed to carrying it to term, basing its decision with the intent of protecting the interests of the minor.

Though consent of guardian is required, when a minor avails abortion services the same consent is not required when the minor decides to continue with the pregnancy. Though the intention of getting consent of guardian is provided in the provision keeping the best interest of the minor in mind, but requiring all adolescent girls to get consent creates problems where it may not be safe or practical for the minor to approach their guardian for such time sensitive matters. Seeking guardians' consent where the guardian or guardian's relative raped the girl, or in more conservative families, where

[139] Id. at 2-3.
[140] Lalchand Verma, Sachin Meena & Deepali Pathak, Unmarried Minor Girls and Pregnancy: Medico-Legal Issues, 6 RUHS J. HEALTH SCI. 158 (2021).
[141] V. Krishnan v. G. Rajan, 1993 SCC OnLine Mad 374.

premarital sex is considered taboo, minor girls from such families will face hardship in availing abortion services due to parental consent requirement. The same has been observed by World Health Organisation, that adolescents maybe deterred from availing reproductive care services if they are required to get consent from their parents or guardian which increases the likelihood of such minors seeking unsafe abortion service providers.[142]

Further there is an additional barrier created on the minors seeking abortion service due to misinterpretation of the Juvenile Justice Act, under which the Child Welfare Committee is established with wide set of powers. Due to these wide powers service providers and committee members themselves believe that it is important for the medical practitioner to receive permission from the committee before terminating a minor's pregnancy. Though such has not been provided to the committee member but the same is used, contrary to the provisions of the MTP Act which explicitly requires only the consent of minor and guardian to conduct abortion.[143]

The High Court of Punjab and Haryana, in the case of Kamla Devi v. State of Haryana & Others,[144] held that there is no requirement of judicial permission or approval before availing of abortion services as the MTP Act explicitly provides that only the consent of the women and requisite medical practitioners opinion is required and in the case of a minor the consent of a guardian as well.

Similarly, in the case of Bashir Khan v. State of Punjab & Another, 2014,[145] the High Court of Punjab and Haryana, while holding the magistrate decision as technically correct, criticised its inaction with the minor's pregnancy, when the Magistrate denied the request for termination, since it did not have the jurisdiction. The High Court observed that the Magistrate should have acted and ensured speedy abortion services be provided to the rape victim instead of dismissing the request on jurisdiction.

Though the legislation and the Courts interpretation of the Act provide for protecting the women's autonomy and reproductive choice but at the same time the same has limited application to minors to the extent that parental consent for availing abortion is

[142] Dipika Jain & Brian Tronic, Conflicting Abortion Laws in India: Unintended Barriers to Safe Abortion for Adolescent Girls, 4 INDIAN J. MED. ETHICS 310, 313 (2019).
[143] Id. at 313.
[144] Kamla Devi v. State of Haryana & Others, CWP No.2007 of 2015.
[145] Bashir Khan v. State of Punjab & Another, Civil Writ Petition No.14058 of 2014.

still required by law, despite the same consent not being required for continuing with the pregnancy, considering both termination or continuation of pregnancy is part of reproductive autonomy of women including minors.

The Court though have been liberal in interpreting the provisions of the MTP Act with respect to minors especially in the cases of minors who were victims of rape. One such case is A (Mother Of X) vs State of Maharashtra,[146] the Supreme Court allowed for termination of pregnancy beyond statutory limit of 24 weeks, of a minor rape victim. The Court relied on a medical boards opinion which states that continuing the pregnancy could severely affect the girl's physical and mental health and that termination of pregnancy at this stage posed no greater risk then full-term delivery.

Further in the case of XYZ (Minor) through her father v State of Maharashtra,[147] the Bombay High Court allowed for termination of pregnancy beyond 24 weeks, of a minor rape victim. The Court further directed that the State should ensure that all medical support is provided to the victims of sexual abuse for undergoing abortion even beyond the statutory limit, provided the medical report certifies that the victim's life will not be endangered.

In the case of XYZ Through her Natural Gurdian I.E. Mother Hirkani Sonu Bhoi v. State of Maharashtra and Others.,[148] the Bombay High Court held that the minor rape victim cannot proceed with the abortion, relying on the expert medical committee's report that there were no foetal abnormalities and that the pregnant adolescent was clinically normal and psychologically stable. The Court denied abortion, having noted that the petitioner was below the age of 18 years and the pregnancy caused by rape is presumed to cause grave injury to the mental health of the victim.

Further in the two other cases decided by the Madhya Pradesh High Court, the Court held that the pregnancy of the minor rape victim cannot be allowed since the medical

[146] A (Mother Of X) vs State of Maharashtra, Petition(s) for Special Leave to Appeal (C) No(s).9163/2024.
[147] XYZ (Minor) through her father v State of Maharashtra, Civil Writ Petition LD-VC-82 OF 2020, Available from: https://bombayhighcourt.nic.in/writereaddata/weborders/PDF/O30062020357.pdf; see also Pramod A. Solanke v. Dean of B.J. Govt. Medical College & Sasoon Hospital, 2020 SCC OnLine Bom 639; Sangita Sandip Dahilkar v. State of Maharashtra, WP No. 5939 of 2020.
[148] XYZ Through her Natural Gurdian I.E. Mother Hirkani Sonu Bhoi v. State of Maharashtra and Others, WP No.792 of 2022.

opinion provided that a termination at 29 and 32 weeks could jeopardise the health of the foetus and the pregnant person.[149]

Further, in the case of N vs. State of NCT of Delhi and Ors.,[150] the Delhi High Court referred to the case of *Suchita Srivastava v. Chandigarh Administration*, and observed that the Supreme Court had stipulated that the State or Court acting as parens patriae cannot override an individual's autonomy in decision whether or not to continue with the pregnancy.

The High Court in this case followed the apex Courts judgment stating that reproductive decisions should lie solely with the individual. The Court in this case held that the 16-year-old rape victim be allowed to terminate her pregnancy which was beyond 26 weeks that is beyond the statutory limit, considering that forcing a minor to continue her pregnancy will increase her physical and mental suffering and subject her to social stigma.

The Court also noted that the risk associated with terminating a pregnancy at 26 weeks was not significantly higher than continuing with the unwanted pregnancy which could cause grave psychological harm to rape survivors, an observation supported by the medical board's opinion. The Court also noted that the absence of foetal abnormalities cannot be used as a ground to curtail the reproductive choice of the victim.

The aforementioned cases decided by the High Courts of Bombay, Madhya Pradesh, and Delhi show that abortion is allowed for a minor rape victim when the medical boards opinion provides that abortion is better for the physical and mental health of the minor girl and is not allowed when the opinion provided that the abortion could cause harm to the minor girl as opposed to continuing with the pregnancy.

Though inconsistencies can be seen between these judgments in the fact that where one Court allows for abortion on the ground that it will harm the minor victim to carry the pregnancy caused as a result of rape and wherein it was held that lack of foetal abnormalities should not curtail a women's right to make reproductive choice. On the contrary the other Courts stopped the termination of pregnancy on ground of the harm that will be caused to the minor girl and also on the ground that it will cause harm to

[149] Victim A Minor Girl Through Her Father F v. The State of Madhya Pradesh and Others, WP No.25361/2021; Victim A v. The State of Madhya Pradesh and Others, WP No. 5009 of 2023.
[150] N Vs. State of NCT of Delhi and Ors., W.P. (Crl.) 2728/2024.

the foetus, considering the lack of foetal abnormalities. Thus, inconsistencies are formed in the reasoning of these judgments albeit the fact that the harm on the minor victim was considered but it was considered along with the harm on the foetus in some cases and without considering harm on foetus in other cases.

The Courts in India have tried to maintain and provide for the termination of pregnancy beyond statutory period specifically for minor rape victims based on medical opinions which provide that continuing of pregnancy would cause more harm than terminating the pregnancy. The Courts have emphasised on the importance of dealing with abortion of minor rape victims in a speedy manner, and ensuring that the victim is able to terminate the pregnancy when the medical opinion provides that it is better for the minor to terminate the pregnancy then continue with the pregnancy.

While India's legal framework governing reproductive rights for minors such as the Medical Termination of Pregnancy Act, 1971 and the Protection of Children from Sexual Offences Act, 2012 (POCSO) remains a critical component of the discussion, it is equally essential to examine community-based interventions that aim to support adolescent girls, especially in marginalized settings. These interventions often bridge the gap between legal entitlements and real-world accessibility, particularly for girls facing socio-economic vulnerabilities.

One such initiative, the Better Life Options Programme, adopts a holistic and multi-sectoral approach in delivering services to pregnant adolescents and young girls. Implemented across urban slums in Delhi and rural areas of Madhya Pradesh and Gujarat, the programme integrates education, literacy, life skills, vocational training, and reproductive health education. Its goal is to broaden the life choices available to adolescent girls, moving beyond mere reproductive health to address the structural determinants of adolescent vulnerability (World Health Organization, 2007). Such initiatives underscore the importance of combining healthcare with economic and educational empowerment in advancing minors' reproductive rights.[151]

Similarly, the Development Initiative Supporting Healthy Adolescents (DISHA) project in India demonstrates the value of community engagement and health system strengthening. DISHA employs a strategy that combines community-level mentoring,

[151] United Nations Population Fund, *supra* note 104, at 55.

participatory dialogue, sexuality education, contraceptive access, and life skills training. These efforts reflect a shift toward adolescent-centred reproductive health models, recognizing that information, autonomy, and support systems are essential for enabling minors to make informed reproductive choices.[152]

Despite these interventions, data continues to reflect significant gaps in access to skilled care for adolescents. A comparative Demographic and Health Surveys (DHS) analysis revealed that in countries including India, Brazil, Bangladesh, and Indonesia, adolescent girls were less likely than adult women to receive skilled care before, during, and after childbirth (Reynolds et al., 2006). This disparity suggests systemic barriers in both awareness and delivery of adolescent-friendly health services, particularly among pregnant minors who may face stigma, legal obstacles, and fear of disclosure under mandatory reporting provisions such as those in the POCSO Act.[153]

These findings highlight the urgent need for India to scale and replicate successful community-based interventions, and to align statutory protections with accessible, adolescent-sensitive health delivery models. While the legal discourse around minors' reproductive autonomy is evolving through court decisions, the on-ground reality requires equally robust social and public health support to ensure those rights are meaningful and actionable.[154]

In conclusion, while the MTP Act provides a legal framework for abortion and recognizes the privacy rights of women, its application to minors remains fraught with practical and legal challenges. The requirement of guardian consent for minors seeking abortion services, though intended to protect their best interests, often operates as a barrier rather than a safeguard especially in cases where involving a guardian is unsafe, unfeasible, or contrary to the minor's welfare. The conflict between the confidentiality provisions of the MTP Act and the mandatory reporting requirements under the POCSO Act further complicates access to safe abortion for adolescents, exposing them to legal scrutiny and societal stigma.

Although the Supreme Court has attempted to resolve this tension by clarifying that medical practitioners need not disclose the identity of minors under POCSO when

[152] Id.
[153] Id.
[154] Id.

reporting MTP procedures, systemic ambiguities and misinterpretations continue to result in unnecessary judicial and administrative hurdles.

Courts have commendably stepped in to authorize terminations beyond statutory limits, particularly in cases involving minor rape victims. Though quite a few problems exist with respect to access to abortion services by minors but at the same time, the Courts have time and again emphasised on the importance of women's bodily autonomy and right of self-determination, which constitute part of the women's fundamental rights enriched under Article 21, and applies to minors as well, subject to the provisions of the MTP Act.[155]

Despite the existence of supportive initiatives like the Better Life Options Programme and the DISHA project, adolescents in India especially those from marginalized backgrounds continue to face significant disparities in access to skilled reproductive healthcare. The lack of adolescent-sensitive services, persistent stigma, and conflicting legal obligations collectively undermine minors' reproductive autonomy and threaten their fundamental rights to health, dignity, and bodily integrity. There is an urgent need to harmonize the legal provisions, streamline procedures, and scale up rights-based, confidential, and accessible healthcare frameworks tailored to the unique needs of adolescent girls.

4.4 Minor's reproductive right in Germany

Germany's approach to abortion is shaped by the Criminal Code (Strafgesetzbuch) and by the Pregnancy Conflict Act (Schwangerschaftskonfliktgesetz).[156] In Germany the Basic Law does not recognise abortion and the Constitution provides for recognition of foetus as a person.

Abortion remains illegal under §218 StGB, but is unpunishable under specific conditions. The most common ground is the counselling regulation provided under Section 218a (1) StGB,[157] which states that a women may have an abortion within the

[155] X (Minor Victim) Vs. State of Uttar Pradesh and others, WRIT C No. 21956 of 2024; Mrs. C Vs. The Principal Secretary Health and Family Welfare Department, Government of NCT of Delhi and others, W.P. (C) 11206/2024; Jegatha D. vs. The Inspector of Police, Ranipet and Ors., W.P. No. 2237 of 2025.
[156] Schwangerschaftskonfliktgesetz [SchKG] [Pregnancy Conflict Act], July 27, 1992, (BGBl. I S. 1398), last amended by Article 1 of the Act of 7 November 2024, (BGBl. 2024 I Nr. 351).
[157] Strafgesetzbuch [StGB] [Penal Code], § 218a (1), https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html.

first twelve weeks of pregnancy that is fourteen weeks after the last menstrual period and if she undergoes mandatory conflict counselling session, whereafter three days of reflection time should be observed after the counselling session and before the abortion procedure. The section further states that this particular law is in place to protect the unborn child.

Another ground to get an abortion without being punished is under Section 218a (2) StGB,[158] which states that if the pregnancy were to pose a danger to the life or physical or mental health of the pregnant women, then the doctor can give a medical indication, and in such a case termination of pregnancy would be illegal, subject to the condition that no alternate way was available to the doctor to avert the said danger. In this case the pregnant women can avail termination of pregnancy after 14 weeks.

The last ground to get an abortion without being punished is under Section 218a (3) StGB,[159] wherein if the pregnancy were to be caused as a result of sexual abuse or rape then in such a case termination of pregnancy can be done till the fourteenth week of pregnancy, and prior counselling in such case is not mandatory but should be offered.

According to the Federal Statistical Office, in 2020, around 95% of abortions were conducted according to the counselling regulation and 4% according to medical indication and around 20 cases according to rape or sexual abuse. This figure has remained quite fairly constant for years.[160]

These laws on abortion apply equally to adult women and minor girls. With respect to minors, German law imposes no special prohibition, but parental rights do play a role. Notably, minors in Germany have rights to confidential healthcare and can consent to medical procedures if deemed capable.[161]

In Germany, the competence of minors to make autonomous decisions regarding abortion is not explicitly addressed by statutory law. Despite the legislature's awareness

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[158] Strafgesetzbuch [StGB] [Penal Code], § 218a (2), https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html.
[159] Strafgesetzbuch [StGB] [Penal Code], § 218a (3), https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html.
[160] Doctors for Choice Germany, *Abortion Law in Germany*, https://doctorsforchoice.de/en/information-2/abortion/law/#:~:text=1,procedure%20itself%20must%20not%20be (last visited May 18, 2025).
[161] pro familia, *Abortion Your Rights*, https://www.profamilia.de/en/for-teenagers/your-rights/abortion#:~:text=Girls%20over%20the%20age%20of,even%20without%20asking%20their%20parents (last visited May 18, 2025).

of the issue, attempts to regulate minors' consent in the context of abortion, such as those proposed in the 1972 reform of the Penal Code, were ultimately abandoned prior to enactment. That draft law would have permitted minors aged sixteen and older to consent independently to abortion, while requiring those under sixteen to obtain the consent of a legal guardian or a guardianship court decision if such consent was withheld.[162]

German abortion law, while generally restrictive, implicitly allows for minor autonomy under certain conditions. The Bundesverfassungsgericht in its decision of May 28, 1993, has emphasized the need to protect unborn life, recognizing its constitutional status as a person with a right to life under Article 2, paragraph 2 of the Basic Law (Grundgesetz). However, the Court has also acknowledged that this right may, in exceptional cases, be outweighed by the pregnant woman's own fundamental rights, particularly when continuation of the pregnancy imposes an unreasonable burden. These principles apply to minors as well, provided they possess the requisite maturity to assume responsibility for their decisions.[163]

The German Federal Constitutional Court has made clear that while minors may bear the legal responsibility for abortion decisions, this presupposes an ability to understand the procedure and its implications. The key determinant is whether the minor has sufficient maturity and comprehension, not just chronological age, to evaluate the nature of abortion and to balance her own interests against those of the unborn child. Consequently, German jurisprudence emphasizes an individualized, case by case assessment over fixed age thresholds when determining a minor's competence to consent.[164]

Family law further constrains parental authority in this context. While parents in Germany hold custodial rights, including the right to make medical decisions for their children, these rights are limited by the child's own constitutional entitlements. Parental authority diminishes as a child matures, especially in contexts involving deeply personal decisions such as abortion. Thus, a minor who demonstrates adequate maturity

[162] Detlev W. Belling & Christina Eber, Teenage Abortion in Germany: With Reference to the Legal System in the United States, 12 J. Contemp. Health L. & Pol'y 475, 478–79 (1996).
[163] Id. at 482-483.
[164] Id. at 494-495.

cannot be compelled by her parents either to undergo or to forgo an abortion against her will.[165]

The German Federal Constitutional Court has underscored the importance of shielding minors from undue parental pressure in abortion decisions. In its 1993 decision, the Court expressed concern that parental influence could amount to coercion, potentially leading to criminal conduct. It emphasized that minors, like adults, must be afforded the space to make such decisions free from external compulsion. Notably, while parental involvement may be appropriate, the ultimate decision must rest with the competent minor.[166]

Medical practitioners are also bound by these legal principles. Where a minor is deemed competent, a physician must respect her decision, and parental consent becomes neither necessary nor determinative. However, when the life or health of the minor is seriously jeopardised due to the pregnancy, parental consent and possibly judicial oversight may be required. Importantly, except in few cases, the best interests of the minor must guide the final decision, particularly where continuation of the pregnancy would result in a severe burden to the minor's health or future well-being.[167]

However, in practice, access to abortion for minors can vary significantly based on region and the discretion of medical providers or counsellors, who may apply a more restrictive interpretation to avoid legal risks. There is no binding decision from the highest civil court on this matter, and lower court rulings are inconsistent. Some have arbitrarily prioritized parental authority, while others have affirmed mature minors' autonomy. The lack of legal clarity, combined with time-sensitive abortion regulations, deters legal appeals and creates uncertainty among practitioners, reinforcing regional disparities and conservative practices.[168]

In conclusion, Germany's legal framework reflects a cautious recognition of minor's reproductive autonomy, allowing mature adolescents, particularly those over 16, to consent to abortion without mandatory parental involvement. The jurisprudence emphasizes individual capacity over fixed age thresholds, aligning in theory with the

[165] Id. at 486-487.
[166] Id. at 484-485.
[167] Id. at 492-493.
[168] Kirsten Scheiwe, Between Autonomy and Dependency: Minors' Rights to Decide on Matters of Sexuality, Reproduction, Marriage, and Parenthood. Problems and the State of Debate – An Introduction, 18 INT'L J.L. POL'Y & FAM. 262, 272 (2004).

principle of evolving capacities recognized under international human rights law. However, despite these progressive elements, abortion remains criminalized in principle under the Penal Code, and is only decriminalized under narrowly defined exceptions that include mandatory counselling and time restrictions. These constraints apply uniformly to both minors and adults, thereby restricting access across the board. Moreover, the lack of statutory clarity on minors' consent and inconsistent lower court interpretations contribute to legal uncertainty and regional disparities, often leaving access to abortion contingent on the discretion of medical providers or counsellors.

4.5 Minor's reproductive right in France

The right to abortion in France has been progressively expanded for all women, including minors. Under the 1975 Loi Veil, or the veil act, abortion was legalized (up to 10 weeks of pregnancy) as a response to women in distress, but the law still operated within the general framework that a non-emancipated minor needed parental authorization under the health code. In practice this meant a minor had to obtain the consent of a parent or guardian before undergoing an abortion, in effect, the public health code then required parental consent for any minor's medical decision. Subsequently, France relaxed these requirements in a series of reforms.

Since 2000, the pharmacist and school nurses in France have been allowed to distribute the morning after pill (which prevents implantation of embryo) to minors without any cost, or prescription and without informing the parents, which continues to apply till now.[169] In 2001, the government adopted Law No. 2001-588 (July 4, 2001),[170] which while extending the legal abortion limit from 10 to 12 weeks, explicitly allowed non-emancipated minor to request an abortion without the consent of her parents. Though the law removed mandatory psychosocial counselling for adult women, the same continued for minors.

The law now provided that minor could choose to get consent from one parent of legal representative and have that person accompany them. The accompanying adult served

[169] Act No. 2000-1209 of 13 December 2000 on emergency contraception (1), https://www.legifrance.gouv.fr/loda/id/JORFTEXT000000755450.
[170] LOI No. 2001-588 of 4 July 2001 on voluntary termination of pregnancy and contraception (1), https://vlex.fr/vid/loi-n-2001-588-824919041#:~:text=La%20pr%C3%A9sente%20loi%20allonge%20le,Ce%20dernier.

only as a support person and was legally bound to confidentiality; the decision and informed consent remained solely with the minor.[171]

Government health guidance confirms that a minor can remain completely anonymous in obtaining an abortion when proceeding without parental consent.[172] Any documentation of the abortion process is kept confidential, and health professionals, bound by penal sanctions under arts. 226-13 Penal Code, cannot reveal it to parents.[173] This legislative shift was driven by the need to protect the privacy and autonomy of pregnant adolescents, many of whom might delay seeking care due to fear of parental involvement.

France encourages and facilitates safe services. Abortions for minors may be provided not only in hospitals and clinics but also by private physicians and midwives (including outside hospitals for medical abortions), as recommended by national health authorities.[174]

The health ministry has promoted resources like ivg.gouv.fr for accessible information. The Public Health Code, provides that a non-emancipated minor has to compulsorily attend counselling before availing abortion services.[175]

It further provides that preferably for such minors, at least one parents consent should be obtained and efforts should be made to persuade the minor for the same during pre-abortion counselling. If the minor still refuses to inform her parent's, then she can avail abortion services provided she is accompanied by an adult of her choice. Moreover, after the abortion the law mandates a follow-up consultation with a focus on contraception specifically for minors, to prevent unintended pregnancies in the future.[176] This two-step care model (pre-abortion and post-abortion counselling) is intended to ensure minors are fully informed and supported at each stage.

In France all abortion services for minors are covered by the national health system at no cost to the patient. Since the 2013 Social Security financing law, public insurance

[171] French Ministry of Health, *Abortion: Information Guide* (2023), https://ivg.gouv.fr/sites/ivg/files/2024-02/guide%20IVG%202023_EN.pdf.
[172] Id. at 22.
[173] Code penal [C. pén.] [Penal Code] art.226-13.
[174] Assemblée Nationale [National Assembly], No. 3383, *Report on the Proposal Aimed at Strengthening the Right to Abortion*, 5th Legislature, Constitution of 4 October 1958 (30 Sept. 2020).
[175] Public Health Code, Article L2212-4
[176] Public Health Code, Article L2212-7

has reimbursed 100% of abortion costs for all women.[177] The financing law guaranteed full coverage of both medical and surgical abortions: minors had already been fully covered, and the 2013 reform extended this to every insured woman. In fact, as of April 2021 the state applied a flat-rate system, i.e. no co-payment or deductible is required for the abortion procedure or related care.[178]

For minors specifically, guidance confirms that the abortion will be free in every respect if parental consent is lacking. All associated charges like doctor visits, lab tests, ultrasounds, anaesthesia, medication and hospital stay are fully reimbursed.[179] In practice a minor presenting for an abortion need only show her health insurance card or mutual coverage; she pays nothing out of pocket. This comprehensive funding is intended to remove financial barriers, especially for adolescents who lack independent resources.

In addition, public health planning has sought to improve geographic and practical accessibility. The 2016 health law required each regional health agency to establish regional IVG or abortion access plans, mapping providers and promoting local services.[180] Contraception and abortion counselling clinics (Planning Familial centres) are made free for minors and often co-located in schools or youth services. Adolescents may also obtain emergency contraception and guidance without cost from school nurses. In sum, the French system emphasizes that minors can obtain abortion care anonymously, safely, and without financial burden.

France's strong statutory protections for abortion have now been elevated to the Constitution. On 8 March 2024, the French Parliament (Congress of Deputies and Senate) adopted a constitutional law explicitly entrenching the right to abortion. The new provision inserts into Article 34 of the Constitution the paragraph: "The law shall determine the conditions under which the woman's freedom to have recourse to voluntary termination of pregnancy is exercised."[181]

By enshrining abortion as a constitutionally protected right, this amendment symbolically places minors' abortion rights under the highest legal protection. Though

[177] Assemblée Nationale, *supra* note 174, at 74.
[178] French Ministry of Health, *supra* note 171, at 74.
[179] Id. at 24-26.
[180] Assemblée Nationale, *supra* note 174, at 74.
[181] Constitutional Law No. 2024-200 of 8 March 2024 on the freedom to resort to voluntary termination of pregnancy (1).

the text refers to la femme or the women, it plainly encompasses all pregnant persons (including girls). It signals that any future constraints on abortion must be weighed against a constitutional commitment to reproductive autonomy. For minors, the amendment means that their right to an abortion including the statutory confidentiality and consent rules outlined above is now backed by the Constitution.

France is bound by international treaties that mandate robust protection of minors' reproductive health. Under the UN Convention on the Rights of the Child (CRC), to which France acceded in 1990, children have the right to health, to privacy, and to have their views respected in matters affecting them. The CRC Committee's guidance has explicitly stressed safe abortion access for adolescents. It has stated that the states should endeavour to ensure that adolescents have access to safe abortion services and ensure that they are also provided with post-abortion care, regardless of whether abortion is legal or not. [182]

In 2023 the Committee also commended France's efforts (such as the 2001 sex education law) and urged stronger implementation of national sexual health strategies for youth.[183]

Similarly, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), ratified by France in 1983, requires non-discrimination in reproductive health care. CEDAW's Committee has emphasized that restrictions on abortion constitute gender-based discrimination and that states must provide safe abortion as part of women's health services.

By affording adolescent girls the same access to abortion as adults, and by shielding them from penalties or forced continuation of pregnancy, France aligns with CEDAW's mandate. The 2024 constitutional amendment, enshrining abortion as a freedom for women, further demonstrates France's commitment to CEDAW principles.

In summary, France's current system not only exceeds the minimum standards set by CRC and CEDAW, but proactively secures minors' reproductive autonomy. Teenagers in France face no legal barriers or costs to abortion; they are informed, supported by

[182] Ctr. for Reprod. Rts., *Breaking Ground: Treaty Monitoring Bodies on Reproductive Rights 2018* (2018), available at https://reproductiverights.org/wp-content/uploads/2020/12/Breaking-Ground-2018.pdf.
[183] Comm. on the Rights of the Child, *Concluding Observations on the Combined Sixth and Seventh Reports of France*, U.N. Doc. CRC/C/FRA/CO/6-7 (June 2, 2023) (advance unedited version).

optional adult accompaniment, and guaranteed privacy. These measures implement the best interest of the child and gender equality imperatives of international law. Any residual concerns (for instance, ensuring adequate service availability in all regions or eliminating unnecessary procedural hurdles) have been noted by committees, but the core framework is consistent with France's treaty obligations. In practice, France's minors' access to abortion is among the strongest in the world, reflecting a seamless integration of domestic law with CRC and CEDAW standards

4.6 Comparison

- *Parental Involvement*

In India and many U.S. states, minors' access to abortion is conditioned upon parental or guardian consent. Indian law mandates a guardian's written consent under the Medical Termination of Pregnancy Act when the pregnant person is below 18 years old. The U.S. lacks uniformity: several states require parental consent or at least notification, often with a judicial bypass option. Germany and France stand in contrast. Germany assumes that girls aged 16 and above are competent to consent on their own, while even younger minors may consent if deemed mature. France has eliminated parental consent entirely through reforms starting in 2001: a minor may access abortion confidentially by being accompanied by a supportive adult of her choice not necessarily a guardian with no power to override the minor's decision.

- *Legal Conditions and Time Limits*

All four jurisdictions allow abortion but differ in procedural requirements and deadlines:

a) **France** permits abortion as a Constitutional right, with confidential access for minors and a multi-step support system involving counselling.

b) **Germany** allows abortion up to 12 weeks with mandatory counselling and a 3-day reflection period.

c) **India** permits abortion up to 20 weeks generally, and up to 24 weeks in certain cases such as rape or minor pregnancy, with strict procedural safeguards.

d) **U.S.** law varied before *Dobbs v. Jackson Women's Health Organization* (2022), with many states allowing abortion up to viability (till 24 weeks); post-*Dobbs*,

several states now ban or severely restrict abortion access even in cases involving minors.

European models tend to emphasize counselling and informed consent, while India and the U.S. place more emphasis on legal oversight and parental control.

- *Judicial Bypass and Alternative Mechanisms*

The U.S. provides a judicial bypass mechanism, constitutionally mandated in states that require parental involvement. However, it is often criticized for being burdensome and inconsistent. India lacks any statutory judicial bypass, leaving litigation or administrative discretion as the only routes for minors without supportive guardians. Germany does not require parental consent as a norm and involves parents only where a minor is under 16 and considered immature. France's alternative is notably more efficient: the minor simply selects an accompanying adult and gives informed consent herself, without the need for a judicial process.

- *Confidentiality and Reporting Obligations*

France and Germany guarantee minors' confidentiality. French law ensures that a minor's choice is protected even from parental discovery, with strict legal sanctions for breach of medical secrecy. Germany also maintains strong medical privacy norms. In contrast, India's POCSO Act requires mandatory reporting of any sexual activity involving minors, even consensual, thus compelling doctors to report adolescent pregnancies to the police effectively breaching confidentiality and deterring minors from seeking care. The U.S. presents a mixed picture, with some states enforcing parental notice and others having more confidential access frameworks.

- *Legal Innovations*

Each jurisdiction has adopted unique mechanisms to address minors' reproductive autonomy:

- **U.S.** pioneered judicial bypass as a constitutional safeguard.
- **France** introduced the adult accompaniment model to balance support and autonomy.
- **Germany** emphasizes presumed competence based on maturity and enforces a counselling-driven, harm-reduction approach.

- **India**, via its 2021 amendment, broadened abortion access to include minors explicitly but retained the requirement of guardian consent and did not resolve the POCSO conflict.

Notably, France's 2024 constitutional amendment now provides the strongest protection in this group, guaranteeing abortion as a fundamental right under Article 34 of the Constitution.

- *Compliance with International Law*

Germany and France are party to both the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Their models reflect alignment with obligations to ensure confidentiality, informed consent, and access to reproductive healthcare for adolescents, though Germany fails under providing access to reproductive healthcare since it prohibits abortion post twelve weeks and prioritises foetal rights over women's reproductive right. India, though also a party to CRC and CEDAW, faces significant criticism for failing to harmonize POCSO with MTP, infringing the rights to privacy, health, and dignity. The U.S. is not a party to CRC or CEDAW, though it has been subject to international criticism under broader human rights frameworks like the ICCPR. European approaches especially France's offer clear models of international compliance and policy coherence.

4.7 Conclusion

The legal treatment of minors' reproductive rights across jurisdictions reflects deeply embedded social, cultural, and constitutional values. France and Germany provide expansive, autonomy-centred frameworks that empower adolescents through presumed competence, confidential access, and integrated public health support. India and the United States, in contrast, impose more legal and procedural hurdles, with significant reliance on parental authority or judicial discretion often creating barriers rather than bridges to care.

France's model, particularly after the 2024 constitutionalizing of the right to abortion, stands out for its legal clarity, access safeguards, and rights-based ethos. Its laws incorporate core international principles: respect for evolving capacities, protection of

health and privacy, and non-discrimination. Germany similarly respects minors' maturity while incorporating systemic safeguards through mandatory counselling.

Meanwhile, India's legal contradiction between the MTP Act and POCSO Act remains unresolved, placing service providers and pregnant minors in a precarious legal position. The United States' state-specific patchwork results in unequal access and legal confusion, especially for economically vulnerable minors.

This comparative analysis shows that the recognition of minors' autonomy and confidentiality balanced with appropriate safeguards and support is essential for fulfilling their reproductive rights. Countries aligned with CRC and CEDAW tend to uphold these values better. Legal reform must not only change statutory texts but also ensure that rights are operationalized in practice through funding, provider training, and youth-centric services. Ultimately, affirming minors' reproductive rights is not merely a matter of legality it is a matter of dignity, equality, and public health.

Chapter 5: Impact of legal frameworks on access to safe abortion

5.1 Introduction

Access to safe abortion care depends critically on the laws and policies in each country. International human rights bodies recognize that restrictive abortion laws jeopardize women's health and rights.

When the access to safe abortion is restricted, many internationally protected human rights are put at risk, including right to life, health, and information, right to equality and non-discrimination, right to privacy and bodily autonomy, right to freedom from torture and cruel, inhuman and degrading treatment, among other rights. These rights are provided under the Universal Declaration of Human Rights and protected by many international treatises like Convention on the Elimination of All Forms of Discrimination Against Women, (CEDAW), International Covenant on Civil and Political Rights, (ICCPR), International Covenant on Economic, Social and Cultural Rights, (hereinafter "ICESCR"), Convention Against Torture (hereinafter "CAT"), and Convention on the Rights of the Child (CRC).[184]

World Health Organisation, (hereinafter "WHO"), provides on the basis of 2019 data that adolescents aged 15 to 16 in middle- or low-income countries, had approximately 21 million pregnancies, of which 50 % were not intended and from these unintended pregnancies, 55% were abortions, often unsafe abortions. WHO, further provides that adolescent mothers aged 10 to 19 years, as compared to women aged 20 to 24 years, faced a higher risk of getting eclampsia, puerperal endometritis, and systemic infections, and that babies born to adolescent mothers face higher risk of low birth weight, premature birth, and severe neonatal conditions.[185]

Further WHO provides that there are various factors that contribute to adolescent pregnancies and births including, child marriage and subsequent pressure to give birth, lack of access to contraception and child sexual abuse. The primary cause of pregnancies should be addressed to ensure lesser pregnancies in adolescents and

[184] Human Rights Watch, *Q&A: Access to Abortion Is a Human Right*, HUM. RTS. WATCH (June 24, 2022, 5:00 PM), https://www.hrw.org/news/2022/06/24/qa-access-abortion-human-right.
[185] World Health Organization, *Adolescent Pregnancy*, WHO (Apr. 10, 2024), https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy.

subsequent abortions. The Sustainable Development Goals, provide for prevention of adolescent pregnancy, childbirth and child marriage in its agenda.[186]

Evidence from over 160 countries demonstrates a clear correlation between the legal grounds for abortion and the incidence of unsafe abortion and abortion-related mortality. Countries that permit abortion on broad socio-economic grounds or at a woman's request, and provide safe, accessible services, experience significantly lower rates of unsafe abortion and related deaths. Conversely, where abortion is highly restricted, unsafe abortion remains prevalent and mortality rates are higher. Notably, the unsafe abortion rate drops dramatically in countries where legal grounds extend beyond protecting a woman's life or health to include foetal impairment, economic or social reasons, or personal choice. Despite variations in data quality and healthcare infrastructure, these patterns consistently show that expanding legal access to abortion, combined with effective healthcare delivery, greatly reduces the harm associated with unsafe abortion.[187]

Over the course of two decades, with advancements in technology, abortion care has become safer. WHO provides that, 98% of unsafe abortion takes place in low- and middle-income countries, even where they are legal, the primary cause of these unsafe abortions are lack of safe abortion services. This observation showcases that legalisation of abortion is not enough, but providing safe abortion services is necessary to reduce unsafe abortion rate.[188]

The legality of abortion did not have an effect on the likelihood of women seeking abortion services for an unintended pregnancy. Restrictive abortion laws do not decrease abortion rate or increase birth rate but rather it increases the number of women availing illegal and unsafe abortions. These restrictions on abortion also lead to many women availing abortion services in other countries, which is costly, and creates inequalities.[189] Unsafe abortions are avoidable and nearly every death or harm caused

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[186] Id.
[187] Marge Berer, National Laws and Unsafe Abortion: The Parameters of Change, 12 Reprod. Health Matters (Supp. 24) 1 (2004), https://doi.org/10.1016/S0968-8080(04)24024-1.
[188] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (WHO/RHR/15.04, 2015), https://iris.who.int/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf.
[189] Id. at 2.

due to unsafe abortion could be avoided through sex education, access to contraception and effect use, providing safe, and legal abortion services.[190]

In countries where abortion is heavily restricted, and permitted only to save a woman's life or protect her health, it is still widely sought and needed. Research shows that unintended pregnancy rates are highest in such settings and lowest where abortion is broadly legal. Consequently, abortion rates are comparable between countries that restrict abortion and countries that have permitted abortion. The analysis, excluded data from China and India due to the large population, found that the rate of abortion is actually higher in restrictive countries. Over the past three decades, the proportion of unintended pregnancies ending in abortion has risen significantly in restrictive countries, from 36% in 1990–1994 to 50% in 2015–2019.[191]

These reports and statistics provide for similar conclusions that it is imperative to have legal abortion access available as well as implementation of such law, that is access to safe abortion services should also be provided. The countries having better access to contraception, and reproductive care, have much less rate of unsafe abortions as compared to countries that do not provide such access.

This chapter examines how the legal and policy environment in the United States, India, Germany, and France affects abortion access and safety.

5.2 Legal frameworks on access to safe abortion in U.S.

Until 2022, U.S. federal law under *Roe v. Wade*, (1973), which was reaffirmed in *Planned Parenthood v. Casey*, (1992), protected a woman's right to abortion until foetal viability (around 24 weeks).

Before *Roe,* abortion was largely unregulated since the procedure was quite dangerous at that point in time, and childbirth was safer. Abortion by mid 1800s was banned in nearly al U.S. States, forcing many women especially those from weak economic background to resort to unsafe abortion, wherein often life-threatening methods were used. Illegal abortions became quite common, such that in 1930, abortion was listed

[190] Id. at 6.
[191] Guttmacher Institute, *Unintended Pregnancy and Abortion Worldwide: Fact Sheet* (Mar. 2022), https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide; see also Jonathan Bearak et al., *Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion: Estimates from a Comprehensive Model for 1990–2019*, 8 Lancet Glob. Health e1152 (2020), https://doi.org/10.1016/S2214-109X(20)30315-6.

officially as the cause of 18% maternal death. Though the death toll declined but it did not decline by much, specifically in 1965, illegal abortion still resulted in 17% of maternal deaths. Studies done on low-income women in the 1960s found that almost 80% of abortions were self-induced instead of doctor performed. i.e. the women themselves tried to attempt a self-induced procedure, instead of having it done by a doctor.[192]

These women who opted for illegal abortion procedures, had to bear the consequence of the unsafe procedure, like in 1962, in New York, there was one hospital admission for incomplete abortion for every 42 deliveries at that particular hospital for the year and another public facility in Los Angeles, had one abortion related admission for every 14 deliveries.[193] Further the difference in abortions availed by different races could be seen in New York, in the 1960s when among white women one in four childbirth related deaths was because of abortion, in contrast for non-white and Puerto Rican women, one in two child birth related deaths were because of abortion.[194]

These facts highlight how a public health toll got created by restrictive laws, such that wealthy women could find safe abortion care either by paying or by travelling to places which provided, while those from non-white communities or from poor economic background, faced the brunt of the restrictive law, being forced to avail unsafe procedures.

In *Roe,* (1973), the Supreme Court for the first time recognized a constitutional right to abortion under the Due Process Clause. The Court held that a woman may choose to have an abortion until foetal viability (the point at which the foetus can likely survive outside the womb). The judgment provided for regulation of abortion only from the second trimester, the state could not impose regulations on first trimester and could regulate in second trimester if abortion were contrary to maternal health, and could restrict abortion in third trimester keeping in mind the compelling state interest in the life of the foetus, but restrictions in third trimester had to provide exceptions where

[192] Rachel Benson Gold, Lessons from Before Roe: Will the Past Be Prologue?, 6 Guttmacher Pol'y Rev. 8, 8–11 (2003).
[193] Id. at 8.
[194] Id. at 10.

abortion could be conducted that is when it was necessary to save the life or health of the mother.[195]

The Hyde Amendment, introduced in 1976, restricts federal Medicaid funding for abortion, allowing it only in cases of rape, incest, or life endangerment. This limitation severely hinders access to abortion for low-income women, forcing many to delay care, carry unwanted pregnancies, or sacrifice basic needs. The burden falls especially hard on women of colour and those already facing economic hardship, deepening health and social inequalities.[196]

A report emphasizes that despite abortion being a constitutional right in the United States, policies like the Hyde Amendment have created a system in which that right is functionally inaccessible to large segments of the population. Interviews with affected women illustrate the real-world consequences of this policy: desperation, debt, untreated medical needs, and disrupted life plans. The report concludes that denying public funding for abortion is not only a public health failure but also a violation of human rights and reproductive autonomy.[197]

In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), the Court reaffirmed Roe's core holding (viability line and health exception) but replaced Roe's trimester framework with the undue burden standard. Under Casey, any restriction on pre-viability abortion that has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion is unconstitutional.

Over the decades after Casey, states enacted a variety of restrictions designed to deter or delay abortion. One such restriction being the Weldon amendment, enacted in 2005, allows health care entities to refuse to provide, pay for, or refer for abortion services based on religious or moral objections, threatening the loss of federal funding for states or agencies that discriminate against such refusals. This has been used to block patient access to essential reproductive care, undermine abortion rights, and enable institutions to deny care without regard for patients' health or autonomy. Critics argue it jeopardizes

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[195] Ariana Eunjung Cha & Rachel Roubein, *Fetal Viability Is at the Center of Mississippi Abortion Case. Here's Why.*, Wash. Post (Dec. 1, 2021), https://www.washingtonpost.com/health/2021/12/01/what-is-viability/ (last visited May 16, 2025)
[196] Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women*, at 10–11 (2010), https://reproductiverights.org/wp-content/uploads/2020/12/Hyde_Report_FINAL_nospreads.pdf.
[197] Id. at 16-18.

informed consent, violates ethical medical standards, and facilitates discrimination under the guise of protecting conscience rights.[198]

In the case of Whole Woman's Health v. Hellerstedt, (2016),[199]the Supreme Court held that the two major restrictions put on abortion clinics were provided for no significant health benefits but rather severely restricted the access to abortion. The Court continued with Casey's ruling and held that an undue burden was put on the women's right to abortion since the requirements put on the abortion service centres would put most of these centres out of business, and was not necessary for improving abortion services.

About half of states imposed waiting periods or written consent requirements for adults or minors. Most states also prohibit use of public funds (such as Medicaid) for abortion beyond the narrow *Hyde Amendment* exceptions of life, rape or incest.[200]

In *Dobbs v. Jackson Women's Health Organization*, (2022), the Supreme Court overruled *Roe/Casey* and returned the power to regulate abortion to the states. Dobbs eliminated the national constitutional right, allowing each state to ban or restrict abortion as it chooses.

After *Dobbs* judgment, 13 states have banned abortion, 6 states have provided for early gestational limits that is between 6 to 12 weeks, 4 states have provided for gestational limits that is between 18 and 22 weeks, 19 states have provided for gestational limit near or at viability and 9 states and DC have no gestational limit.[201]

Federal law also includes the federal partial-birth abortion ban (18 U.S.C. § 1531) and Congress long upheld a global Mexico City Policy barring U.S. funding to foreign NGOs that provide or promote abortions. These statutory and regulatory measures, combined with Dobbs, mean that abortion in the U.S. is now the most heavily regulated medical procedure, especially in anti-abortion states.[202]

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[198] Fact Sheet, *The Weldon Amendment: Interfering with Abortion Coverage and Care*, Guttmacher Inst. (July 2021), https://www.guttmacher.org/fact-sheet/weldon-amendment.
[199] 579 U.S. ___ (2016).
[200] Guttmacher Institute, *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion*, Fact Sheet (May 2021), https://www.guttmacher.org/fact-sheet/hyde-amendment.
[201] Kaiser Family Foundation, Key Facts on Abortion in the United States (July 2024), https://www.kff.org/wp-content/uploads/2024/07/Report-KFF-Key-Facts-Abortion-in-U.S..pdf (updated key facts and data on U.S. abortion post-*Dobbs*).
[202] Id.

Facility and provider restrictions have become widespread: many states require abortion clinics to meet standards of ambulatory surgical centres (e.g. minimum corridor widths, door sizes, equipment) and often impose unnecessary hospital-admitting-privilege rules on doctors. These so-called TRAP (Targeted Regulation of Abortion Providers) laws serve no medical safety purpose but greatly increase costs and logistical hurdles. In April 2025, 23 states had at least one major TRAP law in effect (14 states with stringent surgical-centre requirements, 9 requiring hospital-transfer agreements, 6 requiring admitting privileges, etc.).[203]

In the U.S., abortion is generally very safe when performed in clinical settings, with complication rates far lower than childbirth. However, research suggests that restrictive laws have worsened health outcomes. A Tulane study found that U.S. states with more abortion restrictions (higher abortion policy composite scores) had significantly higher maternal mortality rates than permissive states. For instance, requiring abortions be done by physicians (rather than qualified nurse practitioners or midwives) was linked to a 35–51% higher pregnancy-related mortality. Similarly, state restrictions on Medicaid funding of abortion correlated with a 29% higher maternal death rate. Such data indicate that access to safe abortion care is a material factor in preventing maternal deaths.[204]

Restrictive laws can also produce disturbing clinical scenarios. After Roe's overturn, media reports emerged of women rendered brain-dead who were kept on life support solely because state law forbids abortion after a foetal heartbeat. In Georgia, for example, 30-year-old Adriana Smith (nine weeks pregnant) suffered a massive stroke and was declared brain-dead. Under Georgia's, LIFE Act, (a heartbeat-law enacted post-Dobbs), doctors said they could not remove her ventilator because the foetus had a heartbeat, effectively forcing the family to await some foetal development. This case, similar to others in conservative states, underscores how strict bans (often combined

[203] Guttmacher Institute, *Targeted Regulation of Abortion Providers*, State Laws and Policies (as of April 23, 2025), https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers; see also KFF, *U.S. Abortion Policies*, KFF (Feb. 7, 2025), https://www.kff.org/interactive/womens-health-profiles/united-states/abortion-policies/.
[204] Dovile Vilda *et al.*, *Tightening Abortion Restrictions Threatens Maternal Health in the US*, Am. J. Pub. Health (Mar. 2024).

with foetal personhood language) can override patient or family wishes, potentially leading to maternal harm and ethical dilemmas[205]

A proposed legislation in Congress aims to defund Planned Parenthood by cutting its access to public funding sources like Medicaid. Supporters claim that Federally Qualified Health Centres (FQHCs) can absorb Planned Parenthood's patients. However, studies show this is impractical, as only 56% of FQHCs provide contraceptive care to even 10 women annually far below basic standards. In contrast, Planned Parenthood clinics serve an average of 2,640 female contraceptive clients each year, vastly outpacing FQHCs and other providers. Replacing Planned Parenthood with FQHCs is thus deemed politically driven and medically unsound, especially amid additional threats such as Medicaid reductions and the dismantling of the Title X program, which could severely disrupt access to reproductive healthcare for millions of women.[206]

Anti-abortion groups are invoking the Comstock Act to restrict access to abortion pills like mifepristone, arguing that mailing them is illegal. While courts haven't ruled on this, Justices Alito and Thomas showed interest in the argument. Some state attorneys general and local governments are also citing the Act to challenge pharmacy distribution and abortion access, despite legal doubts about their authority. This marks a new strategy to limit abortion via outdated federal law.[207]

In the wake of the Dobbs decision, the U.S. has seen a drastic escalation in abortion restrictions, with over a dozen states imposing outright bans and many others enforcing early gestational limits. These changes, combined with outdated laws like the Comstock Act and facility-targeting TRAP laws, have made abortion the most heavily regulated medical procedure in the country. Such measures have not only increased logistical and

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[205] Associated Press, *Case of brain-dead pregnant woman kept on life support in Georgia raises tricky questions* (May 15, 2025), https://apnews.com/article/pregnant-woman-brain-dead-abortion-ban-georgia-80b463f0f398d5a9c62f8888739025cb (last visited May 21, 2025); see also Tuhin Das Mahapatra, *What is the Georgia abortion law that forced doctors to keep a brain-dead woman alive? Explaining the LIFE Act*, Hindustan Times (May 15, 2025), https://www.hindustantimes.com/world-news/us-news/what-is-the-georgia-abortion-law-that-forced-doctors-to-keep-a-brain-dead-woman-alive-explaining-the-life-act-101747278680978.html (last visited May 21, 2025).

[206] News Release, *Federally Qualified Health Centers Could Not Readily Replace Planned Parenthood*, Guttmacher Inst. (May 13, 2025), https://www.guttmacher.org/news-release/2025/federally-qualified-health-centers-could-not-readily-replace-planned-parenthood.

[207] Mabel Felix, Laurie Sobel & Alina Salganicoff, *The Comstock Act: Implications for Abortion Care Nationwide*, KFF (Apr. 15, 2024), https://www.kff.org/womens-health-policy/issue-brief/the-comstock-act-implications-for-abortion-care-nationwide/.

financial burdens for patients and providers but also worsened maternal health outcomes studies show significantly higher maternal mortality in restrictive states.

Cases like that of a brain-dead woman kept on life support due to foetal heartbeat laws highlight the extreme consequences of these bans. Additionally, efforts to defund Planned Parenthood and shift care to under-equipped FQHCs, along with threats to abortion pill access, further demonstrate how legal restrictions are dismantling critical reproductive healthcare infrastructure, disproportionately harming low-income and marginalized women.

5.3 Legal frameworks on access to safe abortion in India

India's abortion law originated in the context of high maternal mortality from unsafe abortions. Under British-era law (Indian Penal Code, 1860), almost all abortions were criminalized except to save a woman's life. By the 1960s, this legal ban had driven millions of clandestine abortions and attendant maternal deaths, prompting lawmakers to liberalize the law for health and demographic reasons.[208]

The Medical Termination of Pregnancy (MTP) Act, 1971, was thus enacted to permit abortion under specific conditions, chiefly to protect a woman's life and health. Under the 1971 law, a trained medical doctor (RMP) could terminate a pregnancy: (a) on his opinion that continuance would risk the woman's life or cause grave injury to her physical or mental health (the statute explicitly treats pregnancy from rape or from contraception failure as a grave mental health injury); or (b) if there is a substantial risk that the child would be born with serious abnormalities. For these grounds, one doctor's approval sufficed up to 12 weeks' gestation and two doctors' approval up to 20 weeks. After 20 weeks, the law permitted abortion only if necessary to save the woman's life.[209]

Notably, the MTP Act requires the pregnant woman's consent, no third-party consent is needed except that minors or mentally ill women must have a guardian's consent, although the opinion of requisite medical practitioners is required. [210] These provisions aimed to balance women's reproductive rights and safety against social concerns, and

[208] Satvik N. Pai & Krithi S. Chandra, *Medical Termination of Pregnancy Act of India: Treading the Path Between Practical and Ethical Reproductive Justice*, 48(4) Indian J. Cmty. Med. 510 (2023).
[209] Id.
[210] *Everything You Need to Know About Abortion in India*, Issue 3 (Nov. 2019), https://www.fogsi.org/wp-content/uploads/committee-2020-activities/issue-3-consent-november-2019.pdf (last visited May 20, 2025).

they resulted in a substantial expansion of legal abortion services compared to the prior such restrictive regime.

Since 1971, India's abortion law has been amended periodically to broaden access and clarify procedures. A key 2002 amendment decentralized facility approval: district-level committees were empowered to register private clinics for abortion services, increasing the provider base. The 2003 MTP Rules further specified clinic standards and committee oversight. In practice, these changes sought to involve both public and private sectors in service delivery. However, the gestational limits (20 weeks) and two-doctor requirement remained, and the contraception-failure exception technically applied only to married women, reflecting prevailing social norms.[211]

The most transformative change was the 2021 MTP (Amendment) Act. Enacted in March 2021, it expanded the legal grounds and gestational limits for abortion. These changes were lauded by many as a law that increased the ambit and access of women to safe abortions services.[212]

Under the amendment, all women (including unmarried women and survivors of rape or incest) can obtain legal abortion on ground of contraceptive failure. The Act raised the general upper limit to 20 weeks on the opinion of one doctor and to 24 weeks for certain vulnerable groups (such as minors, victims of sexual violence, or women with disabilities) upon the opinion of two doctors. It also provided that for pregnancies with severe foetal abnormalities, the gestation limit does not apply if approved by a medical board. Also, the gestational limit does not apply if the life of the women is in danger. The amendment added a strict confidentiality clause such that now no doctor may reveal a woman's identity to anyone except a person authorised by law under Section 5A of MTP Act.

[211] Medical Update: Medical Termination of Pregnancy (Amendment) Act, 2002 and Medical Termination of Pregnancy Rules 2003, *Ipas Development Foundation* (May 2008), https://www.ipasdevelopmentfoundation.org/archives/resources/medical-update-medical-termination-of-pregnancy-amendment-act-2002-and-medical-termination-of-pregnancy-rules-2003.
[212] India's Amended Law Makes Abortion Safer and More Accessible, *World Health Organization* (Apr. 13, 2021), https://www.who.int/india/news-room/detail/13-04-2021-india-s-amended-law-makes-abortion-safer-and-more-accessible.

The Supreme Court in 2022 further clarified that marital status cannot limit access: it held that all women are entitled to abortion up to 24 weeks under the MTP Act, striking down any marital-status distinction as arbitrary.[213]

Aside from the MTP Act, India's other laws and policies affect abortion access. For example, all ultrasound clinics must register under the Pre-Conception and Pre-Natal Diagnostic Techniques (hereinafter "PCPNDT Act") Act,[214] which prohibits prenatal sex determination; while aimed at preventing gender-selective abortion, it has sometimes had indirect effects like fear of PCPNDT sanctions, on facilities providing obstetric services.[215]

Though at the same time the PCPNDT Act provides that pre-natal diagnosis can be conducted for detecting abnormalities that have been listed under Section 4(2) of the Act.[216] Further the Bombay High Court in the case of Vijay Sharma v. Union of India,[217] held that the PCPNDT Act was not violative of Article 14 of the Constitution,[218] since terminating pregnancies of unwanted pregnancies due to their gender, did not account for grave mental injury to the women, it further stated that the MTP Act provided for termination of pregnancy on ground of mental injury. The Court held that the women seeking abortion on basis of sex selection are different from women seeking abortion on grounds stipulated under the MTP Act, thereby upholding the constitutionality of PCPNDT Act.

Another conflict with MTP Act is the POCSO Act, which has since been resolved by the Supreme Court in *X v. Principal Secretary, Health & Family Welfare Department, 2002*, wherein the Court took note of how the provision of POCSO Act created a barrier for accessing abortion services by minors, and held that the doctors are not required to reveal the identity and personal details of the minor, seeking abortion services under MTP Act, when reporting under POCSO Act. [219]

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[213] Sara Malkani, *Reproductive Rights*, DAWN (Oct. 23, 2022), https://www.dawn.com/news/1716494/reproductive-rights.
[214] Pre-Conception and Pre-Natal Diagnostic Techniques Act, (1994).
[215] Pritam Potdar et al., *"If a woman has even one daughter, I refuse to perform the abortion": Sex determination and safe abortion in India*, 23 Reprod. Health Matters 45, 114–25 (2015).
[216] Pre-Conception and Pre-Natal Diagnostic Techniques Act, (1994), §4(2).
[217] Vijay Sharma & Anr. v. Union of India, AIR 2008 Bom 29.
[218] India Const. art. 14.
[219] Center for Reproductive Rights, *supra* note 138, at 62.

Comprehensive Abortion Care (CAC) guidelines (latest version 2018–2023) have been issued to train providers and ensure quality service delivery at all public facilities.[220]

On the positive side, the government has integrated safe abortion into national health programs. The National Health Mission's (NHM) Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategy explicitly prioritizes abortion services as part of essential reproductive health care. This strategy highlighted the lack of access or use of contraception especially by adolescents, which results in unintended and unplanned pregnancies, and subsequently unsafe abortions and infections. It further highlights that if abortion services were to be given with an increased access to family planning services, the country could save up to 6,500 crores. It further talked about creating adolescent friendly health clinics and provides for creating a comprehensive abortion care service in India.[221]

National Family Health Survey data from 2019 to 2021, reveals that more than 99% of married men and women between the age of 15 to 49 are aware of at least one contraceptive method, and their usage has increased from 47.8% to 56.6%. further the survey revealed that less then 9.5% of men use condom, moreover female sterilisation has risen from 36% to 37.9% but male sterilisation remains at 0.3%. This data reveals the disproportionate burden of contraception that is borne by women.[222]

In practice, access to abortion services in India involves both the public health system and a large private/informal sector. Official policy allows public health facilities (Primary Health Centres and above) to provide abortion services if a certified provider (trained in CAC) is on staff. In principle, abortions are free at government hospitals and clinics. However, rollout has been uneven. Data from major state surveys (2015–2016) found that only a minority of public facilities actually offered abortion: for example, just 3–14% of PHCs and 27–48% of Community Health Centres (CHCs) provided any

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[220] Ministry of Health & Family Welfare, Govt. of India, *Comprehensive Abortion Care: Training and Service Delivery Guidelines* (2d ed. 2018), https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/CAC_Training_and_Service_Delivery_Guideline.pdf; see also Ministry of Health & Family Welfare, Govt. of India, *Abortion Care: Operational Guidelines* (Apr. 2023), https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/CAC_Operational_Guidelines.pdf.

[221] Ministry of Health & Family Welfare, Gov't of India, *A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India* (Jan. 2013), https://nhm.gov.in/images/pdf/programmes/rmncha-strategy.pdf.

[222] Geeta Pandey, NFHS-5: Why Birth Control Remains a Woman's Burden in India, BBC News (June 27, 2022), https://www.bbc.com/news/world-asia-india-61906015.

terminations. In five of six surveyed states, over 75% of abortion-capable facilities were private clinics, with only 12–23% public. Assam was an exception, where the public sector provided most services. Many smaller or rural public centres lack staff or equipment for even first-trimester care, so women often must seek higher-level facilities or turn to private providers.[223]

Private-sector clinics (including NGO clinics) thus shoulder most service delivery. National surveys estimate that roughly two-thirds of abortions in India use medical abortion (mifepristone/misoprostol) outside health facilities. In the six-state study, 63–83% of women's abortions were with medication abortion outside any facility (mostly via chemists or informal vendors). While many obtain good care from trained pharmacists or doctors, evidence shows that a majority of users get pills from community pharmacies with little or no medical guidance, leading to technically unsafe condition. Some women (a small fraction) undergo surgical abortion in private hospital settings or from unauthorized providers. Across sectors, use of outdated methods (D&C) in some facilities indicates quality gaps.[224]

Despite a liberal law, unsafe abortion remains a major problem in India. Estimates in the late 2010s put the annual number of abortions at roughly 15–16 million. Crucially, most of these occur outside formal settings. A 2023 analysis of NFHS-5 data found that in 2015, about 73% of abortions were carried out outside health facilities.[225] Because of this service gap, an estimated two-thirds of abortions were classified as unsafe in 2007–2011.[226] Unsafe abortion is now recognised as the third leading cause of maternal mortality in India. UNFPA reports that about eight Indian women die every day from complications of unsafe abortion.[227]

Where care is obtained, the safety profile is mixed. Among facility-based abortions, the Guttmacher six-state study found that only a minority of hospitals offer second-trimester services up to the legal limit, potentially delaying care. Many facilities comply

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[223] Susheela Singh et al., *Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs*, GUTTMACHER INST. (2018), https://www.guttmacher.org/report/abortion-unintended-pregnancy-six-states-india.
[224] Id.
[225] Manas Ranjan Pradhan & Daisy Saikia, *Patterns and Correlates of Post-Abortion Complications in India*, 23 BMC Women's Health 97 (2023), https://doi.org/10.1186/s12905-023-02254-x.
[226] Esha Roy, *Report: 67% Abortions in India Unsafe, Cause Nearly 8 Deaths Every Day*, Indian Express (Mar. 31, 2022, 11:43 AM), https://indianexpress.com/article/india/india-unintended-pregnancy-abortion-7845655 (last visited May 21, 2025).
[227] United Nations Population Fund, *supra* note 7, at 6.

with WHO best practices (using medication or vacuum methods for first-trimester cases),[228] but others still use blunt curettage or D&E unnecessarily, increasing risk. Post-abortion complication rates also reflect systemic issues: NFHS-5 found about 16% of women reported complications after an induced abortion, with risks rising significantly when the procedure occurred between 9–20 weeks' gestation.[229]

On the other hand, several indicators suggest incremental improvement. As legal access expands (e.g. with the 2021 amendments), more women can seek safe care early. However, socio-cultural barriers and uneven implementation persist. Women's-rights advocates and health workers note that stigma, lack of information, and patriarchal norms still impede access. For example, many rural women live far from approved facilities or are discouraged from seeking care without male permission, despite the law not requiring it.[230]

Overall, India's experience shows that legal reform is necessary but not sufficient. The MTP Act and its amendments provide a relatively liberal framework, and policymakers publicly commit to universal access to safe abortion. Yet practical access depends on effective health system delivery and social change. As of 2025, the formal legal barriers have largely been removed, but large gaps remain in service delivery: especially in rural areas and among marginalized groups. Government and civil-society sources agree that much work lies ahead to translate India's progressive law into truly accessible, high-quality abortion care nationwide

5.4 Legal frameworks on access to safe abortion in Germany

Following reunification in 1990, West Germany's penal-code regime on abortion, the Beratungsregelung or counselling regulation, was extended to all of unified Germany, largely replacing the more liberal East German system. In 1992 the Bundestag enacted the Maternity and Family Welfare Act, which allowed abortions in the first trimester if the woman first obtained a counselling certificate and waited three days.[231]

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[228] Susheela Singh*, supra* note 223, at 93.
[229] Manas Ranjan Pradhan, *supra* note 225, at 93.
[230] Fateh Guram & Aafreen Khan, *In India, Abortion Access Remains a Pipedream for Many*, FairPlanet (Sept. 11, 2022), https://www.fairplanet.org/story/in-india-abortion-access-a-pipedream (last visited May 19, 2025).
[231] *Demonstration Against the Ruling on Paragraph 218* (May 28, 1993), in *German History in Documents and Images*, https://germanhistorydocs.org/en/a-new-germany-1990-2023/ghdi:image-3446 (last visited May 19, 2025)

This Act was immediately challenged: on May 28, 1993, the Federal Constitutional Court (Bundesverfassungsgericht) in *Abortion case II* upheld the counselling compromise as constitutionally permissible, but firmly reaffirmed the Basic Law's protection of unborn life. The Court held that Article 2(2) GG obliges the state to safeguard the life of the unborn as part of human dignity, and struck down any law such as the earlier 1974 proposal, that did not respect this guarantee.[232]

In particular, the Court declared that the general prohibition on abortion must continue and that without adequate protection of foetal life such law would be unconstitutional. At the same time the Court accepted that an abortion on demand till 12 weeks will technically be illegal but would not incur penalty, if preconditioned on certified counselling. In other words, abortions within 12 weeks accompanied by mandatory counselling are unpunished, resulting in a narrow West German compromise often described as the counselling model.[233]

Following the *Schwangerschaftsabbruch II* decision in 1993, Germany amended its abortion law in 1995 to reinforce the protection of unborn life. Under §218 of the *Strafgesetzbuch* (StGB), abortion remains technically illegal and punishable, though §218a creates a narrow exception: if the procedure is performed by a physician within 12 weeks of conception and after mandatory state-approved counselling, it is not penalized. Outside this counselling clause, abortion is allowed only under strict indications, such as medical necessity or rape. These provisions, including a 3-day waiting period after counselling, remain largely unchanged into the 2020s.[234]

Major constitutional rulings have continued to reinforce this framework. Early on, *BVerfG* had already held (1975) that Article 2(2) GG's right to life includes the unborn;

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[232] New German Abortion Law Agreed, BMJ, July 15, 1995, at 149, https://pubmed.ncbi.nlm.nih.gov/7613423/#:~:text=abortions%20performed%20in%20the%20first,included%20a%20clause%20giving%20social; see also 30 Years Ago: Abortion Reform Overturned, *Bundeszentrale für politische Bildung* (May 24, 2023), https://www.bpb.de/kurz-knapp/hintergrund-aktuell/521296/vor-30-jahren-reform-fuer-schwangerschaftsabbrueche-gekippt/#:~:text=Weiter%20hei%C3%9Ft%20es%20allerdings%2C%20dass,und%20Konfliktlage.

[233] 30 Years Ago: Abortion Reform Overturned, *Bundeszentrale für politische Bildung* (May 24, 2023), https://www.bpb.de/kurz-knapp/hintergrund-aktuell/521296/vor-30-jahren-reform-fuer-schwangerschaftsabbrueche-gekippt/#:~:text=Weiter%20hei%C3%9Ft%20es%20allerdings%2C%20dass,und%20Konfliktlage.

[234] Id; see also Hilary Bowman-Smart & Christin Hempeler, *Abortion in Germany - A (Short) Moment of Hope for Decriminalisation?*, BMJ Med. Ethics Blog (Apr. 19, 2025), https://blogs.bmj.com/medical-ethics/2025/04/19/abortion-in-germany-a-short-moment-of-hope-for-decriminalisation/#:~:text=In%20Germany%2C%20there%20has%20also,diagnosis%20of%20a%20fetal%20condition.

the Court struck down a 1974 statute legalizing abortion on demand as incompatible with the Basic Law. In 1993's decision (88 BVerfGE 203), it reaffirmed that any reform must protect the life of the unborn, so that the core prohibition remained, albeit with few exceptions. To date, no German court has recognized abortion as a constitutional right, instead the Courts has consistently allowed the legislature a wide margin so long as unborn life is protected.

In the past three years Germany's abortion law has seen modest liberalization. More recently, the Court has also confronted restrictions on information and advertising. For example, after a long struggle over §219a StGB i.e. the criminal ban on advertising abortions, which had a chilling effect on any advertisement on abortion altogether, such that even those that do not promote abortion but rather only provide necessary information could be made liable. The Court in June 2023 declared a constitutional complaint moot in view of the statute's repeal. The prominent, §219a StGB, a Nazi era ban on advertising abortion was repealed effective July 19, 2022. From that date physicians may openly provide information on services like the method, location, cost, etc., whereas previously even factual webpages were prosecuted. Notably, in earlier related cases doctors won the right to publish purely factual information about abortion methods, narrowing the scope of §219a.[235]

Concurrently, in March 2023 the federal government established an 18-member Commission for reproductions, which in April 2024 delivered its report on abortion and reproductive technologies. The commission report strongly criticized the current regime. It noted that making abortion in early pregnancy formally criminal is not tenable under constitutional and international scrutiny). It specifically recommended removing abortion from the criminal code in the first trimester and legalize it on request and eliminate the mandatory waiting or counselling delays. For later stages, it urged a more flexible cut-off with broader exceptions: for example, extending the rape exception beyond 12 weeks and allowing abortions under certain other

[235] Press Release No. 51/2023, *Constitutional Complaint Against the Ban on Advertising Abortions After the Abolition of Section 219a of the Criminal Code Unsuccessful* (June 7, 2023), https://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/DE/2023/bvg23-051.html, see also *Giessen Doctor Files Constitutional Complaint*, LTO (Feb. 22, 2021), https://www.lto.de/recht/nachrichten/n/bverfg-verfassungsbeschwerde-kristina-haenel-werbung-werbeverbot-abtreibung-schwangerschaftsabbruch-219a-stgb#:~:text=Parallel%20wurde%20%C2%A7%20219a%20StGB,der%20Abtreibung%20enthalten.

circumstances.[236] As of late 2024, however, the ruling coalition collapsed before passing any reforms.[237]

Another recent incidence, is of Joachim Volz, a senior physician at the Protestant Lippstadt Hospital, who performed medically necessary abortions for 13 years. After the hospital merged with the Catholic Trinity Hospital, he was barred from performing abortions both at work and in his private practice due to the Catholic Church's anti-abortion policies. The merger agreement prohibits abortions except when the mother's life is at risk. Volz challenged this ban in labour court, arguing it violates his medical duties and fundamental rights. The hospital defends the ban based on merger agreements and Catholic doctrine. The case highlights tensions between employment law, religious freedom, and reproductive rights in faith-based healthcare.[238]

Under current law, the vast majority of German abortions are provided safely in medical settings. About 96% of terminations fall under the §218a counselling mandate, with the remainder performed for medical or criminal indications. The Federal Statistical Office (Destatis) reported ~104,000 abortions in 2022 and about 106,000 in 2024, roughly 12–13 per 1,000 women of reproductive age (about 62 per 10,000), figures typical of Western Europe. Most procedures are outpatient: according to Destatis, in 2022 about 83% were done in doctors' offices or clinics, 14% in hospital outpatient settings.[239]

In principle, all statutory health insurance plans cover abortions on medical or rape grounds, but not routine first-trimester cases. Under Germany's social law (§24b SGB V), insurers will pay only when a medical indication or offense-indication applies.

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[236] *Experts Recommend Legalising Abortion in Germany, Media Reports Say*, Reuters (Apr. 9, 2024), https://www.reuters.com/world/europe/experts-recommend-legalising-abortion-germany-media-reports-say-2024-04-09/#:~:text=,constitutional%2C%20international%20and%20European%20scrutiny; see also *Recommends Modernization of Abortion Law*, Ctr. for Reprod. Rts. (Apr. 15, 2024), https://reproductiverights.org/german-expert-commission-recommends-modernization-abortion-law/#:~:text=Germany%20and%20make%20recommendations%20for,reform.

[237] Hilary Bowman-Smart & Christin Hempeler, *Abortion in Germany - A (Short) Moment of Hope for Decriminalisation?*, BMJ Med. Ethics Blog (Apr. 19, 2025), https://blogs.bmj.com/medical-ethics/2025/04/19/abortion-in-germany-a-short-moment-of-hope-for-decriminalisation/#:~:text=In%20Germany%2C%20there%20has%20also,diagnosis%20of%20a%20fetal%20condition.

[238] Tanja Podolski, *A Chief Physician Against the Church*, LTO (May 22, 2025), https://www.lto.de/recht/hintergruende/h/arbg-hamm-2ca182-25-chefarzt-volz-klinikum-lippstadt-katholisch-weisung-schwangerschaftsabbruch.

[239] Press Release, Statistisches Bundesamt (Destatis), 9.9% Increase in Abortions in 2022, Press Release No. 120 (Mar. 27, 2023), https://www.destatis.de/DE/Presse/Pressemitteilungen/2023/03/PD23_120_233.html.

Otherwise, the pregnant woman must pay privately. For low-income women, subsidies are available: one may apply (beforehand) to the insurance fund to cover the cost. In practice, therefore, most women pay out of pocket for an early abortion after counselling.[240]

One significant recent innovation is telemedicine: since 2022, medication abortion via remote prescription (with pills sent by mail after a web consultation) has been legalized, expanding access, especially in underserved regions.[241]

Germany's restrictive abortion laws create major financial and practical burdens, especially for vulnerable women. Since abortion is still criminalised, most women must pay €350–600 out of pocket, with limited public coverage and burdensome red tape. Access varies widely by region, and pill-based abortions though preferred are allowed only up to 7 weeks, below WHO's 12-week guideline. Provider shortages, long travel distances, and outdated methods persist, while migrants, refugees, and low-income women face added barriers due to poor outreach and limited translation services. High contraception costs, a wide gender pay gap, and legal deterrents for doctors further restrict care, with few trained professionals and lingering stigma despite the repeal of § 219a.[242]

Provider availability is a growing concern. Media and surveys document a steep decline in abortion providers and regional disparities. From 2003 to 2021 the number of facilities reporting abortions to Destatis fell by roughly 46% (from about 2,050 to 1,092). Today, many gynaecologists are unwilling to offer abortions, due to stigma or conscientious objection, so women in some areas must travel long distances. An independent study concluded that access is much better in northern and eastern states than in more conservative southern and western ones.[243]

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[240] Doctors for Choice Germany, *Unwanted Pregnancy?*, https://doctorsforchoice.de/en/information-2/abortion/unwanted-pregnancy/#:~:text=The%20public%20health%20insurances%20cover,by%20the%20pregnant%20woman%20herself (last visited May 23, 2025).

[241] Martin Lösch et al., *German E-Health Offerings Expand, but Adoption Remains Uneven*, McKinsey & Co. (Dec. 16, 2022), https://www.mckinsey.com/industries/life-sciences/our-insights/german-e-health-offerings-expand-but-adoption-remains-uneven.

[242] Germany's archaic abortion law creates huge burden for people needing care, 27 September 2024, https://europe.ippf.org/stories/germanys-archaic-abortion-law-creates-huge-burden-people-needing-care.

[243] Rona Torenz et al., *Data on Regional Availability and Accessibility of Abortion Providers in Germany*, 2 Res. Health Serv. Reg. 21 (2023), https://doi.org/10.1007/s43999-023-00036-4.

Further with respect to contraception, Germany requires prescription for availing contraception's. Mandatory health insurance covers hormonal contraceptives, emergency contraception, and IUDs for women under the age of 18. For women aged 20 and older, contraceptives are only covered if prescribed for non-contraceptive medical reasons. Doctor visits, including for prescriptions or contraceptive counselling, are free for those under 18 and cost 10 euros per quarter for adults.[244]

Germany's abortion laws remain technically illegal except under narrow exceptions, reflecting a constitutional mandate to protect unborn life. Abortions within 12 weeks after mandatory counselling are unpunished but still criminalized, creating a legal compromise known as the counselling model. Despite this restrictive framework, abortion in Germany is generally safe and predominantly outpatient, with over 95% performed under legal counselling exceptions. Recent reforms have improved access somewhat, including legalized telemedicine abortion since 2022 and repeal of the ban on doctors advertising abortion services (§219a). However, problems persist due to financial burdens, limited insurance coverage, regional provider shortages, mandatory waiting periods, and restrictions on pill use (only up to 7 weeks, less than WHO recommendations). Vulnerable groups face additional barriers, and provider stigma and conscientious objection reduce availability, making access uneven and costly despite the overall medical safety of abortion in Germany.

5.5 Legal frameworks on access to safe abortion in France

France's prohibition on abortion ended with the landmark Veil Law of January 17, 1975. Championed by Health Minister Simone Veil, this law decriminalized abortion up to 10 weeks of pregnancy (12 weeks of amenorrhea) on medical request.[245] It was passed with a five-year pilot period and made permanent by law in late 1979.[246] Initially the Veil law required two medical consultations, a waiting period, and allowed conscience objections; it did not guarantee health-insurance reimbursement for abortions. Subsequent reforms progressively expanded access. In 1982 the state began fully

[244] Center for Reproductive Rights, *Access to Contraceptives in the European Union: Human Rights, Barriers and Good Practices* (Mar. 2012), https://reproductiverights.org/sites/default/files/documents/crr_eu_contraception_factsheet_v2.pdf.
[245] Law No. 75-17 of Jan. 17, 1975, Relating to Voluntary Termination of Pregnancy, *J.O.*, Jan. 18, 1975, p. 739.
[246] Law No. 79-1204 of Dec. 31, 1979, Amending the Law on Voluntary Termination of Pregnancy, *J.O.*, Jan. 1, 1980, p. 3.

covering the costs of abortion care.[247] A 1993 law criminalized any obstruction to abortion access (making such obstruction a offence of obstruction to IVG) and ended the punishment of women who self-induced abortions.[248] In 2001 the legal time limit was extended from 10 to 12 weeks of gestation.[249] Crucially, a 2012 social security financing law mandated 100% coverage of all abortions (surgical or medical) by national insurance.[250]

Over the 2010s, French law was liberalized further. A 2014 equality law removed the requirement that women prove a state of distress, to qualify for abortion, recognizing abortion as an on-demand right.[251] In January 2016 a health-system modernization law authorized midwives to perform medical abortions that is pill based abortion and eliminated the mandatory seven-day reflection period before consent.[252] During the COVID-19 pandemic (2020) emergency orders temporarily allowed all abortion consultations via telemedicine and extended medication abortion by two weeks (from 7 to 9 weeks gestation).[253] Another reform came into force in 2022, when the Parliament raised the gestational limit from 12 to 14 weeks, permitted parts of the procedure (information and consent) via telehealth, and eased rules on medical abortion (allowing teleconsultation and home administration).[254] Taken together, these legal changes have steadily broadened and normalized abortion access in France.

In early 2024 France took the historic step of enshrining abortion rights in its Constitution. In a joint session of Parliament at Versailles on March 4, 2024, deputies and senators approved by 780-72 votes an amendment to Article 34 declaring that "the law determines the conditions under which the freedom guaranteed to women to have

[247] Law No. 82-1172 of Dec. 31, 1982, on the Coverage of Costs Related to Voluntary Termination of Pregnancy Performed in a Hospital, *J.O.*, Jan. 1, 1983, p. 398.
[248] Law No. 93-121 of Jan. 27, 1993, Containing Various Social Provisions, *J.O.*, Jan. 28, 1993, p. 1487.
[249] Law No. 2001-588 of July 4, 2001, on Voluntary Termination of Pregnancy and Contraception, *J.O.*, July 7, 2001, p. 11123.
[250] Law No. 2012-1404 of Dec. 17, 2012, on the Financing of Social Security for 2013, art. 56, *J.O.*, Dec. 18, 2012, p. 20367.
[251] Law No. 2014-873 of Aug. 4, 2014, for Real Equality Between Women and Men, *J.O.*, Aug. 5, 2014, p. 12949.
[252] Law No. 2016-41 of Jan. 26, 2016, on the Modernization of the Health System, *J.O.*, Jan. 27, 2016, p. 1301.
[253] Decree No. 2020-314 of Mar. 25, 2020, on the Conditions for Access to Medical Abortion in Community Settings, *J.O.*, Mar. 26, 2020, p. 5966.
[254] Law No. 2022-295 of Mar. 2, 2022, Strengthening the Right to Abortion, *J.O.*, Mar. 3, 2022, p. 4327.

recourse to voluntary termination of pregnancy is exercised".[255] This amendment, signed by President Macron on March 8 (International Women's Day) 2024, made France the first country to explicitly guarantee abortion access in its constitution. The overwhelming vote reflected broad public support (around 85% according to polls). President Macron described the reform as a signal to all women that their body belonged to only them.[256] In practice, the constitutional change cements decades of statutory protections: it does not itself alter existing abortion law but prevents future governments from rescinding it without another constitutional vote.[257] Notably, the law left intact France's clause on medical conscience, meaning providers may still decline to perform abortions on personal grounds.

These legal rights are implemented through France's public health system. Abortion care is integrated into standard medical services: whether by surgical procedure or medication, abortions are provided in hospitals, clinics or authorized outpatient settings. Critically, all abortions and related services are fully covered by France's national health insurance. A 2012 financing law mandated 100% reimbursement for IVG, and today patients pay nothing out of pocket for abortion (nor for the required pre- and post-abortion consultations, ultrasounds, or tests).[258] Counselling and information are routinely offered: women receive written guidance on methods and risks, and an optional (mandatory for minors) psychosocial interview is provided in a family planning or social service setting.[259] By law, the doctor or midwife must ensure informed consent.

The pool of authorized providers has also grown. In addition to gynaecologists and obstetricians, general practitioners and midwives regularly perform medication abortions, up to 14 weeks in total. Since 2016 trained midwives may perform medical abortions and through pilot programs, even surgical abortions in health facilities.[260]

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[255] Abortion Rights in the Constitution, *IVG.gouv.fr* (July 31, 2024), https://ivg.gouv.fr/livg-dans-la-constitution; see also Eleanor Beardsley, *France Makes History by Enshrining Abortion Rights in Its Constitution*, NPR (Mar. 4, 2024), https://www.npr.org/2024/03/04/1235217454/france-abortion-rights-constitution.
[256] George Wright, *France Makes Abortion a Constitutional Right*, BBC News (Mar. 4, 2024), https://www.bbc.com/news/world-europe-68471568 (last visited May 16, 2025).
[257] Abortion Rights in the Constitution, *IVG.gouv.fr* (July 31, 2024).
[258] Id.
[259] Id.; see also Directorate for Legal and Administrative Information (Prime Minister), *Voluntary Termination of Pregnancy (IVG)*, SERVICE-PUBLIC.FR (Apr. 25, 2024), https://www.service-public.fr/particuliers/vosdroits/F1551?lang=en#:~:text=,or%20in%20an%20approved%20organization.
[260] Id

During the pandemic authorities officially allowed general practitioners to provide abortion pills and pharmacies to dispense them after tele-consultation. Specialty clinics (centres IVG or family planning clinics) and hospital obstetrics/gynaecology departments follow national clinical protocol, that specify standards of care (e.g. pre-IVG ultrasound) and emphasize patient confidentiality. Non-medical barriers are forbidden, that is any obstruction of access, even dissuasive counselling by unqualified individuals, is punishable under French law.[261] Public information campaigns, and subsidized contraception programs complement these policies, helping ensure that women can access abortion services safely and without stigma.

In 2022 a total of 234,300 abortions were recorded, about 17,000 more than in 2021 and preliminary data for 2023 show a further rise.[262] By contrast, in the mid-2010s France averaged roughly 200,000 abortions per year.[263] The increase in 2022 cannot be explained by the two-week extension alone,[264] indicating broad and sustained demand. Importantly, these abortions occur in a fully medicalized context. According to the WHO, any abortion performed by a trained provider with recommended methods is deemed safe.[265]

In France's system with licensed physicians or midwives overseeing the procedure and follow-up abortion-related complications are extremely rare. In fact, national reports register virtually zero maternal deaths from legal abortion (most recent analyses find no direct abortion fatalities in France).[266] Though the French system provides for one of the best abortion services, it allows doctor to refuse abortion service on the ground of conscience clause, that is on religious grounds, and it has not been sufficiently been

[261] Id.
[262] Annick Vilain, with Jeanne Fresson, *The Number of Voluntary Terminations of Pregnancy Increases in 2022*, No. 1281, STUDIES AND RESULTS, DREES (Sept. 27, 2023), https://drees.solidarites-sante.gouv.fr/publications-communique-de-presse/etudes-et-resultats/le-nombre-des-interruptions-volontaires-de#:~:text=En%202022%2C%20234%20300%20interruptions,la%20prise%20en%20charge%20de.
[263] INED, *Abortions: Evolution of the Number of Abortions and Annual Indices Since 1976, Metropolitan France*, https://www.ined.fr/fr/tout-savoir-population/chiffres/france/avortements-contraception/avortements/#:~:text=2017%20%C2%A0%20204%20000%20%C2%A0,223%20260%20%C2%A0%2034%2C9%200%2C55.
[264] Annick Vilain, *s upra* note 262.
[265] Hillary Margolis, *France Expands Abortion Access in Two Key Moves*, HUM. RTS. WATCH (Mar. 1, 2022), https://www.hrw.org/news/2022/03/01/france-expands-abortion-access-two-key-moves#:~:text=Medication%20abortions%20are%20a%20safe,The%20bill%20also.
[266] Eleanor Beardsley, *France Makes History by Enshrining Abortion Rights in Its Constitution*, NPR (Mar. 4, 2024), https://www.npr.org/2024/03/04/1235217454/france-abortion-rights-constitution#:~:text=,they%20tried%20aborting%20at%20home.

provided in law such that it does not become a barrier to accessing abortion care in the future.[267] The legal and health framework thus ensures that nearly all French women's abortions are safe: maternal health outcomes are excellent and consistent with global standards for comprehensive reproductive care.

5.6 Conclusion

The legal and policy landscapes of France, Germany, the United States, and India demonstrate how specific regulatory choices shape abortion access, safety, and reproductive autonomy, both in law and practice.

Access to contraception plays a foundational role in reducing unintended pregnancies and, by extension, the demand for abortion. France and Germany offer broad, publicly funded access to modern contraceptive methods through national health systems, ensuring coverage for all women, including adolescents. In contrast, the United States and India face persistent barriers. In the U.S., federal restrictions such as the Hyde Amendment and state-level attacks on Planned Parenthood severely curtail access for low-income women. In India, while contraception is technically available through public programs, poor rural infrastructure, lack of awareness, and provider bias often limit practical access. As a result, both countries report higher rates of unintended pregnancies than their European counterparts.

Legal clarity and protection are also crucial. France now offers the strongest protection by constitutionalizing the right to abortion in 2024, ensuring that future rollbacks are unlikely. Germany, though retaining abortion's formal criminality under §218 StGB, decriminalizes procedures following mandatory counselling, creating a relatively stable and rights-aware model. The U.S., post-Dobbs, has no national protection, resulting in a patchwork of highly divergent state laws including total bans. India has liberal statutory provisions, especially after the 2021 amendment to the MTP Act, but lacks constitutional or enforceable rights language, leaving implementation to bureaucratic discretion.

Health system integration and safety vary widely. France and Germany integrate abortion care into routine public healthcare, with most procedures performed in outpatient settings by trained providers. Medical abortion and telemedicine options are

[267] Id.

broadly available, contributing to high safety and low complication rates. By contrast, abortion access in the U.S. is fragmented, often limited to specialized clinics targeted by TRAP laws, and undermined by facility closures. India's public health system performs safe abortions in urban areas, but lack of certified providers in rural regions contributes to a continued burden of unsafe abortions, especially among vulnerable populations.

Equity and financial access further distinguish outcomes. In France and Germany, abortion is fully or mostly covered by public insurance, ensuring financial barriers are minimal. In the U.S., lack of insurance coverage due to Hyde and state laws forces many women to pay out of pocket, delay care, or travel long distances. India's public facilities are meant to provide free abortions, but hidden costs, lack of supplies, and provider shortages frequently force women to turn to unsafe, informal sources.

Impact on maternal health and rights is most visible in outcomes. France and Germany report excellent maternal health indicators and negligible deaths from abortion. In India, unsafe abortions remain a leading cause of maternal mortality despite liberal laws, while in the U.S., research confirms higher maternal death rates in states with abortion restrictions. Extreme legal consequences have emerged: in Georgia, a brain-dead woman was kept on life support because of a heartbeat law. These stark outcomes reveal how legal restrictions can lead not just to denial of services but to ethical and humanitarian crises.

In conclusion, France and Germany exemplify how supportive legal frameworks, public funding, and system integration can ensure abortion is safe, accessible, and equitable. The United States, in contrast, shows how restrictive laws, defunding, and fragmented systems lead to unsafe conditions, inequity, and poor health outcomes. India, though liberal in law, struggles with implementation and rural access, highlighting the need for systemic investment. This comparative evidence confirms that abortion access is best protected where laws enshrine rights, services are publicly funded, and health systems support rather than stigmatize reproductive care.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

The comparative study underscores an enduring tension between state interests and reproductive autonomy. Governments often invoke legitimate aims, in protecting maternal health and potential life but international authorities stress that overly restrictive laws imperil women's lives. For instance, the WHO emphasizes that unsafe abortion is preventable and would ensure much less maternal deaths and that lack of safe abortion service and efficient abortion care is an important public health and human rights issue. In practice, jurisdictions strike different balances. In France and the U.S., broad constitutional or statutory privacy norms have historically allowed abortion on request up to the first trimester (subject to some safeguards), reflecting higher weight on autonomy. Germany's Basic Law, by contrast, has been interpreted to extend a formal right to life to the unborn, so abortion is legal only under narrow indications (such as risk to the mother or rape). India's MTP Act likewise focuses on women's health and expressly denies any foetal rights. In sum, while some systems (e.g. Germany) constitutionally recognize foetal interests, most international charters provide that rights apply after birth and not before. This diversity reflects deep political and moral cleavages, but a common lesson is that amplifying women's autonomy as seen in post-Roe reforms in France and Germany tends to improve public health without true human rights loss.

The legal status of the foetus varies sharply. Germany's Federal Constitutional Court famously held that Article 2(2) of the Basic Law (right to life), must extend to the life of the unborn, obligating the state to protect prenatal life. By contrast, India's law explicitly provides no legal personality or rights to the foetus, focusing solely on safeguarding the pregnant woman's health. The U.S. Supreme Court (prior to 2022) linked foetal protection to viability, allowing states to regulate post-viability abortion (though not to impose an undue burden) again a form of partial personhood. France historically has had no separate foetal rights outside those recognized at birth; notably, in 2024 France became the first country to constitutionally guarantee abortion as a guaranteed freedom (enshrining in law what was already the broadest legal access in Europe). Thus, the comparative record is one of uneven foetal protection: some laws prioritize prenatal life (often at the cost of restrictive access), while others subordinate the foetus entirely to maternal health.

Protection of minors' reproductive rights also differs. France allows any girl under 18 to obtain an abortion without parental consent, subject to a required counselling session and the option of an accompanying adult, with full confidentiality from parents. The law explicitly permits a minor to maintain confidentiality by refusing parental involvement, and mandates that she be assisted by a chosen adult if she proceeds without parental consent. Germany likewise permits minors to access abortion (usually with parental consent, if possible, but with statutory flexibility). In the U.S., about 36 states impose parental involvement laws either consent or notification though almost all allow judicial bypass for mature minors. India's MTP Act requires a guardian's consent for a minor's abortion, reflecting a protectionist stance. However, Indian courts have noted this can conflict with adolescents' rights; indeed, guidelines have had to clarify that doctors need not report an abortion to criminal authorities if a minor requests confidentiality under the MTP framework. In practice, these variances mean French and German teens face fewer legal barriers than many in the U.S. or India. A recurring theme is that confidential and autonomous access improves outcomes: jurisdictions that protect a minor's privacy (France, Canada, the UK) see higher use of safe services, whereas onerous parental requirements (many U.S. states, combined with poor sexual health education) can drive teens to unsafe or unregulated abortions.

Finally, the impact of each country's legal framework on safe abortion access is clear from the data and recent history. In France and Germany, where abortion is legal on broad grounds (up to 14 and 12 weeks respectively) and integrated into public health systems, the vast majority of abortions are performed safely by qualified providers. Both countries show relatively low rates of abortion-related morbidity; for example, robust national health coverage and easy clinic access keep complications rare. The U.S. situation is more mixed: before 2022 many states had legal access but others had heavy restrictions; after Dobbs, a patchwork of bans and limits has emerged, forcing patients to travel long distances or manage abortions by telehealth where allowed. Evidence suggests this has already led to increased delays and self-managed abortions. In India, despite the long-standing MTP Act, a majority of abortions have historically been done outside the formal sector: one study found 67% of abortions in India were unsafe in 2007–11, contributing to preventable maternal deaths. The barriers are partly infrastructural: too few trained providers in rural areas, and outdated legal ceilings (though the 2021 amendment extended the gestational limit to 24 weeks for certain

categories). Overall, the comparison shows that liberal legal frameworks plus health investment yield safer access. As WHO notes, expanding modern contraception and removing barriers to safe abortion bring substantial monetary savings by reducing unintended pregnancies and unsafe procedures. Conversely, restrictive laws correlate with more clandestine abortions and worse health outcomes, as seen in the U.S. and India. In summary, Chapters 2–5 demonstrate that where law respects autonomy (often through broad statutory allowances and supportive services), access is highest and harm lowest; where law emphasizes foetal protection or imposes gatekeeping (parental or spousal consent, mandatory counselling, or criminal penalties), meaningful access shrinks and unsafe practices rise.

6.2 Recommendations

In light of these findings, the following evidence-based recommendations are proposed, drawing on best practices from France, Germany, the U.S., and India:

Comprehensive Sex Education

- Implement age-appropriate, inclusive Comprehensive Sex Education in schools. Curricula should cover contraception, consent, reproductive rights, and gender or power dynamics, as recommended by UNESCO. France and Germany have long provided mandatory sex education from early grades. Studies show comprehensive sex education, that explicitly addresses gender and decision-making, makes unintended pregnancies far less likely to happen. In practice, Central and State governments should mandate comprehensive sex education nationwide, train teachers (as Germany and France do), and involve community leaders to overcome taboos.
- Comprehensive sex education should ensure factual, non-biased content. Programs must be medically accurate and culturally sensitive, that is involving parents and adolescents in the design. Studies have indicated that high-quality comprehensive sex education leads to higher contraceptive use, and lesser unintended pregnancies. U.S. and India can learn from Europe: e.g. France provides confidential counselling and comprehensive information on reproductive rights, and Germany's trainings stress respect and gender equality. Policymakers should fund ongoing monitoring to keep comprehensive sex education relevant and effective.

Contraceptive Availability and Public Health Integration

- Guarantee free or subsidized contraception. All countries should expand family planning services. France's program provides free contraception for young women and uninsured persons in their family planning centres. Further, Germany's provides contraception to all women under the age of 18 under the mandatory health insurance scheme. The WHO observes that contraception ensures lesser rate of unintended pregnancies and any resultant abortions due to such pregnancies.
- India's public health system already distributes free condoms and pills, which can be seen through the recent National Family Health Survey, that states that contraceptive usage has increased to 56.5% but it also points out the disproportionate burden put on women with respect to contraception, with an increase in female sterilisation as opposed to unchanged male sterilisation which remains low. Thus, India should ensure better contraception availability and provide better access to minors, like France and Germany. Further India should also focus their contraception awareness drives on men to ensure that the burden of contraception does not solely lie on one gender.
- Link contraception to maternal health services. Abortion care should be integrated into public health clinics and primary care. India's National Family Planning program and France's maternity clinics (PMIs) offer such services in their clinics, though while in France such services are of impeccable standards on the contrary in India such services are insufficient. Health systems should routinely offer counselling on emergency contraception and modern methods whenever abortion or antenatal care occurs. This integrated approach, adopted widely like in Title X in the U.S., aligns with WHO guidance that family planning is a key element of reproductive health. Monitoring use (e.g. by public health surveys) can identify gaps (as WHO notes, 257 million women have unmet need) and help target interventions (mobile clinics, outreach in rural India, etc.).

Confidentiality and Minor's Access

- Enshrine confidentiality for adolescents. Laws should explicitly allow minors to seek abortion and contraception without parental notification, mirroring

France's model. For example, France permits a non-emancipated minor to go through an abortion procedure with abortion kept from parents, by being accompanied by an adult. India needs similar reforms. In case of clash of the POCSO Act with the MTP Act many minors have been deterred from seeking legal care, despite clear standards laid down by Supreme Court and government guidelines on keeping identity of such minors confidential. Lawmakers should follow recent Indian court directions that doctors should not report a minor's consensual abortion in order to protect her privacy. Enabling anonymous or accompaniment by a trusted adult, will reduce delays and make the process more accessible to many minors.

- Harmonize any issues arising out of conflict of laws. Legislative action should resolve tensions between protective laws. For instance, India could amend POCSO to exempt consensual adolescent abortion from mandatory rape reporting, eliminating the fear of prosecution noted by health advocates, or conduct training of authorities and law enforcement agents to ensure that they are aware of the law and do not impose additional restrictions then what has been stipulated under the MTP Act. In short, confidentiality must be the default, with legal safeguards against undue disclosure (in legislation and professional codes).

Healthcare Infrastructure and Access

- Increase provider networks and telehealth. Safe abortion must be included in universal health coverage. Governments should ensure a sufficient number of trained providers in every region: Germany's public health system used to support many abortion providers, and France guarantees a clinic in each region. India should further train mid-level providers, as allowed under new MTP guidelines and eliminate any requirement that only doctors can provide first-trimester abortions. Telemedicine is a proven method, now used in parts of the U.S., France, and Germany. Telemedicine should be explicitly authorized for medical abortion, expanding access especially in remote areas. WHO recommends that abortion care should be delivered through variety of approaches including but not limited to health facilities, digital intervention and self-care. India could incorporate such e-health initiatives to make access to abortion easier.

- Strengthen post-abortion care. Clinics should routinely offer follow-up and contraception, preventing repeat unintended pregnancy. France's law requires a second consultation focusing on contraception for minors and offers it to adults. Germany's system similarly emphasizes post-abortion support. Public health programs such as India's Health and Wellness Centres, should integrate post-abortion family planning and counselling as standard. Governments can also monitor abortion outcomes via health information systems, or conduct studies to continually assess where access is insufficient.
- Cost effective abortion services: One of the most crucial cost-related recommendations emerging from this comparative study is that abortion services must be entirely free or fully subsidized to ensure equitable access, something that France and Germany have effectively implemented. France offers 100% reimbursement for abortion services, including consultations, medications, procedures, and follow-up care, under its national health system, even for minors and undocumented individuals. This approach eliminates financial barriers and affirms reproductive autonomy as a public health commitment.

  Germany similarly covers the cost of abortion for low-income women following mandatory counselling, with subsidies from federal states ensuring no woman is denied access due to inability to pay.
  In stark contrast, the United States exemplifies how cost barriers can deepen inequality. The Hyde Amendment, by banning federal Medicaid funds for most abortions, forces low-income women, particularly women of colour, to either delay care, seek unsafe alternatives, or carry unwanted pregnancies. This has directly contributed to worsening health outcomes, especially in states with no alternative coverage.

  India, despite its relatively progressive statutory regime under the MTP (Amendment) Act, 2021, still faces implementation challenges: women routinely pay out-of-pocket costs even in public facilities, and rural and marginalized populations suffer the most. To address this, India should adopt a France-style model, explicitly mandating free abortion services under national

health insurance schemes like Ayushman Bharat, including at private empanelled facilities where public infrastructure is inadequate. Specific categories such as minors, adolescents, and rape survivors must be guaranteed cost-free care through streamlined processes. This recommendation aligns with WHO guidelines and is supported by global research showing that even minimal costs can deter timely access to abortion. India must avoid the American model of defunding and instead embrace public financing as a core pillar of reproductive justice.

Legal and Judicial Reforms

- Decriminalize abortion and remove unjustified barriers. In line with WHO's abortion-care guidelines, countries should eliminate punitive provisions and excessive restrictions. For example, laws should remove mandatory waiting periods, third-party approvals, or spousal consent (following the U.S. experience prior to Dobbs where spousal involvement was struck down in Casey as an undue burden). In India, this would mean amending the BNS (sections 88–92) to decriminalize abortion outright, not merely carve out exceptions via the MTP Act. Many nations now permit abortion on request; India might consider allowing abortion simply on request up to a reasonable gestational limit. In practice, France's 2024 amendment to constitutionally guarantee abortion was a bold legal reform; Germany's 1995 law excluded criminal penalties till a certain period, while respecting foetal rights; and several U.S. states have repealed waiting periods. India should study these models and ensure its courts continue to interpret the MTPA liberally (as in X v NCT Delhi, 2022).
- Educate and protect providers. Legal reform must include respect for providers. As WHO notes, health workers who provide abortions need protection from stigma and clear conscience guidelines. Laws should require trained objecting doctors to refer patients promptly (France and Germany oblige referrals) and should not allow refusal without referral. India's 2021 rules already allow mid-level practitioners to provide medical abortion; more broadly, medical education curricula should include abortion care. Judicially, courts should expedite appeals and clarify legal standards like when a minor or rape victim requires an

abortion. For example, just as some High Courts in India now permit girls to abort without further penalty, legislatures should codify these protections.

It is imperative to educate medical professionals to ensure that unnecessary requirements are not seemed from the women availing abortion services as creating additional requirements including but not limited to asking for consent of spouse or family in the case of an adult women, goes beyond the MTP Act and creates a barrier for women seeking abortion services.

Right to make Reproductive Choice as a Constitutional Right

India, while having a more progressive statutory framework in the Medical Termination of Pregnancy (Amendment) Act, 2021, still fails to deliver free and equitable access in practice. Right to make reproductive choice if recognised as a constitutional right under the Indian constitution, would put forth a greater obligation on the state and the authorities to provide better abortion care services and subsequently the rate of unsafe abortion will reduce.

If right to make reproductive choice, is to be included as a fundamental right explicitly, it would provide better protection to the reproductive right of women and ensure that the State is restricted not only on infringing on this right but also has a duty to ensure that the same is not being violated by any other authority or person.

This is both feasible under current law and desirable in terms of long-term stability. The Supreme Court has already laid important groundwork, in Suchita Srivastava v. Chandigarh Administration (2009) it recognized that a women's right to make reproductive choice is part of personal liberty under Article 21. Further, in K.S. Puttaswamy v. Union of India (2017), a nine-judge bench affirmed that the decision of women whether to continue or terminate her pregnancy is an important part of personhood which is protected by the right to privacy. Chief Justice Chandrachud in Puttaswamy, explicitly described reproductive autonomy as part of the constitutional guarantee of dignity and self-determination. Moreover, Article 14's guarantee of equality and Article 15's[268] ban on sex discrimination provides strong support, since

[268] India Const. art. 15.

limiting abortion access almost always burdens women disproportionately, so laws restricting abortion can be seen as impermissibly unequal.

Studies of abortion provision in India have shown that even in government facilities some physicians refuse to perform legally permissible abortions or impose extra-statutory hurdles, for example, demanding spousal consent, despite no such requirements in the MTP Act. Were abortion an explicit fundamental right, any government doctor who denies or delays a service to which a woman is entitled would be actionable for negligence in duty, and the State would be vicariously liable under the doctrine of respondent superior, forcing institutions to adhere strictly to statutory criteria and preventing ad hoc misinterpretations.

The UN Committee under CEDAW, on the Elimination of Discrimination against Women provides that those States that are parties to the Convention should take all necessary steps to ensure that women are able to have access to safe abortion service and to ensure that women are not subject to unsafe abortions. Enshrining the right to abortion as a fundamental right for instance, by amendment to Article 21 (right to life and personal liberty) or via an interpretive declaration would mean that any law, policy, or executive action infringing this right would be subject to the strictest judicial scrutiny.

Constitutionalising abortion would not render it an unfettered liberty. Like other rights under Article 21, it would remain subject to reasonable restrictions so long as those restrictions are narrowly tailored and serve a compelling state interest. India already applies a form of strict scrutiny in this domain: as reaffirmed in Suchita Srivastava v. Chandigarh Administration,115 and under the MTP Act's framework,116 a woman's autonomy is paramount before 24 weeks, while post-24 weeks terminations are permitted only in exceptional circumstances. Elevating abortion to a constitutional right would thus make it substantially harder for future majorities to erode access in the way that occurred in the United States, by requiring any new curbs to survive exacting judicial review.

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APPENDIX

Neha Shajan

COMPARATIVE ANALYSIS OF ABORTION LAWS

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