http://www.ijwhr.net

doi 10.15296/ijwhr.2026.9091

Open Access Original Article

IJWHR

International Journal of Women's Health and Reproduction Sciences
Vol. 14, No. 1, January 2026, 17–28

ISSN 2330-4456

Reproductive Rights in Transition: Legal Frameworks, Judicial Trends, and Public Health Impacts in India, France, and the United States

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Abstract

Objectives: The reproductive rights debate in India, France and the United States points to how constitutionally protected rights, judicial reasoning, and health systems inform access to safe abortion. The Medical Termination of Pregnancy (MTP) Act, 1971 in India has come a long way, but issues persist. Whereas France has continued to broaden the right to abortions, and recently even constitutionalised it, and on the other hand, the U.S. has moved in the opposite direction after the Dobbs v. Jackson case, which reversed Roe v. Wade.

Materials and Methods: Aggregate data on abortion rates and indicators of maternal health status were collected from identified sources. Secondary data were thoroughly analysed to identify trends in abortion and maternal health outcomes in all three jurisdictions. The analysis produced time-trend graphics and descriptive visual charts to illustrate the evolution of the abortion rate.

Results: France exhibits a steady progress in perinatal health outcomes along with a firm, and permissive legislation on abortion with significant post-legalisation reductions in abortion-related maternal mortality. The U.S. experiences sharp oscillations associated with the prohibitive policy changes, especially after Dobbs case, including post-Dobbs case service disruptions and earlier evidence of mortality reduction under Roe v. Wade case. While India shows progressive legal reforms but the health outcomes are mixed showing long-term maternal mortality ratio (MMR) decline, slowed progress post-2015, and pandemic-related maternal care disruption.

Conclusions: Firm rights-based legal environments as is the case in France are linked to better health outcomes, while more restrictive contexts have been shown to reduce access and increase risks to health. Rights-based abortion laws are associated with lower abortion-related maternal mortality, while restrictive regimes show poorer outcomes.

Keywords: Abortion policy, Body autonomy, Constitutional rights, Legislative trends, Reproductive justice

Introduction

The acceptance of the reproductive rights idea is one of the most significant gains in worldwide efforts to uphold human dignity and gender equality. Grounded in the broader rubric of human rights, these rights recognise that all people, irrespective of their gender, have the personal choice to decide freely and responsibly on matters concerning their reproductive control. It was codified at the 1968 United Nations International Conference on Human Rights (1). This pronouncement formed the basis for subsequent developments in international law and policy regarding reproductive autonomy.

The World Health Organisation (WHO) went on to elucidate this perspective by including under the broad rubric of reproductive rights "the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children as well as the right to adequate information and means to do so" (2). It also involves the right to access the best sexual and reproductive health care services, and make free choices about reproduction without suffering discrimination, coercion or violence. Rather than reiterating settled normative definitions, this study examines how reproductive rights are operationalised through law, adjudication, and health systems.

However, the exercise of these rights remains a subject of significant dispute. Reproductive autonomy debates remain simmering in social discourse, across different faith and culture. Disputes over abortion, contraception, sterilisation and sex education for women reveal the enduring conflict between traditional moral norms and modern evolving assertions of individual freedom, rights and bodily autonomy.

Reproductive rights encompass multiple dimensions. These rights include the right to legal and safe abortion, reproductive freedom and the right to make reproductive decisions free from coercion or discrimination (3). These rights converge to protect bodily autonomy and gender equality, providing the foundation for social justice in modern culture.

Received 8 November 2025, **Accepted** 7 January 2026, **Available online** 28 January 2026

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Key Messages

- Access to safe abortion depends on legal rights, judicial interpretation, and health system support.
- Strong, rights-based laws, like in France, lead to better maternal and perinatal health outcomes.
- Restrictive policies in U.S. post-Dobbs policies reduce access and increase health risks; India shows legal progress but uneven health outcomes.

Reproductive rights have been further strengthened through a series of international human rights treaties and global consensus documents. The Vienna Declaration and Programme of Action (1993), Programme of Action of the International Conference on Population and Development (ICPD, 1994) (4) and Beijing Platform for Action established by the Fourth World Conference on Women (FWCW, 1995) (5) altogether brought forward a concept where gender equality and women's empowerment are crucial in achieving sustainable development as well as justice. These international treaties commit states to revising laws and policies that discriminate between men and women, thereby advancing equality for both men and women in all walks of life. These instruments collectively impose affirmative obligations on states to align reproductive health laws with access, equity, and public health objectives.

The realm of social change in this respect is obviously dynamic and complex. India, France, and the United States illustrate three divergent legal trajectories—statutory reform, constitutional entrenchment, and judicial retrenchment—within democratic constitutional systems.

Material and Methods

This study employed a blended design comprising both doctrinal and non-doctrinal approaches. The article is based on legal provisions, case laws, and policy perceptions regarding "abortion". It utilises a secondary data analysis approach, drawing exclusively on pre-existing datasets collected by reputable institutions and organizations. These are based on the most recent comprehensive national health and demographic surveys, government statistical databases and specialised research institutions, namely, for abortion-related data and maternal health indicators from the Centers for Disease Control and Prevention (CDC) and Guttmacher Institute (U.S.), National Family Health Survey (NFHS) (India), and the WHO European Health Information Gateway (France). The selected data sources have complementary strengths. In the U.S., CDC surveillance data offer updated and detailed demographic analyses of abortion, whereas Guttmacher data provide more comprehensive national estimates through facility-level surveys. In the case of India, NFHS data serve as a government-recommended representative source of fertility and pregnancy-related data, measured in a consistent manner. In the case of France, annually standardised data on maternal mortality gathered at a national level and made available through a regional health platform provide a proper source for longitudinal analysis. These series cover long time periods from around 1970 to 2020 and can therefore also be used for a robust comparison across countries. The choice to employ secondary data enables the study to leverage large-scale, systematically collected information, which enhances the generalisability and reliability of findings, while also economising on time and resources that would be required for primary data collection.

The collected secondary data were thoroughly examined to discern patterns and impacts of abortion policies over time. Statistical analyses are used to investigate temporal trends and policy effects, and important variables are illustrated through figures and time trend graphs. These visual tools effectively illustrate changes in abortion rates, maternal mortality, and the legal frameworks surrounding abortion across different jurisdictions and historical periods. This study utilises these mapped trends to investigate the policy changes (legislative liberalisations or restrictions) and their observed health outcomes. This methodological approach provides a clear and empirical basis to assess how shifts in abortion law and accessibility influence broader public health indicators, enabling a nuanced understanding of the interplay between legislation and maternal health over several decades.

Furthermore, this study employed interrupted time series (ITS) analysis using segmented regression, where the policy intervention dummy creates the statistical interruption by comparing pre- and post-policy trends in maternal deaths from abortion (1970–2020) (6).

Where:

$$Yt = \beta_0 + \beta_1 Timet + \beta_2 Act_t + \varepsilon_t$$

Yt = maternal deaths from abortion in year t (1970–2020)

β_0 = baseline intercept

β_1 = Time trend, capturing the natural progression of cases over time

β_2 = immediate level change attributable to policy (primary effect of interest)

Act_t = binary indicator (0 = pre-Act, 1 = post-Act)

ε_t = error term

Specific model implementations:

U.S. – Roe v. Wade (1973): Roe_t = (1970–1972), Roe_t =1 (1973–2020)

U.S. – Planned Parenthood v. Casey (1992): $Casey_t$ = 0 (1970–1991), $Casey_t$ =1 (1992–2020)

France – Veil Act (1975): $Veil_t$ = 0 (1970–1974), $Veil_t$ =1 (1975–2020)

Results

The Rise, Fall, and Fragmentation of Abortion Rights in the United States of America: A Legal and Public Health Timeline

Abortion in the United States has been a battle fought for many years now through moral, medical, and legal

arguments. Moreover, before the 1820s, abortion was not illegal and not broadly a topic of conversation, reflecting entrenched patriarchal norms that reduced women's social roles largely to reproductive functions (7). Most women considered it dutiful to bear children, and abortions, whilst available from trained professionals, were sporadic.

In the mid-19th century, society's attitudes began to change as birth rates declined and corresponding changes in family formations led women to demand their rights as life bearers. The American Medical Association (AMA) launched its crusade to criminalise abortion around 1858 (except when a woman's life was at risk). By 1890, abortion was virtually banned across the nation except in cases where a woman's life was at stake. These laws criminalised not just providers but women seeking advice, driving abortion underground, and the number of unsafe procedures shot up, leading to untold numbers of deaths (8).

Class, race, and geography determined who had an abortion during this period. Affluent city women could visit surreptitious abortionists, while poor and minority women were frequently driven to desperate measures. Furthermore, as restrictions grew, so did the demand for abortion, driven by a dearth of birth control options and an increasing desire among women to have a voice in their reproductive lives.

The discussion of a woman's right to determine her own fertility began in the early 20th century. Debates over abortion that targeted single women began to suffice, for the public, suspiciously not even public yet, debates about abortion, by 1911, and by then, it was clear that public attitudes were changing. Pressure for reform has increased since the 1930s, and by the 1950s and 1960s, some states were starting to permit abortion in cases of rape, incest or a health risk. Colorado became the first state to legalise abortion under some circumstances in 1967, paving the way for more sweeping reform throughout the early 1970s (9).

In Roe v. Wade, 410 U.S. 113 (1973), the U.S. Supreme Court decided that a woman's constitutional right to privacy covered her choice to have an abortion up until fetal viability. This ruling legalised abortion nationwide and recognised women's abortion rights as a function of their autonomy, but it also sparked determined opposition, especially in conservative states.

The Court revisited the Roe case in Planned Parenthood v. Casey, 505 U.S. 833 (1992). It reaffirmed its basic holding but added the undue burden test, which said that states could regulate abortions as long as the regulations did not place a "substantial obstacle" in the path of women seeking them. This shift, in turn, cleared the way for states to enact restrictions, such as parental consent laws and waiting periods, that narrowed the practical scope of Roe's guarantees.

That landscape changed radically with Dobbs v. Jackson Women's Health Organisation, 597 U.S. 215 (2022), the case in which the Court upheld Mississippi's 15-week abortion ban and overruled Roe and Casey. Grounding its decision in historical interpretations of the Fourteenth Amendment, the Court held that the Constitution does not confer a right to abortion and thereby returned regulation of it to individual states.

Figure 1 shows the map of the U.S. that reveals detailed information about its current abortion laws and provides a clear picture of where abortion is expanded access, protected, not protected, hostile, or illegal after the U.S. Supreme Court's 2022 decision to overturn Roe v. Wade. States categorised as having "Expanded Access" have legal and proactively enshrined the right to abortion in law and implemented supportive policies that enhance access to safe abortion. States have been included in "Expanded Access" categories such as California, Connecticut, Hawaii, Illinois, Maryland, Minnesota, New Jersey, New York, Oregon, Vermont, and Washington. "Protected" states have legal or constitutional protections in place, though they may not go as far in facilitating access. States have been included in the "Protected" category, such as Alaska, Arizona, Colorado, Delaware, Kansas, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, Ohio, and Rhode Island. States categorised as "Not Protected" legally permit abortion but lack explicit safeguards, making them vulnerable to future restrictions. States have been included in the "Not Protected" category, such as New Hampshire, New Mexico, Puerto Rico, the Virgin Islands, and Virginia. "Hostile" states impose significant legal and procedural barriers to access, even if abortion remains technically legal. States have been included in the "Hostile" category, such as American Samoa, Florida, Georgia, Guam, Iowa, Nebraska, North

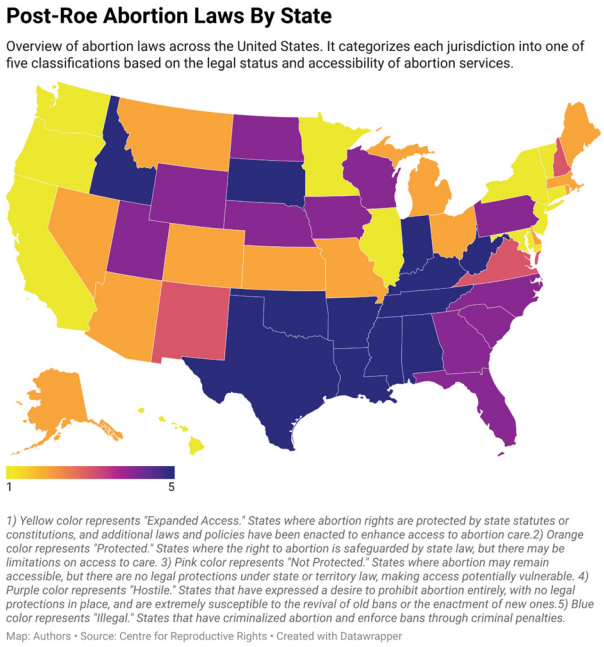

Figure 1. Post-Roe Abortion Laws by U.S.

Carolina, the North Dakota, Northern Mariana Islands, Pennsylvania, South Carolina, Utah, Wisconsin, and Wyoming. Finally, states categorised as "Illegal" have enacted total or near-total abortion bans, often permitting the procedure only in extremely limited circumstances. States have been included in the "Illegal" category, such as Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia.

Figure 2 shows the number of legal abortions in the U.S. for selected years, based on data from the Guttmacher Institute and CDC. It has been observed that since the legalisation of abortion under the Roe v. Wade decision in 1973, the number of abortions performed annually in this country rose steadily, from an estimated 744,000 in 1973 to approximately 1.6 million by 1990, as reported by the Guttmacher Institute. It has been noted that the number of abortions has reached its peak during the late 1980s and early 1990s, as per data provided by both the CDC and the Guttmacher Institute. After 1990, it has been seen a decline trend in the number of abortions. According to estimates from the Guttmacher Institute, the number of abortions in 2020 (930,160 cases) was approximately 40 percent lower than the corresponding figure in 1990 (about 1.6 million cases). Similarly, data reported by the CDC indicate that the number of abortions in 2021 (622,108 cases) was 36 percent lower than in 1990 (approximately 1.4 million cases). Moreover, it has been noticed that the number of abortions has been increasing with the U.S. Supreme Court's ruling in June 2022 to reverse the ruling in the case of Roe v. Wade in the matter of abortion, because of various reasons such as increased telehealth infrastructure, the possibility of mailing abortion pills to the patients, and the reduced cost of abortions performed through virtual abortion clinics compared to the former process (12).

Figure 3 shows trends in maternal mortality between 1970 and 2020, i.e., maternal deaths due to abortion, total maternal deaths, percentage change in maternal deaths, and the maternal mortality ratio, providing a critical perspective from which to interpret the effect of abortion law over time.

In the past, as illustrated in this figure, maternal mortality due to abortion fell dramatically and immediately with the legalisation of abortion by judicial decision in Roe v. Wade in 1973. Abortion-related maternal deaths have declined sharply from 47 (1973) in 1970 to 12 in 2020, with the steepest drop immediately post-Roe v. Wade (1973): 47 (1973), 33 (1974), and 34 (1975), representing a 52 percent reduction within two years (1973 to 1974). It also shows that there has been a decline from almost 50 deaths to fewer than 20 over the last few years. It reflects improved access to safe medical care. Also, consider the impact that legal and medical scrutiny might have on risky abortion procedures, contributing to maternal deaths before legalisation. It has been noted that total maternal deaths and the maternal mortality ratio (MMR) have displayed a rising trend after 1973. Total maternal deaths have increased from 398 deaths in 1985 to 420 deaths in 1991, indicating wider systemic problems in reproductive and maternal healthcare. After 1992, it has been observed that total maternal mortality and the MMR have increased further. The MMR has nearly doubled from 10.7 to 21.1 deaths per 100,000 live births over the 1985 to 2020 period. In 1992, Planned Parenthood v. Casey reaffirmed the right to an abortion but said that states could place some restrictions on it as long as they did not create an "undue burden" on the pregnant person. We see this in the graph: although abortion related maternal deaths stayed low, overall numbers of maternal deaths and MMR continued to rise from the late 1990s. In tandem with state-level restrictions, such as waiting periods, parental consent laws, and targeted regulation of abortion providers (TRAP) laws, it has increasingly limited access to timely and safe reproductive healthcare. The increase has also overlapped

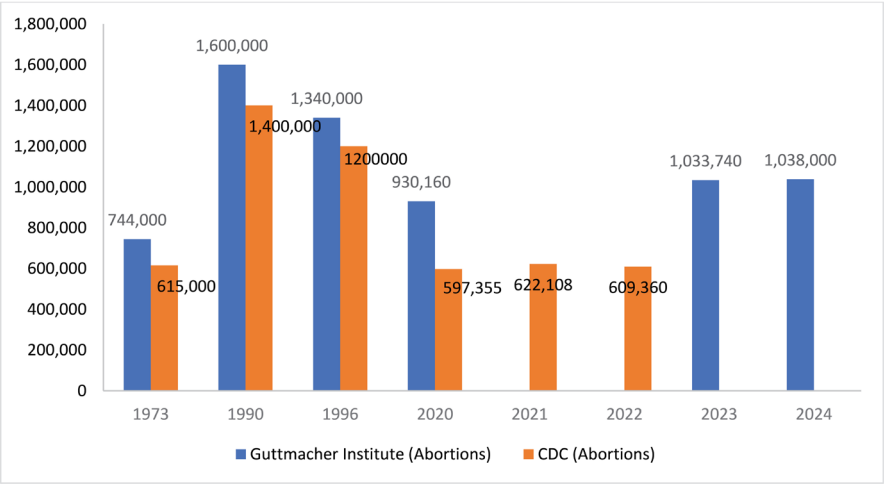

Figure 2. Trend in Legal Abortion in U.S. Since 1973. Source: Calculated by the Authors using data from the Guttmacher Institute (10) and the Centers for Disease Control and Prevention (CDC) (11).

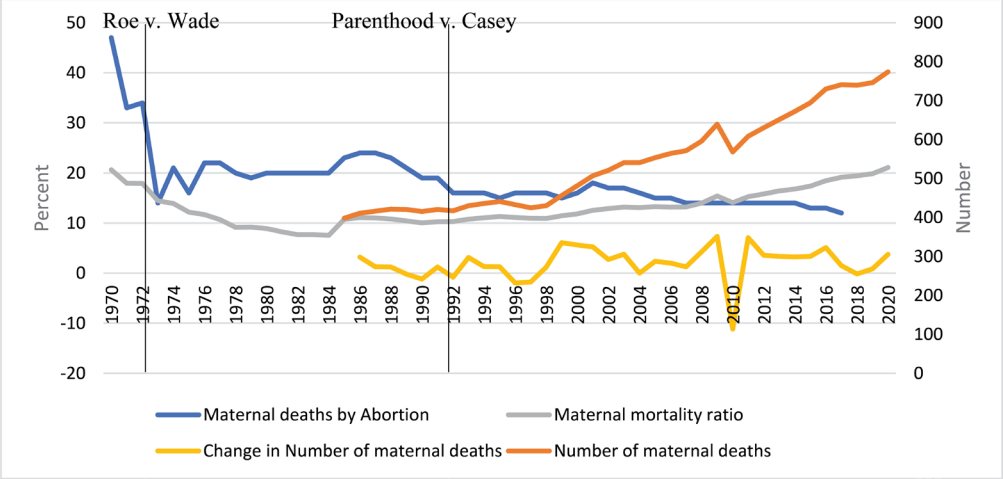

Figure 3. Trends in Maternal Mortality and Abortion-Related Deaths in the United States (1970–2020). Source: Calculated by the Authors using data from the Guttmacher Institute, the CDC, and Statista (13-15). *Notes*: Maternal mortality refers to the death of women during or immediately after pregnancy (within 42 days after termination). Number of maternal deaths: The estimated number of deaths during or shortly after pregnancy each year. Change in number of maternal deaths: calculate the percentage change in the number of maternal deaths. The maternal mortality ratio: The estimated number of women who die from maternal conditions for every 100,000 live births.

with the shuttering of reproductive health clinics in many states, and particularly in regions where there are greater abortion restrictions. A recent study revealed that the total maternal death reported from year to year has increased steadily since 1992, with a higher increase rate after 2010. The rise may be related to restrictive abortion policies, limited access to comprehensive reproductive care, and rises in maternal health problems due to racial disparities, lack of insurance, and changes in policy restricting reproductive rights. The annual change in maternal deaths shows volatile shifts, especially around 2010 and 2012. These sudden dips and spikes could signal policy changes. Notably, 2010 was really the start of an increasingly hostile environment around access to abortion in many states, which could have also had some indirect effect on maternal health outcomes (16).

Overall, the figure collectively illustrates that the legality and availability of abortion services have direct and quantifiable effects on maternal health outcomes. Legalisation of abortion in the 1970s resulted in safer maternal outcomes, whereas recent legal restrictions threaten to reverse those gains, especially in states with poor support systems for pregnant individuals. The evidence shows that protecting and expanding access to comprehensive reproductive health care, including abortion, is essential for reducing maternal death and improving the public's health.

In addition, the Dobbs decision has ushered in a new wave of extreme state-level restrictions, and more than a dozen states have enacted severe abortion limits or prohibitions. These legal shifts are expected to impact already vulnerable populations disproportionately, such as low-income individuals, people of colour, rural residents, and those lacking comprehensive healthcare access. This reversal has transformed reproductive rights in the United States and reinforced the imperative of legislative and policy action to protect women's autonomy, health, and equality as well as preserve their dominion over personal reproductive decisions. While the figure shows a gradual increase in maternal deaths and mortality ratio prior to 2020, these trends are projected to worsen post-2022, especially in restricted states. Research suggests that pregnancy-related mortality could increase by 21 percent to 33 percent if abortion bans remain in effect (17).

France's Reproductive Revolution: The Evolution and Expansion of Abortion Rights

France is generally considered to have one of the most liberal and all-encompassing abortion laws in Europe, achieved through a sequence of deliberate law changes over the last five decades. Legislation took the form of a legal framework since 1975, known as the Veil Act, 1975, which allowed first-trimester abortion on request, up to 10 weeks' gestational age dating from the last menstrual period (LMP) (18). Initially introduced as a temporary measure, the Veil Act was made permanent in 1979, representing a major turning point in the national approach to reproductive rights and public health (19). Over the years, France's policy environment has seen successive reforms that widened access, dismantled procedural obstacles, and continually improved service delivery (20).

Among the significant early improvements was the Roudy Act of 1982, which initiated reimbursement of abortion expenses by state health insurance—a crucial element in overcoming economic barriers (21). The legalisation of Mifepristone (medication abortion) in 1988 made France one of the first countries to enable

safer, less invasive abortion. Furthermore, in 1993, the Neiertz Act pushed the rights framework further by decriminalising self-managed abortion and establishing protections against interference for people seeking or providing abortion services (22).

The next significant advance occurred in 2001 through the Aubry-Guigou Act, which made elective abortion legal up to twelve weeks of pregnancy; eliminated some barriers to service access, such as mandatory psychosocial assessments for adults; and allowed delivery of medical abortion outside of hospitals (23). The 2007 policy benchmark in the French abortion context is specifically about expanding the provision of medication abortion within family planning and health centres, not about a general or separate family planning program. On 19 December 2007, legislation authorised the administration of medication abortion at family planning and health centers ("Centres de planification et d'éducation familiale," or CPEFs). Before this change, medication abortion was largely restricted to hospitals or clinical settings. Between 2013 and 2016, France enacted additional liberalising changes: abortion was made fully reimbursable through public insurance; the legal requirement for a condition of 'distress' was abolished; and the scope of practice for midwives was expanded to include medical and, later, surgical abortion. These changes collectively promoted easier, earlier, and more equitable access across the population. Revolutionary legislation, the Gaillot Act in 2022, which lengthened the legal time limit for gestational abortion to 14 weeks on request and allowed midwives to carry out surgical abortions, thus consolidating a decentralised approach aimed at increasing service accessibility and timeliness. Furthermore, in 2024, that process reached its conclusion with the constitutionalising of abortion rights: permanent and robust legal protection and gender equality in reproductive healthcare (24).

Throughout this evolution, the grounds for abortion in France have been kept broad and inclusive; abortion on request is permitted up to fourteen weeks from LMP, and there are no gestational limits when a woman's life or health (including mental health), or fetal impairment is involved. Economic and social grounds are also valid. Both medical and surgical abortion options are provided across various healthcare settings, including hospitals, clinics, physician and midwife offices, and even at home for eligible medication abortions. Crucially, all services are provided to resident women free of charge, regardless of their socioeconomic status.

Figure 4 shows the total number of abortions for the period from 1970 to 2024. The figure shows a dramatic and immediate increase in the number of legal abortions following the 1975 Veil Act, rising from around 2,000 to over 150,000 by the end of the 1970s. This dramatic rise at first blush covers the switch from unsafe, hidden abortions to safe, reported ones in the health service. However, in the 1980s and early 1990s, the overall numbers remained steady (around 180,000), reflecting that demand remained stable and access began to stabilise. There is also a noticeable jump after 2000, which corresponds with important liberalisations – the more extended period of eligibility (the increase to 12 weeks), the greater availability of medical abortion (particularly non-hospital provision) and the removal of procedural hurdles. After full state coverage began in 2013 and subsequent reforms empowered midwives and broadened provider options, total abortions stabilised between 200,000 and 220,000, reflecting ongoing, unmet contraceptive needs and robust reporting. Importantly, despite these legal relaxations and increased access, the overall number of abortions does not show a runaway increase. Fluctuations are comparatively minor, underscoring that expanded access accommodates rather than accelerates population-level demand.

Figure 5 shows the trend in France from 1970 to 2021. It has been observed from the figure that there is a dramatic and sustained decline in abortion-related maternal mortality over this period. In the years prior to abortion legalisation, France experienced rates of around 25 deaths per 100,000 live births in 1970, with considerable fluctuation due to the prevalence of unsafe abortion methods and restricted access to safe medical care. The

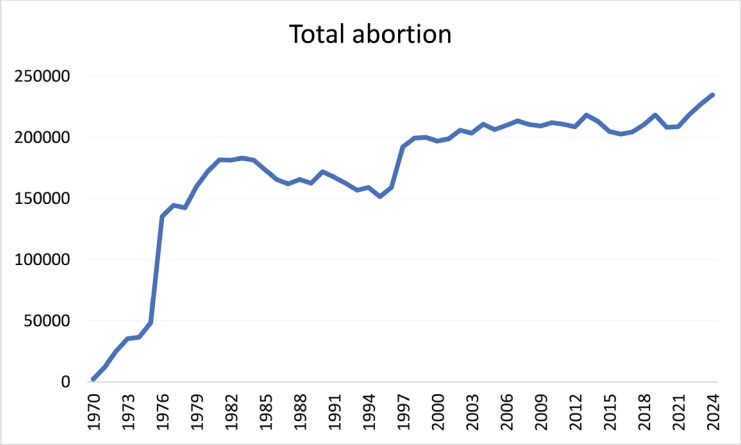

Figure 4. Total Abortions in France (in number). Source: Calculated by the Authors using data from the reports by Johnston (25).

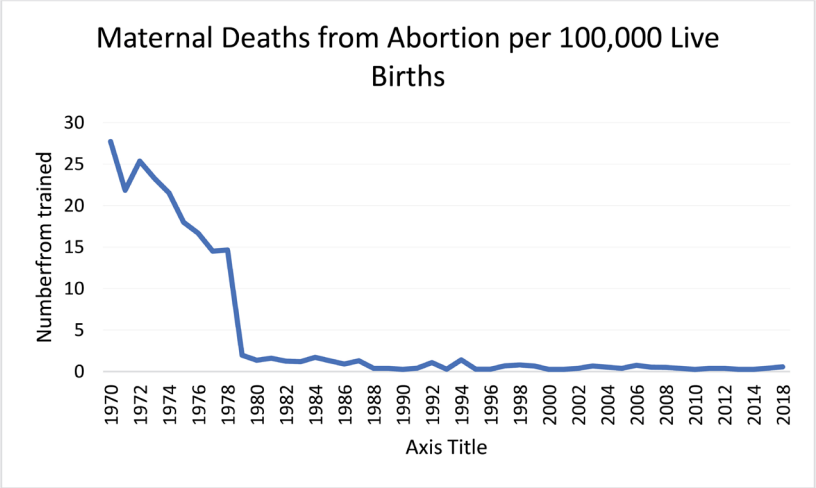

Figure 5. Maternal Deaths From Abortion Per 100,000 Live Births. Source: Calculated by the Authors using data from the WHO, European Health Information Gateway.

most dramatic decline took place when the Veil Act legalised the desirability of women having an abortion up to 10 weeks of gestation, and shaped France's reproductive health policy. After the reform, maternal mortality from abortion plummeted, collapsing to less than 10 deaths per 100000 live births in a few years and continuing even further down over decades. Since about the mid-1980s, abortion-related maternal mortality has levelled off at a very low level — generally around 2 deaths per 100,000 live births. As the 2000s continued up to our most recent data in 2021, the rate hovers near zero, evidence that comprehensive policy, better medical procedures and broad access to legal abortion continue to keep unintended pregnancy rates low. Figures 6 and 7 underscore the reality that comprehensive, rights-based abortion policies, grounded in a universal health system, are at once an instrument of reproductive justice and a powerful means of promoting women's health at the population level.

Reproductive Rights in India: Legal Evolution, Judicial Contradictions, and Maternal Health Outcomes

The history of abortion rights in India exemplifies the gradual transformation in India towards the acceptance of women's right to sexual and reproductive autonomy, including their right to bodily integrity. Initially, the law in India criminalised abortion under the penal provision of Section 312 of the Indian Penal Code, 1860 (now Section 88 of the Bhartatiya Nyaya Sanhita, 2023), except in cases where the procedure was vital to save a woman's life (26). After independence, the Government of India, realising the necessity for change in the existing due process, appointed the Shah Committee in 1964 for an "investigation into the problem in its social, medical and legal aspects" (27). The Committee's extensive suggestions broadly hinted that women's reproductive health and the safety of their health mandated the decriminalisation of the procedure and the establishment of a regulatory mechanism for the provision of access to safe abortion. This, in turn, led to the passage of the Medical Termination of Pregnancy (MTP) Act, 1971, marking an unprecedented legislative pronouncement that aimed to reconcile public health concerns with women's rights (28).

Abortion was made legal under the MTP Act 1971 for a set of conditions, including when continuation of pregnancy was likely to cause grave injury to the physical and mental health of the woman, or when a risk was at risk of severe abnormalities, or when conception was forced, such as in cases of rape, incest, or contraceptive failure. The law allowed for termination until the 20th week of pregnancy but provided exceptions in cases after that point, with judicial consent.

The MTP (Amendment) Act, 2021, which was passed in March 2020, represented a significant leap for India's reproductive rights jurisprudence by increasing the gestation limit for abortion access from 20 to 24 weeks for specific categories of women, such as minors or survivors of rape/incest and pregnant persons carrying fetuses with severe abnormalities (29). It also streamlined procedural requirements, limiting the number of medical opinions required for approval and improving women's access to safe abortion care. Nevertheless, as we have witnessed in this slow journey toward recognition of women's autonomy and human rights, judicial interpretations have oscillated. In the case of X v. The Principal Secretary, SCC Online SC 1321 (2022), the Supreme Court clarified that the right of a woman to ask for termination of her pregnancy is an intrinsic part of her bodily autonomy and decisional privacy, emphasising that marital status cannot be used as a ground for denial of reproductive rights. However, this progressive instinct was countered in X v. Union of India, Writ Petition (Civil) No. 1137 of 2023, which refused to accept a 27-year-old woman's plea for termination of a 24-week pregnancy on the grounds of mental health preference over fetal viability, as she conformed to

statutory eligibility, yet prioritising fetal autonomy at the cost of reproductive choice. Such a contradiction highlights the weaknesses of the MTP framework, which remains too paternalistic and forces women to prove their worth within a narrow legal framework. Together, these conflicting judgments shine light on the problematic paradox of India's reproductive rights jurisprudence, i.e. one which praises women's autonomy in principle but limits it through practice and underscores the imperative for a rights-based approach that places women at its core, incorporating their voices, experiences and choices above medical and legal gatekeeping.

Despite progressive statutory reforms, the realisation of reproductive rights in India remains uneven due to pronounced regional disparities, systemic capacity constraints, and entrenched socio-cultural barriers. Access to safe abortion services continues to vary sharply across states, with rural, tribal, and economically marginalised regions facing acute shortages of registered medical practitioners, authorised facilities, and timely referral mechanisms (30). The MTP framework's continued reliance on doctor-centric approvals, coupled with limited availability of specialists particularly obstetricians and gynaecologists in public health facilities has resulted in procedural delays that disproportionately burden vulnerable women. Ethical and cultural factors further complicate implementation: stigma surrounding abortion, patriarchal family structures, caste hierarchies, and moral policing by healthcare providers frequently undermine women's decisional autonomy, even where legal eligibility is clear. Consequently, India's reproductive rights landscape reflects a persistent gap between legal entitlement and lived access, underscoring that statutory liberalisation alone is insufficient without parallel investments in health infrastructure, provider training, decentralised service delivery, and rights-based sensitisation at the community and institutional levels.

Figure 6 represents the pie charts comparing the prevalence of pregnancy outcomes like miscarriage, abortion, and stillbirth in India during the years 2015-16 and 2019-21. It has been seen from NFHS 4 and 5 that miscarriage comprised the largest percentage of adverse pregnancy outcomes and experienced a marginal increase from 64.33 percent in NFHS 4 to 65.81 percent in NFHS 5. The percentage of stillbirths declined marginally from 9.23 percent to 8.28 percent. Whereas, the percentage of abortions was relatively stable but marginally decreasing from 26.44 percent in NFHS 4 to 25.91 percent in NFHS 5.

Figure 7 shows the trend of the MMR in India from 1985. It has been observed that there has been a consistent and sharp decrease till about 2015, which decreased from nearly 658 deaths per 100,000 live births to 129. The decrease is a reflection of the strengthening of the maternal healthcare system, such as more institutional

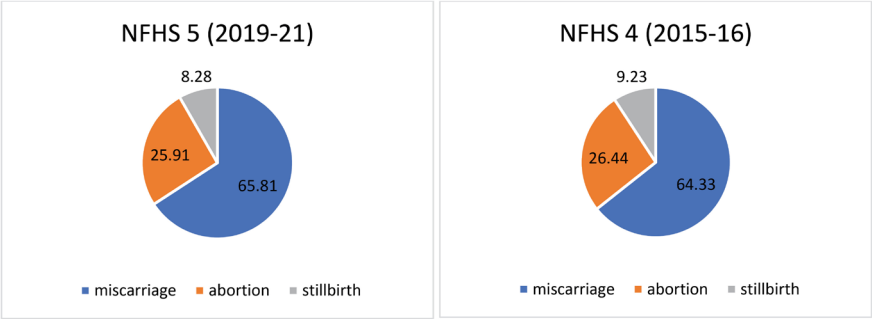

Figure 6. Pregnancy Outcome Pattern in India for the Period of 2015-16 to 2019-2021. Source: Calculated by the Authors using data from NFHS 4 (31) and 5 (32).

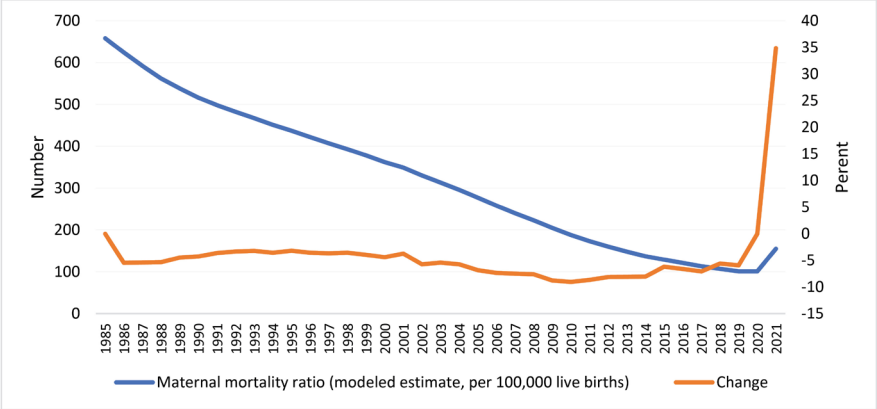

Figure 7. Trend in Maternal Mortality Ratio Since 1985. Source: Calculated by the Authors using data from the World Bank (33).

deliveries, emergency obstetric care, and promotion of safe motherhood activities. However, since 2015, the rate of decline has slowed, suggesting that more focused interventions are needed to deal with lingering issues. There is a steep reversal between 2020 and 2021, with MMR rising by more than 35 percent. The MTP (Amendment) Act, 2021, has been introduced to increase access to safe abortion care by relaxing the gestational limit and criteria for eligible cases, with a view to combating high maternity deaths from unsafe abortion practices, particularly in rural regions. Although the amendment is a progressive step in the form of maternity death reduction policy, some gaps, like a lack of specialists, continue to exist even now. There is no truth to the assertion concerning a 35 percent rise in maternity deaths; nevertheless, it is apparent that there has been a rise in the specific area of maternity mortality, influenced by maternity care service access during the pandemic period (34).

Regression Result

It has been observed from the regression results that Roe v. Wade (1973) has shown a policy effect coefficient of −48.54 (SE = 3.361, t = −14.44, $P < 0.001$), which has indicated a statistically significant immediate reduction of 48.54 maternal deaths from abortion upon implementation in U.S. Whereas, Planned Parenthood v. Casey (1992) has demonstrated a policy effect coefficient of 3.72 (SE = 2.11, t = 1.61, $P = 0.10$), which has indicated a marginally significant immediate increase of 3.72 maternal deaths from abortion in U.S. Furthermore, Veil Act (1975) has revealed a policy effect coefficient of −17.47 (SE = 1.88, t = 9.26, $P < 0.001$), which has indicated a statistically significant immediate reduction of 17.47 maternal deaths from abortion upon implementation in France (Table 1).

The regression results have provided a clear policy-outcome gradient in this research. That is, abortion restrictions have had a significant impact on the escalation in maternal mortality rates from abortion. Whereas abortion relief or legalisation has yielded large immediate effects and strong significance concerning a substantial drop in maternal deaths from abortion. This analysis pattern confirmed that legalisation expansion directly improved maternal health protection and that restrictions failed to improve or even deteriorated maternal health.

Discussion

An in-depth comparative analysis of abortion policy and maternal health outcomes in the United States, France, and India yields important insights for shaping India's reproductive health future.

Learning From France: Comprehensive Law and Universal Access

The French experience shows that adherence to the law and universal health coverage for all abortions can eliminate abortion related maternal mortality and ensure equitable access. Since the abortion decriminalisation of 1975, France has adopted a series of reforms that extended time limits and access to providers (including midwives) and integrated this right into its Constitution. Abortion

Table 1. Impact of Relief and Restriction Act on Maternal Deaths From Abortion in US and France

U.S. (Impact of Roe v. Wade (1973))				
Variable	**Coefficient**	**Standard error**	**t**	***P*>|t|**
$Time_t$	-0.308*	0.052	-5.91	0.000
Roe_t	-48.54*	3.361	-14.44	0.000
Cons	683.47*	102.9	6.64	0.000
No. obs	52			
F(2, 49)	186.7*			
Adj R-squared	0.87			
U.S. (Impact of Planned Parenthood v. Casey (1992))				
Variable	**Coefficient**	**Standard error**	**t**	***P*>|t|**
Time	-0.718*		0.001	0.001
$Casey_t$	3.72***	2.311	1.61	0.10
Cons	1452.637*	417.9892	3.48	0.001
No. obs	52			
F(2, 49)	28.34*			
Adj R-squared	0.53			
France (impact of Veil Act (1975))				
Variable	**Coefficient**	**Standard error**	**t**	***P*>|t|**
Time	-0.21*	0.046	-4.54	0.000
$Veil_t$	-17.47*	1.88	-9.26	0.000
Cons	438.71*	91.18	4.81	0.000
No. obs	49			
F(2, 46)	123.23*			
Adj R-squared	0.83			

Note: * and *** denote a significant level at 1% and 10%, respectively

services are available up to 14 weeks on request, with later abortions allowed for broad health and socioeconomic reasons, and care is provided free of charge to all residents. Empirically, this policy environment produced stable abortion rates (around 14.4–16.8 per 1,000 women aged 15–49), a high percentage of early and medically managed abortions, and, most importantly, a dramatic decline in maternal deaths from abortion: from over 30 per 100,000 live births before legalisation to virtually zero after the 1990s. This illustrates that sustained, barrier-free legal access, supported by a robust public health infrastructure, transforms abortion from a major maternal mortality risk into a routine and safe medical service. Decentralised service provision, removal of unnecessary reflection periods, and full financial coverage have further enhanced France's record on equity and women's rights.

Contrasting Trends from the United States: Policy Instability and Health Risks

The United States provides a cautionary lesson. After the 1973 Roe v. Wade decision, legalised abortion quickly lowered abortion-related maternal deaths, yet, in recent decades, growing policy fragmentation has exposed significant access and health equities. After the Supreme Court overruled the Roe v. Wade case, states have splintered widely: some retain "expanded access," but an increasing number fall into the "hostile" or "illegal" categories, with outright bans or severe restrictions. Empirical data show that every new wave of restrictions — mandatory waiting periods, parent consent and clinic closures — is associated with increases or spikes in the overall rate of maternal mortality, especially since the 1990s. Even as abortion deaths stayed low, the total maternal mortality rate and ratio rose in step with diminished reproductive health access, hitting marginalised populations hardest. Recent research projects maternal mortality could rise 21–33% in abortion ban states if restrictions persist, particularly affecting vulnerable groups and rural areas. Evidence suggests that legal rights, in the absence of practical access, do not protect against adverse health outcomes and that entrenching them is associated with measurable harm.

India's Current Position and Challenges

The MTP Act in India, in the wake of an amendment in 2021, offers a relatively liberal national legal landscape with termination allowed up to 24 weeks for specific categories and at 20 weeks generally. India's MMR has shown significant improvement over the past twenty years, primarily due to enhanced health systems and safer reproductive care. Yet, NFHS and World Bank data indicate persistent obstacles: most adverse pregnancy outcomes are miscarriages; the abortion rate is stable, but about 2.4% of abortions are still unsafe (self-managed or carried out in informal settings), and regional and socioeconomic disparities remain acute. The recent COVID-19 disruptions and implementation lag for new legal provisions caused a reversal in MMR trends in 2021. High abortion stigma, lack of rural provider networks, continued out-of-pocket costs, and gaps in post-abortion contraception and follow-up services all threaten to slow progress and place India at risk of replicating some U.S. outcomes especially if legal gains are not matched by investment in equity, access, and health system strengthening.

Empirically Informed Recommendations for India

- *Progress toward universal access:* Adopt a universal access strategy based on the French model of including abortion as part of comprehensive health care and removing financial and geographic barriers at the national level. Guarantee abortion as a critical health service at all levels and for everyone, urban and rural.
- *Additional liberation and decentralisation of services:* Eliminate procedural and provider-level restrictions that contribute to barriers for early safe abortion. Train and license midwives, nurse practitioners and community health workers to offer abortion care, particularly early medical abortions up to the legal gestational limits. This form of decentralisation, as demonstrated in France, increases early accessibility and reduces complications.
- *Take on stigma and social barriers:* Implement national awareness-raising activities to normalise abortion as a health service and reduce stigma, addressing region-specific barriers drawing inspiration from how France has integrated abortion into practice through its successful approach.
- *Strengthen health infrastructure and follow-up:* Invest in the expansion and regulation of registered facilities, especially in rural and underserved regions. Provide comprehensive postabortion care, including contraception counselling and follow-up, to prevent repeat unintended pregnancies and health problems.
- *Bolster legal protections and rights awareness:* Entrench a legal and safe abortion in the constitution or statute to prevent any future policy change. Conduct periodic review of laws and service implementation to adapt to changing demographic and technological realities, as France has done.
- *Prioritise equity:* Actively target equity gaps by subsidising abortion for low-income women, providing transport assistance, and recruiting female providers from all communities. Establish disaggregated data collection to monitor progress and respond with targeted interventions for high-risk populations.
- *Continuous monitoring and evidence-based adjustments:* Establish solid surveillance and research on abortion rates, complications, patient satisfaction, and obstacles, drawing on the model of routine statistical monitoring in France.

Conclusions

The comparative evidence indicates that sustained improvements in maternal health outcomes are most closely associated with stable, rights-based abortion frameworks that ensure practical access rather than mere formal legality. France demonstrates how legal certainty, and integration of abortion within the broader reproductive healthcare system can substantially reduce unsafe abortions and associated maternal risks. In contrast, the United States reveals a fluctuating trajectory, where periods of expanded constitutional protection improved access, while recent judicial retrenchment has fragmented services and reintroduced public health vulnerabilities. At the same time, debates surrounding fetal interests and viability continue to shape abortion jurisprudence, particularly in later gestational stages, and are frequently invoked to justify regulatory constraints. However, comparative evidence suggests that rights-based frameworks can accommodate such concerns through proportionate regulation without undermining women's autonomy or public health outcomes. In India, although comprehensive outcome-based data remain limited, legislative reforms under the MTP Act and progressive judicial interpretations reflect an uneven but evolving trajectory, constrained by implementation gaps, provider shortages, and persistent social stigma. The comparative lesson for India, therefore, lies not solely in legal liberalisation, but in translating rights into effective access through health-system integration, regulatory clarity, and institutional capacity, thereby aligning reproductive healthcare governance with constitutional commitments to dignity, autonomy, and equality.

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Conflict of Interests

Authors declare that they have no conflict of interests.

Ethical Issues

This study used only publicly available, anonymised secondary data, and no individual participant could be identified. All data were handled and reported responsibly, following ethical norms for secondary data analysis. Therefore, primary ethical approval was not applicable.

Financial Support

None to declare.

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