**International Journal for Research in Social Science & Humanities**
(ISSN: 2208-2697)
Vol. 12, Iss. 01, 2026
DOI: 10.69980/ssh.v12i1.2479

# PHYSICAL SOVEREIGNTY OF A WOMAN'S BODY: RIGHT TO ABORTION, A FUNDAMENTAL RIGHT? A COMPARATIVE ANALYSIS BETWEEN INDIAN AND AUSTRALIAN LAWS

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Received: 26/02/2026, Revised: 06/04/2026, Acceptance: 14/04/2026, Published: 20/04/2026

**ABSTRACT**

The font of the abstract and rest of the manuscript should be in Times New Roman Reproductive autonomy and bodily integrity constitute fundamental human rights, grounded in principles of dignity, privacy, and personal liberty. Every individual possesses the inherent right to make decisions concerning their own body, particularly regarding reproductive matters such as abortion and contraception. However, the physical sovereignty of pregnant persons remains perpetually contested by legal frameworks that seek to balance reproductive rights against state interests in potential fetal life. This paper examines abortion jurisprudence through a comparative analysis of Indian and Australian legal regimes, tracing the evolution of reproductive rights via judicial precedents and employing the Reproductive Justice Framework to establish abortion as a fundamental right.

In India, the right to life and personal liberty enshrined in Article 21 of the Constitution constitutes a foundational fundamental right. The right to abortion is anchored in constitutional guarantees of privacy, autonomy, and bodily integrity. Conversely, Australia's Federal Constitution lacks a dedicated chapter on fundamental rights; instead, legal protections encompassing socio-economic and civic-political freedoms derive from fragmented sources,

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including the Principle of Legality and state and territory human rights charters. Comparative analysis reveals that India's Medical Termination of Pregnancy Act, 1971, despite recent progressive amendments, maintains a provider-centric structure that undermines decisional autonomy. In contrast, Australia's decentralized decriminalization model produces geographic fragmentation and unequal access to reproductive services. This paper explores the emotional, ethical, and legal dimensions of reproductive autonomy through landmark jurisprudence, including Suchita Srivastava v. Chandigarh Administration (2009), Meera Santosh Pal v. Union of India (2017), X v. Union of India (2016), Sarmishtha Chakraborty v. Union of India (2017), and R v. Davidson (1969).

From the author's perspective, pregnant persons should possess autonomous decision-making authority regarding abortion. As fetal development occurs within the pregnant person's body, the ultimate decision to continue or terminate pregnancy must remain exclusively with the pregnant individual. This paper concludes by addressing the necessity for clearly defined abortion laws that uphold bodily integrity and reproductive autonomy, offering recommendations to address ethical challenges that impede reproductive freedom.

**Keywords** – Fundamental Right, Abortion, Physical Sovereignty, Women Rights

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## 1. Introduction

The legal and social discourse surrounding abortion in India has encouraged significant challenges over several decades. While the legal landscape has evolved considerably, abortion laws, much like any other statutory framework, require periodic amendments and inherent flexibility to remain aligned with evolving societal standards. A primary obstacle to the realization of reproductive rights is the persistent conflict between legal provisions, religious beliefs, and ethical norms. Prevailing social attitudes often prioritize adherence to traditional ethical standards and religious tenet over the reproductive autonomy of the pregnant person. Furthermore, there is a pervasive failure to recognize the profound emotional and physical complexities faced by an individual when compelled to carry an unintended pregnancy to term. Such forced continuations often result in severe psychological distress for the parent and can lead to a sense of resentment that fundamentally undermines the parent-child relationship, ultimately affecting the child's well-being. In the author's view, a pregnant person should not be legally or socially compelled to continue a pregnancy against their will. The decision to carry a pregnancy to term or to seek a termination should rest solely with the pregnant person. As it is their body that undergoes the physiological and psychological transformations of pregnancy, they must exercise the final authority over their reproductive choices. Pregnancies resulting from sexual assault impose profound physical and socio-psychological burdens on survivors. Consequently, an unambiguous legal framework for the termination of such pregnancies is essential to safeguard the victim's reproductive autonomy and holistic well-being.

## 2. Background of Abortion Laws in India:

### 2.1 The Era of Criminalization: IPC 1860

Globally, abortion laws have undergone significant evolution, transitioning from strict prohibition to rights-based frameworks. In India, abortion was historically governed by the Indian Penal Code (IPC), 1860, under Section 312 to 318. Prior to 1971, these provisions effectively criminalized abortion in almost all circumstances, except when the procedure was performed in good faith to save the life of the pregnant woman. Under the IPC, voluntarily causing a miscarriage was a punishable offence, carrying penalties of imprisonment, finer or both.[1]

### 2.2 The Catalyst for Change: The Shantilal Shah Committee

The movement toward liberalizing abortion laws in India gained momentum in 1964, driven by alarmingly high rates of maternal mortality resulting from unsafe abortions. Medical professionals frequently encountered women who gravely ill or deceased after seeking terminations from unauthorized practitioners in unhygienic conditions.

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In response, the Government of India appointed the 'Shah Committee 'in 1964, chaired by Mr. Shantilal Shah, who was then the minister for Public Health, Law, and Judiciary for the state of Maharashtra. The committee was mandated to conduct an in-depth analysis of the socio-cultural, legal, and medical aspects of abortion to determine the feasibility of liberalization. In its 1966 report, The Shantilal Shah Committee recommended the legalization of abortions based on humanitarian and medical principles, primarily to safeguard women's health and reduce maternal mortality. The Committee's findings were stark: in a national population then estimated at five hundred million, the report projected an annual total of 6.5 million abortions, comprising 2.6 million natural and 3.9 million induced cases. [2]These findings served as the legislative catalyst for the Medical Termination of Pregnancy (MTP) Bill. The Bill was introduced and subsequently passed by both Houses of Parliament, receiving assent in August 1971. The MTP Act came into force on April 1, 1972, extending to the whole of India. To further streamline clinical procedures and administrative requirements, the Act's regulations were subsequently refined in 1975.[3]

### 2.3 The Statutory Framework: MTP Act, 1971

The MTP Act, 1971, serves as the primary legislation governing legal access to abortion, providing a statutory exception to the criminal provisions of the IPC. The legislative intent, as articulated in the Preamble, is to facilitate access to safe and legal termination under specific circumstances.[4] Under the original Section 3(2) of the Act, Termination was permitted only up to 20 weeks. Moreover, it was stipulated that procedures up to 12 weeks required the opinion of one Registered Medical Practitioner (RMP). For pregnancies between 12 and 20 weeks, the concurring opinion of two RMP's was mandatory.

### 2.4 Modernization: The 2021 Amendment

The Act has undergone pivotal amendments to align with contemporary medical practices and the principles of reproductive autonomy. The MTP(Amendment) Act, 2021, significantly expanded access by raising the upper gestational limit from 20 to 24 weeks for specific categories of vulnerable women, including survivors of sexual assault, minors, and women with disabilities. The revised framework now requires the opinion of one RMP for termination up to 20 weeks, and two RMP's for the 20-to 24-week window. The amendment introduced State-Level Medical Boards to evaluate cases of substantial fetal abnormalities, allowing for termination even beyond 24 weeks. These legislative developments reflect a shift toward harmonizing Indian law with modern clinical standards and the fundamental rights of women.[5]

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## 3. Historical and Contemporary Background of Australian Abortion Law

### 3.1The Colonial Legacy and Early Criminalization

The colonial roots of contemporary abortion law in Australia are derived from the British Offences Against the Person Act 1861. This inherited legal framework imposed a categorical ban on abortion, classifying the procedure as a felony for both the pregnant woman and the practitioner. These restrictive statutes remained virtually unchanged for over a century, providing no statutory exemptions for humanitarian considerations. Consequently, for much of Australia's history, abortion was treated as a matter of criminal justice rather than an issue of public health or reproductive autonomy.

### 3.2 Judicial Liberalization and the "Health Necessity" Precedents

During the mid- 20th century, the legal landscape shifted not through legislative reform, but through landmark judicial interpretations that carved out a "medical necessity" exception. In Victoria, the Menhennit ruling (1969) in R v. Davidson established that an abortion was lawful if it was necessary to protect a woman from danger to her life or her physical or mental health. This precedent was subsequently expanded by the Levine ruling (1971) in New South Wales, which allowed for the consideration of economic and social stresses. These cases created a legal "gray area" where abortion remained technically prohibited in the criminal code but was accessible in practice if medical practitioners could justify health risk.

### 3.3 The Nationwide Transition to Decriminalization

The modern Australia legal experience is characterized by the incremental removal of abortion from criminal statutes, a process known as decriminalization. This movement was initiated by the Australia Capital Territory (ACT) in 2002, which became the first jurisdiction to repeal abortion related offenses from its Crimes Act. Over the following two decades, Victoria, Tasmania, Queensland, and New South Wales followed suit, transferring the regulation of abortion to health-based frameworks. This legislative evolution culminated in late 2023 with the implementation of final reforms in Western Australia, effectively treating abortion as a standard medical service across the continent.

### 3.4 The Regulatory Environment and Patient Rights

In the contemporary landscape, abortion is legalized and governed by health acts in every state and territory, though gestational limits for "on request" access vary, typically ranging from 16 to 24 weeks. A defining feature of the current Australia setting is the introduction of Safe Access Zones. Originating from a 2013 Tasmanian statute and validated by the High Court of Australia in 2019, these laws enforce 150-meter exclusion zones around clinics to protect patients from harassment by anti-choice protestors. Furthermore, while the 2022 decision by the United

Supreme Court in Dobbs v. Jackson, reversing Roe v. Wade, raised global concerns, Australian states have reinforced their statutory protections, prioritizing equitable access and the expansion of telehealth for reproductive healthcare.[6]

**4. Right to Abortion?**

On September 29, 2022, the Supreme Court of India delivered a landmark verdict in X v. Principal Secretary, Health, and Family Welfare Department, affirming that the right to abortion is a fundamental right. The Court held that every woman is entitled to safe and legal abortion services under the Medical of Termination of Pregnancy (MTP) Act.[7] In this historic ruling, the Bench, led by Justice D.Y. Chandrachud, emphasized that for a society to achieve true gender equality, legal interpretations must be 'contemporarily informed'. As the Court aptly observed, 'A changed social context demands a readjustment of our laws. Laws must not remain static and their interpretation should advance the cause of social justice.' This verdict, alongside the 2021 Amendment, has remarkably broadened the scope of reproductive rights in India. [8]

The decision in Justice K.S. Puttaswamy v. Union of India (2017) signaled a paradigm shift in Indian jurisprudence by elevating reproductive autonomy from a mere statutory right to a fundamental one. Building upon the bedrock of earlier precedents like Suchitra Shrivastava v. Chandigarh Administration (2017), the Court established that the right to terminate a pregnancy is an integral component of the constitutional right to reproductive choice. This right is now recognized as a core element of personal liberty under Article 21, rooted in the value of privacy, dignity, and bodily integrity. Consequently, the Puttaswamy judgement expanded the concept of privacy beyond the 'right to be left alone,' transforming it into a robust protection for an individual's ability to make critical life choices.

A significant contribution of the Puttaswamy decision is the clarity it provides regarding the constitutional location of the right to privacy. The various opinions in the judgement anchored this right across different facets of Part III, including Article 14,19,21 and 25. This multi-dimensional approach eliminated previous legal ambiguities, firmly placing a woman's reproductive choices within a protected constitutional domain.

Furthermore, the judgment introduced a rigorous three-pronged assessment to determine the validity of State interference with privacy. For a restriction, such as those found in the MTP Act, to be constitutional, the State must demonstrate: (i) the existence of a law, (ii) a legitimate State aim, (iii) proportionality between the aim and the means adopted. While previous abortion jurisprudence often deferred to 'compelling Sate interests,' the Puttaswamy framework demands higher scrutiny to ensure that restriction in the MTP Act does not amount to unconstitutional limitations on a woman's autonomy.

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Despite this robust judicial foundation, the practical application of Puttaswamy in subsequent case law remains in an inconsistent, nascent phase. While some courts have applied these principles to uphold the rights of minors or survivors of abuse seeking late-term abortions, many High Courts continue to rely on older precedents like Meera Santosh Pal. Often, these courts uphold the underlying principles of autonomy and dignity without explicitly citing Puttaswamy. Thus, while the 2017 judgement provides the necessary theoretical framework for reproductive rights under the concept of privacy, its definitive impact on shaping the implementation of the MTP Act is still being adjudged by evolving judicial trends.[9]

## 5. Comparative Analysis of Abortion Laws: India and Australia

Abortion laws in India are governed by a centralized federal framework known as the Medical Termination of Pregnancy (MTP) Act of 1971, which was significantly amended in 2021. The Act was enacted to balance three primary objectives: the protection of women's health through regulated medical attention, humanitarian considerations for survivors of sexual assault, and eugenic grounds in cases of substantial fetal abnormalities. Under the current MTP framework, a registered medical practitioner may legally perform an abortion if the pregnancy poses a risk to the mother's physical or mental well-being, or if there is a substantial risk of severe physical or mental handicaps in the fetus. The 2021 Amendment modernized these provisions, expanding access to include contraceptive failure for 'any woman and her partner' rather than only married couples, and increasing the gestational limits to reflect advancements in medical technology.[10]

The legal architecture of the MTP Act is defined by several critical sections. Section 3(1) provides a "non-obstante" shield, granting medical practitioners legal immunity from criminal prosecution under the Indian Penal Code, provided the procedure adheres to the Act's guidelines. Section 3(2) establishes a two- tiered gestational system: terminations up to 20 weeks require the opinion of a single medical practitioner formed in 'good faith', while those between 20 and 24 weeks require the consensus of two practitioners. This extended window is reserved for "special categories" of women, including minors. Rape survivors and those whose marital status changed during pregnancy. Furthermore, Section 3(3) mandates that doctors consider the pregnant woman's 'actual or reasonably foreseeable environment' when assessing health risks. The Act also emphasizes consent, under Section 3(4), while a guardian's consent is mandatory for minors or persons with mental illness, the consent of the pregnant woman alone suffices for all other adults.[11]

In the landmark case of Murugan Nayakkar v. Union of India (2017), the Supreme Court of India invoked its extraordinary jurisdiction to permit the medical termination of a 32-week pregnancy for a thirteen-year-old rape survivor. Although the gestational age significantly exceeded the then statutory limit of 20 weeks prescribes by the MTP Act of 1971, the Bench, led by Chief Justice of India, prioritized the victim's fundamental rights to health and bodily integrity. The

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Court's decision was informed by a court-appointed Medical Board's report, which concluded that the minor was experiencing acute trauma resulting from sexual assault. In granting this relief, the Court reinforced the principle that reproductive choice is an essential facet of personal liberty under Article 21 of the Constitution, particularly when pregnancy results from sexual violence and its continuation poses a grave threat to the individual's physical and mental well-being.[12]

Similarly, in XYZ v. The State of Maharashtra (2021), the Bombay High Court addressed a petition from a 25-year-old married woman seeking to terminate a 24-week pregnancy due to severe fetal abnormalities, including Arnold-Chiari Malformation Type II and Spina Bifida. While the pregnancy had reached the statutory threshold, the Court held that a woman's right to reproductive autonomy is paramount. It asserted that compelling a woman to carry a pregnancy to term despite substantial fetal abnormalities constitutes a clear infringement of her rights under Article 21. These rulings demonstrate a consistent judicial trend where Indian courts prioritize constitutional protections over strict statutory limitations when maternal health or fetal morbidities are medically established. [13]

Furthermore, in Nand Kishore Sharma & Ors. V. Union of India (2005)[14], the Rajasthan High Court dismissed a challenge to the constitutional validity of the MTP Act, ruling that the Act is in complete consonance with Article 21 as its primary objective is to protect the life and health of the pregnant woman. The Court emphasized that the anguish caused by pregnancies resulting from rape or contraceptive failure constitutes a grave injury to mental health, thereby justifying legal termination. This case significantly expanded the definition of reproductive rights in India by establishing that reproductive autonomy includes the right to prevent pregnancy through safe, state-sponsored means. It further solidified the principle of State Responsibility, if the State encourages sterilization as a matter of policy, it must provide a safety net when those procedures fail. The Court viewed the economic burden of an unwanted child resulting from a failed procedure as a direct threat to a family's dignity and quality of life.

This Indian jurisprudence aligns closely with the Australian precedent of Veivers v. Connolly (1995). While Veivers addressed a wrongful birth resulting from a failure to diagnose a condition, Nand Kishore Sharma addressed the failure pf a sterilization procedure, both cases highlight a shared legal imperative. They demonstrate that legal systems must account for the socio-economic and psychological impact on a woman when her reproductive choices or the medical procedures she relies upon are compromised. Collectively, these cases across both jurisdictions affirm that reproductive rights are inextricably linked to the broader constitutional guarantees of health, privacy, and a dignified life.

In contrast, Australia lacks a federal abortion law, as the procedure has been decriminalized at the state and territory levels. While the legal status of abortion is consistent across the country, access and gestational limits vary by jurisdiction. In the Australian Capital Territory (ACT),

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abortion is regulated under the Health Act 1993 and is legal at any stage of pregnancy without gestational limits. The ACT's framework is notably grounded in the Human Rights Act 2004, which interprets the "right to life" as commencing at birth, thereby ensuring no constitutional inconsistency with abortion access[15]. Most other Australian states, such as Victoria and the Northern Territory, permit abortion on request up to 24 weeks, while New South Wales, Queensland and South Australia set the limit at 22 weeks. Tasmania remains the most restrictive, allowing "on request" access only up to 16 weeks.

The procedural requirements for late-term abortions in Australia generally involve a transition from individual autonomy to medical oversight. In Victoria, Queensland, and New South Wales, terminations past the 22 or 24- week thresholds require the approval of two doctors who must consider the patient's physical, psychological, and social circumstances. Western Australia, which recently updated its laws, allows access up to 23 weeks and permits nurse practitioners to prescribe medical abortion pills for early-stage pregnancies. A defining feature of Australian jurisprudence is the establishment of "safe-access zones," typically 150 meters around clinics to protect patient privacy and prevent harassment, a protection that is not yet codified in India's federal MTP Act.[16]

Finally, both nations address the ethical dimension of medical practice through different lenses. In Australia, several states legally recognize 'conscientious objection,' allowing doctors to refuse to perform abortions based on personal beliefs, provided they refer the patient to a non- objecting provider[17]. In India, the MTP Act focuses more heavily on the 'good faith' of the practitioner and provides protection under Section 8 against legal proceedings for any damage resulting from a procedure performed according to the Act. While India relies on a centralized statutory exception to criminal law, Australia has moved toward a model of full decriminalization where abortion is treated as a standard component of reproductive healthcare, increasingly accessible via telehealth and mid-level providers.

In the case of Veivers v. Connolly (1995)[18], the Supreme Court of Queensland established a landmark ruling regarding wrongful birth and the legal justification for abortion in the context of fetal anomalies. The plaintiff initiated medical negligence proceedings against her practitioner for failing to diagnose her with rubella during the initial stages of pregnancy. Consequently, the plaintiff gave birth to a child with congenital rubella syndrome, resulting in severe disabilities including deafness, blindness, and cardiac complications. The Court determined that had the plaintiff been correctly diagnosed, she would have sought a termination. Crucially, the Court ruled that such a procedure would have been lawful under the "necessity" of principles established in the Menhennit ruling. The presiding judge reasoned that the lifelong burden of raising a child with profound disabilities posed a "serious danger" to the mother's physical and emotional health. By finding the practitioner negligent and awarding damages for the child's

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lifelong care, the Court reinforced the principle that even under restrictive criminal codes, abortion for fetal abnormalities was legally permissible to safeguard maternal mental health.

The relevance of Veivers v. Connolly is significant when compared to the Indian precedent of XYZ v. State of Maharashtra (2021). Both cases address the legality of terminating a pregnancy following a diagnosis of fetal abnormality, emphasizing that forcing the continuation of such a pregnancy constitutes a threat to the mother's mental and physical well-being. This alignment demonstrates that prior to full decriminalization, the judicial lens in both jurisdictions viewed abortion primarily through the framework of mental health and necessity.

Furthermore, the legitimacy of Safe Access Zones was solidified in Clubb v. Edward; Preston v. Avery (2019)[19], where the High Court of Australia unanimously upheld the constitutional validity of protest-free zones around reproductive health clinics. The appellants, convicted of prohibited protesting in Victoria and Tasmania, argued that the 150 meter "bubble zones" infringed upon the implied constitutional freedom of political communication. However, the High Court dismissed these arguments, concluding that the restriction was proportionate to a legitimate legislative aim. This decision was imperative as it shifted the legal discourse from the mere legality of the abortion procedure to the active protection of the patient's human rights, privacy, and dignity.

## 6. The Implementation Gap: Socio-Legal Realities in India and Australia

In India, the transition from viewing abortion as a criminal act to a reproductive right is complicated by a persistent tension between progressive legislation and deep-seated socio-cultural biases. While the MTP (Amendment)Act,2021 frames abortion as a humanitarian necessity, the practical implementation is often overshadowed by the 'constitutional but criminal' dichotomy. This paradox stems from the fact that while the MTP Act provides a legal "exception," the Indian Penal Code continues to criminalize abortion in principle, creating a "chilling effect" among medical practitioners. Fearing legal repercussions or harassment under the Pre- Conception and Pre-Natal Diagnosis Techniques (PCPNDT) Act 1994, originally designed to curb sex-selective abortion, doctors frequently adopt a defensive medical stance, acting as moral gatekeepers rather than health providers. This often manifests in the demand for unnecessary court mandates, particularly for the minors and survivors of sexual violence, effectively bypassing the statutory protections intended to safeguard their autonomy.[20] In rural India, this gap is exacerbated by a severe shortage of specialists and a lack of sexual autonomy, leading to high maternal and mortality rates. Consequently, unless abortion is fully decriminalized and integrated into a rights-based framework, millions of women will remain vulnerable to unsafe clandestine procedures, undermining the core constitutional principles of bodily integrity and dignity.[21]

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Similarly, Australia reflects a significant disparity between legal decriminalization and equitable access, often described as a "postcode lottery." Although abortion has been removed from the criminal codes in all states and territories, it has not been universally integrated into the public healthcare sector[22]. This has resulted in a 'triple threat' of financial, geographic, and political barriers, particularly for those outside metropolitan hubs. Because many public hospitals 'quietly' refuse to provide elective terminations, often citing conscientious objection patients are frequently forced into a costly private market where out-of-pocket expenses can reach thousands of dollars[23]. This systematic lack of diligence in clinical provision suggests that while abortion is no longer a crime in a legalistic sense, it remains a privilege contingent upon socioeconomic status and proximity to urban centers. Across both jurisdictions, the shared challenge remains clear, the mere existence of a 'right' is insufficient without the institutional will to ensure its universal and dignified accessibility.

## 7. Conclusion

A pregnant individual's rights to bodily integrity and reproductive autonomy including the right to access abortion must be upheld as fundamental. The preservation of the pregnant person's well-being supersedes the rigid adherence to traditional ethical norms. Both India and Australia have seen their legal systems evolve to reflect this necessity through progressive legislative amendments and landmark jurisprudence.

In India, a definitive turning point was Sarmishtha Chakraborty v. Union of India(2017),where the Supreme Court prioritized fundamental rights over the statutory rigidities of the Medical Termination of Pregnancy (MTP) Act, 1971, the Court permitted the termination of a 26-week pregnancy involving severe fetal cardiac abnormalities, declaring that a woman possesses a 'sacrosanct right to her bodily integrity' and affirming that reproductive choice is an inseparable facet of Personal Liberty under Article 21 of the Constitution. By recognizing that the forced continuation of such a pregnancy constitutes severe mental injury, the judiciary expanded the right to life to encompass dignity and mental well-being. This verdict served as a vital precursor to the MTP(Amendment) Act, 202, which codified this shift by legalizing late-term abortions for substantial fetal abnormalities.[24]

Similarly, Australia has undergone a profound legal transformation, moving away from a century of criminalization toward a framework that treats abortion as essential healthcare. The full decriminalization of abortion, finalized by Western Australia's 2023 reforms, marks a significant milestone in the protection of reproductive autonomy. However, true equity remains elusive as a 'postcode lottery' persists, varying jurisdictional limits and 'two doctor's approval requirements maintain a level of medical surveillance over bodily choice. Beyond legal status, barriers such as excessive costs and the persistence of conscientious objection disproportionately affect marginalized populations. To achieve genuine reproductive justice, both nations must continue

moving toward harmonized, public health-integrated systems that ensure reproductive choice is a practical reality for all, regardless of socio-economic status or geography.

## 8. Reference

1. Explained: Abortion laws in India (2023) Hindustan Times. Available at: https://www.hindustantimes.com/india-news/explained-abortion-laws-in-india-101697097757306.html
2. .Abortion in India (2026) Wikipedia. Available at: https://en.wikipedia.org/wiki/Abortion_in_India
3. Abortion laws in India: A look back at the timeline (2024a) Outlook India. Available at: https://www.outlookindia.com/national/abortion-laws-in-india-a-look-back-at-the-timeline-news-212618
4. Medical Termination of Pregnancy Act,1971
5. Team, V.C. (2025a) Medical termination of pregnancy act, provisions, significance, Vajiram and Ravi. Available at: https://vajiramandravi.com/upsc-exam/medical-termination-of-pregnancy-act/
6. Abortion in Australia (2026a) Wikipedia. Available at: https://en.wikipedia.org/wiki/Abortion_in_Australia
7. Kumari, S. and Kishore, J. (2021) Medical termination of pregnancy (amendment bill, 2021): Is it enough for Indian women regarding comprehensive abortion care??, Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8575235/#:~:text=Complications%20arising%20from%20spontaneous%20and,Shanti%20Lal%20Shah%20Committee%20to
8. Dipika Jain, Supreme Court of India judgement on abortion as a fundamental right: Breaking new ground Sexual and reproductive health matters (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10321178/pdf/ZRHM_31_2225264.pdf
9. Centre for Communication Governance at NLU Delhi 1, https://nluwebsite.s3.ap-south-1.amazonaws.com/uploads/the-puttaswamy-effect-exploring-the-right-to-abortion-in-india-ccg-5.pdf
10. Law on abortion in India: An overview, https://lawbhoomi.com/law-on-abortion/
11. Rachit Garg, Abortion law in India iPleaders (2023), https://blog.ipleaders.in/abortion-law-in-india/
12. Murugan Nayakkar v. Union of India (2017) SCC Online SC 1092
13. XYZ v. State of Maharashtra (2021) Criminal Writ Petition Number 177 of 2021
14. Nand Kishor Sharma and Others AIR2006RAJ166, 2006WLC(RAJ)UC411
15. Erica Millar, Abortion provision in Australian public hospitals taylor and francis online , https://www.tandfonline.com/doi/epdf/10.1080/09581596.2025.2500627?needAccess=true.
16. A guide to abortion laws in Australia: State-by-state breakdown, Missing Perspectives (2024), https://missingperspectives.com/posts/abortion-law-australia-list-each-state/
17. Abortion and the law (act), Go To Court (2022), https://www.gotocourt.com.au/criminal-law/act/abortion-law/#:~:text=The%20ACT%20is%20the%20only,Surgical%20or%20medical%3F
18. Veivers v. Connolly (1995) 2Qd R 326
19. Clubb v Edwards; Preston v Avery (2019) HCA 11
20. Aparna Chandra, Constitutional but criminal Verfassungsblog (2023), https://verfassungsblog.de/constitutional-but-criminal/
21. Drishti IAS, Barriers to abortion access in India Drishti IAS (2025), https://www.drishtiias.com/daily-updates/daily-news-analysis/barriers-to-abortion-access-in-india#:~:text=Specialist%20Shortage%3A%20Abortion%20laws%20require,intensive%20care%20uni

ts%20(NICUs)https://www.drishtiias.com/daily-updates/daily-news-analysis/barriers-to-abortion-access-in-india#:~:text=Specialist%20Shortage%3A%20Abortion%20laws%20require,intensive%20care%20units%20(NICUs)

22. Abortion rights and access in Australia: Implications of roe V wade, Australian Human Rights Institute, https://www.humanrights.unsw.edu.au/students/blogs/abortion-rights-access-australia-roe-v-wade
23. How Labor's 2019 election loss was a sliding doors moment for abortion access, ABC News (2025), https://www.abc.net.au/news/2025-06-01/abortion-access-in-australia-financial-and-regional-disadvantage/105291406
24. Sarmishtha Chakraborty v. Union of India (2017) W.P. (C) No 431 of 2017