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Abortion Rights and their Implications on SAARC Countries

RISHU RANJAN* AND NITEE TIWARI**

ABSTRACT

Abortion rights in South Asia reflect a complex interplay of legal frameworks, cultural norms, religious beliefs, and public health priorities. Within the SAARC region, abortion laws range from highly liberal models, such as those in Nepal and India, to some of the most restrictive regimes, in Sri Lanka, Afghanistan, and the Maldives. This divergence creates significant disparities in women's access to safe reproductive healthcare, contributing to unsafe abortions, maternal mortality, and cross-border abortion-seeking. This paper critically examines the legal, socio-cultural, and health dimensions of abortion policies across SAARC countries, analysing how these frameworks align or conflict with regional commitments to gender equality, human rights, and sustainable development. Through comparative legal analysis and a review of public health data, the study finds that restrictive laws not only undermine women's bodily autonomy but also impede SAARC's broader principles of social justice, cooperation, and human development. The paper argues that harmonising reproductive rights standards and adopting a rights-based regional approach are essential for strengthening women's health, advancing gender justice, and promoting equitable development within the SAARC region.

By situating abortion rights within the broader framework of SAARC's commitments to gender equality, social justice, and regional development, the research highlights the extent to which inconsistent and restrictive policies undermine collective progress. The findings demonstrate that the denial of reproductive choice not only violates fundamental rights but also hinders the region's ability to achieve the Sustainable Development Goals, particularly in the areas of health, gender equity, and human development. The paper concludes by arguing for a coordinated regional approach that harmonises minimum reproductive rights standards, strengthens public health systems, reduces stigma, and aligns national laws with international human rights norms to promote a more equitable and progressive South Asian region.

Keywords: *Abortion, Right to Life, Health, SAARC Countries, Maternal Mortality.*

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I. INTRODUCTION

The question of abortion rights occupies a central place in contemporary debates on gender equality, public health, and human rights. In South Asia, where social structures are shaped by deep-rooted religious traditions, patriarchal norms, and uneven socio-economic development, the issue becomes even more complex. Within this region, the South Asian Association for Regional Cooperation (SAARC) serves as the principal platform for promoting collective welfare, regional integration, and socio-economic progress. Established in 1985, SAARC brings together eight member states, namely Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka, under a shared commitment to cooperation, peace, and development. Its foundational principles emphasise respect for sovereignty, the promotion of human dignity, equitable growth, social justice, and collaboration in areas of health, education, and gender empowerment. SAARC's Charter and subsequent declarations highlight the importance of improving the quality of life of the peoples of South Asia, particularly women and marginalised communities, recognising that inclusive development is essential for regional stability.¹

Despite these commitments, the region exhibits wide divergence in the legal, ethical, and socio-cultural approaches to reproductive rights, especially abortion. While countries such as India and Nepal have moved toward more liberal and public-health-centred frameworks, others such as Sri Lanka, Afghanistan, and the Maldives retain stringent restrictions rooted in religious and moral interpretations. These disparities not only influence women's ability to exercise bodily autonomy but also shape broader public health outcomes, including rates of unsafe abortion, maternal mortality, and unmet reproductive care. Moreover, restrictive environments often compel women to seek unsafe or cross-border abortion services, creating additional human rights concerns and socio-economic burdens.

Examining abortion rights within the context of SAARC is therefore crucial, as the issue intersects directly with the organisation's foundational goals of promoting gender equality, advancing human development, and ensuring social justice. Understanding how different legal regimes align with, or conflict with, SAARC principles offers insight into the region's collective progress and challenges in upholding reproductive rights. This paper seeks to explore these intersections by providing a comparative analysis of abortion laws across SAARC member states, assessing their implications for women's health, rights, and regional cooperation.

¹Charter of the South Asian Association for Regional Cooperation, Dec. 8, 1985.

II. ABORTION

Abortion is broadly defined as the intentional termination of a pregnancy before the foetus reaches viability, whether through medical or surgical procedures. Medically, abortion refers to the expulsion or removal of an embryo or foetus from the uterus, resulting in the end of a pregnancy. It may be performed using pharmaceutical methods, such as mifepristone and misoprostol, or through surgical techniques such as manual vacuum aspiration or dilation and evacuation. Abortion is distinct from miscarriage (spontaneous abortion), as it involves a deliberate and informed decision to terminate a pregnancy.

Beyond its clinical definition, abortion occupies an important place in the frameworks of reproductive rights, bodily autonomy, and women's health. Reproductive rights, grounded in international human rights instruments such as the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Conference on Population and Development (ICPD), affirm that individuals have the right to make decisions regarding reproduction free from discrimination, coercion, and violence. This encompasses the right to access safe, legal, and affordable abortion services, the right to obtain accurate reproductive health information, and the right to make decisions about pregnancy based on personal, medical, or socio-economic considerations.²

Central to this framework is the concept of bodily autonomy, which asserts that every individual has the inherent right to control their own body, including decisions about whether to continue a pregnancy. Bodily autonomy encapsulates the rights to privacy, dignity, physical integrity, and self-determination. When states restrict abortion, they effectively limit a person's ability to exercise sovereignty over their own body, often forcing them into unwanted pregnancies, unsafe medical practices, or socio-economic hardship. Such restrictions disproportionately affect women and marginalised groups, undermining equality and perpetuating structural discrimination.

In essence, abortion is not merely a medical procedure but a multidimensional issue that lies at the intersection of health, law, ethics, and human rights. Its definition extends beyond biological processes to encompass the broader rights-based understanding that reproductive choice is fundamental to personal liberty, gender equality, and human development.

²Int'l Conference on Population & Development, Programme of Action, ¶ 7.3, U.N. Doc. A/CONF.171/13 (1994).

III. HUMAN RIGHTS THEORY

Human rights theory provides a foundational framework for understanding abortion not only as a medical procedure but also as an essential aspect of individual freedom, bodily autonomy, and gender equality. Rooted in international human rights instruments, including the Universal Declaration of Human Rights (UDHR), the ICCPR, the International Covenant on Economic, Social and Cultural Rights (ICESCR), and CEDAW, this approach asserts that reproductive choices are intrinsic to human dignity and must be protected by states. Abortion must therefore be analysed within the broader network of interdependent rights, primarily the rights to life, privacy, dignity, health, and equality.

A. Right to Life

The right to life, guaranteed under Article 6 of the ICCPR, is one of the most debated principles in abortion discourse. Human rights theory emphasises that this right belongs first and foremost to the woman or pregnant person. States have a positive obligation to protect life, which includes ensuring access to safe reproductive healthcare. Restrictive abortion laws often compel women to seek unsafe procedures, leading to preventable deaths and compromising the very essence of the right to life.³

International human rights bodies have clarified that the right to life should not be interpreted in a way that forces women to carry unwanted or dangerous pregnancies. Instead, it requires states to create enabling environments where women can access safe abortion services, especially in cases involving threats to life, health risks, sexual violence, or non-viable pregnancies.

B. Right to Privacy

The right to privacy, as recognised under Article 17 of the ICCPR, protects personal decision-making and autonomy over intimate aspects of life, including reproductive choices. Human rights theory asserts that decisions about pregnancy fall squarely within the domain of private life, encompassing a person's physical integrity, family-planning choices, and moral or ethical beliefs.⁴

State interference through criminalisation or overly restrictive procedures (such as mandatory waiting periods, spousal consent, or intrusive medical panels) violates this right by undermining a person's freedom to make decisions about their own body and life path. Courts around the

³U.N. Hum. Rts. Comm., General Comment No. 36: Article 6 (Right to Life), ¶ 8, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2019).

⁴International Covenant on Civil and Political Rights art. 17, Dec. 16, 1966, 999 U.N.T.S. 171.

world, including in India, the United States, and Europe, have upheld reproductive choice as a core aspect of informational, decisional, and bodily privacy.

C. Right to Dignity

Human dignity is the cornerstone of all human rights and is explicitly recognised in the UDHR and numerous regional human rights instruments. In the context of abortion, dignity refers to the inherent worth of individuals as autonomous agents capable of making decisions about their own lives.⁵

Human rights theory views forced continuation of pregnancy as a form of degrading treatment that violates personal integrity and undermines moral agency. When women are denied control over their reproductive choices, they are effectively reduced to reproductive vessels rather than full human beings with equal moral status. Respect for dignity requires that states allow individuals to make profound decisions about pregnancy based on their own values, circumstances, and well-being.

D. Right to Health

The right to the highest attainable standard of physical and mental health, as articulated in Article 12 of the ICESCR, includes access to comprehensive reproductive healthcare, including abortion. Human rights theory emphasises that abortion is a public health necessity: its availability determines maternal mortality, morbidity, and the prevalence of unsafe procedures.⁶

Criminalisation and restrictive laws delay access, increase stigma, and drive women toward unregulated settings. Denial of safe abortion services disproportionately harms poor, rural, young, and socially marginalised women, deepening existing health inequalities. States therefore have an obligation to ensure the availability, affordability, and quality of reproductive services, including post-abortion care and counselling.⁷

E. Right to Equality and Non-Discrimination

Equality is a central principle of human rights law and is enshrined in CEDAW, the ICCPR, and most national constitutions. Human rights theory asserts that restricting abortion constitutes gender-based discrimination, because only women, or those with reproductive capacity, bear the physical, social, and economic burdens of pregnancy.⁸

⁵Universal Declaration of Human Rights, G.A. Res. 217A (III), pmbl., art. 1, U.N. Doc. A/810 (Dec. 10, 1948).

⁶International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.

⁷Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24: Article 12 (Women and Health), ¶ 14, U.N. Doc. A/54/38/Rev.1 (1999).

⁸Convention on the Elimination of All Forms of Discrimination Against Women arts. 12, 16(1)(e), Dec. 18, 1979, 1249 U.N.T.S. 13.

Criminalising or restricting abortion reinforces patriarchal norms by denying women full control over their reproductive and life choices. It affects different groups unevenly: poor women, rural women, unmarried women, adolescents, refugees, and survivors of violence face greater barriers. Equality thus requires not only formal legal access but also effective, affordable, and stigma-free access to safe abortion services.

IV. FEMINIST LEGAL THEORY AND REPRODUCTIVE CHOICE AS EMPOWERMENT

Feminist legal theory offers a critical lens through which abortion and reproductive rights can be understood, arguing that control over reproduction is central to women's freedom, equality, and self-determination. This framework challenges patriarchal legal structures that historically placed reproductive decisions in the hands of the state, religious authorities, or male-dominated societal norms. Feminist scholars argue that autonomy over one's body is fundamental to dismantling gender hierarchy, enabling women to exercise full citizenship, and ensuring substantive, not merely formal, equality.

At its core, feminist legal theory conceptualises reproductive choice as a form of empowerment, rooted in the belief that women must have the freedom to decide whether, when, and under what circumstances to bear children. This empowerment is not only personal but also structural, as it breaks the traditional association of women solely with motherhood and domesticity. Access to safe and legal abortion allows women to pursue education, employment, economic independence, and social participation without being constrained by unwanted pregnancies. The theory therefore links reproductive autonomy directly to women's opportunities, life trajectories, and capacity for self-determination.

Feminist thinkers also highlight how reproductive control intersects with other forms of oppression, such as class, caste, religion, ethnicity, and marital status. Women from marginalised communities often face greater obstacles in accessing abortion, including stigma, financial barriers, rural isolation, and discriminatory healthcare practices. Feminist legal theory critiques these layered inequalities and argues that reproductive rights must be understood not just as individual freedoms but as collective struggles against structural injustice. In this sense, empowerment through reproductive choice becomes a tool for challenging broader systems of gendered power that shape women's health, sexuality, and socio-economic status.

Moreover, feminist scholars assert that denying abortion undermines bodily integrity and reinforces patriarchal control over women's bodies. When the state or society restricts abortion, it effectively asserts authority over women's reproductive capacities, treating them as instruments of cultural, religious, or demographic agendas rather than as autonomous

individuals. Feminist legal theory therefore frames access to abortion as essential for protecting bodily autonomy and resisting coercive cultural expectations about motherhood, sexuality, and women's roles.

In sum, feminist legal theory positions reproductive choice as a transformative form of empowerment, recognising that control over pregnancy is foundational to gender equality, personal agency, and social justice. By affirming the right to abortion, this framework advances a vision of law that respects women's autonomy, addresses intersecting forms of inequality, and supports the creation of societies where women can freely determine the course of their own lives.

V. PUBLIC HEALTH AND DEVELOPMENTAL APPROACH

The public health and developmental approach frames abortion not merely as a legal or moral issue but as a critical component of maternal health, population well-being, and socio-economic development. In regions such as South Asia, where healthcare systems are under-resourced, gender inequality is high, and reproductive norms are strongly shaped by cultural and religious factors, access to safe abortion becomes a decisive factor in determining women's survival, life outcomes, and participation in social and economic life.

A. Maternal Mortality and Morbidity

Maternal mortality is a key indicator of a nation's public health status and socio-economic progress. Unsafe abortions are a major contributor to maternal deaths worldwide, and the burden is disproportionately high in low- and middle-income countries, including those in the SAARC region. When abortion is criminalised or severely restricted, women are forced to seek unsafe, clandestine procedures performed by untrained providers. A lack of timely post-abortion care further increases the risk of infection, haemorrhage, and long-term reproductive complications, and delays caused by legal barriers, mandatory permissions, judicial interventions, or a lack of trained professionals increase medical risk for women with pregnancy complications.

Globally, unsafe abortions contribute to approximately 5 to 13% of maternal deaths, depending on regional variations⁹. In South Asia, the share is often higher owing to limited access to skilled providers, high levels of stigma, rural healthcare shortages, and poor emergency obstetric care. Countries with restrictive laws, such as Sri Lanka, Pakistan, Afghanistan, and the Maldives, tend to have higher proportions of maternal morbidity linked to unsafe procedures, while

⁹WORLD HEALTH ORG., TRENDS IN MATERNAL MORTALITY 2000 TO 2020, at 72-75 (2023).

countries such as Nepal, which liberalised abortion in 2002, saw a significant reduction in maternal mortality following legal reform.¹⁰

B. Unsafe Abortion Statistics

Unsafe abortion is defined by the WHO as the termination of pregnancy performed by individuals lacking the necessary skills or in environments that do not meet minimal medical standards. In South Asia, unsafe abortion persists even where abortion is legal, because of poor awareness, stigma, geographical inaccessibility, and economic barriers.¹¹

Factors contributing to the prevalence of unsafe abortion include criminalisation and fear of prosecution, social stigma (particularly for unmarried women), inadequate availability of female healthcare providers, misconceptions about medical abortion pills, and limited access to contraception, which leads to unintended pregnancies. Studies show that a significant portion of abortions in South Asia remain unsafe even in jurisdictions with liberal laws such as India, where restrictive interpretations, a lack of trained providers, and rural healthcare gaps push women towards unsafe methods. The consequences of unsafe abortion include severe bleeding, infection and sepsis, uterine perforation, infertility, psychological trauma, and death. Unsafe abortions thus represent a preventable public health tragedy directly linked to restrictive legal systems and poor reproductive healthcare infrastructure.

C. Socio-Economic Burdens

The developmental approach recognises that reproductive autonomy and safe abortion access significantly influence socio-economic outcomes for both individuals and states.

Burdens on women and families. A lack of access to safe abortion disproportionately affects low-income women who cannot afford private medical care, rural populations with limited healthcare facilities, adolescents who face greater stigma and lack information, and women in abusive or coercive relationships. The economic consequences include high out-of-pocket medical costs, income loss due to prolonged illness or complications, reduced educational and employment opportunities, and increased financial strain on households, especially where long-term health complications arise.

Burdens on healthcare systems. Unsafe abortions significantly increase the strain on public health infrastructure. Post-abortion complications require emergency care, surgeries, and long

¹⁰SUSHEELA SINGH ET AL., ABORTION WORLDWIDE 2017: UNEVEN PROGRESS AND UNEQUAL ACCESS 14-17 (Guttmacher Inst. 2018).

¹¹WORLD HEALTH ORG., SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 12 (2d ed. 2012).

hospital stays; treating these complications is far more expensive than providing safe abortion or contraception; and healthcare resources are diverted from other essential maternal and child health services.

Burdens on national development. Restrictive abortion laws hinder socio-economic progress: they limit women's ability to participate fully in education and labour markets, high maternal mortality and morbidity reduce overall productivity, and poor reproductive health indicators negatively affect a country's Human Development Index, Gender Equality Index, and Sustainable Development Goals (especially SDG 3 and SDG 5). Access to safe abortion is therefore both a health investment and a developmental necessity.

VI. ABORTION LAWS IN SAARC COUNTRIES

A. India

Under the Medical Termination of Pregnancy Act, 1971 (MTP Act), abortion is legal under a range of conditions: risk to the woman's physical or mental health, rape, foetal abnormalities, and socio-economic grounds.¹² The 2021 amendment expanded access, increasing the gestational limit for certain categories from 20 to 24 weeks, and it removed marital status as a barrier, so that unmarried women and those with non-marital pregnancies can access abortion under the Act. Abortion nonetheless remains formally regulated under penal law (with exceptions), rather than recognised as an absolute right. In practice, barriers remain: access depends on the availability of trained providers, awareness, stigma, and infrastructure, especially in rural or remote areas.

B. Nepal

Nepal legalised abortion in 2002. Under its laws, abortion is permitted under a broad set of conditions, including upon request, making Nepal the most liberal country in South Asia in terms of abortion law.¹³ Approved methods include medical abortion (pills) and surgical abortion (for example, manual vacuum aspiration), and legalisation was motivated by high maternal mortality and the need to improve women's health outcomes. Structural problems nonetheless remain: not all abortions are legal, and many women still face complications or resort to unsafe procedures. Even though the law allows abortion broadly, issues of awareness, access, health infrastructure, and social stigma limit the realisation of these rights.

¹²The Medical Termination of Pregnancy Act, 1971, No. 34, Acts of Parliament, 1971 (India), *as amended by* The Medical Termination of Pregnancy (Amendment) Act, 2021, No. 8, Acts of Parliament, 2021 (India).

¹³The Right to Safe Motherhood and Reproductive Health Rights Act, 2075 (2018), § 15 (Nepal) (permitting abortion on request up to twelve weeks); *see also* The National Penal (Code) Act, 2074 (2017), §§ 188-189 (Nepal).

C. Bangladesh

Under the Penal Code (a colonial-era law), induced abortion is largely criminalised, generally permitted only to save a woman's life. Bangladesh nonetheless uses a policy workaround known as Menstrual Regulation (MR), in place since 1979: a method to regulate menstruation when a period is missed, effectively allowing early termination without explicitly calling it "abortion."¹⁴ MR is allowed up to 12 weeks under certain conditions (depending on whether it is provided by qualified doctors or paramedics). Despite MR, access remains uneven, and many pregnancies still end via unsafe procedures owing to social stigma, limited access, and legal ambiguity.

D. Pakistan

Under its criminal code, abortion is not broadly permitted. The law allows abortion only when the pregnancy threatens the woman's life or to provide "necessary treatment," that is, to protect health.¹⁵ What constitutes "necessary treatment" or a "health risk" is often vaguely defined, which results in restrictive access. As in many restrictive settings, unsafe or clandestine procedures are common, especially among marginalised women.

E. Sri Lanka

Abortion is illegal except when it is essential to save the life of the pregnant woman. The relevant penal provisions criminalise unlawful termination, with possible imprisonment for both the woman and the provider.¹⁶ Repeated attempts to liberalise the law (in 1995, 2011, and 2013) have failed. Despite the restrictions, many women resort to clandestine or "backstreet" abortions, which are often dangerous and unregulated, contributing to health risks.

F. Bhutan

Under Bhutan's penal law (Section 146), abortion is allowed only in very limited cases: when the woman's life is at risk, in instances of rape or incest, or when the pregnancy endangers mental health.¹⁷ Owing to strict laws and a lack of access, many Bhutanese women reportedly travel to neighbouring countries to seek abortions, often under unsafe conditions.

G. Maldives

¹⁴The Penal Code, 1860, §§ 312-316 (Bangl.).

¹⁵Pakistan Penal Code, Act No. XLV of 1860, §§ 338-338F (Pak.) (permitting abortion to save the pregnant woman's life or to provide necessary treatment).

¹⁶Penal Code, Ordinance No. 2 of 1883, §§ 303, 305 (Sri Lanka).

¹⁷The Penal Code of Bhutan, 2004, § 146 (Bhutan).

Abortion laws are restrictive but somewhat less strict than in the most prohibitive regimes: abortion is permitted to protect the woman's life or health. In practice, access remains limited, and social, religious, and structural barriers persist.

H. Afghanistan

Abortion is heavily restricted and generally illegal, except when necessary to save the life of the mother (or, in some interpretations, in cases of severe foetal abnormality). The criminal code provides punishments for abortion, including imprisonment, for both the pregnant woman and providers. As a result of legal restrictions and a lack of safe services, many abortions are clandestine, and maternal mortality related to unsafe abortion remains a serious concern.

VII. PUBLIC HEALTH AND ECONOMIC IMPLICATIONS

In the SAARC region, the public health and economic implications of abortion are profound, as restrictive laws, stigma, and inadequate healthcare infrastructure drive many women toward unsafe and clandestine procedures that contribute significantly to maternal mortality and morbidity. Unsafe abortion remains a leading preventable cause of maternal deaths across South Asia, resulting in severe complications such as haemorrhage, sepsis, infertility, and chronic pelvic disorders, and disproportionately affecting rural, low-income, and marginalised women who lack access to skilled providers or confidential services. Overburdened public health systems face immense strain as hospitals must allocate limited resources (blood transfusions, emergency surgeries, long hospitalisation periods, and intensive post-abortion care) to manage preventable complications that could be avoided through timely access to safe abortion services and contraception. Economically, unsafe abortions impose heavy financial costs on women and their families, including high out-of-pocket medical expenses, loss of income during prolonged recovery, and long-term reductions in productivity due to chronic health issues. Unintended pregnancies that cannot be terminated safely further deepen socio-economic burdens by forcing women to drop out of education or employment, increasing household dependency ratios, and perpetuating cycles of poverty, especially in settings where women's economic contributions are essential for survival. At a macroeconomic level, countries face decreased female labour participation, weakened human capital, and increased healthcare expenditure, undermining progress toward the Sustainable Development Goals related to health, gender equality, and economic growth. Inadequate access to safe abortion services in SAARC countries thus not

only creates a public health crisis but also imposes wide-ranging economic and developmental costs on individuals, families, and national systems.¹⁸

VIII. ALIGNMENT WITH SAARC PRINCIPLES

The question of abortion rights in SAARC countries intersects significantly with the foundational principles of the South Asian Association for Regional Cooperation, which emphasise regional cooperation, social justice, gender equality, poverty alleviation, and the promotion of health and well-being across member states. Although SAARC does not have a binding human rights charter, its objectives, outlined in the SAARC Charter, the Social Charter (2004), and various declarations on women's empowerment, promote equitable access to healthcare, the removal of gender-based discrimination, and the improvement of maternal and reproductive health indicators. Ensuring safe and legal abortion aligns with SAARC's commitment to reducing maternal mortality, as unsafe abortion remains a major public health issue in the region, undermining goals of social development and health security. Furthermore, reproductive choice is intrinsically linked to SAARC's principle of promoting gender equality, since denying women control over their reproductive lives reinforces patriarchy, restricts mobility and education, and perpetuates socio-economic disparities. Abortion access also aligns with the SAARC Development Goals, which call for improved reproductive rights, access to contraception, and the reduction of poverty-related vulnerabilities, conditions often worsened when women are forced to continue unintended pregnancies or resort to unsafe procedures.¹⁹ By advancing abortion rights, SAARC countries move closer to their shared regional objectives of fostering human development, ensuring dignity, and strengthening the health, economic participation, and autonomy of women. However, wide differences in national abortion laws, from liberal frameworks in India and Nepal to restrictive regimes in Afghanistan, Pakistan, the Maldives, and Sri Lanka, create significant policy divergence that challenges regional coherence, highlighting the need for harmonised approaches to women's health within the SAARC framework. Aligning abortion rights with SAARC principles is thus essential not only for upholding women's health and equality but also for fulfilling the region's collective commitments to development, cooperation, and social justice.

IX. CASE LAWS

A. India

¹⁸GUTTMACHER INST., ADDING IT UP: INVESTING IN SEXUAL AND REPRODUCTIVE HEALTH 2019, at 6 (2020).

¹⁹SAARC DEVELOPMENT GOALS 2007-2012.

Suchita Srivastava v. Chandigarh Administration (2009). This landmark case recognised a woman's right to make reproductive choices, including abortion, as a dimension of personal liberty under Article 21 of the Constitution. The Supreme Court held that reproductive autonomy is an integral part of privacy, dignity, and bodily integrity, and affirmed that the state cannot force a woman, including those with mental disabilities, to carry a pregnancy against her will.²⁰

Justice K.S. Puttaswamy (Retd.) v. Union of India (2017). Though not directly an abortion case, the Court's recognition of the right to privacy as a fundamental right strongly reinforced reproductive autonomy and the right to decide about pregnancy without state interference.²¹

B. Nepal

Lakshmi Dhikta v. Government of Nepal (2009). A milestone decision in which the Supreme Court held that denying access to safe abortion violates women's constitutional rights to health, equality, and life. The Court directed the state to make abortion affordable, ensure the availability of services, and create public awareness. This case was critical in expanding reproductive rights in Nepal after abortion was legalised in 2002.²²

Prakash Mani Sharma v. Government of Nepal (2006). This litigation pushed the government to operationalise abortion services nationwide, establish reproductive health programmes, and improve access in rural areas.²³

C. Bangladesh

While Bangladesh does not have a well-known individual case, the policy of Menstrual Regulation (up to 10 to 12 weeks without confirming pregnancy) has been protected through government orders and supported by judicial interpretation. Courts have upheld MR as a crucial component of maternal health, recognising it as a public health need even though abortion is otherwise criminalised.

D. Pakistan

Recent references to a Lahore High Court matter (cited in the manuscript as "Ms. S v. Pakistan") suggest that, under the Hudood provisions and the Penal Code, abortion may be permissible to

²⁰Suchita Srivastava v. Chandigarh Admin., (2009) 9 S.C.C. 1 (India).

²¹Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 S.C.C. 1 (India) (holding that privacy is a fundamental right under art. 21 of the Constitution of India).

²²Lakshmi Dhikta v. Gov't of Nepal, Writ No. 0757 (2009) (Nepal), *reprinted in* 2 J. SAARC L. 47 (2010).

²³Prakash Mani Sharma v. Gov't of Nepal, Writ No. 064-WO-0283 (2006) (Nepal).

save the mother's life or to prevent serious injury, and that courts have begun to expand interpretations to include mental health risks; abortion nonetheless remains largely restricted.

E. Sri Lanka

Although Sri Lanka has no landmark abortion rights case owing to its restrictive law, public interest litigation and advisory opinions (referred to in the manuscript by reference to the Family Planning Association of Sri Lanka) have emphasised the need for legal reform in cases of rape, incest, and severe foetal abnormalities. Courts have occasionally referenced international obligations but have not expanded abortion rights.

X. IMPLICATIONS FOR REGIONAL INTEGRATION AND POLICY

The varying legal frameworks, socio-cultural attitudes, and health system capacities surrounding abortion across SAARC countries have significant implications for regional integration and policy harmonisation. Because reproductive health is central to human development, disparities in abortion laws, from liberal regimes in India and Nepal to highly restrictive systems in Afghanistan, Pakistan, the Maldives, and Sri Lanka, create uneven progress toward shared SAARC goals related to gender equality, maternal health, and poverty reduction. These inconsistencies hinder regional cooperation, as countries cannot collectively advance health security, women's empowerment, or human rights when foundational reproductive rights are unevenly protected. Differences in access also contribute to cross-border reproductive health challenges, such as unsafe abortion practices near borders, the mobility of women seeking services in more liberal jurisdictions, and gaps in regional health surveillance. Moreover, restrictive laws undermine the SAARC Social Charter's commitments to improving maternal health and eliminating discrimination, thereby weakening the region's collective ability to meet targets under the SAARC Development Goals and global frameworks such as the SDGs. For meaningful regional integration, SAARC countries require coordinated policy approaches that emphasise safe abortion, reproductive autonomy, public health investment, and the reduction of gender-based inequalities. Collaborative initiatives, such as shared health databases, regional training programmes, cross-border referral systems, and harmonised public health standards, could strengthen collective capacity and reduce maternal mortality across South Asia. Aligning national abortion policies with broader SAARC priorities is therefore essential not only for advancing women's rights but also for enhancing regional stability, development, and social cohesion.

XI. SUGGESTIONS

To address the challenges of abortion access and strengthen regional integration, several strategic measures can be recommended for SAARC countries.

Legal harmonisation and reform. Member states should be encouraged to expand abortion access beyond life-saving circumstances to include mental health, socio-economic hardship, and cases of sexual violence, in line with international human rights standards.

Strengthening public health infrastructure. This requires increased investment in trained providers, the availability of medical abortion, and the establishment of confidential, accessible reproductive health services in both urban and rural areas.

Awareness and education campaigns. These are essential to reduce stigma, inform women of their rights, and promote safe reproductive practices, especially among adolescents and marginalised populations.

Cross-border collaboration. This can facilitate the sharing of best practices, regional training programmes for healthcare providers, and the development of uniform guidelines for reproductive health services to minimise disparities.

Data collection and research. These should be enhanced to monitor unsafe abortion prevalence, maternal mortality, and service gaps, enabling evidence-based policy decisions.

Integration with development initiatives. Integrating reproductive rights into broader gender equality and development initiatives, such as women's education, economic empowerment, and poverty reduction programmes, can ensure that abortion access is viewed as both a human right and a driver of socio-economic development. Collectively, these measures can align national policies with SAARC's principles, improve maternal and reproductive health outcomes, and strengthen regional cooperation on women's health and rights.

XII. CONCLUSIONS

Abortion rights in SAARC countries represent a critical intersection of law, public health, gender equality, and socio-cultural norms, highlighting both the opportunities and the challenges of ensuring reproductive autonomy in South Asia. The analysis reveals a striking disparity across member states: while countries such as India and Nepal have progressively liberalised abortion laws, providing legal frameworks that recognise reproductive choice and protect maternal health, others, including Afghanistan, Pakistan, the Maldives, Bhutan, and Sri Lanka, maintain highly restrictive regimes that limit access to safe abortion services, perpetuate unsafe practices, and exacerbate maternal morbidity and mortality. Across the region, socio-

cultural and religious factors, ranging from patriarchal family structures and son preference to stigma surrounding premarital pregnancies and religious prohibitions, intensify these barriers, restricting women's autonomy and creating inequities in reproductive health access. From a public health perspective, unsafe abortions remain a leading cause of preventable maternal deaths, placing a disproportionate burden on marginalised women and straining already limited healthcare resources. Economically, these restrictions impose significant costs on women, families, and national health systems, reducing female labour participation, educational attainment, and overall human capital development.

Despite these challenges, there are clear alignments between abortion access and the foundational principles of SAARC, including the promotion of gender equality, social justice, maternal and child health, and human development. Legal recognition of reproductive choice directly advances these goals by reducing maternal mortality, empowering women, and promoting socio-economic development. Moreover, the disparities in national policies underscore the need for regional cooperation, harmonised health standards, and collaborative initiatives, such as cross-border training, knowledge-sharing, and coordinated public health campaigns, to reduce inequities and strengthen reproductive rights across South Asia.

In conclusion, safeguarding abortion rights in SAARC countries is not merely a legal or medical imperative; it is a developmental, social, and human rights priority. Policy reforms that expand access, coupled with investments in healthcare infrastructure, public awareness, and regional collaboration, can enhance women's autonomy, improve health outcomes, and foster sustainable socio-economic development. By addressing legal, cultural, and systemic barriers in a coordinated, rights-based framework, SAARC nations can uphold their commitments to maternal health, gender equality, and regional integration, creating a foundation for a healthier, more equitable, and empowered South Asia.
