

**Title:**

Reproductive self-determination and regulation of termination of pregnancy in Germany - current controversies and developments

**Abstract**

In Germany, efforts to reform current legislation governing access to termination of pregnancy (TOP) have recently gained momentum. In 2023, the German Federal government appointed a “Commission on Reproductive Self-Determination and Reproductive Medicine”, which released recommendations to revise legislation of TOP in April 2024. Currently, TOP is unlawful under the German Criminal Code, with exemptions from punishment for TOP performed within the first 12 weeks of pregnancy following mandatory counselling. Additional exemptions exist in case of criminological or medical-social indications.

The Commission report recommends the decriminalisation of early-stage TOP, and potential abolition of the mandatory counselling requirement. It further recommends a revision of the medical-social indication, due to a lack of clarity of its interpretation. This indication allows for TOP beyond 12 weeks of pregnancy, where there is danger to the pregnant woman's life or health.

This paper provides an overview of Germany's current TOP regulation and the Commission's recommendations, with a particular focus on the ethical and legal challenges posed by the application of the current medical-social indication in cases of fetal anomalies. We argue that while legislative clarity is essential, maintaining a broad interpretation of the medical-social indication is crucial to prevent undue restrictions on TOP access at later gestations.

The Commission report represents a promising step forward in changes for TOP legislation in Germany, and we welcome its call for legal reform. However, given the outcome of the recent federal election in February 2025, it is unlikely that the revision of TOP legislation will be part of the new government's agenda.

**Key words:** termination of pregnancy, abortion, decriminalisation, selective reproduction, medical indication, termination of pregnancy for fetal anomaly, expressivist objection, Germany

## 1. Introduction

In Germany, efforts to reform legislation for access to termination of pregnancy (TOP) have recently gained momentum. Currently, TOP is unlawful and regulated by the Criminal Code (*Strafgesetzbuch* – StGB). However, TOP prior to 12 weeks after conception (14 weeks gestation) is not punishable, and can be accessed upon request; requirements include attendance of mandatory “pregnancy conflict” counselling with a three-day waiting period. Additionally, TOP can be justified – making it not unlawful – for criminological or medical indications, with the latter also applicable at later stages of pregnancy. There have been some encouraging legislative developments over the past few years, including a lifting of restrictions on advertising for TOP services, and a ban on “sidewalk harassment” by anti-TOP protesters [1].

In April 2024, the “Commission on Reproductive Self-Determination and Reproductive Medicine” (*Kommission zur reproduktiven Selbstbestimmung und Fortpflanzungsmedizin*, hereafter “the Commission”), which had been appointed by the German Federal government in 2023, released a comprehensive report encompassing recommendations for the revision of the legal framework of TOP, egg donation, and altruistic surrogacy [2]. Key recommendations include the decriminalisation<sup>1</sup> of TOP in the early stages of pregnancy<sup>2</sup>, the conditional legalisation of egg donation, and either the continued prohibition of altruistic surrogacy or its regulation under strict conditions [3].

The constitution of the Commission was part of the 2021 Coalition Agreement between three liberal or centre-left parties: the Social Democratic Party (SPD), the Alliance 90/The Greens and the Free Democrats (FDP). The Commission consisted of 18 independent experts from medicine, psychology, sociology, health sciences, ethics and law who commenced their work on March 31, 2023. The Commission was organised into two working groups, one focusing on the regulation of TOP, the other focusing on egg donation and altruistic surrogacy [3].

The debate around TOP in Germany emerges from a complex historical and social context that has significantly shaped current legislation and policy. The

protection of “human dignity” is the central principle referenced in Article 1 in the German Constitution or “Basic Law” (*Grundgesetz* – GG). This focus on “dignity” has come about in part as a direct reaction to the atrocities of the past [4]. However, there is significant difficulty in understanding and defining precisely what it means to protect human dignity [5, 6]. Although the Constitution itself does not specifically reference the embryo or fetus, the Federal Constitutional Court has interpreted this principle as applying even to embryos. This has presented significant challenges for the regulation of assisted reproductive technologies [6, 7].

In this paper, we critically examine the Commission’s recommendations for revising Germany’s legislative approach to TOP. We place particular focus on the medical-social indication (§ 218a (2) StGB). This indication allows for TOP after 12 weeks of pregnancy, on the basis of protecting the pregnant woman’s<sup>3</sup> physical and mental health. The discussion around the medical-social indication in Germany highlights how inconsistencies and lack of clarity in legislation can translate into widespread practical problems, with physicians struggling to interpret and apply the law. This can in turn result in barriers for women seeking access to TOP. Understanding these dynamics is pivotal for any country grappling with inconsistencies regarding medical-social indications or discussing potential TOP law reform [8, 9].

We begin the paper by providing a critical overview of the current legislation relating to TOP in Germany, and the key recommendations proposed by the Commission. We then analyse the ethical and practical challenges arising from the medical-social indication. We conclude by providing an outlook on how to move forward with the Commission’s recommendations.

## **2. Current legislation and provision of TOP in Germany**

Under current German legislation, TOP is a crime under paragraph 218 of the Criminal Code. This legislation has been significantly shaped by key decisions by the Federal Constitutional Court [6]. There are, however, three exemptions under which access to TOP can be provided and accessed without punishment. First, according

to § 218a (1) StGB, TOP remains unlawful but is not punishable if carried out upon request and in accordance with the counselling regulation (Beratungsregelung). The Act on Pregnancy in Conflict Situations (Schwangerschaftskonfliktgesetz, SchKG), referred to in § 219 (2) StGB, more extensively outlines the criteria and requirements for the mandatory counselling. Moreover, TOP will be exempt from punishment in the case of a medical indication (§ 218a (2) StGB) or a criminological indication (§ 218a (3) StGB), since TOP is justified in these instances and thus is not considered unlawful.

In 2023, TOP following the counselling regulation made up approximately 96% of all TOPs performed in Germany [10]. It pertains if TOP is a) requested by the pregnant woman following mandatory pregnancy conflict counselling with an approved centre, and at least three days have passed between the counselling and the TOP, as following the requirements of the SchKG; b) performed by a physician who was not involved in the counselling; and c) performed no more than twelve weeks after conception (§ 218a (1) StGB). However, the counselling is not neutral. Although § 5 (1) of the SchKG states that the required counselling ought to be “open-ended” and “not lecture or patronise” the woman, it simultaneously states that “counselling serves to protect the unborn life”. Likewise, § 219 (1) StGB explicitly states that “[counselling] must be guided by efforts to encourage the woman to carry the child to term and to open her up to the prospects of a life with the child; it is intended to help her to make a responsible and conscientious decision. The woman must thereby be aware that at every stage of the pregnancy the unborn child has its own right to life in relation to her”.

TOP following the criminological indication accounted for 0.03% of all TOPs performed in 2023 [10]. The criminological indication applies when TOP is provided in cases of pregnancies resulting from criminal acts, such as sexual assault. TOP according to this indication may be performed if no more than 12 weeks have passed since conception and does not require any counselling.

Finally, TOP following the medical-social indication accounts for approximately 4% of all TOPs [10]. The medical-social indication applies in cases in which “considering the pregnant woman’s present and future circumstances, [the

TOP] is medically necessary to avert a danger to the life of or the danger of grave impairment to the pregnant woman's physical or mental health and if the danger cannot be averted in another manner which is reasonable for her" (§ 218a (2) StGB). A diagnosis of an anomaly or condition in the embryo/fetus is not itself an indication for TOP but, in practice, is considered as a subset of the medical-social indication [2]. When an embryo- or fetopathy is diagnosed, the diagnosing physician must inform the pregnant woman about the medical and psychosocial aspects arising from the diagnosis. Importantly, in this scenario, counselling must be conducted in an open-ended manner (§2a (1) SchKG). In 2010, access to TOP following the medical-social indication was made more restrictive by introducing a three-day waiting period between diagnosis of an embryonic/fetal condition and TOP (SchKG § 2a section 2) [11]. Unlike the two scenarios discussed above, there is no gestational time limitation for TOP following the medical-social indication, and thus it may be applied at any point during the pregnancy. Although possible in theory, in practice, very few clinical institutions provide TOP in very advanced stages of pregnancy [12].

Within Europe, Germany has a rather low TOP rate with 5.6 TOP procedures per 1000 women in reproductive age in 2022, compared to, e.g., France (14.1) or Spain (8.4) [13]. However, there may be a range of explanations for these figures, for example, an openness regarding sexuality on a societal level, a high importance placed on sex education, and good access to safe contraceptives [11]. Furthermore, German women have sought TOP in other countries such as the Netherlands and thus may not be captured in these datasets [11]. National TOP statistics of the Netherlands show that, in 2023, 1362 women from Germany underwent TOP in the Netherlands - the vast majority presumably being second-trimester TOPs [14]. In the Netherlands, access to TOP is available up to fetal viability in emergency situations jointly determined by the pregnant woman and her doctor. Such an emergency situation does not necessarily involve a serious risk to her life or health; any unwanted pregnancy may be considered a form of crisis, therefore qualifying for an abortion [15].

According to § 13 (2) SchKG, German federal states are obliged to ensure a sufficient number of providers performing TOP. Yet, the number of facilities reporting

performed TOPs to the Federal Statistical Office has decreased by 46% between 2003 and 2021 [10], with fewer TOP providers in the south and west of Germany [16]. One reason for a lack of TOP providers may be that physicians are granted a right to refuse to provide TOP on moral grounds (conscientious objection) [17], e.g., religious beliefs [18]. Furthermore, even physicians without moral or religious objections to TOP may be reluctant to provide or advertise it due to a threat of harassment from right-wing extremists [19].

Another critical consideration is insufficient training of healthcare providers in TOP. The training regulations for specialist training in gynaecology and obstetrics by the German Medical Association encompass training in pregnancy conflict counselling and the establishment of an indication for TOP, but do not include the performance of TOP [20]. A qualitative interview study with German medical students and physicians further revealed a lack of education and training on TOP in medical school and specialist training, as well as misconceptions regarding the complications and safety of TOP [18]. This study also identified a lack of understanding of TOP legislation, the taboo and stigmatization surrounding TOP, and hostility towards TOP as significant barriers to TOP provision [18].

### **3. The Commission's recommendations**

#### *Decriminalising early TOP and potentially abolishing pregnancy conflict counselling*

The key recommendations of the report regarding TOP, particularly those that have been highlighted in domestic and international media outlets, concern the decriminalisation of TOP in the early phase of pregnancy.

The report's recommendation to remove the regulation of early TOP from the Criminal Code is in part driven by the inconsistencies generated by the Act on Pregnancy in Conflict Situations: with current legislation, TOP constitutes a criminal procedure. At the same time, however, the state is required to fund services related to the procedure such as conflict counselling though not for the TOP itself. This contradiction is also highlighted by health insurance companies, who will cover some costs relating to early TOP (e.g., counselling), but not the costs of the procedure itself or aftercare; there can be exceptions for those on low incomes [11, 16].<sup>4</sup>

In addition to the call for decriminalisation of early TOP, the report concludes that requirements for mandatory “pregnancy conflict counselling” could be removed, although it is permissible and within the discretion of the legislature. If mandatory counselling is maintained, the report highlights that counselling must be non-directive and unbiased and should not aim at encouraging the woman to carry the child to term, thereby addressing the inconsistencies between different sections of the legislation highlighted above. Additionally, the report suggests reducing the current three-day waiting period between counselling and TOP to 24 hours or removing it altogether.

If TOP in the early stages of pregnancy were to be decriminalised, this would also have implications for the criminological indication. It would become superfluous, as it currently only applies for TOP prior to 12 weeks. This limitation is criticised by the Commission as the trauma associated with rape may cause women to realise their pregnancy late. The Commission therefore recommends extending the gestational limits for the criminological indication.

### *Weighing of constitutional rights*

While the report is clear with its recommendations regarding early-phase TOP, it remains more agnostic on TOP in the “middle phase” (up to viability) and “late phase” (from viability onwards) of pregnancy. The use of viability as a marker rather than trimesters is relevant to the report’s recommendations. However, viability as a marker can shift according to medical, scientific and technological developments [21].

One of the key constraints for a new regulatory framework are the constitutional rights to life and human dignity, which the state has the duty to respect and protect (Art. 2(2) sent. 1, and Art. 1(1), German Basic Law (Grundgesetz, GG)). These have been interpreted as applying to the embryo or fetus [6]. In two separate decisions – in 1975 in West Germany, and in 1993 after re-unification - the Federal Constitutional Court affirmed that, on the basis of the protection of dignity, the state has a duty to protect fetal life and the woman has a duty towards the fetus, implying the duty to continue pregnancy until birth. The decisions highlight that the fetus being protected by the right to life, as a means to guarantee human dignity, can take precedence over the pregnant woman’s right to autonomy or her bodily integrity.

This grounds the court's decision to generally consider TOP unlawful [6], as well as requirements such as mandatory counselling. As described in section 2, the pregnancy conflict counselling aims to “protect unborn life”; such requirements allow the state to fulfil its duties. While the Commission report concludes that these court decisions do not ultimately prevent the development of new regulations, ensuring that new regulations still align with the requirements to protect the constitutional rights that apply to the embryo or fetus is challenging.<sup>5</sup> A key concern is how the decriminalisation of TOP might conflict with previous case law of the Federal Constitutional Court. While decriminalisation of TOP may be achievable, the constraints of these decisions introduce questions about which approach will succeed [22].

The report describes four general legal positions about how to interpret the constitutional rights to life and human dignity. The first is that these rights only apply from birth, because the law refers to the dignity of a human being as an individual, and not human life in general; until the embryo/fetus is a distinct individual, the rights cannot apply. The second position is that the constitutional rights apply from implantation, with full protection. The third position is that the constitutional rights apply to the embryo from implantation, but with less protection than to the human being from birth. This can be seen as somewhat akin to the gradualist view on the moral status of the fetus [23]. The fourth position is that the constitutional rights have “preliminary effects” which relate to the interests of the future person rather than the fetus-as-fetus.

However, a further consideration are the constitutional rights afforded to the pregnant woman, who has a right to life and physical integrity (Art 2(2) GG), as well as others that relate to TOP access (including general personality rights, freedom from gender discrimination, and freedom of conscience). Therefore, the report concludes that the rights of the pregnant woman and the embryo/fetus must be weighed against each other.

From this position, the report argues that the rights of the embryo/fetus should be “fundamentally subordinate” to the rights of the pregnant woman in the “early phase” of pregnancy (p. 246). However, as gestation advances, the rights of the fetus may be given more weight. In the “middle phase”, the weight of the rights between the fetus and the pregnant woman are more ambiguous, and regulation of TOP at these gestations is subject to more discretion on the part of the legislature.

In the “late phase”, the Commission grants significant weight to the fetus being protected by the right to life due to its extrauterine viability and thus recommends that TOP should not generally be made available. However, there remain exceptions where there is a clear medical indication, such as a threat to the pregnant woman’s life or health. This is because balancing the rights of the fetus and the pregnant woman is akin to the balancing of rights of any two people—no person is obliged to sacrifice their life for another’s.

The report further notes that TOP in the middle or late phase does not necessarily need to be regulated under the StGB, nor necessarily be subject to punishment. Rather, it could potentially be regulated under other areas of law. For an overview of the Commission’s recommendations regarding TOP during the different phases of pregnancy see Table 1 below.

The report also has some other legislative recommendations, such as resolving an inconsistency in the criminal code focusing on coercion and TOP - currently, the code only addresses punishment for coercion to abort, and not coercion *not* to abort. Some of the other key matters discussed in the report relate to the lack of clarity associated with the medical-social indication for TOP, which will be outlined in the following section.

	“Early phase”	“Middle phase”	“Late phase”
Description	The first weeks after nidation; the precise definition of the “early phase” is at the discretion of the legislature. Currently, from implantation up to 12 weeks	From the end of the “early phase” (this time point is at the discretion of the legislature to define) to the point of viability	From viability to the point of birth
Balancing of rights	The rights of the embryo or fetus are subordinate to those of the pregnant woman	The rights of the fetus are more equally balanced against those of the pregnant woman; the weight	The rights of the fetus are equally balanced against those of the pregnant woman

		is more ambiguous	
General recommendation	Pregnant women should be able to access TOP legally and with impunity.	Access to TOP depends significantly on the weighing of the abovementioned rights, and the criterion of “unreasonableness”	Pregnant women should not be able to access TOP, with exceptions where there are threats to her life or health.
Specific recommendations or statements about the role of the legislature	TOP in this phase should be removed from the criminal code; it is at the discretion of the legislature to define what counts as the “early phase”	There is discretion on the part of the legislature about the regulation of TOP in this phase; if TOP is not permitted, it may be regulated either in the Criminal Code or in other areas of law	The legislature is not required to regulate “late phase” TOP under the Criminal Code; criminal punishment may be appropriate but is not necessary. Other forms of regulation can be considered

*Table 1: “Phases” of pregnancy and the report’s recommendations*

#### 4. The medical-social indication

While much coverage of the report has focused on its recommendations to decriminalise early TOP, the report also highlights another significant challenge to TOP access at later gestations. This concerns a lack of clarity in how to interpret and apply the “medical-social indication”, which allows for TOP on the basis of threats to the pregnant woman’s life or physical or mental health (see Box 1 for full wording). There are several critical questions relating to the medical-social indication: the nature of the “danger”, the degree or severity of that danger, and when that danger makes continuation of the pregnancy unreasonable (which we refer to here as the “criterion of unreasonableness”). The report recommends that the legislature re-regulate the medical-social indication to provide more clarity, as there are currently no legal criteria for assessing under which conditions a TOP at later gestations is

permissible. This situation leads to ambiguities of how the medical-social indication is applied in practice [12, 18, 24] and may contribute to the fact that few providers offer late-term TOP [25].

„A termination which is performed by a physician with the consent of the pregnant woman is not unlawful if, considering the pregnant woman’s present and future circumstances, the termination is medically necessary to avert a danger to the life of or the danger of grave impairment to the pregnant woman’s physical or mental health and if the danger cannot be averted in another manner which is reasonable for her to accept.“

*Box 1: Full wording of the medical-social indication according to § 218a (2) StGB*

Until 1995, German legislation included the so-called “embryopathic” indication which allowed TOP on the basis of a fetal anomaly until the 22nd week of pregnancy. The embryopathic indication was abolished on the basis that it was a form of discrimination against people with disabilities making judgements about the value of their lives [26]. The view may be reflective of the “expressivist argument” in the ethical debate on selective reproduction. This is the position that selecting against a particular condition or trait inherently “expresses” a negative view of that condition or trait, or of people living with it [27]. The legislation now refers specifically only to the pregnant woman’s life or health and no longer makes explicit references to the health or well-being of the future child.

Despite the abolition of the “embryopathic indication”, research into TOP based on the medical-social indication at later gestations suggests that fetal anomalies are present in many, if not most, cases [12, 28]. In an online survey of German gynaecological departments, only 26 of 46 participating institutions offered late-term TOPs. Of these 26 departments, 92% stated that they would apply the medical indication on the basis of fetal anomalies. However, only 38% would consider applying the medical indication in the case of mental illness in the absence of fetal anomaly [12].

In the absence of an explicit embryopathic indication, physicians are expected to frame the justification for TOP provision in terms of the pregnant woman’s life or health. In case of fetal anomaly, the line of argument is that disability in the future child after birth poses a risk to the pregnant woman’s physical or mental health, e.g., because high levels of care for the child might be necessary. Effectively, this means

that the embryopathic indication not only remains but is in fact wider than the 1995 legislation. This is because with this interpretation of the medical indication, current legislation allows for TOP in the presence of a fetal condition at any stage, where the “embryopathic indication” was only available up to 22 weeks.

In light of this, the report highlights that the medical-social indication as it is currently applied encompasses both a narrower sense and a broader sense. The narrower sense is where the danger to the pregnant woman’s life or health is caused directly by the pregnancy itself. The broader sense is where the danger to the pregnant woman’s life or health is caused by the postnatal existence of the child. TOP following the diagnosis of a fetal anomaly is considered a subset of this broader interpretation of the medical-social indication, and the report underlines that considerable lack of clarity exists with the boundaries of this interpretation. While the report highlights that with increased gestational age, the danger to the women’s life or health must be more severe to make continuation of pregnancy unreasonable, it remains unclear under which circumstances the diagnosis of an anomaly makes continuation of pregnancy unreasonable.

One of our concerns about current lack of clarity regarding the medical-social indication is that it may potentially lead to inequalities in access to TOP - physicians across the country may interpret the medical-social indication differently [24]. Inequalities in access are particularly problematic as few providers offer late-term TOP [12], and they may especially affect pregnant women who live in regions where physicians are more opposed to TOP, and/or women who have limited access to visit other providers.

Furthermore, lack of clarity of the current legislation may unintentionally incentivise practices such as TOP before 12 weeks after screening for prenatal diagnosis through NIPT without confirmation through follow-up diagnostics. Many clinical practice guidelines globally recommend against making a decision to terminate a pregnancy solely based on a screening result, due to test limitations. However, waiting for diagnostic confirmation through amniocentesis or chorionic villus sampling would push the gestation beyond the limit of the first 12 weeks of pregnancy. If there is uncertainty about whether someone would be able to access TOP for a particular fetal condition, this could potentially increase motivation to terminate after a screening result rather than waiting for diagnostic confirmation. A

correlation between the increase in uptake of NIPT and an increase in first-trimester TOP has been reported, but there may be a range of explanations for this [29].

## **5. Where to from here?**

Due to the ambiguities surrounding the medical-social indication, the report recommends a revision of the legislation and potential re-introduction of an embryo-/fetopathic indication to provide more clarity. Germany is far from being the only country where there is confusion about how to interpret a medical-social exception for TOP at later gestations [9, 30, 31]. However, when TOP law reform is discussed, one thing that must be kept in mind is that a medical-social exception can be critical as a mechanism for giving physicians broader discretion to provide TOP at later gestations [31].

Although not the intention of the Commission, our concern is that in efforts to resolve a legislative inconsistency, TOP access at later gestations in Germany may inadvertently become more restricted, even as TOP at earlier gestations becomes less so. If attempts to provide more clarity around criteria for a medical-social indication do not account for a wider interpretation, TOP may become restricted to where there are threats relating to the pregnancy itself (e.g., preeclampsia), and not the reproductive endeavour more broadly. While we agree with the report's recommendation to provide more clarity in the legislation, we strongly believe that any efforts to produce more clarity should fall on the side of viewing the pregnant woman's life and health in terms of the broader reproductive endeavour (e.g. psychosocial effects), not just threats relating specifically to the pregnancy itself.

The decriminalisation of TOP is not just a matter of legislative possibility, but also political will. The political context has shifted considerably in the past year, with major implications for law reform. In November 2024, the coalition between the SPD, Greens and FDP that appointed the Commission collapsed, and a new federal election took place in February 2025. The centre-right Christian Democratic Party (CDU) won the majority and the Alternative für Deutschland (AfD), a far-right party that takes an explicitly anti-TOP position, became the second strongest party [32]. In anticipation of such results, on November 14<sup>th</sup> 2024, following the initiative of the Greens and SPD, a cross-party group of members of parliament had submitted a draft bill for the reform of TOP regulations before the new federal election. Following

the Commission's recommendations, this draft bill included legislative changes such as a) TOP is no longer regulated under the Criminal Code but receives a new regulation under the Act on Pregnancy in Conflict Situations (SchKG), b) TOP in early stages of pregnancy (until 12 weeks) following counselling becomes lawful, c) mandatory counselling remains but the three-day waiting period is omitted, and d) costs for TOP are covered by statutory health insurance. In the draft bill, the conditions for the medical indication remained unchanged and an embryopathic indication was not reintroduced [33]. The draft bill was debated in its first reading in the German Bundestag in December 2024 and referred to the Bundestag's Legal Affairs Committee for further consideration. However, it did not come to a vote before the new election due to resistance from the CDU and FDP [34]. It seems unlikely that the revision of TOP legislation will be part of the new government's agenda.

Overall, we sincerely appreciate the work done by the Commission and believe their report provides an important basis for further discussion and future endeavours to improve provision of TOP in Germany. However, we also wish to conclude by highlighting that legislative change alone is insufficient to ensure equitable, accessible and sustainable TOP services. More medical providers need to be trained in TOP procedures, and reducing the stigmatisation and taboo of TOP socially, culturally and politically is critical.

#### **Footnotes:**

<sup>1</sup> We note that there is some debate about the distinction between “legalisation” and “decriminalisation” in these areas.

<sup>2</sup> The Commission considers the early stage of pregnancy to encompass the first weeks after nidation without specifying a gestational age limit.

<sup>3</sup> We use the direct translation of the German term “die Schwangere” as “pregnant woman” and “die Frau” as “woman” throughout, as these are the terms used in the relevant legislation, while recognising that gestational parents may not identify as women.

<sup>4</sup> Costs for TOP following the criminological or medical-social indications are covered by statutory health insurance as they are not considered unlawful.

<sup>5</sup> See sections 5.1 and 5.2 of the report for a more detailed discussion.



## References

1. Vasel JJ. Verfassungsgerichtliche Verkehungen? 50 Jahre Schwangerschaftsabbruch-I-Entscheidung des BVerfG. 2025;47(2):107-18.
2. Kommission zur reproduktiven Selbstbestimmung und Fortpflanzungsmedizin. Bericht der Kommission zur reproduktiven Selbstbestimmung und Fortpflanzungsmedizin 2024. Available from: <https://www.bmfsfj.de/resource/blob/238402/c47cae58b5cd2f68ffbd6e4e988f920d/bericht-kommission-zur-reproduktiven-selbstbestimmung-und-fortpflanzungsmedizin-data.pdf>.
3. Bundesministerium für Familie, Frauen und Jugend. Sachverständigenkommission legt Abschlussbericht vor 2024 [Available from: <https://www.bmfsfj.de/bmfsfj/aktuelles/alle-meldungen/sachverstaendigenkommission-legt-abschlussbericht-vor-238398#:~:text=Die%20Kommission%20zur%20reproduktiven%20Selbstbestimmung,ihren%20Abschlussbericht%20an%20die%20Bundesregierung>].
4. Foth H. Avoiding 'selection'?—References to history in current German policy debates about non-invasive prenatal testing. *Bioethics*. 2021;35(6):518-27.
5. Sourlas P. Human Dignity and the Constitution. *Jurisprudence*. 2016;7(1):30-46.
6. Halliday S. Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life. *Contemporary Issues in Law*. 2016;13 (4):287-322.
7. Jasanoff S, Metzler I. Borderlands of Life: IVF Embryos and the Law in the United States, United Kingdom, and Germany. *Science, Technology, & Human Values*. 2018;45(6):1001-37.
8. Robinson H. Prenatal testing, disability equality, and the limits of the law. *New Bioeth*. 2023;29(3):202-15.
9. Shaw D, Awoonor-Williams K, Brauer A, Gil L, Morales JP, Chavkin W. Perils and possibilities of health exception laws: A narrative review. *International Journal of Gynecology & Obstetrics*. 2024;164(S1):67-80.
10. Statistisches Bundesamt. Anzahl der Schwangerschaftsabbrüche in Deutschland nach rechtlicher Begründung: Statistisches Bundesamt; 2024 [Available from: [https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Schwangerschaftsabbrueche/Tabellen/03-schwangerschaftsabbr-rechtliche-begrueundung-schwangerschaftsdauer\\_zvab2012.html](https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Schwangerschaftsabbrueche/Tabellen/03-schwangerschaftsabbr-rechtliche-begrueundung-schwangerschaftsdauer_zvab2012.html)].
11. Pro Familia Bundesverband. Schwangerschaftsabbruch. Fakten und Hintergründe 2017 [Available from: <https://www.profamilia.de/fileadmin/publikationen/Fachpublikationen/Schwangerschaftsabbruch/Hintergrund-Schwangerschaftsabbruch.pdf>].
12. Böhm M, Nitzsche R, Walsch J. Klinische Angebote zum Schwangerschaftsabbruch im zweiten und dritten Trimenon – eine explorative Erhebung zur aktuellen Versorgungslage. *Z Sex Forsch*. 2022;35(03):160-5.
13. Eurostat. Abortion indicators 2024 [updated 2024 Jul 8. Available from: [https://ec.europa.eu/eurostat/databrowser/view/demo\\_fabortind/default/bar?lang=en](https://ec.europa.eu/eurostat/databrowser/view/demo_fabortind/default/bar?lang=en)].
14. Inspectie Gezondheidszorg en Jeugd Ministerie van Volksgezondheid, Welzijn en Sport. Jaarrapportage 2023 Wet afbreking zwangerschap (Wafz). 2024.

15. Halliday S, Romanis EC, de Proost L, Verweij EJ. The (mis)use of fetal viability as the determinant of non-criminal abortion in the Netherlands and England and Wales. *Medical Law Review*. 2023;31(4):538-63.
16. Torenz R, Vollmer H, Eckardt S, Wyrobisch-Krüger A, Thonke I, Hahn D. Data on regional availability and accessibility of abortion providers in Germany. *Research in Health Services & Regions*. 2023;2(1):21.
17. Krawutschke R, Pastrana T, Schmitz D. Conscientious objection and barriers to abortion within a specific regional context - an expert interview study. *BMC Med Ethics*. 2024;25(1):14.
18. Baier A, Behnke AL. Barriers to abortion provision: A qualitative study among medical students and gynecologists in Berlin, Germany. *Contraception*. 2024;130:110325.
19. Ulbricht A. Who can talk about abortion? Information, offence, freedom of speech, and the advertising ban in Germany. *Politics*. 2021;44(1):25-38.
20. Bunderärztekammer. (Muster-)Weiterbildungsordnung 2018, Gebiet Frauenheilkunde und Geburtshilfe 2023 [Available from: [https://www.bundesaerztekammer.de/fileadmin/user\\_upload/old-files/downloads/MLogbuch-8-FA\\_Frauenheilkunde-Geburtshilfe.pdf](https://www.bundesaerztekammer.de/fileadmin/user_upload/old-files/downloads/MLogbuch-8-FA_Frauenheilkunde-Geburtshilfe.pdf)].
21. Horn C. Abortion Rights after Artificial Wombs: Why Decriminalisation is Needed Ahead of Ectogenesis. *Medical Law Review*. 2021;29(1):80-105.
22. Heidemann J. Der Diskurs zur Entkriminalisierung des Schwangerschaftsabbruchs – ideologisch induziert oder rechtlich angezeigt? *Die Gynäkologie*. 2024;57(1):52-8.
23. Strong C. The Moral Status of Preembryos, Embryos, Fetuses, and Infants. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*. 1997;22(5):457-78.
24. Nov-Klaiman T, Bowman-Smart H, Horn R. Negotiating severity behind the scenes: prenatal testing in Germany. *European Journal of Human Genetics*. 2024.
25. Geffroy A, Bäß E, Kunze M, Waterstradt I, Schmidt U, Huber-Schumacher S, et al. Praxisorientierter Umgang mit späten Schwangerschaftsabbrüchen und Fetoziden. *Die Gynäkologie*. 2023;56(7):495-501.
26. Kommission für Öffentlichkeitsarbeit und ethische Fragen der Gesellschaft für Humangenetik e.V., Berufsverband Medizinische Genetik e.V. Stellungnahme zur Neufassung des § 218a StGB mit Wegfall der sogenannten embryopathischen Indikation zum Schwangerschaftsabbruch 2001 [Available from: <https://gfhev.de/de/veroeffentlichungen/s-1995-Stellungnahme-zur-Neufassung-218-StGB.PDF>].
27. Hofmann B. 'You are inferior!' Revisiting the expressivist argument. *Bioethics*. 2017;31(7):505-14.
28. Dettmeyer R, Lang J, Axt-Fliehdner R, Birngruber C, Tinneberg H-R, Degenhardt J. Termination of Pregnancy for Medical Indications under Sec. 218a Para. 2 of the German Criminal Code – Real-life Data from the “Gießen Model”. *Geburtshilfe Frauenheilkd*. 2017;77(04):352-7.
29. Liehr T, Weise A. Schwangerschaftsabbrüche: Falsch positive Ergebnisse: *Deutsches Ärzteblatt*; 2023 [Available from: <https://www.aerzteblatt.de/archiv/234336/Schwangerschaftsabbrueche-Falsch-positive-Ergebnisse>].
30. Shachar C, Baruch S, King LP. Whose Responsibility Is It to Define Exceptions in Abortion Bans? *JAMA*. 2024;331(7):559-60.

31. González Vélez AC. "The health exception": a means of expanding access to legal abortion. *Reproductive Health Matters*. 2012;20(40):22-9.
32. The Federal Returning Officer. Bundestag Election 2025 2025 [Available from: <https://bundeswahlleiterin.de/en/bundestagswahlen/2025/ergebnisse/bund-99.html>].
33. Members of Parliament. Draft Bill: Proposal for a Law on the Reform of Abortion Regulations [Gesetzesentwurf: Entwurf eines Gesetzes zur Neuregelung des Schwangerschaftsabbruchs] 2024 [Available from: <https://dserver.bundestag.de/btd/20/137/2013775.pdf>].
34. Legalisierung von Abtreibungen vorerst gescheitert [Legalization of Abortions Failed for Now]. *Tagesschau*. 2025.