

Abortion Law Around the World: Progress and Pushback

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There is a global trend toward the liberalization of abortion laws driven by women's rights, public health, and human rights advocates. This trend reflects the recognition of women's access to legal abortion services as a matter of women's rights and self-determination and an understanding of the dire public health implications of criminalizing abortion.

Nonetheless, legal strategies to introduce barriers that impede access to legal abortion services, such as mandatory waiting periods, biased counseling requirements, and the unregulated practice of conscientious objection, are emerging in response to this trend. These barriers stigmatize and demean women and compromise their health.

Public health evidence and human rights guarantees provide a compelling rationale for challenging abortion bans and these restrictions. (*Am J Public Health*. 2013;103:585–589. doi:10.2105/AJPH.2012.301197)

ACCORDING TO THE MOST RE-cent research, the legal framework in 68 countries worldwide currently prohibits abortion entirely or permits it only to save a woman's life. Conversely, 60 countries allow a woman to decide whether to terminate a pregnancy. A further 57 countries permit abortion to protect a woman's life and health, and an additional 14 permit abortion for socioeconomic motives.¹ These figures indicate that roughly 39% of the world's population lives in countries with highly restrictive laws governing abortion.²

Following World War II, abortion was highly restricted throughout most of the world.³ Since the 1950s, when the liberalization of abortion laws began in Eastern and Central Europe, an unmistakable global trend toward easing legal restrictions on abortion has ensued. The landmark decision of *Roe v. Wade* in the United States can be seen against the backdrop of liberalization of abortion laws in the developed world through the 1960s and 1970s.⁴ Between 1950 and 1985, nearly all industrialized countries—and several others—liberalized their abortion laws.⁵ Furthermore, since 1994, when 179 countries committed to preventing unsafe abortion under the International Conference on Population and Development Programme of Action, more than 25 countries have liberalized their abortion laws. During the same period, only a handful have tightened legal restrictions on abortion.⁶

Despite some notable exceptions,⁷ nearly all countries in the global north and central and eastern Asia currently have liberal abortion

laws, authorizing the service without restrictions as to reason during certain gestational limits or on broad grounds, such as for socioeconomic reasons. By contrast, countries in the global south generally have restrictive abortion laws on the books, with abortion criminalized except for limited circumstances, such as if a woman's health or life is at risk, or in cases of rape, incest, or fetal impairment.⁸

The legal framework for abortion in a given country can be derived from multiple sources, including statutes enacted by legislatures, regulations created by administrative agencies, and court decisions. Many of these laws and policies apply concurrently. Although abortion is a medical procedure, it has historically been addressed in penal codes and characterized as a crime. Penal codes generally set out criminal sanctions for the abortion provider and in some instances also for the woman undergoing the abortion. However, these same penal codes normally recognize exceptions under which performing an abortion does not carry any criminal penalties.⁹

The liberalization of abortion laws using legal means has generally been achieved by amending criminal bans to specify certain circumstances in which there is no legal penalty for abortion. Thus, countries in the first wave of liberalization, in Central and Eastern Europe, saw the introduction of specific circumstances in which abortion carried no criminal sanction.¹⁰ In addition, although most countries (including those with liberal abortion laws) still maintain penal code provisions

delineating the circumstances in which abortion is a crime, penal code provisions have been increasingly replaced or supplemented by public health codes, court decisions, and other regulations and laws addressing the provision of reproductive health care.¹¹ In 2010, for example, Spain (one of the few European countries that had maintained a restrictive abortion law) enacted a law on sexual and reproductive health that eliminated a penal code provision punishing women for illegally procuring abortions and recognized their right to abortion without restrictions as to reason during certain gestational limits and thereafter on specific grounds.¹²

Active campaigning from the women's rights, public health, and human rights fields has worked to considerable effect,¹³ with achievements in law reform reflecting both the recognition of the dire public health implications of criminalizing abortion and the identification of women's access to lawful termination of a pregnancy as a question of women's rights and self-determination. Concurrently, international standards on the protection of women's reproductive rights and their application to abortion have developed considerably.¹⁴ This trend persists despite the recent emergence of an increasingly organized and vehement opposition that seeks to restrict abortion laws and impose barriers to women's access to abortion globally.

Despite the overall global trend of easing legal restrictions on abortion, legal strategies have emerged to introduce new types of barriers that impede women's

access to legal abortion services. An increasingly global and coordinated movement—which pronatalist and religious concerns have fueled in direct response to the worldwide trend toward abortion law liberalization—has instigated such strategies. Although in some countries progressive or retrogressive steps can be classified simply, in others political tugs-of-war have led to measures that pull the specific elements of the legal status of abortion back and forth. Retrogressive steps have been added that introduce new barriers to abortion access rather than altering the overall legal status of abortion, making the achievement of broader reform unrealistic because of the political context or established legal framework.

In Poland, for example, a liberal abortion law in place until the fall of the Soviet Union was restricted in 1993.¹⁵ In 1996, the law was again liberalized, but subsequent efforts, through amendments to the law and a ruling from the constitutional court, again restricted the law.¹⁶ The Polish parliament narrowly rejected a bill that would have introduced an absolute ban on abortion in 2011.¹⁷

Strategies to restrict abortion access have increasingly focused on introducing procedural barriers, through law or policy, that limit the availability of abortion services. Such barriers—introduced primarily in countries with liberal abortion laws, including the United States and Central and Eastern Europe countries—include mandatory and biased counseling requirements,¹⁸ waiting periods,¹⁹ third-party consent and notification requirements,²⁰ limitations on the range of abortion options (e.g., restrictions on medical abortion, including specific bans on misoprostol²¹), and limitations on abortion funding.

Currently, 26 US states have a waiting period, which is normally 24 hours,²² and nine states require counseling that provides inaccurate information about negative mental health consequences of abortion.²³ In 2011, the Russian parliament established a mandatory waiting period for abortions and considered several other procedural barriers to abortion.²⁴ In 2009, the Slovak Republic introduced several procedural barriers to abortion access, including a mandatory counseling requirement, a 48-hour waiting period, and the extension of the parental consent requirement to all minors²⁵ when previously it had applied only to girls younger than 16 years.²⁶

A further impediment to abortion access results from the unregulated conscientious objection of health care providers and others. The right to refuse to perform services because of moral or religious objections is governed by national laws that vary in the scope of limits of conscientious objection and that invite differing interpretations.²⁷ Although insufficient research has been conducted into the prevalence of unregulated conscientious objection, case law and limited research shows that it is increasingly invoked in countries where opposition to recent liberalization is strong (e.g., Colombia)²⁸ and where there are attempts to reverse the legalization of abortion (e.g., Poland).²⁹ A growing body of jurisprudence delineates the justifiable limits on the exercise of conscientious objection in this context, including when pharmacists, nurses, judges, and health care institutions invoke it.³⁰

ABORTION LAW AND PUBLIC HEALTH

The World Health Organization has identified unsafe abortion

as a serious public health problem since 1967³¹ and affirms in its most recent technical guidance the scale of this public health impact.³² World Health Organization evidence shows that when faced with an unplanned pregnancy and irrespective of legal conditions, women all over the world are highly likely to have an induced abortion. Legal restrictions that limit the grounds on which a woman may terminate a pregnancy increase the percentage of unlawful and unsafe procedures.³³ The maternal mortality ratio per 100 000 live births owing to unsafe abortion is generally higher in countries with major restrictions and lower in countries where abortion is available without restrictions as to reason or under broad conditions.³⁴ Thus, the public health impact of unsafe abortion is directly linked to its legal status.

Abortion's legal status affects its access in numerous ways, both directly and indirectly. Criminalization renders the procedure illegal and, for many women, unsafe. In addition, criminalization and other legal restrictions can indirectly produce a chilling effect that makes even legal abortions difficult to access.³⁵ A recent report of the United Nations high commissioner for human rights to the United Nations Human Rights Council in examining the preventable causes of maternal mortality and morbidity finds that restrictive abortion laws lead to health providers', police's, and others' responses that discourage care-seeking behavior.³⁶ These responses include withholding care until a woman confesses to having had an illegal abortion and reporting women who have symptoms of a spontaneous or induced abortion to the police because of perceived or real pressure or legal requirements.³⁷

In countries that permit abortion only on narrow legal grounds, information about legal services is often unavailable. Consequently, some women presume that they are not entitled to a legal abortion although this may not be the case.³⁸ Health providers may also lack training in safe abortion procedures, have insufficient information to be able to act within the law, or be reluctant to interpret legal grounds. The lack of care protocols and effective procedures to guide health providers' decision-making to ensure laws are correctly interpreted has led to devastating consequences for women seeking abortions.³⁹ Moreover, health providers' fears of criminal sanction promote a restrictive interpretation of laws and, as a result, more unsafe abortions or delays that have secondary health consequences.⁴⁰

Procedural barriers, such as the mandatory waiting periods and biased counseling requirements we have mentioned, can delay care and hinder access to safe services, which in turn demean women as competent decision-makers and increase health risks.⁴¹

Notably, however, the technical advancement of medical abortion, particularly through the use of misoprostol, has been a revolutionary development in reducing rates of abortion-related morbidity and mortality.⁴² Misoprostol was originally marketed to prevent and treat gastric ulcers, but it is also a safe and effective means of pregnancy termination.⁴³ Women worldwide, particularly in Latin America, are increasingly self-administering misoprostol off-label to terminate their pregnancies.⁴⁴ Thus, in settings with restrictive abortion laws or significant access barriers, women are increasingly able to self-induce safe abortions.⁴⁵ Moreover, as

misoprostol can be stored at room temperature and administered by nonphysicians, it has increased women's access to safe abortion services in many resource-limited settings.⁴⁶

Nonetheless, not only does evidence clearly illustrate the negative public health impact of excessive abortion restrictions, but it also supports the case for abortion law liberalization. According to South Africa's National Committee of Confidential Inquiries into Maternal Deaths, liberalization in the country⁴⁷ in 1996 led to a 91% decline in abortion-related maternal mortality between 1994 and 1998–2001. One study showed an “immediate positive impact on morbidity,”⁴⁸ in particular arising from infection, and another concluded that a “cautious assessment of the magnitude of the reduction [in maternal mortality] confirms that it is large.”⁴⁹

Evidence from Nepal, where revisions to the country's legal code in 2002 granted women the right to terminate a pregnancy up to 12 weeks without restriction as to reason and later on specific grounds, suggests that liberalization has contributed to a decline in complications from unsafe abortion.⁵⁰ Following the liberalization of Romania's abortion law in 1989, maternal mortality dramatically decreased.⁵¹ In the United States, in the years following the *Roe v. Wade* decision, maternal mortality significantly declined as a result of the decrease in unsafe abortions, clearly demonstrating the public health impact of *Roe v. Wade*'s implementation.⁵²

CONCLUSIONS

Evidence of the public health implications of excessive legal restrictions on abortion cannot be ignored. Authoritative research

conducted in the wake of liberalization provides a further rationale for contesting such restrictions on public health grounds. This public health rationale has supported many efforts toward abortion law reform in such countries as Colombia, Ethiopia, and Guyana.

However, those who seek to maintain or introduce restrictive legal regimes for abortion contest the public health evidence that supports the case for lifting excessive legal restrictions on abortion. Such efforts either deliberately avoid the facts or rely on debunked public health evidence to motivate ideology-driven agendas. In the United States, for example, several states have mandated counseling for women seeking abortion services and required them to receive information about purported negative mental health consequences of abortion or a link between abortion and increased risk of breast cancer in an attempt to coerce women to continue unwanted pregnancies.⁵³ These efforts overlook, or ignore, authoritative studies that debunk the myth of a connection between having an abortion and increased mental health risks and disprove any link between abortion and an increased risk of breast cancer.⁵⁴

Other purported justifications for abortion restrictions on public health grounds misrepresent and oversimplify risks and other considerations related to women's health during pregnancy. In Russia, for example, recent restrictions on abortions after 12 weeks of pregnancy have been justified by pointing to an increased risk of maternal mortality resulting from later term abortions.⁵⁵ Although abortion does indeed carry a greater risk of potential complications the later it is performed, this apparent concern for women's

lives is seen to be disingenuous when examined in the light of studies showing that the risk of death associated with childbirth is far greater than is the risk associated with legal abortion.⁵⁶

The argument that forcing women to carry pregnancies to term will reverse trends of demographic decline also underpins restrictions on women's access to abortion in countries such as Russia.⁵⁷ There is no evidence of a connection between restrictions on access to abortion and increased birth rates. As we have discussed, women who wish to terminate their pregnancies will seek this service whether it is legal or not. When abortion services are highly restricted, women are often forced to procure unsafe abortions, which may jeopardize their health and lives.

Excessive legal restrictions have myriad repercussions in addition to whether abortion services are available. Excessive restrictions stigmatize women seeking abortions and discriminate against those who lack the knowledge and understanding of legal grounds for abortion and vulnerable groups, such as poor and rural women and girls. Further research should be conducted into the regional and subnational discrepancies in abortion access resulting from excessive legal restrictions. Where legal restrictions render abortion inaccessible or difficult to access, wealthier women and those based in urban areas may be the only ones able to access private services or travel to obtain abortion services.⁵⁸

Such restrictions on abortion also create systemic problems leading to practices that are inevitably unsafe. Where abortion is prohibited, public health and safety regulations for its provision cannot exist; thus the training and

licensing of health providers is limited.⁵⁹ On these and other grounds, the United Nations special rapporteur on the right to health has characterized the criminalization of abortion as incompatible with the right to the highest attainable standard of health.⁶⁰

We believe that, with time, the public health impact of new kinds of legal and policy barriers introduced to restrict abortion access will become evident. Evidence already shows that mandatory waiting periods compromise women's health by delaying care and women's ability to access safe and legal abortion services,⁶¹ but further research is essential. Although the risks associated with abortion are small, waiting periods cause greater numbers of women to delay the procedure until the second trimester of pregnancy, when the risk of complications rises geometrically.⁶² Similarly, the coercive nature of biased counseling requirements providing medically inaccurate information could lead women to make decisions that jeopardize both their physical and mental health. Such restrictions demean and stigmatize women.⁶³

The public health implications of excessive legal restrictions on abortion are devastating. Reliable public health evidence and the application of human rights guarantees provide a compelling rationale for challenging abortion bans and other restrictions.⁶⁴ The wave of liberalization of abortion laws responded to public health evidence and, more recently, human rights arguments. The ideologically and religiously motivated backlash against abortion is increasingly resorting to misrepresentations and avoidance of public health evidence, and it is undermining human rights standards applicable in this context. The movement that has so successfully

campaigned for abortion liberalization must continue to assert these strong grounds or face pushback on the gains achieved. ■

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Endnotes

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6. Rahman et al., "Global Review of Laws; Reed Boland and Laura Katzive, "Developments in Laws on Induced Abortion: 1998-2007," *International Family Planning Perspectives* 34, no. 3 (2008): 110-120; Center for Reproductive Rights, *Abortion Worldwide: 17 Years of Reform* (New York, 2011), http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub_bp_17_years.pdf (accessed September 20, 2012); Rebecca J. Cook, Bernard M. Dickens, and Laura E. Bliss, "International Developments in Abortion Law From 1988

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16. In 1996, Poland's abortion law was liberalized to permit abortion on social and economic grounds. Act of August 30, 1996. However, the constitutional court invalidated the revised law the following year. Ruling of the Constitutional

Tribunal of May 28, 1997, sign. of the records K 26/96 (Pol.) (unofficial translation). In December 1997, the parliament enacted new legislation eliminating social and economic grounds for abortion. Law of January 7, 1993 on Family Planning, Human Embryo Protection, and Conditions of Legal Pregnancy Termination amended as of December 23, 1997 (Pol.) (unofficial translation provided by Federation for Women and Family Planning).

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20. "Some laws require a woman or girl to obtain the consent of her spouse or parent before undergoing an abortion, whereas others require abortion providers to secure approval from another physician, medical committee or court before performing an abortion" (p. 73). Reed Boland, "Second Trimester Abortion Laws Globally: Actuality, Trends and Recommendations," *Reproductive Health Matters* 18, no. 36 (2010): 67-89.

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'Ob osnovah ohranai grajdan v Rossijskoi Federatzii,'" <http://www.rg.ru/2011/11/23/zdorovie-dok.html> (accessed September 20, 2012). According to article 55, §3, if a woman is in her 4th to 7th week of pregnancy or 11th to 12th week of pregnancy, she must observe a waiting period of 48 hours before she can access abortion services. For a woman in the 8th to 10th weeks of pregnancy, the waiting period is seven days. Additionally, on February 6, 2012, the Russian government issued a decree, the Social Ground for Artificial Termination of Pregnancy, signed by Prime Minister Vladimir Putin. This decree establishes that the only social ground for abortion between the 12th and 22nd weeks of pregnancy is rape. Previously, abortion was authorized for four social indications during this period. "Postanovlenie Pravitelva Rossijskoi Federacii ot 6 fevralia 2012 g. N 98 g. Moskva: 'O socialno, pokazanii dlia iskusstvennogo preriavania beremennosti,'" <http://www.rg.ru/2012/02/15/98-dok.html> (accessed September 20, 2012).

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28. Previously, abortion was prohibited with no explicit exceptions. Penal Code, promulgated by Law 599 of 2000 (Colombia). Following a ruling by the constitutional court of Colombia, abortion is now permitted to save a woman's life or mental or physical health or in cases of rape, incest, or severe fetal impairment. Women's Link Worldwide, "C-355/2005: Excerpts of the Constitutional Court's Ruling That Liberalized Abortion in Colombia"; 2007, http://www.womenslinkworldwide.org/pdf_pubs/pub_c3552006.pdf (accessed September 20, 2012). Judges have subsequently invoked conscientious objection when refusing to hear appeals in connection with

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30. See, for example, Corte Constitucional de Colombia, May 28, 2009, "T-388/09/Acción de Tutela" (Colombia) in which the constitutional court of Colombia noted that judicial authorities cannot refuse a woman an abortion on the basis of conscience claims. It also noted that institutions cannot refuse a woman an abortion on the basis of conscience claims. It indicated that only the physician directly performing the abortion can object to the provision of services and to do so, he or she must submit a written statement explaining the objection and refer a woman to a physician who is willing and able to perform the abortion. See also *Pichon and Sajous v. France*, No. 49853/99, Eur. Ct. H. R., Admissibility Decision (October 2, 2001) (holding that "as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products" [p. 4]).
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