Global Developments in Laws on Induced Abortion: 2008–2019

CONTEXT: *Evidence shows that laws that restrict abortion do not eliminate its practice, but instead result in women having clandestine abortions, which are likely to be unsafe. It is important to periodically assess changes in the legal status of abortion around the world.*

METHODS: *The criteria for legal abortion as of 2019 for 199 countries and territories were used to distribute them along a continuum of six mutually exclusive categories, from prohibited to permitted without restriction as to reason. The three most common additional legal grounds that fall outside of this continuum—rape, incest and fetal anomaly—were also quantified. Patterns by region and per capita gross national income were examined. Changes resulting from law reform and judicial decisions since 2008 were assessed, as were changes in policies and guidelines that affect access.*

RESULTS: *Legality correlated positively with income: The proportions of countries in the two most-liberal categories rose uniformly with gross national income. From 2008 to 2019, 27 countries expanded the number of legal grounds for abortion; of those, 21 advanced to another legality category, and six added at least one of the most common additional legal grounds. Reform resulted from a range of strategies, generally involving multiple stakeholders and calls for compliance with international human rights norms.*

CONCLUSIONS: *The global trend toward liberalization continued over the past decade; however, even greater progress is needed to guarantee all women's right to legal abortion and to ensure adequate access to safe services in all countries.*

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The grounds under which abortion is legal are key to its safety. Whether women experiencing unintended pregnancies are able to interrupt them legally—and safely—varies greatly by where women live. Legally restricting this common procedure does not reduce the rate at which it occurs.[1] Instead, legal restrictions result in women having clandestine abortions to avoid stigma and prosecution, despite the health risk often posed by abortions that occur outside the law. Indeed, the proportion of abortions considered to be "least safe" (i.e., done by an untrained provider using a nonrecommended method) rises with increasing legal restrictions: Less than 1% of abortions are least safe in countries that allow abortion without restriction as to reason, compared with 31% in those where abortion is outlawed outright or legal only to save the woman's life.[2]

Complications are exceedingly rare where abortion is legal: When done according to best-practices guidelines, just 0.5% of first-trimester abortions result in complications that need facility-based care.[3] Directly comparable data are unavailable on how often illegal—or legal but highly stigmatized—procedures result in the need for care; however, nearly seven of every 1,000 women of reproductive age in developing regions received postabortion care (PAC) after an unsafe procedure in 2012.[4] This estimated annual total of seven million women, however, fails to include women who are unable or simply too ashamed to seek care needed after an unsafe procedure, as well as those who die before reaching a source of care.

This article, the third in a series, reviews the legal status of abortion throughout the world from 2008 through 2019. As in the two preceding reviews, which summarized developments from 1985 to 1997,[5] and from 1998 to 2007,[6] we provide an overview of how national laws currently regulate abortion and which countries have changed their laws over roughly the past decade. Periodically assessing trends in how national laws restrict abortion is valuable at the country, regional and global levels. It provides essential information to a wide range of stakeholders—policymakers, service providers, researchers and advocates—working to make abortion safer and more accessible.

APPROACH

For this review, we rely on a classification system developed by the Center for Reproductive Rights (CRR) that categorizes 199 countries, territories and administrative jurisdictions* on the basis of national-level law, including

* This total reflects the precedent established by CRR of examining laws in all 193 United Nations member states, plus two nonmember states (Kosovo and the State of Palestine) and four territories or other administrative jurisdictions (Hong Kong, Northern Ireland, Puerto Rico and Taiwan).

judicial decisions with the force of law.[7] We use primary sources of law only when CRR's category placement differs from the exact wording of the law, as was the case for three countries: Ethiopia,[8] Mozambique[9] and Rwanda.[10] Complementary regulations on abortion, such as ministerial guidelines or codes of medical ethics, may guide implementation of these laws—or conflict with the law—but we rely only on national-level law to assure uniformity and comparability. For Australia, Mexico and Micronesia, which decide abortion law at the state rather than the federal level, we place each country in the category that covers the largest proportion of the population. Our review of developments over time relies on CRR's report assessing 20 years of reform, as of 2013;[11] individual countries' laws in effect before changes occurring from 2014 through 2019; and CRR's data pertaining to laws in effect as of December 2019.[7]

We use the six-way classification system to distribute countries into mutually exclusive categories, and examine how the proportions in these categories shift by geographic or economic grouping. The hierarchical classification orders legal grounds cumulatively, by successively adding health and socioeconomic grounds until laws no longer restrict abortion as to reason. We emphasize that this categorization accords with a literal reading of the law in force in each country, which may differ from how that law is applied in practice. We also acknowledge that the laws governing abortion practice are highly nuanced, containing various additional legal grounds that do not always fit into our predesignated categories. Nonetheless, to meaningfully quantify how abortion is regulated and record trends over time, we need to apply a strictly comparable standard.

Countries that prohibit abortion altogether are placed in category 1, and those that permit abortion without restriction as to reason, in category 6. The intermediate categories present successive grounds, and starting with category 3, each includes the previous category's grounds. Category 2 includes countries that explicitly allow abortion only to save the woman's life. The two earlier installments in this series collapsed categories 1 and 2. We keep them separate to emphasize that category 2 countries must provide legal abortions to save women's lives; to indicate that category 2 countries can allow additional legal criteria of rape, incest and fetal anomaly; and to establish clear baselines of either category 1 or category 2 for countries that move across the continuum over time.

Countries in category 3, which inherently incorporates the exception to save the woman's life, also allow abortion to preserve the woman's health.† These laws commonly refer to "health" or "therapeutic" grounds. We keep this category separate from the next, category 4, which includes countries that also explicitly allow abortion to protect the woman's mental health. We recognize that this is an imperfect solution, because laws in category 3 can be interpreted to include mental health. However, this distinction enables us to track when a country moves to expressly include mental health. Category 5 encompasses the three preceding groupings' legal grounds and adds socioeconomic reasons. Such reasons most often account for a woman's existing children, her living conditions or her "actual or reasonably foreseeable environment."

Countries specify numerous other legal grounds for abortion that fall outside the six-category continuum. The most common of these are rape, incest or fetal anomaly.‡ We quantify the extent to which countries in any of the four intermediate categories have any of these most common additional legal grounds. We consider such additional legal grounds to be valid only if any woman—not just a subset of women—can qualify for an abortion on these grounds. For example, Zambia's legal ground for rape is restricted to statutory rape, which is sexual activity below the age of consent;[12] because women aged 16 and older cannot qualify for the rape exception, we do not classify Zambia as having this additional ground. Similarly, because Brazil allows abortion for just one type of fetal anomaly, rather than for any, that country is not classified as having the additional ground of fetal anomaly.[13]

The slight majority (58%) of countries in category 6 set the gestational age limit for on-request abortions at 12 weeks.§ Many countries in all applicable categories extend these limits when the woman's life or health is in danger, as well as on the specific ground of fetal anomaly, which in many cases can be diagnosed only after the first trimester of pregnancy. Rather than comprehensively report such ground-specific gestational limits, which vary widely across and within countries (i.e., they can be decided at the state or the federal level) and have not been systematically compiled in a single source, we give a few illustrative examples.

We also quantify a few legal restrictions that affect abortion access, such as requirements for consent from spouses or from parents or guardians. Although other eligibility requirements exist for access, including mandated counseling requirements and waiting periods, these are not quantified in this article, as they are less consistently identified in documents with the force of law. Nor do we identify what are often referred to as conscientious objection clauses, which permit practitioners to opt out of administering abortion services for religious or other beliefs. Again, we provide only illustrative examples of such developments, rather than a comprehensive overview.

†Nearly all countries in category 3—those with no explicit mention of mental health—do not modify the word "health" at all. Just two, Monaco and Zimbabwe, limit the health exception explicitly to physical health.

‡Others include when the pregnant woman is mentally impaired, is HIV positive, is a minor, is a minor unprepared for motherhood or is in distress; or when the pregnancy results from forced marriage, contraceptive failure or forced artificial insemination.

§This value and all numbers of weeks of gestation in this article refer to the time since last menstrual period. The values for the few countries that quantify pregnancy in weeks since conception, which would be two weeks less, have been recalculated to make all gestational ages strictly comparable. For specifics on the 28 category 6 countries whose gestational limit differs from 12 weeks, see reference 17.

Finally, government restrictions and rationing of health services in response to the COVID-19 pandemic in 2020 have doubtlessly undermined access to safe abortion in many contexts. We are unable to address the impact of the pandemic within the scope of this analysis, which is limited to the legal status of abortion through 2019.

OVERVIEW OF LAWS AS OF DECEMBER 2019

Continuum of Legal Grounds

Of 199 countries and territories, 24 (12%) prohibit abortion altogether (Table 1). Some 41 countries (21%) allow abortion to save the woman's life only, and 32 (16%) to both save the woman's life and preserve her health, without explicit mention of mental health. Another 25 countries (13%) do explicitly include mental health, and 11 (5%) also permit abortion on socioeconomic grounds. Finally, in 66 of the world's countries (33%), women are legally entitled to an abortion without restriction as to reason.

Should poorer countries have more restrictive laws than wealthier countries, women living in the former would be doubly disadvantaged: Not only would women living in poorer, restrictive countries be less likely to have a safe legal abortion to begin with, but they would also be less likely to receive needed PAC because of limited national health budgets and relatively weak health systems. We measured wealth by the World Bank's calculation of gross national income (GNI) and classification of countries into four income groups, for calendar year 2019.[14] Our analysis shows that wealth has a positive association with legality: Europe (except Eastern Europe) and Northern America, which have the most high-income countries, have the least restrictive abortion laws. Charting legality by per capita GNI confirms this pattern. The likelihood of abortion being highly or moderately restricted (i.e., categories 1–4) is inversely related to wealth. Some 42% of high-income countries, 58% of upper-middle-income countries, 74% of lower-middle-income countries and 90% of low-income countries fall into these restrictive categories. Conversely, the proportion of countries that have broadly liberal abortion laws (categories 5 and 6) rises uniformly with per capita income, from 10% of low-income countries to 58% of high-income countries.

Whereas noting the number of countries in each category is important for identifying divergences and commonalities, considering differences in population size provides insight into the numbers of women affected by restrictive laws. Using women of reproductive age (15–49) as our unit of analysis,[15] rather than countries, shows that some 42% of the world's women live where abortion is highly or moderately restricted (Figure 1). This global average masks huge differences by region, with just 0–5% of women in Europe and Northern America living in restrictive countries, compared with 97% of women in Latin America and the Caribbean.¶ At the most-restrictive end of the spectrum, 15% of women in Africa live where abortion is prohibited altogether (category 1), by far the largest proportion among major world regions. Otherwise, the proportion living where abortion is prohibited ranges from 0% in Northern America to 7% in Latin America and the Caribbean.

Additional Grounds: Rape, Incest and Fetal Anomaly

The most common of additional legal grounds that fall outside the six-category continuum are the grounds of rape, incest and fetal anomaly. Because countries in category 1 do not permit abortion under any circumstance, and countries in category 6 permit abortion without restriction as to reason, we quantify these additional grounds among only the relevant countries in categories 2–5. These grounds can be crucial to enabling women to get a safe and legal abortion in otherwise highly restrictive countries. For example, as of 2019, 12 countries in category 2 (i.e., those with the sole health ground of saving the woman's life) also allow legal abortion on at least one of these additional grounds (Table 1).**

Among the 109 countries or territories in the intermediate categories, 51 (47%) have none of these additional grounds; 27 (25%) have one or two; and 31 (28%) have all three. Most of the countries in the last group are in Sub-Saharan Africa, which may partly reflect the influence of prescriptive language in the African Union's Maputo Protocol that abortion must be legal in these three circumstances.[16] Notably, the countries' addition of these three grounds began prior to the protocol's adoption in 2003 and has continued over the past 15 years.[5,6]

Procedural Restrictions on Access

In addition to specifying the grounds on which abortion is legal, laws often establish administrative, procedural and regulatory requirements that directly affect women's access to legal abortion. Where such requirements do not confer a health or other benefit to women, they can hinder access. For example, many countries require consent from a parent or guardian or from a spouse as a prerequisite to legal abortion. Of the 175 countries and territories with at least one legal ground for abortion (those in categories 2–6), 39 require either parental consent or notification for minors.[17] These countries mostly permit abortion on broad legal grounds (categories 5 and 6), and are concentrated in Europe. However, 12 countries or territories in categories 2–6 require married women to obtain their spouse's consent for a legal abortion.†† Of these, only Turkey is in category 6—meaning that it is the sole country allowing abortion on request while requiring a married woman to obtain her husband's consent.

¶These data are based on the United Nations Population Division's assignment of countries into regions, according to which Mexico is considered part of Latin America, rather than Northern America.

**Bhutan, Brazil, Chile, Côte d'Ivoire, Gabon, Gambia, Indonesia, Iran, Mali, Mexico, Panama and Sudan.

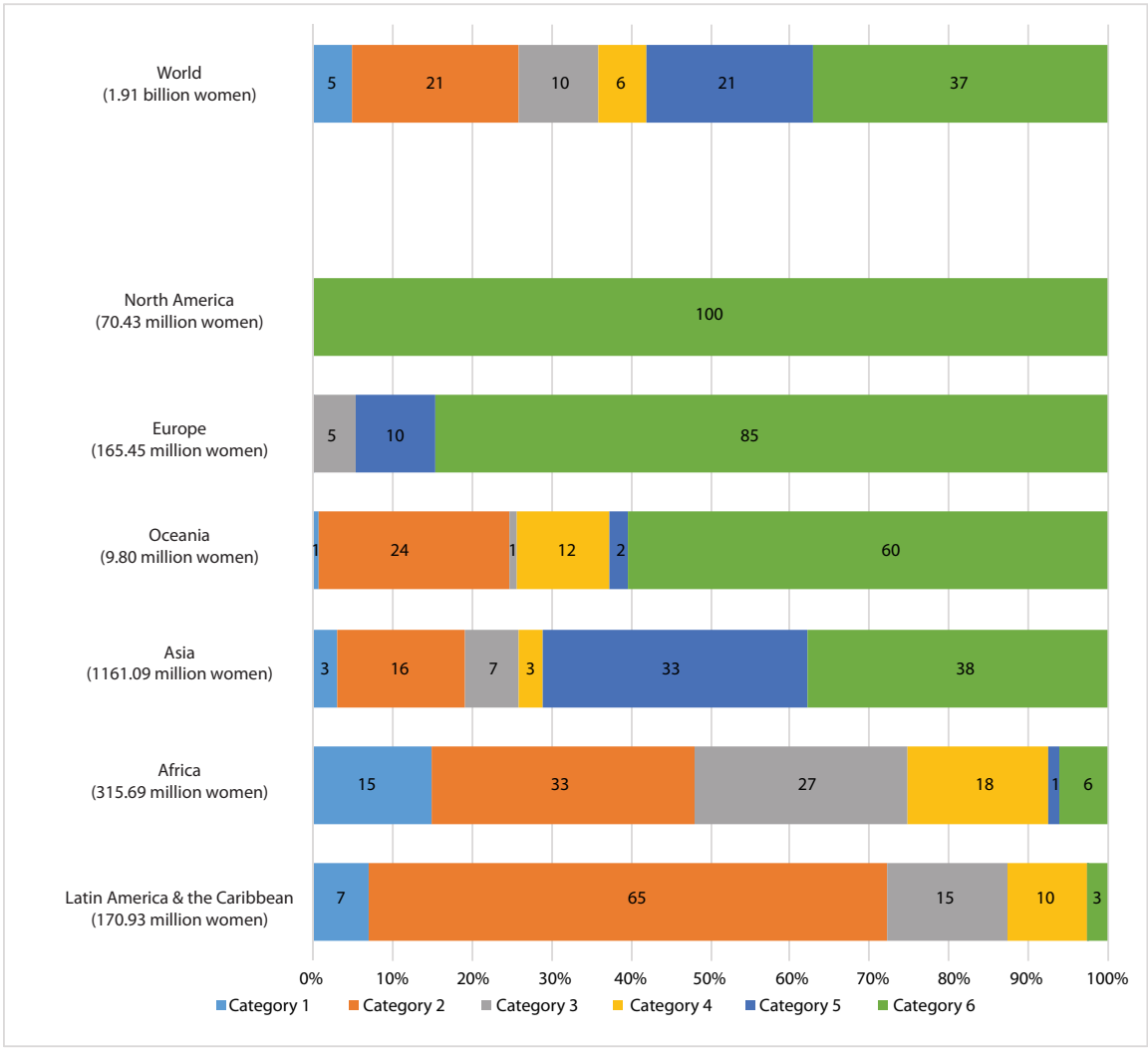
††Equatorial Guinea, Indonesia, Japan, Kuwait, Morocco, Saudi Arabia, South Korea, Syrian Arab Republic, Taiwan, Turkey, United Arab Emirates and Yemen.

TABLE 1. Distribution of 199 countries and territories, by abortion legality category and the three most common additional grounds, according to World Bank gross national income group, 2019

Abortion legality	Low (n=29)	Lower-middle (n=50)	Upper-middle (n=55)	High (n=65)
Category 1 (n=24) **None**	Haiti Madagascar Sierra Leone	Angola Congo El Salvador Egypt Honduras Laos Mauritania Micronesia Nicaragua Philippines Senegal	Dominican Republic Iraq Jamaica Marshall Islands Suriname Tonga	Andorra Malta Palau San Marino
Category 2 (n=41) **To save woman's life**	Afghanistan Gambia (F) Malawi Mali (R,I) Somalia South Sudan Sudan (R) Syria (SC,PC) Uganda Yemen (SC)	Bangladesh Bhutan (R,I) Côte d'Ivoire (R) Kiribati Myanmar Nigeria Papua New Guinea Solomon Islands Sri Lanka State of Palestine Tanzania Timor-Leste (PC)	Brazil (R) Dominica Gabon (R,I,F) Guatemala Indonesia (R,F,SC) Iran (F) Lebanon Libya Mexico (R,F) Paraguay Tuvalu Venezuela	Antigua and Barbuda Bahrain Brunei Chile (R,F) Oman Panama (R,F,PA) United Arab Emirates (SC,PC)
Category 3 (n=32) **To save woman's life and preserve her health (but with no explicit mention of mental health)**	Burkina Faso (R,I,F) Burundi Central African Republic (R,I,F) Ethiopia (R,I,F) Guinea (R,I,F) Niger (F) Togo (R,I,F)	Benin (R,I,F) Cameroon (R) Comoros Djibouti Kenya Lesotho (R,I,F) Morocco (SC) Pakistan Vanuatu Zimbabwe (R,I,F)	Argentina (R) Costa Rica Ecuador Equatorial Guinea (SC,PC) Grenada Jordan Peru	Bahamas Kuwait (F,SC,PC) Liechtenstein (PC) Monaco (R,I,F) Poland (R,I,F,PC) Qatar (F) Saudi Arabia (SC,PC) South Korea (R,I,F,SC)
Category 4 (n=25) **To save woman's life and preserve her health, with explicit mention of mental health**	Chad (R,I,F) Democratic Republic of the Congo (R,I,F) Eritrea (R,I) Liberia (R,I,F) Mozambique (R,I,F) Rwanda (R,I,F)	Algeria Bolivia (R,I) Eswatini (R,I,F) Ghana (R,I,F)	Botswana (R,I,F) Colombia (R,I,F) Malaysia Namibia (R,I,F) Saint Lucia (R,I) Samoa Thailand (R,F)	Israel (R,I,F) Mauritius (R,I,F,PC) Nauru (R,I,F) New Zealand (I,F) Northern Ireland Saint Kitts and Nevis Seychelles (R,I,F) Trinidad and Tobago
Category 5 (n=11) **To save woman's life and preserve her health, plus socioeconomic grounds**		India (R,F,PC) Zambia (F)	Belize (F) Fiji (R,I,F,PC) Saint Vincent and the Grenadines (R,I,F)	Barbados (R,I,F,PC) Finland (R,F) Great Britain (F) Hong Kong (R,I,F) Japan (R,SC) Taiwan (R,I,F,SC,PC)
Category 6 (n=66) **No restriction as to reason (with gestational and other requirements)**	Guinea-Bissau North Korea Tajikistan	Cabo Verde Cambodia (PC) Kyrgyzstan Moldova (PC) Mongolia Nepal Sao Tome and Principe Tunisia Ukraine Uzbekistan Viet Nam	Albania (PC) Armenia (PC) Azerbaijan Belarus Bosnia and Herzegovina (PC) Bulgaria China Cuba (PC) Georgia (PC) Guyana Kazakhstan Kosovo(PC) Maldives Montenegro (PC) North Macedonia (PC) Russian Federation Serbia (PC) South Africa Turkey (SC,PC) Turkmenistan	Australia Austria Belgium Canada Croatia (PC) Cyprus Czech Republic (PC) Denmark (PC) Estonia France Germany Greece (PC) Hungary Iceland Ireland Italy Latvia (PC) Lithuania (PC) Luxembourg Netherlands Norway (PC) Portugal (PC) Puerto Rico Romania Singapore Slovakia (PC) Slovenia (PC) Spain (PC) Sweden Switzerland United States (PC) Uruguay (PC)

Notes: The three most common additional grounds that are not on the continuum: R=rape; I=incest; and F=fetal anomaly. World Bank per capita gross national income thresholds for calendar year 2019: <$1,036 for low-income countries; $1,036–4,045 for lower-middle-income countries; $4,046–12,535 for upper-middle-income countries; and >$12,535 for high-income countries (see reference 14). SC=spousal consent required. PC=parental consent (or notification, for the United States) required. For gestational-age limits for category 6 countries, see reference 17. *Sources*: References 7–10.

FIGURE 1. Percentage distribution of women aged 15–49, by abortion legality category worldwide, according to region, 2019



Notes: The six categories on the legal continuum of abortion grounds are 1=none; 2=to save woman's life; 3=to save woman's life and to preserve her general health (but with no explicit mention of mental health); 4=to save woman's life and to preserve her general health, with explicit mention of mental health; 5=to save woman's life and to preserve her general/mental health, plus broad socioeconomic grounds; and 6=no restriction as to reason (with gestational and other requirements). Data based on the United Nations Population Division's assignment of countries into regions, according to which Mexico is considered part of Latin America, rather than Northern America. *Sources*: References 7–10, 15.

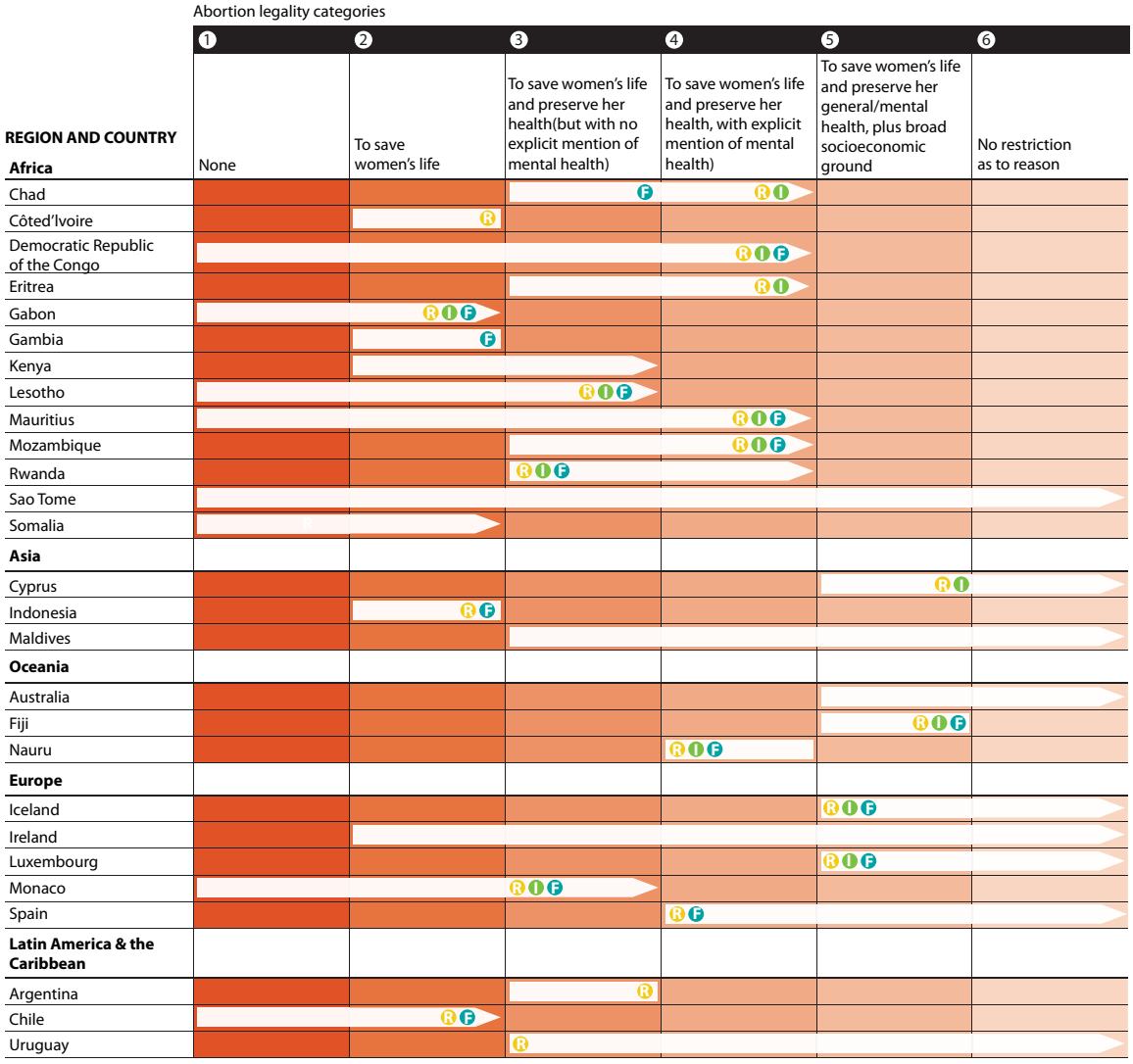
Criminal Penalties

The majority of countries, including many permitting abortion without restriction as to reason, regulate abortion in their penal codes, which set prison terms and fines for abortions that occur outside of the law. Punishments vary widely across countries. Laws in most countries in categories 1–5 punish both the woman and the health professional or layperson who performs the abortion; further, the penal codes of at least 28 countries sanction the dissemination of information to the public about the availability of abortion.[18] Côte d'Ivoire, for example, imposes prison terms ranging from six months to three years for this offense, even if such information does not result in an abortion actually taking place.[19]

Whereas most countries never apply such sanctions, others actively prosecute women and providers. For example, prosecutions for abortion continue in El Salvador,[20] Mexico[21] and Nepal.[22] The ongoing prosecutions in Nepal are especially concerning. Despite the country allowing abortion without restriction as to reason, regulations are still enshrined in the criminal code, so women are penalized for abortions alleged to have not met these regulations. Even after restrictive laws have been reformed, their damaging effects can continue, because most liberalizations are not retroactive. Rwanda is an exception: In April 2019, the country's president, Paul Kagame, pardoned some 370 people who had been convicted of abortion-related offenses, demonstrating the potential for government actors to redress the issue, when they choose to.[23]

Finally, some countries lower fines or reduce prison terms in extenuating circumstances, such as when an abortion is needed to hide a woman's "shame" or preserve her or her family's "honor," as in Angola,[24] the Philippines[25] and South Sudan,[26] among other countries.

FIGURE 2. Countries that expanded legal grounds for abortion, with progression across categories of abortion legality and addition of any of three most common legal grounds, 2008–2019



Notes: Many grounds for legal abortion are independent from a country's categorization on the legal continuum. Most common are those permitting abortion in the cases of rape, incest and fetal anomaly; these are indicated for the four continuum categories where these additional grounds logically apply. The symbols for these additional grounds correspond with a country's continuum category at the time the additional grounds were enacted. R=rape. I=incest. F=fetal anomaly. *Sources*: Baseline and endline for countries with reform between 2008 and 2013—*for Argentina, Fiji, Indonesia, Kenya, Lesotho, Luxembourg, Mauritius, Monaco, Spain, Somalia and Uruguay*: reference 11; *for Gambia and Sao Tome and Principe*: individual national laws, available by contacting the authors. Baseline and endline for countries with reform between 2014 and 2019—*for Australia, Chad, Chile, Côte d'Ivoire, Cyprus, Democratic Republic of the Congo, Eritrea, Gabon, Iceland, Ireland, Maldives, Mozambique, Nauru and Rwanda*: individual national (and state, for Australia) laws, available by contacting the authors and (*except for Mozambique and Rwanda*) reference 7.

Ethiopia considers extreme poverty as a mitigating factor in sentencing.[8]

DEVELOPMENTS FROM 2008 THROUGH 2019

The global trend, observed from 1997 to 2007, toward expanding grounds for legal abortion continued from 2008 to 2019. During this period, no country went backward along the legality continuum, and 27 expanded their number of legal grounds for abortion (Figure 2). Of the countries that expanded grounds, 21 moved to another legality category, and six added at least one of the three most common additional grounds. Eight countries–Chile, Democratic Republic of the Congo, Gabon, Lesotho, Mauritius, Monaco, Sao Tome and Principe, and Somalia–moved from total prohibition to allowing abortion under at least one legal ground. Of these, Somalia's liberalization was the narrowest, and Sao Tome and Principe's the broadest.

There were also regional variations across law reforms. Sub-Saharan Africa registered the largest number of countries that expanded grounds (13), which likely reflects the impact of the Maputo Protocol. In Latin America and the Caribbean, reform was centralized in the Southern Cone region, with Argentina, Chile and Uruguay all expanding the legality of abortion. Across other regions, progress was much more geographically dispersed.

Pathways of Reform

Abortion law reform occurred predominately through legislation and judicial decisions, with constitutional reform playing a minor role. International and regional protocols and conventions supported national-level actors who advocated for legal reform.

• *Legislation*. Liberalizations predominantly occurred through legislation, in many cases by reforming penal codes. Chile is one of several countries that took this route. In 2017, then-president Michelle Bachelet spearheaded the effort to overturn the country's absolute prohibition on abortion; as of that year, Chile permits abortion when the woman's life is at risk, and in cases of rape or fatal fetal anomaly.[27] The country's Constitutional Court overruled challenges to the new law by affirming that it accorded with Chile's constitution.[28] Another high-income South American country, Uruguay, decriminalized abortion in 2012 to become the first Latin-heritage category 6 country.[29] With its decriminalization that same year, Sao Tome and Principe moved across the entire legality continuum,[30] something that no other country has done except Nepal.[31] More recently, Iceland's parliament adopted legislation in May 2019 permitting abortion on request up to 22 weeks.[32]

• *Judicial decisions*. Several domestic court decisions also led to significant legal reforms. In 2012, Argentina's National Supreme Court issued a decision clarifying that the law permits abortion for all women whose pregnancy resulted from rape, not just women with intellectual disabilities, as the law's ambiguous wording implied; the decision further clarified that no judicial authorization was needed beforehand.[33] That same year, Brazil's Federal Supreme Court ruled that abortion must be permitted in cases of anencephaly, a fatal neural tube defect.[13]

Judicial decisions have often taken into account precedents and recommendations made by international and regional human rights bodies. For example, Democratic Republic of the Congo illustrates the potential for member states of the African Union to turn safe abortion provisions in the Maputo Protocol into domestic law. The Protocol requires ratifying countries to legalize abortion through category 4, with all three most common additional grounds.[16] Twelve years after its 2006 ratification of the treaty, Democratic Republic of the Congo published the Protocol in its legal gazette.[34] Because the country's constitution elevates international law above domestic law, the publication of the Maputo Protocol in 2018 meant that its criteria superseded the country's penal code, converting the protocol into national law. The president of the Constitutional Court issued a legal memo affirming this hierarchy and preventing prosecutions on the newly legal Maputo grounds.[35]

• *Constitutional reform*. Three countries enacted constitutional measures that affected the legality of abortion. Kenya's 2010 constitution, which was decided on a referendum, moved the country along the spectrum to allow abortions needed to protect the woman's health.[36] Somalia's new constitution, approved in 2012, authorized abortion to save the life of the woman.[37] And, in May 2018, Ireland held a referendum on repealing the Irish constitution's Eighth Amendment. That 1983 amendment had recognized the right to life of the "unborn" and placed it on equal footing with that of the pregnant woman.[38] After the solid majority voted to repeal (66%),[39] Ireland swiftly enacted a law permitting abortion on request within the first 12 weeks of pregnancy.[40]

A handful of federal and state constitutions were amended over the past decade to include the protection of life from conception. Such amendments were enacted in Kenya, and in 17 of Mexico's 32 states—although seven of these state amendments contain language saying "except where contraindicated by law."[41] Amendments to protect life before birth do not always have direct legal bearing on abortion, but they often create uncertainty about the legal status of abortion; some countries' courts refer to them in efforts to justify restrictions on abortion.

Developments in Access

Laws that permit abortion under particular grounds are not necessarily accompanied by access to safe abortion services under those grounds. Full and effective implementation of the law is essential to exercise any legal right. Several countries recently improved access by expanding implementation of their existing law through legislation, judicial decisions, ministerial guidelines and other government policies. Such policies often provide legal certainty by clarifying, through procedural specifications, when abortions are permitted, who can provide them, which methods are allowed and where they can take place.

Yet these same policies can also erect barriers that impede access to legal abortion. Such barriers may include requirements for approvals from multiple physicians in countries with very few doctors to begin with. The condition that only a specific type of medical professional can administer abortion care prevents task-sharing across levels of personnel, which would enhance availability and lower costs.[42] The related regulations that unnecessarily restrict abortion provision to higher-level health facilities further limit timely access, as do procedural prerequisites, such as waiting periods and mandatory directive counseling (as opposed to informed consent counseling).[43]

• *Legislation*. In France, a 2014 gender-equality law removed a requirement that women be "in distress" to qualify for a legal abortion; medical professionals who deny access to, or refuse to provide information about, legal abortion services are also sanctioned by French law.[44] Two countries reduced financial barriers: Israel, in 2014,[45] extended the age range for which women automatically qualify for a government-subsidized abortion,‡‡ and Nepal, in 2018,[46] made abortion free of charge for anyone unable to afford one.

‡‡Before 2014, abortions were included in the government-paid "health basket" for women who were younger than 20 or older than 40, as well as for those of any age whose pregnancy resulted from rape or incest, or whose health was threatened; now any woman through age 33 is entitled to a subsidized abortion for any reason.

Many other countries, however, enacted legislation meant to restrict access to legal abortion—often by moving gestational limits to earlier in pregnancy. From 2008 through 2019, a total of 18 U.S. states' laws (excluding those struck down) moved gestational age limits for legal abortion from viability to 20 or 22 weeks.[47] Three nations (Armenia, the Russian Federation and Slovakia)[48] and three U.S. states (Arizona, North Carolina and Tennessee) enacted another common retrogressive measure: mandatory waiting periods before undergoing a legal abortion.[47] Another eight U.S. states lengthened existing waiting periods. Macedonia and the Russian Federation added mandatory directive counseling requirements,[48] as did Arizona, Iowa and North Carolina—these latter bringing the total of U.S. states with such counseling laws to 30.[47] Further, Macedonia and 12 U.S. states passed legislation requiring all woman seeking an abortion to have a fetal ultrasound, bringing the U.S. state total to 15. Three states mandate that the provider show the image to the woman.

• ***Judicial decisions.*** In 2009, in Nepal, *Lakshmi v. Nepal* resulted in the country's Supreme Court ordering the government to ensure the accessibility and affordability of legal abortion services.[49] In 2014, Bolivia's Constitutional Court struck down a requirement that judicial authorization is needed to access abortion for pregnancies resulting from rape.[50] In 2016, the U.S. Supreme Court's decision in *Whole Woman's Health v. Hellerstedt* clarified that regulations on abortion must confer benefits that outweigh the burden placed on women, thereby striking down regulations designed to make abortions harder to access.[51] These included requirements for hospital admitting privileges and of physical building dimensions.

• ***Ministerial guidelines.*** Ghana and Peru offer laudable examples of guidelines' potential to enhance access. Ghana's 2012 *Prevention & Management of Unsafe Abortion: Comprehensive Abortion Care Services, Standards and Protocols* contained several directives that enhance access, including the mandate that, in cases of rape, the woman is not required to provide legal evidence—her word is sufficient.[52] Peru's abortion guidelines, from 2014,[53] followed successful petitions before two United Nations (UN) human rights treaty bodies, which oversee countries' compliance with human rights treaties. The UN's CEDAW Committee, in *LC v. Peru*, and its Human Rights Committee, in *KL v. Peru*, both issued condemnations of Peru's denial of legal abortion services to women seeking them.[54,55]

However, provisions within ministerial guidelines are also more vulnerable, because guidelines are more easily revoked than constitutional, legislative and judicial instruments, as illustrated by events in Kenya and Uganda. In 2012, Kenya's Ministry of Health published the *Standards & Guidelines for Reducing Morbidity & Mortality from Unsafe Abortion* in an effort to clarify the law on abortion and disseminate safe abortion guidelines.[56] The next year, these were withdrawn under dubious circumstances, with a notice threatening sanctions for providers who underwent training on safe abortion care. Similarly, in 2012, Uganda updated its *National Policy Guidelines for Sexual and Reproductive Health Services*, but the legal grounds permitting abortion in cases of rape, incest and fetal impairment—contained in an earlier 2006 version—had been removed.[57] A subsequent version of these guidelines issued in 2015 was immediately challenged by stakeholders and removed from force, and as of 2019, none has been reinstated—leaving women seeking abortion and health workers without guidance on legal and administrative requirements or best practices.[58]

Developments in International Human Rights Law

International legal norms continue to affect the evolution of national abortion laws. Building on progress made in international consensus documents, such as the 1994 International Conference on Population and Development's Programme of Action and the 1995 Beijing Declaration and Platform for Action, UN human rights treaty bodies have recognized restrictive abortion laws to be human rights violations. Nearly all have called on countries to reform such laws to comply with their human rights obligations. For example, in 2013, in *Mellet v. Ireland,* the UN's Human Rights Committee recognized that criminalizing abortion violates international human rights law and called on Ireland to undertake law reform including, if needed, constitutional reform.[59]

Decriminalization, an essential step toward ensuring access and reducing stigma, has been taken up in a series of treaty bodies' recommendations issued to signatory states. Indeed, regional human rights bodies have played similarly important roles over the past decade: In two Polish cases, the European Court of Human Rights affirmed Council of Europe member states' obligations to guarantee access to legal abortion, and to ensure that providers' conscientious objection does not deny patients legal health care.[60,61] In an Italian case, the European Committee of Social Rights recognized that widespread conscientious objection hindering access to abortion services can violate the right to health.[62,63]

Similarly, the Inter-American Commission on Human Rights, and its related Inter-American Court of Human Rights, have ordered the Nicaraguan and Salvadoran governments to provide medical care where it had been denied on the basis of restrictive abortion laws. In the 2010 Nicaraguan case, the court ordered the government to provide the cancer treatment that had been withheld from a pregnant women on the basis that it could provoke a miscarriage.[64] In the 2013 Salvadoran case, the court ordered that an abortion be provided to prevent the death of a pregnant woman.[65] Furthermore, the African Commission on Human and Peoples' Rights launched a continental Campaign for the Decriminalization of Abortion in Africa, in 2016, to ensure states' compliance with the Maputo Protocol's specified legal grounds for safe abortion.[66] The following year, leaders from across the continent endorsed the Africa Leaders' Declaration on Safe, Legal Abortion as a Human Right.[67]

DISCUSSION AND CONCLUSIONS

Classifying countries and their progress along a legality spectrum is a first step toward learning the extent to which women at least qualify for a legal, safe abortion. It is encouraging that women's ability to legally qualify for an abortion improved over the past decade and that the global liberalization trend has continued. No country moved backward by removing legal grounds, although several imposed requirements that make timely abortions harder to access. The broader pattern of adding legal grounds resulted mainly from a general consensus on the need to eradicate unsafe abortion and to guarantee women's reproductive autonomy.[68]

Successful reform means different paths in different subregions and countries, and what worked well in some cultural contexts, even when modified for other settings, may not yield similar results. This overview does not cover the many efforts at reform that either fell short or stalled—testament to the difficulty of changing a practice that has been culturally and religiously proscribed for centuries. For example, promising attempts to add legal grounds in Angola, Bolivia and Sierra Leone have stagnated, in some cases because the political moment—and therefore the opportunity to seize an opening for reform—has passed. In other instances the opposite occurred, as mass demonstrations in Poland[69] and Spain[70] thwarted draft bills that would have banned or further restricted abortion.

Even when successfully adopted, more legal grounds for abortion do not inevitably translate to more access. Countries can take years to establish an environment enabling safe and accessible abortion services. Among the long list of steps governments must take are informing and educating all relevant parties (e.g., the general public, politicians, health care personnel, pharmacy personnel, police and the judiciary) about abortion legality; training health care personnel in best practices for abortion provision; facilities acquiring and keeping up-to-date equipment and medication; ensuring widespread availability and affordability of abortion services; and establishing accountability mechanisms to address denials of services and poor quality of care. Perhaps the hardest barrier to overcome is entrenched stigma, which continues to exist in all settings. Even in countries permitting abortion without restriction as to reason, the weight of stigma can still motivate some women to risk their health by seeking potentially unsafe abortions outside of official channels.[71]

The lack of clarity over what constitutes the "health" ground continues to hinder access. All member states of the World Health Organization (WHO) have adopted its definition of health, as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,"[72] and in its guidance on safe abortion, WHO has called on member states to interpret health grounds in line with this definition.[73] However, progress toward this basic goal is still minimal.

Access to safe procedures can also be curtailed by inchoate or inconsistent laws. Many countries' abortion provisions are confusing or even contradictory, creating uncertainty about when abortion is, in fact, legal. The complexities of establishing legal precedence in the face of conflicting provisions are probably best illustrated by the example of Democratic Republic of the Congo. As of 2019, the country had three concurrent provisions: the penal code outlawing all abortions;[74] a public health law allowing abortions to save the pregnant woman's life and in cases of fetal anomaly incompatible with life;[75] and the official publication of the Maputo Protocol into the national legal register, with a high court circular establishing the protocol's criteria as national law.[34,35] Given the constitutional provision that international law supersedes domestic law in the country,[76] it is presumable that the grounds in Maputo continue to be in force. For legal clarity in any country, conflicting criteria in national-level laws must be harmonized, as must inconsistencies between the content of laws and their implementing policies or guidelines.

Implementation of the law is critical. Several countries have made safe abortions widely available with only a few legal grounds. The example of Ethiopia stands out: In 2006, the country enhanced access to legal abortion by allowing health professionals to accept women's stated age without documentation;[77] the penal code already specified that the victim's word sufficed to qualify for abortions resulting from rape or incest.[8] As a result of these and other reforms, the proportion of abortions in Ethiopia that are legal and performed in health facilities nearly doubled from 2008 to 2014, from 27% to 53%.[78] Ethiopia also expanded the reach and quality of PAC for still-clandestine procedures. The likely combined impact of these reforms can be seen in substantial declines in abortion-related deaths, as reported in a review of maternal mortality between 1980 and 2012.[79] Even where the law permits abortion on limited grounds only, broad interpretations of such grounds and disseminating accurate information about misoprostol can reduce rates of unsafe abortion and afford women greater reproductive autonomy.

Laws that establish early gestational limits can deny women their right to legal procedures, given the number of steps already inherent in accessing abortion. When time-consuming bureaucratic preconditions that have nothing to do with safety or quality of care (e.g., waiting periods and mandated directive counseling) are required within constrained gestational limits, the ability to access abortion within the law can be jeopardized. Delays in accessing a first-term procedure can cause women to seek abortion at a later gestational age, which fewer professionals are trained in.[42] Women might opt for a clandestine procedure or be compelled to carry an unintended pregnancy to term, which has its own set of risks and challenges.[80,81] Gestational limits must be calibrated to ensure that they do not undermine access to legal abortion, and limits must always be extended for special circumstances. The pandemic-related lockdowns and suspensions of access to

abortion care in 2020 are a prime example of how unforeseen circumstances can force women to seek abortions beyond legal gestational limits.

Although the wording of conscientious objection clauses is supposed to prevent their large-scale use, illegal coordinated institutional-level refusals to provide abortion services have been recorded.[82,83] Such abuses of conscientious objection can delay or ultimately deny women legal abortion. Granting such objections rests on the accompanying requirement that women be referred immediately to another provider who is willing and able to provide the service. It is essential that countries monitor the extent to which women are denied their legal right to an abortion and, where necessary, institute measures to enforce the law. A promising avenue toward fewer objections to provide abortions lies in the expanded use of medication abortion, because providers around the world express less objection to giving woman pills than to doing surgical procedures.[84]

The increased use of medication abortion—either the combination protocol of mifepristone plus misoprostol, or misoprostol alone—has created many opportunities to expand access and improve safety. In particular, medication abortion methods can make clandestine abortions safer in restrictive settings. Evidence demonstrates that the increasingly widespread use of misoprostol alone in one such country, Brazil, led to less-severe complications from clandestine procedures,[85] and thus likely fewer deaths. Other studies have shown that merely providing information about correct misoprostol use, though not the drug itself, reduces the likelihood that clandestine abortions will be unsafe.[86,87]

But developments in medical and communications technologies have outpaced the laws that regulate abortion. Many outdated laws require that medication abortion be provided in tertiary health facilities and only by professionals with the highest level of training; these rules have clearly outlived their relevance, as medication abortion can be provided safely by a wide range of personnel in primary health centers.[42] In addition, WHO has endorsed two of three steps in self-managed medication abortion.[88] As the accuracy and availability of multilevel pregnancy tests improve, women will be better able to assess the completeness of their medication abortion on their own.[89] As women gain more control over when and where they can have a safe abortion, the laws restricting abortion legality and access will become increasingly ill-advised and unnecessarily punitive, and will serve primarily to undermine reproductive autonomy. In the meantime, archaic laws and regulations need to be updated to reflect the new reality.

Absent legal reform, addressing complications by improving the quality and coverage of PAC must remain on the international health agenda. At present, better PAC is imperative to reduce disability and death from the abortions that inevitably occur in countries with restrictive laws. However, making abortion legal under broad criteria and enabling access for women in all countries would make the most sense of all. Doing so would be a major step toward better health and greater reproductive autonomy worldwide.

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RESUMEN

Contexto: *La evidencia muestra que las leyes que restringen el aborto no eliminan su práctica, sino que dan como resultado que las mujeres se sometan a abortos clandestinos, que probablemente no sean seguros. Es importante evaluar periódicamente los cambios en la situación legal del aborto en todo el mundo.*

Métodos: *Se utilizaron los criterios que definen el aborto legal aplicados en 199 países y territorios a partir de 2019 para distribuirlos a lo largo de un continuo de seis categorías mutuamente excluyentes, desde prohibido totalmente hasta permitido sin restricción en cuanto a razón. También se cuantificaron las tres causales legales adicionales más comunes que caen fuera de este continuo: violación, incesto y anomalía fetal. Se examinaron los patrones por región y el ingreso nacional bruto per cápita. Se evaluaron los cambios resultantes de la reforma legal y las decisiones judiciales a partir de 2008, así como los cambios en las políticas y lineamientos que afectan el acceso a los servicios.*

Resultados: *La legalidad se correlacionó positivamente con el ingreso: las proporciones de países en las dos categorías más liberales aumentaron uniformemente con el INB. De 2008 a 2019, 27 países ampliaron el número de causales legales para el aborto; de ellos, 21 avanzaron a otra categoría de legalidad y seis agregaron al menos una de las causales legales adicionales más comunes. La reforma fue el resultado de una variedad de estrategias, que generalmente involucran a múltiples partes interesadas y exigen el cumplimiento de las normas internacionales de derechos humanos.*

Conclusiones: *La tendencia mundial hacia la liberalización continuó durante la última década; sin embargo, se necesitan avances aún mayores para garantizar el derecho de todas las mujeres al aborto legal y para asegurar un acceso adecuado a servicios seguros en todos los países.*

RÉSUMÉ

Contexte: *Les données montrent que les lois restrictives de l'avortement n'éliminent pas sa pratique, mais qu'elles conduisent plutôt les femmes à l'avortement clandestin, souvent non médicalisé. Il importe d'évaluer régulièrement l'évolution de la légalité de l'avortement dans le monde.*

Méthodes: *Les critères de l'avortement légal en 2019 concernant 199 pays et territoires ont servi de base à leur répartition le long d'un continuum de six catégories mutuellement exclusives, de l'interdiction absolue à l'autorisation sans restriction de motivation. Les trois raisons légales supplémentaires les plus courantes en dehors de ce continuum – le viol, l'inceste et la malformation fœtale – ont aussi été quantifiées. Les tendances par région et en fonction du revenu national brut par habitant ont été examinées. Les changements survenus du fait de la réforme légale et de décisions judiciaires depuis 2008 ont été évalués, de même que l'évolution des politiques et des directives qui affectent l'accès.*

Résultats: *La légalité présente une corrélation positive avec le revenu: les proportions de pays compris dans les deux catégories les plus libérales augmentent uniformément avec le RNB. De 2008 à 2019, 27 pays ont accru le nombre de raisons d'admission légale de l'avortement. Parmi eux, 21 ont progressé vers une autre catégorie de légalité, tandis que six ajoutaient au moins une des raisons supplémentaires les plus courantes. La réforme est le produit de diverses stratégies, impliquant généralement plusieurs intervenants et l'appel au respect des normes internationales en matière de droits humains.*

Conclusions: *La tendance mondiale à la libéralisation s'est poursuivie ces 10 dernières années. Plus de progrès encore sont cependant nécessaires pour garantir le droit de toutes les femmes à l'avortement légal et assurer un accès adéquat à des services sécurisés dans tous les pays.*

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