Global Abortion Policies Database: A descriptive analysis of the regulatory and policy environment related to abortion

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Abortion laws
Abortion policies

Abstract

The World Health Organization (WHO) Safe abortion: technical and policy guidance for health systems states that regulatory, policy, and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed. Although some regulatory requirements facilitate access, where they act as barriers, they can deter women from seeking safe abortion care. We use data available in the Global Abortion Policies Database as of February 2019 to review policies related to regulatory requirements identified as access barriers in the Safe abortion guidance. We include only countries where such policies apply, i.e., where abortion is lawful on the woman’s request, with no requirement for justification and/or for one or more legal grounds. The results demonstrate the variation that exists in regulatory requirements, but little remains known about how they are implemented in practice and the implications on how women access and how providers offer safe abortion services.

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Introduction

The World Health Organization (WHO) Safe abortion: technical and policy guidance for health systems states that an enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care [1]. The legal categories are only one aspect of the legal and policy environment that affects women’s access to safe abortion [2]. Additional health system and service delivery requirements may also exist, and they can be codified in laws, regulations, and policies. These may facilitate or restrict access and service provision, but in places that these policies restrict access, women may be deterred from seeking safe care.

Barriers to accessing care contribute to the burden of unsafe abortions. Between 2010 and 2014, approximately 25 million unsafe abortions took place [3]. Special Procedures of the Human Rights Council have stated that countries should take measures to ensure that lawful abortions are not only safe but also accessible [4]. Regulatory and policy barriers that hinder access to and timely provision of safe abortion care should be removed [1]. Furthermore, standards and guidelines should be developed and updated with the intent of eliminating barriers to obtaining the highest attainable standard of sexual and reproductive health.

In this paper, our main objective is to use data extracted from the Global Abortion Policies Database and to report on the number of countries that have legal, regulatory, or administrative policies that potentially impact safe abortion access focusing on the existence of selected policies that may act as barriers, or where the lack of a facilitative policy could create a barrier.

Methods

Global Abortion Policies Database (GAPD), launched in 2017, is a tool that presents information of abortion laws and policies beyond the legal categories of abortion and includes additional access requirements, information related to service provision, and conscientious objection for all WHO member states. We use data available in the GAPD as of February 2019. The methods used for collecting, classifying, and coding data in the GAPD, as well as information about the nuances that exist within countries’ laws related to the legal categories of abortion, have been described elsewhere [2,5].

We reviewed the content and wording of laws, policies, standards and guidelines, legal judgments, and other official statements (hereinafter referred to as “policies”) related to barriers identified in the Safe abortion guidance. We begin each section within the results alongside italicized information from the WHO guidance and report on the existence of policies related to limiting access to information; mandatory counseling, requirements for third-party authorizations, regulatory approval or registration for essential medicines, restrictions on the range of providers or facilities, refusal of care, and mandatory waiting periods.

We included only countries where such policies would apply, i.e., where abortion is lawful on the woman’s request with no requirement for justification and/or for one or more legal ground(s). We excluded countries where abortion is prohibited in all circumstances (Andorra, Dominican Republic, El Salvador, Gabon, Guinea-Bissau, Haiti, Honduras, Holy See, Madagascar, Malta, Nicaragua, Palau, Philippines, San Marino, Senegal, and Suriname) and countries where laws prohibit unlawful abortion but do not specify exceptions for lawful abortion (Antigua and Barbuda, Dominica, Gambia, Jamaica, Sierra Leone, Saint Kitts and Nevis, and Tonga).

Further, we also excluded countries where data on the policy and regulatory environment were not available in the GAPD (Democratic People’s Republic of Korea, Equatorial Guinea, Maldives, Marshall Islands, Micronesia, Niue, and Saint Vincent and the Grenadines), eight countries (Australia, Bosnia and Herzegovina, Canada, China, Mexico, Nigeria, United Kingdom of Great Britain and Northern Ireland, and the United States) that may regulate abortion at the subnational level are also not included in the analysis. Thus, we analyzed data for 158 countries.

The information in the database is limited by accessibility of source documentation and the ability to translate source documents.
Results

Access to information and counseling

The provision of complete, accurate, easy-to-understand information is an essential part of good-quality abortion services. Failing to provide public information on the legal status of abortion, as well as censoring, withholding or intentionally misrepresenting information about abortion services can result in a lack of access to services or delays, increasing health risks for women. While many women have made a decision to have an abortion before seeking care, every pregnant woman who is contemplating abortion should receive adequate relevant information and be offered counseling from a trained health-care professional with comprehensive knowledge and experience of different methods of abortion. Counseling is a focused, interactive process through which one voluntarily receives support, additional information and guidance from a trained person, in an environment that is conducive to openly sharing thoughts, feelings and perceptions. Provision of counseling to women who desire it should be voluntary, confidential, and non-directive.

Twenty-eight of the 158 countries analyzed (18%) restrict access to one or more types of abortion-related information. Eleven of these 28 countries (39%) are in Africa, 6 (21.5%) each in Asia and Europe, 2 (7%) in Latin America, and the remaining 3 (11%) are in Oceania.

Restrictions typically include the prohibition of advertising, including the display of materials or commodities related to abortion, the performance of any act that can be seen as encouraging the use of abortion services, and/or even providing counseling. One country (Russian Federation) permits advertising related to abortion services; however, the advertisement must be accompanied by a warning that abortion causes infertility and other harmful effects to health. Furthermore, the warning must make up more than 10% of the advertising space and cannot be accompanied by any statements related to the safety of health care services.

Counseling on the abortion decision is required before an abortion procedure in 19/158 (12%) countries,13 of which are in Europe. Counseling may require provision of information related to the current developmental stage of the embryo or fetus, or the potential physical and/or psychological risks associated with abortion, including impaired fertility, anxiety, and depression. In 3 countries (Albania, Portugal, and Slovakia), women must also receive information related to available pregnancy services or organizations that provide moral and financial support.

Third-party authorizations

1. Service provider or other professional

A woman seeking an abortion is an autonomous adult. Autonomy means that mentally competent adults do not require the authorization of any third party, such as a husband, partner, parent or guardian, to access a health service. Third-party authorization should not be required for women to obtain abortion services. The requirement for authorization by spouse, parent or hospital authorities may violate the right to privacy and women’s access to health care on the basis of equality of men and women.

One hundred five countries of the 158 countries analyzed (66.5%) require authorizations by one or more health care providers (See Table 1). Many countries do not specify whether this individual is in addition to the person directly involved in provision of the abortion. Countries also may require authorization by a group of professionals (e.g., a committee, captured in the database under “other”), or may not specify the number of authorizations required.

In Africa, 30 of the 105 countries (29%) require authorization by a health care provider or other types of professional. Of the 10 countries that require authorization by 1 doctor, only 2 countries (Sao Tome and Principe and Lesotho) specify that this individual must be someone other than the attending doctor. Two countries (Zimbabwe and Burundi) with the requirement for 2 provider

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1 Africa: Angola; Asia: Georgia, Indonesia, Kyrgyzstan, Kazakhstan; Europe: Albania, Belgium, Germany, Hungary, Iceland, Latvia, Netherlands, Portugal, Russian Federation, Slovakia, Spain, North Macedonia, and Ukraine; and Latin America and the Caribbean: Guyana and Chile.
authorizations specify the need for at least one of the two authorizations to come from a doctor that is different than the one providing the service, while 1 country states that both doctors must be different (Namibia). In Zambia and Morocco, 1 of the 3 authorizations can come from the attending physician. In 4 countries, authorization must come from a college of medical specialists, public prosecutor, or the director of the health facility. In Mozambique, it is unclear how many authorizations are required, as the Penal Code states that authorization is required by two health professionals different from the attending physician, while a recent Ministerial Decree only requires that the authorization be by a health professional qualified to do so. Four countries (Tunisia, South Africa, Sao Tome and Principe, and Cabo Verde) do not require authorizations when the abortion is on request; in Botswana and Burkina Faso, an authorization is also not required when the pregnancy is the result of rape or incest. In South Africa, the single authorization requirement is increased to 2 authorizations when the gestational age exceeds 20 weeks.

Thirty Asian countries (29%) also require authorization. In India, the number of authorizations required increases from 1 to 2 when the pregnancy has exceeded 12 weeks of gestation, whereas Cambodia requires 2 or 3 providers, but no information of when it should be 2 or 3. Details of the number of authorizations required in Azerbaijan, Japan, and Timor-Leste are similarly unclear, as they are not specified. In Kazakhstan, an expert in the medical indication being put forth as the basis for the abortion must be included in the group of professionals authorizing the procedure, as well as the head of the health institution in which the procedure will take place. A social worker must be included in the authorizing committee in Israel, where one committee member must also be a woman, while in Georgia, a lawyer must be included. In Syrian Arab Republic and Thailand, 1 of the 2 authorizations must be from an individual in addition to the attending provider.

In Europe, 32 of the 105 countries (30%) require authorizations, and some countries’ policies are also quite detailed regarding the specifics of which authorizations are needed. For example, in Poland and Portugal, the policy specifies that the authorization must be from an individual other than the abortion service provider, while in Ireland and Monaco, 1 of the 2 individuals authorizing can include the attending provider. In Spain, where a single authorization is required for life, 2 authorizations are required for fetal anomaly, which must then be confirmed by a multidisciplinary team. In Slovenia and Slovakia, authorizations must include a social worker and the director of the health facility, respectively. In Serbia, when the gestational age exceeds 20 weeks, consultation with an ethics committee is required. In several countries, committees or commissions are required when an abortion is based on fetal impairment. In Finland, however, a report from social welfare authorities, midwife, or public health personnel is also needed when the delivery and care of a child would place a considerable strain on the woman (this includes cases where the woman is less than 17 or more than 40 years of age at the time of conception or has four children). In one country, which does not require authorization for abortions performed on request, the policy states that an authorization is required where the abortion is medically contraindicated. Authorization by a health care provider or other type of professional is required in many fewer countries in Latin America and the Caribbean and Oceania.

### Table 1
Provider third-party authorizations.

<table>
<thead>
<tr>
<th>Region</th>
<th>Africa</th>
<th>Asia</th>
<th>Europe</th>
<th>Latin America</th>
<th>Oceania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required authorizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 provider</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2 providers</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>3 providers</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>13</td>
<td>21</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total N of 105 (%)</td>
<td>30 (29)</td>
<td>30 (29)</td>
<td>32 (30)</td>
<td>12 (11)</td>
<td>1 (0)</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages do not add up to 100%.*
2. Parental and spousal consent

Approximately one-third (57/158) of countries that permit abortion require parental consent for minors; most of these (24/57) are in the European region. Twenty-eight percent of these countries (16/57) do not specify the age below which consent is required. Of the 41 countries that do specify an age, the range is from 14 to 18 years with a median of 16 years.

In almost all countries that require parental consent, an alternative individual is permitted to consent in place of a parent; 2 countries do not specify whether this is permitted. These individuals may include a legal guardian, medical commission or tribunal, or other judicial authority. In one country (Turkey), when the consenting individual is a legal guardian, the permission of a Justice of the Peace is also required. Twelve countries require spousal consent (Indonesia, Japan, Kuwait, Morocco, Qatar, Republic of South Korea, Saudi Arabia, Syria, Timor-Leste, Turkey, United Arab Emirates, and Yemen). In Timor-Leste, spousal consent can substitute for the woman's consent. Some countries require spousal authorization for special cases, and not otherwise, including when the abortion is for social reasons (e.g., Kyrgyzstan), or where a fetal anomaly or life threat exists (e.g., Mongolia). Malaysia requires spousal approval for Muslim women but not for non-Muslims.

In Bahrain, the policy states that the person in charge of the woman must provide consent, but no additional information is provided as to who that person must be. In Finland, before the final decision is made, the person who impregnated her must be given an opportunity to express his opinion.

Provision of essential medicines

The WHO model list of essential medicines includes combination mifepristone and misoprostol for medical abortion.

Essential medicines are often specified on an official list of authorized drugs, most often an essential medicines list (EML). Although countries often adapt the WHO model list, some only include misoprostol for gynecological indications generally or for nongynecological indications. Information about whether these medications can be sold or distributed by pharmacies or drug stores may also be specified in national policies (See Table 2).

Fifty of the 158 countries analyzed (32%) include mifepristone and/or combination mifepristone—misoprostol in their national EML or some other official list of authorized drugs; 56% of these 50 countries are in Europe. These medications are permitted to be sold or distributed by pharmacies or drug stores in 4 countries in Africa, 1 in Asia, 7 in Europe, and 1 country in Latin America. Nine countries in Europe and 1 country in Oceania explicitly state that this is not permitted.

However, misoprostol alone is included on an official list of medications in 104 (66%) countries. Of these 104 countries, misoprostol is permitted to be sold or distributed by pharmacies or drug stores in 4 countries in Africa, 6 in Asia, 11 in Europe, and 1 country in Latin America, while 1, 4, 6, 3, and 1 country explicitly prohibits this practice in each of the respective regions.

Regulation of providers and facilities

1. Regulation of providers

Restrictions on the range of service providers (e.g. gynaecologists only) or facilities (e.g. tertiary level only) that are legally authorized to provide abortion reduce the availability of services and their equitable

<table>
<thead>
<tr>
<th>Region</th>
<th>Africa</th>
<th>Asia</th>
<th>Europe</th>
<th>Latin America</th>
<th>Oceania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes mifepristone –/– misoprostol N (% of 50)</td>
<td>12 (24)</td>
<td>8 (16)</td>
<td>28 (56)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Includes misoprostol only Total N of 104 (%)</td>
<td>23 (22)</td>
<td>28 (27)</td>
<td>29 (28)</td>
<td>15 (14)</td>
<td>9 (1)</td>
</tr>
<tr>
<td>Gynecological indications</td>
<td>17</td>
<td>20</td>
<td>14</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Non-gynecological indications</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Indications not specified</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

a Due to rounding, percentages do not add up to 100%.
geographic distribution, requiring women to travel greater distances for care, thereby raising costs and delaying access. Abortion care can be safely provided by any properly trained health-care provider, including midlevel (i.e. non-physician) providers. The term “midlevel providers” includes a range of non-physician clinicians (e.g. midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors, and others).

One hundred seven of the 158 countries analyzed (68%) provide some information about the types of health care providers who can perform or participate in induced abortion services. Fifty-five of the 107 (51%) countries specify that specialists can provide abortion services, while 60 countries (56%) state that the provider must be a physician (specialty not specified). Four countries in Africa, 3 countries in Asia, and 2 countries in Europe explicitly permit abortion provision by someone other than a physician including a nurse or midwife (See Fig. 1).

Twenty-four of the 158 countries analyzed (15%) expressly prohibit nurses from providing abortions, with almost half (11) of these located in Europe. Similarly, 22 countries (14%) prohibit midwives from providing abortions, 10 of which are in Europe.

2. Regulation of facilities

Medical abortion; vacuum aspiration for pregnancies of gestational age up to 12–14 weeks and for management of incomplete abortion; clinical stabilization, provision of antibiotics, and uterine evacuation for women with complications of abortion; and a broad range of contraceptive methods, including IUDs, implants, and injectables can be provided at the primary-care level on an outpatient basis.

Of the 158 countries analyzed, only 192 (12%) countries’ policies specify that abortion provision can occur at the primary care level. Twelve countries explicitly prohibit abortion service provision at the primary care level.

Refusal of care

Health-care professionals sometimes exempt themselves from abortion care on the basis of conscientious objection to the procedure. While the right to freedom of thought, conscience, and religion is protected by

![Fig. 1. Who can provide abortion services.](image-url)
international human rights law, international human rights law also stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental human rights of others. Health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. In the absence of a readily available abortion-care provider, this practice can delay care for women in need of safe abortion, which increases risks to their health and life. Where referral is not possible, the health-care professional who objects, must provide safe abortion to save the woman's life and to prevent serious injury to her health.

Fifty-six of the 158 countries analyzed (35%) permit service providers to conscientiously object to provision of abortion care; 54 of these countries do not specify the type of the health care provider permitted to do so, while 1 country allows both public and private providers to object, and 1 country only permits public providers to do so. Twenty-nine (52%) of these countries require health care providers to refer the woman to another person who will provide her with legal abortion services. Only 1 country (Ethiopia) explicitly prohibits refusal of care in their policy document. Twenty-one countries specify that a provider cannot object in cases of life threat.

Although 2 countries (France and Uruguay) permit private facilities to object to provision of abortion services, the policies in 7 countries require additional duties of the health care professional or health care institution. For example, in Mozambique, if there is no available service provider, the individual seeking abortion must be transferred to another health unit. Similarly, in Belgium, contact details of an abortion service provider must be given to the woman, and all medical files must be available to the new provider. In Slovakia, the identified service provider must not be located too far from the individual's home or place of employment. In Slovenia and Norway, the health facility must ensure that abortion services are available regardless of whether individuals who refuse to provide care are employed there. In Colombia, health care institutions must respond to an abortion request and carry out the requested abortion within 5 days if possible. In Portugal, no more than 5 days can pass between the woman's initial abortion request and the first consultation. Doctors in New Zealand, however, who conscientiously object to abortion provision, must only inform the person that abortion services are available elsewhere; no effort to facilitate the transfer of care is required.

Waiting periods

Mandatory waiting periods are often required by laws or regulations and/or administrative procedures imposed by facilities or individual providers and can have the effect of delaying care, which can jeopardize women's ability to access safe, legal abortion services, and demeans women as competent decision-makers. Abortion services should be delivered without delay; states should consider eliminating waiting periods that are not medically required and expanding services to serve all eligible women promptly.

Of the 158 countries analyzed, 25 countries' policies (16%), 16 of which are in Europe, require women to comply with a mandatory waiting period, ranging from 2 to 7 days (See Table 3). Waiting periods may commence at various points, including at the time of first request for a procedure, during consultation and/or counseling, or after a service provider has sent a required notification to an authoritative body. Waiting periods may vary depending on the legal category upon which the woman is accessing the abortion. For example, a mandatory waiting period is required only for abortions on request in Georgia, Ireland, and Slovakia. In North Macedonia, if there is a justified medical indication, no waiting period is required. Similarly, if the woman is a minor or with limited legal capacity, the waiting period is waived in North Macedonia. Waiting periods may also vary depending on a woman's gestational age. In the Russian Federation, for example, the waiting period is 48 h if the pregnancy of the woman is between 4 and 7 weeks or 11 and 12 weeks, but the waiting period is 7 days for pregnancies between 7 and 10 weeks. In Albania, the waiting period may be shortened from 7 to 2 days at the physician's discretion, where the pregnancy is approaching the point at which a permitted gestational limit may be exceeded. Similarly, in Georgia, the waiting period is reduced from 5 to 3 days if the pregnancy is in the twelfth week.
In 2012, there were approximately 85 million unintended pregnancies [6]. Between 2010 and 2014, of the 56.3 million annual abortions [7], approximately 25 million unsafe abortions took place [3], resulting in approximately 23,000 abortion-related deaths each year [8]. Regulatory requirements can be facilitative or restrictive, but where they exist as access barriers, they may have a cumulative effect, compounding each other and making it more difficult for individuals to obtain services [9]. Barriers to accessing care contribute to the burden of unsafe abortions. Such barriers can delay access to services, increase costs, and increase the risk of unsafe abortion [9].

The results demonstrate that the most common additional requirement women face is the need to obtain an authorization from a third party, which does not respect women as autonomous and competent decision makers. The decision to have children or not should not be limited by partners, parents, or the State [10], nor should States support substituted consent by spouses [11]. Human rights treaty bodies have recognized the importance of autonomous decision-making, calling on States to remove third-party authorization requirements [12].

Abortion policies and services should protect the health and human rights of all women, including adolescents, who should have access to confidential counseling and advice without parental or legal guardian consent, in accordance with their evolving capacities [13]. Prohibiting access to information on legal termination of pregnancy can have detrimental consequences for health and safety, especially as it relates to adolescents who may resort to clandestine abortion providers if they think they will be required to obtain permission from their parents or guardians [1]. Minors can often make independent decisions related to pregnancy, including for the receipt of antenatal care [14,15]. Abortion procedures are often singled out as a procedure for which a minor may not consent, despite being a decision that is directly related to pregnancy. Yet, as evidenced by research within the United States, abortion is estimated to be 14 times safer than childbirth for pregnant women generally [16].

**Table 3**

<table>
<thead>
<tr>
<th>Countries by Region</th>
<th>N = 25</th>
<th>Length of Time (days)</th>
<th>Point of Commencement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angola</td>
<td>3</td>
<td>Time of request</td>
<td></td>
</tr>
<tr>
<td>Sao Tome &amp; Principe</td>
<td>3</td>
<td>Day of presentation to facility</td>
<td></td>
</tr>
<tr>
<td>Armenia</td>
<td>3</td>
<td>Day of application</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>Varies from 3–5</td>
<td>Admission</td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>2</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Singapore</td>
<td>2</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albania</td>
<td>7</td>
<td>Time of request</td>
<td></td>
</tr>
<tr>
<td>Belgium</td>
<td>6</td>
<td>First consultation with the providing physician</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>3</td>
<td>Day after counselling</td>
<td></td>
</tr>
<tr>
<td>Hungary</td>
<td>3</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>3</td>
<td>Certification of gestational age</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>7</td>
<td>First consultation</td>
<td></td>
</tr>
<tr>
<td>Latvia</td>
<td>3</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Luxembourg</td>
<td>3</td>
<td>First consultation</td>
<td></td>
</tr>
<tr>
<td>Montenegro</td>
<td>3</td>
<td>Written application</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>5</td>
<td>First consultation</td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>3</td>
<td>First consultation</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>3</td>
<td>First consultation</td>
<td></td>
</tr>
<tr>
<td>Russian Federation</td>
<td>Varies from 2–7</td>
<td>First consultation</td>
<td></td>
</tr>
<tr>
<td>Slovakia</td>
<td>2</td>
<td>Physician sends notification to National Health Information Center</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>3</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>North Macedonia</td>
<td>3</td>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guyana</td>
<td>2</td>
<td>Time of request</td>
<td></td>
</tr>
<tr>
<td>Saint Lucia</td>
<td>2</td>
<td>Time of request</td>
<td></td>
</tr>
<tr>
<td>Uruguay</td>
<td>5</td>
<td>First consultation</td>
<td></td>
</tr>
</tbody>
</table>
When regulatory requirements create access barriers, the risks related to duration of pregnancy are amplified and may cause women to exceed legally allowable gestational limits, precluding them from lawful abortion. For example, meeting requirements for mandatory counseling and mandatory waiting periods may result in the need for multiple visits to the provider, which both causes delays and increases the costs associated with safe abortion. Delays are an inherent feature in obtaining abortion services even without a mandated waiting period, as evidenced by a study from New Zealand, which has no mandatory waiting period. For women seeking early abortion, an average of 10 days passed between the point of first contact and the time at which the appointment was made. An additional 10 days passed between the point at which appointments were made and the first visit. On average, it took 25 days between the date of the first visit and the date of the abortion [17]. Opportunity costs such as time lost from paid employment or childcare expenses, as well as travel expenses, especially for women in peri-urban and rural areas, may make the costs associated with an abortion service insurmountable.

Although waiting periods may be reduced in cases where the pregnancy has advanced beyond a certain point, they typically apply regardless of gestational age. Women may find it difficult to navigate the requirements around waiting periods, especially in countries such as the Russian Federation, where different time limits apply to pregnancies at 4–7 weeks, 7–10 weeks, and 11–12 weeks. Additionally, women and service providers may not always be clear about when such waiting periods begin. As the results demonstrate, several countries describe the start of a waiting period as the time of request for services. However, little information is provided as to whether, for example, this refers to the time at which the woman makes the appointment or when she makes her request to the referring provider if faced with a conscientious objector. Furthermore, where access is further restricted due to conscientious objection, health services should be organized in such a way as to ensure that refusal of care does not prevent women from accessing services to which they are entitled under the applicable legislation.

The impact of access barriers may be further magnified in peri-urban and rural settings, where access to a physician can be quite limited owing to lack of infrastructure, remoteness, and the lack of transport [18], leading women to turn to unsafe procedures. As described in the results, more than 50% of countries require physician providers, and only 12% of countries explicitly permit abortion at the primary care level. Yet, abortion care can be safely provided by properly trained health care providers, including nonphysician providers who are trained in basic clinical procedures related to reproductive health [19].

It is for this reason that human rights treaty bodies have called on States to take measures to ensure that legal and safe abortion services are not only available but also accessible and of good quality [20], which includes ensuring provision of essential medicines listed in the WHO Essential Medicines List [21]. Currently, 66% of countries include misoprostol on an official medicines list, but only 32% of countries include mifepristone. Inclusion on an EML or official list does not speak to access, as additional steps are needed to ensure availability to individuals, including registration and procurement. Access could, however, be further expanded using telemedicine services or the expansion of abortion services in primary care settings.

This paper focuses on only one aspect of the regulatory environment around abortion; facilitative regulatory requirements can also impact access to safe abortion. Countries that have created an enabling policy environment have seen positive impacts on maternal morbidity and mortality. For example, in Ethiopia, with the development of new cadres of healthcare providers and the expansion of service provision into the second trimester, women are better able to access safe services [22]. Similarly, in Uruguay, after legal reform, access to safe abortion was facilitated by policies focused on medical abortion provision, which meant fewer infrastructure and training requirements [23]. However, case studies suggest that political will and local ownership are critical for successful and enduring policy reform [24], and further research is needed to better investigate the public health impacts of these policies.

The WHO has a role in providing global public goods that help to ensure health for all people within and across national boundaries [22]. Included in WHO’s core functions are “shaping the research agenda and stimulating the generation, translation, and dissemination of valuable knowledge,” as well as “setting norms and standards, and promoting and monitoring their implementation” [25]. Most countries “have ratified legally binding international treaties and conventions that protect human
rights … [and] the right to the highest attainable standard of health” [1]. By utilizing the information within the GAPD as a starting point from which to understand the various legal, regulatory, or administrative policies that exist within countries, alongside the WHO Safe abortion evidence-based guidance, countries may be better enabled to strengthen safe abortion care to protect the health of women.

Conclusion

Abortion policies may be facilitative or restrictive; however, regulatory, policy, and programmatic barriers that hinder access should be removed. Abortion access must also be considered within the broader context of sexual and reproductive health care. Further research is needed to better understand the impact of these requirements on access to safe abortion services.

List of abbreviations

GAPD  Global Abortion Policies Database
WHO  World Health Organization

Research data for this article

The data generated and/or analyzed during the current study are available in the publicly available Global Abortion Policies Database [http://abortion-policies.srhr.org].

Conflict of interest statement

The authors declare that there is no conflict of interest regarding the publication of this manuscript. The views expressed in this article are those of the authors and do not necessarily represent the views of, and should not be attributed to, the World Health Organization.

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Research agenda

- Additional research is needed to assess the public health impacts of regulatory requirements related to access to safe abortion services.
- Additional research is needed to assess the cumulative effect of regulatory requirements related to access to safe abortion services, especially in the global context.

References


