Country Profile: United Kingdom of Great Britain and Northern Ireland

Region: Northern Europe

Last Updated: 11 July 2022

Identified policies and legal sources related to abortion:
- Reproductive Health Act
- General Medical Health Act
- Constitution
- Criminal / Penal Code
- Civil Code
- Ministerial Order / Decree
- Case Law
- Health Regulation / Clinical Guidelines
- EML / Registered List
- Medical Ethics Code
- Document Relating to Funding
- Abortion Specific Law
- Law on Medical Practitioners
- Law on Health Care Services
- Other

List of ratified human rights treaties:
- CERD
- CCPR
- 2nd OP
- CEDAW
- CAT
- CRC
- CRC-OP
- CRC:OPAC
- CRC:OPIC
- CMW
- CRPD
- CEDAW:OP
- CEDAW-OP
- CRC:OPSC
- CESCR
- CESCR-OP
- CAT
- CAT-OP
- Maputo Protocol

Related Documents

From Criminal / Penal Code:
- Offences against the Person Act, 1861
- Isle of Man Criminal Code, 1872
- Northern Ireland Criminal Justice Act, 1945

From Ministerial Order / Decree:
- United Kingdom Approval home use second stage early medical abortion DoH, 2018

From Case Law:
- Greater Glasgow Health Board (Appellant) v. Doogan and another (Respondents) (Scotland), 2014
- R (Axon) v. Secretary of State for Health, 2006
- Royal College of Nursing of the United Kingdom v. Department of Health and Social Security, 1981

From Health Regulation / Clinical Guidelines:
- Northern Ireland Reference Guide to Consent for Examination, Treatment or Care, 2003
- Northern Ireland Guidance for Health and Social Care Professionals on Termination of Pregnancy, 2016
- UK Northern Ireland Guidance for medical profession, 2019
- Guernsey Abortion Regulations 2022

From EML / Registered List:
- United Kingdom National Formulary, 2014

From Abortion Specific Law:
- United Kingdom Abortion Act, 1967
- Isle of Man Termination of Pregnancy (Medical Defences) Act, 1995
- Jersey Termination of Pregnancy Law, 1997
- United Kingdom Isle of Man Abortion Reform Act, 2019
- Guernsey Abortion Law post amendment 2021

From Other:
- United Kingdom Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy
- United Kingdom Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing

Concluding Observations:
- CEDAW
- CEDAW
- CRC
- CRC
- CESCR
- SR VAW
- CESCR
- CRPD
- CAT
- CEDAW

Persons who can be sanctioned:
A woman or girl can be sanctioned
Providers can be sanctioned
A person who assists can be sanctioned

## Abortion at the woman’s request

| United Kingdom of Great Britain and Northern Ireland | Not Specified |
| Guernsey (United Kingdom of Great Britain and Northern Ireland) | Not Specified |
| Isle of Man (United Kingdom of Great Britain and Northern Ireland) | Gestational limit: 14 |
| Jersey (United Kingdom of Great Britain and Northern Ireland) | Not Specified |
| Northern Ireland (United Kingdom of Great Britain and Northern Ireland) | Gestational limit: 12 |

## Legal Ground and Gestational Limit

### Economic or social reasons

- **Not specified**

  When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

  **Related documents:**
  - Abortion Act, 1967

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

- Health grounds shall reflect WHO’s definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.

  **Source document:** WHO Abortion Care Guideline (page 16)

### Additional notes

- The Act 1967 states that in determining whether the continuance of a pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family or whether the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, account may be taken of the pregnant woman’s actual or reasonably foreseeable environment.

  **Related documents:**
  - Abortion Act, 1967 (page 1)

### Foetal impairment

- **Yes**

  **Related documents:**
  - Abortion Act, 1967 (page 1)

### Gestational limit

- **Weeks: no limit specified**

  **Related documents:**
  - Abortion Act, 1967 (page 1)

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

- Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

  **Source document:** WHO Abortion Care Guideline (page 64)

- Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.

  **Source document:** WHO-Safe-Abortion-Guidance-2012.pdf#page=103
### Rape

**Not specified**

- When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

**Related documents:**
- Abortion Act, 1967

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### Incest

**Not specified**

- When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

**Related documents:**
- Abortion Act, 1967

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### Intellectual or cognitive disability of the woman

**Not specified**

- When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

**Related documents:**
- Abortion Act, 1967

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### Mental health

**Yes**

**Related documents:**
- Abortion Act, 1967 (page 1)

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### Gestational limit

**Weeks:** no limit specified

**Related documents:**
- Abortion Act, 1967 (page 1)

---

### WHO Guidance

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**Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person.** The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest. *Abortion Care Guideline § 2.2.2.*

**Source document:** WHO Abortion Care Guideline (page 64)

**Additional notes**

Abortion is not an offence when the pregnancy has not exceeded its twenty-fourth week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman. It is also not an offence when the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, with no gestational limit specified. The Abortion Act 1967 states that in determining whether the continuance of a pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family or whether the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.
### Physical health

**Related documents:**
- Abortion Act, 1967 (page 1)

### Gestational limit

**Weeks:** no limit specified

### WHO Guidance

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Health grounds shall reflect WHO's definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.

> Source document: WHO Abortion Care Guideline (page 16)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.


### Additional notes

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### Health

**Not specified**

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### WHO Guidance

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> Source document: WHO Abortion Care Guideline (page 16)

### Life

**Yes**

### Gestational limit

**Weeks:** no limit specified

### WHO Guidance

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> Source document: WHO Abortion Care Guideline (page 64)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.


### Other

The continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family.

### Related documents:
- Abortion Act, 1967 (page 1)

### Additional notes

The Abortion Act 1967 states that in determining whether the continuance of a pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family or whether the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, account may be taken of the pregnant woman's actual or reasonably foreseeable environment. The gestational limit is 24 weeks.
### Economic or social reasons

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**Related documents:**
- Abortion Law post amendment, 2021

### Foetal impairment

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**Related documents:**
- Abortion Law post amendment, 2021 (page 5)

#### Gestational limit

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**Related documents:**
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### Rape

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**Related documents:**
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### Incest

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**Gestational limit**

Weeks: No limit specified

- Abortion Law post amendment, 2021 (page 1)

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**Additional notes**

The gestational limit is 24 weeks.

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**Gestational limit**

Weeks: 23

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

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**WHO Guidance**

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- **Source document:** WHO-Safe-Abortion-Guidance-2012.pdf#page=103
Foetal impairment

Yes

Related documents:
- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

Gestational limit

Weeks: No limit specified

From the start of the 24th week of the gestation period abortion services may be provided upon request by or on behalf of a woman if the registered medical practitioner attending her is of the opinion, formed in good faith, and after taking such specialist medical advice as appears to the practitioner to be appropriate, that the continuance of the pregnancy would involve risk to her life, greater than if the pregnancy were terminated. In determining whether the continuance of a pregnancy would involve a risk to the health of the woman account may be taken of her actual or reasonably foreseeable environment.

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

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Source document: WHO Abortion Care Guideline (page 64)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.


Rape

Yes

Related documents:
- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

Gestational limit

Weeks: 23

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

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<tr>
<td><strong>Source document</strong>: WHO Abortion Care Guideline (page 16)</td>
<td></td>
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</tr>
</tbody>
</table>
Health

Yes

Related documents:
- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

Gestational limit

Weeks: 23 weeks

From the start of the 24th week of the gestation period abortion services may be provided upon request by or on behalf of a woman if the registered medical practitioner attending her is of the opinion, formed in good faith, and after taking such specialist medical advice as appears to the practitioner to be appropriate, that the continuance of the pregnancy would involve risk to her life, greater than if the pregnancy were terminated. In determining whether the continuation of a pregnancy would involve a risk to the health of the woman account may be taken of her actual or reasonably foreseeable environment.

Other unlawful intercourse (distinct from rape and incest)

Related documents:
- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

Life

Yes

Related documents:
- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

Gestational limit

Weeks: No limit specified

From the start of the 24th week of the gestation period abortion services may be provided upon request by or on behalf of a woman if the registered medical practitioner attending her is of the opinion, formed in good faith, and after taking such specialist medical advice as appears to the practitioner to be appropriate, that the continuance of the pregnancy would involve risk to her life, greater than if the pregnancy were terminated. In determining whether the continuation of a pregnancy would involve a risk to the health of the woman account may be taken of her actual or reasonably foreseeable environment.

Other

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:
- Jersey Termination of Pregnancy Law, 1997

Jersey (United Kingdom of Great Britain and Northern Ireland)

Economic or social reasons

Related documents:
- Jersey Termination of Pregnancy Law, 1997

Other

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:
- Jersey Termination of Pregnancy Law, 1997

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Health grounds shall reflect WHO’s definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.

Source document: WHO Abortion Care Guideline (page 16)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.

Related documents:

- Jersey Termination of Pregnancy Law, 1997 (page 6)

### Gestational limit

**Weeks:** 24

- Jersey Termination of Pregnancy Law, 1997 (page 6)

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is not viable. Grounds-based approaches that require fetal impairments to be fatal for abortion to be lawful frustrate providers and leave women no choice but to continue with pregnancy.

Being required to continue with a pregnancy that causes significant distress violates numerous human rights. Abortion Care Guideline § 2.2.2.

**Source document:** WHO Abortion Care Guideline (page 64)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.

**Source document:** WHO-Safe-Abortion-Guidance-2012.pdf#page=103

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**Rape**

- Not specified

  When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

  **Related documents:**

  - Jersey Termination of Pregnancy Law, 1997

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

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**Source document:** WHO Abortion Care Guideline (page 64)

---

**Incest**

- Not specified

  When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

  **Related documents:**

  - Jersey Termination of Pregnancy Law, 1997

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

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**Source document:** WHO Abortion Care Guideline (page 64)

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**Intellectual or cognitive disability of the woman**

- Not specified

  When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

  **Related documents:**

  - Jersey Termination of Pregnancy Law, 1997
Mental health

Related documents:
- Jersey Termination of Pregnancy Law, 1997 (page 6)

Gestational limit

Weeks: No limit specified
- Jersey Termination of Pregnancy Law, 1997 (page 6)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Health grounds shall reflect WHO’s definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.
- Source document: WHO Abortion Care Guideline (page 16)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.

Physical health

Related documents:
- Jersey Termination of Pregnancy Law, 1997 (page 6)

Gestational limit

Weeks: No limit specified
- Jersey Termination of Pregnancy Law, 1997 (page 6)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Health grounds shall reflect WHO’s definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.
- Source document: WHO Abortion Care Guideline (page 16)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.

Health

Not specified

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:
- Jersey Termination of Pregnancy Law, 1997

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Health grounds shall reflect WHO’s definitions of health, which entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Abortion Care Guideline § 2.2.2.
- Source document: WHO Abortion Care Guideline (page 16)
### Life

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>- Jersey Termination of Pregnancy Law, 1997 (page 6)</td>
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### Gestational limit

<table>
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<tr>
<th>Weeks:</th>
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<tbody>
<tr>
<td>Related documents:</td>
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### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available where the life and health of the woman, girl or other pregnant person is at risk. Abortion Care Guideline § 2.2.2.

- Source document: [WHO Abortion Care Guideline (page 64)](WHO-Safe-Abortion-Guidance-2012.pdf#page=103)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.


### Other

| The woman's condition causes her distress |
| Related documents: |
| - Jersey Termination of Pregnancy Law, 1997 (page 6) |

### Northern Ireland (United Kingdom of Great Britain and Northern Ireland)

#### Economic or social reasons

<table>
<thead>
<tr>
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### WHO Guidance

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Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.


#### Foetal impairment

| Yes |
| Related documents: |
| - The Abortion Regulations 2020 (page 3) |

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

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- Source document: [WHO Abortion Care Guideline (page 64)](WHO-Safe-Abortion-Guidance-2012.pdf#page=103)

Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including forcing them to seek clandestine abortions and suffer social inequities. Safe Abortion Guidelines, § 4.2.1.7.


### Additional notes

- A registered medical professional may terminate a pregnancy where two registered medical professionals are of the opinion, formed in good faith, that there is a substantial risk that the condition of the fetus is such that— (a) the death of the fetus is likely before, during or shortly after birth; or (b) if the child were born, it would suffer from such physical or mental impairment as to be seriously disabled.
The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. The Abortion Care Guideline recommends against laws and other regulations that restrict abortion by grounds. The guideline recommends abortion be available on the request of the woman, girl or other pregnant person.

Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This requires that abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest. Abortion Care Guideline § 2.2.2.

Source document: WHO Abortion Care Guideline (page 64)
### Health

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### Life

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<tr>
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<tbody>
<tr>
<td>The Abortion Regulations 2020 (page 3)</td>
</tr>
</tbody>
</table>

#### Gestational limit

<table>
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<tr>
<th>Weeks: no limit specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Abortion Regulations 2020 (page 3)</td>
</tr>
</tbody>
</table>

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### Other

Additional notes:

The requirement for authorization by two registered medical practitioners does not apply in cases of emergency.
### Authorization in specially licensed facilities only

**Not specified**

- **Related documents:**
  - Abortion Act, 1967
  - Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) – and supported in the community – to allow for expansion of health worker roles, including self-management approaches. To ensure both access to abortion and achievement of Universal Health Coverage (UHC), abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. Abortion Care Guideline § 1.4.1.

*Source document: WHO Abortion Care Guideline (page 52)*

### Judicial authorization for minors

**Not specified**

- **Related documents:**
  - Abortion Act, 1967
  - R (Axon) V Secretary of State for Health, 2006
  - Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

*Source document: WHO Abortion Care Guideline (page 83)*

### Judicial authorization in cases of rape

**Not applicable**

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.

*Source document: WHO Safe Abortion Guidance 2012.pdf#page=104*

### Police report required in case of rape

**Not applicable**

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.

*Source document: WHO Abortion Care Guideline (page 83)*

### Parental consent required for minors

**No**

**Related documents:**

- R (Axon) V Secretary of State for Health, 2006 (page 1)

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women’s access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

*Source document: WHO Abortion Care Guideline (page 83)*

**Additional notes**

In Axon v Secretary of State for Health, the court held that it is lawful for healthcare professionals to provide an abortion to women under the age of 16 without the parental knowledge or consent provided they are satisfied that she understands all aspects of any advice and treatment, she cannot be persuaded to inform her parents or allow the health professional to do so, her health is likely to suffer unless she receives treatment and it is in her best interests to receive treatment without parental consent.
Spousal consent

Not specified
When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:
- Abortion Act, 1967
- R (Axon) V Secretary of State for Health, 2006
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

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Source document: WHO Abortion Care Guideline (page 81)

Ultrasound images or listen to foetal heartbeat required

Not specified
When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:
- Abortion Act, 1967
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The right to refuse information, including the right to refuse viewing ultrasound images, must be respected. The Abortion Care Guideline recommends against the use of ultrasound scanning as a prerequisite for providing abortion services for both medical and surgical abortion. Abortion Care Guideline § 3.3.5.

Source document: WHO Abortion Care Guideline (page 85)

Compulsory counselling

Not specified
When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

Related documents:
- Abortion Act, 1967
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

While counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it. The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality.

Counselling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements.

The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual’s situation and needs. Abortion Care Guideline § 3.2.2.

Source document: WHO Abortion Care Guideline (page 77)

Compulsory waiting period

No

Related documents:
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 23)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mandatory waiting periods delay access to abortion, sometimes to the extent that women’s access to abortion or choice of abortion method is restricted. The Abortion Care Guideline recommends against mandatory waiting periods for abortion. Abortion Care Guideline § 3.3.1.

Source document: WHO Abortion Care Guideline (page 79)

Mandatory HIV screening test

No

Related documents:
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 26)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.3.

Source document: WHO Abortion Care Guideline (page 59)
<table>
<thead>
<tr>
<th>Other mandatory STI screening tests</th>
<th>No</th>
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<tbody>
<tr>
<td>Related documents:</td>
<td>- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 26)</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Regulatory, policy and programmatic barriers - as well as barriers in practice - that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.

Source document: WHO Abortion Care Guideline (page 59)

<table>
<thead>
<tr>
<th>Prohibition of sex-selective abortion</th>
<th>Not specified</th>
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</table>
| Related documents:                  | - Abortion Act, 1967  
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy  
- Offences against the Person Act, 1861 |

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

In situations where abortion is restricted for sex selection purposes, terminating a pregnancy for this reason is likely to involve an unsafe procedure carrying high risks. Any policies or guidelines on the use of technology in obstetric and fetal medicine should take into account the need to ensure women's access to safe abortion and other services - efforts to manage or limit sex selection should also not hamper or limit access to safe abortion services. Preventing gender-biased sex selection: an interagency statement.

Source document: Preventing Gender-Biased Sex Selection (page 17)

<table>
<thead>
<tr>
<th>Restrictions on information provided to the public</th>
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<tr>
<td>Related documents:</td>
<td>- Advertising and Non Broadcast Codes 12 Medicines, Medical devices, Health-related and Beauty Products (page 7)</td>
</tr>
</tbody>
</table>

**List of restrictions**

Marketing communications for services offering advice on unplanned pregnancy must make clear if the service does not refer women directly for a termination. Given that terminations are lawful only in some circumstances […] marketers may wish to seek legal advice.

- Advertising and Non Broadcast Codes 12 Medicines, Medical devices, Health-related and Beauty Products (page 7)

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Dissemination of misinformation, withholding of information and censorship should be prohibited.

Information should be accessible and understandable, including formats catering to low-literacy and differently abled populations. Different modalities exist for the provision of information on abortion, e.g. remote access via hotlines and telemedicine, and through approaches such as harm reduction and community-based outreach, as well as in-person interactions with health workers. Abortion Care Guideline § 3.2.1.

Source document: WHO Abortion Care Guideline (page 74)

<table>
<thead>
<tr>
<th>Restrictions on methods to detect sex of the foetus</th>
<th>No data found</th>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

A woman is entitled to know the status of her pregnancy and to act on this information. Prenatal tests and other medical diagnostic services cannot legally be refused because the woman may decide to terminate her pregnancy. Safe Abortion Guidelines § 4.2.1.4.


<table>
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**Guernsey (United Kingdom of Great Britain and Northern Ireland)**
<table>
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<th>Authorization of health professional(s)</th>
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<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>• Abortion Law post amendment, 2021 (page 5)</td>
<td></td>
</tr>
</tbody>
</table>

### Number and cadre of health-care professional authorizations required

1

**Recognised Medical Practitioner**

Regulations require medical practitioners on whose opinion under section 3(1) of the Abortion (Guernsey) Law, 1997 a pregnancy is terminated to certify that opinion and give that certificate or a copy of it to the authorised person terminating the pregnancy before the termination is carried out. They also provide for that certificate to be kept as medical records.

- Abortion Law post amendment, 2021 (page 5)
- Abortion Regulations, 2022 (page 7)

### Judicial authorization for minors

**Not specified**

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

**Related documents:**

• Abortion Law post amendment, 2021

### Judicial authorization in cases of rape

**Not applicable**

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.

**Source document:** WHO Abortion Care Guideline (page 81)

### Police report required in case of rape

**Not applicable**

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.

**Source document:** WHO Abortion Care Guideline (page 64)
While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

Source document: WHO Abortion Care Guideline (page 81)

While counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it. The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality. Counseling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements.

The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual’s situation and needs. Abortion Care Guideline § 3.2.2.

Source document: WHO Abortion Care Guideline (page 77)
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Related documents</th>
<th>Source document</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory waiting period</td>
<td>Not specified</td>
<td>• Abortion Law post amendment, 2021</td>
<td>WHO Abortion Care Guideline (page 79)</td>
<td></td>
</tr>
<tr>
<td>Mandatory HIV screening test</td>
<td>Not specified</td>
<td>• Abortion Law post amendment, 2021</td>
<td>WHO Abortion Care Guideline (page 79)</td>
<td></td>
</tr>
<tr>
<td>Other mandatory STI screening tests</td>
<td>Not specified</td>
<td>• Abortion Law post amendment, 2021</td>
<td>WHO Abortion Care Guideline (page 79)</td>
<td></td>
</tr>
<tr>
<td>Prohibition of sex-selective abortion</td>
<td>Not specified</td>
<td>• Abortion Law post amendment, 2021</td>
<td>Preventing Gender-Biased Sex Selection (page 17)</td>
<td></td>
</tr>
<tr>
<td>Restrictions on information provided to the public</td>
<td>No data found</td>
<td></td>
<td>WHO Abortion Care Guideline (page 74)</td>
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</tr>
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</table>
### Restrictions on methods to detect sex of the foetus

<table>
<thead>
<tr>
<th>Authorization of health professional(s)</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8 )</td>
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</table>

### Number and cadre of health-care professional authorizations required

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Authorization in specially licensed facilities only</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Doctor (Specialty Not Specified), Specialist Doctor, Including OB/GYN</td>
</tr>
</tbody>
</table>

From the start of the 24th week of the gestation period, the medical practitioner attending the woman must take such specialist medical advice as appears to the practitioner to be appropriate, that —

(a) the termination is necessary to prevent grave long-term injury to her health;

(b) the continuance of the pregnancy would involve risk to her life, greater than if the pregnancy were terminated;

(c) there is a substantial risk that because of its physical or mental condition the foetus would die before or during labour;

(d) there is a substantial risk that, were the child born alive, — (i) the child would die shortly after birth because of severe foetal developmental impairment; or (ii) the child would suffer a serious impairment which is likely to limit both the length and quality of the child's life.

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 8)

### Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

### To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) – and supported in the community – to allow for expansion of health worker roles, including self-management approaches. To ensure both access to abortion and achievement of Universal Health Coverage (UHC), abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. Abortion Care Guideline § 1.4.1.
<table>
<thead>
<tr>
<th>Judicial authorization for minors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td>United Kingdom Isle of Man Abortion Reform Act, 2019</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

Source document: WHO Abortion Care Guideline (page 81)

<table>
<thead>
<tr>
<th>Judicial authorization in cases of rape</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td>United Kingdom Isle of Man Abortion Reform Act, 2019</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.


<table>
<thead>
<tr>
<th>Police report required in case of rape</th>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.


<table>
<thead>
<tr>
<th>Parental consent required for minors</th>
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<tbody>
<tr>
<td>Related documents:</td>
<td>United Kingdom Isle of Man Abortion Reform Act, 2019 (page 11)</td>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

Source document: WHO Abortion Care Guideline (page 81)

**Additional notes**

Parental consent is only required in cases where the woman is below 16 years of age and in the opinion of the relevant professional or pharmacist attending her, she does not have sufficient maturity and intelligence to understand the nature and implications of the proposed treatment. In such cases the medical practitioner attending the woman must obtain the consent of the parent or guardian of, or another person acting in loco parentis in relation to, the woman; and must be satisfied that the decision to consent to the termination of the pregnancy is being taken in good faith and in the best interests of the woman.
<table>
<thead>
<tr>
<th>Spousal consent</th>
<th>Not specified</th>
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<tbody>
<tr>
<td>Related documents:</td>
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<table>
<thead>
<tr>
<th>Ultrasound images or listen to foetal heartbeat required</th>
<th>Not specified</th>
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<tbody>
<tr>
<td>Related documents:</td>
<td>United Kingdom Isle of Man Abortion Reform Act, 2019</td>
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</table>

<table>
<thead>
<tr>
<th>Compulsory counselling</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Related documents:</td>
<td>United Kingdom Isle of Man Abortion Reform Act, 2019</td>
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</table>

<table>
<thead>
<tr>
<th>Mandatory HIV screening test</th>
<th>Not specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td>United Kingdom Isle of Man Abortion Reform Act, 2019</td>
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</tbody>
</table>

The right to refuse information, including the right to refuse viewing ultrasound images, must be respected. The Abortion Care Guideline recommends against the use of ultrasound scanning as a prerequisite for providing abortion services for both medical and surgical abortion. Abortion Care Guideline § 3.3.5.

The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual’s situation and needs. Abortion Care Guideline § 3.2.2.

Mandatory waiting periods delay access to abortion, sometimes to the extent that women’s access to abortion or choice of abortion method is restricted. The Abortion Care Guideline recommends against mandatory waiting periods for abortion. Abortion Care Guideline § 3.3.1.

Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Requirement</th>
<th>Related documents</th>
</tr>
</thead>
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<tr>
<td>Other mandatory STI screening tests</td>
<td>Not specified</td>
<td>When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</td>
</tr>
<tr>
<td>Prohibition of sex-selective abortion</td>
<td>Yes</td>
<td>Related documents: United Kingdom Isle of Man Abortion Reform Act, 2019 (page 13)</td>
</tr>
<tr>
<td>Restrictions on information provided to the public</td>
<td>No</td>
<td>Related documents: United Kingdom Isle of Man Abortion Reform Act, 2019 (page 11)</td>
</tr>
<tr>
<td>Restrictions on methods to detect sex of the foetus</td>
<td>No data found</td>
<td>WHO Guidance: No data found</td>
</tr>
<tr>
<td>Other</td>
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<td>Authorization of health professional(s)</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Related documents:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Jersey Termination of Pregnancy Law, 1997 (page 6)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Number and cadre of health-care professional authorizations required**

2
Registered Medical Practitioner who is Authorized to carry out Terminations

In cases of foetal impairment, one of the medical practitioners authorizing the abortion must be a pediatric specialist.

- Jersey Termination of Pregnancy Law, 1997 (page 6)

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

- Source document: WHO Abortion Care Guideline (page 81)

**Additional notes**

In cases of foetal impairment, one of the medical practitioners authorizing the abortion must be a pediatric specialist.

<table>
<thead>
<tr>
<th>Authorization in specially licensed facilities only</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>• Jersey Termination of Pregnancy Law, 1997 (page 6)</td>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) – and supported in the community – to allow for expansion of health worker roles, including self-management approaches. To ensure both access to abortion and achievement of Universal Health Coverage (UHC), abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. Abortion Care Guideline § 1.4.1.

- Source document: WHO Abortion Care Guideline (page 52)

**Additional notes**

There is no requirement for an abortion to be performed in an approved place in cases where the termination is deemed necessary to save a woman’s life.

<table>
<thead>
<tr>
<th>Judicial authorization for minors</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>• Jersey Termination of Pregnancy Law, 1997</td>
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**WHO Guidance**

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The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

- Source document: WHO Abortion Care Guideline (page 81)

<table>
<thead>
<tr>
<th>Judicial authorization in cases of rape</th>
<th>Not applicable</th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>• Jersey Termination of Pregnancy Law, 1997</td>
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</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Source document</th>
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<tbody>
<tr>
<td>Police report required in rape</td>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. There shall be no procedural requirements to “prove” or “establish” satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information). These restrictions subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion. The Abortion Care Guideline recommends abortion be available on the request of the woman, girl or other pregnant person. Abortion Care Guideline § 2.2.2.</td>
<td>WHO Abortion Care Guideline (page 64)</td>
</tr>
<tr>
<td>Parental consent required for minors</td>
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</tr>
<tr>
<td>Spousal consent</td>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts. While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women’s access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.</td>
<td>WHO Abortion Care Guideline (page 81)</td>
</tr>
<tr>
<td>Ultrasound images or listen to foetal heartbeat required</td>
<td>The right to refuse information, including the right to refuse viewing ultrasound images, must be respected. The Abortion Care Guideline recommends against the use of ultrasound scanning as a prerequisite for providing abortion services for both medical and surgical abortion. Abortion Care Guideline § 3.3.5.</td>
<td>WHO Abortion Care Guideline (page 85)</td>
</tr>
<tr>
<td>Compulsory counselling</td>
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<tr>
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<tr>
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<td></td>
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<tr>
<td>Jersey Termination of Pregnancy Law, 1997 (page 6)</td>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

While counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it. The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality.

Counselling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements.

The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual’s situation and needs. Abortion Care Guideline § 3.2.2.

**Additional notes**

There is a requirement of counselling in cases where a woman seeks an abortion because her condition causes her distress.

<table>
<thead>
<tr>
<th>Compulsory waiting period</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>Jersey Termination of Pregnancy Law, 1997 (page 6)</td>
<td></td>
</tr>
</tbody>
</table>

**Waiting period**

First consultation 7 DAYS

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mandatory waiting periods delay access to abortion, sometimes to the extent that women's access to abortion or choice of abortion method is restricted. The Abortion Care Guideline recommends against mandatory waiting periods for abortion. Abortion Care Guideline § 3.3.1.

**Additional notes**

The waiting period requirement applies in cases where the woman's condition causes her distress.

<table>
<thead>
<tr>
<th>Mandatory HIV screening test</th>
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<tbody>
<tr>
<td>Related documents:</td>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.

**Other mandatory STI screening tests**

**Not specified**

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

**Related documents:**

| Jersey Termination of Pregnancy Law, 1997 |

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

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<tr>
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<tr>
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</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

In situations where abortion is restricted for sex selection purposes, terminating a pregnancy for this reason is likely to involve an unsafe procedure carrying high risks. Any policies or guidelines on the use of technology in obstetric and fetal medicine should take into account the need to ensure women's access to safe abortion and other services - efforts to manage or limit sex selection should also not hamper or limit access to safe abortion services. Preventing gender-biased sex selection: an interagency statement.

Source document: Preventing Gender-Biased Sex Selection (page 17)

<table>
<thead>
<tr>
<th>Restrictions on information provided to the public</th>
<th>No data found</th>
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</thead>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Dissemination of misinformation, withholding of information and censorship should be prohibited.

Information should be accessible and understandable, including formats catering to low-literacy and differently abled populations. Different modalities exist for the provision of information on abortion, e.g. remote access via hotlines and telemedicine, and through approaches such as harm reduction and community-based outreach, as well as in-person interactions with health workers.

Source document: WHO Abortion Care Guideline (page 74)

<table>
<thead>
<tr>
<th>Restrictions on methods to detect sex of the foetus</th>
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</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

A woman is entitled to know the status of her pregnancy and to act on this information. Prenatal tests and other medical diagnostic services cannot legally be refused because the woman may decide to terminate her pregnancy.


<table>
<thead>
<tr>
<th>Other</th>
<th>In cases where the woman's condition causes her distress: On the day the termination is carried out, the woman is ordinarily resident in Jersey or has been resident in Jersey for the period of 90 days immediately preceding that day.</th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td>Jersey Termination of Pregnancy Law, 1997 (page 6)</td>
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</table>

<table>
<thead>
<tr>
<th>Northern Ireland (United Kingdom of Great Britain and Northern Ireland)</th>
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<tbody>
<tr>
<td>Authorization of health professional(s)</td>
<td>Yes</td>
</tr>
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</table>

**Number and cadre of health-care professional authorizations required**

1 or 2 (depending on the ground and gestational limit)

Registered Medical Professional

Source document: WHO Abortion Care Guideline (page 81)

The Abortion Regulations 2020 (page 2)

Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.
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<thead>
<tr>
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<th>Not specified</th>
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<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>• Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
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<tr>
<td><strong>WHO Guidance</strong></td>
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<tr>
<td>The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.</td>
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</tr>
<tr>
<td>To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) – and supported in the community – to allow for expansion of health worker roles, including self-management approaches. To ensure both access to abortion and achievement of Universal Health Coverage (UHC), abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. Abortion Care Guideline § 1.4.1.</td>
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<td><img src="source" alt="Source document: WHO Abortion Care Guideline (page 52)" /></td>
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<table>
<thead>
<tr>
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<tr>
<td>Related documents:</td>
<td></td>
</tr>
<tr>
<td>• Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
<td></td>
</tr>
<tr>
<td><strong>WHO Guidance</strong></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.</td>
<td></td>
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<tr>
<td><img src="source" alt="Source document: WHO Abortion Care Guideline (page 52)" /></td>
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<table>
<thead>
<tr>
<th>Judicial authorization in cases of rape</th>
<th>Not applicable</th>
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<tr>
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<tr>
<td><strong>WHO Guidance</strong></td>
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<td><strong>WHO Guidance</strong></td>
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<table>
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<th>Parental consent required for minors</th>
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</tr>
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<td>• Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
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<td><strong>WHO Guidance</strong></td>
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</tr>
<tr>
<td><img src="source" alt="Source document: WHO Abortion Care Guideline (page 52)" /></td>
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<tr>
<td>Spousal consent</td>
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<td>Related documents:</td>
<td>Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
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<table>
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<tr>
<th>Ultrasound images or listen to foetal heartbeat required</th>
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<td>Related documents:</td>
<td>Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
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<table>
<thead>
<tr>
<th>Compulsory counselling</th>
<th>Not specified</th>
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<tbody>
<tr>
<td>Related documents:</td>
<td>Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
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<table>
<thead>
<tr>
<th>Compulsory waiting period</th>
<th>Not specified</th>
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<td>Related documents:</td>
<td>Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
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<table>
<thead>
<tr>
<th>Mandatory HIV screening test</th>
<th>Not specified</th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td>Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
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</tbody>
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The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements. Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women’s access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. The Abortion Care Guideline recommends that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. Abortion Care Guideline § 3.3.2.

The right to refuse information, including the right to refuse viewing ultrasound images, must be respected. The Abortion Care Guideline recommends against the use of ultrasound scanning as a prerequisite for providing abortion services for both medical and surgical abortion. Abortion Care Guideline § 3.3.5.

Counselling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements.

The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality.

Counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it. The right to refuse counselling when offered must be respected. Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality.

The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services. Therefore, it is important for the counsellor to be aware of and sensitive to the individual’s situation and needs. Abortion Care Guideline § 3.2.2.

Mandatory waiting periods delay access to abortion, sometimes to the extent that women’s access to abortion or choice of abortion method is restricted. The Abortion Care Guideline recommends against mandatory waiting periods for abortion. Abortion Care Guideline § 3.3.1.

Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § Box 2.1.
<table>
<thead>
<tr>
<th>Other mandatory STI screening tests</th>
<th>Not specified</th>
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</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td>• Reference Guide to Consent for Examination, Treatment or Care, 2003</td>
</tr>
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</table>

### Prohibition of sex-selective abortion

<table>
<thead>
<tr>
<th>Not specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related documents:</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Regulatory, policy and programmatic barriers - as well as barriers in practice - that hinder access to and timely provision of quality abortion care should be removed. Abortion Care Guideline § 2.1.

*Source document: WHO Abortion Care Guideline (page 59)*

### Restrictions on information provided to the public

<table>
<thead>
<tr>
<th>Not specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related documents:</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Dissemination of misinformation, withholding of information and censorship should be prohibited. Information should be accessible and understandable, including formats catering to low-literacy and differently abled populations. Different modalities exist for the provision of information on abortion, e.g. remote access via hotlines and teledmedicine, and through approaches such as harm reduction and community-based outreach, as well as in-person interactions with health workers. Abortion Care Guideline § 3.2.1.

*Source document: Preventing Gender-Biased Sex Selection (page 17)*

### Restrictions on methods to detect sex of the foetus

| No data found |

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

A woman is entitled to know the status of her pregnancy and to act on this information. Prenatal tests and other medical diagnostic services cannot legally be refused because the woman may decide to terminate her pregnancy. Safe Abortion Guidelines § 4.2.1.4.

*Source document: WHO-Safe-Abortion-Guidance-2012.pdf#page=103*

### Other

#### Clinical and Service-delivery Aspects of Abortion Care

**United Kingdom of Great Britain and Northern Ireland**
The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

### Methods allowed

#### Vacuum aspiration

No data found

The Royal College of Obstetricians and Gynaecologists has produced a Clinical Guideline on the care of women requesting induced abortion which addresses these issues. This is accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

#### Dilatation and evacuation

No data found

The Royal College of Obstetricians and Gynaecologists has produced a Clinical Guideline on the care of women requesting induced abortion which addresses these issues. This is accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

#### Combination mifepristone-misoprostol

No data found

The Royal College of Obstetricians and Gynaecologists has produced a Clinical Guideline on the care of women requesting induced abortion which addresses these issues. This is accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

#### Misoprostol only

No data found

The Royal College of Obstetricians and Gynaecologists has produced a Clinical Guideline on the care of women requesting induced abortion which addresses these issues. This is accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

#### Other (where provided)

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Vacuum aspiration is recommended for surgical abortions at or under 14 weeks to be provided by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.

The Abortion Care Guideline recommends against the practice of dilatation and sharp curettage (D&C), including for sharp curette checks (i.e. to “complete” the abortion) following vacuum aspiration. Abortion Care Guideline § 3.4.1.

Dilation and evacuation (D&E) is recommended for surgical abortions at or over 14 weeks to be provided by generalist medical practitioners and specialist medical practitioners. Vacuum aspiration can be used during a D&E. Abortion Care Guideline § 3.4.1.

The recommended method for medical abortion is mifepristone followed by misoprostol (regimen differs by gestational age). Abortion Care Guideline § 3.4.2.

The Abortion Care Guideline recommends the use of misoprostol alone, with a regime that differs by gestational age. Evidence demonstrates that the use of combination mifepristone plus misoprostol is more effective than misoprostol alone. Abortion Care Guideline § 3.4.2.
<table>
<thead>
<tr>
<th>Country recognized approval (mifepristone / mife-misoprostol)</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related documents:</td>
<td>* British National Formulary, 2014 (page 4)</td>
</tr>
</tbody>
</table>

### Pharmacy selling or distribution

No

Mifepristone is approved for inpatient or specialist team administration only.

- * British National Formulary, 2014 (page 4)

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 μg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 μg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

Source document: WHO Abortion Care Guideline (page 55)

### Misoprostol allowed to be sold or distributed by pharmacies or drug stores

Yes, with prescription only

- * British National Formulary, 2014 (page 4)

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

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Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

Source document: WHO Abortion Care Guideline (page 55)
### Where can abortion services be provided

**Primary health-care centres**
- Not specified
  - Abortion Act, 1967
  - Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

**Secondary (district-level) health-care facilities**
- Yes
  - Abortion Act, 1967 (page 2)

**Specialized abortion care public facilities**
- Not specified
  - Abortion Act, 1967
  - Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

**Private health-care centres or clinics**
- Not specified
  - Abortion Act, 1967
  - Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

**NGO health-care centres or clinics**
- Not specified
  - Abortion Act, 1967 (page 2)

**Other (if applicable)**
- Any treatment for the termination of pregnancy must be carried out in an NHS hospital or in a place approved by the Secretary of State for that purpose. Women with pregnancies not exceeding nine weeks and six days who have taken Mifepristone at a clinic may carry out the second stage of treatment (taking Misoprostol) at home (the place where they have their permanent address or usually reside).

### National guidelines for post-abortion care

**No data found**
- Where there is evidence of the existence of a source document that could not be accessed, including those that could not be translated for any reason, this information is provided in an accompanying note.

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

**Source document**: WHO Abortion Care Guideline (page 48)

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

**Source document**: WHO Abortion Care Guideline (page 50)

The Royal College of Obstetricians and Gynaecologists has produced a Clinical Guideline on the care of women requesting induced abortion which addresses these issues. This is accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion
## Where can post-abortion care services be provided

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Data Availability</th>
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<tbody>
<tr>
<td>Primary health-care centres</td>
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<tr>
<td>Secondary (district-level) health-care facilities</td>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
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<td>No data found</td>
</tr>
<tr>
<td>Other (if applicable)</td>
<td>No data found</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. Telemedicine services should include referrals (based on the woman’s location) for medications (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services. Abortion Care Guideline § 3.6.1.

Source document: WHO Abortion Care Guideline (page 133)

## Contraception included in post-abortion care

**Yes**

**Related documents:**
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 25)

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

All contraceptive options may be considered after an abortion. For individuals undergoing surgical abortion and wishing to use contraception, Abortion Care Guideline recommends the option of initiating the contraception at the time of surgical abortion. For individuals undergoing medical abortion, for those who choose to use hormonal contraception, the Abortion Care Guideline suggests that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. For those who choose to have an IUD inserted, Abortion Care Guideline suggests IUD placement at the time that success of the abortion procedure is determined. Abortion Care Guideline § 3.5.4.

Source document: WHO Abortion Care Guideline (page 126)

**Additional notes**

The Royal College of Obstetricians and Gynaecologists has produced a Clinical Guideline on the care of women requesting induced abortion which addresses these issues. This is accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

## Insurance to offset end user costs

**No**

**Related documents:**
- Other (if applicable)

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where user fees are charged for abortion, this should be based on careful consideration of ability to pay, and fee waivers should be available for those who are facing financial hardship and adolescent abortion seekers. As far as possible, abortion services and supplies should be mandated for coverage under insurance plans as inability to pay is not an acceptable reason to deny or delay abortion care. Furthermore, having transparent procedures in all health-care facilities can ensure that informal charges are not imposed by staff. Abortion Care Guideline § 1.4.2.

Source document: WHO Abortion Care Guideline (page 53)
The Abortion Care Guideline recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance. Abortion Care Guideline § 3.3.8.

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

No official guidance was found which supports an interpretation of the 1981 judgment to the effect that trained registered nurses and midwives may perform abortions by surgical methods under the kind of supervision the 1981 judgment sets out.

- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 13)
- Royal College of Nursing of the United Kingdom v Department of Health and Social Security (page 1)

Midwife/nurse-midwife

Yes

In 1981 the House of Lords considered the requirement under the 1967 Abortion Act that an abortion should be performed by a registered medical practitioner in RCN v DHSS [1981], a case involving second-trimester medical terminations. Three of the five judges found that a registered medical practitioner must “accept responsibility for all stages of the treatment for the termination of the pregnancy” and must “be available to be consulted or called on for assistance from beginning to end of the treatment.” But a “the doctor need not do everything with his own hands; the requirements of the subsection are satisfied when the treatment for termination of a pregnancy is one prescribed by a registered medical practitioner carried out in accordance with his directions and of which a registered medical practitioner remains in charge throughout.” (10)

The Department of Health accordingly advises as follows: “…in relation to medical terminations, the courts have decided that provided the RMP personally decides upon, initiates and takes responsibility throughout the process, the protection offered by the Act will apply to the RMP and to any other person participating in the termination under his or her authority. Certain actions may therefore be undertaken by registered nurses or midwives provided they are fully trained and where the provider has agreed protocols in place. For example, a nurse or midwife may administer the drugs used for medical abortion once these have been prescribed by a doctor.” (4)

No official guidance was found which supports an interpretation of the 1981 judgment to the effect that trained registered nurses and midwives may perform abortions by surgical methods under the kind of supervision the 1981 judgment sets out.

- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 13)
- Royal College of Nursing of the United Kingdom v Department of Health and Social Security (page 1)

Doctor (specialty not specified)

Not specified

- Abortion Act, 1967
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

Specialist doctor, including OB/GYN

Not specified

- Abortion Act, 1967
- Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy

Other (if applicable)

Registered Medical Practitioner

In 1981 the House of Lords considered the requirement under the 1967 Abortion Act that an abortion should be performed by a registered medical practitioner in RCN v DHSS [1981], a case involving second-trimester medical terminations. Three of the five judges found that a registered medical practitioner must “accept responsibility for all stages of the treatment for the termination of the pregnancy” and must “be available to be consulted or called on for assistance from beginning to end of the treatment.” But a “the doctor need not do everything with his own hands; the requirements of the subsection are satisfied when the treatment for termination of a pregnancy is one prescribed by a registered medical practitioner carried out in accordance with his directions and of which a registered medical practitioner remains in charge throughout.” (10)

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- Abortion Act, 1967 (page 1)
- Royal College of Nursing of the United Kingdom v Department of Health and Social Security (page 1)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance. Abortion Care Guideline § 3.3.8.

Source document: WHO Abortion Care Guideline (page 97)
<table>
<thead>
<tr>
<th>Extra facility/provider requirements for delivery of abortion services</th>
<th>Referral linkages to a higher-level facility</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 24)</td>
</tr>
<tr>
<td>Availability of a specialist doctor, including OB/GYN</td>
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</tr>
<tr>
<td></td>
<td>• Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 11)</td>
</tr>
<tr>
<td>Minimum number of beds</td>
<td>Not specified</td>
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<tr>
<td></td>
<td>• Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy</td>
</tr>
<tr>
<td>Other (if applicable)</td>
<td>Approval by the Secretary of State for Health which depends on compliance with the Abortion Act 1967 (1) and regulations made under that Act; the requirements set out in regulations made under the Health and Social Care Act 2008(3); and the Required Standard Operating Procedures set out in the Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion) (4) Independent healthcare providers must register with the Care Quality Commission and have received written approval from the Secretary of State for Health.</td>
</tr>
<tr>
<td></td>
<td>• Abortion Act, 1967 (page 2)</td>
</tr>
<tr>
<td></td>
<td>• Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (page 1)</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual themself, and the location of service provision (from among recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. A plurality of service-delivery approaches can co-exist within any given context. Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide access to scientifically accurate, understandable information at all stages; access to quality-assured medicines (including those for pain management); back-up referral support if desired or needed; linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception. Best Practice Statement 49 on service delivery. Abortion Care Guideline § 3.6.1.

**Source document:** WHO Abortion Care Guideline (page 132)

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**Guernsey (United Kingdom of Great Britain and Northern Ireland)**

<table>
<thead>
<tr>
<th>National guidelines for induced abortion</th>
</tr>
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<tbody>
<tr>
<td>The Guernsey Abortion Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods. The guidelines are accessible at: <a href="http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion">http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion</a></td>
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**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

**Source document:** WHO Abortion Care Guideline (page 50)
Methods allowed

Vacuum aspiration
The Guernsey Abortion Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

Dilation and evacuation
The Guernsey Abortion Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

Combination mifepristone-misoprostol
The Guernsey Abortion Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

Misoprostol only
The Guernsey Abortion Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

Other (where provided)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Vaccuum aspiration is recommended for surgical abortions at or under 14 weeks to be provided by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.

The Abortion Care Guideline recommends against the practice of dilation and sharp curettage (D&C), including for sharp curette checks (i.e. to “complete” the abortion) following vacuum aspiration. Abortion Care Guideline § 3.4.1.

- Source document: WHO Abortion Care Guideline (page 101)

Dilation and evacuation (D&E) is recommended for surgical abortions at or over 14 weeks to be provided by generalist medical practitioners and specialist medical practitioners. Vacuum aspiration can be used during a D&E. Abortion Care Guideline § 3.4.1.

- Source document: WHO Abortion Care Guideline (page 103)

The recommended method for medical abortion is mifepristone followed by misoprostol (regimen differs by gestational age). Abortion Care Guideline § 3.4.2.

- Source document: WHO Abortion Care Guideline (page 106)

The Abortion Care Guideline recommends the use of misoprostol alone, with a regime that differs by gestational age. Evidence demonstrates that the use of combination mifepristone plus misoprostol is more effective than misoprostol alone. Abortion Care Guideline § 3.4.2.

- Source document: WHO Abortion Care Guideline (page 106)

Country recognized approval
(mifepristone / mife-misoprostol)

No data found

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 μg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 μg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

- Source document: WHO Abortion Care Guideline (page 101)

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- Source document: WHO Abortion Care Guideline (page 55)

Country recognized approval
(misoprostol)

No data found

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

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- Source document: WHO Abortion Care Guideline (page 55)
### Where can abortion services be provided

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<th>Primary health-care centres</th>
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### National guidelines for post-abortion care

The Guernsey Abortion Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion)

### Contraception included in post-abortion care

The Abortion Care Guideline recommends the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. Telemedicine services should include referrals (based on the woman’s location) for medicines (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services. Abortion Care Guideline § 3.6.1.

### Insurance to offset end user costs

No data found

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**Related documents:**
- Abortion Law post amendment, 2021

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

**Source document:** WHO Abortion Care Guideline (page 48)

The Guernsey Abortion Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion)

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

**Source document:** WHO Abortion Care Guideline (page 50)

The Abortion Care Guideline recommends the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. Telemedicine services should include referrals (based on the woman’s location) for medicines (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services. Abortion Care Guideline § 3.6.1.

**Source document:** WHO Abortion Care Guideline (page 133)

All contraceptive options may be considered after an abortion. For individuals undergoing surgical abortion and wishing to use contraception, Abortion Care Guideline recommends the option of initiating the contraception at the time of surgical abortion. For individuals undergoing medical abortion, for those who choose to use hormonal contraception, the Abortion Care Guideline suggests that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. For those who choose to have an IUD inserted, Abortion Care Guideline suggests IUD placement at the time that success of the abortion procedure is determined. Abortion Care Guideline § 3.5.4.

**Source document:** WHO Abortion Care Guideline (page 126)

Where user fees are charged for abortion, this should be based on careful consideration of ability to pay, and fee waivers should be available for those who are facing financial hardship and adolescent abortion seekers. As far as possible, abortion services and supplies should be mandated for coverage under insurance plans as inability to pay is not an acceptable reason to deny or delay abortion care. Furthermore, having transparent procedures in all health-care facilities can ensure that informal charges are not imposed by staff. Abortion Care Guideline § 1.4.2.

**Source document:** WHO Abortion Care Guideline (page 53)
Who can provide abortion services

- Nurse
  - Not specified
- Midwife/nurse-midwife
  - Not specified
- Doctor (specialty not specified)
  - Not specified
- Specialist doctor, including OB/GYN
  - Not specified
- Other (if applicable)
  - An authorized person is a recognised medical practitioner, or (b) a person who is registered as a nurse or midwife in the register maintained by the Committee under section 3 of the Registered Health Professionals Ordinance, 2006.
  - Not specified

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance. Abortion Care Guideline § 3.3.8.

Source document: WHO Abortion Care Guideline (page 97)

Extra facility/provider requirements for delivery of abortion services

- Referral linkages to a higher-level facility
  - Not specified
- Availability of a specialist doctor, including OB/GYN
  - Not specified
- Minimum number of beds
  - Not specified
- Other (if applicable)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual themself, and the location of service provision (from among recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. A plurality of service-delivery approaches can co-exist within any given context. Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide access to scientifically accurate, understandable information at all stages; access to quality-assured medicines (including those for pain management); back-up referral support if desired or needed; linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception. Best Practice Statement 49 on service delivery. Abortion Care Guideline § 3.6.1.

Source document: WHO Abortion Care Guideline (page 132)

Isle of Man (United Kingdom of Great Britain and Northern Ireland)

National guidelines for induced abortion

There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion.

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

Source document: WHO Abortion Care Guideline (page 50)
Vacuum aspiration
There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion).

Dilation and evacuation
There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion).

Combination mifepristone-misoprostol
There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion).

Misoprostol only
There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion).

Other (where provided)

### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Vacuum aspiration is recommended for surgical abortions at or under 14 weeks to be provided by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.

The Abortion Care Guideline recommends against the practice of dilation and sharp curettage (D&C), including for sharp curette checks (i.e. to "complete" the abortion) following vacuum aspiration. Abortion Care Guideline § 3.4.1.

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The recommended method for medical abortion is mifepristone followed by misoprostol (regimen differs by gestational age). Abortion Care Guideline § 3.4.2.

- **Source document**: WHO Abortion Care Guideline (page 106)

The Abortion Care Guideline recommends the use of misoprostol alone, with a regime that differs by gestational age. Evidence demonstrates that the use of combination mifepristone plus misoprostol is more effective than misoprostol alone. Abortion Care Guideline § 3.4.2.

- **Source document**: WHO Abortion Care Guideline (page 106)

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### Country recognized approval (mifepristone / mifepristone - misoprostol)

No data found

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### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 μg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 μg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

- **Source document**: WHO Abortion Care Guideline (page 55)

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

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- **Source document**: WHO Abortion Care Guideline (page 55)

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### Country recognized approval (misoprostol)

No data found

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### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines.

Inclusion in the NEML is one important component of ensuring that quality medicines are available.

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Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

- **Source document**: WHO Abortion Care Guideline (page 55)
Where can abortion services be provided:

- Primary health-care centres
  - Not specified
- Secondary (district-level) health-care facilities
  - Not specified
- Specialized abortion care public facilities
  - Not specified
- Private health-care centres or clinics
  - Not specified
- NGO health-care centres or clinics
  - Not specified
- Other (if applicable)
  - Terminations of pregnancy are to take place in a national health hospital, meaning “a hospital vested in the Department for the purposes of the National Health Service Act 2001” or in other premises approved for the purpose by the Department of Health and Social Care.

Related documents:
- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 7)

There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion.

National guidelines for post-abortion care:

- Primary health-care centres
  - No data found
- Secondary (district-level) health-care facilities
  - No data found
- Specialized abortion care public facilities
  - No data found
- Private health-care centres or clinics
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The Abortion Care Guideline recommends the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. Telemedicine services should include referrals (based on the woman’s location) for medicines (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services. Abortion Care Guideline § 3.6.1.

Source document: WHO Abortion Care Guideline (page 133)
Contraception included in post-abortion care

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

All contraceptive options may be considered after an abortion. For individuals undergoing surgical abortion and wishing to use contraception, Abortion Care Guideline recommends the option of initiating the contraception at the time of surgical abortion. For individuals undergoing medical abortion, for those who choose to use hormonal contraception, the Abortion Care Guideline suggests that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. For those who choose to have an IUD inserted, Abortion Care Guideline suggests IUD placement at the time that success of the abortion procedure is determined. Abortion Care Guideline § 3.5.4.

*Source document:* WHO Abortion Care Guideline (page 126)

**Additional notes**

There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion.

Insurance to offset end user costs

No data found

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where user fees are charged for abortion, this should be based on careful consideration of ability to pay, and fee waivers should be available for those who are facing financial hardship and adolescent abortion seekers. As far as possible, abortion services and supplies should be mandated for coverage under insurance plans as inability to pay is not an acceptable reason to deny or delay abortion care. Furthermore, having transparent procedures in all health-care facilities can ensure that informal charges are not imposed by staff. Abortion Care Guideline § 1.4.2.

*Source document:* WHO Abortion Care Guideline (page 53)

Who can provide abortion services

**Related documents:**

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 9)

**Nurse**

Yes

A person may participate in the provision of abortion services if, but only if, that person is authorised by the Department, possesses the appropriate skill in relation to the gestation period.

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 9)

**Midwife/nurse-midwife**

Yes

A person may participate in the provision of abortion services if, but only if, that person is authorised by the Department, possesses the appropriate skill in relation to the gestation period.

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 9)

**Doctor (specialty not specified)**

Not specified

- United Kingdom Isle of Man Abortion Reform Act, 2019

**Specialist doctor, including OB/GYN**

Not specified

- United Kingdom Isle of Man Abortion Reform Act, 2019

**Other (if applicable)**

Medical practitioner

A person may participate in the provision of abortion services if, but only if, that person is authorised by the Department, possesses the appropriate skill in relation to the gestation period.

- United Kingdom Isle of Man Abortion Reform Act, 2019 (page 9)

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance. Abortion Care Guideline § 3.3.8.

*Source document:* WHO Abortion Care Guideline (page 97)
The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Vacuum aspiration
The Termination of Pregnancy (Jersey) Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

Dilatation and evacuation
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Combination mifepristone-misoprostol
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Misoprostol only
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Source document: WHO Abortion Care Guideline (page 55)
### National guidelines for post-abortion care

The Termination of Pregnancy (Jersey) Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion)

#### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

*Source document:* WHO Abortion Care Guideline (page 50)

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The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. Telemedicine services should include referrals (based on the woman's location) for medicines (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services. Abortion Care Guideline § 3.6.1.

*Source document:* WHO Abortion Care Guideline (page 133)

#### Contraception included in post-abortion care

No data found

#### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

All contraceptive options may be considered after an abortion. For individuals undergoing surgical abortion and wishing to use contraception, Abortion Care Guideline recommends the option of initiating the contraception at the time of surgical abortion. For individuals undergoing medical abortion, for those who choose to use hormonal contraception, the Abortion Care Guideline suggests that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. For those who choose to have an IUD inserted, Abortion Care Guideline suggests IUD placement at the time that success of the abortion procedure is determined. Abortion Care Guideline § 3.5.4.

*Source document:* WHO Abortion Care Guideline (page 126)

#### Additional notes

The Termination of Pregnancy (Jersey) Law does not provide guidance on the provision of services. There are Clinical professional guidelines on the provision of abortion by the Royal College of Obstetricians and Gynaecologists outlining various methods, which may be of relevance. The guidelines are accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion)

#### Insurance to offset end user costs

No data found

#### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where user fees are charged for abortion, this should be based on careful consideration of ability to pay, and fee waivers should be available for those who are facing financial hardship and adolescent abortion seekers. As far as possible, abortion services and supplies should be mandated for coverage under insurance plans as inability to pay is not an acceptable reason to deny or delay abortion care. Furthermore, having transparent procedures in all health-care facilities can ensure that informal charges are not imposed by staff. Abortion Care Guideline § 1.4.2.

*Source document:* WHO Abortion Care Guideline (page 53)
Who can provide abortion services

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Not specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife/nurse-midwife</td>
<td>Not specified</td>
</tr>
<tr>
<td>Doctor (specialty not specified)</td>
<td>Not specified</td>
</tr>
<tr>
<td>Specialist doctor, including OB/GYN</td>
<td>Not specified</td>
</tr>
<tr>
<td>Other (if applicable)</td>
<td>Approved Registered Medical Practitioners</td>
</tr>
</tbody>
</table>

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance. Abortion Care Guideline § 3.3.8.

Source document: WHO Abortion Care Guideline (page 97)

Extra facility/provider requirements for delivery of abortion services

<table>
<thead>
<tr>
<th>Referral linkages to a higher-level facility</th>
<th>Not specified</th>
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</thead>
<tbody>
<tr>
<td>Availability of a specialist doctor, including OB/GYN</td>
<td>Not specified</td>
</tr>
<tr>
<td>Minimum number of beds</td>
<td>Not specified</td>
</tr>
<tr>
<td>Other (if applicable)</td>
<td>Approved Registered Medical Practitioners</td>
</tr>
</tbody>
</table>

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

There is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual themself, and the location of service provision (from among recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. A plurality of service-delivery approaches can co-exist within any given context. Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide access to scientifically accurate, understandable information at all stages; access to quality-assured medicines (including those for pain management); back-up referral support if desired or needed; linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception. Best Practice Statement 49 on service delivery. Abortion Care Guideline § 3.6.1.

Source document: WHO Abortion Care Guideline (page 132)

National guidelines for induced abortion

Yes, guidelines issued by the government

Related documents:
- The Abortion Regulations 2020 (page 2)

WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

Source document: WHO Abortion Care Guideline (page 50)
Methods allowed

<table>
<thead>
<tr>
<th>Method</th>
<th>Approval</th>
<th>Country recognized approval (mifepristone / mifepristone-misoprostol)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacuum aspiration</td>
<td>Not specified</td>
<td>Yes - The Abortion Regulations 2020 (page 4)</td>
</tr>
<tr>
<td>Dilatation and evacuation</td>
<td>Not specified</td>
<td></td>
</tr>
<tr>
<td>Combination mifepristone-misoprostol</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Misoprostol only</td>
<td>Not specified</td>
<td></td>
</tr>
<tr>
<td>Other (where provided)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Vacuum aspiration is recommended for surgical abortions at or under 14 weeks to be provided by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.

The Abortion Care Guideline recommends against the practice of dilatation and sharp curettage (D&C), including for sharp curette checks (i.e. to "complete" the abortion) following vacuum aspiration. Abortion Care Guideline § 3.4.1.

**Source document**: WHO Abortion Care Guideline (page 101)

Dilation and evacuation (D&E) is recommended for surgical abortions at or over 14 weeks to be provided by generalist medical practitioners and specialist medical practitioners. Vacuum aspiration can be used during a D&E. Abortion Care Guideline § 3.4.1.

**Source document**: WHO Abortion Care Guideline (page 103)

The recommended method for medical abortion is mifepristone followed by misoprostol (regimen differs by gestational age). Abortion Care Guideline § 3.4.2.

**Source document**: WHO Abortion Care Guideline (page 106)

The Abortion Care Guideline recommends the use of misoprostol alone, with a regime that differs by gestational age. Evidence demonstrates that the use of combination mifepristone plus misoprostol is more effective than misoprostol alone. Abortion Care Guideline § 3.4.2.

**Source document**: WHO Abortion Care Guideline (page 106)

**Country recognized approval (misoprostol)**

<table>
<thead>
<tr>
<th>Method</th>
<th>Approval</th>
<th>Country recognized approval (misoprostol)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data found</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines. Inclusion in the NEML is one important component of ensuring that quality medicines are available.

For induced abortion, Mifepristone (200 mg) and misoprostol (200 μg), are recommended in the WHO EML. The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 μg).

Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system. Abortion Care Guideline § 1.4.4.

**Source document**: WHO Abortion Care Guideline (page 55)

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent and should be included in the relevant clinical care/service delivery guidelines. Inclusion in the NEML is one important component of ensuring that quality medicines are available.

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**Source document**: WHO Abortion Care Guideline (page 55)
<table>
<thead>
<tr>
<th>Where abortion services can be provided</th>
<th>Related documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Abortion Regulations 2020 (page 3)</td>
</tr>
<tr>
<td>Primary health-care centres</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>The Abortion Regulations 2020 (page 3)</td>
</tr>
<tr>
<td>Secondary (district-level) health-care facilities</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>The Abortion Regulations 2020 (page 3)</td>
</tr>
<tr>
<td>Specialized abortion care public facilities</td>
<td>Not specified</td>
</tr>
<tr>
<td>Private health-care centres or clinics</td>
<td>Not specified</td>
</tr>
<tr>
<td>NGO health-care centres or clinics</td>
<td>Not specified</td>
</tr>
<tr>
<td>Other (if applicable)</td>
<td>The woman's home provided certain criteria are met.</td>
</tr>
<tr>
<td></td>
<td>If the woman having a termination a) has a pregnancy not exceeding 10 weeks of gestation and if she has b) been prescribed Mifepristone and Misoprostol to be taken for the purposes of terminating the pregnancy and c) taken the first part of the medication at the authorised healthcare centre/location, she may take the second part of the treatment at home.</td>
</tr>
<tr>
<td></td>
<td>The Abortion Regulations 2020 (page 4)</td>
</tr>
</tbody>
</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

Source document: WHO Abortion Care Guideline (page 48)

<table>
<thead>
<tr>
<th>National guidelines for post-abortion care</th>
<th>Not specified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.</td>
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</table>

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

National standards and guidelines for abortion care should be evidence based and periodically updated and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines. Abortion Care Guideline § 1.3.3.

Source document: WHO Abortion Care Guideline (page 50)

<table>
<thead>
<tr>
<th>Where post abortion care services can be provided</th>
<th>Primary health-care centres</th>
</tr>
</thead>
<tbody>
<tr>
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Source document: WHO Abortion Care Guideline (page 133)
<table>
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<tr>
<th>Contraception included in post-abortion care</th>
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<tbody>
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<td><strong>WHO Guidance</strong></td>
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<tr>
<th>Insurance to offset end user costs</th>
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</tr>
<tr>
<td>Nurse</td>
</tr>
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<td>Yes</td>
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<tr>
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<tr>
<td>Doctor (specialty not specified)</td>
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<tr>
<td>Specialist doctor, including OB/GYN</td>
</tr>
<tr>
<td>Not specified</td>
</tr>
<tr>
<td>Other (if applicable)</td>
</tr>
<tr>
<td>Registered medical practitioner</td>
</tr>
<tr>
<td>- The Abortion Regulations 2020 (page 2)</td>
</tr>
<tr>
<td><strong>WHO Guidance</strong></td>
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</table>

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<tr>
<th>Extra facility/provider requirements for delivery of abortion services</th>
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</tr>
<tr>
<td>Source document: WHO Abortion Care Guideline (page 132)</td>
</tr>
</tbody>
</table>
**United Kingdom of Great Britain and Northern Ireland**

**Public sector providers**

### Individual health-care providers who have objected are required to refer the woman to another provider

**Not specified**

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

The Royal College of Obstetricians and Gynaecologists has produced a Clinical Guideline on the care of women requesting induced abortion which addresses these issues. This is accessible at: [http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion](http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion)


### WHO Guidance

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

The Abortion Care Guideline recommends that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. Abortion Care Guideline § 3.3.9.

**Source document:** WHO Abortion Care Guideline (page 98)

### Additional notes

This does not apply where it is necessary to save life or prevent grave permanent injury to the woman's physical or mental health.

In a 2014 judgment the Supreme Court considered whether the right to conscientious objection amounted to a right to object to any involvement with patients in connection with the termination of pregnancy to which a person has a conscientious objection. The Supreme Court found that the section of the Abortion Act 1967 on conscientious pertains to “the acts made lawful by section 1” of the Act, not “the host of ancillary, administrative and managerial tasks that might be associated with those acts.”

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### Related documents:

- Abortion Act, 1967 (page 5)
- Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (page 1)

---

**Private sector providers**

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- Abortion Act, 1967
### Private facilities

<table>
<thead>
<tr>
<th>Facility type not specified</th>
<th>Related documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not specified</strong></td>
<td>Abortion Act, 1967</td>
</tr>
<tr>
<td></td>
<td>Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy</td>
</tr>
</tbody>
</table>

**WHO Guidance**

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Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

Source document: WHO Abortion Care Guideline (page 48)

### Facility type not specified

<table>
<thead>
<tr>
<th>Related documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion Act, 1967</td>
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Source document: WHO Abortion Care Guideline (page 48)

### Neither Type of Facility Permitted

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Source document: WHO Abortion Care Guideline (page 48)

### Guernsey (United Kingdom of Great Britain and Northern Ireland)

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**Individual health-care providers who have objected are required to refer the woman to another provider**

Yes

Conscientious objection does not apply unless the person who has a conscientious objection, without delay - makes any arrangements necessary to allow another person, who is lawfully authorised to participate in the treatment and does not have a conscientious objection, to participate in the treatment in place of the person who has a conscientious objection.

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Source document: WHO Abortion Care Guideline (page 98)

**Additional notes**

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**Additional notes**

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### Northern Ireland (United Kingdom of Great Britain and Northern Ireland)

#### Public sector providers

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**Related documents:**
- The Abortion Regulations 2020 (page 9)

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**Related documents:**
- The Abortion Regulations 2020 (page 9)
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**Related documents:**
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Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

*Source document: WHO Abortion Care Guideline (page 48)*

### Facility type not specified

**Not specified**

When there is no explicit reference to an issue covered in the questionnaire in the relevant document(s), this is noted and no interpretation was made.

**WHO Guidance**

The following descriptions were extracted from WHO Abortion Care Guideline. Where there is a specific Recommendation, this is stated. Otherwise, these are excerpts.

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Abortion Care Guideline § 1.3.1.

*Source document: WHO Abortion Care Guideline (page 48)*
## Indicators

Country specific information related to sexual and reproductive health indications. As data for the Sustainable Development Goal (SDG) indicators related to sexual and reproductive health become available, these will be provided, through periodic updates.

### Goal 1. End poverty in all its forms everywhere

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1 Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)</td>
<td>No data</td>
</tr>
<tr>
<td>1.3.1 Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable</td>
<td>No data</td>
</tr>
<tr>
<td>1.4.2 Proportion of total government spending on essential services (education, health and social protection)</td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 3. Ensure healthy lives and promote well-being for all at all ages

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 Maternal mortality ratio</td>
<td>7 (2017)</td>
</tr>
<tr>
<td>3.1.2 Proportion of births attended by skilled health personnel</td>
<td>No data</td>
</tr>
<tr>
<td>3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods</td>
<td>No data</td>
</tr>
<tr>
<td>3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group</td>
<td>12.5 (2015-2020)</td>
</tr>
<tr>
<td>3.8.2 Number of people covered by health insurance or a public health system per 1,000 population</td>
<td>No data</td>
</tr>
<tr>
<td>3.c.1 Health worker density and distribution</td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex</td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 5. Achieve gender equality and empower all women and girls

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex</td>
<td>No data</td>
</tr>
<tr>
<td>5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age</td>
<td>No data</td>
</tr>
<tr>
<td>5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence</td>
<td>No data</td>
</tr>
<tr>
<td>5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18</td>
<td>No data</td>
</tr>
<tr>
<td>5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age</td>
<td>No data</td>
</tr>
</tbody>
</table>
### Additional Reproductive Health Indicators

5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

5.6.2 Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

5.a.1 (a) Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

5.b.1 Proportion of individuals who own a mobile telephone, by sex

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

8.5.2 Unemployment rate, by sex, age and persons with disabilities

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 10. Reduce inequality within and among countries

10.2.1 Proportion of people living below 50 per cent of median income, by age, sex and persons with disabilities

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

10.3.1 Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

16.1.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.2.2 Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.3.1 Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.6.1 Primary government expenditures as a proportion of original approved budget, by sector (or by budget codes or similar)

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.6.2 Proportion of the population satisfied with their last experience of public services

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.7.1 Proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service, and judiciary) compared to national distributions

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.10.1 Number of verified cases of killing, kidnapping, enforced disappearance, arbitrary detention and torture of journalists, associated media personnel, trade unionists and human rights advocates in the previous 12 months

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

16.b.1 Proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
</tbody>
</table>

### Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

17.8.1 Proportion of individuals using the Internet

<table>
<thead>
<tr>
<th>Country</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No data</td>
</tr>
<tr>
<td>Category</td>
<td>Value</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Percentage of married women with unmet need for family planning</td>
<td>No data</td>
</tr>
<tr>
<td>Percentage of births attended by trained health professional</td>
<td>99 (1998)</td>
</tr>
<tr>
<td>Percentage of women aged 20-24 who gave birth before age 18</td>
<td>2 (2009-2013)</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>1.68 (2018)</td>
</tr>
<tr>
<td>Legal marital age for women, with parental consent</td>
<td>16 (2009-2017)</td>
</tr>
<tr>
<td>Legal marital age for women, without parental consent</td>
<td>18 (2009-2017)</td>
</tr>
<tr>
<td>Gender Inequalities Index (Value)</td>
<td>0.12 (2017)</td>
</tr>
<tr>
<td>Gender Inequalities Index (Rank)</td>
<td>25 (2017)</td>
</tr>
<tr>
<td>Mandatory paid maternity leave</td>
<td>yes (2020)</td>
</tr>
<tr>
<td>Median age</td>
<td>40.5 (2020)</td>
</tr>
<tr>
<td>Population, urban (%)</td>
<td>83.398 (2018)</td>
</tr>
<tr>
<td>Percentage of secondary school completion rate for girls</td>
<td>1 (2013)</td>
</tr>
<tr>
<td>Gender parity in secondary education</td>
<td>1.032 (2015)</td>
</tr>
<tr>
<td>Percentage of women in non-agricultural employment</td>
<td>49.2 (2013)</td>
</tr>
<tr>
<td>Proportion of seats in parliament held by women</td>
<td>28.5 (2017)</td>
</tr>
<tr>
<td>Sex ratio at birth (male to female births)</td>
<td>1.05 (2018)</td>
</tr>
</tbody>
</table>