IPPF

From choice, a world of possibilities

Access to safe abortion

A tool for assessing legal and other obstacles

IPPF International Planned Parenthood Federation

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Acknowledgments

Written by Marcel Vekemans, Upeka de Silva and Manuelle Hurwitz.

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Forewords

Ensuring women's rights

My hope is that this tool for carrying out individual country analysis of legislation related to abortion will be useful to you, and those with whom you work in civil society, professional associations, academia and government.

Although in theory there are currently only four countries where abortion is absolutely forbidden under any circumstances, in actual practice many countries allow only very limited access, or limit equitable legal access to safe abortion, by a range of actions.

The analysis which can result from this tool will provide a basis for advocacy to address these issues in each country, so ensuring that women's right to safe, legal abortion, and to autonomy, bodily integrity, and the highest standard of mental and physical health can be realized.

In this way we can contribute to ensuring that 68,000 women do not die each year as a result of unsafe abortion, and that millions more do not suffer preventable disability and injury.

For those of you who are involved in IPPF Member Associations this tool will be a critical element in developing your advocacy plan, implementing abortion-related services, including referral, and in specific projects such as the Global Comprehensive Abortion Care project and the International Federation of Gynecology and Obstetrics (FIGO) partnership. I look forward to hearing reports on your progress.

I would particularly like to thank Marcel Vekemans and all those involved in this work for providing us with this tool which can help us to make a real difference to women's lives – now and in the future.

Dr Gill Greer
Director-General
International Planned Parenthood Federation

Pursuing justice and equity

Ensuring access to safe abortion services for women across the world is one of the most critical challenges we face in our work today. This tool adds to our knowledge base and will hopefully support us all in pursuing justice and equity. I would like to express sincere gratitude for the hard work put in by the team in developing this essential document. Let us maintain our commitment to this challenge and remain brave and angry.

Dr Nono Simelela
Director, Technical Knowledge and Support
International Planned Parenthood Federation

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Analysis

Analysis of abortion laws and obstacles

Chapter 1

Introducing the guide

IPPF promotes and supports a woman's right to choose the number and spacing of her children, to use contraception to prevent unwanted pregnancy and to have access to safe, legal abortion.

1. Tackling obstacles and injustice

Although there are very few countries where abortion is completely illegal (and even in most of these countries the "state of necessity" can be invoked to save a woman's life), in no country is access to abortion completely without barriers. There are always conditions placed which reflect a society's or a government's reluctance to allow women to access safe abortion. Such barriers are many and are incredibly complex. It is often difficult for a citizen, a health care provider or a human rights campaigner to understand (and sometimes even to find) the local, national or state abortion law(s). In addition to legal requirements – often constituting barriers to accessing safe abortion – various other barriers can reduce a woman's ability to access a legal, safe abortion.

This guide is an assessment tool that professionals and other interested people can use to become aware of legal and other obstacles that make access to safe abortion difficult or impossible.

The guide also highlights the injustice that women can face. We hope that you will be inspired to act against any such injustice where it exists.

2. About this guide

In a given country or place, assessing the laws and the legal and other obstacles concerning access to safe abortion is a necessary **preliminary** step, if we want to know exactly how women can obtain legal, safe and comprehensive abortion care.

The first part of the guide provides the technical background, offering an analysis of abortion laws and obstacles. We examine terminology, where to find abortion laws and regulations, the foundations of the abortion laws, legal conditions for abortion, and legal and other procedural barriers. This part of the guide does not need to be read word for word – you can use it as an overview, read the chapters that particularly interest you and use the information as a reference when conducting the practical assessments.

The second part of the guide – the assessments section – starts with an introduction which explains how the tool can be used successfully to assess legal and other obstacles in a given country or setting. Health care providers and all other stakeholders can use the tool for providing health care or for advocating and communicating, so that these activities take into account the existing laws and the unnecessary obstacles put in the way of safe abortion access and provision.
All questions are cross-referenced to the corresponding theoretical chapter. The tool is intended to be helpful in determining how abortion services can be provided up to the fullest extent of the law.

Chapter 2

Rationale and methodology used to develop this tool and guidelines for use

The World Health Organization, and many other organizations and experts, have highlighted the fact that unsafe abortion is a major public health problem and a major human rights issue.

1. Rationale

An estimated 42 million abortions are performed each year, and 20 million of them are considered unsafe because they are performed by unskilled providers and/or in unsanitary conditions.[1,2] An estimated 529,000 girls and women die from pregnancy-related causes each year, almost all of them in developing countries; 68,000 (13 per cent) of these deaths are due to unsafe abortion.[3] In some countries this percentage is much higher.

As well as an unmet need for contraception,[4] these unacceptable statistics reflect women's inability to access safe abortion services, often due to the existence of legal barriers. However, obstacles to abortion provision include more than the conditions laid out in national abortion laws. There are various non-legal obstacles which can be:

- structural (for example the remoteness of a village)
- procedural and administrative (for example waiting periods, authorization requirements, cost factors)
- moral (for example conscientious objection on the part of providers)
- medical (for example special extra-legal requirements)
- ideological (for example harassment at clinic entrances by anti-women's rights militants)
- service-related (for example perceived or known low quality of care)
- put forward by family or husband/partner

or any structure that removes the decision making process from the hands of the woman.

The purpose of this tool is to help professionals and other stakeholders to improve their knowledge of the local legal framework, and to identify non-legal obstacles that impede access to safe abortion services. The ultimate aim is to support increased access to safe abortion services to the fullest extent of the national (or, in federal states, sometimes local) law, to all women in need, and to inspire advocacy initiatives to remove legal restrictions on, and barriers to, safe abortion.

This is not a straightforward task. Not only does it require a sound knowledge and interpretation of the terminology of laws, but it also requires a cultural awareness (understanding a society's underlying values) to comprehend and analyze non-legal obstacles. Consequently, this tool offers 'food for thought' and aims to encourage readers to think critically about the different issues involved. As stated by Cook and Dickens, "the lack of clarity in many laws is a serious dysfunction. Health care providers' apprehensions cause them to decline involvement so that women resort to illegal and unsafe practices in cases where the law actually allows procedures by skilled, qualified providers."[5]

For IPPF, the goal of this tool is to help all our Member Associations to improve access to safe abortion, working within the legal context, as well as to advocate for the removal of restrictions on, and barriers to, safe abortion.

2. Methodology used to develop this tool

Initially, a sample of countries was selected and their laws analyzed. The selection was done according to the following criteria: restrictiveness[6] of the law, IPPF regional membership[7] and accessibility of the law in English, French, Portuguese or Spanish. Further countries were later included to illustrate specific issues. Finding abortion laws was a challenge in some cases; translations from local language(s) are not always available and are sometimes quite difficult to locate.

The examples include the following countries: Bangladesh, Barbados, Belgium, Benin, Brazil, Cameroon, Canada, Cuba, Czech Republic, Ecuador, Egypt, Ethiopia, France, Germany, Ghana, Greece, Guyana, Honduras, India, Indonesia, Israel, Italy, Kuwait, Lebanon, Malta, Mauritius, Mexico, Mongolia, Morocco, New Zealand, Pakistan, Peru, Poland, South Africa, Thailand, Turkey, United Kingdom, USA and Zambia.

3. Guidelines for use

The first part of this guide is an analysis of abortion laws and obstacles. Chapter 3 introduces terminology. The main concepts and expressions used in the legal framework are defined and/or explained, for example duration of pregnancy, viability, health and sexual rights. Chapter 4 discusses international treaties, conventions, agreements and covenants regulating abortion issues. Chapter 5 provides the fundamentals of abortion laws, and Chapters 6 and 7 analyze laws related to abortion and obstacles to accessing safe abortion.

The second part of this guide is a practical assessment tool designed by IPPF for professionals and others interested in the abortion issue. It will enable you to analyze extensively your local abortion laws and related regulations, and the extra-legal obstacles to accessing safe abortion. Having first identified your abortion-related mandate (such as service provision or advocacy), we guide you through a set of questions that help you to explore the relevant laws and circumstances governing abortion. This part of the guide is intended to help you to **consider the relevant questions**: answers are not provided, as they are very country specific or even state specific. Examples are given for each question to offer a good understanding of each issue.

We also encourage you to undertake a careful analysis of the practical, 'de facto' situation, which is equally important for identifying obstacles beyond legal provisions that prevent access to safe abortion services.

IPPF encourages dissemination of this tool among its Member Associations and other health care providers, volunteers and partners, as well as among stakeholders involved or interested in the safe abortion issue. The tool can also be used in group work, and during workshops, by providers, volunteers, activists, leaders and members of the public.

Chapter 3

Terminology

This chapter introduces terminology. The main concepts and expressions used in the legal framework are defined and/or explained, for example duration of pregnancy, viability, health and sexual rights.

1. Stages of foetal development and start of personhood[8]

Beginning of human life

Life is a continuum. Spermatozoons and ova are living entities, but before fertilization there is no "new human life." Defining the beginning of a new human life at conception (= fertilization) raises problems because there are several possibilities: sometimes the fertilized egg disappears ('resorption') and does not develop into an embryo; implantation can fail. Spontaneous early miscarriage, molar pregnancy and ectopic pregnancy are other possibilities. At IPPF we believe there is no "new human life" in such cases. Most laws around the world define the beginning of a new human life as occurring at birth. Anti-women's rights groups claim that "new human life" starts at fertilization. In *Vo v. France* (2004),[9] the European Court of Human Rights ruled that "there is no European consensus on the scientific and legal definition of the beginning of life."

Conception

Conception is the fusion of the spermatozoon and the ovum. Synonym: fertilization. Conception is not a synonym for implantation, which is when the pre-embryo attaches to the internal uterine lining. IPPF considers implantation to be the beginning of pregnancy.[10]

Gestational age

Gestational age is usually considered to be the age of an embryo or foetus (or newborn infant) from the first day of the woman's last menstrual period.[11]

Legal terms

'De jure' means "according to law; by right; legal."
'De facto' means "done in fact but without strict legal authority;" it contrasts with 'de jure'. A "state of necessity" means a situation where the sole means of safeguarding an essential interest is to adopt a conduct not in conformity with the law.

Implantation

Implantation means the attachment of the embryo to the wall of the uterus. This is generally regarded as the start of pregnancy by medical professionals. Synonym: nidation.

Pregnancy

Pregnancy is the period from implantation (or, according to some laws, from fertilization or, a synonym, conception) to birth. Trimesters: first, up to 14 weeks of gestation; second, 14–28 weeks; third, 28 weeks to delivery.

Quickening

This is the first foetal movements that a pregnant woman can feel. This occurs at about 16–17 weeks of gestation. It corresponds to the idea in some religious traditions that this is when the foetus gets its soul.

Stages of foetal development

Just after fertilization, the ovum is called a 'zygote'. The next stages are morula and blastocyst, the pre-embryo stages. From days 7–14 to week 10 the term 'embryo' is used, and beyond this stage the term 'foetus' is used. At birth, the foetus becomes a newborn (a baby, an infant).

There are also definitions of stages of development according to religious laws. Muslim theologians have concluded that killing foetuses is not permissible as soon as it can be spoken of as a 'child' – a person whose parts are fully formed and into whom a soul has been breathed. However, there is no agreement among these theologians as

to the exact point in time when this happens. The Hanafi (predominant in Turkey, the Middle East and Central Asia) and Shafi (South-east Asia, Southern Arabia and parts of East Africa) schools allow abortions to be performed up to day 120. For the Maliki school (prevalent in North and Central Africa) an abortion is permissible with the consent of the woman and the authorization of the man up to day 40.[12]

2. Start and duration of pregnancy

Many abortion laws put restrictions on the time span within which abortions can be sought. There are several ways of calculating the gestational age for this purpose. Confusion is caused by terminological ambiguities in laws: many refer to the number of weeks from the beginning of pregnancy without specifying when a pregnancy legally begins. Is this on the first day of the last menstruation? At ovulation? At conception? At implantation?

From a medical perspective, or by using common sense, a pregnancy starts with the implantation of the fertilized egg in the lining of the uterus. In theory, this means around the first day of the last menstrual period plus 19 days; in practical terms, this means two weeks after the beginning of the last menstrual period. However, the gestational age of a pregnancy – for higher accuracy and indisputability – is usually measured by health care providers from the first day of the last menstrual period. In a country's law, the upper time limit might be specified as from the first day of the last menstrual period, or from ovulation, or from implantation, or it might not be specified. It may even be that there are different upper time limits depending on the reasons why an abortion is sought.

3. Viability of the foetus

Viability is the stage when the foetus could survive outside the womb. This depends on a number of factors such as the weight at birth, the gestational age, the sex of the foetus, the state of medical science and the medical facilities available at a particular location. Some abortion laws permit the procedure up until viability of the foetus, which the US Supreme Court defined in *Roe v. Wade* (1973), as "potentially able to live outside the mother's womb, albeit with artificial aid."[13] Often, in laws, no precise gestational age is given for viability. Similarly, there is no World Health Organization definition of viability. Viability is most often set between 24 (sometimes 20 or 22) and 28 weeks of gestation (from the first day of last menstrual period), or if the birth weight reaches 500g.

The mental and physical health risks and disabilities associated with premature births can be severe. These risks can, in some legal contexts, be regarded as falling within "risk of foetal impairment," which may be a reason for the provision of abortion.

4. Definition of abortion

Abortion is the termination of an already established pregnancy (in other words, a method that acts after implantation). The abortion may be induced (voluntarily performed) or spontaneous.[14]

5. Definition of health

5.1 Physical and mental health

The World Health Organization provides the following holistic definitions. Health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[15] Mental health is "… not just the absence of mental disorder. It is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[16]

In some abortion laws, women are permitted to have an abortion if there is a threat to their health. Some of these laws do not distinguish between physical and mental health, which can allow for restrictive or liberal interpretations. The latter can even include socio-economic and other reasons, such as rape, incest or a diagnosis of foetal impairment, as constituting threats to the mental health of the pregnant woman, which could result in negative consequences, such as depression or suicidal tendency.

Some abortion laws state specifically that the pregnant woman's social and economic environment, whether actual or foreseeable, should be taken into account when considering threats to health,[17] as this environment has an influence on her health.

5.2 Reproductive and sexual health

The definition of reproductive health adopted at the Cairo International Conference on Population and Development in 1994 (as shown in the box) captures the essential characteristics that make reproductive and sexual health unique compared to other fields of health. Reproductive

health extends before and beyond the years of reproduction, and is closely associated with socio-cultural factors, gender roles, and the respect and protection of human rights, especially – but not only – in regard to sexuality and personal relationships.[18]

5.3 Reproductive rights

The same conference provided a definition of reproductive rights. Abortion is not mentioned, but the wording "… the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so …" can be interpreted as including the right to abortion. Of course, controversy arose, leading to the US, Vatican and other countries' attitudes not to use (and prevent the use of by others) the term "reproductive rights" whenever the right to abortion can be supposed to be part of these rights.

Reproductive health and rights, as defined in the Programme of Action of the International Conference on Population and Development

"**Reproductive health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

"In line with the above definition of reproductive health, **reproductive health care** is the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (Paragraph 7.2)

"Bearing in mind the above definition, **reproductive rights** embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents ..." (Paragraph 7.3)

United Nations document A/CONF.171/13: Report of the ICPD, www.un.org/popin/icpd/conference/offeng/poa.html; www.who.int/mediacentre/factsheets/fs220/en/

Chapter 4

Where to find abortion laws

Here we discuss international treaties, conventions, agreements and covenants regulating abortion issues.

1. National laws

It might be difficult to obtain all the legal materials in a given country. The legal provisions governing abortion are not always located within one text. The most common place is the criminal law related to offences against persons. Sometimes the constitution addresses abortion, directly or indirectly. However, with the liberalization of abortion laws, legal provisions can be found in a variety of places. Public health codes or medical ethics codes may contain special provisions that clarify how to interpret an abortion law or impose additional conditions. Moreover, in common law countries, abortion may not be governed by a specific law, but by a court decision (for example in the USA).

For more information, you could link up with lawyers or human rights organizations to access information on laws and to assist with interpretation. (See also the introduction to the assessment section, on page 44.)

A fairly exhaustive list of abortion laws in English and other main languages can be found at http://annualreview.law.harvard.edu/population/abortion/abortionlaws.htm

A list of country profiles that include overviews on abortion laws worldwide can be found at www.un.org/esa/population/publications/abortion/index.htm, the United Nations Economic and Social Development website. The information presented is not always the most up to date so it is essential to double-check with other references and/or texts. For a summary of world abortion laws, see www.reproductiverights.org/pub_fac_abortion_laws.html

A further complication may arise from the federal nature of some countries. As the individual sub-jurisdiction – usually states – of these countries have their own separate laws more than one abortion law may be in effect within a country.

In a few cases, the existence of multiple texts, each with conflicting provisions, can make it difficult to determine the exact nature of the law and policy concerning abortion in a specific country.[19] The lack of clarity in many laws is a serious dysfunction. Health care providers' apprehensions cause them to decline involvement, so that women resort to illegal and unsafe practices in cases where the law actually allows procedures by skilled, qualified providers. A contribution that lawyers can make to reproductive health is to clarify the scope of abortion that is lawful within their jurisdictions, and inform governments, health care providers and the general public of services that can be lawfully provided.[20]

In some countries, customary laws (see opposite) are as important as formal laws in determining the rights of women (and are sometimes even more important). Laws and customs are the outcome of historical experience (including colonialism which brought statutory laws), local power, culture and religion.[21] This produces the 'living law' – rules that govern women's lives. All too frequently women are made to believe that these customary laws are 'natural' and immutable, even where statutory laws contradict the customs.[22]

2. International treaties, conventions, agreements and covenants

International legal support for a woman's right to exert control over her own body, and for a woman's right to autonomy, can be found in numerous international treaties and other instruments. To find out which United Nations treaties a country has signed, visit www.unhchr.ch/tbs/doc.nsf/Statusfrset?OpenFrameSet and http://annualreview.law.harvard.edu/population/womenrights/womenrights.htm

The United Nations maintains a library of international treaties, and gives useful explanations on the hierarchy between international treaties (and agreements, conventions, charters, protocols, declarations, memoranda of

understanding, modus vivendi and exchange of notes) and country laws and constitutions.

In principle, international treaties, when ratified by a country, supersede its national law: they are 'binding'.[23] (In fact, this depends on what the country's constitution says about the status of international treaties – they can supersede national law or constitutions, be on an equal footing, or supersede national laws but not the constitution.) It is a positive development that the international community has a right to observe what goes on worldwide in the field of human and especially women's rights: "[…] States are not sovereign to exercise unfettered intervention in their citizens' lives but are accountable to transcending principles of human dignity that require their respect for individuals' rights."[24] You can find more details about international conventions and treaties in the Annex on page 33. For full explanations, see http://untreaty.un.org/English/guide.asp

The table on the next page shows which parts of some important treaties, covenants, conventions, declarations and programmes of action address the abortion issue. This is based on information in *Safe and Legal Abortion is a Woman's Human Right*, Briefing Paper, Center for Reproductive Rights, www.reproductiverights.org/pdf/pub_bp_safeandlegal.pdf

3. Customary laws, Islamic (Shari'ah) laws

'Customary law' is defined as a traditional common rule or practice that has become an intrinsic part of the accepted and expected conduct in a community, and is treated as a legal requirement. Customary international law refers to law that is established from the practices and beliefs of nations. It is derived not from treaties or conventions but how things are done by nations over time. Its unwritten rules are generally accepted as binding as a result of long use.

Islamic Shari'ah laws can be considered customary law. In some countries Shari'ah law is the law or part of the law. For example, in Pakistan the penal code has been revised by the Supreme Court to take into consideration the Islamic law. The revised law became permanent in 1997 and defines the stages of pregnancy in terms of the formation of organs and limbs according to Islamic law principles.

Important treaties, covenants, conventions, declarations and programmes of action which address the abortion issue

Human rights	Instruments										
	Universal Declaration of Human Rights[1]	International Covenant on Civil and Political Rights[2] (ICCPR)	International Covenant on Economic, Social and Cultural Rights[3]	Women's Convention[4]	Children's Convention[5]	American Convention on Human Rights[6]	Banjul Charter[7]	European Convention on Human Rights[8]	Vienna[9]	Cairo[10]	Beijing[11]
The right to life, liberty and security	Article 3	Article 6.1 Article 9.1			Article 6.1 Article 6.2	Article 4.1 Article 7.1	Article 4 Article 6	Article 2.1 Article 5.1		Principle 1 Paragraph 7.3 Paragraph 7.17 Paragraph 8.34	Paragraph 96 Paragraph 106 Paragraph 108
The right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment	Article 5	Article 7			Article 37	Article 5.1 Article 5.2	Article 5	Article 3	**Paragraph 56		
The right to be free from gender discrimination	Article 2	Article 2.1	Article 2.2	Article 1 Article 3	Article 2.1	Article 1 Article 17.4	Article 2 Article 3 Article 18.3	Article 14	*Paragraph 18	Principle 1 Principle 4	Paragraph 214
The state obligation to modify customs that discriminate against women				Article 2 Article 5	Article 24.3				*Paragraph 18 **Paragraph 38 **Paragraph 49	Paragraph 5.5	Paragraph 224
The right to health, reproductive health and family planning			Article 10.2 Article 12.1 Article 12.2	Article 10 Article 11.2 Article 11.3 Article 12.1 Article 14.2	Article 24.1 Article 24.2		Article 16 Article 18.1		**Paragraph 41	Principle 8 Paragraph 7.45	Paragraph 89 Paragraph 92 Paragraph 267
The right to privacy		Article 17.1			Article 16.1 Article 16.2	Article 11		Article 8			Paragraph 106 Paragraph 107
The right to determine the number and spacing of one's children				Article 16.1						Principle 8	Paragraph 223

1 www.un.org/Overview/rights.html
2 www.hrweb.org/legal/cpr.html
3 www.cies.ws/PaperDocuments/PDF/CovenantonEconomicSocialandCulturalRights.pdf
4 www.hrweb.org/legal/cdw.html
5 www.ohchr.org/english/law/pdf/crc.pdf
6 www.cidh.org/Basicos/basic3.htm
7 www1.umn.edu/humanrts/instree/z1afchar.htm
8 http://conventions.coe.int/Treaty/en/Treaties/Word/005.doc
9 www.ohchr.org/english/law/pdf/vienna.pdf (*Vienna Declaration and Programme of Action, United Nations World Conference on Human Rights; ** Vienna Programme of Action)
10 www.un.org/popin/icpd2.htm
11 www.un.org/womenwatch/daw/beijing/beijingdeclaration.html and www.un.org/womenwatch/daw/beijing/platform/index.html

Chapter 5

The foundations of the abortion laws

The fundamentals of abortion laws are explored in this chapter, looking at issues such as human rights, the right to life, the right to health and women's right to reproductive self-determination.

1. Human rights

Abortion laws most often penalize induced abortion but allow it in special circumstances or, within a limited time frame, without restriction. Very few countries do not accept abortion in any circumstance. The fundamental reasons to advocate for allowing abortion in certain circumstances include public health, and human rights and women's rights aspects (eliminating unsafe abortion; avoiding pregnancy-related negative physical and/or mental health consequences for the woman; avoiding the birth of a severely impaired child).

The woman's rights and the rights of her foetus can be in opposition. It is important here to distinguish between legal rights, which differ from country to country, and 'non-legal' rights based on moral, ethical, philosophical or religious considerations, which differ from individual to individual, and from religion to religion. It is important to note that no international standards assimilate the rights of a foetus to the rights of a person.

Women have undeniable rights to life, to health, to non-discrimination and to reproductive self-determination, and cannot be comparable to foetuses. It is extremely important to be clear about the fact that all life (even other than human) has 'value', but that only 'persons', including women, have 'rights'.

IPPF has developed a Charter on Sexual and Reproductive Rights, which includes the rights which in theory justify access to legal abortion for all women. The Charter (1996) is available at www.ippf.org

Why abortion is a human rights issue has been usefully demonstrated, inter alia, by Human Rights Watch and by the Center for Reproductive Rights,[25] which we summarize in this chapter.

2. Women's right to life

The right to life of a human being is protected in multiple human rights instruments. Because unsafe abortion is closely associated with high rates of maternal mortality, laws that force women to resort to unsafe procedures infringe upon women's right to life. In 2000, in interpreting Article 6.1 of the International Covenant on Civil and Political Rights, the UN Human Rights Committee called upon states to inform the committee of "any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions."[26]

3. 'Right to life' of the foetus

Worldwide, jurisprudence maintains mostly that the foetus is not yet a human person, and therefore has no specific right to life.[27] Many opponents to abortion will quote the "right to life of the unborn child." However, regional commissions, the European Court of Human Rights and many national courts worldwide have refused to declare categorically that the foetus is a subject of the right to life. Consequently, deciding upon the protection of the interests of the foetus is left to the countries. Indeed, recognizing that it is only from birth that the child acquires legal personality, most national legislative enactments stipulate that legal capacity begins with birth. While some countries protect certain interests of the foetus, others do not, and while very few countries prohibit abortion with no exception most permit abortion for some reasons (for example in order to protect the life of the woman; for the protection of the physical and mental health of the woman; for economic difficulties; when there is foetal impairment, etc).

In vitro fertilization, a procedure which is legal almost everywhere, involves the destruction (or the eternal

conservation in frozen state) of the embryos which are not implanted. In such circumstances, embryonic life is not protected, which shows that the right to life of a foetus is not an absolute. Despite wide acceptance of this, opponents to a woman's right to decide over her own body and whether or not to have children advocate for legal protection of new life from the moment of conception, arguing that 'the right to life' of an embryo or foetus must prevail over the rights of a woman.

In 2004, the European Court of Human Rights refused to extend the right to life to foetuses, and so refused to adopt a ruling that would have called into question the validity of laws permitting abortion in 39 member states of the Council of Europe (see the section Beginning of human life on page 9 and endnote 9).

4. Women's right to health

Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) provides for the right to "the highest attainable standard of health."

Unsafe abortion can have devastating effects on women's health. Where death does not result from unsafe abortion, women may experience long-term disabilities, such as chronic pelvic pain, chronic pelvic inflammatory disease and infertility. Safe abortion services protect women's right to health. The right to health has been interpreted by various treaty monitoring bodies to require governments to take appropriate measures to ensure that women are not exposed to the risks of unsafe abortion. Such measures include removing legal restrictions on abortion and ensuring access to high quality abortion services. Indeed, the Programme of Action adopted at the United Nations International Conference on Population and Development in Cairo in 1994 states that governments should "deal with the health impact of unsafe abortion as a major public health concern."[28]

At the Beijing Fourth World Conference on Women in 1995, the international community reiterated this language and urged governments to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions." In addition, in a paragraph addressing research on women's health, the Beijing Platform for Action urges governments "to understand and better address the determinants and consequences of unsafe abortion."[29]

In 1999, at the five-year review of the International Conference on Population and Development, governments approved a provision recognizing the need for greater safety and availability of abortion services. Paragraph 63 (iii) states that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health."[30]

5. Women's right to non-discrimination

The right to gender equality is a fundamental principle of human rights law. According to the Convention on the Elimination of All Forms of Discrimination against Women (1979), "discrimination against women" includes laws that have either the "effect" or the "purpose" of preventing a woman from exercising any of her human rights or fundamental freedoms on a basis of equality with men.[31] Laws that ban abortion have that effect and that purpose. Indeed, restricting abortion has the effect of denying women access to a procedure that may be necessary for realizing their right to health. Denying women access to medical services which enable them to regulate their fertility, to access assisted reproduction or to terminate a pregnancy, amounts to refusing to provide health care that only women need.[32]

6. Women's right to reproductive self-determination

A woman's right to make decisions regarding her own body is supported by a number of human rights instruments, which ensure freedom in decision making about private matters. Such provisions include protection of the right to physical integrity, the right to decide freely and responsibly the number and spacing of one's children, and the right to privacy. Although many people believe that governments should play no role in making that decision for the woman, many governments do, in the form of abortion laws or of one-child or two-child policies.

The freedom to terminate a pregnancy is limited almost everywhere by law or medical deontology (the study of the nature of duty and obligation) to a certain period of time, with variations related to the motives for the voluntary termination of a pregnancy.

Nevertheless, respect for a woman's right to plan her family requires governments to make abortion services legal, safe and accessible to all women. There are a number of circumstances in which abortion may be a woman's only

means of exercising this right. For example, a woman who becomes pregnant through an act of non-consensual sex would be forced to bear a child were she denied her right to an abortion. For women who live in settings in which family planning services and education are unavailable, access to safe abortion services may be the only means of controlling their family size. Finally, contraceptive failure will inevitably occur among some of those women who regularly use contraception, and they too may require abortion services.

7. Women's right to privacy and physical integrity, and to be free from inhuman and degrading treatment

International bodies have recognized and are likely to continue to recognize these as rights implicated in the context of abortion. These rights appear in civil and political rights treaties such as the International Covenant on Civil and Political Rights.

8. Public health and other considerations

Almost all countries have set conditions in which abortion is legal. It can be assumed that the above rights have been taken into consideration to various extents. Besides individual rights to health, public health issues (in other words decreasing maternal morbidity and mortality) are an important pillar on which the abortion laws rest and, again, the importance given to this is varied, reflecting to what level the right to health and especially women's health is protected by governments.

In addition, some other aspects need to be considered when discussing abortion laws:

- family health (the fate of the family if the woman/mother dies, or is ill or disabled)
- costs (to individuals, families, health care systems, countries)
- equity (access by young people, or by those living in poverty)
- isolated, rural or uneducated women
- refugees
- illegal immigrants
- displaced persons
- abuse of women (pregnancy after rape, incest)

What is universally lacking in abortion-related legislation is the role of the male partner, the 'father of the pregnancy' (in French, 'le géniteur').

Chapter 6

Legal conditions for abortion

This chapter discusses the main conditions or grounds on which abortion is authorized as found in legal texts and documents. It also presents the main legal and other barriers that prevent access to safe abortion services.

1. Risks to a woman's life

One of the main grounds on which abortions are authorized is "to save a woman's life." This may be explicit or it may be implicit, for example on grounds of "necessity." Most penal codes contain general provisions on necessity that allow acts that would otherwise be considered illegal to be carried out without punishment when they are necessary to preserve a good. Whether this defence would hold up in court is dependent on each country situation and should be clarified.

Example 1. Egypt: Article 61 of the penal code states that "a person who commits a crime in case of necessity to prevent a grave and imminent danger which threatens him or another person shall not be punished […]" Although most commonly such grounds justify the performance of an abortion only when the life of the pregnant woman is endangered, in Egypt it is sometimes interpreted as encompassing cases where the pregnancy may cause serious risks to the health of the pregnant woman or even cases of foetal impairment.

Very few countries (for example Chile, Malta, El Salvador, Nicaragua) prohibit abortion altogether and do not authorize it to save a woman's life. However, it is a matter of dispute whether a defence of necessity might be allowed to justify an abortion for saving the life of the woman and, in addition, judicial systems are often too weak to support it. For instance, the penal code of El Salvador contains general provisions on **necessity** that allow acts that would otherwise be considered illegal to be carried out without punishment when necessary to preserve a good.[33]

Example 2. Malta: Abortion is prohibited in all circumstances.[34] The person performing the abortion is subject to imprisonment for 18 months to three years, as is a woman who performs an abortion on herself or consents to its performance. A physician, surgeon, obstetrician or apothecary who performs an abortion is subject to imprisonment for 18 months to four years and lifelong prohibition from exercising his or her profession. It is unclear whether an abortion could be legally performed to save the life of a pregnant woman under general criminal law principles of necessity. Specific provisions allowing an abortion to be performed for this purpose were removed from the code in 1981.

2. Risks to a woman's physical health

Legal texts sometimes specify that abortion is allowed "to preserve a woman's physical health" or in case of "a risk of grave injury to the physical health of a woman" or "grave danger to a woman's health."

Example 3. Cameroon: Penal code, Chapter V, Section 337: "(1) Any woman procuring or consenting to her own abortion shall be punished with imprisonment […]; (2) Whoever procures the abortion of a woman, notwithstanding her consent, shall be punished with imprisonment […] Section 338: Whoever by force used against a woman with child […] causes intentionally or unintentionally the death […] of the child shall be punished […] Section 339: Neither of the two foregoing sections shall apply to acts performed by a qualified person and proved necessary for the saving of the mother from grave danger to her health."

A list of specific conditions exists in the laws of some countries, but often there is room for interpretation due to a lack of precision in the law. The World Health Organization definition of health (see page 10) is – or should be – the reference.

3. Risks to a woman's mental health

The interpretation of 'mental health' varies. The World Health Organization does not provide a specific definition of mental health, but its definition of health (see page 10) encompasses mental health. A useful definition that could be adopted is the one proposed in 1999 by the attorney general of the USA: "Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society."[35]

Risks to a woman's mental health can overlap with other motives, for example in cases of rape (see this page) or severe strain caused by psychological or socio-economic circumstances (see page 21). However, there are often no clarifications on the limits of using "risk to mental health" as a reason for abortion, which could arguably range from the occurrence of mild depression to severe distress including risk of suicide. Many countries include "to preserve a woman's mental health" as a legal indication for abortion. Sometimes the indication only refers to permanent injury to mental health. Some countries read mental health into broad health exception without the law specifically stating mental health. The United Nations Human Rights Committee did this in a case from Peru (see www.reproductiverights.org/pdf/Interights_KL_v_Peru.pdf).

Example 4. Barbados: "The written statement of a pregnant woman stating that she reasonably believes that her pregnancy was caused by an act of rape or incest is sufficient to constitute the element of grave injury to mental health. The treatment for the termination of a pregnancy of not more than 12 weeks' duration may be administered by a medical practitioner if he is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to […] or grave injury to her […] mental health."[36]

Example 5. Thailand: "The therapeutic termination of pregnancy […] shall be performed on the following conditions: […] In case of necessity due to the mental health problem of the pregnant woman, which has to be certified or approved by at least one medical practitioner other than the one who will perform the medical termination of pregnancy. […] For this purpose there shall be clear medical indications that the pregnant woman has […] a mental health problem and the examination and diagnosis shall be recorded in the medical record and kept as evidence."[37]

Example 6. Ghana: "It is not an offence [...] if an abortion is caused […] where the continuance of the pregnancy would involve […] injury to her […] mental health […]."[38]

Example 7. New Zealand: "The following matters […] may be taken into account in determining […] whether the continuance of the pregnancy would result in serious danger to her life or to her physical or mental health: […] the person doing the act believes that the miscarriage is necessary […] to prevent serious permanent injury to her […] mental health."[39]

In example 11 on page 20, the indications for mental health and rape overlap.

4. Pregnancy after rape, incest or other criminal offence

Some laws state that if a pregnancy is the result of a criminal offence, abortion is legal. A criminal offence is often understood as rape and incest, and can include statutory rape (sex with a minor).[40] Sometimes rape, incest and named conditions (for example pregnancy after sexual relations with a woman living with a mental disability or a mental illness; sexual relations obtained under threat) or unnamed conditions are summarized under the wording "when pregnancy results from an unlawful act."

Example 8. Poland: "A criminal act […] is not committed by a physician who undertakes this procedure in a health care establishment in the public sector, in cases in which […] there are valid reasons, confirmed by an attestation on the part of the Office of the Public Prosecutor, for suspecting that the pregnancy resulted from an unlawful act."[41]

Example 9. Brazil: "The penalty is increased […] se a gestante não é maior de 14 (quatorze) anos, ou é alienada ou débil mental, ou se o consentimento é obtido mediante fraude, grave ameaça ou violência."[42] *[… if a pregnant woman is aged less than 14 years, or is alienated or mentally deficient, or if her consent has been obtained fraudulently, by grave threats or violence. Unofficial translation.]*[43]

Example 10. Cameroon: "In a case of pregnancy resulting from rape, abortion by a qualified medical practitioner after certification by the prosecution of a good case shall constitute no offence."[44]

In the next example, the indications for rape and mental health overlap.

Example 11. India: "A registered medical practitioner shall not be guilty of any offence if […] the continuance of the pregnancy would involve a risk […] or a grave injury to her […] mental health. […] Explanation: Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman."[45]

Example 12. New Zealand: "Any act […] is done unlawfully unless, in the case of a pregnancy of not more than 20 weeks' gestation, the person doing the act believes […] that the pregnancy is the result of sexual intercourse between (i) A parent and child; or (ii) A brother and sister, whether of the whole blood or of the half blood; or (iii) A grandparent and grandchild; or (c) that the pregnancy is the result of sexual intercourse that constitutes an offence against section 131 (1) of this Act;[46] or (d) that the woman or girl is severely subnormal […] (b) […] that there are reasonable grounds for believing that the pregnancy is the result of sexual violation."[47]

Incest is commonly defined in terms of "sexual activity between family members,"[48] or "sexual penetration involving people who are closely related – for example, a father and daughter, a mother and son, sex between a brother and sister, sexual contact between a child and his/her uncle."[49] There exist variations of this kind of definition with respect to the degree of family relation.[50] Hence, "some jurisdictions consider only those related by birth, others also include those related by adoption or marriage; some prohibit relations only with nuclear family members while others prohibit relations with aunts and uncles, nephews and nieces, and cousins as well."[51]

Incest can be defined[52] variously, including as "sexual activity with a person you would not be allowed to marry." This definition may facilitate the identification of which sexual relations can be regarded as incest.

Example 13. South Africa: "Incest" means sexual intercourse between two persons related to each other in a degree which precludes a lawful marriage between them.[53]

Procedural requirements vary. Some countries require the case to be brought to court or reported to the authorities before permission for an abortion can be granted, thus discouraging many women from seeking to obtain an abortion on these grounds.[54] In addition, proving rape or incest can be very difficult, involving at times police, judges, physicians, witnesses, certificates and judgements. The process can take a long time and can make it virtually impossible to undergo an abortion for rape. The Islamic law in particular makes proof of rape very difficult, if not impossible.

While the availability of safe abortion services in the case of rape increases access in principle, in reality it only increases access if women are able to receive the service by stating their case to the service provider rather than having to fulfil administrative requirements.

5. Foetal impairment (risks to foetus)

The risk of foetal impairment is a common legal indication for abortion. Some countries specify the type and level of impairment necessary to justify this ground. There is usually no gestational time limit. Some countries do not explicitly list foetal impairment but include it in "preserving physical health."

Example 14. Benin: "L'interruption volontaire de grossesse n'est autorisée que dans les cas suivants […]: lorsque l'enfant à naître est atteint d'une affection d'une particulière gravité au moment du diagnostic […]."[55] *[Elective abortion is only allowed in the following situations: when the unborn child presents an ailment of a particular gravity at the moment of the diagnosis. Unofficial translation.]*

Example 15. Poland: "A criminal act […] is not committed by a physician who undertakes this procedure in a health care establishment in the public sector, in cases in which […] a prenatal diagnosis established by two physicians other than the physician carrying out the procedure […] has demonstrated the presence of a serious and irremediable defect in the foetus."[56]

Example 16. France: "L'interruption volontaire d'une grossesse peut, à toute époque, être pratiquée si […] il existe une forte probabilité que l'enfant à naître soit atteint d'une affection d'une particulière gravité reconnue comme incurable au moment du diagnostic."[57] *[Elective abortion can, at any moment, be performed if there is a high probability that the unborn child suffers from an ailment of a particular gravity recognized as incurable at the time of the diagnosis. Unofficial translation.]*

Example 17. Kuwait: "When the pregnancy is of less than four months' duration, an abortion is allowed […] if it is established that the foetus would be born with a serious physical or mental injury, that it cannot be expected that the injury is curable."[58]

The risk of foetal impairment is sometimes advocated to firmly advise or even to oblige a woman to abort, in case of a substantial risk of transmitting a dangerous genetic disease or a serious disability to the infant. In some instances, positive HIV status has been used to coerce women to have an abortion.[59]

6. Socio-economic grounds

This is one of the most ambiguous terms in abortion legislation. Sometimes this differs little from "available on request," as liberal interpretations are generally possible. These can take into account circumstances such as a woman's resources, age, marital status or the number of existing children.[60] However, more or less subtle nuances do exist, and more or less liberal interpretations occur. When a socio-economic ground is recognized, usually the physical and mental health grounds are recognized, as well as, most often, the rape, incest and foetal impairment reasons.[61]

Example 18. South Africa: "A pregnancy may be terminated […] from the 13th up to and including the 20th week of the gestation period if a medical practitioner […] is of the opinion that […] the continued pregnancy would significantly affect the social or economic circumstances of the woman."[62]

Example 19. Zambia: "… account may be taken of the pregnant woman's actual or reasonably foreseeable environment."[63]

Example 20. Ethiopia: Apart from the general extenuating circumstances justifying ordinary mitigation of the punishment […] the Court may mitigate it without restriction […] because of extreme poverty.[64]

Example 21. Barbados: "The medical practitioner must take into account the pregnant woman's social and economic environment, whether actual or foreseeable."[65]

7. Available on request

This is the most liberal condition, even though time limits might be stricter. Various requisites can limit the liberality of the conditions, such as imposed delays, parental or spousal notifications or permissions, administrative steps, mandatory counselling, specified categories of clinical settings and/or providers and so on (see Chapter 7). Abortion on request is sometimes based on the notion of "distress" (see example 23): the woman simply declares that the pregnancy causes distress, which conceptually brings it also close to the "preserving mental health" condition.

Example 22. Guyana: "[…] the termination of a pregnancy of not more than eight weeks' duration […] may be administered or supervised by a medical practitioner. It is not necessary that the treatment […] should be administered in an approved institution."[66] *[Note: No condition is attached as a prerequisite.]*

Example 23. Belgium: "Il n'y aura pas d'infraction lorsque la femme enceinte, que son état place en situation de détresse, […] et que cette interruption est pratiquée […] avant la fin de la douzième semaine de la conception; […] dans de bonnes conditions médicales, par un médecin, dans un établissement de soins où existe un service d'information […] notamment sur les droits, aides et avantages garantis par la loi […] aux mères célibataires ou non, et à leurs enfants, sur les possibilités offertes par l'adoption […], sur les moyens […] de résoudre les problèmes psychologiques et sociaux posés par sa situation. Le médecin […] doit informer des risques médicaux actuels ou futurs qu'elle encourt à raison de l'interruption de grossesse; rappeler les diverses possibilités d'accueil de l'enfant à naître […] ; s'assurer de la détermination de la femme. […] Le médecin ne pourra pratiquer l'interruption de grossesse que six jours après la première consultation […]."[67] *[There will be no infraction if the pregnant woman is in a situation of distress, [...] and if the termination takes place […] before the end of the twelfth week since conception; […] in good medical conditions, by a physician, in a medical care institution that includes an information service […] on the legally guaranteed rights, assistance and advantages […] to mothers, single or not, and to their children, on the possibilities related to adoption […], on the ways psychological and social problems related to her situation can be solved. The physician has an obligation to inform of the actual and future risks she incurs because of the termination of the pregnancy; to remind her of the various possibilities of welcoming the child to be […]; to ascertain the determination of the woman. [...] The physician can only perform the abortion six days after the first consultation […]. Unofficial translation.]*

Example 24. Mongolia: "To become a mother is a matter for women and the decision lies with them. Within the first 3 months of a pregnancy by women's request, […] abortion is performed by physicians under hospital conditions."[68]

8. Other reasons

There are many other legal conditions for authorizing abortion, including:

- being mentally disabled (for example Guyana: "being a person of unsound mind")[69]
- being incapable of taking care of an infant (for example Namibia: "the woman due to a permanent mental handicap or defect is unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus")[70]
- failure of contraception (for example Guyana: "pregnancy in spite of the use in good faith of a recognised contraceptive method by the pregnant woman or her partner;"[71] India: "failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children")[72]
- being too young or too old (for example New Zealand: "the age of the woman or girl concerned is near the beginning or the end of the usual child-bearing years;"[73] Israel: "if the woman is under marriage age or has completed her fortieth year")[74]
- extra-marital relations (for example Israel: "the pregnancy is due to [...] extramarital relations")[75]
- risk to existing children (for example Zambia: "risk of injury to the physical or mental health of any existing children of the pregnant woman")[76]
- being HIV positive (for example Guyana: "where the pregnant woman is known to be HIV positive")[77]

9. Compulsory or forced abortions

Even in countries where access to abortion is severely restricted, some women are forced to undergo terminations for reasons such as national efforts towards population control (for example China's one-child policy), being HIV positive[78] or being mentally disabled.[79] This is often linked to compulsory sterilization as well. Sometimes these requirements are not stipulated in laws but are imposed in practice by health professionals. On the other hand, as in Armenia for example, states make explicit mention of punishments for forced abortions.[80]

10. Other liberal legal situations

A few countries have used quite original approaches to the abortion issue.

Example 25. Canada: Canada is one of a very small number of countries without a law restricting abortion. Abortion is treated like any other medical procedure and is governed by provincial and medical regulations.[81]

Example 26. Cuba: Abortions are available on request under health regulations. Since 1965 abortion has been available on request up to the 10th week of gestation for all married women and for unmarried women over the age of 18. Single women under 18 require parental permission. After 10 weeks, abortions can be performed only with the approval of the health authorities. In actual practice, over 95 per cent of all abortion requests are approved and solutions are found for minors requiring assistance.[82]

Chapter 7

Procedural barriers (legal and others)

Legalized abortion does not necessarily mean safe and accessible abortion. Even in countries where the law permits abortion on broad grounds, procedural barriers – such as compulsory waiting periods, authorization/consent requirements, restrictions on abortion providers and facilities, or mandatory medical authorizations – may prevent or undermine access to services, as do the lack of protocols on how to get a legal abortion, and weak judicial systems to implement the law. Any analysis of the legal and policy environment of abortion must include a detailed review of all existing legal barriers to the provision of and access to safe abortion services. Some of the main obstacles are described in this chapter.

1. Time limits

Most countries that permit abortions with or without restrictions as to reason place limits on the period during which the procedure may be obtained.[83] Time limits vary significantly among countries and they also vary according to the legal ground for abortion. An additional difficulty is that there is often an ambiguity on how to calculate the beginning of the pregnancy (see page 10).

Example 27. Guyana: Abortion is available on request up to the eighth week; between weeks 8–12 the grounds are risk to physical or mental health of the woman, rape or incest, being HIV positive, failure of contraception; between weeks 12–16 on the same grounds as above but with the approval of two medical practitioners; after 16 weeks only if three medical practitioners are of the good faith opinion that the abortion is necessary to save the woman's life or to prevent grave permanent injury to her health or that of her child.[84]

Example 28. France: On request before the end of the 12th week (without any explanation about when the pregnancy legally starts).[85]

Example 29. Turkey: "The uterus may be evacuated until the end of the 10th week of pregnancy (without any explanation about when the pregnancy legally starts)."[86]

Example 30. United Kingdom: "… the pregnancy has not exceeded its 24th week."[87]

Example 31. South Africa: "Gestation period" means the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last.[88]

Example 32. USA: The Supreme Court held that a foetus was not a person and was therefore not entitled to protection guaranteed by the US Constitution until it reached the point of viability.[89] Viability was defined as occurring between 24 and 28 weeks of gestation.[90]

2. Restrictions on performing institutions or personnel

Many countries restrict access to abortion by specifying the types of medical facilities in which abortion can be performed and the categories of health providers that may perform the procedure. In addition, there are sometimes restrictions on the structures of the clinics, or on specific procedures (and, in addition, some unnecessary procedures can be made mandatory).

Example 33. India: "… a registered medical practitioner, meaning a medical practitioner who […] has such experience or training in gynaecology and obstetrics […]. No termination of pregnancy shall be made in accordance with this Act at any place

other than (a) a hospital established or maintained by Government, or (b) a place for the time being approved for the purpose of this Act."[91]

Example 34. Guyana: "… an authorized medical practitioner […] in an approved institution. "Authorized medical practitioner" [is] "any person duly qualified medical practitioner […] being either a specialist in obstetrics and gynaecology or a medical practitioner authorized in accordance with regulations."[92]

Example 35. Israel: "… in recognized medical institution." The law gives a very detailed description of the requirements (including medical equipment) for a dispensary to be recognized as a suitable facility in case of a pregnancy of not more than 10 weeks. Beyond 10 weeks, only hospitals are "recognized" but with extra conditions.[93]

Example 36. South Africa: The termination of a pregnancy may also be carried out during the first 12 weeks of the gestation by a registered midwife who has completed the prescribed training course.[94]

Despite progress in safe abortion techniques, most countries restrict the performing personnel to medical doctors and performing institutions to registered facilities. This hinders access. In India, a majority of abortions take place outside the legal framework. The provision limiting abortion providers to highly trained physicians particularly affects access to safe abortion services for women in rural settings.[95] A lack of providers can also be related to low income for health care providers or to brain-drain of health professionals.

3. Medical approvals/authorization

A number of countries require abortion providers to obtain approval from other professionals prior to performing an abortion. In some countries with restrictive abortion laws, physicians have to consult with other doctors to certify that an abortion is necessary to save a woman's life.[96] Even in countries with relatively liberal laws such as Great Britain, New Zealand or Israel, the laws require the approval of two physicians or of a group of professionals before an abortion.

Example 37. Lebanon: "When an abortion is considered desirable […] from a medical point of view, it may be performed […] when the treating physician or surgeon consults two physicians who both give their agreement."[97]

Example 38. United Kingdom: "A person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith […]."[98]

Example 39. India: "… where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are of opinion, formed in good faith, that […]."[99]

Example 40. Israel: "Approval […] shall be by a committee of three. Its members shall […] be designated by the manager of the institution, and in the case of another recognized medical institution, by the Minister of Health or a person empowered by him in that behalf. The committee shall consist of (1) a qualified medical practitioner holding the title of specialist in obstetrics and gynaecology; (2) another qualified medical practitioner practising obstetrics and gynaecology, internal medicine, psychiatry, family medicine or public health; (3) a person registered as a social worker."[100]

Many laws impose a precise process of medical approval or authorization, entailing delays, but these are usually waived in case of emergency.

Example 41. Israel: "The approval shall be in writing and shall set out the ground justifying the interruption of the pregnancy." "The members of the Committee shall sign an approval in text of form 4 in the Appendix, which shall be delivered to the applicant by the secretary."[101]

Example 42. Zambia: "Any certificate of an opinion […] shall be given before the commencement of the treatment for the termination of pregnancy to which it relates."[102]

Example 43. Barbados: The requirements (for a medical approval) do not apply "where the treatment to terminate the pregnancy is immediately necessary to save the life of the pregnant woman or to prevent permanent injury to her physical or mental health."[103]

Obtaining authorizations can take time and, as a consequence, the legal time limit for obtaining the abortion may be exceeded.

4. Access to remedies

Some laws oblige the involvement of judges in certain circumstances to allow or deny abortion. Sometimes judges, police, prosecutors or health authorities deny access even when access is legal, as shown by two recent cases. In Mexico, in 2006, a girl who was raped at the age of 13 was denied an abortion due to the personal and religious beliefs of the justice and health authorities. Although first trimester abortion is legal in cases of rape throughout Mexico, the procedure is nearly impossible to access due to a regulatory void that allows public officials to abuse their authority.[104] In Peru, in 2005, a 17-year-old woman was forced to carry a fatally impaired foetus to term, even though she was legally entitled to an abortion.[105]

Governments have a clear obligation to ensure that women's rights – including their right to safe abortion – cannot be curtailed at the whim of public officials.

5. Spouse/partner authorization

Authorization by a third party, husband or parent, is a requirement in a significant number of countries. The Center for Reproductive Rights lists 12 countries requiring spousal authorization.[106] In some of these, however, the need for the husband's authorization can be bypassed in case of emergency, or if the physician considers that the intervention is absolutely necessary. For example, spousal authorization is required in Morocco, but the chief medical officer of a prefecture may override the husband's refusal if a physician is able to demonstrate that the procedure is necessary to protect the woman's health.[107]

Example 44. Morocco: "L'avortement n'est pas puni lorsqu'il constitue une mesure nécessaire pour sauvegarder la santé de la mère et qu'il est ouvertement pratiqué par un médecin ou un chirurgien avec l'autorisation du conjoint. Si le praticien estime que la vie de la mère est en danger, cette autorisation n'est pas exigée. Toutefois, avis doit être donné par lui au médecin-chef de la préfecture ou de la province. A défaut de conjoint, ou lorsque le conjoint refuse de donner son consentement ou qu'il en est empêché, le médecin ou le chirurgien ne peut procéder […] qu'après avis écrit du médecin-chef de la préfecture ou de la province attestant que la santé de la mère ne peut être sauvegardée qu'au moyen d'un tel traitement."[108] *[Abortion is not punished if it constitutes a necessary intervention to preserve the mother's health and is openly practised by a physician or a surgeon, with the spouse's authorization. If the practitioner considers that the mother's life is endangered, this authorization is not requested. However, the practitioner's opinion must be communicated to the head physician of the prefecture or province. If there is no spouse, or if the spouse refuses to give his permission or is prevented from giving it, the physician or the surgeon can only proceed after having a written opinion of the head physician of the prefecture or province certifying that the mother's health can only be preserved by such a treatment. Unofficial translation.]*

Example 45. Turkey: "The consent of the spouse shall be required in order to evacuate the uterus or for sterilization."[109]

Sometimes the spousal authorization is only needed in case of emergency or if the woman is unconscious.

Example 46. Indonesia: "In an emergency situation as an effort to save the life of pregnant mother and/or her foetus [… an abortion …] can only be conducted […] with the approval of the related pregnant mother or her husband or her family. The main authority to give an approval is in the hands of the pregnant woman concerned. The approval can be given by their husband or other family members only if the pregnant woman is in the state of being unconscious or unable to give such an approval."[110]

6. Parental authorization

If the woman is a minor, parental authorization for abortion is required in 28 countries. Sometimes, parents can be substituted by specified other categories of persons. In some countries notification is recommended but not imposed. The French example shows an interesting solution: the adolescent can be accompanied by an adult of her choice. In some cases, the physical and mental health of a minor (and even her life) can be endangered if the parents are informed. Some countries take provisions on parental authorization that are found in their general laws and apply these to abortion requests.

Example 47. South Africa: "In case of a pregnant minor, a medical practitioner or a registered midwife […] shall advise such minor to consult with her parents, guardian […] before the pregnancy is terminated: provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them."[111]

Example 48. India: "No pregnancy of a woman, who has not attained the age of 18 years […] shall be terminated except with the consent in writing of her guardian."[112]

Example 49. France: "Si la femme est mineure non émancipée, le consentement de l'un des titulaires de l'autorité parentale ou, le cas échéant, du représentant légal est recueilli. Si la femme mineure non émancipée désire garder le secret, le médecin doit s'efforcer, dans l'intérêt de celle-ci, d'obtenir son consentement pour que le ou les titulaires de l'autorité parentale ou, le cas échéant, le représentant légal soient consultés […]. Si la mineure ne veut pas effectuer cette démarche ou si le consentement n'est pas obtenu, l'interruption volontaire de grossesse ainsi que les actes médicaux et les soins qui lui sont liés peuvent être pratiqués à la demande de l'intéressée […]. Dans ce cas, la mineure se fait accompagner dans sa démarche par la personne majeure de son choix".[113] *[If the woman is a non-emancipated minor, the authorization of one of the parental authority holders or, if need be, of the legal representative is obtained. If the non-emancipated minor woman wants to keep the secret, the physician must, in her interest, obtain her consent before consulting the parental authority holders or, if need be, the legal representative. If the minor does not want to take this step or if the consent is not obtained, the abortion and the related medical interventions and care provided can take place at the request of the concerned woman. In such case, the minor will be accompanied in taking these steps by the adult she chooses. Unofficial translation.]*

Example 50. Turkey: "In the case of minors, it shall be contingent on permission by a parent; in the case of persons under legal guardianship, either because they are minors or because they are mentally incompetent, it shall be contingent on the consent of the minor and the legal guardian, as well as the permission of a justice of the peace. […] The requirement of obtaining permission from a parent or from a justice of the peace may be waived if there could be danger to life or to a vital organ unless urgent action is taken."[114]

7. Consent of a mentally disabled woman

Normally abortion can only be performed on a woman who gives informed consent. In many countries abortion laws consider women living with a mental disability as not being able to give their consent. The medical deontology, however, says that whenever possible a mentally disabled person should have a role in the decision making process, regardless of his/her legal capacity.

Example 51. Ecuador: "El aborto practicado por un médico, con el consentimiento de la mujer o de su marido o familiares íntimos, cuando ella no estuviere en posibilidad de prestarlo, no será punible […] si el embarazo proviene de una violación o estupro cometido en una mujer idiota o demente. En este caso, para el aborto se requerirá el consentimiento del representante legal de la mujer."[115] *[An abortion performed by a physician, with the consent of the woman or her spouse or her closest family, if she is not able to approve by herself, will not be punishable if the pregnancy follows rape or depravity committed on an idiot or demented woman. In such case, before the abortion it is necessary to obtain the authorization of the legal representative of the woman. Unofficial translation.]*

8. Declaration of abortion services

Some countries impose the declaration of all abortions, in order to follow up the number of abortions over time, and to periodically assess abortion laws. Evaluation commissions have been created. Sometimes small statistically non-significant changes could be used to 'demonstrate' that the law is 'lax'. When abortion is liberalized or decriminalized, there can be a pseudo-increase in its occurrence as previously hidden abortions are now recorded in official statistics. On the other hand, an artificial decrease in the number of abortions can appear over time when an increasing number of abortions are performed in the private sector and are not declared. In addition, in some countries, abortions later than 22 weeks' gestation are considered (and registered) as induced births.

9. Counselling requirements

Many laws demand that a pregnant woman be given counselling before having an abortion. At these sessions, women may be given information about sources of support for married and unmarried mothers, about help on social and psychological problems resulting from pregnancy, and other issues.[116] Sometimes, counselling seeks to discourage abortion, or even provides medically inaccurate information.

It is important when looking at each country's legal context to analyze the type and quality of counselling provided. This requires an analysis of both 'de jure' and 'de facto' situations as this information is not always apparent in the legal texts.

Example 52. Barbados: "Before carrying out […] the termination of a pregnancy, a medical practitioner must counsel the woman […] or ensure that the woman has been counselled by a person authorized by the Minister. A person who counsels a woman […] must advise her on courses of action that are available as alternatives to the termination of the pregnancy, inform her of the operative procedures and the possible immediate and long-term effects of the termination of her pregnancy, advise her of methods of contraception and the availability of family planning services, give such advice as to enable her to deal with the social and psychological consequences of the termination of her pregnancy, and in the case of a woman deciding to continue her pregnancy, advise her on the availability of adoption, fostering or other services."[117]

Example 53. South Africa: "The State shall promote the provision of non-mandatory and non-directive counselling before and after the termination of pregnancy."[118]

Example 54. Germany: "Counselling of Pregnant Women in an Emergency or Conflict Situation. (1) The counselling serves to protect unborn life. It should be guided by efforts to encourage the woman to continue the pregnancy and to open her to the prospects of a life with the child; it should help her to make a responsible and conscientious decision. The woman must thereby be aware, that the unborn child has its own right to life with respect to her at every stage of the pregnancy and that a termination of pregnancy can therefore only be considered under the legal order in exceptional situations, when carrying the child to term would give rise to a burden for the woman which is so serious and extraordinary that it exceeds the reasonable limits of sacrifice. The counselling should, through advice and assistance, contribute to overcoming the conflict situation which exists in connection with the pregnancy and remedying an emergency situation. […] (2) The counselling must take place […] through a recognized Pregnancy Conflict Counselling Agency. […] The physician who performs the termination of pregnancy is excluded from being a counsellor."[119]

10. Waiting periods

Counselling requirements are often accompanied by a mandatory waiting period. During this period, women are expected to reflect on their decision and consider their various options.[120] If women only have a limited time after finding out that they are pregnant to meet the requirements about gestational age to have an abortion, mandatory waiting periods can significantly impede access to abortion. In addition, waiting periods adversely affect women who have to travel long distances to medical facilities. And while abortion, if done safely, is one of the safest medical procedures performed today, risks of complications increase with gestational age.

The assumption is that women need time, after having received counselling, to make a well-reasoned decision about whether or not to terminate the pregnancy. In fact, mandatory delay requirements do not seem to serve actual health purposes and rather are intended to discourage abortion. In general, a woman requesting abortion has made up her mind, and delays are obstacles for women, entail increased expenses, travel difficulties and medical risks.[121]

Example 55. France: "Si la femme renouvelle […] sa demande d'interruption de grossesse, le médecin doit lui demander une confirmation écrite; il ne peut accepter cette confirmation qu'après l'expiration d'un délai d'une semaine suivant la première demande de la femme, sauf dans le cas où le terme des douze semaines risquerait d'être dépassé. Cette confirmation ne peut intervenir qu'après l'expiration d'un délai de deux jours suivant l'entretien prévu […], ce délai pouvant être inclus dans celui d'une semaine prévu ci-dessus." [122] *[If the woman confirms her request for an abortion, the physician must ask for a written confirmation; he can only accept this confirmation after the expiry of a one-week delay since the first request made by the woman, except if there could be a risk that the twelve-week limit be exceeded. This confirmation can only take place after the expiry of a two-day delay since the requested interview; this delay can be included in the one-week delay foreseen above. Unofficial translation.]*

Example 56. Belgium: "Le médecin ne pourra au plus tôt pratiquer l'interruption de grossesse que six jours après la première consultation prévue."[123] [*The physician can perform the abortion not earlier than six days after the first compulsory consultation. Unofficial translation.]*

Example 57. Italy: "The physician […] shall request her to reflect for seven days." [124]

In the US, many states require that at least 18 or 24 hours elapse between the time when the counselling is provided and the abortion is performed. This results in many women having to make two trips to the health care provider in order to obtain an abortion.[125]

11. Restrictions on abortion advertising

Some countries, even with liberal laws, restrict advertising on abortion. This affects information on the legal status of abortion, on where abortion services are provided and on abortion methods. Restrictions on advertising deprive women, and men, of much-needed information, and decrease access to services. Some countries specify that information can only be given at family planning centres or by professionals.

Example 58. Cameroon: "No person shall indulge in acts capable of provoking or facilitating abortion, including (a) displaying, offering, causing to be offered, selling, putting up for sale, causing to be sold, distributing or causing to be distributed in any manner whatever, any medicines and substances, intrauterine catheters and similar articles; (b) making speeches in public places or meetings; (c) selling, putting up for sale or offering even in private, displaying, posting up or distributing on highways or in public places, or distributing at home, mailing under wrapper or in an envelope whether or not sealed, or surrendering to any distribution or transport agent, books, scripts, printed matter, advertisements or notices, posters, drawings, pictures or symbols; or (d) advertising doctors' offices or so-called offices."[126]

Example 59. Greece: (1) "A person who publicly or by circulating printed texts or graphic or pictorial representations advertises or promotes, even indirectly, medicaments or any other articles or methods as enabling a voluntary termination of pregnancy to be performed or, likewise, offers his own services or those of another to perform, or participate in, a voluntary termination of pregnancy shall be liable to a period of imprisonment not exceeding two years. (2) The provision of information or explanations of a medical nature on voluntary termination of pregnancy in family planning centres or in the course of training physicians or persons lawfully empowered to employ methods for the voluntary termination of pregnancy, and the publication of articles and the like in specialized medical and pharmaceutical journals, shall not constitute an offence."[127]

12. Conscientious objection

Conscientious objection permits medical providers to refuse to provide certain health services based on religious or moral objections. This shields providers from liability for refusing to offer services that their patients are legally entitled to receive. Conscientious objection clauses, when overly or improperly invoked, deny access to services and violate providers' duty of care to patients. Health care providers may not invoke conscientious objection when patients require emergency care such as when their lives or health are at risk, and they should not be exempted from providing related services such as post-abortion care. Health care providers who refuse to provide reproductive health services on grounds of conscience should give notice to patients of their unwillingness to provide such services, and be legally obliged to refer their patients to other appropriate and conveniently accessible providers.[128]

Conscientious objection should apply to individuals, not institutions. In particular, public sector institutions operating with government funds should guarantee availability of all legal services.

Regulations concerning conscientious objection are mainly covered by medical guidelines or guidelines of the performing institutions, although they also appear in national laws.

Institutions that provide abortion-related activities and that are pro-women's rights should only recruit pro-women's rights staff, or at least only professionals who are willing to provide abortion and/or empathetic support to women who request abortion.

Example 60. Israel: "A gynaecologist shall not […] be required to interrupt the pregnancy if such is contrary to his conscience or medical judgment."[129]

Example 61. New Zealand: "No registered medical practitioner, registered nurse, or other person shall be under any obligation to perform or assist in the performance of an abortion […], to fit or assist in the fitting, or supply or administer or assist in the supply of any contraceptive, or to offer or give any advice relating to contraception, if he objects to doing so on grounds of conscience."[130]

Example 62. UK: "No person shall be under any duty […] to participate in any treatment authorised by this Act to which he has a conscientious objection. [But] nothing […] shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."[131]

13. Penalties for illegal abortion and related activities

It is important to understand the penalties stipulated for provision and procurement of illegal abortions and to be aware of what happens in practice. How are (sometimes very harsh) laws implemented in practice? Are the providers and/or the women penalized?

Example 63. Bangladesh: "Whoever voluntarily causes a woman with child to miscarry […] not caused in good faith […] be punished with imprisonment […] for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment […] for a term which may extend to seven years, and shall also be liable to fine."[132]

Example 64. Mauritius: "Any person who, […] procures the miscarriage of any woman quick with child, or supplies the means of procuring such miscarriage, whether the woman consents or not, shall be punished by penal servitude for a term not exceeding 10 years. […] The like punishment shall be pronounced against any woman who procures her own miscarriage […] any physician, surgeon, or pharmacist who points out, facilitates or administers the means of miscarriage shall, […] be liable, on conviction, to penal servitude."[133]

Example 65. Cuba: La sanción es de privación de libertad de dos a cinco años si el hecho […]: a) se comete por lucro; b) se realiza fuera de las instituciones oficiales; c) se realiza por persona que no es médico.[134] *[The sanction is deprivation of liberty for two to five years if the procedure: a) is performed for financial gain; b) is performed in unofficial institutions; c) is performed by a person who is not a physician. Unofficial translation.]*

14. Extra-legal barriers

These are barriers that are not usually encompassed in national legislation but are part of abortion-related practices and/or the country's socio-cultural and economic situation.

Lack of medical staff

In some countries, or parts of countries (such as in rural, mountainous, poor or remote areas, and in refugee camps), legal abortion services or certain types of abortion services (such as drug-induced or late abortion) can be hard or impossible to obtain. Sometimes it is a consequence of the absence of trained professionals, which in turn can result from the lack of training given in abortion provision. Such training should be accessible by (or mandatory for) obstetricians/gynaecologists, nurse-midwives and interested general practitioners. Medical and nursing schools and centres of excellence in abortion care should organize such training. Sometimes the lack of providers is due to excessive restrictions on the kinds of health professionals allowed to perform abortions, or on the kinds of institutions licensed to provide abortions.

Lack of efficient services

Access to safe abortion services should not be an arduous task for the client. However, inefficient health systems result in long waiting lists and delayed and/or multiple appointments. Such bureaucracy burdens the client, and may also deny the client a legal abortion in countries where there is a time limit to when a legal abortion can be obtained. Over-medicalization of abortion also increases delays and costs, adversely affecting access. Examples include requiring general anaesthesia and hospital stays; and setting arbitrarily short time limits, for example eight weeks for manual vacuum aspiration which in reality is easily performed up to 12 weeks. Moreover, providers who invoke conscientious objection without referring the client elsewhere, who ask for parental or partner authorization, and impose waiting periods despite the absence of such requirements in the national law, further hinder access to safe abortion services.

Lack of drugs, equipment and optimal quality of care

In order to provide quality abortion services, providers and institutions need to have access to the best possible equipment, materials, supplies, drugs, infection control procedures, and procedures for the disposal of clinical waste and foetal tissue. Most countries provide aspiration or dilation and curettage. However, fewer countries choose medical abortion methods using, for example, mifepristone/misoprostol or misoprostol alone, due to lack of registration of the drug(s). In addition, access to ultrasound, local and general anaesthesia, and the existence of efficient referral mechanisms are necessary to ensure good quality of care. Many countries have national protocols and guidelines which may or may not address the abortion issue and, if they exist, may or may not be implemented. The documents are usually issued by the ministry of health, and sometimes by professional associations. The World Health Organization published guidance in 2003[135] and IPPF published guidelines in 2004.[136] In addition, IPPF has developed guidelines and

protocols for first trimester surgical and medical abortion (in press).[137]

Where there is no quality care – particularly respect for confidentiality and supportive counselling – women may recourse to illegal abortion.

Lack of information

The public (and health care providers) may lack knowledge of the law and of where to obtain legal abortion services. Information dissemination activities undertaken by non-governmental organizations, health care providers and the mass media may help alleviate this barrier.

Costs

The high cost of abortion services can also be a huge barrier to access. Costs vary depending on the type of abortion service, the facility in which it is undertaken (whether at a national hospital or a private one) and even on the reason for the abortion. Informal or 'under the table' fees sometimes increase the official cost.

Example 66. Czech Republic: A fee is charged for abortions performed after eight weeks of gestation. The fee can be waived only if the abortion is medically indicated.[138]

Example 67. UK: "…abortion is available free of charge through the National Health Service, or it may be paid for privately."[139]

Example 68. France: Social security covers 70 per cent of the costs of care and hospitalization associated with lawful termination of pregnancy.[140]

Activities of anti-women's rights activists

Women have been harassed or even assaulted at the entrance to abortion clinics, and sometimes prevented from entering the clinics. In several countries, laws have been enacted to counteract the violent tactics of some citizens who oppose abortion. In France, for example, obstruction of abortion services, either by disrupting abortion facilities or by threatening providers or procurers of abortion services, has been a criminal offence since 1993.[141]

Lack of governmental commitment

In many countries with restrictive abortion laws, governments informed of the huge mortality and morbidity related to unsafe abortion do not liberalize their abortion laws, even though this would improve the situation and give women their rights. Many reasons come into play: these include the influence of religions, public opinion not being overly convinced, ignoring the huge costs related to care after unsafe abortion, political struggles between parties and leaders, or influence of 'stronger' countries.

Additional barriers faced by young women

In addition to all the legal and extra-legal barriers mentioned above, young pregnant women seeking abortion services are faced with even more obstacles.

Special attention is needed on the additional barriers that affect young women's access to safe abortion services. While abortion remains controversial in general it is intensified when it concerns young women. In general, young women are not expected to be sexually active. Unmarried pregnant young women and girls are stigmatized for becoming pregnant as well as for seeking an abortion by those who are anti-women's rights, or they may be forced to have an abortion by those who want to hide or deny the pregnancy. In addition, young women do not have easy access to accurate information and high quality supportive services. As a result they often delay obtaining an abortion and/or may seek help from an unqualified person.

15. The special case of medical (drug-induced) abortion

In the absence of rules and regulations applying specifically to medical abortion, procedural barriers (such as restrictions on eligible institutions, on staff allowed to perform abortions and on time spent in institutions) applying to surgical abortion apply to medical abortion, undermining the whole reason to allow medical abortion.

Chapter 8

Conclusion

We hope that these explanations and examples clarify the many challenges raised by trying to interpret abortion laws.

The first part of this guide can be used to demonstrate how respecting women's rights to health and self-determination can shape the development of liberal abortion laws. Moreover, the legal and other restrictions outlined here highlight the extent to which women all over the world face violations of their fundamental rights. This awareness is intended to be informational and motivational. Informed by research, an analysis of the situation in each country surely demonstrates the critical need for strategic advocacy to enable women to fully realize their rights.

The second part of this guide – the assessments section which starts on page 43 – is intended to help you to assess your local law, and to compare laws from various countries. It also provides space for planning activities to further the aim of increasing access to safe abortion services.

Annex

United Nations Treaty Collection: Treaty Reference Guide

Extracts shortened by M Vekemans, IPPF

Introduction

This guide provides a basic overview of the key terms employed in the UN Treaty Collection to refer to international instruments binding at international law: treaties, agreements, conventions, protocols, declarations, etc. The purpose is to facilitate a general understanding of the scopes and functions of international instruments by which states establish rights and obligations among themselves. No precise nomenclature exists, and the meaning of the terms used varies from State to State, from region to region and instrument to instrument. Some of the terms can be interchanged: an "agreement" might also be called a "treaty". The title has no overriding legal effects, and although the instruments differ by title, they have common features and international law has applied basically the same rules to all of these instruments. These rules are the result of long practice among the States, which have accepted them as binding norms in their mutual relations: they are regarded as international customary law. The 1969 Vienna Convention on the Law of Treaties ("1969 Vienna Convention", entered into force in 1980) contains rules for treaties concluded between States. The 1986 Vienna Convention on the Law of Treaties between States and International Organizations or between International Organizations (still not entered into force), added rules for treaties with international organizations as parties.

Article 102 of the Charter of the UN provides that "every treaty and every international agreement entered into by any Member State of the UN shall as soon as possible be registered with the Secretariat and published by it". All treaties and agreements registered, "whatever their form and descriptive name", are published in the UN Treaties Series (see http://www.un.org/Depts/dhl/resguide/spectreat.htm). The expressions "treaty" and "international agreement" embrace a variety of instruments: unilateral commitments, declarations by UN Member States accepting the obligations of the UN Charter, declarations of acceptance of the compulsory jurisdiction of the International Court of Justice, and unilateral declarations that create binding obligations between the declaring nation and other nations.

Treaties: All instruments binding at international law concluded between international entities, regardless of their formal designation, including agreements involving international organizations. A "treaty" has to meet various criteria: it has to be a binding instrument; the instrument must be concluded by states or international organizations with treaty-making power; it has to be governed by international law. Usually the term is reserved for matters of some gravity that require more solemn agreements. Their signatures are usually sealed and they normally require ratification. The use of the term "treaty" for international instruments has declined in the last decades in favor of other terms.

Agreements: They are usually less formal and deal with a narrower range of subject-matter than "treaties". There is a tendency to apply the term to bilateral or restricted multilateral treaties signed by the representatives of government departments, but are not subject to ratification. Typical agreements deal with matters of economic, cultural, scientific, technical cooperation, and financial matters. Nowadays the majority of international instruments are designated as agreements.

Conventions: The Statute of the International Court of Justice refers to "international conventions, whether general or particular" as a source of law. "Convention" is synonymous with "treaty" but generally used for formal treaties with a broad number of parties. Conventions are normally open for participation by the international community as a whole, or by a large number of states.

Protocols: A term used for agreements less formal than "treaties" or "conventions", to cover the following kinds of

instruments: (a) An instrument subsidiary to a treaty, drawn up by the same parties, dealing with ancillary matters (e.g., the interpretation of clauses of the treaty, or the regulation of technical matters). Ratification of the treaty will normally ipso facto involve ratification of such a protocol. (b) An Optional Protocol to a Treaty establishes additional rights and obligations to a treaty. It is usually adopted on the same day, but is of independent character and subject to independent ratification. (c) A Protocol based on a Framework Treaty is an instrument with specific obligations that implements the general objectives of a framework or umbrella convention. (d) A Protocol to Amend is an instrument that amends one or various former treaties.

Declarations: They are not always legally binding. The term is often chosen to indicate that the parties do not intend to create binding obligations but merely want to declare certain aspirations. Declarations can however be intended to be binding at international law. It is necessary to establish in each individual case whether the parties intended to create binding obligations, but this can be a difficult task. Some "declarations" may gain binding character at a later stage. E.g.: the 1948 Universal Declaration of Human Rights. Declarations intended to have binding effects could be (a) a treaty in the proper sense; (b) an interpretative declaration annexed to a treaty; (c) an informal agreement with respect to a matter of minor importance; (d) a series of unilateral declarations.

Glossary of terms relating to Treaty actions

For more details, see the 1969 Vienna Convention on the Law of Treaties, www.molossia.org/lawoftreaties.html

Adoption: the formal act by which the form and content of a proposed treaty text are established. The adoption takes place through the consent of the states participating in the treaty-making process. A treaty can also be adopted by an international conference convened for setting up the treaty, by a vote of two thirds of the states present and voting, unless, by the same majority, they have decided to apply a different rule.

Acceptance and Approval: The instruments of "acceptance" or "approval" of a treaty have the same legal effect as ratification and express the consent of a state to be bound by a treaty. Acceptance and approval have been used instead of ratification when, at a national level, constitutional law does not require the treaty to be ratified by the head of state.

Accession: "Accession" is the act whereby a state becomes a party to a treaty already negotiated and signed by other states. It has the same legal effect as ratification.

Act of Formal Confirmation: An equivalent for the term "ratification" when an international organization expresses its consent to be bound to a treaty.

Amendment: Refers to the formal alteration of treaty provisions affecting all the parties to the particular agreement.

Authentication: The procedure whereby a treaty is established as authentic and definitive. Once a treaty has been authenticated, states cannot unilaterally change its provisions.

Declarations: Sometimes states make "declarations" as to their understanding of some matter or as to the interpretation of a particular provision. Unlike reservations, declarations merely clarify the state's position and do not purport to exclude or modify the legal effect of a treaty.

Definitive Signature: When the treaty is not subject to ratification, acceptance or approval, "definitive signature" establishes the consent of the state to be bound by the treaty.

Entry into Force: The provisions of the treaty determine the date on which the treaty enters into force. Where multilateral treaties are involved, it is common to provide for a fixed number of states to express their consent for entry into force. Some treaties provide for additional conditions or an additional time period to elapse after the required number of countries have expressed their consent. A treaty enters into force for those states which gave the required consent. A treaty may provide that, upon certain conditions having been met, it shall come into force provisionally.

Objection: Any signatory or contracting state has the option of objecting to a reservation, inter alia, if, in its opinion, the reservation is incompatible with the object and purpose of

the treaty. The objecting state may further declare that its objection has the effect of precluding the entry into force of the treaty as between objecting and reserving states.

Provisional Application: The use of **provisional application** clauses in treaties is a consequence of the need to give effect to treaty obligations prior to a state's formal ratification of or accession to a treaty.

a) **Provisional application of a treaty that has entered into force:** occurs when a state undertakes to give effect to the treaty obligations provisionally (its domestic procedures for ratification/accession have not yet been completed).
b) **Provisional application of a treaty that has not entered into force:** occurs when a state notifies that it would give effect to the legal obligations specified in that treaty **provisionally**. Provisional application terminates if a state notifies the other states of its intention of not becoming a party to the treaty.

Provisional Entry into Force: Some treaties include a **provisional entry into force**, should the formal criteria for entry into force not be met within a given period, or if a number of parties to a treaty which has not yet entered into force decide to apply the treaty as if it had entered into force. The legal obligations are the same as in a treaty that has entered into force.

Ratification: Ratification defines the international act whereby a state indicates its consent to be bound to a treaty. Ratification grants states the time-frame to seek approval for the treaty on the domestic level and to enact the legislation to give domestic effect to that treaty.

Registration and Publication: The Charter of the UN provides that "every treaty and every international agreement entered into by any Member of the UN after the present Charter comes into force shall as soon as possible be registered with the Secretariat and published by it". Treaties or agreements that are not registered cannot be invoked before any organ of the UN. Registration promotes transparency and the availability of texts of treaties to the public.

Reservation: A declaration made by a state to exclude or alter the legal effect of certain provisions of the treaty in their application to that state. Reservations can be made when the treaty is signed, ratified, accepted, approved or acceded to. Reservations must not be incompatible with the object and the purpose of the treaty. A treaty might prohibit reservations or only allow for certain reservations.

Revision: Basically, the same as amendment. Some treaties provide for a revision additional to an amendment. In that case, "revision" refers to an overriding adaptation of the treaty to changed circumstances, whereas "amendment" refers to a change of singular provisions.

Signature ad referendum: A representative may sign a treaty "ad referendum", i.e., under the condition that the signature is confirmed by his state.

Signature Subject to Ratification, Acceptance or Approval: Where the signature is subject to ratification, acceptance or approval, the signature does not establish the consent to be bound. However, it expresses the willingness of the signatory state to continue the treaty-making process. The signature qualifies the signatory state to proceed to ratification, acceptance or approval, and creates an obligation to refrain from acts that would defeat the object and the purpose of the treaty.

Further reading

Catholics for a Free Choice
www.cath4choice.org

Center for Reproductive Rights
www.reproductiverights.org
Abortion laws: www.reproductiverights.org/pdf/pub_fac_abortionlaws.pdf
On religion and abortion: www.reproductiverights.org/pdf/pub_bp_tk_religious.pdf
On adolescents and abortion: www.reproductiverights.org/pdf/pub_bp_tk_adolescents.pdf
A toolkit for action: www.reproductiverights.org/pub_toolkit_for_action.html

Family Health International
www.fhi.org

Guttmacher Institute
www.guttmacher.org
Fact sheets: www.guttmacher.com/sections/abortion.php

Harvard University
Abortion laws: http://cyber.law.harvard.edu/population/abortion/abortionlaws.htm

Ipas
www.ipas.org

IPPF
www.ippf.org
First trimester abortion: surgical and medical guidelines and protocols (in press): available on request at GCACPinfo@ippf.org

United Nations Population Division
www.un.org/esa
www.un.org/esa/population/publications/abortion/profiles.htm
www.un.org/esa/population/publications/2007_Abortion_Policies_Chart/2007_WallChart.pdf

World Health Organization
www.who.int
Technical and policy guidelines: www.who.int/reproductive-health/publications/safe_abortion

Office of the High Commissioner for Human Rights
www.ohchr.org/EN/Pages/WelcomePage.aspx#
Complete texts of the international human rights treaties and accompanying documents such as General Comments: www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx

Endnotes

1 World Health Organization (1992) *The Prevention and Management of Unsafe Abortion*. Report of a Technical Working Group (WHO/MSM/92.5), Geneva: WHO.

2 World Health Organization (2007) *Unsafe Abortion. Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*, Geneva: WHO, www.who.int/reproductive-health/publications/unsafeabortion_2003/ua_estimates03.pdf

3 Population Reference Bureau (2005) *Unsafe Abortion. Facts and Figures*, www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=12766

4 UNFPA *State of World Population 2004. Unmet Need*, www.unfpa.org/swp/2004/english/ch6/page3.htm

5 Cook RJ and Dickens BM (2003) Human rights dynamics of abortion law reform, *Human Rights Quarterly*, 25(9) pp1–59.

6 For this, the classification from level 1 to 5 (strictest to most permissive) of the Center for Reproductive Rights was used. Each of the five categories is represented in the sample. See *The World's Abortion Laws 2007* at www.reproductiverights.org/pub_fac_abortion_laws.html

7 Each IPPF region is represented by at least one country.

8 Vekemans M, Asif K and Simelela N (2008) *Glossary of Terms Related to Abortion* (unpublished draft), London: International Planned Parenthood Federation.

9 Cour européenne des Droits de l'Homme, www.echr.coe.int/fr/Press/2004/juillet/Arr%C3%AAtdeGrandeChambreVocFrance080704.htm

10 Controversy exists about the beginning of pregnancy. The American College of Obstetricians and Gynecologists states that "A pregnancy is considered to be established only after implantation is complete" (www.guttmacher.org/pubs/tgr/08/2/gr080207.html); the Catholic Church considers human life must be protected "from the moment of conception" (www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html); the British Medical Association uses the term "established pregnancy i.e. after implantation" (www.bma.org.uk/ap.nsf/Content/AbortionTimeLimits); the Austrian abortion law states "the beginning of pregnancy is the moment of nidation" (http://annualreview.law.harvard.edu/population/abortion/Austria.abo.htm).

11 *A Global Review of Laws on Induced Abortion*, www.guttmacher.org/pubs/journals/2405698.pdf

12 Syed IB (not dated) *Abortion*, Islamic Research Foundation International, www.irfi.org/articles/articles_101_150/abortion.htm

13 Roe *v.* Wade, 1973, http://caselaw.lp.findlaw.com/scripts/getcase.pl?navby=CASE&court=US&vol=410&page=113

14 For the technical aspects of abortion, see (1) Terki F and Malhotra U (2004) *IPPF Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services*, third edition, Chapter 12, London: International Planned Parenthood Federation, pp278–96, http://content.ippf.org/output/ORG/files/5860.pdf; (2) World Health Organization (2003) *Safe Abortion: Technical and Policy Guidance for Health Systems*, www.who.int/reproductive-health/publications/safe_abortion/

15 World Health Organization (2007) *Mental Health*, www.who.int/mediacentre/factsheets/fs220/en/

16 Same as note 15.

17 UN, Department of Economic and Social Affairs, Population Division "II. Country Profiles: Description and Review of Variables: A. Abortion Policy: 1. Grounds on which abortion is permitted: f. Termination of pregnancy for economic or social reasons" in *Abortion Policies: A Global Review*, Volumes I (2001), II (2001), III (2002), New York: United Nations, www.un.org/esa/population/publications/abortion/doc/Notes.doc

18 World Health Organization (2004) *Reproductive Health*, www.who.int/reproductive-health/publications/strategy_small_en.pdf

19 *Major Dimensions of Abortion Policy*, www.un.org/esa/population/publications/abortion/doc/intro.doc

20 Same as note 5.

21 Balchin C (ed) (2003) *Women, Law, and Society: An Action Manual for NGOs*, Pakistan: Shirkat Gah – Women's Resource Centre.

22 *Conceptualising Islamic Law, CEDAW and Women's Human Rights in Plural Legal Settings* (2006) www.unifem.org.in/PDF/complete%20study.pdf

23 This, however, is not always put into practice.

24 Same as note 5.

25 See www.hrw.org/backgrounder/americas/argentina0605/ and www.crlp.org/pdf/pub_bp_safeandlegal.pdf

26 See alinea 10 of www.unhchr.ch/tbs/doc.nsf/(Symbol)/13b02776122d4838802568b900360e80?Opendocument

27 An indirect way to attribute a foetus with an ambiguous status occurs in cases of "double murder" when a pregnant woman is murdered, thereby killing her unborn foetus. See www.whitehouse.gov/news/releases/2004/04/20040401-3.html

28 Programme of Action of the International Conference on Population and Development, Cairo, Egypt, 1994, § 8.25, UN Doc. A/CONF.171/13/Rev.1, 1995, www.iisd.ca/Cairo/program/p00000.html

29 The Beijing Declaration; The Platform for Action, 4th World Conference on Women, Beijing, China, 1995 § 106K, UN Doc. A/CONF.177/20, www.un.org/womenwatch/daw/beijing/platform

30 Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, UN GAOR, 21st Special Session, New York, USA, 1999, UN Doc. A/S-21/5/Add.1, 1999, www.un.org/popin/unpopcom/32ndsess/gass.htm

31 Convention on the Elimination of All Forms of Discrimination against Women, adopted 18 December 1979, article 1, G.A. Res. 34/180, UN GAOR, 34th Session, Supp. No. 46, at 193, UN Doc. A/34/46 (1979) (entered into force 3 September 1981), www.un.org/womenwatch/daw/cedaw/committee.htm

32 Committee on the Elimination of Discrimination against Women, 20th Session, General Recommendation 24 on Women and Health (1999), www.un.org/womenwatch/daw/cedaw/committee.htm

33 *UN Abortion Policies*, www.un.org/esa/population/publications/abortion/doc/elsalv1.doc

34 Malta. Criminal Code, 2003, articles 241–243A.

35 US Department of Health and Human Services (1999) *Mental Health: A Report of the Surgeon General – Executive Summary*, Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

36 Barbados. Medical Termination of Pregnancy Act (Act No. 4 of 1983), Section 4.

37 The Thai Medical Council's Regulation on Criteria for Performing Therapeutic Termination of Pregnancy, 2006, in accordance with Section 305 of the Criminal Code of Thailand, No. 5(2).

38 Ghana. Criminal Code, article 58.

39 New Zealand. Crimes acts, 1961 to 1999, article 187A(2)(3).

40 Same as note 5.

41 Poland. Penal Code article 149a(3)4.

42 Brazil. Código Penal article 126.

43 The authors have translated laws themselves. These are not official translations. At least one example in English is given each time an example appears in another language (French, Spanish, Portuguese).

44 Cameroon. Penal Code, Section 339(2).

45 India. The Medical Termination of Pregnancy Act No. 34 of 1971, as amended by Act No. 64 of 2002, 3 (b)(i) Explanation I.

46 Section 131 (1) concerns "Sexual conduct with dependent family member." See www.legislation.govt.nz/libraries/contents/om_isapi.dll?clientID=1844598441&infobase=pal_statutes.nfo&jd=a1961-043%2fs.131-ss.1&record={18F1A}&softpage=DOC#JUMPDEST_a1961-043/s.131-ss.1

47 New Zealand. Crimes acts, 1961 to 1999, article 187A (1)(b)(i,ii,iii)(c,d)(2)(b).

48 http://en.wikipedia.org/wiki/Incest#Incest_taboos_throughout_human_society

49 Larsen D *"Incest" – Your Guide to Abuse/Incest Support*, http://incestabuse.about.com/cs/incestrecovery/g/defincest.htm

50 For example, in many Islamic countries marrying first cousins is common and is not considered incestuous.

51 http://en.wikipedia.org/wiki/Incest#Sexual_relations_between_cousins_and_other_distant_relatives

52 IPPF has no formal definition of incest.

53 South Africa. Women's rights on Termination of Pregnancy Act, 1996, 1(iii).

54 Same as note 5.

55 Benin, Law No. 2003–04 on Reproductive and Sexual Health, ch. 4, article 17 (2003).

56 Poland. Penal Code, article 149a (3)3.

57 France. Loi n° 2001-588 du 4 juillet 2001 article 10 article 11 Journal Officiel du 7 juillet 2001.

58 Kuwait. Law-Decree No. 25/1981, article 12.2.

59 Marcan-Markar M *HIV-positive Women Pay High Price to be Mothers*, http://ipsnews.net/shakti/0910_2.asp

60 Same as note 12.

61 *The World's Abortion Laws* (2007) www.reproductiverights.org/pdf/pub_fac_abortionlaws.pdf

62 South Africa. Women's rights on Termination of Pregnancy Act, 1996, 2(1)(b)(iv).

63 Zambia. Termination of Pregnancy Act, 1972, Section 3(2).

64 Ethiopia. Criminal Code, Proclamation No. 414/2004, article 550.

65 Barbados. Medical Termination of Pregnancy Act (Act No. 4 of 1983), Section 4(3).

66 Guyana. Medical Termination of Pregnancy Act 1995 5(1-2).

67 Belgium. Code penal, article 350.

68 Mongolia. Decree No. 200, 1989, Amendment to the Health Law. Paragraph 56.

69 Guyana. Medical Termination of Pregnancy Act 1995, 2(1)(g).

70 Namibia. The Abortion and Sterilization Act (1975), as amended through Act 48 of 1982, 3(1)(e).

71 Guyana. Medical Termination of Pregnancy Act 1995, 6(1)(e).

72 India. The Medical Termination of Pregnancy Act No. 34 of 1971, as amended by Act No. 64 of 2002, 3(2)(ii) Explanation II.

73 New Zealand. Crimes acts, 1961 to 1999, article 187A (2)(a).

74 Israel. Criminal Law Amendment (Interruption of Pregnancy) Law, 1977, 5(a)(1).

75 Israel. Criminal Law Amendment (Interruption of Pregnancy) Law, 1977, 5(a)(2).

76 Zambia. Termination of Pregnancy Act, 1972, Section 3(1)(a)(iii).

77 Guyana. Medical Termination of Pregnancy Act 1995, 6(1)(d).

78 Bianco M *Women, The Girl Child and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)*, www.un.org/womenwatch/daw/csw/Bianco2001.htm

79 Raye KL (1999) *Violence, Women and Mental Disability*, www.mdri.org/report%20documents/violencewomenmd.doc

80 International Helsinki Federation for Human Rights, www.ihf-hr.org/viewbinary/viewdocument.php?doc_id=2051

81 *UN Abortion Policies*, www.un.org/esa/population/publications/abortion/doc/canada1.doc

82 *UN Abortion Policies*, www.un.org/esa/population/publications/abortion/doc/cubasr1.doc

83 Center for Reproductive Rights (2004) *Crafting an Abortion Law that Respects Women's Rights: Issues to Consider. Briefing Paper*, New York, NY: Center for Reproductive Rights, www.reproductiverights.org

84 Guyana. Medical Termination of Pregnancy Act 1995, 6(1).

85 France. Law No. 79-1204 of 31 December 1979, http://cyber.law.harvard.edu/population/abortion/France.abo.htm

86 Turkey. The Population Planning Law. Law No. 2827 of 24 May 1983, http://annualreview.law.harvard.edu/population/abortion/TURKEY.abo.htm

87 United Kingdom. The Abortion Act 1967 (as amended). The Abortion Regulations 1991, Statutory Instrument No. 499 of 1991, 3(3).

88 South Africa. Women's rights on Termination of Pregnancy Act, 1996, 1(1)(ii).

89 Roe *v.* Wade, 1973, see http://supreme.justia.com/us/410/113/case.html

90 *UN Abortion Policies*, www.un.org/esa/population/publications/abortion/doc/unitedstates.doc

91 India. The Medical Termination of Pregnancy Act No. 34 of 1971, as amended by Act No. 64 of 2002, 2(d) and 4(a).

92 Guyana. Medical Termination of Pregnancy Act 1995, 2(1)(b).

93 Israel. Criminal Law Amendment (Interruption of Pregnancy) Law, 1977, 1.

94 South Africa. Women's rights on Termination of Pregnancy Act, 1996. 2(2).

95 Ipas, India, 2005, www.ipas.org/english/where_ipas_works/asia/india/index.pdf

96 Center for Reproductive Rights (1998) *A Global Review of Laws on Induced Abortion, 1985–1997*, New York, NY: Center for Reproductive Rights, www.reproductiverights.org

97 Lebanon. Presidential Decree No. 13187 of 20 October 1969, article 31 and article 31(2).

98 United Kingdom. The Abortion Act 1967 (as amended) 1(1).

99 India. The Medical Termination of Pregnancy Act No. 34 of 1971, as amended by Act No. 64 of 2002, 3(2)(b).

100 Israel. Criminal Law Amendment (Interruption of Pregnancy) Law, 1977, 4.

101 Israel. Criminal Law Amendment (Interruption of Pregnancy) Law, 1977, 5(d) and 13(f).

102 Termination of Pregnancy Regulations (Statutory Instrument No. 219 of 1972), section 2(2).

103 Barbados. Medical Termination of Pregnancy Act (Act No. 4 of 1983), Section 6.

104 The Center's Cases, www.reproductiverights.org/crt_ab_access_legal.html

105 Same as note 104.

106 www.reproductiverights.org/pdf/pub_fac_abortionlaws.pdf: the countries listed are Equatorial Guinea, Japan, Kuwait, Malawi, Maldives, Morocco, Republic of Korea, Saudi Arabia, Syria, Taiwan, Turkey and United Arab Emirates.

107 Center for Reproductive Rights (2005) *The World Abortion Laws. 2005*, New York, NY: Center for Reproductive Rights, www.reproductiverights.org

108 Morocco. Code Pénal, 1962 as amended by Law No. 181-66, 1967, Chapitre VIII, section I, article 453.

109 Turkey. Law No. 2827, 1983, Population Planning Law, 6.

110 Indonesia. Law No. 23 of 1992 regarding health, article 15 (1) and (2)c and Paragraph (2) Point c.

111 South Africa. Women's rights on Termination of Pregnancy Act, 1996, 5(3).

112 India. The Medical Termination of Pregnancy Act No. 34 of 1971, as amended by Act No. 64 of 2002, 3(4)(a).

113 France. Code pénal, article L2212-7 (Loi n° 2001-588 du 4 juillet 2001 article 1 article 7).

114 Turkey. Law No. 2827, 1983, Population Planning Law, 6.

115 Ecuador. Código Penal, article 447.

116 Same as note 83.

117 Barbados. Medical Termination of Pregnancy Regulations, 1983 (Official Gazette, Suppl. No. 41, 19 May 1983) Section 4(3)(b).

118 South Africa. Women's rights on Termination of Pregnancy Act, 1996, 4.

119 Germany. Penal code, Section 219.

120 Same as note 12.

121 Center for Reproductive Rights (2003) *Access to Abortion: Mandatory Delay and Biased Information Requirements*, www.crlp.org/pub_fac_medabor2.html

122 France. Public Health Code, article L2212-5. (Loi n° 2001-588 du 4 juillet 2001 article 1 article 6).

123 Belgium. Code pénal, article 350 3°.

124 Italy. Law No. 194 of 22 May 1978, 5.

125 Guttmacher Institute *Mandatory Counseling and Waiting Periods for Abortion. State Policies in Brief as of April 1 2008*, www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf

126 Cameroon. Law No. 80-10 of 14 July 1980, www.un.org/esa/population/publications/abortion/doc/camero1.doc

127 Greece. Penal code, article 305.

128 Same as note 12.

129 Israel. Criminal Law Amendment (Interruption of Pregnancy) Law, 1977, 7.

130 New Zealand. Contraception, Sterilisation, and Abortion Acts 1977-1991, 46(1).

131 United Kingdom. The Abortion Act 1967 (as amended) 4(1) and (2).

132 Bangladesh. Penal Code (Act XLV, 1860), Section 312.

133 Mauritius. Criminal Code, article 235.

134 Cuba. Código Penal (Act No. 62 of 29 December 1987), article 267.2.

135 *Safe Abortion: Technical and Policy Guidance for Health Systems*, www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf

136 *IPPF Medical and Service Delivery Guidelines* (2004) www.ippf.org

137 International Planned Parenthood Federation (In press) *First Trimester Abortion: Surgical and Medical Guidelines and Protocols.* London: IPPF.

138 Czech Republic. Law on abortion, 20 October 1986, 9.

139 *UN Abortion Policies*, www.un.org/esa/population/publications/abortion/doc/unitedkingdom.doc

140 *Sterilization Laws and Government Funding for Family Planning Services in EU Countries* (2006) www.astra.org.pl/sterilization.pdf

141 *UN Abortion Policies*, www.un.org/esa/population/publications/abortion/doc/france1.doc

The assessment

Introduction to the assessment of legal and other obstacles to accessing safe abortion services

This part of the guide is a tool intended to be used to enable those working in sexual and reproductive health services to better understand their own laws, regulations and obstacles relating to abortion services and, thereby, to support a woman's right to the highest attainable standard of health. This will be achieved by providing services to the fullest extent of the law and by advocating for increased access to safe abortion. The assessment process can be done as an individual or as a team exercise which includes managers, service providers and volunteers. If necessary, experts in law and human rights should be involved in the process, which should ultimately identify obstacles to providing safe and legal abortion-related services, and find ways to overcome them.

Assessing the laws and the legal and other obstacles concerning access to safe abortion is a necessary **preliminary** step enabling us to ensure women's rights to obtain legal, safe and comprehensive abortion care.

Getting started

If you are undertaking the assessment as an individual you need to have access to all the relevant documents relating to abortion laws and regulations as well as contact details of experts in law and human rights to provide necessary support and clarification. In federal states, ensure you have the local and federal laws as needed and relevant.

If the assessment is being undertaken as an organizational learning exercise, the following tips may be useful.

Select a lead person to coordinate the assessment and to facilitate the overall process. This role could be filled by more than one person. The coordinator/facilitator should ideally:

- have good leadership and facilitation skills
- have previous involvement in self-assessment or group work activities
- have experience as a trainer (although they do not have to be a professional trainer)
- be respected by colleagues
- have knowledge of, or understanding about, sexual, reproductive and human rights

The self-assessment process can take the form of a workshop with all relevant stakeholders (for example staff and volunteers from IPPF, national and international partner organizations, medical and legal professionals).

Before the meeting, the coordinator/facilitator should:

- Gather as much background material as possible on the local abortion laws and policies (see Further reading on page 37, particularly the Center for Reproductive Rights, Harvard University and IPPF). See the local penal code, constitution (if relevant), abortion/termination of pregnancy act and public health law. Consult lawyers and, if present locally or nationally, specialized non-governmental organizations.
- Contact partner organizations or experts in the fields of law and human rights to participate or provide support.
- Inform all staff and volunteers about the initiative. Specifically, tell them what it is about, what the aims are, what the process entails and who will be involved.
- Make sufficient copies and provide all participants with the relevant documents in advance so that they become familiar with the material before the self-assessment exercise.
- Ensure adequate space for everyone and arrange the room in a way that encourages group discussions and activities. For practical purposes, and to minimize costs, hold the assessment exercise in a place that most participants can reach easily.
- Make the necessary travel arrangements for participants (including travel costs and per diems).
- Make arrangements for refreshments as required by internal procedures; this often plays an important part in making participants feel comfortable.
- Prepare materials for the working sessions (flip chart paper, pens, transparencies or projector, as required).

The coordinator/facilitator should:

- be familiar with the subject discussed
- create participatory group discussions in which all participants feel safe to express their opinions
- help all participants to understand and interpret the questions appropriately
- be flexible and open to suggestions, changes, interruptions and lack of participation – be aware that participants may feel inhibited, especially if they are in their work environment
- decide who will facilitate and who will take notes; it is efficient to work with flip charts and to make notes on all the outcomes
- go through the questions and discuss them: not all questions can be tackled in one session – you may need more meetings or need to divide into smaller groups to look at the different sections

After the meeting, the coordinator/facilitator should prepare a summary document (see page 84 for a sample format) and share it with the participants.

Remember … to include all relevant stakeholders in the assessment exercise: managers, programme staff, board or council members, partners, experts in law and human rights, professionals (such as physicians, nurses/midwives, journalists), activists from women's organizations, and relevant community and religious leaders.

Answering the questions

It may be convenient to divide the participants into smaller groups, each to look at an aspect of the assessment questions and then report back to the whole group. When using the assessment, feel free to add any further issues that you feel should be discussed.

The column labelled 'Comment' should be used to:

- provide evidence, examples and clarifications to support a '**yes**' answer
- explain why an answer might be '**no**'
- include further questions or comments

The column labelled 'Source of information' should be used to make a record of the origins of the legal or policy requirements or the references used.

Suggested exercise

Share in groups the possible reasons behind the requirements. It should help to raise awareness of the extent to which access to safe abortion is unnecessarily restricted and will highlight areas for targeted advocacy.

Section 1 Preparatory questions

1. Policy and services	Yes	No	Comment
1. Does your organization have a policy on abortion?	☐	☐	
2. Does your organization provide abortion services in your clinic? *Please specify the services and abortion techniques available.*	☐	☐	
3. Does your organization refer clients to other facilities to obtain a safe abortion?	☐	☐	
4. Does your organization refer clients to other facilities for treatment of abortion complications or post-abortion care?	☐	☐	
5. Does your organization undertake abortion-related advocacy activities?	☐	☐	

2. Laws	Yes	No	Comment
1. Do you have access to all your national laws relating to abortion?	☐	☐	
2. Do you have access to the abortion-related guidelines/policies of your Ministry of Health?	☐	☐	
3. If you provide abortion services in your clinic, do you have access to your abortion-related policies?	☐	☐	
4. If you refer clients to other facilities for abortion services, do you have access to their abortion-related policies?	☐	☐	

Section 2 Legal conditions for abortion

1. How is the gestational period measured?

See Chapter 3, section 2	Yes	No	Comment	Source of information
1. **Since the first day of last menstrual period.**	☐	☐		
2. **Since presumed ovulation.**	☐	☐		
3. **Since implantation.**	☐	☐		
4. **Gestational duration is not specified.**	☐	☐		
5. **Other.** *Please specify.*				

2. Medical grounds

	Yes	No	Comment	Source of information
1. **Is abortion legal to save the life of the woman?** *See Chapter 6, section 1* *Please include explanation/definition in the comment section.*	☐	☐		
Does an official form need to be filled in?	☐	☐		
2. **Is abortion legal in the case of necessity?**	☐	☐		
Does an official form need to be filled in?	☐	☐		
3. **Is abortion legal to preserve a woman's physical health?** *See Chapter 6, section 2* *Please include explanation/definition in the comment section.*	☐	☐		
Does an official form need to be filled in?	☐	☐		
4. **Is abortion legal to preserve a woman's mental health?** *See Chapter 6, section 3* *Please include explanation/definition in the comment section.*	☐	☐		
Does an official form need to be filled in?	☐	☐		

Continued on next page

2. Medical grounds continued	Comment	Source of information
5. What happens in practice?		

3. Foetal impairment	Yes	No	Comment	Source of information
1. Is abortion legal in the case of foetal impairment? *See Chapter 6, section 5*	☐	☐		
2. Is the type of impairment explained?	☐	☐		
3. Does a doctor need to establish the impairment?	☐	☐		
4. If yes:				
– How many doctors need to be involved?				
– What qualifications are required of the doctor?				
– Does an official form need to be filled in?	☐	☐		
5. Does the case need to be brought before a court? *Please explain.*	☐	☐		
6. What happens in practice?				

4. Social grounds	Yes	No	Comment	Source of information
1. **Is abortion legal if the pregnancy is a result of rape?** *See Chapter 6, section 4* *Please include explanation/definition in the comment section.*	☐	☐		
2. **Is abortion legal if the pregnancy is a result of incest?** *Please include explanation/definition in the comment section.*	☐	☐		
3. **Is abortion permitted in case of statutory rape?*** *Please include explanation/definition in the comment section.*	☐	☐		
4. **Is a medical certificate required to prove the rape?**	☐	☐		
5. **Is the medical certificate required to prove mental distress as a result of rape and thereby permission for an abortion?**	☐	☐		
6. **Does the incident need to be reported to the police, as a requirement for accessing legal abortion?**	☐	☐		
7. **Does the case need to be brought before a court of law, to obtain a legal abortion?**	☐	☐		
8. **What happens in practice?**				

* Sexual contact with a person below the age of consent (minor).

5. Economic, social or psychosocial reasons	Yes	No	Comment	Source of information
1. **Is abortion legal for economic, social or psychosocial reasons?** *See Chapter 6, section 6*	☐	☐		

Continued on next page

5. Economic, social or psychosocial reasons continued	Yes	No	Comment	Source of information
2. Is consideration given to the woman's actual socio-economic environment?	☐	☐		
3. Is consideration given to the woman's foreseeable socio-economic environment?	☐	☐		
4. Is consideration given to the health and lives of other children?	☐	☐		
5. Is consideration given to the psychosocial* circumstances of the woman?	☐	☐		
6. Other considerations. *Please explain.*				
7. What evidence needs to be provided?				
8. What happens in practice?				

* This includes consideration for the difficulties that the woman will face because, for example, her partner has left her, she has just started a new job, she has no home.

6. Abortion on request	Yes	No	Comment	Source of information
1. Is abortion available on request? *See Chapter 6, section 7*	☐	☐		
2. If yes:				
– Is an oral request sufficient?	☐	☐		

Continued on next page

6. Abortion on request continued	Yes	No	Comment	Source of information
– **Is a second oral request required after consultation?**	☐	☐		
– **Is a written request required?** *Please indicate if a special form is available.*	☐	☐		
– **Is a waiting period mandatory?**	☐	☐		
– **Other requirements.** *Please specify.*				
3. What happens in practice?				

7. Other reasons

See Chapter 6, section 8

	Yes	No	Comment	Source of information
1. Is abortion available for psychological reasons? *If yes, please explain.*	☐	☐		
2. Is abortion available on the condition that the woman suffers from mental disability? *If yes, please explain.*	☐	☐		
3. Is abortion available on the condition that there was a failure of contraception?	☐	☐		
4. Is abortion available on the condition that the age of the woman makes pregnancy inappropriate? *Please explain upper or lower age limits.*	☐	☐		
5. Is abortion available on the condition that the pregnancy is a result of extra-marital relations?	☐	☐		

Continued on next page

7. Other reasons continued	Yes	No	Comment	Source of information
6. Is abortion available on the condition that the woman is HIV positive?	☐	☐		
7. Other reasons under which abortion is made available. *Please specify.*				
8. What happens in practice?				

8. Compulsory or forced abortion	Yes	No	Comment	Source of information
1. Are there instances where abortion is made compulsory or is forced? *See Chapter 6, section 9*	☐	☐		
2. Is it forced if the woman suffers from mental disability? *If yes, please explain requirements/ authorizations and procedure.*	☐	☐		
3. Is it forced if the age of the woman makes pregnancy inappropriate? *Please explain upper or lower age limits.*	☐	☐		
4. Is it forced if the pregnancy is a result of extra-marital relations?	☐	☐		
5. Is it forced if the woman is HIV positive?	☐	☐		
6. Is it forced if her family size has reached a prescribed maximum?	☐	☐		
7. Is it forced for other reasons? *Please specify.*	☐	☐		

Continued on next page

8. Compulsory or forced abortion continued	Yes	No	Comment	Source of information
8. Is long-term sterilization required after the abortion? *Please explain how these requirements are enforced:* – **In the law.** – **In practice.**	☐	☐		

Section 3 Procedural barriers

1. Time limit

See Chapter 7, section 1

	Yes	No	Comment	Source of information
1. What is the time limit (since first day of last menstruation) within which an abortion can be performed? *If the time limit changes under different circumstances, please explain it within the comment section. If the time limit is since ovulation, please explain it in the comment section.*				
– 4–7 weeks.	☐	☐		
– 8–11 weeks.	☐	☐		
– 12–15 weeks.	☐	☐		
– 16–19 weeks.	☐	☐		
– 20–23 weeks.	☐	☐		
– 24–28 weeks.	☐	☐		
– Over 28 weeks.	☐	☐		
– Other. *Please specify.*	☐	☐		

Continued on next page

1. Time limit continued	Yes	No	Comment	Source of information
2. Are there exceptions to when time limits are required?				
– To protect the woman's life.	☐	☐		
– In the case of severe foetal impairment.	☐	☐		
– Other. *Please specify.*	☐	☐		
3. Are there requirements for waiving the time limit?	☐	☐		
– Authorized by medical practitioner. *Please indicate if it is more than one.*	☐	☐		
– Authorized by another professional.	☐	☐		
– Other. *Please specify.*	☐	☐		
4. What happens in practice?				

2. Performing institutions

See Chapter 7, section 2

	Yes	No	Comment	Source of information
1. Are the types of medical facilities in which abortions can be performed specified?	☐	☐		

Continued on next page

2. Performing institutions continued	Yes	No	Comment	Source of information
2. If yes:				
– It needs to be in a government hospital or clinic.	☐	☐		
– It needs to be in a government approved hospital or clinic.	☐	☐		
– It can be in any clinic with a licence to perform abortions.	☐	☐		
– It can be in any clinic with minimum essential facilities. *Use the comment section to describe the required facilities.*	☐	☐		
– It can be on an outpatient basis (no overnight stay).	☐	☐		
– Other requirements. *Please specify.*	☐	☐		
3. If no, please indicate where it usually is (or could be) performed.				
4. When can these requirements be waived?				
– If gestation is less than 12 weeks.	☐	☐		
– To protect the woman's life.	☐	☐		
– To protect the woman's physical health	☐	☐		
– To protect the woman's mental health.	☐	☐		
– Other. *Please specify.*	☐	☐		
5. What happens in practice?				

3. Performing personnel

See Chapter 7, section 2

	Yes	No	Comment	Source of information
1. Are there specified staff who are allowed to perform an abortion?	☐	☐		
2. If yes:				
– It needs to be a physician.	☐	☐		
– It needs to be a registered obstetrician gynaecologist.	☐	☐		
– It can be a midwife or nurse.	☐	☐		
– Other. *Please specify.*	☐	☐		
3. Does the practitioner need a special licence to perform abortions?	☐	☐		
4. If no, please indicate who usually performs abortions.				
5. What happens in practice?				

4. Medical approvals

See Chapter 7, section 3

	Yes	No	Comment	Source of information
1. Does a medical practitioner need to approve the abortion?	☐	☐		

Continued on next page

4. Medical approvals continued	Yes	No	Comment	Source of information
2. If yes, how many medical practitioners need to authorize the procedure?				
3. Who are the authorizing personnel?				
– Registered obstetrician gynaecologist.	☐	☐		
– Physician (MD).	☐	☐		
– Surgeon.	☐	☐		
– Psychiatrist.	☐	☐		
– Other specialist. *Please specify.*	☐	☐		
– Director of hospital/clinic.	☐	☐		
– Social worker.	☐	☐		
– Representative from Ministry of Health.	☐	☐		
4. Does the authorization need to be in writing? *If there are special forms for this purpose please explain and provide form(s).*	☐	☐		

Continued on next page

4. Medical approvals continued	Yes	No	Comment	Source of information
5. When is a medical practitioner required?				
– At all times.	☐	☐		
– If there is serious risk to the woman's life.	☐	☐		
– If the pregnancy is a result of rape.	☐	☐		
– If the pregnancy is a result of incest.	☐	☐		
– If it is on mental health grounds.	☐	☐		
– If the woman is a minor.	☐	☐		
– In case of foetal impairment.	☐	☐		
– If the last menstrual period was less than 12 weeks ago.	☐	☐		
– If the last menstrual period was between 12–19 weeks ago.	☐	☐		
– If the last menstrual period was more than 20 weeks ago.	☐	☐		

Continued on next page

4. Medical approvals continued	Yes	No	Comment	Source of information
6. Are there exceptions to when medical approvals are necessary?				
– In an emergency, to protect the woman's life.	☐	☐		
– Other. *Please specify.*	☐	☐		
7. Are there requirements for waiving the medical approval?				
– Signature of performing physician.	☐	☐		
– Signature before commencement of procedure.	☐	☐		
– Signature provided no later than 24 hours after the procedure.	☐	☐		
– Other. *Please specify.*	☐	☐		
8. What happens in practice?				

5. Judicial approvals

See Chapter 7, section 4

	Yes	No	Comment	Source of information
1. Is judicial approval required for an abortion?	☐	☐		

Continued on next page

5. Judicial approvals continued	Yes	No	Comment	Source of information
2. If yes, does it have to be:				
– A representative from the Ministry of Justice.	☐	☐		
– A lawyer.	☐	☐		
– A magistrate.	☐	☐		
– A judge.	☐	☐		
– Other. *Please specify.*	☐	☐		
3. Does the authorization need to be in writing? *If there are special forms for this purpose please explain and provide form(s).*	☐	☐		
4. When is judicial approval required?				
– At all times.	☐	☐		
– If there is serious risk to the woman's life.	☐	☐		
– If the pregnancy is a result of rape.	☐	☐		
– If it is on mental health grounds.	☐	☐		
– If the woman is a minor.	☐	☐		
– If the last menstrual period was less than 12 weeks ago.	☐	☐		
– If the last menstrual period was between 12–19 weeks ago.	☐	☐		
– If the last menstrual period was 20 or more weeks ago.	☐	☐		
5. Are there exceptions to when judicial approvals are necessary?				
– In an emergency, to protect the woman's life.	☐	☐		
– Other. *Please specify.*	☐	☐		

Continued on next page

5. Judicial approvals continued	Comment	Source of information
6. What happens in practice?		

6. Spousal/partner authorization

See Chapter 7, section 5

	Yes	No	Comment	Source of information
1. Is spousal/partner authorization required?	☐	☐		
2. If the couple is unmarried, is partner authorization required?	☐	☐		
If yes, what is required?				
– Written authorization (i.e consent is required).	☐	☐		
– Notification (i.e spouse is required to be informed only).	☐	☐		
– Spouse/partner needs to accompany the woman.	☐	☐		
– Medical staff are required to encourage the client to seek spousal support, but the service is not denied to the client if spouse is not consulted.	☐	☐		
– Other. *Please specify.*	☐	☐		
3. When is spousal authorization not required?				
– To protect the woman's life.	☐	☐		
– To protect the woman's physical health.	☐	☐		
– To protect the woman's mental health.	☐	☐		
– Other. *Please specify.*	☐	☐		

Continued on next page

6. Spousal/partner authorization continued	Yes	No	Comment	Source of information
4. What needs to be done in order to waive the authorization requirement? *Please explain.*				
5. Are there people other than the professional staff that need to authorize the termination of a married woman's pregnancy? *If yes, please specify, for example the husband.*	☐	☐		
6. If spousal/parental authorization is not required, do providers still request it in practice?	☐	☐		

7. Parental/guardian authorization

See Chapter 7, section 6

	Yes	No	Comment	Source of information
1. Is parental* authorization required for young women?	☐	☐		
2. If yes, what is the age limit?				
– 16.	☐	☐		
– 18.	☐	☐		
– 21.	☐	☐		
– Other. *Please specify.*	☐	☐		
3. If yes, what is required?				
– Written authorization from one parent.	☐	☐		
– Written authorization of both parents.	☐	☐		
– Notification of one parent.	☐	☐		
– Notification of both parents.	☐	☐		
– Other. *Please specify.*	☐	☐		

* Please note that 'parent' has been used to mean both parent and guardian.

Continued on next page

7. Parental/guardian authorization continued	Yes	No	Comment	Source of information
4. If parental authorization is not required, should another adult authorize the procedure, for example social worker, adult friend or family member?	☐	☐		
5. If parental authorization is not required, does a minor need to be accompanied by an adult of her choice?	☐	☐		
6. If parental authorization is not required, are medical staff required to encourage the client to seek adult support, but not to deny the service to the client if no adult is consulted?	☐	☐		
7. When is parental authorization not required?				
– To protect the woman's life.	☐	☐		
– To protect the woman's physical health.	☐	☐		
– To protect the woman's mental health.	☐	☐		
– Other. *Please specify.*	☐	☐		
8. What needs to be done in order to waive the authorization requirement? *Please explain.*				
9. Are there other laws related to parental authorizations? *If yes, please specify.*	☐	☐		
10. If parental authorization is not required, do providers still request it in practice?	☐	☐		

8. Consent and confidentiality* *See Chapter 7, sections 5–7*	Yes	No	Comment	Source of information
1. Does the client have to sign a formal request consenting to the abortion procedure?	☐	☐		

Continued on next page

* In the event that there are laws requiring parental and spousal authorization, please assume that confidentiality in this case refers to all other persons.

8. Consent and confidentiality continued	Yes	No	Comment	Source of information
2. Is this request anonymous? *If no, please explain what information is required.*	☐	☐		
3. Where is this document held?				
4. Are there special procedures for obtaining the consent of a woman deemed unable to provide consent, for example a minor, a woman 'of unsound mind'? *Please explain.*	☐	☐		
5. Is confidentiality guaranteed? *Please explain.*	☐	☐		
6. Are there circumstances in which confidentiality cannot be guaranteed, for example in cases of abuse? *If yes, please explain when it is so.*	☐	☐		
7. Please explain what needs to be done where confidentiality cannot be guaranteed, for example inform patient, offer support.				
8. What happens in practice?				

9. Declaration of abortion services

See Chapter 7, section 8

	Yes	No	Comment	Source of information
1. Do abortion services need to be declared to the authorities? *If yes, to which authority?*	☐	☐		
2. Does the performing medical practitioner need to sign a declaration relating to the abortion procedure?	☐	☐		
3. Does the client need to sign this declaration?	☐	☐		

Continued on next page

9. Declaration of abortion services continued	Yes	No	Comment	Source of information
4. What other information is required?				
5. Is there a time limit for the declaration?	☐	☐		
6. Where is this document held?				
7. What is the penalty for failure to declare?				
8. What happens in practice?				

10. Legal counselling requirements

See Chapter 7, section 9

	Yes	No	Comment	Source of information
1. By law, is pre-abortion counselling mandatory?	☐	☐		
If yes,				
– Must the counsellor be the performing physician?	☐	☐		
– Must the counsellor be someone other than the performing physician? *Please specify qualifications.*	☐	☐		
– By law, must the counselling contain dissuasive elements to prevent abortion?	☐	☐		
– By law, must the counselling content be of a supportive nature to help the woman and promote choice?	☐	☐		

Continued on next page

10. Legal counselling requirements continued	Yes	No	Comment	Source of information
2. What topics are covered in the counselling?				
– Reasons for abortion.	☐	☐		
– Possible alternatives.	☐	☐		
– The abortion procedure.	☐	☐		
– Possible immediate effects.	☐	☐		
– Possible long-term effects.	☐	☐		
– Contraception.	☐	☐		
– Support and care available.	☐	☐		
3. Does the client need to reconfirm her request for an abortion following the counselling?	☐	☐		
4. If yes, does this need to be in writing? *Please indicate if there is a special form and provide it.*	☐	☐		
5. How long before the procedure should the counselling take place?				
6. Explain the rationale and process of the counselling.				
7. What happens in practice?				

11. Waiting periods

See Chapter 7, section 10	Yes	No	Comment	Source of information
1. Is there a mandatory waiting period between the request for an abortion and the actual procedure?	☐	☐		

Continued on next page

11. Waiting periods continued	Yes	No	Comment	Source of information
2. How is the initial request defined?				
– Telephone call.	☐	☐		
– Visit to general practitioner.	☐	☐		
– Visit to obstetrician gynaecologist.	☐	☐		
– Visit to abortion clinic.	☐	☐		
– Other. *Please specify.*	☐	☐		
3. How long does the client need to wait between the initial request for an abortion and the actual procedure?				
– Less than 48 hours.	☐	☐		
– Between 48 hours and eight days.	☐	☐		
– More than eight days.	☐	☐		
4. When can a client be exempt from waiting?				
– When the pregnancy is close to the legal time limit permitted for abortion.	☐	☐		
– When it is a medical emergency.	☐	☐		
5. What happens in practice?				

12. Advertising abortion services

See Chapter 7, section 11

	Yes	No	Comment	Source of information
1. Are there restrictions on providing the public with information on abortion?	☐	☐		

Continued on next page

12. Advertising abortion services continued	Yes	No	Comment	Source of information
2. If yes, what does it apply to?				
– Materials (posters, leaflets etc) on abortion.	☐	☐		
– Public announcements on abortion (speeches, radio, TV).	☐	☐		
– Other. *Please specify.*	☐	☐		
3. What information is prohibited?				
– Advertising abortion services.	☐	☐		
– Advertising substances or methods that induce abortion.	☐	☐		
– Other. *Please specify.*	☐	☐		
4. What are the penalties for engaging in these activities?				
– Fine.	☐	☐		
– Imprisonment.	☐	☐		
– Other. *Please specify.*	☐	☐		
5. What information is allowed?				
– Information published in specialized journals.	☐	☐		
– Medical information given in family planning centres.	☐	☐		
– Information given in the course of training physicians (those lawfully empowered to perform abortions).	☐	☐		
– Other. *Please specify.*	☐	☐		

Continued on next page

12. Advertising abortion services continued	Yes	No	Comment	Source of information
6. Is the information specifying when abortion is legally allowed made available to the public?	☐	☐		
7. Is the information specifying where legal, safe abortion services can be accessed made available to the public?	☐	☐		
8. What happens in practice?				

13. Conscientious objection

See Chapter 7, section 12

	Yes	No	Comment	Source of information
1. Are there regulations concerning conscientious objection?	☐	☐		
2. If yes, where are they set out?				
– In the abortion law.	☐	☐		
– In the penal code, in the constitution.	☐	☐		
– In the Ministry of Health medical guidelines.	☐	☐		
– In the guidelines of each health institution.	☐	☐		
– Other. *Please specify.*	☐	☐		
3. Who is entitled to claim conscientious objection?				
– Institutions.	☐	☐		
– Practitioners.	☐	☐		
– Nurses assisting in the abortion procedure.	☐	☐		
– Those handling administrative tasks relating to abortion.	☐	☐		
– Those handling foetuses and foetal tissue.	☐	☐		

Continued on next page

13. Conscientious objection continued	Yes	No	Comment	Source of information
– **Medical students witnessing abortions.**	☐	☐		
– **Any person participating in any treatment for the termination of a pregnancy.**	☐	☐		
– **Other.** *Please specify.*	☐	☐		
4. Who is not allowed to claim conscientious objection?				
– **Institutions.**	☐	☐		
– **Practitioners.**	☐	☐		
– **Nurses assisting in the abortion procedure.**	☐	☐		
– **Those handling administrative tasks relating to abortion.**	☐	☐		
– **Those handling foetuses and foetal tissue.**	☐	☐		
– **Medical students witnessing abortions.**	☐	☐		
– **Any person participating in any treatment for the termination of a pregnancy.**	☐	☐		
– **Other.** *Please specify.*	☐	☐		
5. On which grounds can conscientious objection be claimed?				
– **Religious beliefs.**	☐	☐		
– **Moral beliefs.**	☐	☐		
– **Other.** *Please specify.*	☐	☐		
6. Do the conscientious objectors need to be certified?	☐	☐		

Continued on next page

13. Conscientious objection continued	Yes	No	Comment	Source of information
7. If yes, how do they obtain it?				
– **By making a statement in court.**	☐	☐		
– **Other.** *Please specify.*	☐	☐		
8. Are institutions obliged to keep a list of objectors?	☐	☐		
9. What are the requirements when claiming conscientious objection?				
– **The client needs to be informed immediately.**	☐	☐		
– **A referral needs to be made.** *Please specify by whom.*	☐	☐		
– **Those claiming conscientious objection may not impose it on others.**	☐	☐		
– **Other.** *Please specify.*	☐	☐		
10. When can conscientious objection not be claimed?				
– **If the woman's life is in danger.**	☐	☐		
– **If there is a risk to the woman's physical health.**	☐	☐		
– **If there is a risk to the woman's mental health.**	☐	☐		
– **If the mission of health services would not be complied with.**	☐	☐		
– **In relation to giving advice on abortion.**	☐	☐		
– **In relation to referrals for abortion.**	☐	☐		
– **Other.** *Please specify.*	☐	☐		
11. Are there instances when legal conscientious objection is invoked but legal referrals are not made? *Please explain.*	☐	☐		

Continued on next page

13. Conscientious objection continued	Comment	Source of information
12. What happens in practice?		

14. Penalties for illegal abortion and related activities

See Chapter 7, section 13

Activity *Includes performing an abortion, procuring an abortion, attempting to procure an abortion, supplying abortion-inducing materials and other activities.*	**Penalty** *Can include fines, imprisonment and other sentences.*	**Source of information** *As before, please include the source of the information in the 'Source of information' column.*

What happens in practice?

Please use this space to explain whether these penalties are enforced or not.

Section 4

Extra-legal barriers *v.* facilitating factors/good practices

See Chapter 7, section 14

1. Services	Yes	No	Comment	Source of information
1. Is abortion training included in medical curricula?	☐	☐		
2. If yes, who receives it?				
– Doctors.	☐	☐		
– Nurses.	☐	☐		
– Midwives.	☐	☐		
3. Is it provided at all training institutions? *Please explain.*	☐	☐		
4. Do you ensure that you recruit staff able to perform abortion services?	☐	☐		
5. Do you provide training to your staff on providing high quality safe abortion services?	☐	☐		
6. How many centres/clinics provide services?				
7. How many are located in rural areas?				
8. Are they located near public transport services?	☐	☐		
9. Are there outreach services? *If yes, please describe the services: who are the clients, who are the providers?*	☐	☐		

Continued on next page

1. Services continued	Yes	No	Comment	Source of information
10. Can appointments for abortion services be made within a week? *Please explain waiting times and appointment procedures.*	☐	☐		
11. Are multiple appointments required? *Please indicate how many.*	☐	☐		
12. Do you have links with a court system for obtaining a legal abortion? *If yes, please describe.*	☐	☐		

2. Protocols on abortion services	Yes	No	Comment	Source of information
1. Can the client administer a medical abortion or part of a medical abortion at home?	☐	☐		
2. Is general anaesthesia, which may constitute a significant barrier to access, required for surgical abortion? *Please indicate if it is an option, and if it constitutes an obstacle to access, at least for some women.*	☐	☐		
3. Are patients required to stay overnight? *If yes, please state after which abortion technique(s).*	☐	☐		
4. Are the different abortion methods used up to the fullest time limit permitted, for example manual vacuum aspiration up to 12 weeks from last menstrual period? *Please use the section on drugs on the next page to explain further.*	☐	☐		
5. Is a follow-up visit required? *If yes, please state when for each method.*	☐	☐		
6. Is it mandatory for the provider to provide post-abortion contraceptive services?	☐	☐		
7. Are there special regulations for repeat abortions? *If yes, please specify.*	☐	☐		

Continued on next page

3. Drugs and equipment	Yes	No	Comment	Source of information
Which methods are available? *If there are conditions on their use (time limits) please include them in the comments.*				
1. Mifepristone and misoprostol.	☐	☐		
2. Mifepristone and gemeprost.	☐	☐		
3. Misoprostol alone.	☐	☐		
4. Gemeprost alone.	☐	☐		
5. Methotrexate and misoprostol.	☐	☐		
6. Other medical methods.	☐	☐		
7. Manual vacuum aspiration.	☐	☐		
8. Electric vacuum aspiration.	☐	☐		
9. Dilatation and curettage.	☐	☐		
10. Dilatation and evacuation.	☐	☐		
11. Other surgical methods. *Please specify.*	☐	☐		
Are the following drugs registered in your country?				
12. Mifepristone (RU486).	☐	☐		
13. Misoprostol (Cytotec).	☐	☐		
14. Methotrexate.	☐	☐		
15. Gemeprost.	☐	☐		
16. What happens in practice?				

Continued on next page

3. Drugs and equipment continued	Yes	No	Comment	Source of information
17. Are some of these drugs available/obtained on the black market, or by mail or abroad? *If yes, please comment.*	☐	☐		
18. Is there significant use of self-induced abortion using the drugs?	☐	☐		

4. Cost of abortion services	Yes	No	Comment	Source of information
1. Does national insurance cover costs related to abortions? *If yes, please explain.*	☐	☐		
2. Is abortion available free of charge?	☐	☐		
3. If yes, under which circumstances?				
– If the woman is under 18 years of age.	☐	☐		
– If performed at a government hospital or clinic.	☐	☐		
– If the pregnancy is a result of a crime (rape, incest).	☐	☐		
– If the woman is living in conditions of poverty. *Please explain the criteria used.*	☐	☐		
– Other. *Please explain.*	☐	☐		
4. If no, how much does it cost?*				
– In a private clinic with beds.	☐	☐		
– In a private outpatient clinic.	☐	☐		
– In a government hospital/clinic.	☐	☐		
5. What is the cost of an abortion on the black market? *Please specify average cost and highest cost.*				

Continued on next page

* Please take this opportunity to compare the costs of the different methods of abortion in the different clinics (government, private, black market).

4. Cost of abortion services continued	Yes	No	Comment	Source of information
6. Is there an organizational policy on cost of abortion services: for example the maximum chargeable, client contributions etc?	☐	☐		
7. What happens in practice?				

5. Disposal of foetal tissue	Yes	No	Comment	Source of information
1. Are there regulations relating to the disposal of foetuses?	☐	☐		
2. If yes, which method is specified?				
– Incineration before 24 weeks.	☐	☐		
– Burial before 24 weeks.	☐	☐		
– Incineration after 24 weeks.	☐	☐		
– Burial after 24 weeks.	☐	☐		
– Method depends on woman's wishes.	☐	☐		
– Other. *Please explain.*	☐	☐		
3. Are there regulations about the location of the disposal? *Please explain.*	☐	☐		
4. Can a foetus be taken home by the client?	☐	☐		
5. What happens in practice?				

6. Social environment*	Comment	Source of information
1. What are the positions of the political parties on abortion? *Please consider all the main parties and answer accordingly.*		
2. What does the community think about abortion?		
– Religious leaders.		
– Parents' associations.		
– Teachers' associations.		
– Community activists.		
– Celebrities.		
3. What does the board of your organization think about abortion?		
4. What do the trustees/volunteers of your organization think about abortion?		
5. What do your staff think about abortion?		
6. What do your youth groups think about abortion?		

* The answers to these questions could be a result of a plenary discussion and could also lead to the identification of areas needing further exploration.

Continued on next page

6. Social environment continued	Yes	No	Comment	Source of information
7. How is abortion portrayed in the media?				
8. Are there active anti-choice groups? *Please specify.*	☐	☐		
9. Are there active pro-choice groups? *Please specify.*	☐	☐		

Now that you know the law, please refer to the IPPF Quality of Care Self-assessment Tool and the IPPF Medical and Service Delivery Guidelines on how to provide comprehensive high quality safe abortion services. See also the Further reading section on page 37.

Section 5 International and constitutional human rights instruments

It is important to have a good understanding of human rights treaties – their importance and your government's obligations to implementing the agreements in the treaties. It is also important to know which parts of which treaties could be applicable for access to safe abortion. The table on pages 82 and 83 shows some questions that you can explore about international and regional human rights instruments.

1. What does your constitution say about the implementation of international human rights instruments for protecting citizen's rights such as the right to non-discrimination, to health, to life, and to protection from inhuman and degrading treatment?

For further information, see:

- Ratifications and Reservations 2006, www.ohchr.org/english/countries/ratification/index.htm and
- The UN Status of Ratification of the Principal International Human Rights Treaties 2006, www.ohchr.org/english/bodies/docs/RatificationStatus.pdf

The Convention against Torture,* the Convention on the Rights of Persons with Disabilities,** and the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights*** documents may also be interesting and relevant.

The Africa Protocol on Women's Rights might also be relevant.

* Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, www.hrweb.org/legal/cat.html

** Convention on the Rights of Persons with Disabilities, www.un.org/disabilities/default.asp?id=150

*** Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights, www.achpr.org/english/_info/court_en.html

International and regional human rights instruments

	International human rights instruments					Regional human rights instruments	
	Universal Declaration of Human Rights	**International Covenant on Civil and Political Rights**	**International Covenant on Economic, Social and Cultural Rights**	**Convention on the Elimination of All Forms of Discrimination against Women**	**Convention on the Rights of the Child**	**American Convention on Human Rights**	
2. Which human rights instruments have your country signed up to?							
3. Which human rights instruments have your country ratified?							
4. Have any reservations been made? *Provide details relating to sexual and reproductive health and rights.*							
5. Have the treaty monitoring bodies made any recommendations or general comments relating to sexual and reproductive health and rights in your country? *Please provide details.*							
6. Have these instruments been codified in national legislation?							

				Conference documents		
	African Charter on Human and Peoples' Rights	European Convention on Human Rights	Arab Charter on Human Rights	Vienna	International Conference on Population and Development	Beijing

Section 6 Summary of national abortion law and policy

1. What are the legal conditions for abortion? *Include the time limits.*	
2. Who has to authorize the abortion?	
3. What are the main extra-legal barriers for eligible women to access legal services, for example costs, availability of methods, etc.	

Section 7 Next steps

1. What areas need clarification?

What areas need clarification?	Who is responsible?	When will it be done?

In order to provide services to the fullest extent of the law, and facilitate increased and easy access to safe abortion, what do you need to put in place? Consider:

- workshops with stakeholders on values clarification, raising awareness and commitment
- internal advocacy
- training at various levels
- information, education and communication activities
- staffing
- upgrading facilities, improving quality of care, introducing menstrual regulation or modern abortion techniques (manual vacuum aspiration, medical abortion)
- creating new facilities
- data collection, situational analysis (mainly using existing research)
- operational research
- partnering (for example with local representatives of IPPF, the World Health Organization, UNFPA, FIGO, Ipas, professional associations, students' associations, non-governmental organizations, Amnesty, human rights associations, Marie Stopes, Population Council, cooperating agencies, media representatives, decision makers, parliamentarians, lawyers, religious leaders and others).

2. What now needs to be put in place?

What needs to be put in place?	Who is responsible?	When will it be done?

3. Which areas do you need to advocate on?

What areas do you identify for advocacy?	Who is responsible?

4. What are the specific activities that you would like to undertake as a result of this exercise?

What activities should be undertaken?	Who is responsible?

Some ideas for moving forward to increase access to safe abortion

- Put in place a system to collect national, regional and international news on abortion-related issues. Collecting this information and data can support informed advocacy efforts and help staff to keep up to date with the latest news on abortion.
- Keep abreast of your country's human rights reporting requirements so that your organization can contribute to shadow reports to ensure that sexual and reproductive health issues, including abortion, are discussed by the relevant human rights bodies.
- Establish partnerships with sexual health, human rights and other organizations to take the agenda on safe abortion forward.

Photos by: IPPF/Irish Family Planning Association [front cover]; IPPF/Chloe Hall/Indonesia [page 4]; and IPPF/Jenny Matthews/Nepal [page 42].

IPPF

From choice, a world of possibilities

Access to safe abortion

A tool for assessing legal and other obstacles

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

Although there are very few countries where abortion is completely illegal (and even in most of these countries the "state of necessity" can be invoked to save a woman's life), in no country is access to abortion completely without barriers. There are always conditions placed which reflect a society's or a government's reluctance to allow women to access safe abortion. Such barriers are many and are incredibly complex.

In a given country or place, assessing the laws and the legal and other obstacles concerning access to safe abortion is a necessary preliminary step, if we want to know exactly how women can obtain legal, safe and comprehensive abortion care. This guide is an assessment tool that professionals and other interested people can use to become aware of legal and other obstacles that make access to safe abortion difficult or impossible.

The guide also highlights the injustice that women can face. We hope that you will be inspired to act against any such injustice where it exists.

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