



World Health
Organization

human
reproduction
programme **hrp.**
research for impact
UNDP · UNFPA · UNICEF · WHO · WORLD BANK

Towards a supportive law and policy environment for quality abortion care: evidence brief

Towards a supportive law and policy environment for quality abortion care: evidence brief

ISBN 978-92-4-006240-5 (electronic version)

ISBN 978-92-4-006241-2 (print version)

© **World Health Organization 2022**

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

Suggested citation. Towards a supportive law and policy environment for quality abortion care: evidence brief. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <https://www.who.int/copyright>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Towards a supportive law and policy environment for quality abortion care: evidence brief

Background

Access to quality abortion care is a critical public health, equality and human rights issue. Legal restrictions and other barriers mean many women¹ find it difficult or impossible to access quality abortion care and they may induce abortion themselves using unsafe methods or seek abortion from unskilled providers. Data show that abortion rates are not significantly different in countries where abortion is highly restricted compared with those where abortion is broadly legal (1). However, the proportion of abortions that are unsafe is significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws, and developing countries bear the burden of 97% of unsafe abortions (2). Putting in place evidence-based, human rights-compliant law and policy is one of the critical steps in ensuring an enabling environment – along with access to information and a well functioning health system – so that everyone who needs it has access to quality, comprehensive abortion care.

Aims of this brief

This evidence brief is intended to supplement the World Health Organization (WHO) *Abortion care guideline* (3), focusing on the recommendations related to law and policy. This brief provides illustrations of and insights into steps that can be taken at the national, local and health-care facility level to create an enabling environment for quality abortion care. While legal, regulatory, policy and service-delivery contexts may vary from country to country, this document aims to facilitate evidence-based decision-making with respect to quality abortion care.

KEY AUDIENCES

- Policy-makers
- Directors, managers and senior health workers at health-care facilities
- Civil society actors

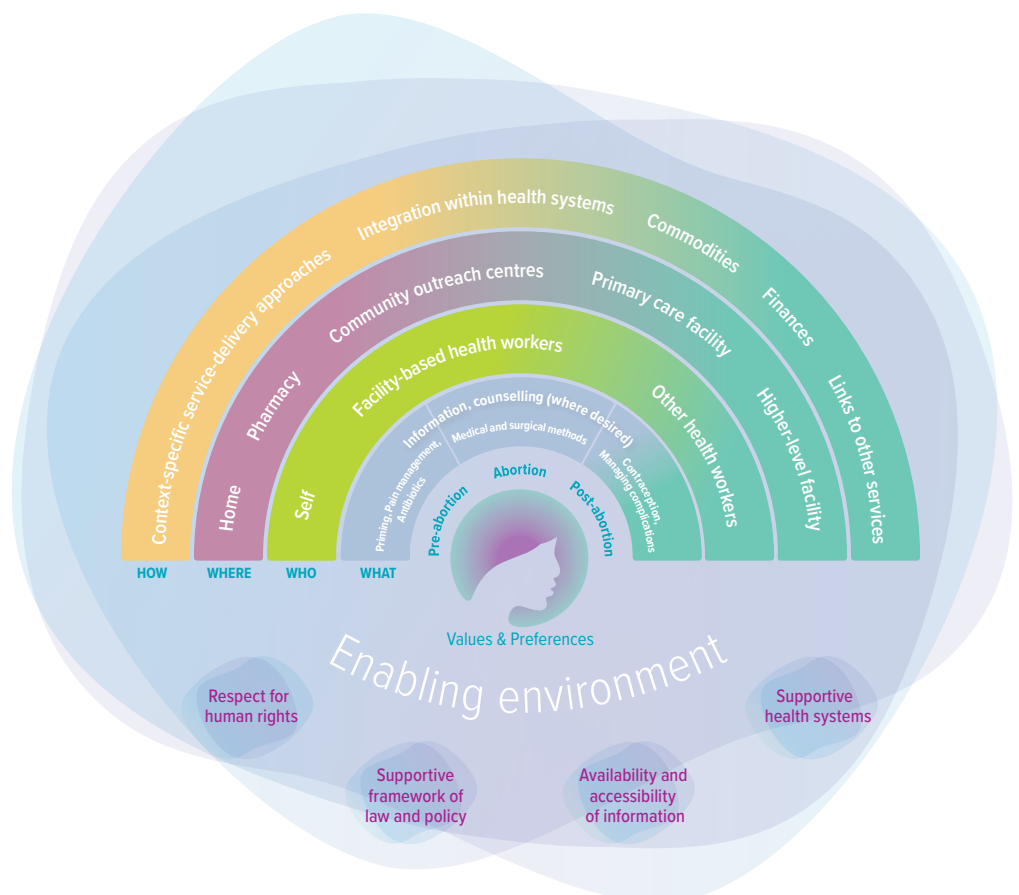
¹ WHO's *Abortion care guideline* and this evidence brief recognize that most of the available evidence on abortion can be assumed to be derived from research among study populations of cisgender women, and that cisgender women, transgender men, nonbinary, gender-fluid and intersex individuals with a female reproductive system and capable of becoming pregnant may require abortion care. To be concise and facilitate readability, when referring to all gender diverse people who may require abortion care, the guideline and this evidence brief use the word "women" most often, although the terms "individual", "person" and "abortion seeker" are also used. Providers of sexual and reproductive health services, including abortion care, must consider the needs of – and provide equal care to – all individuals; gender identity or its expression must not lead to discrimination.

What is quality abortion care?

Quality abortion care is comprehensive abortion care that is **effective** (evidence-based, improves the health of individuals and communities, responsive to needs), **efficient** (maximizes resource use, minimizes waste), **accessible** (timely, affordable, geographically reachable and provided in a setting where skills and resources are appropriate to medical need), **acceptable** (incorporating the preferences and values of individual service users and the context of their communities), **equitable** (without disparities between populations) and **safe** (by the safest means possible and in a way that reduces avoidable harm). Underpinning these components is the principle that abortion care be provided in a human rights-compliant way.

Comprehensive abortion care comprises information, abortion management (including induced abortion and care related to pregnancy loss), and post-abortion care.

What is an enabling environment for quality abortion care?



An enabling environment is the foundation of quality, comprehensive abortion care. The three cornerstones of an enabling environment are:

- Respect for human rights, including supportive law and policy
- The availability and accessibility of information, and
- A supportive, universally accessible, affordable and well functioning health system.

The *Abortion care guideline* explains that supportive law and policy for quality abortion care means:

- Countries ratify international and regional human rights treaties and conventions addressing health, including sexual and reproductive health (SRH).
- Laws and policies promote SRH for all, and are consistent with sexual and reproductive health and rights.
- There are appropriate administrative, political and judicial arrangements to facilitate quality abortion care, including accessible, transparent and effective mechanisms providing remedies. These include:
 - accessible mechanisms for women to challenge denial of abortion in a timely manner, and
 - appropriate monitoring mechanisms for failure to facilitate quality care, including regular review and reform of law and policy to recognize and remove barriers to quality abortion care.
- Policies minimize the rate of unintended pregnancy by providing quality contraceptive information and services, including a full range of contraceptive methods (emergency, short-acting and long-acting methods).
- All people and communities receive the health services they need, without suffering financial hardship and without any discrimination.

For further details on the components of an enabling environment for abortion care, please refer to [section 1.3](#) of the guideline document, including Box 1.1 (3).

What does the *Abortion care guideline* say about law and policy?

Most countries regulate abortion² in ways that pose barriers to quality abortion care. This includes criminalizing abortion, imposing restrictions on when abortion is legal – or which health workers can provide it – that are not based on clinical or rights-based considerations, and imposing requirements that must be met before abortion can be obtained. The *Abortion care guideline* builds on previous WHO recommendations related to the removal of regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care (4, p. 9), now providing seven specific, interdependent, and interrelated recommendations for law and policy.

RECOMMENDATION 1: Criminalization

Recommend the full decriminalization of abortion.

RECOMMENDATION 2: Grounds-based approaches

a. *Recommend against* laws and other regulations that restrict abortion by grounds.

b. *Recommend* that abortion be available on the request of the woman, girl or other pregnant person.

RECOMMENDATION 3: Gestational age limits

Recommend against laws and other regulations that prohibit abortion based on gestational age limits.

RECOMMENDATION 6: Mandatory waiting periods

Recommend against mandatory waiting periods for abortion.

RECOMMENDATION 7: Third-party authorization

Recommend that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution.

RECOMMENDATION 21: Provider restrictions

Recommend against regulation on who can provide and manage abortion that is inconsistent with WHO guidance.

RECOMMENDATION 22: Conscientious objection

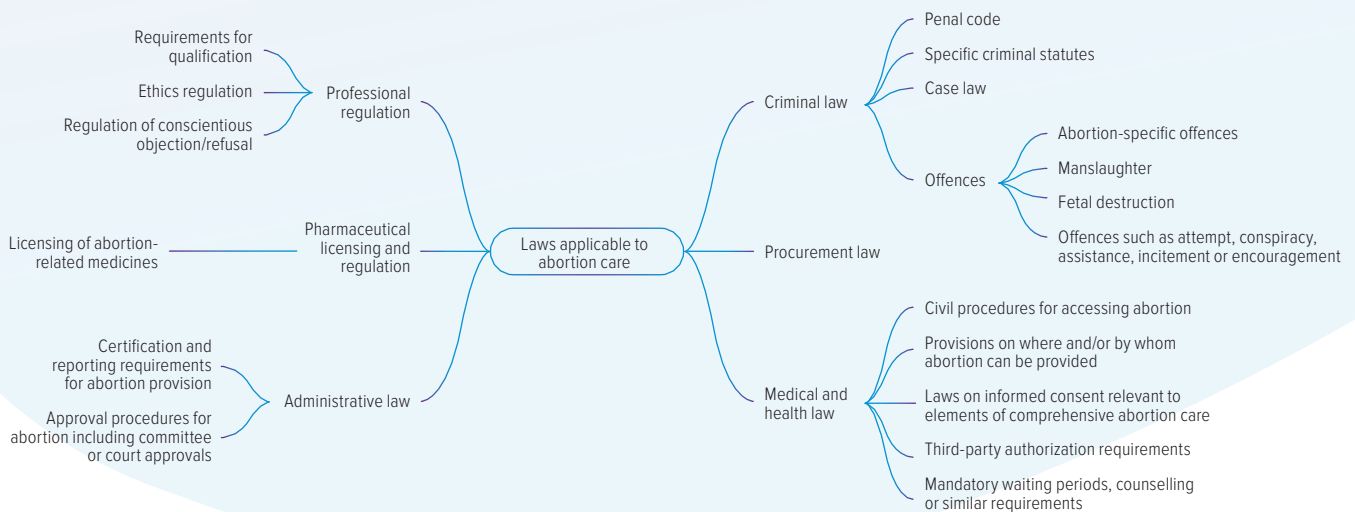
Recommend that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.

² Throughout, this refers to consensual abortion. Forced or coerced abortion would constitute serious assaults and serious human rights violations (i.e. torture, cruel, inhuman or degrading treatment).

Law, policy and abortion care

The law and policy that governs comprehensive abortion care varies widely across countries and settings. In most countries, “abortion law” comprises a wide range of laws, regulations and policies. These can include criminal law, medical law, health law, administrative law, pharmaceutical regulation, procurement law, professional regulation of health workers, employment law and contract law, among others. Such legal frameworks may also interact with other areas of law and policy – for example on HIV, contraception or maternal health – in the context of abortion. In some jurisdictions, there may be very little formal law on abortion, while in others, the laws on abortion may be extensive and might contain contradictions or inconsistencies.

FIGURE: Mapping applicable laws



All seven of the issues addressed by the recommendations – criminalization, grounds-based approaches, gestational age limits, mandatory waiting periods, third-party authorization, provider restrictions and conscientious objection – pose barriers to access to abortion and have negative effects on the exercise of human rights. Furthermore, barriers and harms sometimes result from how law and policy are applied in practice. For example, women are sometimes subjected to unnecessary demands like requiring spousal consent even when the law does not mandate this, refusals to provide abortion where health workers consider the woman “undeserving” even though the law permits abortion in her case, or a health worker’s refusal to refer the woman to a different health worker who is willing to provide abortion even if such referral is required by law.

Factors that impact how abortion-related laws and policies are applied in practice to limit access to quality abortion include: a lack of legal clarity, lack of clear guidance, biases based on personal preferences or opinions, lack of knowledge or understanding of the law, facility-level policy that is more restrictive than the law, failure to ensure sufficient funding for provision of abortion care through public health systems, financial incentives to divert women from publicly funded to privately paid-for (out of pocket) abortion care, stigma of abortion, harmful gender stereotypes (e.g. women viewed primarily as childbearers and mothers), and over-cautious interpretation of law because of the criminalization of abortion outside of limited circumstances.

In many settings, practices have been developed to mitigate these barriers; these provide useful insights into effective pathways to reform. Such practices include: self-managed abortion, the provision of information and direct assistance through women’s organizations and peer-support groups, the application of progressive interpretations of existing legislation to increase access to quality abortion, and the existence of a mechanism to promptly appeal denial of abortion. Where they have been used, knowledge of these practices and their effects already exists and is available to legislators and policy-makers through the work of civil society organizations, public health researchers and others.

Implementing the seven recommendations on law and policy contained in the guidance can help to ensure that law and policy supports quality abortion care. Aligning health system practices with these recommendations is likely to require reform to law, technical protocols and facility-level policies; this process will also enable States to fulfil their international human rights obligations to reform laws that are discriminatory and harmful (5, 6, 7, 8).

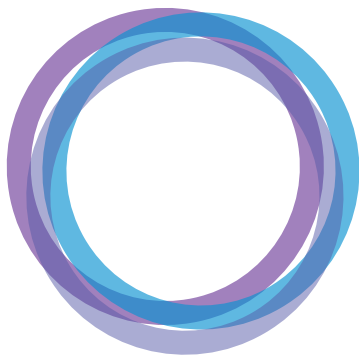
Supportive law and policy

The aim of implementing the law and policy recommendations in the *Abortion care guideline* is to establish some of the core components of an enabling environment for quality abortion. WHO's 2006 quality of care framework provides a practical approach to identifying the steps required to ensure quality of care, including the role of law and policy (9). This framework is reflected in the *Abortion care guideline* recommendations, including the seven relating to law and policy. The framework, which provides practical guidance on the right to the highest attainable standard of physical and mental health, defines quality care as being effective, efficient, accessible, acceptable/patient centred, equitable and safe.³

Attribute of quality care	Meaning	Law and policy implications	Relevant recommendations ⁴
Effective	Care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need	Law and policy that is based on international human rights standards and aims at maximizing health outcomes	All 54 recommendations in the guideline
Efficient	Care delivered in a manner that optimizes resource use and avoids waste	Removing law and policy that contributes to resource diversion and drain, such as additional record keeping due to criminalization, additional file preparation due to grounds-based approaches, or provider shortage due to provider restrictions	<i>Law and policy:</i> 1, 7, 21, 22 <i>Service delivery:</i> 19, 20, 24, 26, 28, 30, 33, 37, 38, 39, 40, 44, 45, 46, 47, 48 <i>Clinical services:</i> 23, 25, 27, 29, 31, 32, 35, 36, 41, 42, 43 <i>Self-management:</i> 49, 50
Accessible	Care that is timely, geographically reachable, and provided in a setting where skills and resources are appropriate to medical need	Law and policy that does not impose unnecessary delays through restrictions like mandatory waiting periods, third-party authorization requirements, or grounds- and criminalization-related processes of certification or investigation Law and policy that is based on international human rights standards and ensures continuity of care, including timely and appropriate referral in cases of conscientious objection or refusal, and removal of provider restrictions that do not align with WHO guidance	<i>Law and policy:</i> 1, 2, 3, 6, 7, 21, 22 <i>Service delivery:</i> 4, 5, 19, 20, 39, 40, 43, 48, 49 <i>Clinical services:</i> 10, 34, 41, 42, 43 <i>Self-management:</i> 49, 50
Acceptable/ person-centred	Care that takes into account the preferences and aspirations of individual service users and the cultures of their communities	Law and policy that ensures respect for the informed choices and wishes of those seeking abortion, is based on international human rights standards, and does not stigmatize women's choices through biased or inaccurate information, mandatory waiting periods, third-party authorization requirements, criminalization, or grounds-based approaches	<i>Law and policy:</i> 1, 2, 3, 6, 7, 22 <i>Service delivery:</i> 4, 5, 49 <i>Clinical services:</i> 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 31, 34, 48 <i>Self-management:</i> 50, 51, 52, 53, 54
Equitable	Care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status	Law and policy that is based on international human rights standards and aims at maximizing health outcomes, including removal of law and policy that hinder access to abortion	<i>Law and policy:</i> 1, 2, 3, 7, 21, 22 <i>Service delivery:</i> 4, 5 <i>Clinical services:</i> 47 <i>Self-management:</i> 49, 50
Safe	Care that minimizes risks and harm to service users	Removal of legal impediments to ensuring safe care, such as unnecessary provider or facility restrictions, or non-evidence-based pharmaceutical restrictions on abortion medicines	<i>Law and policy:</i> 1, 21, 22 <i>Service delivery:</i> 24, 26, 28, 30, 33, 37, 38, 39, 40 <i>Clinical services:</i> 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 23, 25, 27, 29, 31, 32, 35, 36, 41 <i>Self-management:</i> 50, 51, 52, 53, 54

³ In a later document (2018), WHO builds on this framework with a view to providing further nuance for operational purposes. While the core elements remain the same, the later framework articulates further the components of quality care as being effective, safe, people centred, timely, equitable, integrated and efficient. See *Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care*, available at: <https://apps.who.int/iris/handle/10665/272357>.

⁴ These are indicative recommendations. All recommendations are relevant to all attributes, but we include here recommendations that bear direct relevance to the corresponding attribute in order to demonstrate how the guidance, including its law and policy recommendations, relates to quality of care.



Immediate practical changes to implement

Recognizing that changing laws and policies is an iterative process, to get started, there are practical changes to support quality abortion care than can be implemented immediately. While these will vary according to local context, they might include suspending the use of criminal law as it applies to abortion, providing information on abortion, taking practical steps to put the pregnant person at the centre of the process and respect her informed choices, arranging for continuity of care (including prompt referral in cases of conscientious objection), and providing clear guidance to health workers on rights-based abortion care.

While some of these actions can only be done by the government, other immediate changes could be undertaken by individual health workers and health-care facilities. The exact form these actions take will depend on factors like the existing law, the availability of resources, and the existing organization of the health system. The table below provides indicative examples of possible immediate actions, accompanied by illustrative case studies.

Action	Government	Health-care facilities	Health workers	Illustrative case study of the actions
Suspend the application of and repeal criminal law	<p>Repeal obligations to report suspected abortion.</p> <p>Make clear that health workers are not required or expected to report suspected abortion.</p> <p>Stop arrests, investigations and prosecutions for abortion.</p> <p>Release persons in prison for abortion-related offences.</p>	<p>Explain to health workers and women that investigations, prosecutions and punishment for abortion are no longer taking place.</p> <p>Develop facility-level policies and guidance for providing abortion care.</p>	<p>Provide care in compliance with government policy on suspension or repeal of criminal law, e.g. do not report suspected abortion to law-enforcement authorities.</p> <p>Provide quality abortion care based on women's preferences.</p>	<p>Abortion was a crime in Northern Ireland (10). In 2018, the United Kingdom Supreme Court confirmed that criminalizing abortion in cases of fatal fetal abnormality, rape and incest was not compatible with the European Convention on Human Rights, following an application by the Northern Ireland Human Rights Commission (11). Also in 2018, the Committee on the United Nations Convention on the Elimination of all forms of Discrimination against Women stated that the law breached women's rights, and recommended immediate suspension of all prosecutions, investigations and arrests (12). This was done in 2019; abortion was decriminalized and interim guidance was published (13). Following a consultation, the legal framework for abortion provision was developed in 2020–2021 (14, 15) (i.e. abortion was legalized). The subsequent commissioning of services to provide abortion was substantially delayed.</p>
Put the person at the centre	<p>Stop requirements for third-party authorization for abortion.</p> <p>Promote rights-based interpretation and application of existing law, including interpreting any existing grounds broadly and in alignment with the WHO definition of health.⁵</p> <p>Remove any mandatory waiting periods for abortion.</p> <p>Make provision for non-biased, voluntary counselling.</p> <p>Repeal non-evidence-based provider restrictions.</p>	<p>Provide a welcoming, safe and supportive environment for abortion seekers.</p> <p>Cease outdated practices in abortion care, and adjust existing protocols to reflect evidence-based recommendations.</p> <p>Cease any unrequired authorization or procedures for verification of grounds, and facility-level mandatory waiting periods.</p> <p>Familiarize health workers with rights-based interpretation of existing law, including any existing grounds.</p> <p>Repeal facility-level non-evidence-based provider restrictions.</p>	<p>Provide respectful health care.</p> <p>Familiarize self with and apply rights-based interpretation of existing law, including any existing grounds.</p> <p>Cease any practices of questioning or seeking to verify abortion seekers' representations relating to, for example, their age, experience of rape or sexual violence.</p> <p>Cease outdated practices in provision of abortion care, and develop practices that are in line with evidence-based recommendations.</p> <p>Recognize one's own biases and take steps to ensure they do not impact on provision of abortion care.</p>	<p>Access to quality abortion remains difficult in Colombia, and many women do not seek abortion within the health system because of fear of criminalization (16). The Constitutional Court of Colombia held that abortion must be available where pregnancy is a result of non-consensual sexual activity, where the pregnant woman's physical or mental health is at risk, and where the pregnancy involves fetal malformation incompatible with life (17). Most legal abortions are provided on the health ground. Nongovernmental organizations (NGOs) and other experts have co-developed a rights-based, broad interpretation of the grounds for legal abortion, with a focus on ensuring that "health" is understood broadly, and reflects the WHO definition of health⁵ (18).</p> <p>In 2005, Ethiopia reformed its law to allow abortion where pregnancies result from rape or incest, if the fetus has a severe malformation, or where the pregnant woman is under 18 (19). It is also permitted when there is a risk to the woman's life. <i>The Technical and procedural guidelines for safe abortion services in Ethiopia</i> (20) affirm a woman-centred approach, explaining that the woman's statement of her age being under 18 or claim of rape or incest are sufficient to authorize abortion, and that eligible women should receive abortion within three days of contacting the health services. The guidelines define woman-centred abortion care as including services "that support women in exercising their sexual and reproductive rights" (20).</p>

⁵ Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (30).

Action	Government	Health-care facilities	Health workers	Illustrative case study of the actions
Provide information	<p>Publicize government policy on suspension or repeal of criminal law.</p> <p>Provide accurate information on abortion, including on when, where and how abortion is available.</p>	<p>Publicize decriminalization in clear, accessible ways appropriate to the population being served.</p> <p>Provide accurate information on abortion.</p>	<p>Reassure women about the suspension or repeal of criminal law.</p> <p>Provide person-specific and accessible information on abortion.</p>	<p>In 2007, Mexico City reformed its abortion law to define “abortion” for legal purposes as “the interruption of pregnancy after the 12th week of gestation” (21). In practice, this means that pregnancy can be terminated on request up to 12 weeks. As part of its implementation efforts, Mexico City established a 24-hour hotline, which provides information on available free and legal abortion services. Information was also distributed by NGOs on national and local radio, in the Metro (rapid transit) system, through flyers and online. More than 85% of the population of Mexico City reports knowing about the programme (22).</p>
Ensure access to sustainable and integrated services	<p>Identify, fund and implement person-centred care pathways, at a minimum where the life and health of the woman, girl or other pregnant person is at risk, or where carrying a pregnancy to term would cause them substantial pain or suffering.</p> <p>If necessary, arrange and fund transfer of care outside the jurisdiction, with agreement of the receiving jurisdiction.</p> <p>Implement any required changes to ensure availability of appropriate goods and medicines.</p> <p>Make provision for multiple service-delivery models.</p> <p>Implement clear requirements for timely referral by conscientious objectors, as applicable.</p> <p>Put in place an accessible process for timely appeal against denial of abortion.</p>	<p>Provide timely referral where SRH services are not available in the facility, including in cases of conscientious objection.</p>	<p>Familiarize oneself with the identified care pathways.</p> <p>Provide timely referral where one does not provide relevant care, including in cases of conscientious objection.</p>	<p>In 2002, Nepal liberalized its law and allowed for abortion in certain circumstances (23), and the Safe Pregnancy Termination Procedural Order was approved in 2003 (24), at which stage abortion provision under the new law began. Policies and actions that were implemented to ensure access to sustainable and integrated services included:</p> <ul style="list-style-type: none"> • authorizing facilities to provide abortion services • setting out a clear fee structure for abortion care provision • coordinating with private sector providers • outlining clinical techniques to be used, including introducing medical abortion • establishing clear referral practices and care pathways into facility-level care • providing training for and sensitizing health workers • authorizing staff nurses and auxiliary nurse midwives to provide medical abortion. <p>In 2012, the Nepal Supreme Court guaranteed access to affordable abortion services (25).</p> <p>In 2021, Argentina introduced legal abortion on request during the first 14 weeks of pregnancy (26). While the law permits conscientious objection by an individual health worker, this is regulated in a clear way. Institutions/facilities may not claim conscientious objection. If an institution does not have a health worker willing to provide abortion services, the attending health worker must refer the abortion seeker to another health worker who can provide abortion services. The cost of the woman’s travel to the provider must be covered by the referring practitioner/institution. Health workers may not refuse to terminate the pregnancy if the pregnant person’s life or health is in danger, requiring immediate and urgent attention. Conscientious objection may not be used by practitioners as a basis for refusing to provide post-abortion health care (26, 27).</p>

Questions to help inform law- and policy-makers

Indicative questions relating to each law and policy recommendation in the guideline, and based on human rights standards, are provided in the table below. These questions reflect those that WHO and the United Nations Population Fund (UNFPA) have previously outlined to guide those responsible for setting law and policy in developing an enabling environment for quality abortion (28, 29). It may be useful to consider these questions when examining the law and policy implications in a specific setting.

Recommendation	Indicative questions
1. <i>Recommend</i> the full decriminalization of abortion.	<p>Are there any criminal offences associated with abortion?</p> <p>Who do the offences apply to?</p> <p>Are any criminal laws applied to anyone who avails of, supports someone who avails of, provides or becomes aware of abortion?</p> <p>Have any persons been arrested, prosecuted or sentenced in relation to abortion? If so, what provisions of the law were used?</p> <p>Are people reported for suspected abortions? If so, who is reported, and by whom?</p> <p>Do the laws have disproportionate impacts on particular groups?</p> <p>Has the State considered the negative health consequences of criminalization?</p>
2a. <i>Recommend against</i> laws and other regulations that restrict abortion by grounds. 2b. <i>Recommend</i> that abortion be available on the request of the woman, girl or other pregnant person.	<p>On what grounds is abortion available?</p> <p>How are those grounds interpreted and applied in practice?</p> <p>In practice, are people able to access abortion on those grounds?</p> <p>Are informal grounds applied at health-care facility or health worker level?</p> <p>Do laws, regulations and policies guarantee the provision of quality abortion care in line with human rights?</p> <p>Are health workers educated and trained to provide rights-based services related to abortion?</p>
3. <i>Recommend against</i> laws and other regulations that prohibit abortion based on gestational age limits.	<p>Are there gestational age limits for access to abortion?</p> <p>Are informal gestational age limits applied at facility or health worker level?</p> <p>In practice, are people able to access abortion according to these gestational age limits?</p> <p>Do laws, regulations and policies guarantee the provision of quality abortion care in line with human rights?</p>
6. <i>Recommend against</i> mandatory waiting periods for abortion.	<p>Does the law impose a mandatory waiting period for access to abortion?</p> <p>Are informal mandatory waiting periods imposed at facility or health worker level?</p> <p>Do laws, regulations and policies guarantee the provision of quality abortion care in line with human rights?</p>
7. <i>Recommend</i> that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution.	<p>Is abortion available in law and in practice without the authorization of any third party, including parents, spouses, courts, committees or multiple medical professionals?</p> <p>Are people's rights to confidentiality and privacy effectively protected?</p>
21. <i>Recommend against</i> regulation on who can provide and manage abortion that is inconsistent with WHO guidance.	<p>Are there restrictions on the categories of health workers who can provide abortion care?</p> <p>Do these restrictions reflect the evidence on which health workers can safely and efficiently provide quality abortion care, as contained in the WHO guidance?</p> <p>Are pregnant women recognized as capable of self-management of medical abortion (any or all component parts of the process)?</p>
22. <i>Recommend</i> that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.	<p>Does the exercise of conscientious objection jeopardize people's access to quality abortion?</p> <p>Is conscientious objection regulated so that it does not operate as a barrier to those wishing to access abortion?</p>

Conclusion

Laws and policies on abortion that are designed with quality of care in mind can contribute to ensuring an enabling environment in which women can avail of, and health workers can provide, quality abortion care and enjoy the full range of sexual and reproductive health and rights (SRHR). With a clear understanding of the relevant law and its application, law- and policy-makers can identify ways in which the law, policy and other elements of an enabling environment could be organized to maximize access to SRHR, including quality abortion care, to align with the recommendations in [the WHO guidance](#) and with [international human rights law](#). Legislators and policy-makers will thus be equipped to undertake context-appropriate, rights-based and effective reform to ensure supportive law and policy for access to quality abortion.

References

1. Bearak J, Popinchalk A, Ganatra B, Moller AB, Tunçalp Ö, Beavin C, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *Lancet Glob Health*. 2020;8(9):e1152–61. doi:10.1016/S2214-109X(20)30315-6.
2. Ganatra B, Gerdtts C, Rossier C, Johnson BR, Tunçalp Ö, Assifi A, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *Lancet*. 2017;390(10110):2372-81.
3. Abortion care guideline. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/349316>).
4. Safe abortion: technical and policy guidance for health systems, second edition. Geneva: World Health Organization; 2012 (<https://apps.who.int/iris/handle/10665/70914>).
5. General Comment No. 22: The right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights). Geneva: United Nations Committee on Economic, Social and Cultural Rights; 2016 (E/C/12/GC/22).
6. General Comment No. 36: Article 6 of the International Covenant on Civil and Political Rights, on the right to life. Geneva: United Nations Human Rights Committee (124th session); 2018 (CCPR/C/GC/36).
7. General Recommendation No. 34: The rights of rural women. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2016 (CEDAW/C/GC/34).
8. General Recommendation No. 35: Gender-based violence against women, updating general recommendation No. 19. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2017 (CEDAW/C/GC/35).
9. Quality of care: a process for making strategic choices in health systems. Geneva: World Health Organization; 2006 (<https://apps.who.int/iris/handle/10665/43470>).
10. Offences against the Person Act 1861. Chapter 100. UK Public General Acts.
11. In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland). United Kingdom Supreme Court; 2018 ([2018] UKSC 27).
12. Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2018 (CEDAW/C/OP.8/GBR/1; <https://digitallibrary.un.org/record/1480026>).
13. Northern Ireland (Executive Formation etc.) Act 2019. Chapter 22. UK Public General Acts.
14. The Abortion (Northern Ireland) Regulations 2020. No. 345. Health and Personal Social Services, Northern Ireland. UK Statutory Instruments.
15. The Abortion (Northern Ireland) Regulations 2021. No. 365. Health and Personal Social Services, Northern Ireland. UK Statutory Instruments.
16. Determinantes del aborto inseguro y barreras de acceso para la atención de la interrupción voluntaria del embarazo en mujeres colombianas. Bogotá: Ministerio de Salud y Protección Social, United Nations Population Fund; 2014.
17. Decision C-355/2006. 10 May 2006. Topics: Abortion. Bogotá: Constitutional Court of Colombia; 2006.
18. González Vélez AC. “The health exception”: a means for expanding access to legal abortion. *Reprod Health Matters*. 2012;20(40):22–9. doi:10.1016/s0968-8080(12)40668-1.
19. The Criminal Code of the Federal Democratic Republic of Ethiopia. Proclamation No. 414/2004. Addis Ababa: Federal Democratic Republic of Ethiopia; 2005.
20. Technical and procedural guidelines for safe abortion services in Ethiopia. Addis Ababa: Federal Democratic Republic of Ethiopia, Family Health Department; 2006.

21. Decree reforming the Federal District Penal Code and amending the Federal District Health Law [in Spanish]. Mexico City: Official Gazette of the Federal District; 2007;(70):2–3.
22. Van Dijk MG, Arellano Mendoza LJ, Arangure Peraza AG, Toriz Prado AA, Krumholz A, Yam EA. Women's experiences with legal abortion in Mexico City: a qualitative study. *Stud Fam Plann*. 2011;42(3):167–74. doi:10.1111/j.1728-4465.2011.00278.x.
23. Muluki Ain (Eleventh Amendment), 2059 No. 28(a), Chapter on Life. Government of Nepal; 2002.
24. Safe Pregnancy Termination Service Order, 2059. Kathmandu: Richoi Associates; 2002.
25. Nepal Supreme Court, Lakshmi Dhikta v. Government of Nepal, Writ petition No. WO-0757, 2067 (2007).
26. Ley 27.610: Acceso a la Interrupción Voluntaria del Embarazo, 30 December 2020. Buenos Aires: Honorable Congreso de la Nación Argentina; 2021.
27. Ley 27.610. Estándares legales para la atención de la interrupción del embarazo, Nota tecnica 3. Dirección Nacional de Salud Sexual y Reproductiva, Ministerio de Salud, Argentina; 2021.
28. Sexual health, human rights and the law. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/175556>).
29. A guide in support of national human rights institutions: country assessments and national inquiries on human rights in the context of sexual and reproductive health and well-being. New York (NY): United Nations Population Fund; 2019 (https://unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2019_EN_Support_of_national_human_rights_report_29_online.pdf).
30. Constitution of the World Health Organization. Adopted in 1946. Entered into force in 1948. Geneva: World Health Organization; 1946 (<https://www.who.int/about/governance/constitution>).

For more information, please contact:

Department of Sexual and Reproductive Health and Research

World Health Organization
20, avenue Appia
1211 Geneva 27
Switzerland

Email: srhrp@who.int

Website: [https://www.who.int/teams/sexual-and-reproductive-health-and-research-\(srh\)](https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh))

