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Policy surveillance for a global analysis of national abortion laws

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Abstract: *Policy surveillance offers a novel and important method for comparing law across jurisdictions. We used policy surveillance to examine abortion laws across the globe. Self-managed abortion, which generally takes place outside formal healthcare settings, is increasing in prevalence and can be safe. We analysed provisions that do not account for the prevalence of self-managed abortion and evidence of its safety. Such provisions require that abortion take place in a formal healthcare setting. We also analysed criminal penalties for non-compliance. Our method included development of a legal framework, an iterative process of refining coding schemes and procedures, and rigorous quality control. We limited our analysis to liberal abortion laws for two reasons. Abortion laws globally trend towards less restrictive. In addition, we aimed to focus on how laws relate to abortion outside a formal healthcare setting specifically and excluded laws that prohibit abortion more broadly. We found that in all countries with liberal national abortion laws, the law permits only healthcare professionals or trained health workers to perform legal abortion and the majority require the abortion to take place in a specified health facility. With policy surveillance methods we can illuminate characteristics of law across many jurisdictions and the need for widespread reform, toward laws that reflect scientific evidence and the way people have abortions.* DOI: 10.1080/26410397.2022.2064208

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Background

The use of medications for self-managed abortion is safe, effective, and an increasingly common method for ending unwanted pregnancy.[1–5] While governments around the world are reforming abortion laws to make them less restrictive, reformed laws generally do not accommodate the practice of self-managed abortion.[6] We set out to use policy surveillance – a scientific method that can be used to analyse legal data across multiple jurisdictions – to examine abortion laws across the globe as they relate to self-managed abortion.

Self-managed abortion describes when "a pregnant person performs their own abortion without clinical supervision."[7] People who self-manage their abortions with medication may get drugs from pharmacies, drug sellers or through online services or other outlets.[4,8] They can receive information on how to end a pregnancy with pills and what to expect through the process from friends, family, community groups, hotlines, pharmacists and medicine sellers, or the internet.[7] For some people, abortion outside the formal health setting may be preferable to in-clinic abortion, particularly for groups who face systematic discrimination and lack accessible and acceptable formal health care. During the COVID-19 pandemic, self-managed abortion has become even more important for people seeking abortion, to avoid risk of infection associated with an in-person visit with a healthcare provider and the associated travel.[9]

Governments around the world have liberalised abortion laws to improve access and uphold human rights. However, even recently liberalised abortion laws continue to impose medically unnecessary requirements for abortion which are not based on evidence.[6] Evidence is growing that people can safely end their pregnancies with misoprostol alone or with mifepristone, without the involvement of a healthcare worker and outside a healthcare facility.[1–5] As access to and awareness of abortion with medicine has grown, abortion outside formal healthcare settings has become safer. Previously, pregnant people ended pregnancies outside formal healthcare settings through invasive methods such as sticks, chemicals, or physical force.[10] But with non-invasive medicines, the risk to health and life associated with clandestine abortion is reduced. In its new Abortion Care Guideline, the World Health Organization recommends, for abortions at fewer than 12 weeks, the option of self-management of the medical abortion process, in whole or in part.[11] Researchers have attributed self-managed abortion with pills to a worldwide decrease in abortion mortality.[12]

In many countries, abortion is specifically regulated by the criminal law. Generally, national abortion laws impose criminal penalties on people who seek abortion, individuals who help them (including providers), or both, and allow exceptions to criminalisation for specific reasons.[13,14] or within an allowable gestational period.[15] Where abortion is broadly legal, abortion laws set out certain conditions under which abortion is permitted, which include performance of abortion in specific healthcare facilities or by specific cadres of healthcare professionals. However, such conditions overall do not reflect current evidence of the safety of medical abortion.

Methods

We used policy surveillance, a public health law research method,[16] to assess requirements that abortion be provided within the formal health care system contained in abortion laws globally.[17] Our research represents the first application of policy surveillance methods to abortion laws globally. This method included development of a legal framework, an iterative process of refining coding schemes and procedures, and rigorous quality control. We created a protocol and codebook for the research, available online.[18]

With traditional methods of analysing law, legal researchers are challenged to compare law across many jurisdictions. This is especially true for global comparisons of national abortion law and the conditions required for legal abortion around the world, due to the large number of both provisions and jurisdictions. For a global depiction, lawyers and researchers have categorised laws according to the grounds under which abortion is allowed.[19] However, such categorisation neglects requirements for legal abortion such as third-party consent requirements, requirements around who can perform the abortion and where, and waiting periods, among others.[11,20] Since 2017, researchers have been afforded access to information on requirements for legal abortion via the Global Abortion Policies Database (GAPD), created by the World Health Organization,[21] but rigorous methods for comparing abortion laws and policies globally have been lacking.

Policy surveillance, a scientific method that can be used to analyse legal data across multiple jurisdictions, can help. Policy surveillance is the "systematic, scientific collection and analysis of laws of public health significance."[22] Data created from policy surveillance has been used for a variety of research and advocacy purposes, including comparing health outcomes across jurisdictions[23] and to evaluate and rank jurisdictions to advocate for policy change.[24] The Policy Surveillance Program at Temple University Law School's Center for Public Health Law Research has used policy surveillance methods to provide a general overview of abortion regulation under US state law, through the creation of a database covering 15 types of abortion regulation.[18,25]

Legal framework

Given the growing prevalence of self-managed abortion and evidence of its safety, we focused on provisions that do not fit the practice of self-managed abortion. We identified features of abortion law that fail to accommodate evidence around self-managed abortion through previous legal research. These provisions require the abortion-seeker to interact with healthcare workers or visit healthcare facilities to obtain legal abortion.[26] We narrowly examined the law as written and did not account for specific interpretations by courts of law or understanding among law enforcement or activist groups. Many varied actors

and actions facilitate access to self-managed abortion around the world.[27] In some contexts, law enforcement authorities or courts may consider self-managed abortion and the actions to support it outside the purview of the abortion law. However, the application and enforcement of law was not within the scope of our research.

We situate our research in the context of growing liberalisation of national abortion laws over the past few decades, as governments act to make abortion more accessible.[28] With a few notable exceptions – including the United States, Nicaragua, and Poland – changes to abortion laws worldwide have favoured fewer restrictions.[29] Approaches to regulation of abortion law are contested in countries across the globe but we assume here that governments that enact liberal laws do so generally in support of abortion access. Here we analysed laws that are liberal, which we define as allowing abortion for economic grounds, social grounds, and/or any grounds and omitted those that are more restrictive.

We identified provisions of liberal abortion laws that fail to accommodate both current evidence of medical abortion safety and the growing prevalence of abortion without supervision of a healthcare worker and outside a health facility. We analysed requirements that permit only healthcare professionals or trained health workers to provide an abortion or verify that an individual's circumstances are within permissible grounds prior to an abortion. Such requirements could allow for telemedicine abortion, which includes interaction with a healthcare professional remotely, as do recent regulatory changes in response to COVID-19.[30] We also analysed provisions that only permit abortion when it takes place within a health facility.

Restrictive abortion laws prohibit all abortions, including those that take place inside a formal health setting and under supervision of a healthcare professional. Restrictive laws also reflect lawmakers' interest in limiting abortion access. Therefore, provisions within restrictive abortion laws are not germane to our specific focus on abortion outside formal healthcare settings. As governments around the globe reform laws to allow abortion in a greater number of circumstances and increase access to abortion, we highlight barriers that apply to abortion outside the formal health care system, including self-managed abortion, for consideration in future reform.

Collection of laws and relevant provisions

To obtain legal text, researchers collected laws and, in most cases, extracted text from the WHO Global Abortion Policies Database. The GAPD is a project of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) in partnership with the Population Division of the United Nations Department of Economic and Social Affairs (UNDP). Where legal text was unavailable through GAPD, researchers extracted text from other sources (detailed below). While the GAPD provides data on specific characteristics of abortion law, researchers for this project only used the GAPD for source documents.

The GAPD was compiled by staff at WHO and UNDP (the secretariat). The secretariat identified data-collection partners based on "working capacity, language proficiencies, and professional networks that might aid in source document retrieval."[31] Partners developed document search strategies based on suggestions by the secretariat. Search strategies are detailed in the methods document available through the database and include: general Google searches; specific specialised database searches; searches of ministry of health and ministry of justice websites; requests to personal contacts with local knowledge on abortion policies; requests through contacts in professional networks; and requests to international non-governmental organisations.[31]

Researchers for the current project only included legal text from GAPD source documents. Legal text consists of penal codes, specific acts pertaining to abortion, and court rulings. Legal texts that did not pertain to the research scope were excluded, as were non-legal texts available through the GAPD. Non-legal texts available through the GAPD include clinical guidelines, codes of ethics, and ministry guidelines and regulations. Because of variations in the level of authority of various non-legal texts, such texts were not comparable and were therefore excluded.

To identify provisions within the source documents that pertained to abortion, researchers either relied on information available through the GAPD or conducted keyword searches of the source documents. Some of the source documents were identified in the GAPD, and in this case, researchers simply extracted the source document as identified. Where GAPD did not identify the

provisions within the source document that regulated abortion, as in the case of full penal codes, for example, researchers used keywords to search legal text to identify provisions related to abortion. We identified keywords that apply to abortion to identify laws pertaining to abortion and added keywords as we encountered them in the legal texts. These included "abortion," "termination of pregnancy," "spontaneous miscarriage," "death of a fetus," "mother," "fetus," "unborn child," and "womb."

Coding procedures and quality control

We developed a research protocol, which included a coding scheme we created to identify and record observable features of the laws and help ensure the variability and reliability of the data.[25] We contrast our method here with traditional legal research, which is based on interpretation of legal rules and precedent. We developed and applied the coding scheme,[17] using an iterative process in which we created response categories according to the words contained in the laws: for example, words in the law designating which health workers are permitted to provide abortion. We entered our coding questions into the MonQcle, a web-based software-coding platform, and used it to create a cross-sectional legal assessment mapping study or legal data set. For consistency and transparency, decisions related to the application of the coding scheme were discussed as a group and recorded in the research protocol. Source legal text in each jurisdiction was referenced to answer the coding questions.

We categorised "medical practitioners," "medical doctors," and "specialist doctors" as "doctors" for this analysis. The meaning of medical practitioner varies by country, but one long-standing meaning of medical practitioner is medical doctor. For example, in the United Kingdom, the list of registered medical practitioners is created by the General Medical Council and limited to medical doctors registered to practice in the UK.[32] We developed categories to ensure overall consistency, but we note that the meaning of registered medical practitioners could have been expanded in regulations to include midlevel providers.[33] In Zambia, under the Health Professions Act, the term "medical practitioner" is replaced with "health practitioner" and an open question remains as to the interpretation of "medical practitioner" under prior law, including the abortion law.[34] Additionally, we categorised "nurses" and "midwives" as "midlevel providers."

A team of legal researchers from the Center for Public Health Law Research coded the data, under supervision of Adrienne Ghorashi. To ensure data quality, researchers blindly redundantly coded 100% of the records in four subsequent batches. Coding divergences in each batch were compared by the supervisor and resolved as a team. All divergence rates and coding rules developed through the iterative review process were recorded in a research protocol.[17] To ensure reliability of the final data, a statistical quality control (SQC) procedure was conducted at the completion of this dataset. To conduct SQC, a random sample of coding instances was taken from the dataset for the researchers to code blindly and compare against original coding. SQC was conducted until divergences were at or below 5%. SQC was conducted after the dataset was completed on 16 March 2020. At that time, the divergence rate was 4.38%. Each divergence was then reviewed as a team and resolved.

Analysis of legal data

For this analysis, we compared features of national abortion laws that require abortion to take place within the formal health care system, across countries and geographic regions (defined by the United Nations Statistics Division).[35] We focused on jurisdictions where abortion is broadly permitted because we wanted to focus our analysis specifically on requirements that allow abortion within but not outside the formal health care system, to draw attention to barriers contained in liberal laws. For the purposes of this analysis, we defined liberal abortion laws as those that allow abortion for economic grounds, social grounds, and/or any grounds. Subnational abortion laws and more restrictive laws were excluded. Because Canada does not specifically regulate abortion by law, it was also excluded from the analysis.

Quantitative legal data was downloaded from the MonQcle coding system in CSV format. Descriptive statistics (frequencies and percentages) were calculated for features of national abortion laws including type of health care providers permitted to provide abortion care, verification of circumstance requirements, locations where abortion is legally permitted, and penalties for individuals participating in unlawful abortion.

All analyses were done using Stata/SE 15.1.

Limitations

The laws we analysed consisted of abortion laws available through the GAPD. Authorities could apply other laws to abortion outside the formal health care system, including laws regulating healthcare professionals, homicide and fetal protection laws, prescription drug laws, laws regulating disposal of medical waste and fetal remains, among others. Questions of how these and other laws relate to abortion are outside the scope of this project. Because we relied on the GAPD, we did not capture laws that changed after GAPD updates.

Researchers excluded six countries because the text was not available through the GAPD. These countries are Afghanistan, Democratic Republic of North Korea, Maldives, Niue, Saint Vincent and the Grenadines, and Saudi Arabia. The United States was also excluded because of the existing data and analysis on US state law.[18] Some legal text was referenced by the GAPD but unavailable for coding. There were two reasons for this: either a link to an external site was broken or an image of a legal text was of poor quality and could not be copied. In these cases, researchers used alternate sources for the legal text. For the penal codes of Algeria, Egypt, Iraq, Syria, and Tunisia, researchers extracted text available through WIPOLEX,[36] a legal database by the World Intellectual Property Organization. For the penal code of Sudan, researchers extracted text available through the National Sexual Rights Law and Policy Database.[37] For Gambia, Estonia, Guyana, and Thailand, researchers transcribed legal text in English from an image that was of poor quality.

For texts in languages other than English and for which the GAPD did not identify the provision of the document that regulates abortion, researchers first used Google Translate to translate keywords to search the document and identify the provisions of the legal text to be extracted. Once the relevant provisions were identified, researchers extracted the text and then used Google Translate to translate extracted text into English for coding. Where the translated text was ambiguous or appeared to be inaccurate, we asked staff and partners to provide or clarify the English translation. Where available, researchers used secondary sources to clarify and corroborate translations and issues. We recognise that in the translation process, we may have missed nuances in the translated laws.

Our analysis does not address regulatory documents that may develop the definition of specific types of health professionals: for example, in Ghana, where midlevel providers are included as "medical practitioners" according to the Abortion Standards and Protocols.[33] In addition, laws and policies may enable doctors to delegate their authority to provide abortion to midlevel providers.

Results

We included national and subnational laws in our dataset, but for this paper limited our analysis to national abortion laws. Of the 177 national abortion laws that we included, we identified 53 (30%) countries with liberal abortion laws. Among the countries with liberal abortion laws, seven (13%) were in Africa, four (8%) in the Americas, 12 (23%) in Asia, 30 (57%) in Europe, and none in Oceania.

In all 53 countries with liberal national abortion laws, only healthcare professionals or trained health workers are permitted to perform legal abortion. The types of healthcare professionals who are permitted to provide abortion are specified in 39 (74%) of the 53 national abortion laws. The types of healthcare professionals who are specified to legally provide abortion are doctors (74%), midlevel providers (8%), pharmacists (2%), and lay health workers (2%). In 14 (26%) national laws, a healthcare professional is required, but the type is not specified (Table 1).

In most countries with liberal abortion laws – 39 (74%), doctors are permitted to provide abortion. Of those, 35 laws *only* permit doctors to provide abortion and 11 (1 in Asia and 10 in Europe) require the abortion doctor to be a specialist.

The national laws of four countries allow multiple types of healthcare professionals to provide abortion care. These include Cambodia (doctors, midwives), France (doctors, midwives), Nepal ("qualified and registered health worker"), and South Africa (doctors, midwives, nurses).

Among the 53 countries with liberal abortion laws, health professionals are required to verify whether a pregnant person's reasons for seeking abortion are within permissible grounds in 35

Table 1. Types of health care professionals permitted to provide abortion care by region (*n* = 53)[a]

Type of health care worker	Africa (*n* = 7)		Americas (*n* = 4)		Asia (*n* = 12)		Europe (*n* = 30)		Total (*n* = 53)	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Doctors	7	100%	3	75%	6	50%	23	77%	39	74%
Midlevel providers	1	14%	0	0%	2	17%	1	3%	4	8%
Pharmacists	0	0%	0	0%	1	8%	0	0%	1	2%
Lay health workers	0	0%	0	0%	1	8%	0	0%	1	2%
Health worker type not specified	0	0%	1	25%	6	50%	7	23%	14	26%

[a]Percentages may sum to more than 100% because some laws specify more than one type of health care professional that can provide abortion care.

(66%) countries, while no such verification is required under the laws of 18 (34%) countries (Table 2).

A small majority – 32 (60%) – of nation-level liberal abortion laws only permit legal abortion in specified health facilities. These locations include health facilities designated by the government to provide abortion (43%), hospitals (30%), primary and secondary health care facilities (8%), and government health facilities (6%) (Table 3).*

Given that abortion is regulated by the penal code, abortion laws generally provide criminal penalties for individuals who provide abortion outside the scope of the law. Of the 53 countries with liberal abortion laws, 50 (94%) specify that specific individuals are subject to penalties for participating in unlawful abortion. Twenty-three (43%) national liberal abortion laws only penalise anyone who assists the pregnant person with the abortion and seven (13%) subject only pregnant people to criminal penalties as a consequence of undergoing an unlawful abortion. Twenty (38%) abortion laws penalise both the pregnant person and anyone who assists them. We noted regional variations with regard to criminal penalties for pregnant people who undergo unlawful abortion. A greater proportion of liberal national abortion laws in Africa (86%) and the Americas (100%) penalise the pregnant person for unlawful abortion as compared with Asia (42%) and Europe (40%) (Table 4).

Table 2. Requirements for healthcare professionals to verify a pregnant person's reasons for seeking an abortion are within permissible grounds before providing care by region (*n* = 53)

Geographic region	Total # of countries	Require verification of circumstance?			
		Yes		No	
	n	*n*	%	*n*	%
Africa	7	2	29%	5	71%
Americas	4	3	75%	1	25%
Asia	12	10	83%	2	17%
Europe	30	20	67%	10	33%
Total	53	35	66%	18	34%

*Primary health care facilities are usually the first point of contact with a health professional, while secondary facilities typically provide services by medical specialists.

Table 3. Locations where abortion is legally permitted by region (n = 53)[a]										
	Africa		Americas		Asia		Europe		Total	
Location where abortion is permitted	(n = 7)		(n = 4)		(n = 12)		(n = 30)		(n = 53)	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Hospitals	2	29%	0	0%	3	25%	11	37%	16	30%
Primary health care facilities	0	0%	0	0%	0	0%	2	7%	2	4%
Secondary health care facilities	0	0%	0	0%	0	0%	2	7%	2	4%
Health facilities designed to provide abortion	5	71%	0	0%	5	42%	13	43%	23	43%
Government health facilities	0	0%	0	0%	0	0%	3	10%	3	6%
Locations not specified	2	29%	4	100%	5	42%	10	33%	21	40%

[a]Percentages may sum to more than 100% because some laws specify more than one location where abortion is legally permitted.

Table 4. Individuals subject to criminal penalties for participating in unlawful abortions in liberal abortion laws by region (n = 53)										
Individual subject to criminal penalty	Africa		Americas		Asia		Europe		Total	
	(n = 7)		(n = 4)		(n = 12)		(n = 30)		(n = 53)	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Pregnant person only	1	14%	1	25%	2	17%	3	10%	7	13%
Anyone who assists the pregnant person only	1	14%	0	0%	7	58%	15	50%	23	43%
Pregnant person and anyone who assists them	5	71%	3	75%	3	25%	9	30%	20	38%
Not specified	0	0%	0	0%	0	0%	3	10%	3	6%

Discussion

Our results illustrate significant gaps between the growing practice of self-managed abortion and the laws that govern abortion in liberal settings. By requiring a healthcare worker to provide the abortion or verify that it is legal and requiring the abortion take place in a specified health facility, liberal abortion laws fail to accommodate evidence around the safety and practice of self-managed abortion.

While policy surveillance allows for big-picture comparison, it does not elucidate information about application of law. Application and enforcement of abortion laws depend on the actions and biases of law enforcement authorities, judges, health workers, community members, and others at the national and local level. Individuals who have power to enforce and interpret law may deem the various actions and actors involved in self-managed abortion as outside the scope of abortion law and not seek enforcement against

them. Conversely, law enforcement authorities may use laws regulating abortion and others to exact criminal penalties upon individuals – particularly members of groups who face discrimination. Empirical research is lacking on the perception and experience of abortion law enforcement among people who self-manage their abortions and those who help them.

Policy surveillance methods enabled us to make observations about several features of abortion laws across numerous jurisdictions. Unlike traditional legal research, policy surveillance allows researchers to translate law into scientific data through rigorous methods. By analysing the national law of each country using an identical approach for each law, we were able to make comparisons across jurisdictions about the specific features of the law. Policy surveillance can be used in the future by researchers to compare laws across jurisdictions and identify trends and common features in need of reform.

Laws that have been reformed to allow abortion fail to accommodate recent shifts in the ways individuals end their pregnancies, with growing access to abortion medicines. This failure may be a result of the fact that abortion law is slower to change than abortion practice. In addition, abortion laws may reflect lawmakers' overall reluctance to trust pregnant people to manage their own abortions, without the involvement of designated health professionals to serve as gatekeepers.

The gap between liberal abortion laws and the growing practice of self-managed abortion is further illustration of the fact that the criminal law is ill-equipped to regulate abortion, a common health need experienced by pregnant people all over the world. Policy surveillance can be used by future researchers and advocates to illuminate widespread gaps between law, evidence, and practice, toward laws that enable safe and healthy outcomes for people who need abortion and individuals who help them.

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Résumé

La surveillance des politiques offre une nouvelle méthode importante pour comparer les lois

Resumen

La vigilancia de políticas ofrece un método novedoso e importante para comparar las leyes en

d'une juridiction à l'autre. Nous avons utilisé la surveillance des politiques pour examiner les législations sur l'avortement dans le monde. La prévalence des avortements autogérés, qui se déroulent généralement en dehors de l'environnement formel des soins de santé et peuvent être sûrs, augmente. Nous avons analysé les dispositions qui ne tiennent pas compte de la prévalence des avortements autogérés et des données sur leur sécurité. Ces dispositions exigent que l'avortement ait lieu dans un environnement formel de soins de santé. Nous avons aussi analysé les sanctions pénales en cas de non-respect. Notre méthode comprenait l'élaboration d'un cadre juridique, un processus itératif d'affinage des modalités et procédures de codage, et un contrôle rigoureux de la qualité. Nous avons limité notre analyse aux lois libérales sur l'avortement pour deux raisons. Les lois sur l'avortement dans le monde tendent à être moins restrictives. De plus, nous souhaitions nous centrer sur la manière dont les lois se rapportent à l'avortement précisément en dehors d'un cadre formel de soins de santé et nous avons exclu les lois qui interdisent plus généralement l'avortement. Nous avons découvert que dans tous les pays avec des lois nationales libérales sur l'avortement, la législation permet uniquement aux professionnels de santé ou aux agents de santé qualifiés de pratiquer des avortements légaux et la majorité des lois exigent que l'avortement se déroule dans un établissement de santé déterminé. Avec les méthodes de surveillance des politiques, nous pouvons mettre en lumière les caractéristiques des lois d'une juridiction à l'autre et montrer qu'il est nécessaire d'opérer une vaste réforme en vue de l'adoption de lois qui reflètent les données scientifiques et la manière dont les personnes avortent.

diferentes jurisdicciones. Utilizamos la vigilancia de políticas para examinar las leyes sobre aborto en todo el mundo. El aborto autogestionado, que generalmente ocurre fuera de los ámbitos formales de servicios de salud, es cada vez más prevalente y puede ser seguro. Analizamos las disposiciones que no toman en cuenta la prevalencia del aborto autogestionado ni la evidencia de su seguridad. Dichas disposiciones exigen que el aborto se efectúe en un ámbito formal de servicios de salud. Además, analizamos las sanciones penales por incumplimiento. Nuestro método consistió en la elaboración de un marco jurídico, un proceso iterativo de refinar los esquemas y procedimientos de codificación, y un riguroso control de la calidad. Limitamos nuestro análisis a las leyes liberales sobre aborto por dos razones. Las leyes sobre aborto a nivel mundial tienden a ser menos restrictivas. Procuramos enfocarnos en cómo se relacionan las leyes con el aborto fuera del ámbito formal de servicios de salud en particular, y excluimos las leyes que prohíben el aborto de manera más general. Encontramos que, en todos los países con leyes nacionales liberales sobre aborto, la ley permite que solo profesionales de salud o trabajadores de salud capacitados efectúen la interrupción legal del embarazo y la mayoría de esas leyes disponen que el aborto se efectúe en un establecimiento de salud especificado. Con los métodos de vigilancia de políticas podemos iluminar las características de la ley en numerosas jurisdicciones y la necesidad de una reforma generalizada de las leyes que refleje la evidencia científica y la manera en que las personas tienen abortos.