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Abstract

The aim of this paper is to provide a panoramic view of laws and policies on abortion around the world, giving a range of country-based examples. It shows that the plethora of convoluted laws and restrictions surrounding abortion do not make any legal or public health sense. What makes abortion safe is simple and irrefutable—when it is available on the woman's request and is universally affordable and accessible. From this perspective, few existing laws are fit for purpose. However, the road to law reform is long and difficult. In order to achieve the right to safe abortion, advocates will need to study the political, health system, legal, juridical, and socio-cultural realities surrounding existing law and policy in their countries, and decide what kind of law they want (if any). The biggest challenge is to determine what is possible to achieve, build a critical mass of support, and work together with legal experts, parliamentarians, health professionals, and women themselves to change the law—so that everyone with an unwanted pregnancy who seeks an abortion can have it, as early as possible and as late as necessary.

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Toward a definition of decriminalization of abortion

In simple terms, the decriminalization of abortion means removing specific criminal sanctions against abortion from the law, and changing the law and related policies and regulations to achieve the following:

- not punishing anyone for providing safe abortion,
- not punishing anyone for having an abortion,
- not involving the police in investigating or prosecuting safe abortion provision or practice,
- not involving the courts in deciding whether to allow an abortion, and
- treating abortion like every other form of health care—that is, using best practice in service delivery, the training of providers, and the development and application of evidence-based guidelines, and applying existing law to deal with any dangerous or negligent practices.

Some history

Abortion was legally restricted in almost every country by the end of the nineteenth century. The most important sources of such laws were the imperial countries of Europe—Britain, France, Portugal, Spain, and Italy—who imposed their own laws forbidding abortion on their colonies.

According to the United Nations Population Division's comprehensive website on abortion laws, legal systems under which abortion is legally restricted fall into three main categories, developed mostly during the period of colonialism from the sixteenth century onward:

- common law: the UK and most of its former colonies—Australia, Bangladesh, Canada, India, Ireland, Malaysia, New Zealand, Pakistan, Singapore, the United States, and the Anglophone countries of Africa, the Caribbean, and Oceania;
- civil law: most of the rest of Europe, including Belgium, France, Portugal, Spain, and their former colonies, Turkey and Japan, most of Latin America, non-Anglophone sub-Saharan Africa, and the former Soviet republics of Central and Western Asia. In addition, the laws of several North African and Middle Eastern countries have been influenced by French civil law; and
- Islamic law: the countries of North Africa and Western Asia and others with predominantly Muslim populations, and having an influence on personal law, for example, Bangladesh, Indonesia, Malaysia, and Pakistan.[1]

Historically, restrictions on abortion were introduced for three main reasons:

1. Abortion was dangerous and abortionists were killing a lot of women. Hence, the laws had a public health intention to protect women—who nevertheless sought abortions and risked their lives in doing so, as they still do today if they have no other choice.
2. Abortion was considered a sin or a form of transgression of morality, and the laws were intended to punish and act as a deterrent.
3. Abortion was restricted to protect fetal life in some or all circumstances.

Since abortion methods have become safe, laws against abortion make sense only for punitive and deterrent purposes, or to protect fetal life over that of women's lives. While some prosecutions for unsafe abortions that cause injury or death still take place, far more often existing laws are being used against those having and providing safe abortions outside the law today. Ironically, it is restrictive abortion laws—leftovers from another age—that are responsible for the deaths and millions of injuries to women who cannot afford to pay for a safe illegal abortion.

This paper provides a panoramic view of current laws and policies on abortion in order to show that, from a global perspective, few of these laws makes any legal or public health sense. The fact is that the more restrictive the law, the more it is flouted, within and across borders. Whatever has

led to the current impasse in law reform for women's benefit—whether it is called stigma, misogyny, religion, morality, or political cowardice—few, if any, existing laws on abortion are fit for purpose.

Efforts to reform abortion law and practice since 1900

The first country to reform its abortion law was the Soviet Union, spurred by feminist Alexandra Kollantai, through a decree on women's health care in October 1920.[2] Since then, progressive abortion law reform (the kind that benefits women) has been justified on public health and human rights grounds, to promote smaller families for population and environmental reasons, and because women's education and improved socioeconomic status have created alternatives to childbearing. Perhaps most importantly, controlling fertility has become both technically feasible and acceptable in almost all cultures today. Yet despite 100 years of campaigning for safe abortion, the use of contraception has been completely decriminalized while abortion has not.

Abortion is one of the safest medical procedures if done following the World Health Organization's (WHO) guidance.[3] But it is also the cause of at least one in six maternal deaths from complications when it is unsafe.[4] In 2004, research by WHO based on estimates and data from all countries showed that the broader the legal grounds for abortion, the fewer deaths there are from unsafe abortions.[5] In fact, the research found that there are only six main grounds for allowing abortion apply in most countries:

- ground 1 – risk to life
- ground 2 – rape or sexual abuse
- ground 3 – serious fetal anomaly
- ground 4 – risk to physical and sometimes mental health
- ground 5 – social and economic reasons
- ground 6 – on request

With each additional ground, moving from ground 1 to 6, the findings show that the number of deaths falls. Countries with almost no deaths from unsafe abortion are those that allow abortion on request without restriction.

This is proof that that the best way to consign unsafe abortion to history is by removing all legal restrictions and providing universal access to safe abortion. But the question remains, how do we get from where things are now to where they could (and should) be?

Attempts to move from almost total criminalization to partial (let alone total) decriminalization of abortion have been slow and fraught with difficulties. Why? Because the best way to control women's lives is through (the risk of) pregnancy. The traditional belief that women should accept "all the children God gives," the recent glorification of the fetus as having more value than the woman it is dependent on, and male-dominated culture are all used extremely effectively to justify criminal restrictions. Nevertheless, the need for abortion is one of the defining experiences of having a uterus.

Globally, 25% of pregnancies ended in induced abortion in 2010–2014, including in countries with high rates of contraceptive prevalence.[6] Increasingly, thanks to years of effective campaigning, more and more women are defending the need for abortion, as well as the *right* to a safe abortion—and access to it if and when they need it. Moreover, a growing number of governments, in both the Global North and more recently the Global South, have begun to acknowledge that preventing unsafe abortions is part of their commitment to reducing avoidable maternal deaths and their obligations under international human rights law.

While some people still wish that this could be achieved through a higher prevalence of contraceptive use or post-abortion care alone, the facts are against it. Those facts include both the occurrence of contraceptive failure among those who do use a method and the failure to use contraception, both of which are common events and sexual behaviors.

The role of international human rights bodies in calling for law reform

A new layer of involvement in advocacy for safe

abortion, based on an analysis of how existing laws affect women and girls and whether they meet international human rights standards, has emerged in recent years. United Nations human rights bodies—including the Human Rights Committee, the Committee on the Elimination of Discrimination against Women, the Committee on Economic, Social and Political Rights, the Working Group on discrimination against women in law and practice, and the Special Rapporteurs on the right to the highest attainable standard of health, the rights of women in Africa, and torture—have played an increasingly visible role in calling for progressive abortion law reform.[7]

Regional bodies such as the Inter-American Court of Human Rights, the European Court of Human Rights, and the African Commission on Human and Peoples' Rights (ACHPR) have been very active in this regard as well. The ACHPR called in January 2016 for the decriminalization of abortion across Africa, in line with the Maputo Protocol, and renewed that call in January 2017, making waves across the region.[8]

Legalize or decriminalize: What's in a word?

Interestingly, no human rights body has gone so far as to call for abortion to be permitted at the request of the woman, yet many have called for abortion to be decriminalized. This raises the question of what is understood in different quarters by the term "decriminalization."

For many years, the abortion rights movement internationally has called for "safe, legal abortion." More recently, calls for the "decriminalization of abortion" have also emerged. Do these mean the same thing? In simplistic terms, they might be differentiated like this: legalizing abortion means keeping abortion in the law in some form by identifying the grounds on which it is allowed, while decriminalizing abortion means removing criminal sanctions against abortion altogether.

In that sense, abortion is legal on one or more grounds (mostly as exceptions to the law) in all but a few countries today, while Canada stands out as the only country to date that, through a Supreme Court decision in 1988, effectively decriminalized abortion altogether.[9] No other country, no matter how liberal its law reform, has been willing to take abortion completely out of the law that delimits it.

However, this distinction is often not what is meant. Instead, the two terms are used interchangeably—that is, abortion may be legalized *or* decriminalized on some *or* all grounds. No one is likely to be able to change this lack of differentiation in terminology. Nevertheless, it is crucial when recommending abortion law reform to be clear what exactly is and is not intended. I will come back to this later in the paper, after exploring the complexity of the changes being called for, no matter which of the two terms is used.

The law on abortion in countries today

Criminal restrictions on the practice of abortion are contained in statute law—in other words, laws passed by legislatures, sometimes as part of criminal or penal codes, which consolidate a group of criminal statutes. In the UK, for example, abortion was criminalized in sections 58 and 59 of the Offences against the Person Act of 1861, with one aspect further defined in the Infant Life Preservation Act of 1929, and then allowed on certain grounds and conditions in Great Britain (but not Northern Ireland) in the 1967 Abortion Act, which was then amended further in the Human Fertilisation and Embryology Act of 1990. In the 1967 Abortion Act, legal grounds for abortion are set out as exceptions to the criminal law, yet the 1861 act is still in force and still being used to prosecute illegal abortions today.[10]

Ireland, formerly a part of the UK, was also subject to the 1861 Offences against the Person Act and revoked sections 58–59 only in the Protection of Life during Pregnancy Act of 2013, which imposed its own almost total criminalization of abortion.[11] Sierra Leone, a former British colony, also revoked the 1861 Offences against the Person Act in the Safe Abortion Act, passed in December 2015 and again a second time unanimously in February 2016. That act allows abortion on request during the first 12 weeks of pregnancy, and until week 24 in cases of rape,

incest, or risk to health of the fetus or the woman or girl, but it was not finally signed into law.[12]

At the end of the twentieth century, abortion was legally permitted to save the life of the woman in 98% of the world's countries.[13] The proportion of countries allowing abortion on other grounds was as follows: to preserve the woman's physical health (63%); to preserve the woman's mental health (62%); in case of rape, sexual abuse, or incest (43%); fetal anomaly or impairment (39%); economic or social reasons (33%); and on request (27%).

The number of countries in 2002 that permitted each of these grounds varied greatly by region. Thus, abortion was permitted upon request in 65% of developed countries but only 14% of developing countries, and for economic and social reasons in 75% of developed countries but only 19% of developing countries.[14] Some countries permit additional grounds for abortion, such as if the woman has HIV, is under the age of 16 or over the age of 40, is not married, or has many children. A few also allow it to protect existing children or because of contraceptive failure.[15]

These percentages, published in 2002, are out of date, but they have not changed dramatically. In late 2017, research updating the world's laws on abortion and adding new information about related policies, conducted under the aegis of the Department of Reproductive Health and Research/Human Reproductive Programme at WHO, will be incorporated into the United Nations Population Division's website.[16]

Regulating abortion

There is much more to this story, however. In addition to statute law, other ways to liberalize, restrict, or regulate access to abortion, which also have legal standing, include the following:

- national constitutions in at least 20 countries, such as the Eighth Amendment to the Constitution (1983) in Ireland;
- supreme court decisions, such as in the United States (1973, 2016), Canada (1988), Colombia (2006), and Brazil (2012), as well as higher court decisions, such as in India (2016, 2017) allowing individual women abortions beyond the 20-week upper limit;
- customary or religious law, such as interpretations of Muslim law that allow abortion up to 120 days in Tunisia and the United Arab Emirates but do not allow abortion at all in other majority Muslim countries;
- regulations that require confidentiality on the part of health professionals on the one hand, but on the other hand require health professionals to report a criminal act they may learn of, for example, while providing treatment for complications of unsafe abortion;
- medical ethical codes, which, for example, allow or disallow conscientious objection; and
- clinical and other regulatory standards and guidelines governing the provision of abortion, such as reporting guidelines, disciplinary procedures, parental or spousal consent, and restrictions on which health professionals may provide abortions and where, who may approve an abortion, and which methods may be used—as adjuncts to (though not always formally part of) the law.

Reed Boland has found that the distinction between laws and regulations governing abortion is not always clear and that some countries, usually those where abortion laws are highly restrictive, have issued no regulations at all. In the most complex cases, there are multiple texts over many years which may contain conflicting provisions and obscure and outdated language. The upshot may be that no one is sure when abortion is actually allowed and when it isn't, which may serve to stop it being provided safely and openly at all.[17]

Uganda is a case in point. According to a recently published paper by Amanda Cleeve et al., Uganda's Constitution and Penal Code conflict with each other, leading to ambiguous interpretations and lack of awareness of the fact that abortion *is* legal to protect women's health and life. Moreover, while Uganda has a national reproductive health policy, it is not supported in law and is not

being implemented. In 2015, in order to clarify this situation, the minister of health and other stakeholders developed *Standards and Evidence-based Guidelines on the Prevention of Unsafe Abortion*. These included details of who can provide abortions, and where and how, and assigned health service responsibilities, such as level of care and post-abortion care. However, the guidelines were withdrawn in January 2016 due to religious and political opposition.[18]

Post-abortion care to treat the consequences of unsafe abortions has been instituted since it was approved in the International Conference on Population and Development's Programme of Action in 1994, in countries where there was little or no prospect of law reform, as a stopgap measure, to save lives. But this has not been a success in African countries such as Tanzania, where, under the 1981 Revised Penal Code, it remains unclear whether abortion is legal to preserve a woman's physical or mental health or her life, and where 16% of maternal deaths are still due to unsafe abortions.[19] Although the government has tried to expand the availability of post-abortion care, a 2015 study found that "significant gaps still existed and most women were not receiving the care they needed."[20] In early 2016, according to a CCTV-Africa report, the newly appointed prime minister, in tandem with the president, threatened to dismiss and possibly imprison doctors performing illegal abortions following recent reports of doctors in both public and private hospitals accepting payments for doing abortions and a reported increase in cases of complications.[21]

Sometimes, other laws unrelated to abortion create barriers. In Morocco, the abortion law was established in 1920 when Morocco was a French protectorate. In May 2015, following a public debate arising from reports of women's deaths from unsafe abortion, a reform process to expand legal protections was initiated by a directive of the king. According to the Moroccan Family Planning Association, despite a consensus that abortion should be permitted within the first three months if the woman's physical and mental health is in danger, and in cases of rape, incest, or congenital malformation, unmarried women would be excluded because it is illegal to have sex outside marriage.[22]

In India, a very liberal abortion law for its day was passed in 1971, but it has been poorly and unevenly implemented, such that high rates of morbidity and mortality persist to this day.[23] Even 15 years ago, the process for clinic registration as an approved abortion provider was arduous, limiting the number of clinics.[24] Moreover, two other laws have led to restrictions on abortion access: the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, which forbids ultrasound for purposes of sex determination and has led to restrictions on all second-trimester abortion provision, and the Protection of Children from Sexual Offences Act, which requires reporting of underage sex, so that minors who become pregnant cannot feel safe if they seek an abortion.[25]

Restricting abortion without changing the law

Decent laws and policies can be sabotaged and access to abortion can be restricted without amending the law itself, but instead through policies pressuring women to have more children, public denunciation of abortion by political and religious leaders, or restricting access to services. Bureaucratic obstacles may be placed in women's paths, such as requiring unnecessary medical tests, counselling even if women feel no need for it, having to get one or more doctors' signatures, having to wait between making an appointment and having an abortion, or having to obtain consent from a partner, parent(s) or guardian, or even a judge.

In Turkey, for example, in 1983, in response to population growth, the government passed a law allowing fertility regulation, termination of pregnancy on request up to 10 weeks after conception, and sterilization. A married woman seeking an abortion was required only to obtain her husband's permission or submit a formal statement of assumption of all responsibility prior to the procedure.[26] In recent years, however, President Erdogan has taken a pronatalist stance and urged Turkish couples to have at least three children. Since 2012, he has been calling abortion murder, expressing opposition to

the provision of abortion services and threatening to restrict the law. Women protested against these threats in such large numbers in 2012 that to date there have been no changes to the law itself. But administrative changes were made in order to make the procedure for booking an appointment for an abortion—which is still primarily provided by gynecologists in hospitals—more difficult.

These changes have made it nearly impossible to obtain an abortion in a state hospital; indeed, some state hospitals have stopped providing abortions altogether. Although comparative data are not available, a 2016 study found that of 431 state hospitals with departments of obstetrics and gynecology, only 7.8% provided abortions without restriction as to reason, 78% provided abortions only if there was a medical necessity, and 11.8% did not provide abortions at all. Of the 58 teaching and research hospitals with departments of obstetrics and gynecology, only 17.3% provided abortion services without restriction as to reason, 71.1% only if there was a medical necessity, and 11.4% not at all. Overall, 53 of 81 provinces in Turkey did not have a state hospital that provided abortions without restriction as to reason, although this is permitted under the law.[27]

Thus, the availability of safe abortion depends not only on permissive legislation but also on a permissive environment, political support, and the ability and willingness of health services and health professionals to make abortion available. In contrast to Turkey, Ethiopia is an example of the success of that support.

Law reform for the better—slowly but surely

In 2005, Ethiopia liberalized its abortion law. Previously, abortion was allowed only to save the life of the woman or protect her physical health. The current law allows abortion in cases of rape, incest, or fetal impairment, as well as if the life or physical health of the woman is in danger, if she has a physical or mental disability, or if she is a minor who is physically or mentally unprepared for childbirth.[28] This is a liberal law for sub-Saharan Africa, but for a long time, little was known about the extent of its implementation. In 2006, the government published national standards and guidelines on safe abortion that permitted the use of misoprostol, with or without mifepristone, in accordance with WHO guidance. A nationwide study in 2008 by the Guttmacher Institute estimated that within a few years, 27% of abortions were legal, though most abortions were still unsafe.

A 2011 study by Jemila Abdi and Mulugeta Gebremariam found that Ethiopian health care providers' reasons for not providing abortions were mainly personal or due to lack of permission from an employer or the unavailability of services at their facility. Only 27% felt comfortable working at a site where abortion was provided. Reasons for not being comfortable were mainly religious, but also included personal values and a lack of training. Although 29% thought it should be a woman's choice to have an abortion, 55% disagreed. The study also uncovered a lack of medical equipment and trained personnel, and bureaucratic problems at clinical sites.[29]

Even so, major efforts were and are still being made to improve access at the primary level by constructing more health centers and training more mid-level providers. Between 2008 and 2014, the proportion of abortions provided in health facilities almost doubled. In 2014, almost three-fourths of facilities that could potentially provide abortions or post-abortion care did so, including 67% of the 2,600 public health centers nationwide, 80% of the 1,300 private or nongovernmental facilities, and 98% of the 120 public hospitals. The proportion of all abortion-related services provided by mid-level health workers increased from 48% in 2008 to 83% in 2014. While a substantial number of abortions continue to occur outside of health facilities, the proportion is falling, showing that change is possible but also that it takes time.[30]

In recent decades in Latin America, a combination of legal reforms, court rulings, and public health guidelines have improved access to safe abortion for women.[31] These include allowing abortion on request in the first trimester of pregnancy, as in Mexico City (since 2007), and in Uruguay (since 2012). In Argentina, Bolivia, Brazil, Colombia, and

Costa Rica, higher courts have been instrumental in interpreting the constitutionality and scope of specific grounds for abortion, though their judgments are not always implemented. In countries such as Peru, guidelines issued by hospitals or by governments at federal or state levels govern the enforcement of permitted grounds.[32] Additional steps needed constitute a huge task, as Ethiopia has shown—training providers and ensuring that services provide legal abortions, as well as informing women that these changes are taking place and that services are available.

Self-use of medical abortion in the absence of law and policy reform

In other Latin American countries, abortion laws have remained highly restrictive in spite of campaigns for women's sexual and reproductive rights and human rights for more than 30 years. As a result, and thanks to the advent of new technology, women have begun to take matters into their own hands. An uncounted number of women, probably in the millions, has been obtaining and using misoprostol to self-induce abortion (widely available for gastric ulcers) from a range of sources—pharmacies, websites, black market—since its abortifacient effectiveness was first discovered in the late 1980s. This practice, begun in Brazil, has spread to many other countries and regions. In response, legal restrictions and regulations on access to medical abortion pills have been imposed by countries such as Brazil and Egypt in an effort to stop the unstoppable.

Moreover, in the past decade, feminist groups have set up safe abortion information hotlines in at least 20 countries, and health professionals are providing information and access to abortion pills via telemedicine, including Women Help Women, Women on Web, safe2choose, the Tabbot Foundation in Australia, and TelAbortion in the United States.[33]

In Uruguay, which has hospital-based outpatient abortion care, Lilian Abracinskas, executive director of Mujer y Salud en Uruguay, said in a recent interview, "*In Uruguay, we don't have doctors who do abortions. Abortion with pills is the only way and it isn't possible to choose another method, such as manual vacuum aspiration. Health professionals are willing to be involved before and after, but not in the abortion.*"[34] Thus, abortion service delivery has been reduced to providing information, prescribing pills, and conducting a follow-up appointment if the woman has concerns. It can be that simple (although it does restrict access to aspiration and surgical methods).

Abortion law as a political football and a weapon against women

While the overall trend globally is toward more progressive laws, some countries where the right-wing has taken power have gone backward. In Chile, from 1931 to 1989, the law allowed abortion on therapeutic grounds, described in the Penal Code as "termination of a pregnancy before the fetus becomes viable for the purpose of saving the mother's life or safeguarding her health." Pinochet, the dictator who overthrew the Allende government, banned abortion in 1989 as he left office, leaving no legal grounds at all.[35] It took until 2016 for Michelle Bachelet's government, during her second term in office, to introduce a bill permitting three grounds for legal abortion—to save the woman's life, in cases of rape or sexual abuse, and in cases of fatal fetal anomaly—which are more narrow than what was in place between 1931 and 1989 but are the best that its supporters think they can achieve today.[36]

In Russia, the law has gone back and forth between permissive and restrictive with every change of political head of state. Stalin made abortion illegal when he took over from Lenin, and then after 1945, abortion was again permitted on broad grounds across the Soviet Union and in its satellite countries in Eastern Europe and West Asia, while under Vladimir Putin a long list of restrictions has been imposed, greatly reducing the number of grounds on which abortion is permitted. In January 2016, a bill aiming to "rule out the uncontrolled use of pharmaceutical drugs destined for termination of pregnancy" was tabled in parliament. It would have banned retail sales and limited the list of organizations permitted to buy medical abortion pills wholesale. It would also have banned abor-

tions in private clinics and removed payment for them from state insurance policies. And it would not have allowed abortions to be covered by state health care unless the pregnancy threatened the woman's life. The bill was withdrawn after strong public protest that was coordinated by the Russian Association for Population and Development; however, attempts at further restriction are likely to continue.[37]

In a number of Central and Eastern European countries, the backlash against communist rule and the increasing influence of conservative religious figures has led to regular attempts to undermine permissive abortion laws. Poland has had the worst of it. In 1993, a liberal law was replaced by a very restrictive law that removed "difficult living conditions" as a legal ground for abortion, leaving only three grounds: serious threat to the life or health of the pregnant woman, as attested by two physicians; cases of rape or incest if confirmed by a prosecutor; and cases in which antenatal tests, confirmed by two physicians, demonstrated that the fetus was seriously and irreversibly damaged.[38] This law, in spite of an attempt to ban all abortions in 2016, remains in place due to months of national action by women's groups, including a national women's strike on October 3, 2016. However, in November 2016, the government approved a regulation offering pregnant women carrying a seriously disabled or unviable fetus a one-time payment of €1,000 to carry the pregnancy to term, even if the baby would be born dead or die soon after delivery. The package includes access to hospice and medical care, psychological counselling, baptism or a blessing and burial, and a person who will act as an "assistant to the family" and coordinate the support. The purported aim was to reduce the number of legal abortions on grounds of fetal anomaly.[39] This horrendous proposal, nasty anti-abortion propaganda, and systematic pressure on hospitals in Poland to stop doing abortions on medical grounds exemplify the right-wing extremism of the anti-abortion movement today, whose epicenter is in the United States and whose war on women sometimes feels relentless.[40]

But this is not stopping women from having abortions.

Keeping laws and policies that benefit women in clear sight

Cuba was the first country in Latin America and the Caribbean to reform its abortion law in favor of women, with a law that remains unique. Since 1965, abortion has been available on request up to the tenth week of pregnancy through the national health system. The Penal Code, adopted in 1979, says that an abortion is considered illegal only if it is without the consent of the pregnant woman, is unsafe, or is provided for profit.[41]

In Japan, the law allowing abortion, enacted in 1948, was initially based on eugenics but was a liberal law in practice. Under this law, abortion became the primary mode of birth control in the country. The law was reformed in 1996 to omit all references to eugenics. Abortion is now permitted to protect health, which includes socioeconomic reasons, and in cases of sexual offenses. Abortion was and remains the main form of fertility control. The great majority of abortions fall under the health protection indication. Nearly all abortions are in the first trimester.[42]

In recent years in some countries, laws to legalize abortion are found in public health statutes, court decisions, and policies and regulations on sexual and reproductive health care, rather than as part of the criminal law. Uruguay's 2012 law is an example of public health legislation that sets out procedures and health care standards for the provision of abortion services.[43]

In December 2014, the parliament of Luxembourg voted to remove abortion from the Penal Code up to 12 weeks of pregnancy and said that the woman no longer had to show she was "in distress" due to her pregnancy. Regulations on who can provide abortions were also revised.[44] In France, in 2014, 2015, and 2016, the 1975 Veil Law was reformed to increase access to abortion and reduce barriers. Women no longer have to be in a "state of distress" in France either, but need only request an abortion. The required seven-day "reflection period" between the request for an abortion and the abortion itself was also dropped. Most recently, midwives are now permitted to provide medical abortion, and the costs for all abortions are now reimbursed.[45]

Sweden's law is among the most liberal,

though abortion is not entirely decriminalized. The Swedish law was amended in 1938, 1946, 1963, 1975, 1995, 2007, and 2008. Abortion is available on request up to 18 weeks. After that, permission from the National Board of Health and Welfare is required and may not be granted if the fetus is viable. Appeal is not permitted. Regulations govern who provides abortions and where. Any person not authorized to practice medicine who performs an abortion on another person can be fined or imprisoned for up to a year. Abortion is subsidized by the government; 95% of abortions take place before 12 weeks, and almost none after 18 weeks. Most are medical abortions.[46]

In Australia, each state and the Capital Territory have a different law, ranging from very liberal to very restrictive; several are in the process of change.[47] In the United States in 1973, the Supreme Court held that criminalizing abortion violated a woman's right to privacy and said that abortion should be a decision between a woman and her doctor. However, the court also held that US states have an interest in ensuring the safety and well-being of pregnant women, as well as the potential of human life. This opened a door to restrictions that become greater as pregnancy progresses, opening a Pandora's box for states to impose restrictions that are tying up state and federal courts to this day:

- first trimester: a state cannot regulate abortion beyond requiring that the procedure be performed by a licensed doctor in medically safe conditions;
- second trimester: a state may regulate abortion if the regulations are reasonably related to the health of the pregnant woman; and
- third trimester: the state's interest in protecting the potential human life outweighs the woman's right to privacy, and the state may prohibit abortions unless abortion is necessary to save her life or health.[48]

It is impossible not to think that no law is the best law when it comes to abortion, which brings us back to Canada, where abortion has not been restricted since 1988 and is available on request with no stipulations as to who must provide it or where.[49] Although abortion is not easily accessible in remote areas, and Canada was exceedingly slow to approve mifepristone,[50] opposition to abortion has never developed a foothold. The benefits for women of having no law are crystal clear.[51]

Legalization or decriminalization: Closing the circle

Although recent calls for the decriminalization of abortion by human rights bodies, politicians, and some feminist groups aim to decriminalize only certain grounds and conditions related to abortion, these are far better than nothing. Thus, in Chile, El Salvador, Honduras, and Peru, where abortion is severely legally restricted, calls to "decriminalize abortion" include only three to four grounds—to protect the life and health of the woman, in cases of severe or fatal fetal anomalies, and as a result of rape or sexual abuse. While the great majority of abortions are not for these reasons, they are the only grounds that stand a chance of achieving majority approval through law reform in settings where "everything" is simply not in the cards.

In Africa, the Maputo Protocol is legally binding on the 49 states that have ratified it. The 2016 call by the ACHPR for the decriminalization of abortion across Africa is based on the Maputo Protocol, which calls for safe abortion to be authorized by states "in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus."[52] However, in January 2017, at the African Leaders' Summit on Safe and Legal Abortion, the ACHPR went further, calling for safe, legal abortion as a human right, which by any definition surely exceeds the Maputo Protocol's boundaries.[53]

At bottom, the extent of decriminalization aimed for is a choice between the ideal and the practicable, and reflects the extent to which abortion is seen as a bona fide form of health care—not just by advocates for the right to safe abortion but also by politicians, health professionals, the media, and the public. The fact that abortion *is* still

legally restricted in almost all countries is not just a historical legacy but indicative of the continuing ambivalence and negativity about abortion in most societies, no matter how old or where the law originally came from.

Some abortion rights supporters seem to have an underlying fear that without leaving *something* in the criminal law, "bad things" may start to happen. Canada proves this is not the case. Granted, not everywhere is Canada. But there are general criminal laws that allow the punishment of wrongdoing—such as forcing a woman to have an abortion against her will, giving her medical abortion pills without her knowledge, or causing injury or death through a dangerous procedure. These are laws against grievous bodily harm, assault, or manslaughter, which can be applied without the need for a criminal statute on abortion.

Changing the law to benefit women

Successfully changing the law on abortion is the work of years. Advocates do not get a lot of chances to change the law and need to decide what they want to end up with before campaigning for it, with the confidence that whatever they propose has a chance of being implemented. Another chance may not come again soon.

Allies are crucial. Most important are parliamentarians, health professionals, legal experts, women's groups and organizations, human rights groups, family planning supporters—and above all, women themselves. Achieving a critical mass of support among all these groups is key to successful law reform, as is defeating the opposition, which can have an influence beyond its numbers.

Those unable to contemplate no law at all must confront the fact that each legal ground for abortion may be interpreted liberally or narrowly, and thereby implemented differently in different settings, or may not be implemented at all. The challenge is to define which abortions should remain criminal and what the punishment should be. Even if only some grounds would be considered acceptable, the question of who decides and on what basis remains when reforming existing law.

Wording becomes critical to supporting good practice. For example, grounds which are based on risk are particularly tricky. The definition of "risk" is itself complex, and the extent of risk may be hedged with uncertainty. Risk to the woman's life, health, or mental health and risk of serious fetal anomaly have been subjected to challenge and disagreement among professionals. As Christian Fiala, head of the Gynmed Ambulatorium in Austria, has noted, "There is only one way to be sure a woman's life is at risk, that is—after she dies."[54]

Reed Boland explores the importance of wording in depth with regard to the health ground for abortion:

> *The wording of [the health] indication varies greatly from country to country, particularly given the range of languages and legal traditions involved. Sometimes … there must be a risk to health. Great Britain's law, for example … allows abortion where "continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman …" Sometimes … there must be a danger to health. Burkina Faso's Penal Code permits abortions when "continuation of the pregnancy … endangers the health of the woman …" And in some countries there must only be medical or health reasons. In Vanuatu, there must be "good medical reasons", in Djibouti "therapeutic reasons", and in Pakistan a requirement of "necessary treatment". These concepts are not necessarily the same.*[55]

Legislating on second-trimester abortions presents particular difficulties. Many laws say little or nothing about second-trimester abortions, which has a proscriptive effect. Second-trimester abortions constitute an estimated 10–15% of abortions globally, but as many as 25% in India and South Africa due to poor access to services. When they are unsafe, they account for a large proportion of hospital admissions for treatment of complications and are responsible for a disproportionate number of deaths. Hence, the law should protect second-trimester abortions assiduously. Yet social disapproval of these abortions can run high, and laws tend to be increasingly restrictive as pregnancy progresses, even laws that are liberal with regard to the first tri-

mester. The mistaken belief that second-trimester abortions can be legislated away persists, despite the facts.[56]

Restrictive abortion laws are being broken on a daily basis by millions of women and numerous abortion providers. Even in countries where the law is less restrictive, research shows that the letter of the law is being stretched in all sorts of ways to accommodate women's needs. Yet opposition and a stubborn unwillingness to act continue to hamper efforts to meet women's need for abortion without restrictions.

Conclusions

It should be clear that the plethora of convoluted laws and restrictions on abortion do not make any legal or public health sense. What makes abortion safe is simple and irrefutable—when it is available on the woman's request and universally affordable and accessible. From this perspective, few existing laws are fit for purpose but merely repeat every possible permutation of the self-same restrictions.

The aim of this paper was not to provide answers or roadmaps, because in every country prevailing conditions must be taken into account. The aim was to motivate transformative thinking about whether any criminal law on abortion is necessary. Treating abortion as essential health care is a major step forward, and where the national setting insists on some sort of law, advocates could draft the simplest, most supportive law possible, placing first-trimester abortion care at the primary and community level, ensuring second-trimester services, involving mid-level providers, increasing women's awareness of services and the law, aiming for universal access, integrating WHO-approved methods, and addressing social attitudes to reduce opposition. Space did not permit me to raise the issues of cost and public versus private services, but they are two major aspects that deserve priority consideration.

If it were up to me, all criminal sanctions against abortion would be revoked, making abortion available at the request of the only person who counts—the one who is pregnant. And as with all pregnancy care, abortion would be free at the point of care and universally accessible from very early on in pregnancy.

Canada has proved that no criminal law is feasible and acceptable. Sweden has proved that abortions after 18 weeks can effectively disappear with very good services, and WHO has shown that first-trimester abortions can be provided safely and effectively at the primary and community level by trained mid-level providers and provision of medical abortion pills by trained pharmacy workers. Finally, web- and phone-based telemedicine services are showing that clinic-based services are not required to provide medical abortion pills safely and effectively.

But to achieve these goals, or something close to them, it takes a strong and active national coalition, a critical mass of support, and—with luck and knowing what the goalposts are—less than 100 years of campaigning to make change happen on the ground.

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