

# Toward Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion: A Review of the Last Decade of Legal Reform

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## Abstract

Since the late 1980s, people have safely self-managed their abortions with medication, changing the landscape of abortion. This practice continues to evolve and expand and has been identified as a cause of decline in severe abortion-related morbidity and mortality. However, developments in medical abortion and self-management have yet to be reflected in the way abortion is regulated. Building on the need for evidence and human rights-based laws, this article explores developments in abortion laws from around the world between 2010 and 2020 to explore the extent to which they have contributed to an enabling environment for self-managed abortion. We focus on recent laws—those adopted in the past 10 years—for which we had access to information for analysis. We observe that laws in force still retain clinical settings and the involvement of medical professionals as the desirable circumstances for an abortion to take place and that even those that have liberalized access still retain some degree of criminalization for the pregnant person who carries out a self-managed abortion or for those who support the process. We conclude that there is enough evidence and support from international human rights standards to ground legal developments that enable self-managed abortion.

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## Introduction

Since the late 1980s, people have self-managed their abortions with medication to safely end their pregnancies, ever since pregnant Brazilians discovered that a drug originally developed for gastric ulcers (misoprostol) could be used as an abortifacient.<sup>1</sup> Medical abortion continues to be widely practiced and has been identified as a cause of decline in severe abortion-related morbidity and mortality.<sup>2</sup>

For the purposes of this paper, we define self-managed medical abortion (SMMA) as the process that involves the provision of drugs from pharmacies, drug sellers, or online outlets, without a prescription from a clinician, followed by a woman's self-management of the abortion process, including care-seeking for any complications.<sup>3</sup> While self-managed abortion is and has been a prevalent practice for centuries, increased access to abortion medicines and the growing network of organizations that support people who self-manage entail a significant change to the abortion landscape.<sup>4</sup> The advent of telemedicine—the remote assessment and treatment of patients by health providers—has likewise increased the prevalence of abortion with medicines.<sup>5</sup> But because SMMA does not involve formal supervision by a health care worker, its practice raises legal issues unique from those concerning telemedicine abortion.

Abortion outside the clinical context no longer refers to the emblematic unsafe methods of earlier times.<sup>6</sup> Self-managed abortion requires that we reevaluate long-established relationships between “safety,” “legality,” and “self-management.” That is, self-managed abortion has disrupted the idea that legal abortion is safe and illegal abortion unsafe. Self-managed abortion also debates who can be a “provider” and challenges the meanings of safety that have been—for the most part—discussed within a biomedical frame.

However, developments in SMMA have yet to be reflected in the way abortion is regulated. In general, abortion laws (including those that have been recently reformed, as we show here) criminalize people who have abortions without the involvement of a health care professional or who do so outside the formal health care system.<sup>7</sup> In

most countries, criminal law permits abortion only with the involvement of a health care professional. Furthermore, criminal law and other unnecessary regulatory restrictions create vulnerability and risk by censoring information or curbing access to essential medicines.<sup>8</sup> This means that self-managed abortion, while safe and effective from a public health perspective, still poses risks in a legal sense. While the criminalization of people who self-manage their abortions using any method is unsupported by public health and human rights, SMMA has further exposed the inadequacies of these laws.

### *Regulation of abortion during COVID-19*

In the context of service disruptions caused by the COVID-19 pandemic, which are estimated to account for seven million unplanned pregnancies, access to abortion is increasingly relevant.<sup>9</sup> People have greater difficulty getting contraceptives because of interruptions to supply chains, restrictions on travel that prevent people from getting to health facilities, and the diversion of health care workers' time and attention to COVID patients.<sup>10</sup> Indeed, millions of people under quarantine or shelter-in-place orders have reduced access to abortion, and a number of governments have restricted health care to “essential services” while excluding abortion.<sup>11</sup> In the Netherlands, for example, court cases are showcasing the need for simplified abortion access, reducing or eliminating the need for physical interactions with health care personnel.<sup>12</sup>

Some countries have already adopted measures to ensure access: the United Kingdom's Department of Health and Social Care has confirmed that it will allow people to manage medical abortions at home. Similarly, Marie Stopes in South Africa is supporting people in self-managing abortions at home.<sup>13</sup> In the United States, the Food and Drug Administration has signaled that it will not enforce in-person dispensing requirements for abortion drugs during the pandemic.<sup>14</sup> These measures show that burdensome requirements are unnecessary, and they confirm what SMMA feminist networks have known for decades: a different, less medicalized model is not only desirable but possible.<sup>15</sup>

These measures reducing barriers to access to medical abortion have been crafted as options within a formal health care system (rather than self-managed abortion) and are temporary and considered exceptional.<sup>16</sup> It is important not to lose the momentum and to capitalize on this window of political opportunity to advance a simpler, less medicalized, and evidence-based model of abortion care.

### *Toward laws based on human rights and evidence*

The 2019 report of the Lancet – O’Neill Institute Commission on Global Health and the Law shows how evidence-based laws, when effectively implemented and fairly enforced, can create the conditions for good health and, conversely, how laws that are not informed by evidence and human rights could instead undermine health and justice, entrenching inequality and discrimination.<sup>17</sup> Unequivocally, the World Health Organization (WHO) affirms that “[g]iven the clear link between access to safe abortion and women’s health, it is recommended that laws and policies should respect and protect women’s health and their human rights.”<sup>18</sup>

Using the framework for evidence- and rights-based law proposed by the Lancet – O’Neill Institute Commission, this article analyzes developments in national abortion laws from around the world between 2010 and 2020 to assess the extent to which they have embraced the potential of self-managed abortion. We briefly outline the latest evidence and human rights that should guide any legal reform. We focus on recent laws—those adopted in the past 10 years—for which we had access to information for analysis.

While the Lancet – O’Neill Institute Commission recommends that laws be fairly enforced, implementation and enforcement are outside the scope of this paper. The degree of legal risk faced by people seeking SMMA and those who help them rests on enforcement, and legal risk can be disproportionately experienced by groups who face discrimination in other areas. Much research is needed to document and understand the expe-

riences of individuals who face legal consequences related to SMMA. However, the focus of this paper is the problematic nature of laws as drafted.

To identify the latest developments in abortion laws, we consulted the Center for Reproductive Rights’ *World’s Abortion Laws Map* and WHO’s Global Abortion Policies Database.<sup>19</sup> We also consulted the newsletter of the International Campaign for Women’s Right to Safe Abortion. Self-managed abortion entails a constellation of actors and activities that are regulated not only by abortion laws but also by other areas of law and policy, such as drug regulations, laws on the provision on information, and others.<sup>20</sup> Therefore, our analysis is limited by the fact that we examined only abortion laws.

### Growing evidence supporting self-managed medical abortion

Medical abortion is effective, safe, and acceptable and does not require specific training or specialization.<sup>21</sup> There is extensive evidence showing that mifepristone and misoprostol or misoprostol alone can be self-administered to induce a safe, discrete and non-invasive abortion.<sup>22</sup> These drugs have a consistently proven success rate of over 85% (95% if used together) through the 12th week of pregnancy, and WHO supports the use of these drugs for first-trimester abortions.<sup>23</sup> Furthermore, recent research indicates that SMMA can be an effective and safe option for abortion even beyond the first trimester (up to 24 weeks), with accompaniment group support and linkages to the formal health system.<sup>24</sup>

Less burdensome models of access to abortion drugs (both within and outside the formal health care context) show the potential of medical abortion. Abigail Aiken et al. recently reported low rates of adverse events experienced by those who received medical abortion through telemedicine. In their study, women self-identified potentially serious adverse events, and most sought medical attention when advised to do so; no deaths were reported.<sup>25</sup> Self-administration of pills for early abortion with limited involvement of health professionals is effective and has similar outcomes to medical abortion

administered by professionals in health facilities.<sup>26</sup> In a study conducted in Ireland and Northern Ireland, almost all (97%) felt that the home use of pills had been the right choice, and most (70%) reported feeling “relieved” after the abortion.<sup>27</sup> Furthermore, the work of feminist organizations that bring the medicines to local communities and internet-based services that combine information with service delivery by postal or courier services has been instrumental in evincing the safety and effectiveness of self-management with minimal interaction with institutionalized systems of medical care.<sup>28</sup>

The potential public health impact of medical abortion has already been documented. Indeed, Susheela Singh et al. have recognized the connection between the increased use of medical abortion and the safety of abortion. The authors state that “[o]ne of the most important developments in terms of the safety of abortion is the steady increase in the use of medical abortion, which is likely having an important impact on abortion-related morbidity and mortality.”<sup>29</sup>

Within the international regulatory framework, WHO has embraced SMMA. In its 2012 publication *Safe Abortion: Technical and Policy Guidance for Health Systems*, WHO not only endorses mifepristone and misoprostol as a safe and reliable combination therapy for medical abortion but also notes that they are exempt from routine follow-up care in the absence of complications.<sup>30</sup> Since 2015, these drugs have been included in the WHO Model List of Essential Medicines.<sup>31</sup> At the time of their inclusion in 2015, these drugs were considered “complementary.” In 2019, the 21st model list reclassified them as “core” medicines and removed the need for close medical supervision.<sup>32</sup> Listing misoprostol and mifepristone as core medicines indicates that this combination should be a priority for governments and health care institutions to publicly finance and supply.

Furthermore, according to WHO, women themselves have an important role to play in caring for their own health through self-assessment and self-management.<sup>33</sup> Indeed, WHO recognizes that “self-management of medical abortion is an intervention that can take place without direct su-

pervision of a health-care provider; in this situation, the woman herself can be considered a health-care provider.”<sup>34</sup>

Not only is it much less expensive than clinic-based care on average, but self-managed abortion offers a series of comparative advantages.<sup>35</sup> The ability to complete the procedure from home increases the potential for privacy, convenience, and control over the process. Indeed, Heidi Moseson et al. found that SMMA—rather than a “last resort”—was the “preferred option over clinic-based models of abortion care, due, among other reasons, to considerations about autonomy, privacy, confidentiality and perceived mistreatment by formal health systems.”<sup>36</sup> Researchers have found that “some people, such as those who have reason to distrust the medical system, may opt to self-manage abortion for reasons other than lack of access to a clinic, such as increased privacy and autonomy.”<sup>37</sup>

As the evidence continues to grow, it is by now clear that SMMA holds great potential as a model for wider access.<sup>38</sup>

## Human rights standards

International human rights standards set the foundation for legal reform to enable SMMA. For decades now, human rights bodies have advanced norms that cover the various components of SMMA, from the right to sexual and reproductive health—including the right to abortion—to the right to benefit from scientific progress. We refer here to the three latest general comments issued by United Nations treaty monitoring bodies.<sup>39</sup>

In March 2016, the Committee on Economic, Social and Cultural Rights adopted General Comment 22 on the right to sexual and reproductive health, which aims to assist state parties with the implementation of their international obligations regarding the right to sexual and reproductive health.<sup>40</sup> Among other matters, General Comment 22 affirms that states have an obligation to adopt “appropriate legislative” measures to achieve the full realization of sexual and reproductive health and rights.<sup>41</sup>

This general comment affirms that the right to

sexual and reproductive health is an integral part of the right to health and recognizes abortion services as a component part of the right to health.<sup>42</sup> It notes that states have an obligation to repeal or eliminate laws, policies, and practices that criminalize, obstruct, or undermine an individual's or a particular group's access to health facilities, services, goods, and information, including abortion.<sup>43</sup> Laws that criminalize or restrict access to abortion are cited as examples of laws that must be repealed.<sup>44</sup>

Furthermore, the general comment lists core obligations that include the prevention of unsafe abortion, the provision of medicines according to the WHO Model List of Essential Medicines (which includes misoprostol and mifepristone), and the right to access comprehensive education and information on sexual and reproductive health.<sup>45</sup>

One of the most recent (and arguably crucial) components of the puzzle of international human rights law in terms of abortion is the Human Rights Committee's General Comment 36 on the right to life. This general comment, which interprets Article 6 of the International Covenant on Civil and Political Rights—one of the most important and widely ratified international human rights treaties of the United Nations system—holds that states “must provide ... legal and effective access to abortion” in expansive terms.<sup>46</sup> Additionally, it declares that states “may not regulate” abortion in a manner that compels resorting to “unsafe abortion” and that states “should revise their abortion laws accordingly.”<sup>47</sup>

Furthermore, the Committee on Economic, Social and Cultural Rights' newly adopted General Comment 25 on science and economic, social, and cultural rights demands that states adopt a gender-sensitive approach to the right to enjoy the benefits of scientific developments. This approach is of particular relevance to the right to sexual and reproductive health and requires that governments ensure access to up-to-date scientific technologies, including “medication for abortion.”<sup>48</sup> Prior to the adoption of this general comment, the United Nations Special Rapporteur on cultural rights had already underscored that “[t]he rights to science and to culture should both be understood as including

a right to have access to and use information and communication and other technologies in self-determined and empowering ways.”<sup>49</sup>

These international human rights standards set the grounds for the creation of an enabling environment for SMMA that includes the removal of all legal and regulatory barriers to abortion, access to essential medicines for abortion, and access to nonbiased, evidence-based information. While international bodies are limited in terms of the sanctions they can order, and much work is needed to further strengthen international standards, the general direction is fairly clear, meaning that these standards can and should be used to pressure states to invoke reform.<sup>50</sup>

## The global legal landscape

Over the past decade, several countries worldwide have adopted new legislation on abortion and liberalized access. However, the model of access proposed by self-managed abortion, which builds on the decriminalization and the de-medicalization of the process, is far from being enabled in these new abortion laws. Rather, the majority of laws still rely on an overmedicalized model of access that threatens with criminal sanctions those who self-manage and those who support people who self-manage. These laws clash with the evidence and the human rights standards described above.

### *Uruguay*

Uruguay gained international praise in 2012, when it passed one of the most liberal abortion laws in Latin America. The Voluntary Termination of Pregnancy Act (Law 18,987) waives criminal penalties for abortion until the 12th week. There are a few legally prescribed exceptions: in cases of rape, a pregnant person can access an abortion without fear of criminal liability until the 14th week of pregnancy, and in cases where a pregnancy endangers the health of a pregnant person, it can be terminated at any point.

However, according to the abortion law, in order for an abortion to be legal—and thus not a crime, punished accordingly—a woman needs to

go through the following chronological steps: (1) a medical consultation with an obstetrician-gynecologist; (2) a second consultation with an interdisciplinary team who informs the woman of the procedure, its “inherent health risks,” and the available alternatives; (3) a mandatory waiting period of five days; (4) a consultation to confirm the woman’s willingness to follow through with the procedure; (5) the abortion itself; and (6) a post-abortion consultation.<sup>51</sup> Law 18,987 does not substantially change the existing Criminal Code, from 1938, which still applies to all those cases in which an abortion does not meet the prescribed requirements set by the law.<sup>52</sup>

In 2011, before the adoption of the law, Uruguay had introduced a “harm reduction” approach.<sup>53</sup> This approach consisted of providing people seeking abortions with a “before abortion” and an “after abortion” visit to a reproductive health polyclinic in which information on misoprostol and its use was provided.<sup>54</sup> This model was built on the fact that people were procuring and using misoprostol to self-manage their abortions despite misoprostol not being available over the counter for abortion (misoprostol was available in retail pharmacies for the treatment of gastric ulcers).<sup>55</sup> The availability of the drug in the informal market, now coupled with the provision of information and post-abortion care, has resulted in a model that is being replicated internationally.<sup>56</sup>

After the passing of the law, in 2013, the Ministry of Health updated its medicines list (Formulario Terapéutico de Medicamentos) and removed the drug from retail pharmacies (for any indication), restricting the dispensation of mifepristone and misoprostol to intra-hospital pharmacies.<sup>57</sup> This closed the regulatory door to access medicines in the formal market for self-managed abortions outside of the burdensome process set by the law.

### Chile

After two years of congressional deliberations, in September 2017 Chile adopted a new abortion act that allows abortion in certain cases. Previous to this, Chile was one of the few countries in the world

that did not permit abortion under any circumstances. The complete ban on abortion—initiated in 1989 by General Pinochet during the civic-military dictatorship—was lifted with this law.<sup>58</sup>

The new law adopts the model of *causales* (grounds) and gestational limits and allows abortion when a woman’s life is in danger, when there are fetal anomalies incompatible with life, and in the case of rape (within 12 or 14 weeks, depending on the age of the pregnant person). The law requires that a doctor confirm whether the legal requirements are met for the first two grounds, and in the case of rape a psychosocial team must confirm the gestational age of the pregnancy and evaluate the woman’s statement regarding the rape.<sup>59</sup> The law requires the doctor to be a surgeon (*médico cirujano*), limiting the range of health care professionals who can provide abortions. Abortions outside these grounds still fall under articles 342–345 of the Criminal Code, which criminalize the pregnant person, whoever assists or “causes” an abortion, and the medical professional who intervenes.<sup>60</sup>

Interestingly, Chile is one of the many countries where informal networks provide accurate information on how to self-manage an abortion. One hotline alone answered 20,000 calls between 2009 and 2013, and hotlines have been crucial for informing people of the correct and safe use of misoprostol for abortion.<sup>61</sup> In 2014, misoprostol could be purchased on the informal market in Chile for prices ranging anywhere from US\$70 to 215, although on-the-ground information points to much higher prices.<sup>62</sup> The introduction and widespread use of misoprostol in Chile has been singled out as one of the causes of the reduction in the rate of septic abortions, which was a major problem during the 1980s.<sup>63</sup> Feminist networks have been at the forefront of abortion access, advocating for the expansion of self-managed abortion beyond the first trimester.<sup>64</sup> However, the law did not follow suit.

### Ireland

Until 2018, Ireland had one of the world’s most restrictive abortion laws. Since 1970, a “hidden

diaspora” of more than 170,000 Irish women has traveled to England for abortion, and an increasing number of women in Ireland are self-managing their abortions.<sup>65</sup>

After the referendum held in May 2018 to repeal the Constitution’s Eighth Amendment, Ireland adopted a new law on abortion. The Health (Regulation of Termination of Pregnancy) Act 2018, in force as of January 2019, lifts the near-total ban on abortion imposed since 1983.<sup>66</sup> The act legalizes abortion on request up to 12 weeks of pregnancy after a mandatory three-day waiting period. The law provides no exceptions for cases in which the 12-week limit is crossed during the waiting period, or because of delays due to traveling from rural areas or waiting for further tests ordered by a doctor. After the 12th week, the procedure for accessing an abortion requires the involvement of two doctors (an obstetrician and another “appropriate medical practitioner”) and is permitted only in cases of a condition likely to lead to death of the fetus, a risk to the pregnant woman’s life or health, and an emergency. Two medical practitioners need to be of the opinion that the conditions are fulfilled, which gives doctors a wide margin of discretion, especially with regard to terms such as “[risk] of serious harm to health” that are not defined in the law. In 2017, for example, the Abortion Support Network reported that two women who had attempted suicide more than once were denied abortions.<sup>67</sup>

Abortions provided outside of the procedure set by the law are criminally prohibited. While the act does not criminalize the pregnant person themselves, other people (such as family members, support networks, and doctors) who assist a pregnant person in obtaining an abortion outside of the provisions of the law can be subject to a prison sentence of up to 14 years.<sup>68</sup>

### *Isle of Man*

The Isle of Man Abortion Reform Act 2019 came into effect in May 2019.<sup>69</sup> This law allows abortion on a woman’s request in the first 14 weeks of pregnancy. Article 6 details the conditions that need to be satisfied for abortion services to be provided. During the period between the 15th and 23rd week

of pregnancy, abortion may be provided in cases of sexual assault, a risk to the woman’s health, fatal or severe fetal impairment, or serious social indications. Abortion is also permitted when the pregnancy would cause risk to the pregnant woman’s life or if the baby, when born, would suffer serious impairment or die shortly after birth.

Article 7 of the law lists the people who may participate in the provision of abortion services. The law expands the scope of people who can provide abortion to include medical practitioners, nurses, midwives, and pharmacists. They need to be authorized by the Department of Health and Social Care, demonstrate that they possess the appropriate skill in relation to the gestation period, and be registered in the corresponding council. Outside this list of professionals, anyone who participates in the provision of abortion services commits an offense punishable with a fine or seven years’ custody (sec. 7), and those who prescribe or supply medication for abortion also commit an offense punishable with a fine or five years’ custody (sec. 11). The law explicitly states that the provision of advice or information about abortion is not an offense, and this includes information about obtaining an abortion abroad or via electronic communications (art. 10).

When it comes to medical abortion, a pharmacist or a “relevant professional” can prescribe and supply the “relevant products.” Relevant professionals are those listed in paragraph (a) or (d) of the definition of “health care professional” in section 3 of the Health Care Professionals Act 2014: a registered medical practitioner or a member of the profession of nursing or midwifery who is a registrant.<sup>70</sup>

### *New Zealand*

In April 2020, New Zealand adopted one of the most liberal abortion laws in the world. The Abortion Legislation Act 2020 represents the first substantial change to abortion laws in New Zealand in 43 years.<sup>71</sup> The issue was previously regulated by the Contraception, Sterilisation and Abortion Act 1977 and the Criminal Code.

The new act legalizes abortion on request until 20 weeks. In this instance, the woman can self-refer

to an abortion provider (rather than requiring a referral from her health care provider), and while the involvement of a health professional is required, it does not necessarily have to be a doctor. Expanding in this way the range of professionals who can provide abortions is in line with the evidence discussed in the second section of this paper. The act substantially expands the scope of registered health practitioners who can provide abortions: doctors, midwives, nurse practitioners, and registered nurses. It also removes the requirement that abortions need to be performed on licensed premises.<sup>72</sup>

After 20 weeks, abortion is legal and available if the “health practitioner reasonably believes that the abortion is clinically appropriate in the circumstances.” To make that assessment, the health practitioner needs to consult at least one other qualified health practitioner and have regard to the woman’s physical health, mental health, and overall well-being.

The Abortion Legislation Act repeals the offense of procuring or attempting to procure an unlawful abortion set out in section 44 of the Contraception, Sterilisation and Abortion Act, the need for an abortion supervisory committee (section 10), and the requirement that abortions need to be certified by two certifying consultants. It also amends the Crimes Act 1961 and amends section 183 by establishing penalties of a maximum of five years of imprisonment for those other than health practitioners who procure, or attempt to procure, an abortion. The amendment explicitly states that a pregnant woman herself cannot be guilty of an offense under this section (as had previously been the case). However, the offense remains for non-health practitioners, meaning that those who are “unqualified” providers or people who provide support or assistance still face the risk of criminalization.<sup>73</sup>

### *Thailand*

Abortion is currently regulated in articles 301–305 of the Thai Criminal Code. The code, last amended in 1957, defines offenses in relation to induced abortion as “any actions causing the delivery of a dead fetus.” Section 301 of the Criminal Code states that “[a]ny woman causing her own abortion or

allowing another person to cause it shall be punished with not more than three years of prison or a fine of not more than six thousand Baht, or both.” Under article 305, abortion can be performed only by a physician for two specific conditions: risk to the woman’s health and pregnancy arising from rape.<sup>74</sup> Several problems arise in the interpretation and implementation of the law since, for example, there is no definition of health.

Despite the restrictive laws, it is estimated that around 300,000 to 400,000 abortions occur each year; “almost all of these are done ‘underground’ with appalling morbidity and mortality,” according to the *Thai Journal of Obstetrics and Gynaecology*.<sup>75</sup> The National Essential Medicines List includes the mifepristone-misoprostol combipack as an approved treatment for ending pregnancies in a hospital setting.<sup>76</sup>

In February 2020, the Constitutional Court ruled that section 301 violates sections 27 and 28 of the 2017 Constitution, which endorse equal rights between men and women, as well as the right and liberty of everyone in their life and person. The decision reads, “The Constitutional Court resolves in the majority that Sections 301 and 305 of the criminal code should be amended to conform with the current situation.”<sup>77</sup> The ruling does not annul or derogate the law but gives the government 360 days to amend it.

Following this judgment, a new law entered into force on February 7, 2021.<sup>78</sup> This law amends the abovementioned sections by allowing abortion on request until the 12th week of pregnancy. The Medical Council of Thailand and the Royal Thai College of Obstetricians and Gynaecologists both recommend the 12-week limit.<sup>79</sup> Criminal penalties remain for those who have abortions after week 12 and outside of the grounds set by the country’s Medical Council (by a qualified professional in cases of sexual assault, threat to the mother’s physical or emotional health, and if the fetus is known to have abnormalities). The new wording of section 301 reduces the penalties to no longer than six months of jail and a fine no higher than 10,000 baht.

While constituting an important step, the newly adopted law follows the traditional model,

retaining criminal penalties and a medicalized model of access. Activists continue to advocate for further decriminalization reform.<sup>80</sup>

### Argentina

In August 2018, the Argentinian Senate held a historic vote on a law that decriminalized abortion during the first 14 weeks of pregnancy. After 23 hours of intense debate, the bill was adopted by a very narrow margin in the lower house (129 in favor and 125 against) but was later rejected in the Senate (31 in favor and 37 against).<sup>81</sup> A new bill was debated in December 2021, culminating in the passing of Law 26,710.<sup>82</sup>

The new law represents a clear move toward the liberalization of abortion by recognizing a right to access abortion care on request until the 14th week of pregnancy. It specifically amends the Criminal Code (art. 86) to state that abortion is not a crime when done before the 14th week. After the 14th week, the law provides for a system of *causales*, allowing abortion in cases of rape or risk to the pregnant woman's life or health.

Crucially, the new wording of article 86 repeals the need for the involvement of a doctor in order for the abortion to be exempt from criminal penalties, representing a clear move toward demedicalization. However, under the new law, pregnant people and those who assist and support them outside the grounds and time frames provided by the law still risk criminal prosecution. The law also creates a new crime for health care personnel who hinder or obstruct access to abortion (art. 85 bis).

Similar to Chile, the country has a long history of networks of *acompañantes* (abortion access companions), which have been key in ensuring people's access to abortion and helping them self-manage their abortions.<sup>83</sup> The Socorristas en Red, for example, has provided training for doctors on the use of misoprostol and has strengthened collaboration between the formal and informal systems (for example, the network refers people to abortion-friendly providers if additional medical support is needed, and clinicians refer people to the network for early termination).<sup>84</sup> These groups

have expressed that they will continue to serve people who need abortions, seeing their work as an alternative—rather than a subsidiary—to institutionalized systems of care.<sup>85</sup> In 2018 alone, they accompanied more than 7,000 people in self-managing their abortions.<sup>86</sup>

### Conclusion

This “fragmented landscape” of abortion laws and regulations has been considered to make no legal or public health sense.<sup>87</sup> The restrictions on abortion (including self-managing) discussed above show that abortion is still construed as an exceptional matter that necessarily requires medical intervention or supervision.<sup>88</sup> Self-managed abortion and the growing body of evidence come to change the model of access to abortion but also question the portrayal of abortion as an exceptional matter that requires medical control or supervision.<sup>89</sup>

Despite being a very common and safe experience (if given the conditions), abortion continues to be overregulated. However, the discussions around abortion are rarely restricted to health and human rights arguments, with technical, political, religious, and many other factors coming into play. Undoubtedly, we acknowledge that law reform is a convoluted process that requires a series of strategic political compromises. Clarifying what the basic tenets of legal reform should be (in line with the latest human rights standards and available evidence) can help separate the wheat from the chaff in abortion debates.

The findings of our review show that while the recently adopted laws are a move toward liberalization, much more work is needed to bring the domestic frameworks into line with the evidence and human rights. Most of the reforms embrace partial decriminalization or exception-based criminalization. This means that abortion remains punishable under the law in certain circumstances, such as when requirements of gestational age, waiting periods, or specific grounds are not met. Furthermore, laws continue to criminalize those who provide support to people who self-manage,

leaving a constellation of actors—who have played a crucial part in making SMMA safe(r)—exposed to the risks of criminalization.<sup>90</sup>

First, all of the laws discussed above still retain some criminal provisions related to abortion. For example, while criminal penalties are repealed for women themselves in Ireland and New Zealand, family members, support networks, and friends who assist a pregnant person in obtaining an abortion outside of the provisions of the law still risk criminal prosecution. In line with the framework proposed above, the available evidence and human rights standards clearly indicate the need for the decriminalization of abortion, including for those who support self-managed abortion.

This, of course, does not leave pregnant people unprotected, as general criminal offenses that apply to all medical treatment, quality of products, and more would continue to apply to non-consensual or dangerously negligent procedures. There is no continuing role for specific laws on abortion care, and in those cases where criminal sanctions may remain appropriate, specific abortion offenses are unnecessary because existing general principles of criminal law are sufficient to support prosecutions.<sup>91</sup>

Second, we found that many of the laws still conceive of abortion as a “procedure” that is “performed” by somebody other than the pregnant person. As we saw above, some of the laws in force still retain the clinical settings and the involvement of (one or more) medical professionals as the desirable (and therefore decriminalized) setting for an abortion to take place. Uruguay’s law, for example, requires various consultations with medical professionals, a mandatory five-day waiting period, and a consultation with a multidisciplinary team before a woman can obtain a prescription and self-administer the misoprostol at home.<sup>92</sup> We see this as part of a worrisome trend whereby laws expand access, but within a medicalized model that continues to create vulnerability and risk for people who self-manage and people who support them outside of the procedures set by the law. We conclude that while the introduction of abortion provision within institutionalized systems of care is to be celebrated, the demedicalization and decriminalization of

abortion should go hand in hand.

Besides decriminalization, an enabling legal environment for self-managed abortion would require us to look beyond abortion laws. It would mean lifting legal and policy barriers to SMMA that fall outside of abortion laws. Namely, this includes removing all regulatory restrictions on access to misoprostol and mifepristone (making them available and accessible over the counter) and adopting robust legislation on access to information that ensures that evidence-based, scientifically accurate comprehensive information on how to safely self-manage abortions is made widely available without censorship.<sup>93</sup>

While laws are deeply contextual, it is increasingly impossible to speak of a purely domestic abortion law, and lawmakers and framers often seek inspiration from other jurisdictions and from international law.<sup>94</sup> Highlighting the progress and shortcomings of recently adopted laws from around the world can help us create a roadmap for further reform in other contexts: abortion should not be a matter of criminal law, and people who access abortions and people who support and accompany them should not fear harassment, stigma, or criminalization. Lawmakers no longer can justify health care provider involvement or unnecessary restrictions. There is enough evidence and support from international human rights standards to ground developments toward an enabling legal environment for SMMA.

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