Realizing the Full Decriminalization of Abortion:

A Comprehensive Approach Through Public Health and International Human Rights Law

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Abstract

Over the past few decades, there has been mounting consensus within the international human rights and public health communities that restrictive abortion laws violate a range of fundamental human rights and are detrimental to individuals' health and well-being. Indeed, human rights bodies have taken steadily more progressive stances on abortion, and global public health entities also increasingly recognize that abortion is a public health need. Centering sexual and reproductive health and rights, and abortion specifically, in discussions of strengthening health systems presents opportunities to expand support for abortion rights. This article integrates evidence from three perspectives—demographic, health and legal—to present arguments for the liberalization of abortion laws that are more compelling than each perspective alone. Drawing on human rights law and updated evidence on abortion, the article demonstrates that the criminalization of abortion creates significant barriers to accessing legal abortion services by generating stigma, failing to guarantee patients' confidentiality, and disproportionally impacting marginalized and rural communities. To guarantee access to abortion services free from stigma, and in accordance with human rights, states must remove all abortion provisions from the penal code and incorporate abortion regulations within health codes, as done for other medical procedures. Both full decriminalization of abortion and health system policy reforms, with a particular emphasis on reaching vulnerable groups, are essential for all people to fully realize their right to make autonomous reproductive health decisions and to have access to the information and services necessary to achieve this right free from discrimination, coercion, and violence.

I. Introduction

The consensus within the international human rights and public health community is that restrictive abortion laws violate a range of fundamental human rights, including the rights to health, life, privacy, freedom from gender discrimination, and freedom from torture and from cruel, inhumane and degrading treatment.[1] United Nations (UN) treaty monitoring bodies, which provide authoritative guidance about states' human rights obligations, have repeatedly acknowledged the direct relationship between laws that criminalize or restrict abortion and their negative physical and mental health outcomes, including maternal mortality and morbidity resulting from unsafe abortion.[2,3,4] Indeed, international and regional human rights bodies have taken steadily more progressive stances on abortion, contributing to advances in national legal frameworks through legislative and policy reforms, as well as through judicial decisions on abortion.[5] Nonetheless, 42% of all women live in countries with restrictive abortion laws, including 93% in Sub-Saharan Africa and 97% in Latin America and the Caribbean.[6] Further, the United States (US) Supreme Court's recent decision in *Dobbs v. Jackson Women's Health Organization* to remove all US federal protections for abortion has sparked the adoption of abortion bans and other restrictions in states throughout the United States.[7] As a result, 58% of US women of reproductive age live in states that have demonstrated hostility toward abortion rights.[8]

The COVID-19 pandemic affected the provision of health care, including sexual and reproductive health (SRH) services worldwide, with governments adopting a range of approaches to mitigate this impact.[9] These included policies to reduce obstacles to abortion and to ensure equity in access to SRH care. The adoption of such policies demonstrates that consideration of sound scientific evidence can guide the equitable provision of care and can be replicated to advance access to safe abortion.[10]

This article integrates evidence from the demographic, health, and legal perspectives to discuss the liberalization and decriminalization of abortion laws and to demonstrate that the criminalization of abortion creates significant barriers to accessing legal abortion services by generating stigma, failing to guarantee patients' confidentiality, and disproportionally impacting marginalized and rural communities. Liberalization of existing laws (broadening the grounds under which abortion is legally permitted) is a critical step in expanding access to safe abortion care. However, changing the law alone does not guarantee that abortion services become more available and accessible. Law reform may be insufficient in the absence of *decriminalization* of abortion (the complete removal of all regulations on voluntary abortion from a country's penal code). Once abortion has been decriminalized, states can then relocate the regulation of abortion to other noncriminal legislation or to the realm of professional medical standards, like any other medical procedure. By removing criminal penalties on abortion, states can increase the availability of, and access to, safe abortion services and promote the fulfillment of fundamental human rights, including the rights to life, health, equality and nondiscrimination.

II. Occurrence of Abortion Around the World

Women in all regions of the world obtain abortions, although the incidence varies across regions. During the period 2015–2019, 73 million abortions occurred around the world each year; the annual abortion rate was 39 per 1,000 women aged 15–49, ranging from 17–21 per 1,000 in Europe, North America and Oceania to 32–33 per 1,000 in Sub-Saharan Africa and Latin

America and the Caribbean and to 43–53 per 1,000 in subregions of Asia and North Africa (Table 1).[11] Over the past 30 years, the abortion rate has remained relatively steady at the global level. Only Europe and North America saw a large, consistent decline, from 46 per 1,000 in 1990–1994 to 17 per 1,000 in 2015–2019.

Table 1. Abortion rates for the world and for all major global regions, by selected time period*

	1990–1994	2000–2004	2015–2019	% change from 1990–1994 to 2015-2029	Probability of change (%)
World	40	35	39	–3	62
Region					
Sub-Saharan Africa	27	31	33	24	87
West Asia & North Africa	61	56	53	–14	71
Central & South Asia	40	35	46	15	71
East & Southeast Asia	38	36	43	13	74
Latin America	35	35	32	–8	66
Europe & North America	46	27	17	–63	100
Income					
High	21	18	15	–31	100
Middle	45	38	44	–4	62
Low	36	39	38	4	60

*Abortions per 1,000 women aged 15–49.

Sixty-one percent of the 121 million unintended pregnancies that occurred annually during the period 2015–2019 ended in abortion. Globally, this proportion has increased over the past three decades, from 51% in 1990–1994, and it has risen in all subregions except Europe and North America and Oceania.[11]

Notably, abortion rates are not correlated with abortion law status (Table 2): Estimates for 2015–2019 show that the average abortion rate for countries that permit abortion under broad criteria is 40 per 1,000 women aged 15–49. Countries that prohibit abortion altogether also have a rate of 40 abortions per 1,000 women aged 15–49. The rate among countries in other restrictive categories (such as where abortion is permitted only to save a woman's life or to preserve her physical or mental health) is similar (36 per 1,000).[11]

Table 2. Global abortion rates, by broad legal status and World Bank income grouping, for selected time periods*

	1990–1994	2000–2004	2015–2019	% change from 1990–1994 to 2015-2019	Probability of change (%)
Broadly legal	44	36	40	–8	73
Broadly legal (excluding India & China)	46	32	26	–43	100
High income	17	15	11	–36	100
Middle income	52	42	48	–8	72
Middle income (excluding India & China)	95	56	45	–53	100
Low income	40	37	34	–15	81

Restricted					
High income	44	34	32	–28	94
Middle	31	31	36	16	88
Low	34	40	39	15	80

*Abortions per 1,000 women aged 15–49.

Thus, women around the world seek abortion at similar rates, regardless of their country's legal framework. What differs is that where abortion laws are highly restrictive, people face obstacles—legal, social, economic, or other—to exercising their reproductive autonomy, with negative consequences for their health, lives, privacy and more.

III. Abortion Safety and Implementation of Access to Services

To ensure the safe provision of abortions, the World Health Organization (WHO) publishes guidelines that cover each component of comprehensive abortion care.[12] WHO's guidance states that "abortion, using medication or a simple outpatient surgical procedure, is a safe health-care intervention, when carried out with a method appropriate to the gestational age of pregnancy and—in the case of a facility-based procedure—by a person with the necessary skills."

In practice, however, abortion safety largely depends on countries' abortion laws and their implementation. Abortions are much more likely to be safe where laws are liberal and well-implemented, or where safe services are widely accessible despite restrictive laws. In contrast, abortions are much more likely to be unsafe where the law is highly restrictive, or where abortion is permitted under broad criteria, but access is poor.[13]

Globally, during the period 2010–2014 (the most recent estimate available), an estimated 55% of all abortions were classified as safe and 45% as unsafe (meaning that these abortions either were done using methods not recommended by WHO or were performed by untrained providers).[14] Unsafe abortion has a serious impact on people's health, well-being and survival. In 2012, roughly 7 million women were treated at health facilities for complications of unsafe abortion in developing regions of the world.[15] An estimated 24,000 women died of complications from unsafe abortion in 2019—8% of all maternal deaths in low- and middle-income countries (LMICs).[16]

Almost all unsafe abortions took place in LMICs, many of which have restrictive abortion laws, and they varied in degree: Unsafe abortions with the most severe potential health consequences (15% of all abortions) were classified as "least safe"—that is, they did not use a method recommended by WHO *and* they were not done by a trained provider. The remaining unsafe abortions (30%) were deemed "less safe," as one of these factors applied, but not both.[14] The proportion of all abortions classified as least safe is especially high in Africa (48%), much lower in Latin America and Asia (17% and 8%, respectively), and negligible in North America and Europe (less than 0.1%).[14] The proportion of abortions that are least safe varies widely by

countries' income, from 54% of all abortions in low-income countries to 20% in lower middle-income countries, 5% in upper middle-income countries and 1% in high-income countries.[†]

IV. Evolution of Abortion Access as a Human Right

Abortion access was first recognized as an international human right in 1994 at the International Conference on Population and Development (ICPD), where 179 countries adopted the first international consensus document in which states recognized that reproductive rights are human rights already enshrined in domestic and international law.[17] The ICPD Programme of Action called upon governments to strengthen their commitment to women's health by addressing unsafe abortion and supporting a woman's right to make her own reproductive decisions. In 1995, the Fourth World Conference on Women adopted the Beijing Declaration and Platform of Action, which recognized that women's human rights include the right to have control over their own bodies and the right to decide freely and responsibly on matters relating to their sexuality, including SRH, free from coercion, discrimination and violence.[18] Then, in 1998, the Asian Human Rights Charter articulated that women should be given the full right to control their SRH, free from discrimination or coercion.[19]

Global recognition of the right to abortion access expanded further in 1999, when the Committee on the Elimination of Discrimination against Women (CEDAW) adopted its General Recommendation No. 24 on Article 12 of the Convention (Women and Health), which urged states to decriminalize abortion "when possible."[4] Between 2000 and 2004, two UN treaty monitoring bodies—the Human Rights Committee (HRC) and the Committee on the Rights of the Child—explicitly called on states to legally permit abortion, at minimum, when a pregnancy poses a risk to a woman's life or health, when it results from rape or incest, and in cases of fatal fetal impairment.[20,21]

Furthermore, at the regional level, the African Union enshrined the right to abortion under certain circumstances in 2003 in its major human rights treaty, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (known as the Maputo Protocol).[22] This instrument is binding for all countries that ratify it. The Maputo Protocol was the first regional treaty explicitly recognizing reproductive rights and health as a human right, including access to abortion. It requires states to authorize abortion in cases where the life or health (physical or mental) of the woman is at risk, and in cases of rape, incest, and severe fetal impairment. The Maputo Protocol is still the only human rights instrument whose text (adopted by states parties) explicitly requires abortion to be permitted on certain grounds.

By 2004, human rights bodies began recognizing instances in which lack of access to safe abortion violated other fundamental human rights. For example, in 2004, the HRC noted with concern that total bans on abortion can create situations in which pregnant people are forced to seek high-risk unsafe abortions, violating the rights enshrined in the International Covenant on Civil and Political Rights (ICCPR).[23] The HRC then expanded its recognition of the importance of abortion access through its decision in the groundbreaking case *K.L. v. Peru,* in which it

[†] In World Bank classifications, "low-income" corresponds to a 2018 gross national income per capita of $1,025 or less, "lower-middle–income" to $1,026–3,995, and "upper-middle–income" to $3,996–12,375 (World Bank, World Bank country and lending groups (2020 fiscal year), 2019, https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-countryand-lending-groups.).

established that denying people access to abortion can amount to cruel, inhuman and degrading treatment, as well as being a violation of the rights to privacy and personal integrity.[24]

The Convention on the Rights of People with Disabilities, adopted in 2006, was the first UN human rights treaty to formally identify the right to SRH as a human right.[25] That year, the Yogyakarta Principles also recognized SRH as a fundamental aspect of the right to health.[26] By 2008, CEDAW,[4] the HRC[27] and the Committee on Economic, Social and Cultural Rights (CESCR)[28] had all condemned absolute bans on abortion and urged states to eliminate punitive measures for women and girls who undergo abortions and for health care providers who deliver abortion services.

By 2010, global and regional human rights bodies recognized the right to safe and legal abortion when the pregnancy poses a risk to the woman's life or health, when the pregnancy results from rape or incest, and in cases of severe fetal impairment. The following decade witnessed increased global and regional human rights jurisprudence recognizing that access to safe and legal abortion under certain circumstances is grounded in fundamental human rights. In 2011, in *L.C. v. Peru,*[29] CEDAW ordered Peru to change its legislation to expand the right to access safe and legal abortion, by decriminalizing abortion in cases of rape and sexual abuse and ensuring that safe and legal abortion services were accessible in cases where the pregnancy risked a woman's physical and mental health.

Previously, human rights bodies had only obligated states to provide access to abortion under circumstances already legal in the country.[24] CEDAW's groundbreaking precedent extended the right to abortion access beyond the existing legal framework for abortion in Peru and acknowledged that the failure to provide access to abortion when a pregnant woman's health was at risk amounted to gender discrimination. This decision was also the first time a human rights body required a state to broaden its abortion law to permit access to abortion in cases of rape.

Around the same time, legal recognition of access to abortion was evolving at the regional level in Latin America. The Inter-American Court of Human Rights' decision in *Artavia Murillo et al. ("in-vitro fertilization") v. Costa Rica* determined that fertilized ova are not entitled to human rights protections prior to implantation and that once implanted they are subject to incremental and gradual protection in accordance with their development in the womb, which should still be proportional to the restrictions imposed on the pregnant person's human rights.[30] The Court's determination that the American Convention on Human Rights does not provide absolute prenatal protections was a turning point in the acknowledgment and protection of reproductive rights in Latin America. This decision also marked the first time the Court had ruled on the scope of the Convention's controversial Article 4.1, effectively ending previous arguments that it afforded an absolute right to life prior to birth.

In a landmark 2016 case that advanced abortion rights, the HRC held in *Mellet v. Ireland* that prohibiting and criminalizing abortion in cases where the life of the fetus is at risk violates women's rights to freedom from cruel, inhuman or degrading treatment and to privacy and equality, as enshrined in the ICCPR.[31] This was the first instance in which an international or regional court or quasi-judicial body explicitly and unequivocally held, in a decision on an individual complaint against a state, that prohibiting and criminalizing abortion violates women's human rights.[32] Building on the precedent established in *L.C. v. Peru,* the HRC demanded that Ireland broaden its abortion law and then extended the ruling by stating that Ireland should

reform its abortion law entirely—even amending its constitution, if necessary. A similar decision followed in 2017, when the HRC's holding in *Mellet v. Ireland* was confirmed in *Whelan v. Ireland*.[33] These two decisions did not confine the right to access abortion to specific circumstances and firmly noted that the state must ensure access to abortion.‡

In 2019, the HRC adopted *General Comment No. 36 on the Right to Life*,§ in which it articulated a formal right to an abortion: "States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable."[2]

Thus, in the 30 years between 1990 and 2020, global and regional human rights bodies identified, articulated and then developed their recognition of access to abortion as a human right. This evolution moved from recognizing access to safe and legal abortion in cases of rape, incest, severe fetal impairment, or when the life or health of the pregnant woman is at risk to articulating that the criminalization of abortion violates human rights; by 2020, human rights bodies were urging states to decriminalize abortion under all circumstances.[2,34]

Global and regional human rights bodies' increasing recognition of access to safe and legal abortion services has had positive effects on jurisprudence around the world. Regional and domestic courts have applied emerging human rights standards on abortion by urging states to liberalize abortion laws. For example, CEDAW's decision in *LC v. Peru* influenced the Inter- American Court of Human Rights' decision in *Artavia Murillo*. These decisions led Peru to issue a protocol of access to therapeutic abortion and Costa Rica to legalize and support access to in- vitro technologies for people struggling with infertility. Likewise, the HRC's decisions in *Mellet* and *Whelan* were cited in the report of Ireland's Joint Oireachtas Committee on the 8th Amendment as one of three main reasons why constitutional reform on abortion was necessary.[35]
In the resulting public referendum, Irish citizens voted to liberalize the abortion law, moving from a near total abortion ban to permitting abortion without restriction as to reason up to 12 weeks' gestation.[36] Similarly, the adoption of the Maputo Protocol was followed by a wave of abortion law reforms among African countries, many of which adopted more liberal abortion laws after becoming parties to the Protocol.[6] In sum, the adoption of liberal human rights norms around legal access to abortion at the international and regional levels has positively impacted jurisprudence and abortion law reform at the national level.

V. Trends in abortion law reform and implementation

While four in 10 women around the world live in countries with highly restrictive abortion laws, these proportions are much higher in Sub-Saharan Africa (93%) and Latin America and the Caribbean (97%).[6] Moreover, about 60% of all abortions in Latin America and 30% in Africa are classified as "less safe," and 17% in Latin America and 48% in Africa were classified as *least*

‡ Ireland reformed its abortion law in 2019, following a referendum in 2018 that was heavily influenced by the HRC's decisions in the *Mellet* and *Whelan* cases.
§ General Comments are authoritative guidance documents that human rights bodies publish detailing states' obligations under the different articles contained in the relevant Convention. In General Comment No. 36, the HRC articulated a state's obligations under Article 6 of the ICCPR.

safe.[14] It is worthwhile to examine in closer detail the trends in abortion law liberalization in these regions and how laws are implemented.

In some cases, adoption of a more expansive abortion law can lead to increases in access to abortion care, but neither liberalization of abortion laws nor removal of procedural barriers automatically translate into improved access. Abortion laws in both Latin America and Sub- Saharan Africa were considerably liberalized between 2000 and 2019, yet over the period 2010–
2015, large proportions of all abortions there were unsafe.[14] It is also noteworthy that liberalization of abortion laws did not lead to an increase in abortion incidence; in fact, there was no significant change in abortion rates during that time.

Reform in Sub-Saharan Africa

Over the last 30 years, 23 countries[**] in Sub-Saharan Africa liberalized their abortion laws, predominantly through legislative reform.[37,38,39] Of these, 12[††] removed complete bans on abortion. Five (Benin, Chad, Côte d'Ivoire, Kenya and Mali) also expanded exceptions to permit abortion beyond cases when the life of the pregnant woman is at risk. Twenty-two (all but Somalia) introduced laws permitting abortion on additional grounds, including health risks, rape, and/or incest. Finally, three (Mozambique, Sao Tome and Principe, and South Africa) adopted progressive legislation to allow abortion on request up to varying gestational limits.

Many of these countries liberalized their abortion laws following the 2003 adoption of the Maputo Protocol.[6,22] This suggests that the Protocol's provisions obligating states parties to permit abortion when the woman's life or health are at risk or when the pregnancy is the result of sexual assault, rape, incest, or severe fetal impairment may have had a positive impact on legislative reform processes in the region. For example, Togo ratified the Maputo Protocol in 2005[40] and in 2007 added explicit legislation on abortion to save a woman's life and to protect her health, as well as in cases of rape, incest or severe fetal impairment.[41] Prior to this legislation, Togo's Penal Code did not explicitly mention abortion, and the service was considered illegal under most or all circumstances.[42]

The pace of liberalization in Sub-Saharan Africa has increased over the past 30 years. Only three countries (Botswana, Burkina Faso and South Africa) liberalized their abortion laws between 1990 and 1999.[39,40] Then, between 2000 and 2010, 10 countries[‡‡] removed restrictions from their abortion laws, with two (Eswatini and Niger) removing complete abortion bans.[§§37] Between 2011 and 2019, 11 countries liberalized their laws, with two (Chad and Central African Republic) further broadening previously amended laws. Five countries in the first half of the decade and four in 2012 alone expanded legal grounds for abortion.[37] Between 2015 and 2019, Chad, Côte d'Ivoire, DRC, Eritrea and Gabon liberalized their abortion laws to permit abortion

[**] Angola, Benin, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, the Democratic Republic of the Congo (DRC), Ethiopia, Eritrea, Eswatini (formerly Swaziland), Gabon, Guinea, Kenya, Lesotho, Mali, Mauritius, Mozambique, Niger, Rwanda, Sao Tome and Principe, Somalia, South Africa and Togo.

[††] Angola, Burkina Faso, Central African Republic, DRC, Eswatini, Gabon, Lesotho, Mauritius, Niger, Sao Tome and Principe, Somalia and Togo

[‡‡] Benin, Central African Republic, Chad, Eswatini, Ethiopia, Guinea, Kenya, Mali, Niger and Togo.

[§§] Although abortion was also considered completely illegal in Togo, it was not explicitly mentioned in the law, nor did it have an explicit abortion ban. Thus, it is not considered to have removed a complete ban.

on broader grounds.[39] DRC, Eritrea and Gabon transformed their laws from total prohibition of abortion under any circumstances to permitting abortion in cases where the pregnancy risks the life of the pregnant person. (The DRC and Eritrea also added exceptions to permit abortion in cases where the pregnancy risks the *health* of the pregnant person.)[37,39]

Implementation of new abortion provisions has varied widely depending on the country, but Ethiopia presents a clear example of how access to safe abortion services expanded after abortion law liberalization. In 2004, Ethiopia amended its penal code to permit abortion to preserve a woman's life or health and in instances of rape, incest or severe fetal impairment, as well as where the woman is a minor or when she has a physical or mental injury or disability.[39] Prior to 2004, Ethiopia only allowed abortion in cases where the woman's life or health was at risk.[43] This legislative change was implemented by expanding public-sector health facilities' capacity to provide abortion services, including by increasing the total number of facilities and the proportion offering abortion care, as well as by training mid-level providers to offer the service. Abortion services at these facilities were performed by trained medical professionals, thereby making them much safer than clandestine abortions. The percentage of all abortions provided at approved facilities increased to about 25% by 2008[44] and to 50% by 2014.[45] Although less-restrictive abortion laws do not directly translate to improved access, the example of Ethiopia shows the potential positive impact of such legislative change.

Latin America and the Caribbean

Expansive abortion law reform has also occurred in Latin America over the past 30 years. In addition to *LC v. Peru*, the HRC issued an important decision regarding Argentina. In 2011, in *LMR v. Argentina*, it demanded that Argentina guarantee access to legal abortion services in cases of rape.[46] One year later, Argentina amended its abortion law, permitting legal abortion for all women in cases of rape. This change clarified previous law, which was often interpreted to permit abortion only in cases of rape for women with psychosocial or intellectual disabilities. Then, after years of dedicated advocacy by abortion rights activists, Argentina's abortion law was eventually repealed. As of January 15, 2021, access to safe and legal abortion was permitted without restriction as to reason up to 14 weeks' gestation.[47]

At the national level, several countries have reformed their abortion laws through jurisprudence. In 2006, the Constitutional Court of Colombia struck down the country's absolute abortion ban on constitutional grounds.[48] Grounding its decision in human rights (including the rights to life, health, equality and non-discrimination, liberty and freedom from violence), the Court carved out exceptions to the penal code's criminalization of abortion, permitting women to terminate pregnancies where the pregnancy poses a risk to their life or physical or mental health and in cases of rape, incest or fatal fetal impairment. Then, in 2022, thanks to a legal challenge seeking full decriminalization of abortion[49], the Constitutional Court removed criminal provisions for all abortions up to 24 weeks' gestation, consequently permitting abortion on request.[50]

In 2012, the Supreme Court of Brazil ruled that abortion must be permitted in cases of anencephaly.[51] Previously, abortion was only legal to save the woman's life or in cases of rape.[52] The Court's decision recognized that compelling a woman to carry to term an anencephalic fetus could severely affect her mental health[51] and potentially cause suffering so great that it could constitute torture. The Court further noted that compelling a woman to carry such a pregnancy to

term would violate her sexual and reproductive rights as well as her rights to dignity, liberty, self-determination, health and privacy.

In 2014, the High Court of Bolivia invalidated the requirement that women who become pregnant as a result of rape receive judicial authorization prior to accessing abortion services.[53] Reflecting on the standards set forth by several UN treaty monitoring bodies, including CEDAW, the HRC and the Committee against Torture, the Court ruled that the state must guarantee that women who become pregnant as a result of rape have access to abortion services to protect their liberty, dignity, life, health and personal integrity. However, this decision only removed the requirement for judicial authorization; it did not change the legal status of abortion in Bolivia.

In 2021, the Supreme Court of Mexico issued a groundbreaking decision unanimously recognizing a constitutional right to safe, legal and free abortion services within a "short period" of time in early pregnancy.[54] Beyond the "short period" of time, the Court recognized that abortion must also be permitted under certain circumstances, including when the pregnancy poses a risk to the pregnant person's life or health, when it results from rape, or where there is a severe fetal impairment. The decision imposed positive obligations on all states in Mexico to fulfill this right to abortion, including by providing free abortion services within an undefined "short period" of time in early pregnancy. The Court also applied gender-neutral language, noting that Mexican states must recognize this constitutional right for all people who have the capacity to become pregnant, regardless of gender. The Court's landmark recognition of a right to abortion, the provision of free abortion services during early pregnancy, and the inclusive language used in the decision constitute a critical step toward decriminalization of abortion and its recognition as a human right in Latin America.

Other countries in Latin America have liberalized their abortion laws through legislation. For example, in 2014, Uruguay adopted a new abortion law permitting abortion on request up to 12 weeks of pregnancy (and in cases of rape, up to 14 weeks' gestation).[55] The new abortion law also permits abortion beyond 12 weeks when the pregnancy posed a threat to the life or health of the woman, or in cases of fatal fetal impairment. The prior law had permitted abortion only in cases of rape and where the woman's life or health was at risk.[56]

VI. The Case for Decriminalization

There is an emerging global consensus that abortion should be decriminalized (the complete removal of all regulations on voluntary abortion from a country's penal code).[3,4,57,58] Human rights bodies, the WHO and advocates have highlighted the detrimental impacts of the criminalization of abortion.[4,12,59] Criminal penalties on abortion often create barriers to—and even indirectly criminalize—access to abortion on grounds that are legally permissible in a country. Examples of such barriers include increased stigma in accessing legal abortion services, fear of criminal repercussions for performing abortions, and fear of seeking care after a miscarriage or a legal abortion.[12] Even in countries that have expanded access to legal abortion on certain grounds but that also still impose criminal penalties for other grounds, women can be incarcerated for attempting to access a legal abortion. For example, although Nepal permits abortion on request, women have been prosecuted for illegal abortions under the existing criminal sanctions.[60] Criminalization of abortion has also led some countries to incarcerate women who experienced miscarriages and obstetric emergencies; for example, in El Salvador, at

least 17 women have been imprisoned under the criminal abortion ban, many because of miscarriages.[61]

In addition, the existence of criminal penalties for abortions performed outside of explicit legal grounds creates a chilling effect for medical professionals, for people seeking abortion services or for third parties.[12] Even when women attempt to access abortion services on grounds that are legally permissible, if the state determines the service to be outside the scope of the law, it renders the abortion illegal and exposes all parties involved to criminal penalties.[12] In many countries, such penalties can be particularly harsh for health providers who perform abortions that the state deems illegal, thereby further limiting access to legal abortions and driving some to seek out clandestine abortion services performed by untrained persons. For example, under Nicaragua's criminal abortion ban, providers receive a harsher sentence than patients and could be disqualified from practicing medicine if they are convicted,[62] while in Malawi, any person who helps someone procure an abortion could be subject to three years in prison.[63]

Further, state-mandated criminal penalties amplify stigma around abortion access, even for the grounds where abortion is legal.[12] The criminalization of abortion generates stigma in accessing any abortion services, regardless of the legality of the abortion. Stigma can also hinder access to health services, as people may experience negative consequences from their communities if it is discovered that they accessed abortion services, especially if confidentiality cannot be guaranteed.

For example, while Ghana, Colombia, and Nepal have all taken impressive strides in abortion law reform, all three still criminalize abortion on certain grounds. Although criminalization looks different in each country, the impact is similar, demonstrating the urgent need to decriminalize abortion on all grounds. As a result, despite these countries' abortion law reforms, women still encounter serious barriers to ensuring access to legal abortion services, due to the chilling effect caused by the abortion provisions in the penal code.

Ghana

Since 1960, Ghana's remarkably liberal abortion law has allowed abortion in cases of rape, incest, severe fetal impairment or "defilement of a female idiot,"[***] or if they are performed to protect the physical or mental health or life of the pregnant person.[64] Ghana also closely regulates the people who are licensed to perform abortions, limiting the procedure to registered and trained health personnel at an approved facility.

However, the law governing abortion resides within the Penal Code, where abortion is criminalized under any circumstances outside of the articulated exceptions. This legal environment of part liberalization and part criminalization enables a climate of fear around the legality of abortion and possible criminal accountability for the provider and/or pregnant person. This fear drives pregnant people to seek clandestine abortions. Many Ghanaian women seek illegal or clandestine abortions, and complications from unsafe abortions contributed substantially to Ghana's estimated 2017 maternal mortality rate of 310 maternal deaths per 100,000 live births.[65,66]

[***] We recognize this language as inherently ableist and discriminatory against people living with disabilities.

Colombia

Prior to 2006, abortion was criminalized under all circumstances.[67] In that year, however, the Constitutional Court struck down total criminalization, recognizing that criminalizing all forms of abortion did not balance the rights of the pregnant person and the fetus, especially when less-restrictive regulations were available that did not violate women's fundamental rights, as enshrined in the Constitution of Colombia.[68] The decision legalized abortion in cases of rape, incest and fatal fetal impairment or to protect the life or health of the pregnant person. In 2022, the Constitutional Court removed criminal provisions up to 24 weeks, after which abortion is permitted on the grounds recognized in the 2006 decision.[69] This revolutionary leap was possible thanks to the *Causa Justa*[70] movement and has enabled many pregnant people to access abortion. In practice, however, abortion access in Colombia remains unequal, as economic and geographic disparities in the accessibility and affordability of health clinics have created sizable barriers, especially for economically disadvantaged people and those living in rural communities.[71]

At the same time, Colombia still has criminal provisions regulating abortion.[68] Although abortion is now widely permitted, criminalization, even in some circumstances, can perpetuate stigma and result in a chilling effect on access to legal abortion services. This chilling effect is amplified by the failure to guarantee confidentiality for those accessing legal abortion services. For example, the mere fact that abortion is criminalized in some circumstances can place health providers under strong social and cultural pressures, influencing their decision to report people who seek abortion services.[72] As a result, providers may mistakenly believe that a pregnant person is seeking an illegal abortion and report them. A 2014 study found that breaches of confidentiality occurred in 42% of legal abortions performed at government-sponsored health clinics.[73] The study also noted that the government's failure to guarantee the confidentiality of people who seek legal abortions is one of the main barriers to care and often deters people from seeking safe abortion services.

On the other hand, health providers who fail to report an abortion can also receive strong legal sanctions, even if they mistakenly believed they did not have a duty to report.[71] Breach of confidentiality can also lead to prosecution, in which people seeking abortions are reported and forced to undergo criminal investigations to prove they sought an abortion under legally permissible circumstances.[†††74] Advocates have noted that the lack of confidentiality around abortion access stems from stigma, ignorance and institutional disapproval of abortions and that the fear of criminal sanctions is a compelling reason for pregnant people to seek clandestine abortions, even if they are accessing abortion for a legally permissible reason.[75,76]

Although Colombia has strong national legal protections for health care and privacy, the fear of legal sanctions around the criminalization of abortion is more powerful.[74] It is undeniable that health care providers feel the weight of the stigma and the negative connotations associated with abortion as something bigger than their own duty to comply with those laws. The criminalization of an act carries stigma for the entirety of that act, regardless of the parameters of criminality.[77] Criminalizing abortion procedures under certain circumstances generates stigma and negative connotations for all forms of abortion services, consequently creating and exacerbating barriers

[†††] The Office of the Attorney General in Colombia reported that between 1998 and 2019, 73% of criminal investigations involving illegal abortions were reported by hospital staff.

to access, especially for economically disadvantaged people and those living in rural communities.

Nepal

Until 2002, Nepal had criminalized abortion in every instance in its Penal Code.[78] In 2002, however, the government reformed the law, permitting abortion on request up to 12 weeks' gestation and up to 18 weeks' for pregnancies caused by rape or incest.[79,80] This sudden transformation is highly unusual, as most countries' laws gradually move over the course of years or decades from restrictive to liberal, through amendments to existing laws, jurisprudence or new laws.[37] Nepal also included provisions recognizing the fundamental right to reproductive health and rights in its interim Constitution in 2007 and later in the final version of its Constitution in 2015.[81]

In September 2018, Nepal adopted the Safe Motherhood and Reproductive Health Rights Regulation ("SMRHR Act"), a comprehensive law that aims to respect, protect and fulfill reproductive rights and maternal health.[82] The SMRHR Act includes an array of guarantees related to reproductive health and rights, including access to safe abortion, and recognizes the right to decide the number and spacing of one's children. It acknowledges abortion as an aspect of the right to reproductive health guaranteed by the Constitution and expands the law to permit abortion up to 28 weeks' gestation in cases of rape, incest, severe fetal impairment, or where the pregnancy risks the life or health of the pregnant woman. The Act also guarantees access to all reproductive health services free of charge at any government health facility and requires all levels of government to create a separate budget specifically for the provision of reproductive health services. Today, Nepal has one of the most progressive legal frameworks on abortion in the world.

However, abortion remains criminalized in Nepal on certain grounds, and women have reportedly been prosecuted under the abortion provisions in the penal code.[60] Although the Act includes concrete provisions to guarantee abortion access, it did not revoke the abortion provisions in the penal code. The Act also notes that all abortions occurring outside of the parameters associated in the law—such as receiving an abortion from an unlisted provider or at an unlisted health facility, accessing an abortion on request beyond 12 weeks' gestation that is outside the list of permitted circumstances, or accessing an abortion in cases of rape or incest for a pregnancy beyond 18 weeks' gestation—are criminalized according to the Penal Code.[83,84]

A national study conducted in 2014 estimated that 17% of induced abortions were illegal and treated in facilities for complications and that the majority of abortions (58%) did not meet all legal requirements.[85] Criminal sanctions for abortions accessed outside the permitted grounds include imprisonment and/or large fines.[86] Pregnant women and girls have been prosecuted under these criminal sanctions in the past, generating reluctance to access legal abortion services in Nepal.[85] In 2018, the CEDAW Committee urged Nepal to amend the Act to broaden its definition of legal abortion to include and remove the criminal penalties.[87]

Effects of Criminalization

The challenges that governments in Nepal, Ghana and Colombia face when balancing access to legal abortion and prosecuting illegal abortions with criminal penalties demonstrate that criminalization of abortion undermines health care and violates fundamental human rights. The

chilling effect of a culture of fear around access to abortion can lead to stigmatization of abortion, severely limiting accurate information about safe and legal services, and can create confusion around the circumstances under which abortion is legal. These barriers to care limit the accessibility of legal abortion. The separation of the abortion law from the penal code and the removal of criminalized provisions may help to alleviate the stigma and eliminate concerns of criminal liability for providing or receiving an essential health service.

The criminalization of abortion creates significant barriers to accessing legal abortion services by generating stigma, failing to guarantee patients' confidentiality, and disproportionally impacting marginalized and rural communities. Criminalizing abortion also constitutes a disproportionate use of the punitive power of the State, and pregnant people should never be subjected to State prosecution for exercising a decision over their own body. Criminal restrictions on abortion do not deter the incidence of abortion; rather, they compel people to undergo unsafe abortion and to abstain from seeking postabortion care, placing their lives and health at risk.[12,88]

Furthermore, the mere perception that abortion is unlawful can lead health care staff to stigmatize people seeking abortion, which risks discrimination and harassment. Instead, penal codes must be revised to remove criminal penalties for voluntary abortion, including punitive measures for individuals seeking abortion services, providers and anyone assisting a pregnant person in accessing abortion services. States should also remove any criminal penalties for dissemination of evidence-based information on abortion. Decriminalizing abortion and shifting regulation into health codes will reduce stigma and barriers to access and support the fulfillment of fundamental human rights.

VII. Conclusions and implications

The past three decades have seen steady, incremental progress in the liberalization of abortion laws, with some evidence showing positive outcomes where liberal abortion laws have been adopted. However, most countries in Latin America and Africa still have highly restrictive abortion laws, and few have succeeded in implementing access to abortion services under existing laws, whether liberalized or not. While expanding the legal criteria under which abortion is permitted is a necessary first step toward making safe, legal services available, decriminalization is an equally essential step, because regardless of how broad any exceptions carved out by liberalization are, penalizing abortion creates a chilling effect, affecting the willingness of people to seek, and of providers to offer, abortion services. The experiences in Colombia and Ghana demonstrate that liberalization alone is not sufficient to ensure access to abortion services, even under criteria that are legal in the country. Finally, abortion is an essential service that people in all countries need, regardless of countries' abortion laws or income level. Yet in most countries where the law has been recently liberalized, barriers to provision of abortion services remain strong, and access to legal abortion services remains uneven and unequal.

At the same time, human rights agreements have evolved and now provide strong support for the right to access abortion as part of the fundamental human right to health, life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment. The discourse around criminalization of abortion has also evolved, culminating in a consensus among

human rights bodies that states need to decriminalize abortion to comply with human rights obligations.

The development of a consensus on a comprehensive, integrated definition of sexual and reproductive health and rights and on a package of essential SRH interventions also increases the momentum towards policy and programmatic changes to improve access to legal and safe abortion services.[89,90] The Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights developed such a comprehensive definition, framed in a human rights perspective, that encompasses reproductive health, reproductive rights, sexual health and sexual rights. Two of its specifications are especially relevant for access to abortion care: that all individuals have the right to "have their bodily integrity, privacy and personal autonomy respected," and that all have the right to "decide whether, when and by what means to have a child or children and how many children to have." A key part of the package of essential interventions that reflects the SRH components included in the integrated definition is "safe abortion services and treatment of complications of unsafe abortion." The fact that there is now broad agreement on a comprehensive definition and an essential package of interventions provides a strong foundation for advocates and policymakers as they work toward expanding access to SRH services, including abortion.

But situating abortion as part of a comprehensive approach goes beyond even the provision of SRH care. The right to health, recognized in human rights treaties globally and regionally[22,91,92,93] follows the WHO's definition of health: "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Therefore, the right to health entails much more than physical wellness and encompasses the full spectrum of factors responsible for well-being. The CESCR elaborates that the right to health includes "underlying determinants of health," or social determinates of health, such as gender equity, health information and education (including for SRH), safe housing, and healthy working and environmental conditions, as well as necessities such as safe drinking water, sanitation facilities and food that is safe to consume. CESCR also recognizes that health services must be available, accessible (e.g., affordable), acceptable (e.g., ethical and culturally appropriate), and of good quality.[94]

An advantage of including abortion care within a broader constellation of rights-based policies and programs that ensure individuals are able to decide whether and when to have children and that also create safe and healthy conditions for having and raising children is that it reduces abortion's vulnerability to stigma and political opposition. Such policies include accessible and comprehensive SRH information, counseling and services; employment laws guaranteeing paid parental leave at birth and when the child is sick; the provision of free education; patient-friendly public health systems that offer free or affordable pediatric and reproductive health services; and anti-discrimination laws protecting pregnant people in the workplace. Taken together and when fully implemented, these policies enable individuals to exercise their reproductive autonomy and achieve better SRH outcomes throughout their lifetime. This shift in perspective further strengthens arguments in support of liberalization of abortion laws, decriminalization of abortion and provision of accessible, quality abortion care.

However, none of these packages of services, no matter how comprehensive, are effective if only certain sectors of the population have real access to them. In 2017, the World Bank and WHO released a report documenting that half of the world's population had no full coverage to access

essential heath care services,[95] meaning that access depends on individuals' financial capacity to pay for services out of pocket. In 2011, an estimated 97 million people were pushed into extreme poverty from the hardship of covering health care expenses, and another 122 million were pushed into moderate poverty. The international community,[96] global health organizations[89] and human rights bodies[97] recognize that guaranteeing universal health coverage is the main way to ensure that every individual and community has access to health care, irrespective of their circumstances.

The Guttmacher-*Lancet* Commission's recommended package provides a blueprint for countries in their health systems planning and is of particular importance to inform countries' inclusion of SRH interventions in their efforts toward achieving universal health coverage. It is critical to ensure that the full package of SRH services, including abortion care, is recognized as essential and therefore incorporated into national health policies as countries progress toward universal health coverage.[89] In adopting the Sustainable Development Goals (SDGs) in 2015, UN member states reaffirmed their commitment to ensure universal access to SRH services. As WHO stated, "This included the goal to ensure healthy lives and promote the well-being of all people at all ages (SDG 3), and to achieve gender equality and women's empowerment (SDG 5). Combined, these goals are significant drivers for countries to increase access to SRH services, ensure their affordability, and advance gender equality."[89] Further, health financing policies need to be designed so that they prioritize the most vulnerable groups of people. Barriers to SRH care most directly impact people already marginalized from accessible, quality health care—such as people with low incomes, young people, LGBTQ individuals, racial and ethnic minorities and indigenous people, and people with disabilities.

This approach to integration of SRH care into health systems is gaining momentum in a range of country contexts. For example, in 2020, Zambia became the first country in Sub-Saharan Africa to introduce universal health coverage financing reforms that cover a range of family planning methods, including oral contraceptives, implants, injectables, intrauterine devices, emergency contraception, SRH services and abortion.[98] The inclusion of chronically neglected and politicized interventions like safe abortion and comprehensive sexuality education in universal health coverage packages can help mainstream these services in health policies and programs and generate broader public support for them. In Nepal, the SMRHR Act offers an expansive guide for the provision of SRH services throughout the country.[81] The Act ensures that SRH services are accessible, available, affordable and of high quality and include abortion care, recognizing that abortion services are an essential component of comprehensive reproductive health services. The Act also requires all levels of government (national, regional and local) to create a budget specifically for providing the SRH services stipulated within the Act. Instead of attempting to unite a patchwork of isolated policies, this inclusive approach to SRH service delivery recognizes the right to health by ensuring the provision of the full package of SRH services.

Continued efforts to liberalize abortion laws are essential for the many countries that still have highly restrictive laws. In addition, it is equally important to decriminalize abortion under all circumstances, to reduce stigma and fear among people and providers. To guarantee access to safe and legal abortion services free from stigma, and in accordance with human rights, states must remove all abortion provisions from the penal code and incorporate abortion regulations within health codes, as is done for other medical procedures. Currently, there is a growing consensus among global and regional human rights bodies that states should broadly enable

access to abortion services. This recognition of access to abortion as a human right will likely continue to expand as human rights bodies hear more cases and are presented with more evidence on the importance of states securing access to safe abortion services to respect, protect and fulfil their human rights obligations.

Evidence is directing us to enter a new stage in our human rights advocacy around access to abortion. It is time to expand advocacy on the liberalization of abortion laws to call for full decriminalization of voluntary abortions. However, decriminalization of abortion is not sufficient to guarantee access to safe and legal abortions in the absence of efforts to hold states accountable for adopting and implementing access to SRH services. To ensure access to abortion services, comprehensive SRH policies must be in place, and the essential package of SRH services must be included in universal health coverage plans and implementation. Establishment of a robust legal and human rights foundation for liberalization and decriminalization of abortion laws, combined with robust evidence on the universality of the need for abortion and on the key barriers to its provision, will provide stakeholders with compelling grounds for the work ahead to enable all people to achieve their right to sexual and reproductive health and well-being.

Author Contributions:

All co-authors significantly contributed to the research, analysis and drafting of this article. Authors' individual contributions to the manuscript:

- Alejandra Cardenas led the development of this article, including by conceptualizing the legal arguments and outline for the article, leading the review process including providing essential guidance and critical reviews each section involving human rights law, and conducting a final review and approval for submission.
- Susheela Singh led the development of the public health sections of this article, providing critical insight and guidance for the development of the public health arguments, researching and interpreting public health data on abortion, providing critical reviews on all public health data, analysis, and arguments, and conducting a final review for approval and submission.
- Margaret Harpin contributed to the design of the article by drafting the initial outline, researching, analyzing, and drafting the legal arguments and sections applying international human rights law, reviewing and revising content in collaboration with the other co-authors, and conducting a final review for approval and submission.
- Sophia Sadinsky contributed to the design of the article by developing the public health sections of the article, including interpreting public health data, drafting public health arguments, reviewing and revising public health content, and conducting a final review for approval and submission.

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