CENTER *for*
REPRODUCTIVE
RIGHTS

Legal and Policy Barriers to Self-Managed Abortion: A Comparative Analysis of 39 Jurisdictions

September 2024

Introduction

Self-managed abortions are a safe, private, and self-directed way to end a pregnancy outside the formal healthcare sector. They are performed without clinical supervision, such as in the privacy of one's home, commonly with medication, such as misoprostol and mifepristone. The World Health Organization (WHO) recommends that individuals have the option to self-manage abortion using medication during at least their first 12 weeks of pregnancy.[1] The WHO recognizes that individuals can safely and effectively self-assess their eligibility for abortion and self-administer abortion medication,[2] making self-managed abortion a critical tool for enabling individuals to safely exercise reproductive freedom.

Despite this, legal and policy barriers to self-managed abortion remain pervasive. Even in countries with permissive abortion laws, regulations on medication abortion, location-based requirements, and limitations on the use of telemedicine, among other barriers, limit the ability of those who want to self-manage an abortion from legally doing so. Mapping laws and policies on self-managed abortion is an essential step towards understanding the prevalence of barriers and creating a plan for legal reforms. In this report, the Center for Reproductive Rights ("the Center") presents the findings from our effort to map the legal and policy barriers that exist in nearly 40 countries. Over time, this mapping will also enable the Center to track progress, impediments, and global trends.

Self-managed abortion (SMA) refers to **abortions undertaken without clinical supervision.** This can be done through medication abortion, medicinal herbs, or other methods. The World Health Organization (WHO) recommends that individuals have the option to self-manage abortion using medication abortion during at least their first 12 weeks of pregnancy.

Interactive visualizations of the findings presented in this report are available here. In addition, the complementary Self-Managed Abortion: In-Depth Country Data has detailed information and citations on the laws of every country featured in this analysis.

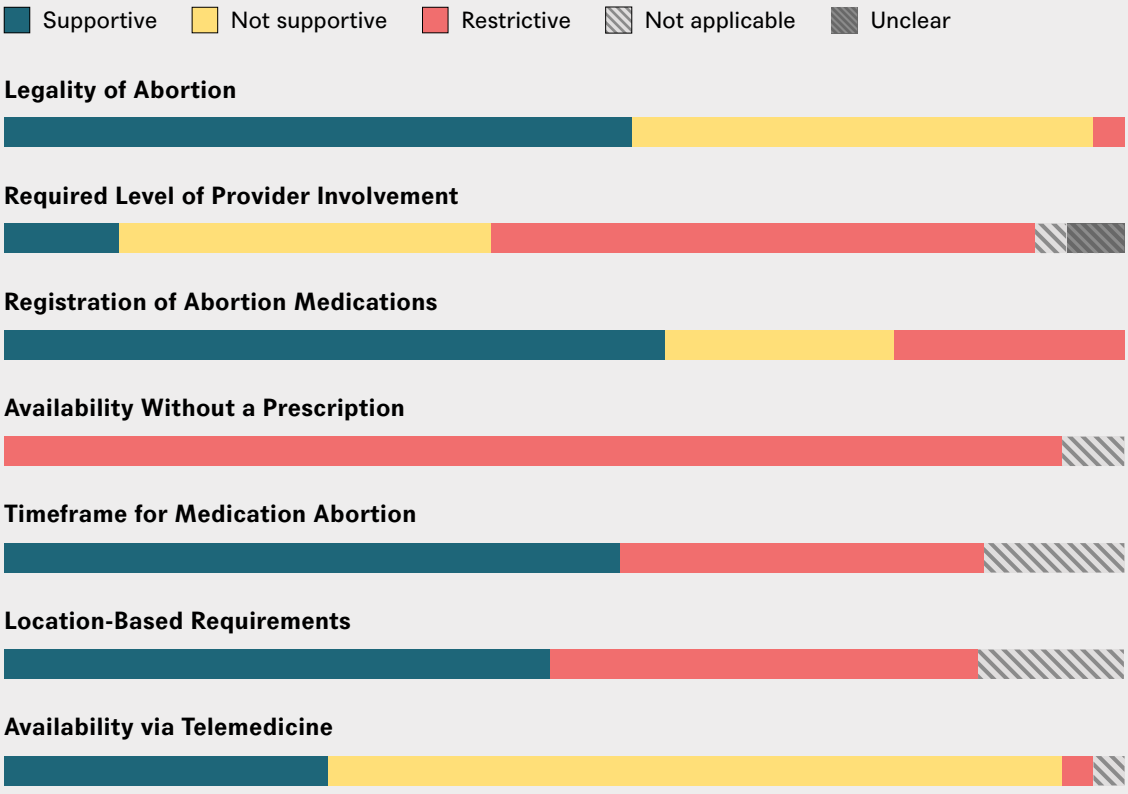
Methodology

Building on a preliminary mapping published in 2022, we undertook an extensive analysis of national-level laws and policies on self-managed abortion across 39 countries, states, and jurisdictions. The term "countries" is used throughout this report to encompass all of these jurisdictions, while we acknowledge that they have distinct legal status. We selected these jurisdictions to ensure a geographically distributed sample that encompasses both liberal and restrictive abortion laws and prioritizes contexts where the Center for Reproductive Rights is actively working.

Pro bono attorneys conducted initial research, with an emphasis on research being conducted by attorneys licensed in the respective countries they were researching. This research was reviewed by staff at the Center who also conducted complementary research. For most countries surveyed, these findings were then validated by experts on abortion rights in those respective countries.

While analyzing the findings, the study's authors recalibrated the indicators utilized in the 2022 publication to make them more universally applicable and responsive to nuances in countries' legal and policy frameworks. Ultimately, seven indicators were adopted to assess the legal and policy environments on self-managed abortion: 1) legality of abortion on request until 12 weeks gestation; 2) provider involvement; 3) registration of abortion medications; 4) availability of medication abortion without prescription; 5) the timeframe in which medication abortion is permitted; 6) explicit location-based requirements for medication abortion; and 7) telemedicine. The current status of each indicator across each of the surveyed countries and states were then mapped and global and regional trends and key opportunities for creating more enabling legal and policy frameworks for self-managed abortion were identified.

Overview of Findings by Metric



Overview of Findings by Metric:

This chart highlights the number of countries that are categorized as "supportive," "not supportive," "restrictive," "not applicable," or "unclear" for each of the 7 metrics. The current status of SMA varies significantly by metric. An interactive version of this graphic and this report's findings are available here.

Metric 1:

Legality of Abortion

Ensuring that abortion is legal on request is an essential prerequisite for enabling individuals to exercise reproductive autonomy. For a full analysis of abortion legality worldwide, please refer to the Center's World Abortion Laws Map which maps abortion laws in almost every country in the world. For the purposes of this report, this indicator is limited to whether abortion is legal on request until 12 weeks gestation, in order to understand the law's position as it relates to WHO's recommendation that people can safely self-manage abortion using medication abortion during that timeframe.

Abortion is available on request until 12 weeks.

- Argentina
- Belgium
- California, USA
- Canada
- Colombia
- Colorado, USA
- France
- Germany
- Ireland
- Italy
- Mexico City
- Mozambique
- Nepal
- Netherlands
- New York, USA
- New Zealand
- Norway
- South Africa
- Sweden
- Thailand
- Uruguay
- Washington, USA

Abortion is only permitted on certain grounds.

- Brazil
- Chile
- Costa Rica
- Ecuador
- Ethiopia
- Great Britain (England and Wales, Scotland)
- India
- Indonesia
- Kenya
- Nigeria
- Pakistan
- Peru
- Rwanda
- Sri Lanka
- Tanzania
- Uganda

Abortion is prohibited altogether.

- Philippines

Takeaways

- **Abortion is allowed on request until at least 12 weeks of gestation in the majority of countries surveyed.** This is a crucial prerequisite for self-managed abortion. When abortion is only permitted on restricted grounds, pregnant people are denied the right to decide whether they want an abortion outside the narrow parameters of the law, which often require a third person to authorize access, and exposes the person accessing care to legal risk for ending a pregnancy outside the formal healthcare sector.
- **Within the yellow category, the permitted grounds for abortion vary significantly.** Several of the countries surveyed only allow abortion on very limited grounds to save the life or health of the pregnant person. Other countries also permit exceptions for socioeconomic reasons, rape, incest, and fetal diagnoses. In countries where abortion is available on request up to a specific gestational age, these same limited grounds often apply after the request period has ended. Whenever these restrictions apply, a self-managed abortion becomes significantly harder due to provider authorization requirements.
- **Only one country surveyed prohibits abortion altogether.** The Philippines is the only country surveyed that completely prohibits abortion, making it an extreme outlier among the 39 countries examined. This prohibition means that any form of self-managed abortion is illegal.
- **Jurisdictions surveyed for this study skew towards more permissive abortion laws relative to countries globally.** As shown in the Center's World Abortion Laws Map, less than 40% of countries permit abortion on request through the first 12 weeks gestation, whereas about 10% prohibit abortion altogether. By contrast, more than 50% of jurisdictions surveyed for this study permit abortion on request until at least 12 weeks and only one country (2.5%) surveyed for this study completely prohibit abortion. Finally, all four U.S. states selected for this study have broadly permissive abortion laws, whereas abortion is heavily restricted or effectively banned in large swaths of the U.S.

Examples of Enabling Laws and Policies

France: In March 2024, France became the first country in the world to explicitly enshrine the right to abortion in its constitution.[3] This constitutional amendment, which designates abortion as a "guaranteed freedom," was adopted with overwhelming support from French lawmakers.[4] Additionally, in 2022, France extended its gestational limit for abortion from 14 weeks to 16 weeks.[5]

Colombia: In February 2022, the Colombian Constitutional Court decriminalized abortion up to 24 weeks of pregnancy.[6] In its landmark ruling, the Court recognized that the continued criminalization of abortion undermined access to legal abortion care resulting in violations of the right to health and the equality of women and girls.[7] It also reaffirmed that the right to abortion is constitutionally protected as a fundamental right.

Nepal: Nepal's 2018 Safe Motherhood and Reproductive Health Rights Act recognizes abortion care as an aspect of reproductive health (which is protected as a fundamental right by the 2015 Constitution)[8] and allows abortions on request up to 12 weeks of gestation.[9] The Act also guarantees free reproductive healthcare services at government facilities and mandates budget allocations at all levels to support these services.[10]

Recommendations

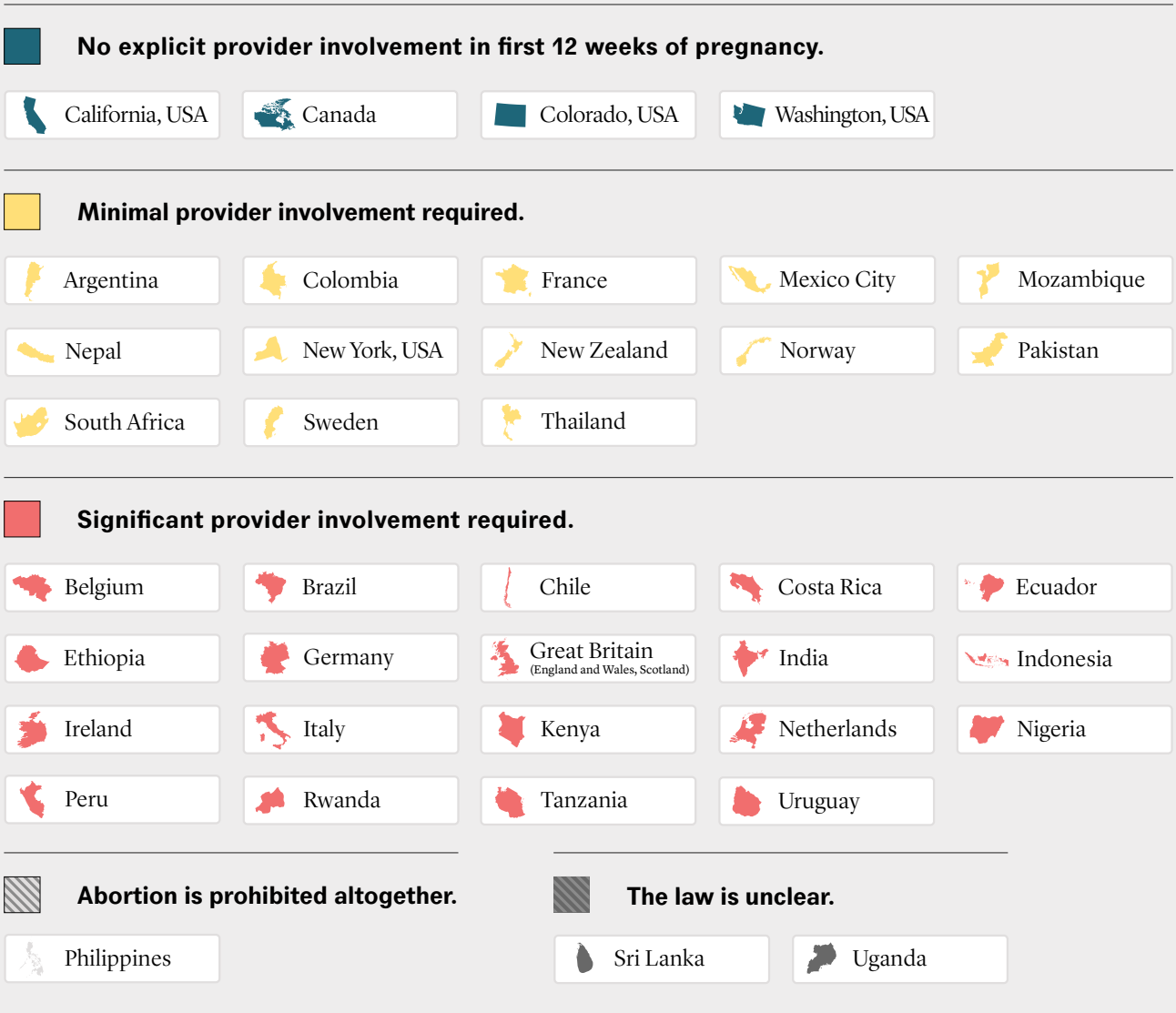
States should:

- **Liberalize abortion laws to enable people to access to abortion on request and fully decriminalize abortion.** Abortion should be regulated based on health, well-being, and human rights—not in a way that only carves out legal exceptions, minimizes autonomy, and imposes potential criminal liability.
- **Recognize abortion as a human right, including self-managed abortion.** By affirming in law and policy that abortion is a right, states can better protect all people seeking abortion care and those who support or assist them in doing so.

Metric 2:

Required Level of Provider Involvement

In alignment with the WHO guidelines, an enabling legal environment would permit individuals who prefer to self-manage their abortion using medication to do so without the direct supervision of a health care professional. Yet, instead of centering individuals' preferences about whether and how to engage with health care providers in accessing abortion care, many law and policy frameworks mandate provider involvement in various facets of abortion. Examples of minimal provider involvement include requirements that abortion must be administered by a qualified provider, a medical consultation to ensure informed consent or rule out contraindications is required, and/or a provider must confirm the gestational age. (Note: Once pregnancy reaches a specified gestational age, these countries may require a higher level of provider involvement.) Examples of significant provider involvement include requirements for psychosocial counseling that goes beyond informed consent, certification that the patient has complied with a mandatory waiting period, and/or formal authorization that the patient is legally eligible for an abortion. This metric, like others in this publication, is evaluated in isolation from other metrics, such as prescription requirements and in-person or location-based requirements (which are addressed in metrics four and six, respectively).



Takeaways

- **The four jurisdictions that did not mandate provider involvement are all in Northern America: Canada and three U.S. states (California, Colorado, and Washington).**
- **The overwhelming majority of countries mandate provider involvement.** This includes physical examinations, mandatory counseling (often including psychosocial components), certification of compliance with waiting periods, and legal restrictions limiting the procedure to doctors. These requirements hinder self-management of abortion and increase the overall burden on individuals seeking an abortion.
- **Even in countries where abortion is permitted on request, provider involvement requirements remain common.** Eighteen of the 22 countries allowing abortion on request require some form of provider involvement. Six mandate significant provider involvement with detailed procedural requirements to obtain an abortion such as mandatory or biased counseling, the involvement of multiple physicians or a multidisciplinary team, or verification of compliance with a mandatory waiting period.

Examples of Enabling Laws and Policies

Four jurisdictions surveyed did not explicitly require provider involvement:

Washington, U.S.: Washington recognizes that "the state may not deny or interfere with a pregnant individual's right to choose to have an abortion prior to viability of the fetus"[11] While Washington explicitly authorizes a broad range of health care practitioners to administer abortion care,[12] it also exempts pregnant people and anyone assisting someone who is voluntarily having an abortion from criminal liability.[13]

California, U.S.: California law recognizes that a pregnant person may self-administer an abortion prior to viability[14] and protects the pregnant person, and anyone who assists a pregnant person, from criminal liability for obtaining an abortion.[15]

Canada: In Canada, there is no legislation that outlines requirements for obtaining an abortion, including the involvement of healthcare providers.

Colorado, U.S.: Colorado law recognizes a pregnant person's right to have an abortion and broadly prohibits the State from burdening access to abortion.[16] There are currently no laws or policies in Colorado that explicitly require provider involvement for individuals seeking abortion services.[17]

Recommendations

States should:

- Remove provider involvement requirements in line with WHO Guidelines that recognize people can safely self-manage abortion using medication abortion without the direct supervision of a healthcare professional.
- Recognize that unnecessary provider involvement requirements disadvantage underserved communities and divert critical resources that could be allocated to providing other essential health services.
- Expand the range of providers who are eligible to administer abortion care in line with WHO Guidelines, with the goal of ensuring access to a skilled provider for those who prefer to access abortion in this way while also enabling people who prefer to self-manage their abortions to do so.
- Improve access to quality, accurate information on medication abortion to ensure that those who self-manage without provider involvement can do so safely and effectively.

Metric 3:

Registration of Abortion Medications

The WHO recommends the use of mifepristone and misoprostol for medication abortion. If mifepristone is not available, misoprostol alone can be administered for safe and effective abortions,[18] although the WHO advises that the combination of mifepristone and misoprostol is more effective.[19] Mifepristone and misoprostol have been included on the WHO List of Essential Medicines since 2005.[20] An enabling environment for medication abortion requires that both mifepristone and misoprostol are registered by the country's pharmaceutical regulatory body and officially approved for abortion purposes.

Where countries' drug registration systems do not specify the purposes for use, this analysis relies on ministerial guidelines, the country's official essential medicines list, or self-regulatory professional bodies' official guidelines to determine approved usages. This metric does not consider whether off-label use (deviating from the registration and official guidelines) of mifepristone and/or misoprostol is common in practice.

Both pills are registered and approved for abortion.

- Belgium
- Canada
- Chile
- Colombia
- Ecuador
- Ethiopia
- France
- Germany
- Great Britain (England and Wales, Scotland)
- India
- Ireland
- Italy
- Kenya
- Mozambique
- Nepal
- Netherlands
- Nigeria
- Norway
- South Africa
- Sweden
- Tanzania
- Thailand
- Uruguay

Both pills are registered but at least one is not approved for abortion.

- Argentina
- California, USA
- Colorado, USA
- Mexico City
- New York, USA
- New Zealand
- Uganda
- Washington, USA

At least one of the pills is not registered.

- Brazil
- Costa Rica
- Indonesia
- Pakistan
- Peru
- Philippines
- Rwanda
- Sri Lanka

Takeaways

- **In most of the countries surveyed, both mifepristone and misoprostol are registered and approved for abortion.** This registration is an essential prerequisite for enabling people to access medication abortion.
- **In countries where at least one of the medications is not approved for abortion purposes, off-label use is common.** Even though the medication is not necessarily approved for abortion, in many countries it is still prescribed for that purpose. However, the lack of explicit approval for abortion purposes can nonetheless be a barrier for access to medication abortion.
- **Countries where only one medication is registered have all registered misoprostol and not mifepristone.** Some of these countries approve misoprostol for abortion, while others recommend it for completely different purposes. Although the WHO recognizes that misoprostol alone can safely be used for medication abortion, it recommends the combination of mifepristone and misoprostol as the more effective procedure.[21] Therefore, the absence of registration for both medications impedes access to the most effective medication abortion method.

Recommendations

States should:

- Ensure both misoprostol and mifepristone are registered for abortion. Where such medications are not registered and widely available, people may use online pharmacies lacking rigorous quality control, unintentionally purchase counterfeit drugs, or resort to unsafe methods to try to end a pregnancy.
- Ensure both medications are explicitly approved and recommended for abortion care. Although off-label use may be common in some countries, recognizing their use for medication abortion can result in important guidance and legal security for healthcare providers involved in administering such care.
- Take steps to safeguard the legality of and access to mifepristone and misoprostol, especially where attacks on the medications are motivated by a desire to obstruct access to abortion care.

Metric 4:

Availability of Medication Abortion Without Prescription

In an enabling environment, medication abortion pills are available without a prescription. The combination regimen of mifepristone and misoprostol has been found to be safer than many non-prescription drugs.[22] Availability of medication abortion without a prescription empowers individuals to exercise their rights to autonomy, while also increasing privacy by giving people the means to end a pregnancy without interference.

Both mifepristone and misoprostol are registered and do not require a prescription.

No countries in the selected region fit within this category.

One medication does not require a prescription and the other either requires a prescription or is not registered/legally available.

No countries in the selected region fit within this category.

Both medications require a prescription OR one requires a prescription, and the other is not registered/legally available.

- Argentina
- Belgium
- Brazil
- California, USA
- Canada
- Chile
- Colombia
- Colorado, USA
- Ecuador
- Ethiopia
- France
- Germany
- Great Britain (England and Wales, Scotland)
- India
- Indonesia
- Ireland
- Italy
- Kenya
- Mexico City
- Mozambique
- Nepal
- Netherlands
- New York, USA
- New Zealand
- Nigeria
- Norway
- Pakistan
- Peru
- Rwanda
- South Africa
- Sri Lanka
- Sweden
- Tanzania
- Thailand
- Uganda
- Uruguay
- Washington, USA

N/A: Neither mifepristone nor misoprostol are registered/legally available.

- Costa Rica
- Philippines

Takeaways

- **No country surveyed allows access to misoprostol and mifepristone without a prescription.** Even the most liberal jurisdictions in our analysis, where other aspects of abortion care are relatively accessible, require a prescription for these medications. Consequently, individuals must always consult a healthcare provider to obtain an abortion, rather than self-assessing their eligibility and purchasing the medication over the counter. Stringent prescription requirements create a critical gap in accessibility, even in countries with abortion laws that are otherwise rights-based and centered on individuals' autonomy.
- **The uniform requirement for prescriptions across different legal frameworks suggests that there is room for policy evolution.** If policymakers aim to improve access to abortion care, reevaluating the necessity of prescription mandates for misoprostol and mifepristone is an important starting point. Reducing or eliminating prescription requirements would significantly enhance access, particularly for people with limited access to health care or who have historically faced mistreatment or abuse in healthcare settings.

Benefits of Removing Prescription Requirements

Removing prescription requirements on misoprostol and mifepristone can increase abortion access, especially in communities and geographic areas where abortion is highly stigmatized and/or that lack healthcare facilities and medical professionals. Prescription requirements significantly impede the ability to self-manage an abortion, forcing individuals to navigate logistical, cultural, and financial barriers, which can exacerbate inequalities and disproportionately affect underserved populations. Further, those who self-source medication abortion face potential criminal liability for violating laws and regulations related to procurement and distribution of pharmaceuticals. Indeed, there are examples from countries around the world of individuals who have been imprisoned for violating such laws when self-managing abortion.[23] Although all countries surveyed have a prescription requirement, there are measures countries can take to make these requirements less burdensome, such as explicitly permitting telemedicine, enabling providers to send medication abortion by mail, and facilitating online access to high-quality medication abortion.

Recommendations

States should:

- Remove prescription requirements for medication abortion while also ensuring people have access to timely, accurate information on how to safely and effectively use medication abortion (e.g. proper dosage, instructions for use, contraindications).
- Mitigate the harm of current prescription requirements by decriminalizing the use of medication abortion without a prescription for both people having abortions and those assisting them in accessing medication abortion pills.
- Mitigate the harm of current prescription requirements by enabling a broad range of health care providers, such as pharmacists, pharmacy workers, community healthcare workers, and traditional and complementary medicine professionals, among others, to administer and counsel people on how to safely and effectively use medication abortion, in line with WHO guidelines.[24]

Metric 5:

Permitted Timeframe for Medication Abortion

An enabling legal environment recognizes that medication abortion can take place, at least, within the first 12 weeks of pregnancy, in accordance with WHO's explicit recognition that pregnant people can safely self-manage their abortion during that time without supervision of a healthcare professional. When medication abortion is limited to before 12 weeks, people are unnecessarily compelled to have procedural abortions (also known as surgical abortions) or, for those unwilling or unable to utilize the formal healthcare sector, to seek out potentially unsafe abortion methods.

Please note that this metric does not account for off-label use of medication abortion beyond the officially approved or recommended timeframe. In some countries, shorter time limits in pharmaceutical regulatory bodies' registration of mifepristone/misoprostol have been supplanted by longer recommended timeframes in ministerial or self-governing professional body guidelines. In those cases, the categorization relies on the guidelines, with any deviations from the registration noted in the SMA: Legal Analysis by Country report.

There is no explicit time limitation on medication abortion before 12 weeks.

- Argentina
- Brazil
- Chile
- Colombia
- Ecuador
- Ethiopia
- Great Britain (England and Wales, Scotland)
- Ireland
- Kenya
- Mexico City
- Mozambique
- New Zealand
- Nigeria
- Norway
- Pakistan
- Peru
- Rwanda
- South Africa
- Sweden
- Thailand
- Uruguay

The timeframe in which medication abortion is allowed is less than 12 weeks.

- Belgium
- California, USA
- Canada
- Colorado, USA
- France
- Germany
- India
- Italy
- Nepal
- Netherlands
- New York, USA
- Tanzania
- Washington, USA

Medication abortion is not legally permissible.

- Costa Rica
- Indonesia
- Philippines
- Sri Lanka
- Uganda

Takeaways

- **About half of the countries surveyed (21) allow medication abortion during the first 12 weeks of pregnancy.**
- **Thirteen countries limit medication abortion before 12 weeks gestation.** Among these countries, most limit medication abortion to before nine weeks gestation. In recent years there has been an increase in research and publications on the safety of medication abortion throughout and beyond 12 weeks of gestation, notably endorsed in the 2022 WHO Abortion Care Guideline. As these findings gain acceptance, the global legal landscape should evolve in response to science and research.
- **Regionally, Latin America has the most liberal policies regarding this metric.** Every country surveyed in the region, except for one, falls under the green category. The exception is Costa Rica, which is classified as N/A since neither misoprostol nor mifepristone are registered in the country. Despite this limitation, Costa Rica's Therapeutic Abortion Protocol outlines misoprostol as the suggested method for abortion in the first 12 weeks of pregnancy. The other regions surveyed have greater variation in their policies.
- **Several countries surveyed had conflicting information on the timeframe that medication abortion can be utilized, with narrower timeframes recognized by the pharmaceutical regulatory body compared to ministerial guidelines.** In such instances, the analysis relied on the ministerial guidelines which commonly dictate the practice of health care providers. The narrower timeframes used by these pharmaceutical regulatory bodies align with outdated data on the safety and efficacy of medication abortion throughout pregnancy.

Examples of Enabling Laws and Policies

The WHO does not specify a gestational limit for medication abortion.[25] Instead, the WHO provides different guidelines depending on gestation, particularly on the quantity of the dose, the frequency of administration of the drugs, the method of administration, and the person administering it.

Ethiopia: Ethiopia's ministerial guidelines set forth how to utilize medication abortion until 28 weeks gestation, in addition to a range of procedural options for abortion care.[26]

New Zealand: New Zealand's clinical guidelines on abortion provide detailed recommendations on using medication abortion before 20 weeks gestation and beyond, in addition to procedural options.[27]

Thailand and Sweden: Both countries allow for the use of medication abortion well beyond the 12 weeks recommended by the World Health Organization for self-management, with Thailand allowing its use through 24 weeks[28] and Sweden through 22 weeks.[29]

Recommendations

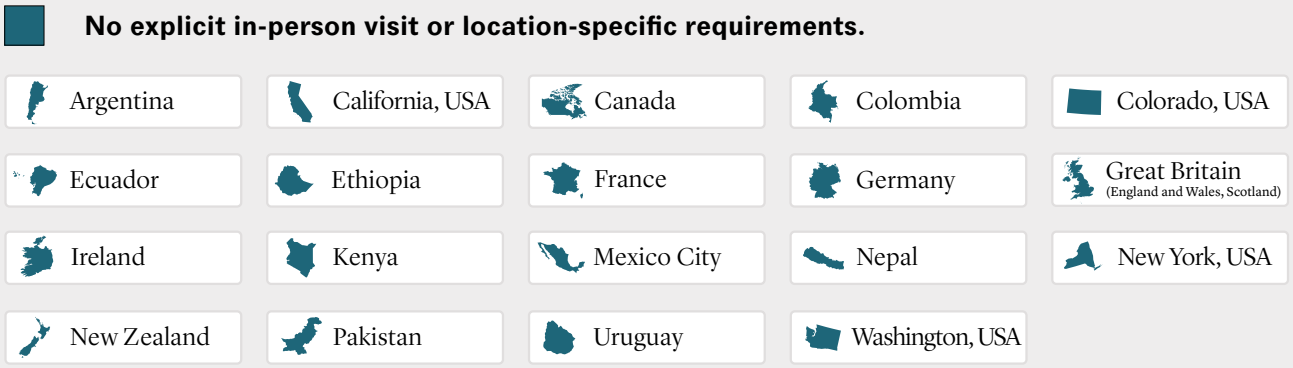
States should:

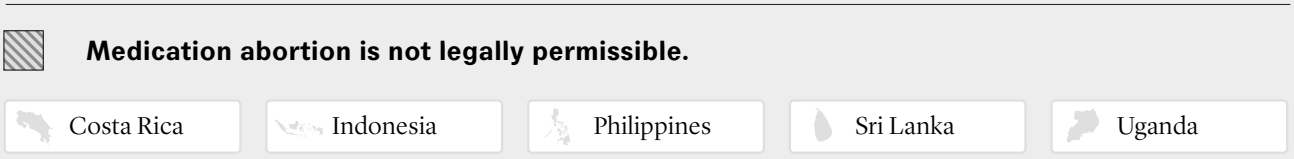
- Reform their ministerial guidelines and drug registrations to recognize that medication abortion can be safely used through 12 weeks of gestation without clinical supervision, in accordance with WHO standards.
- Reconcile existing conflicts between ministries of health and pharmaceutical regulatory bodies in favor of greater access to medication abortion. Where such conflicts cannot be easily reconciled, states should consider interim measures to ensure providers and people seeking abortion care have legal security and practical access to medication abortion without clinical supervision up to 12 weeks gestation.
- Promote quality, accurate information on the safety and effectiveness of medication abortion, particularly early in pregnancy when people may be more likely to self-manage abortion.

Metric 6:

Location-Based Requirements

An enabling environment allows pregnant people to self-administer medication abortion without pre-or post-abortion visits in-person and permits them to choose where they want to take the medication. The International Federation of Gynecology and Obstetrics recognizes that in-person consultations are not essential to the provision of safe and effective abortions,[30] and the WHO recommends that, for pregnancies up to 12 weeks of gestation, individuals should be able to self-assess eligibility for medication abortion, self-administer the appropriate medication, and self-assess the success of the abortion. Requirements that individuals physically visit a health facility for a consultation or ultrasound prior to accessing medication abortion, or that they take the medications in a facility or otherwise in the presence of a healthcare provider undermine access to care and contradict guidance from health authorities.





Takeaways

- **Location-based requirements remain common for medication abortion.** While several countries have temporarily or permanently relaxed their location-based requirements since the onset of the COVID-19 pandemic, nearly half of the countries analyzed still explicitly mandate at least one in-person visit to a healthcare facility for medication abortion. These mandates significantly hinder accessibility for many individuals seeking abortion services, particularly those with limited resources or those living in remote areas.
- **The regulations in these countries mandating administration of medication in a healthcare facility are not justified by safety standards.** Typically, these countries require at least one pill, usually mifepristone, to be administered under a healthcare worker's supervision at a healthcare facility. However, substantial research shows that individuals can safely self-administer both abortion medications without direct supervision by a healthcare worker.
- **The requirement for in-person visits directly impacts the feasibility of fully remote abortion services via telemedicine.** In countries with strict location-based requirements, individuals cannot benefit from the convenience and increased accessibility that telemedicine offers, undermining efforts to modernize and improve abortion care.

Examples of Enabling Laws and Policies

There are a number of good practices for enabling people to end a pregnancy in the location of their choosing:

Ethiopia: Although the Ethiopian Criminal Code mandates that abortions must be provided by a "recognized medical institution,"[31] ministerial guidelines have clarified that this includes locations outside traditional facilities.[32] These guidelines explicitly permit self-administering medication abortion if the pregnant person has access to a provider for examinations and counseling as well as a "mobile health team approach" for remote areas.[33]

France: The French Public Health Code stipulates that abortions can be carried out remotely[34] and the French Health Ministry has published a detailed guide for medication abortion, explicitly allowing for self-administration of mifepristone and misoprostol at home.[35]

Argentina: Argentina's law does not stipulate specific location requirements, or that any provider involvement must occur at a health facility and affirms that medication abortion is safe for outpatient and self-managed administration.[36]

Pakistan: Pakistan's ministerial guidelines explicitly recognize that "Whenever possible, women/girls should be offered a choice of taking the misoprostol at home or in the healthcare facility, as different women/girls have different needs and desires. For some women/girls, home may be a more private place but for others, the healthcare facility may afford a greater degree of privacy."[37]

Recommendations

States should:

- Eliminate the need for in-person visits and location-based requirements for medication abortion. Such requirements undermine the effectiveness of other critical developments in access to abortion care, such as the use of telemedicine and expanding the range of providers who can administer medication abortion. They also divert critical resources away from the provision of other types of care.
- Reocognize that such laws disproportionately undermine access to medication abortion for underserved populations, such as people in rural settings, people living in poverty, and Indigenous populations. Such requirements may be particularly harmful for people averse to accessing care through formal settings, such as those who have previously experienced rights violations in healthcare facilities.
- Guarantee people the right to self-manage an abortion in the location of their choosing.

Metric 7:

Availability via Telemedicine

An enabling environment ensures that individuals can access abortion services via telemedicine or other telehealth services. The WHO recommends telemedicine as an alternative to in-person interactions with a healthcare provider to provide medication abortion services.[38]

Abortion via telemedicine is explicitly permitted.

- California, USA
- Colombia
- Colorado, USA
- France
- Great Britain (England and Wales, Scotland)
- Ireland
- Mexico City
- New York, USA
- New Zealand
- Washington, USA

Abortion via telemedicine is neither explicitly permitted nor prohibited.

- Argentina
- Belgium
- Canada
- Chile
- Costa Rica
- Ecuador
- Ethiopia
- Germany
- India
- Indonesia
- Italy
- Kenya
- Mozambique
- Nepal
- Netherlands
- Nigeria
- Norway
- Pakistan
- Peru
- Rwanda
- South Africa
- Sri Lanka
- Sweden
- Tanzania
- Thailand
- Uganda
- Uruguay

Abortion via telemedicine is explicitly not permitted.

- Brazil

Abortion is prohibited altogether.

- Philippines

Takeaways

- **Only a few countries have established regulations explicitly addressing abortion via telemedicine, and these laws are all very recent.** Nearly all of these countries have explicitly embraced abortion via telemedicine, with some of them implementing such provisions during the COVID-19 pandemic. This recent trend, supported by growing research and endorsement from the WHO Abortion Care Guidelines, offers pathways for more countries to implement progressive regulations allowing telemedicine for abortion.
- **In countries without specific regulations on telemedicine abortions, the availability of telemedicine abortion varies considerably.**
  - Some countries impose location-based restrictions (see metric 6), which impede a completely remote abortion process via telemedicine, although consultations and misoprostol administration can often still be conducted remotely.
  - By contrast, other countries, while lacking explicit regulations on telemedicine abortions, generally have enabling legislation for telemedicine and treat abortion as other healthcare procedures, thus making remote access to abortion likely feasible in practice.
- **The scarcity of policy on telemedicine abortions presents both opportunities and challenges.** On one hand, the absence of explicit prohibition may provide pathways for individuals to obtain abortions via telemedicine. Further, countries without specific regulations on telemedicine abortion might be more inclined to adopt progressive global trends and permit telemedicine for abortion. On the other hand, the lack of specific regulations may hinder the development of telemedicine infrastructure. Additionally, the lack of regulatory clarity may deter abortion providers from offering telemedicine services, fearing legal repercussions.

Examples of Enabling Laws and Policies

New Zealand: In addition to explicitly permitting abortion by telemedicine,[39] New Zealand has established a National Abortion Telehealth Service to facilitate entirely remote medication abortions up to ten weeks gestation. It is a completely free service for those who are eligible for publicly funded healthcare.[40]

Colombia: Guidelines from the Ministry of Health recognize that abortion services must be available throughout the country and requires regional and local Health Secretariats to ensure the availability of telemedicine abortion services.[41] In such cases, the Ministry of Health explicitly recognizes that medication abortion can be mailed to individuals.

Mexico: The abortion guidelines explicitly recognize that abortion via telemedicine has proven to be effective, safe, and highly acceptable to users and facilitates access to care in rural areas. The guidelines also echo WHO's recognition that abortion should be available via telemedicine.[42]

Recommendations

States should:

- Explicitly affirm the accessibility of abortion via telemedicine and recognize that it is safe, effective, and resource efficient. The countries surveyed that explicitly permitted abortion through telemedicine did so through different modalities, such as incorporating it into ministerial guidelines on abortion, integrating abortion explicitly into telehealth guidelines, and providing financing for telehealth abortion services.
- Establish systems to promote access to abortion via telemedicine, such as New Zealand's National Abortion Telehealth Service, which facilitates entirely remote early medication abortions.[43]
- Overturn restrictions that prevent people from using telemedicine for abortion, such as bans on the practice and location-based requirements for medication abortion.

Conclusion

Self-managed abortion has the potential to enable people across the globe to safely and effectively access abortion in a private and supportive environment of their own choosing, free from burdensome restrictions and unnecessary costs. Self-managed abortion using medication is an important option to the unsafe abortions that kill scores of women and girls each year, particularly in places where abortion is highly stigmatized and for those who lack access to or prefer not to utilize the formal healthcare sector. In short, enabling people to self-manage abortion using medication is integral to the fulfillment of the full range of individuals' human rights, including the rights to reproductive autonomy, equality and non-discrimination, dignity and self-determination.

Yet, as this analysis shows, legal and policy barriers to self-managed abortion remain pervasive, even in countries with relatively permissive abortion laws. Many countries continue to enact laws that perpetuate unnecessary legal and regulatory hurdles that expose pregnant people and the friends, family, or acquaintances that support them to significant legal risks. The WHO is unequivocal in recognizing that people can safely manage their own abortions using medication up to 12 weeks gestation; as such, there is no reason for these laws and policies to continue to impose such barriers to individuals' access to care.

Laws and policies on abortion must be reformed to be grounded in health and human rights and support individuals' autonomy, privacy, and self-determination. This includes permitting abortion on request at least through 12 weeks gestation; removing unnecessary provider involvement requirements; registering medication abortion, recognizing its use through at least 12 weeks gestation, and removing prescription requirements; removing in-person requirements for abortion care; and explicitly authorizing abortion via telemedicine. By taking these steps, states can dismantle unnecessary barriers to self-managed abortion and replicate good practices being employed by other countries.

Finally, this analysis can serve as the foundation for future efforts to track laws and policies and identify progress and regression around self-managed abortion. Taking stock of where we are in this moment is a critical step towards raising awareness of the challenges we continue to face around self-managed abortion. But it is only by tracking this over time that we can fully understand where such roadblocks are being effectively removed and which are so stubbornly entrenched that more concerted efforts are needed.

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