

Legal abortion:

a comparative analysis
of health regulations

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The full text of this book and the laws and regulations of the different countries are available on the CD included with this publication, as well as additional information on the issue.

Please note that the English version of *Legal Abortion: A Comparative Analysis of Health Regulations* contains some additional text and slight changes from the Spanish version. These changes arose from discussions with the editorial review committee and suggestions from the team at the International Reproductive and Sexual Health Programme, Faculty of Law, University of Toronto.

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Legal abortion:

a comparative analysis of health regulations

A review of Latin America and
selected countries in Europe and Africa

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Contents

Preface	9
Foreword	11
Executive summary	15
I. Methodology	21
i. Criteria used to select the countries	23
ii. Criteria used for the analysis	24
iii. The consultation process	27
II. Objectives	29
III. The legal situation of the countries analyzed	33
i. Countries that stipulate legal grounds for abortion with provisos for gestational age in non-criminal laws and regulations	35
ii. Countries that criminalize abortion except in special circumstances as stated in their penal code	38
IV. Comparative analysis of the regulations	41
i. Organization of services	43
ii. Service quality: guaranteeing rights and quality standards	66
iii. Education and training of service providers	114
iv. Data collection, monitoring and oversight systems	118
v. Funding of services	128
vi. Administrative issues	130
Some conclusions	142
V. Recommendations for developing regulations that guarantee access to abortion services	145
i. Barriers	149
ii. Recommendations	155
Index of laws and regulations	193
Index of documents	197

Preface

Supporting a woman's right to choose to legally and safely terminate her pregnancy is central to the mission of the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). To achieve this mandate, IPPF/WHR has developed and implemented regional initiatives that promote equity, social justice and equality of rights in the delivery of health services, with the aim of improving opportunities in the field of sexual and reproductive health. These strategies are implemented in coordination with IPPF/WHR Member Associations and allied organizations that are committed to ensuring the full exercise of these rights and to promoting safe and legal abortion in Latin America and the Caribbean.

IPPF/WHR believes that the right to achieve the highest standard of health is a basic human right. It also believes that efforts to achieve well-being through health promotion and comprehensive services must include at least three main components: reducing the occurrence of unwanted pregnancy – and, therefore, the need for abortion – by promoting policies for comprehensive sexuality education and access to contraception; promoting women's right to make informed decisions about their lives with freedom and integrity; and increasing access to legal abortion services. Timely and equitable access to quality abortion services as permitted by law must, therefore, form one of the fundamental components of sexual and reproductive health policies.

It is within this framework that IPPF/WHR initiated this comparative analysis of health regulations for legal abortion in several countries in Latin America and the Caribbean. The goal was to examine current trends in this area. To expand the analysis, this comparison also includes health regulations from countries outside the region that represent major advances or new thinking. In addition, the team has created a model regulation, which includes the essential elements for guaranteeing women's access to safe, legal and timely abortion services.

IPPF/WHR hopes this comparative analysis will form a basis for decision making that will advance sexual and reproductive health and that it will also contribute to efforts to

find common ground in the face of challenges that continue to cause controversy and inhibit consensus. In many cases, the analysis aims to identify measures that in and of themselves may constitute barriers to access rather than creating conditions that enable women to exercise their rights.

This publication is the first attempt to establish a model regulation based on a comparison of current regulations. The next crucial step must be to develop strategies that incorporate the vision of clients and health professionals, whose perspectives and experiences of legal abortion services enable them to determine the true effectiveness of regulations.

This initial effort to present a model regulation arose out of the conviction that decriminalization, and even legalization, of abortion is not enough to guarantee access to safe, timely and quality abortion services. The establishment of effective policies and health regulations is an essential step to ensure compliance with the law. These policies, in turn, can be used to make sure that health systems offer women with unwanted pregnancies a range of integrated services that focus on their health and well-being, to create instruments that deepen the commitment of health professionals and clarify their responsibilities, and to guarantee that mechanisms are in place for women to exercise their rights to legal abortion.

Carmen Barroso

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Foreword

This report provides a comparative analysis of health regulations designed to ensure the implementation of laws enabling the provision of legal abortion services. The proposed model regulation sets minimum standards for what is required by governments and health care providers to ensure women's access to safe, dignified and timely services. It is an important document that should be widely read by those concerned with improving the delivery of abortion services to all women, irrespective of their circumstances.

Significantly, the report takes a human rights approach. It explains how regulations should be designed in order to comply with women's human rights and fundamental freedoms. A human rights approach provides a language and a process by which harms are recognized, named and identified as human rights violations, and ultimately rectified.

Naming of the harmful treatment to which women are subjected in their various pathways to abortion services is especially important, because so often the treatment is not understood as harmful. Naming a practice as harmful is a precondition to remedying it, in much the same way that diagnosing a condition as a disease is essential for its treatment.

Harms to which women are exposed in the abortion context can be understood as harms that fail to distribute health resources according to women's health care needs (distributional harms), and harms that are detrimental to women's dignity, autonomy and privacy (recognition harms). This report addresses both kinds of harms, because women can not access services unless they are available, and will not access services unless they are treated with compassion and respect. The proposed model regulation explores the ways in which governments and health care providers can address and remedy both distributional and recognition harms.

Indicators are often helpful in identifying these harms. Some countries have developed a series of health service indicators that measure the quality of the delivery of the service,

and health status indicators that measure the outcomes of the health service. Important health status indicators include morbidity and mortality rates from unsafe abortion and, for example, the percentage of abortions performed during the first 10 weeks of pregnancy. These indicators need to be disaggregated by age, rural status and, for example, ethnicity, to ensure that subgroups of women have equal and timely access to services. Where deaths due to unsafe abortion are high, health status indicators can be used to name the harms to women, and to quantify their impact.

Determining how these harms constitute human rights violations is the next step in a human rights approach. This requires identifying the human rights, whether expressed in national constitutions, international human rights treaties or national laws, or health regulations, and explaining why the harm constitutes a violation. The distributional harms can be conceived as violating rights such as

- the right to the highest attainable standard of care because services are not adequately provided,
- the right to nondiscrimination in access to care because services are not equally available to all women irrespective, for example, of their age, race, disability, rural location, or ability to pay.

Recognition harms may violate rights such as

- the right to be free from inhuman or degrading treatment because of the dignity denying treatment to which women are subjected,
- the right to liberty or security of the person because of the denial of women's decisional autonomy or her moral agency.

Once the harms are named and it is understood which human rights are violated, the next step in a human rights approach is to hold those accountable for the human rights violations they have caused. Indicators shift the burden to governments to explain why they are not doing more to address the preventable causes of women's premature death. Holding violators of human rights standards accountable is central to a human rights approach to abortion. Those who violate women's human rights in the abortion context can be held accountable in multiple ways, including politically, professionally and legally. Indicators, for example, can be used legally to argue before a court of law, or before human rights tribunals that women are being discriminated against on account of their sex-specific health care needs.

The ways in which violators will be held accountable will often depend on the context. For example, ministries of health might be held legally accountable for neglecting health services, such as abortion, that only women need. Neglecting health care that only

women need is a form of discrimination against women that ministries are obligated to address and remedy. As this report explains, this neglect can come in many ways, such as not supplying the necessary medications, and not providing the necessary training for health care providers.

This report will be invaluable to communities working together to eliminate discrimination and other human rights violations in the abortion context, and ensure that governments distribute health care services for sex-specific needs, and that all women, irrespective of their circumstances, are accorded recognition and respect in their various pathways to abortion.

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Executive summary

This publication – *Legal Abortion: A Comparative Analysis of Health Regulations* – is the result of a comparative analysis of laws and health regulations governing access to legal abortion in 13 countries: Bolivia, Brazil, Canada, Colombia, Guyana, Italy, Mexico, Norway, Panama, Peru, Puerto Rico, South Africa and Spain.

As described in the foreword, this publication seeks to promote access to safe and legal abortion services by developing health regulations and guidelines that are grounded in a human rights framework. Applying a human rights framework to the delivery of health services is fundamental to achieving the right to health for all citizens and creating a health system in which people are empowered to freely make decisions about their lives. There is no area where this is more important than in the provision of sexual and reproductive health services, particularly abortion-related services.

The challenge remains of how to genuinely apply and integrate these rights into the actual delivery of services and the way that health systems are run. Efforts to define the right to health by international human rights bodies and scholars have identified that the right to health requires the following four key features of health care services: availability, accessibility, acceptability and adequate quality.¹ The implementation of comprehensive and well-designed health regulations is an important way to ensure that these features are put in place. As described throughout this document, there are countries around the world whose laws permit abortion in specific circumstances. However, in practice, there are tremendous barriers for women seeking to access these services. The failure of governments to provide these lawfully entitled services constitutes a violation of both local laws and international human rights standards.² While the existence of health

¹ Cook, R and Dickens, BM (2003) Human rights dynamics of abortion law reform. *Human Rights Quarterly*. 25, pp.1–59.

² Cook, RJ (2009) Transparency in the delivery of lawful abortion services. *Canadian Medical Association Journal*. 180(3), pp.272–273.

regulations and ethical and quality of care standards will not remove all barriers to access, they are an essential element of transparent health services.

There is no universally agreed upon definition of a human rights approach to health; however, health policies and guidelines that follow a human rights framework are grounded in certain key elements. These include the principle of non-discrimination – guaranteeing that such policies aim to eliminate differential access to health services and ensure that all clients receive ethical treatment. Another key element is the involvement of community members and civil society groups in developing and implementing national and local health-related policies. Such a framework also includes mechanisms to hold governments accountable in their legal obligations to respect, protect, promote and fulfill the right to health. When governments are negligent in these obligations, citizens must have access to systems of redress that will hold the government to account. Finally, within such a framework, there must be acknowledgement of the underlying determinants of health and the need to coordinate with other sectors to improve health outcomes and access to health services.³

As the work of Paul Hunt and others shows, the creation of indicators and standards to monitor states' implementation of the right to health is an essential part of a broader human rights approach to health care.⁴ The comparative review of health regulations in this publication, and the proposed model regulation for legal abortion services, are an innovative attempt to establish minimum standards for what is required of governments and health providers to ensure that women have access to safe, high quality abortion services as permitted under the law. IPPF/WHR hopes that efforts to create new regulations, or improve existing ones, will be carried out in close collaboration with governments, civil society and community actors in order to guarantee that health service provision is firmly grounded in a human rights framework.

The book is organized into a prologue and five chapters. The first chapter, **Methodology**, includes explanations of the criteria used to select countries and to find and analyze information, as well as details about the consultation process used to produce the book.

The second chapter, **Objectives**, sets out the goals of the publication. These highlight the fact that regulations should reduce or eliminate barriers to access to services, and

³ Yamin, AE (2002) Challenges and possibilities for innovative praxis in health and human rights: reflections from Peru. *Health and Human Rights*. 6(1), pp.35–62.

⁴ Backman, G, Hunt, P, Khosla, R et al (2008) Health systems and the right to health: an assessment of 194 countries. *The Lancet*. 372(9655), pp.2047–2085.

provide clarity and a framework for health providers on how to implement safe abortion services. The objectives are:

- to compare abortion-related laws and regulations enacted by different countries⁵
- to create a tool that provides information on the measures and content contained in the different regulations that can be used to guide decision making on laws and regulations that facilitate access to legal abortion services
- to create a model proposal for health regulations and guidelines that foster timely access to safe and legal abortion services

The third chapter – [Legal situations of the countries analyzed](#) – describes the legal situation of abortion in each of the selected countries and classifies each country according to whether abortion is partially or fully legal. Countries that stipulate specific grounds for legal abortion in their non-criminal laws and regulations include Canada, Guyana, Italy, Norway, Puerto Rico and South Africa. Countries that criminalize abortion except in special circumstances as stated in their penal code include Bolivia, Brazil, Colombia, Mexico, Panama, Peru and Spain.⁶

The fourth and longest chapter is the [Comparative analysis of the regulations](#), which is organized by various criteria. These criteria were defined on the basis that they would ideally be included in abortion regulations in order to effectively eliminate barriers and guarantee timely access to legal abortion services, or they were a part of the current regulations in the countries researched.⁷

⁵ Because this publication is intended for use by decision makers and lobbying groups, the comparative analysis is extensive. IPPF/WHO hopes that it will be used as a guide for creating regulations that protect women's rights. Countries may choose from the many components those that best fit their situation.

⁶ Extensive information about the legal situation of each country is included in the CD that accompanies this publication.

⁷ The analysis addresses the following topics: **organization of services** (guiding principles; service networks at all levels; determining referral and counter-referral systems and their operation; level of care of services. It includes determining the level of care in accordance with duration of pregnancy; service provision models; counseling and support models/activities. It includes different options for unwanted pregnancy; services for young people; models of care for abortion in specific circumstances (for example, rape); professionals with authorization to perform the procedure; guaranteeing service provision; post-abortion counseling and care; timeframes for service provision). **Service quality: guaranteeing rights and quality standards** (informed consent: general rules for consent, consent of minors, consent of women who cannot directly give it themselves, conscientious objection; confidentiality of services: medical confidentiality; privacy of services; consideration of the client's culture; systematic dissemination of information to promote services to the general public; content of information provided to individual women; protocols for surgical and medical abortion. Specifically, it includes measures on laboratory tests and ultrasound before an abortion; pregnancy tests; pain management; description of abortion techniques (surgical and medical); prophylactic antibiotics; management of complications; establishing biosecurity standards; infrastructure requirements for service provision; accreditation mechanisms for professionals; gestational limits). **Education and training of service providers** (education and training in medical and psychosocial aspects (gender perspective, rights and empowerment) of abortion for all health personnel (physicians, midwives, nurses and

The fifth and final chapter offers [recommendations for health regulations on legal abortion](#). These recommendations are essentially guidelines for defining the components and principles that should be included in all abortion regulations in order to promote access to services and guarantee that sexual and reproductive rights related to abortion can be exercised. The chapter therefore includes an analysis of potential sources of barriers to access: barriers related to the organization of services; barriers related to service quality and the exercise of rights; barriers related to data collection, monitoring and oversight systems; economic barriers; and administrative barriers.

The chapter also presents recommendations to reduce each set of barriers: measures to reduce barriers related to the organization of services; measures to eliminate barriers related to service quality and rights; measures to eliminate barriers related to the education and training of health professionals; measures to eliminate barriers related to data collection, monitoring and oversight systems; measures to reduce barriers due to costs; and measures to reduce administrative barriers.

The recommendations included in the final chapter stem from the belief that legal reform alone is not enough to guarantee access to safe and timely abortion services. Health regulations are essential for increasing women's awareness of their rights to safe abortion, for ensuring the existence of instruments that make it possible to enforce these rights, particularly women's right to life, and for ensuring the implementation of quality services. Put simply, the model can serve as an important political advocacy tool for countries where there are no abortion regulations or where existing regulations are not designed to protect women's sexual and reproductive rights. It is important to emphasize that the success of such regulations also depends on the presence of committed health professionals who have not only been adequately trained at a technical level, but who also understand the importance of their role in working for social change through the provision of quality and humane sexual and reproductive health services.

counselors); continuing education at health facilities; emotional support for women and respect for their decisions; eliminating harmful customary practices such as requiring partner's consent; social and/or moral sanctions against abortion, and so on; the role of health sciences faculties; creating a multi-disciplinary team to manage unwanted or unplanned pregnancies). **Information, monitoring and oversight systems** (data management systems, including reporting complications and infections (epidemiological monitoring system); monitoring and oversight systems of facilities that provide services; appeal or review mechanisms when services are denied; prohibition against labor or social discrimination against abortion providers; sanctions for denying services; management of medical records). **Funding of services** (service costs: payment; instruments to identify the socio-economic situation of different populations). **Administrative issues** (requirements for accessing abortion services; defining and clarifying grounds for abortion; availability of abortion drugs (misoprostol and mifepristone); grounds for denial of services).

These recommendations must form part of a comprehensive package of sexual and reproductive health care policies that provide the necessary services for women facing unwanted pregnancies and create measures to prevent future unwanted or unplanned pregnancies. In the area of prevention, there are two important areas of action: implementation of quality sexuality education, and promotion of and access to contraceptive methods, including methods for preventing pregnancy and sexually transmitted infections (dual protection). In relation to services for women with unwanted pregnancies, the full range of options should be available: termination of pregnancy (by medical or surgical abortion) where allowed by law, promotion of risk-reduction strategies for unsafe abortion, outpatient care for incomplete abortion, adoption counseling and, finally, for those women who decide to continue the pregnancy, quality prenatal, childbirth and post-partum care with appropriate social support as well as the existence of social policies that support and protect parents and families.

I. Methodology

I. Methodology

i. Criteria used to select the countries

After establishing the criteria, the following countries were selected for the comparative analysis: **Bolivia, Brazil, Canada, Colombia, Guyana, Italy, Mexico, Norway, Panama, Peru, Puerto Rico, South Africa** and **Spain**. This small sample size is not intended to be representative of the Latin America and Caribbean region, or of other regions. Instead, because there are few regulations in the region, this selection enabled the research team to undertake a fairly complete analysis of the situation and, in particular, of the measures being undertaken to ensure access to legal abortion services.⁸ The selection was made based on the following criteria:

- ❑ countries with regulations on access to legal abortion services⁹;
- ❑ inclusion of some countries to ensure subregional representation in the Americas;
- ❑ inclusion of some countries where IPPF/WHO Member Associations are participating in a regional safe abortion project;
- ❑ countries with ground-breaking regulations (European countries, generally speaking);
- ❑ countries with regulations that provide information pertinent to an analysis of more advanced legal situations with respect to abortion (South Africa¹⁰ and Norway) or where the regulations have been in place for a long time (Italy and Spain).

⁸ To reach this conclusion, a larger preliminary group of countries was identified and then the internet was used to research which countries had the best or most extensive regulations. The research examined the websites of ministries of health, parliaments, women's organizations, associations of gynecologists and obstetricians, international agencies and institutions, and websites specifically about abortion in each country as well as thematic issues.

⁹ Regulations on incomplete abortion and hemorrhage during the first trimester were not included because, although they often support health care for abortions already initiated – often performed in unsafe conditions – they do not address legal abortion services, which are the focus of this publication.

¹⁰ In **South Africa**, the abortion regulations were enacted within the broader process of establishing a new, democratic government.

ii. Criteria used for the analysis

The regulations were analyzed based on the elements that would ideally be found in specific regulations governing access to legal abortion, as well as on the criteria and recommendations for abortion-related public health guidelines set out by various international bodies.¹¹ Together, these criteria formed the basis for the research, the analysis itself and the recommendations in Chapter V. The criteria were refined during the research stage: some criteria that were initially included for the model recommendations were not included in the analysis because there was insufficient information about them in the regulations of the selected countries; they were, however, not excluded from the model.

The model includes all the elements believed to contribute significantly to guaranteeing rights to access legal abortion services. Each component, if included in public health regulations, would contribute to the reduction and/or elimination of barriers to access. Additionally, for each section of the analysis, concrete information was sought on adolescents in order to address their particular situation and to make recommendations that would specifically foster the exercise of their sexual and reproductive rights.

Finally, it is important to clarify that this analysis has two limitations in its reporting. Firstly, regulations on post-abortion care were not included, because the focus is on access to legal abortion services. Secondly, the information concentrates on regulations that exclusively address legal abortion; therefore, it is possible that other types of regulations or laws that may address issues discussed in the analysis were not included. For these reasons, when it is stated that the regulations analyzed do not address a specific issue, it is important to bear in mind that these limitations are inevitable given the scope of this project.

Following is a list of the issues and criteria that were analyzed in the comparison:

¹¹ Examples include the World Health Organization, International Federation of Gynecology and Obstetrics (FIGO), Latin American Federation of Obstetric and Gynecological Societies (FLASOG), IPPF, Ipas and the Pan American Health Organization. The rulings of various constitutional courts, such as in Colombia, were also considered.

Organization of services

- ▮ guiding principles
- ▮ service networks at all levels: local, departmental and national
- ▮ determining referral and counter-referral systems and their operation
- ▮ level of care of services, including outpatient care and second trimester abortion care: this includes determining the level of care in accordance with the duration of pregnancy
- ▮ service provision model
- ▮ counseling and support models/activities that encourage women's autonomous decision making and do not seek to dissuade women; these include different options for unwanted pregnancy: continuing the pregnancy, legal abortion services, adoption
- ▮ services for young people: these include mechanisms for payment of services, when payment is required
- ▮ models of care for abortion in specific circumstances (for example, rape)
- ▮ professionals with authorization to perform the procedure
- ▮ entities responsible for guaranteeing service provision
- ▮ post-abortion counseling and care: access to contraceptives and other sexual and reproductive health services
- ▮ timeframes for service provision

Service quality: guaranteeing rights and quality standards

- ▮ informed consent:
 - i.* general rules for consent
 - ii.* consent of minors
 - iii.* consent of women who cannot directly give it themselves
- ▮ conscientious objection
- ▮ confidentiality of services: medical confidentiality
- ▮ privacy of services
- ▮ consideration of the client's culture; for example, availability of health professionals who speak different languages
- ▮ systematic dissemination of information to promote services to the general public: this includes education about rights related to legal abortion
- ▮ content of information provided to individual women
- ▮ protocols for surgical and medical abortion (service delivery guidelines or compulsory laws and regulations); specifically, measures on:
 - ▮ laboratory tests and ultrasound before an abortion (HIV/AIDS, syphilis, other blood tests, and so on)
 - ▮ pregnancy tests
 - ▮ pain management

- ▣ description of abortion techniques (surgical and medical)
- ▣ prophylactic antibiotics
- ▣ management of complications
- ▣ establishing biosecurity standards

▣ infrastructure requirements for service provision, including certification and accreditation of facilities

▣ accreditation mechanisms for professionals

▣ gestational limits

Education and training of service providers

▣ education and training in medical and psychosocial aspects of abortion (gender perspective, rights and empowerment) for all health personnel (physicians, midwives, nurses and counselors)

▣ continuing education at health facilities

▣ emotional support for women and respect for their decisions

▣ eliminating harmful customary practices (for example, requiring partner's consent, social and/or moral sanctions against abortion)

▣ the role of health sciences faculties/medical schools

▣ creating a multi-disciplinary team to manage unwanted or unplanned pregnancies

Information, monitoring and oversight systems

▣ data management systems, including reporting complications and infections (epidemiological monitoring system)

▣ monitoring and oversight systems of facilities that provide services

▣ appeal or review mechanisms when services are denied

▣ prohibition against employment or social discrimination against abortion providers

▣ sanctions for denying services

▣ management of medical records

Funding of services

▣ service costs: payment mechanisms (including sliding scale fees)

▣ instruments to identify the socio-economic status of different populations

Administrative issues

▣ requirements for accessing abortion services: criminal report, legal-medical examination and number of health professionals involved in determining if the procedure should be performed

▣ defining and clarifying grounds for abortion

▣ availability of abortion drugs (misoprostol and mifepristone)

▣ grounds for denial of services

Based on this outline, the internet was researched for information on each of the countries in order to identify regulations that addressed these issues. Once the legal framework for each country had been identified, specific regulations were evaluated so that the comparative analysis could be created. Information on abortion regulations was also collected from key contacts in each of the countries.

iii. The consultation process

Throughout the process, the comparative analysis – which included selecting countries, creating a matrix to analyze information on abortion regulations, comparing countries and developing the model regulation – was discussed with a group of four organizations in the region whose members are well-known leaders and activists in the areas of law, research and/or the provision of abortion services.¹² In addition, ongoing discussions were held with the safe abortion division of IPPF/WHR. This range of viewpoints, and the unique information provided by each organization, enriched and refined the discussions and the final publication. Finally, an editorial committee of well-known medical and ethics professionals from the region was formed to review the final document and contribute their perspectives.¹³ The English edition included an additional editorial review process with involvement from well-known legal scholars, activists and professionals in sexual and reproductive health.¹⁴

¹² Luisa Cabal, Center for Reproductive Rights, USA; Silvina Ramos, Centro de Estudios de Estado y Sociedad (CEDES), Argentina; María Luisa Sánchez, Grupo de Información en Reproducción Elegida (GIRE), Mexico; and Cristina Villarreal, ORIENTAME, Colombia.

¹³ Leonel Briozzo, Iniciativas Sanitarias, Uruguay; Vicente Díaz, MEXFAM; Aníbal Faúndes, FIGO; Tania di Giacomo do Lago, Coordinator of Women’s Health, Department of Health of the State of San Pablo; Rodolfo Gómez Ponce de León, Ipas; Ana Labandera, President of the Asociación Obstétrica del Uruguay; and Luis Tavera Orozco, FLASOG.

¹⁴ Milton Castelan, University of Toronto; Maria Mercedes Cavallo, University of Toronto; Rebecca Cook, University of Toronto; Cara Davies, University of Toronto; Bernard Dickens, University of Toronto; Sandra Dughman, University of Toronto; Joanna Erdman, University of Toronto; Martin Hevia, University of Toronto; Manuelle Hurwitz, IPPF, London; Nelcia Robinson, CAFRA; Upeka de Silva, IPPF, London.

II. Objectives

II. Objectives

The main objectives of the project were:

- to compare abortion laws and regulations enacted by different countries¹⁵
- to create a tool that provides information on the measures and content contained in the different regulations that can be used to guide decision making on laws and regulations that facilitate access to legal abortion services
- to create a model proposal for health regulations that foster timely access to safe and legal abortion services

The proposed model regulation should be seen as a tool for reducing or eliminating barriers in order to promote access to services, and to provide clarity and guidance to health providers on how to implement safe abortion services.

This model can be used by different sectors of society – both governmental and non-governmental – that advocate for sexual and reproductive rights and the provision of legal abortion services in an effort to guarantee women’s health and well-being.

In addition, the comparative analysis is a valuable tool for making decisions. It provides national authorities in different countries with information about developments both in Latin American and Caribbean countries as well as other regions. An overview of these developments is important to understand the trends in abortion regulations and to see which clearly favor a rights framework and which, on the contrary, may even create barriers to access or undermine rights. With this overview, governments have the option to choose measures that foster sexual and reproductive rights with the understanding

¹⁵ Because this publication is intended for use by decision makers and lobbying groups, the comparative analysis is extensive. IPPF/WHR hopes that it will be used as a guide for creating regulations that protect women’s rights. Countries may choose from the many components those that best fit their situation.

that these rights are a fundamental element of the right to health and therefore of human rights in general.

Maternal deaths due to unsafe abortion clearly demonstrate inequality and the violation of women's rights. Inequality is revealed by the fact that abortion-related complications most commonly affect the poorest women, the least educated women, and women who live in isolated areas or who belong to indigenous or minority cultures. The violation of rights, and specifically the right to life, is revealed by the fact that most deaths related to unsafe abortion are preventable. These two realities should serve as weighty arguments to encourage governments to implement health measures that protect these rights.

III. The legal situation of the countries analyzed

III. The legal situation of the countries analyzed

The legal situation in the selected countries was determined by reviewing the penal codes in countries that generally criminalize abortion with some special exceptions, and by reviewing non-criminal laws in countries that generally determine access according to duration of gestation. Although there are exceptions, the countries in general are divided into two groups: (i) countries that formulate legal grounds for abortion in non-criminal laws and regulations; and (ii) countries that penalize abortion except in special circumstances as set out in their penal code.

Countries that formulate legal grounds for abortion in non-criminal laws and regulations	Countries that criminalize abortion except in special circumstances as stipulated in their penal code
Canada ¹	Bolivia
Guyana	Brazil
Italy	Colombia
Norway	Mexico
Puerto Rico	Panama
South Africa	Peru
	Spain

¹ The situation of Canada differs somewhat from the other countries in this group. Abortion was decriminalized in Canada as a result of a Supreme Court ruling, which rendered the section on abortion in the penal code unconstitutional. While the section still remains in the penal code, it is of no force or effect.

i. Countries that stipulate legal grounds for abortion with provisos for gestational age in non-criminal laws and regulations

Canada, Guyana, Italy, Norway, Puerto Rico and South Africa belong to this group. In these countries, although there are grounds that limit access to legal abortion, often related to gestational age, transgressing these laws does not result in criminal punishment.

In **Canada**, abortion was legalized by a Supreme Court ruling, which found that the penal code provision criminalizing abortion was in conflict with the Canadian Charter of Rights and Freedoms, specifically the article establishing the right to life, liberty and security of the person (*R versus Morgentaler, 1988*).

In **Guyana**, there are no limitations on abortion before eight weeks of pregnancy. Between eight and 12 weeks, pregnancy can be terminated if (i) the continuation of the pregnancy would involve risk to the life of the pregnant woman or grave injury to her physical or mental health (in the latter case, the woman's current and future economic and social situation is considered);¹⁶ (ii) there is substantial risk that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped; (iii) the pregnant woman is not capable of taking care of an infant because she is a person of unsound mind; (iv) where the pregnant woman reasonably believes that her pregnancy was caused by an act of rape or incest and submits a statement to that effect; (v) where the pregnant woman is known to be HIV-positive; and (vi) where there is clear evidence that the pregnancy resulted in spite of the use in good faith of a recognized contraceptive method by the pregnant woman or her partner (Art. 6). After 16 weeks, abortion is allowed only to save the life of the woman or to prevent grave permanent injury to the physical or mental health of the woman or of her unborn child (Art. 7, Medical Termination of Pregnancy Act, 1995).

In **Italy**, a pregnancy may be terminated before 90 days when it poses a grave danger to the physical or mental health of the mother; due to her social, economic or family situation; due to the circumstances of the conception;¹⁷ or due to fetal anomaly or malformation (Art. 4). After 90 days, an abortion may be performed if the pregnancy or labor puts the mother's life at risk or fetal malformations are present that pose a danger to the mother (Art. 6, Regulation for the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

In **Norway**, similar to South Africa, a pregnancy can be terminated before 12 weeks without restriction. After 12 weeks it can be terminated (i) when the pregnancy, childbirth

¹⁶ The original states: «In determining whether the continuance of a pregnancy would involve risk of grave injury to the health of a pregnant woman as mentioned in subsection (1)(b)(i), a medical practitioner or authorized medical practitioner shall take into account the pregnant woman's entire social and economic environment, whether actual or foreseeable...»

¹⁷ From the context, it is clear that this refers to sex crimes. The original states: «Per l'interruzione volontaria della gravidanza entro i primi novanta giorni, la donna che accusi circostanze per le quali la prosecuzione della gravidanza, il parto o la maternità comporterebbero un serio pericolo per la sua salute fisica o psichica, in relazione o al suo stato di salute, o alle sue condizioni economiche, o sociali o familiari, o alle circostanze in cui e' avvenuto il concepimento...»

or care of the child may result in unreasonable strain¹⁸ on the physical or mental health of the woman; (ii) when the pregnancy, childbirth or care of the child may place the woman in a difficult life situation; (iii) when there is a major risk that the child may suffer from a serious disease as a result of its genotype, or disease or harmful influences during pregnancy; (iv) when the pregnancy is the result of criminal behavior described in the penal code;¹⁹ and (v) when the woman is suffering from severe mental illness or is mentally retarded to a considerable degree. After the 17th week, a pregnancy may be terminated only if there are important reasons to do so.²⁰ However, if the fetus is considered viable, the termination shall not be approved (Art. 2, Act No. 50 concerning Termination of Pregnancy, 1975, with Amendments, 1978).

In [Puerto Rico](#), abortion is legal in the same circumstances as in the United States under the *Roe versus Wade* decision. This guarantee was granted in the decision *Acevedo Montalvo versus Hernández Colón*, 377 Federal Supp. 1332, 1974, of the US District Court for Puerto Rico. Under the law, termination may not be denied in any situation before the fetus is viable. After fetal viability, termination can be denied unless there is a risk to the woman's life or health, which includes physical, emotional, psychological and familial factors as well as the woman's age.

In [South Africa](#), abortion is permitted without restrictions before 12 weeks at the woman's request. Between 13 and 20 weeks of gestation it is permitted if (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; (iii) the pregnancy resulted from rape or incest; or (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman. After 20 weeks, a pregnancy may be terminated only if (i) it would endanger the woman's life; (ii) it would result in a severe malformation of the fetus; or (iii) it would pose a risk of injury to the fetus (Art. 2, Choice on Termination of Pregnancy Act and Amendment, 1996 and 2004).

18 The context indicates a level of suffering that a woman is not reasonably expected to endure. In other texts, this situation is described as 'undue burden'.

19 [Rape, incest and sexual relations with minors younger than 16 years of age.](#)

20 The original states: «A pregnancy may not be terminated after the eighteenth week of pregnancy has elapsed unless there are particularly important grounds for doing so.»

ii. Countries that criminalize abortion except in special circumstances as stated in their penal code

This group includes Mexico and Colombia, although their legal situations are somewhat unique.

In **Bolivia**, termination of a pregnancy is permitted when the pregnancy is the result of rape, abduction for sexual purposes that is not followed by marriage, statutory rape²¹ or incest, and to avoid danger to the life or health of the mother if this danger cannot be avoided by other means (Art. 266, [Penal Code, 1972](#)).

In **Brazil**, abortion is permitted if there are no other means of saving the woman's life or if the pregnancy is the result of statutory rape or another act of sexual violence (Art. 128, [Penal Code](#)). Case law has also established grounds for abortion in the case of fetal malformation incompatible with life outside the uterus, and these grounds were reiterated in the Technical Regulations for Humane Abortion Care. As a result, abortions are in fact authorized by judges or at a woman's request in cases of fetal malformation incompatible with life, such as anencephaly, Patau's syndrome and renal agenesis. To obtain an abortion in such cases, the woman must request authorization from a judge or public prosecutor and must have a medical opinion.

In **Colombia**, abortion was decriminalized in some circumstances by a [Constitutional Court](#) ruling, which found that criminalizing abortion in certain circumstances was in conflict with the Constitution. The technical regulations reiterated the exceptions: (i) when continuing the pregnancy constitutes a danger to the life or health of the woman as certified by a physician; (ii) when a grave malformation of the fetus makes life unviable as certified by a physician; (iii) when the pregnancy is the result of a duly reported act constituting carnal access or a non-consensual and abusive sexual act or non-consensual artificial insemination or implantation of a fertilized egg or incest (3. Definitions (*Definiciones*), Technical Regulations on Care for the Voluntary Interruption of Pregnancy (*Norma Técnica para la Atención de la Interrupción Voluntaria del Embarazo ILE*)).

In **Spain**, terminations are authorized up to 22 weeks when there is a grave danger to the health or life of the woman or it is believed that the fetus will be born with grave physical or mental defects or until 12 weeks when the pregnancy is the result of rape (Art. 417 bis, [Penal Code](#)).

²¹ Statutory rape refers to sexual relations that involve some type of coercion or power imbalance (due to age or other factors). In the United States, for example, statutory rape refers to any sexual relationship between a minor and someone who is over 18, even if it is consensual.

In **Mexico**, the [Mexico City penal code](#) was modified in April 2007 to allow terminations during the first 12 weeks of pregnancy without restriction (Art. 144, [Mexico City Penal Code](#)). After 12 weeks, the penal code sets out the following grounds for abortion: when the pregnancy is the result of rape or non-consensual artificial insemination; when not performing an abortion would result in grave consequences to the woman's health; when a diagnosis gives sufficient grounds that the fetus has genetic or congenital defects that could result in physical or mental damage to such an extent that they may put the survival of the fetus at risk; and when the pregnancy is the result of criminal behavior on the part of the woman (Art. 148, Mexico City Penal Code).

In **Panama**, a pregnancy may be terminated when conception is the result of rape, or grave health conditions endanger the life of the mother or of the fetus (Art. 144, [Penal Code](#)).

In **Peru**, abortion is allowed when it is the only means of saving the life of the expectant mother or to avoid serious and permanent harm to her health (Art. 119, [Penal Code, 1924](#)).

IV. Comparative analysis of the regulations

IV. Comparative analysis of the regulations

This chapter forms a comparative analysis of the health regulations in effect in the countries selected for this survey. The analysis is based on the outline described in the chapter on methodology.

i. Organization of services

i. Guiding principles

Two regulations, in Brazil and Colombia, establish guiding principles for the provision of legal abortion services. Establishing principles as a part of the regulations is important because they act as parameters to guide service delivery and implementation of the provisions. In practice, these principles guide health providers when there is doubt about the meaning of a provision or about how he or she should act in a situation not specified in law.

In **Brazil**, personalized and humane care for women accessing legal abortion services is based on respect for the four core bioethical principles, which include:

- a. autonomy: the woman's right to make decisions about her body and life
- b. beneficence: the ethical obligation to maximize the benefit and minimize the harm (do good)
- c. nonmaleficence: actions must always cause the least harm to the patient, reducing the adverse or undesirable effects of one's actions (do no harm)
- d. justice: health professionals must act with impartiality and cannot allow social, cultural, religious, moral or other aspects to interfere in their relationships with women

According to the regulations, health care for women must always be a guaranteed priority and services must be provided by a professional; above all, the woman's freedom, dignity, autonomy, and ethical and moral authority to make decisions must be respected,

and all prejudices and preconceptions that may dehumanize the care must be laid aside (5. Professional Ethics, [Technical Regulations for Humane Abortion Care, 2005](#)).

In **Colombia**, the [Technical Regulations on Care for the Voluntary Interruption of Pregnancy](#) state that services shall be provided in accordance with the guiding principles of accessibility, timeliness, security, appropriateness and continuity (6. Characteristics of Service (*Características del Servicio*)).

ii. Service networks at all levels: local, departmental and national

Most regulations that set out the legal provision of abortion services do not define the extent of their jurisdiction. A few specify that they are national in scope or define how they apply to other levels of governmental and geographic divisions.²² For example, in **Italy**, the [Regulation for the Social Protection of Motherhood and Voluntary Interruption of Pregnancy \(1978\)](#) explicitly stipulates that the state, regions and local entities, as part of their powers and obligations, are responsible for the promotion and development of health and social services for abortion (Art. 1).

Spain clarified in the [Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions](#) (*Real Decreto sobre Centros Acreditados y Dictámenes Preceptivos para la Práctica de Abortos Legales, 1986*) that the health authority in each region shall monitor availability of the necessary services, including the urgent diagnostic techniques that make it possible to perform abortions within the legally established time periods (Art. 5).

In **Colombia**, [Regulatory Decree 4444 of 2006](#) mandates that legal abortion services be available in all national territories (Art. 1). The most recent regulatory provision says that the Health Promotion Entities (insurers) and the Departmental and District Health Offices (which are responsible for local public sector services) must refer to the Ministry of Social Welfare's General Office on Service Quality those institutions that, within the network, are authorized to provide low, medium and high level gynecological-obstetric services, and have professionals who are willing to provide abortion services. This information shall be kept current and available for clients who require these services and shall be reported annually to the Ministry's General Office on Service Quality ([Circular 031 of 2007](#)).

In **Norway**, county municipalities are required to organize hospital services so that the women in their area may have a pregnancy termination performed at any time, taking into

²² Governmental and geographic divisions refer to governmental districts that generally correspond to geographical areas. In some countries they are called territorial bodies, in others they are called departments, municipalities, counties, states, and so on.

account the limitations imposed by health personnel who object for reasons of conscience (Art. 14, [Act No. 50 concerning Termination of Pregnancy, 1975, with Amendments, 1978](#)). The regulation reiterates this obligation (Art. 19) and also assigns authority to the county medical officer, in consultation with the county municipality,²³ to decide which hospital units and institutions shall serve specific geographical areas (Art. 19, [Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975](#)).

The explicit definitions in the regulations of Colombia and Norway regarding availability of services are important because they serve as tools that women can use to demand services in specific institutions.

By contrast, countries such as **Peru, Puerto Rico, Panama, Mexico, Brazil** and **Bolivia** do not have provisions of this kind.

iii. Formulating referral and counter-referral systems and how they work

When regulations mention referral and counter-referral systems²⁴ within the health sector, it is to establish that providers of low complexity abortion services must always have a referral system in place for patients with complications. Very few explicitly establish counter-referrals for family planning counseling at lower levels of care in spite of the fact that it is a critical aspect of comprehensive sexual and reproductive health care. **Norway** specifically provides for referrals to another county in exceptional situations and for referrals to receive information about social assistance services that can be provided at the woman's request. The latter is more correctly a transfer out of the health system and, as a result, does not necessarily fit the concept of a referral, as discussed later.

In **Mexico**, referrals are provided for in the following terms: «Physicians belonging to primary level care facilities, who are not able to perform the procedure, shall refer the pregnant woman in an appropriate, responsible and timely manner to a hospital that provides legal abortions and where it is likely that such a procedure can be performed» (Art. 9 of the [General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City \(Lineamientos Generales de Organización y Operación de los Servicios de Salud relacionados con la Interrupción del Embarazo en el Distrito Federal\)](#)).

²³ From the context of the law, it is understood that the county medical officer is an administrative authority in the health sector with jurisdiction over a geographic region. Similarly, the county municipality seems to mean a governmental authority with a specific geographic jurisdiction.

²⁴ Counter-referral systems involve referrals back to the original referring institution (in this case referrals back to an institution of lower level care for family planning or other follow-up care).

In **Spain**, the Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions (1986) requires health establishments that may perform abortions up to 12 weeks to have a hospital referral center for cases where it is necessary (Art. 1).

In **Puerto Rico**, abortions may be performed in family planning and abortion centers with some limitations on the services provided, including: «The facility shall have established in writing a contract or formal agreement with a hospital facility within a one (1) mile radius and with the ambulance services necessary for the use of a patient suffering from complications, as well as with other support services» (Art. H, [General Regulation for the Operation of Health Facilities in Puerto Rico](#) (*Reglamento General para la Operación y el Funcionamiento de las Facilidades de Salud en Puerto Rico*), 1999).

The Technical Regulations for Humane Abortion Care (2005) in **Brazil** set out a comprehensive referral system not limited to the health sector. Medical teams are required to identify and satisfy health needs and risks in each case and to resolve them in accordance with the technical capacity of the establishment or by directing patients to referral services, women's groups or feminist non-governmental organizations (3. Protection and Counseling).

The referral and counter-referral system in **Colombia** is mentioned in various sections of the regulations. In essence, system administrators and health professionals are obligated to guarantee the operation of the referral and counter-referral systems to ensure the transfer of pregnant women with medium to high complexity cases when complications occur and when it is merited by the duration of the pregnancy or the woman's health. They must also ensure counter-referrals in low complexity cases to services promoting sexual and reproductive health and family planning (Art. 2 of Regulatory Decree 4444 of 2006). The regulations clearly define the different levels of health care facilities (community, low, medium, high), the services each provides and referrals across them (Appendix 1).

Similarly, in **Guyana**, the [Medical Termination of Pregnancy Act – Legal Supplement B \(1995\)](#) requires general physicians or authorized general physicians to offer counseling after performing an abortion or to refer the woman to an institution or approved provider for counseling (Art. 2).

In **South Africa**, abortion care – as in Colombia – begins at the primary level of care. However, care provided at this level has the sole purpose of examining and preparing the woman for the procedure. For a pregnancy of less than 12 weeks, a referral is made to a secondary level institution, and for a pregnancy of more than 12 weeks, to a tertiary or secondary level institution with gynecological back-up services ([Referral Guidelines for Clients Requesting a Termination of Pregnancy](#)). The regulations state that referrals to hospital care must be made:

- ❑ if the pregnancy is over 12 weeks
- ❑ if complications are suspected
- ❑ if the woman has an acute or chronic medical condition, such as heart disease, asthma, diabetes, anemia, blood clotting disorders, drug or alcohol abuse, or suspected ectopic pregnancy ([Protocol for Termination of Pregnancy Services, Department of Health: Western Cape](#))

Additionally, South Africa provides for referrals that take into account the level of complexity and geographical considerations by indicating that if services are not available in primary care institutions, clients who request an abortion must be referred to the appropriate regional or district institution designated for such purposes (Art. 1.5). Finally, the following principles apply to referrals:

- ❑ a referral letter from the health worker must accompany the client; all relevant information must be included in the letter
- ❑ a telephone booking must be made in all cases
- ❑ a record must be kept of the numbers of clients referred so that the demand for the service can be monitored ([Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape](#))

All these provisions can be found in [Circular H97/2000](#).

In **Norway**, referrals are provided in two specific cases. The first is when the woman, after receiving information about the procedure and social assistance that may be provided,²⁵ requests additional information (Art. 3). The second case occurs when – taking into account the woman’s wishes – the procedure must be performed outside the county where she lives. In this case, the county medical official must refer her to another hospital unit or institution for the procedure to be performed (Art. 14, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975).

Panama, Peru and Italy do not explicitly specify these types of systems in their abortion regulations.

iv. Services and level of care

Colombia establishes a relationship between level of care and weeks of gestation. [Appendix 1 of the Technical Regulations](#) clearly indicates the level of care needed for the termination of pregnancy in accordance with weeks of gestation. At the first level of

²⁵ From the context of the law, it is understood that this is information about the forms of social assistance available to the woman if she decides to continue the pregnancy.

care, abortions can be performed by vacuum aspiration up to 12 full weeks of pregnancy (up to 15 with well-trained providers) and medical abortion up to nine full weeks of pregnancy. At the secondary level, abortion services can be provided in all circumstances and stages of pregnancy that are permitted by current law. Consequently, all the above services can be provided at a high or tertiary level of care.

In **South Africa**, there is a clear division about which services can be provided at each level of care. As a result, clients who request a termination of pregnancy service shall enter the Provincial Health system at the primary care level (Art. 1.2, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape). However, for the procedure itself, they must be referred to secondary care (less than 12 weeks), to tertiary care (after 12 weeks) or to a secondary level hospital (if it has a gynecological back-up service) (Referral Guidelines for Clients Requesting a Termination of Pregnancy). Overall, the regulations express the need to decentralize termination of pregnancy services to community health centers and primary care clinics as soon as possible (Art. 1.1, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

In **Spain** and **Guyana**, although the regulations do not refer to levels of care, they do establish different training requirements depending on the number of weeks of pregnancy at which the termination is performed. (See Infrastructure requirements for service provision on page 106.)

v. Service provision model

Two countries clearly propose a model of integrated care for women: Colombia and Brazil.

In **Colombia**, abortion regulations conform to a model that includes not only the procedure, but also all related and complementary services. The Technical Regulations on Care for the Voluntary Interruption of Pregnancy state: «Integrated care for the voluntary interruption of pregnancy includes management of abortion complications and, within an integrated framework of sexual and reproductive health, access to other services, such as pre- and post-abortion counseling, family planning counseling, access to effective methods of contraception, prevention of sexually transmitted infections, HIV/AIDS, sexual and reproductive rights and in general all services that promote self-care of the woman's health» (Art. 6, Characteristics of Service).

In **Brazil**, the integrated model of care includes services similar to those included in the Colombian model. Called the 'support model', it clearly emphasizes a rights focus and prioritizes ensuring proper support for women. The objective of the Technical Regulations for Humane Abortion Care (2005) is to set out a humane and personalized care model for

women who have an abortion. The regulations provide guidelines for care, but they also offer a new paradigm for women, health institutions and society that transforms abortion care into a safe, sustainable and effective service. The regulations include the following essential elements to implement the model:

- a close relationship between the community and health professionals to prevent unwanted pregnancies and unsafe abortion, mobilize resources and guarantee services that meet the community's expectations
- support and counseling that respond to the woman's emotional and physical health needs and to other concerns that may arise
- appropriate clinical care for abortion and related complications, based on ethical, legal and bioethical criteria
- the provision of post-abortion family planning services and counseling for women who want to get pregnant again
- integration with other services that advance women's health and the social inclusion of women²⁶ (1. Conceptual Framework for Abortion Care)

vi. Counseling and support models

All the regulations that include measures to promote a woman's autonomous decision making begin with a warning that health professionals should not try to influence her decision. Some regulations – such as those in Peru, Colombia and Brazil – specify not only the form of the counseling but also some of the components it must include. The regulations in **Peru** and **Brazil** even suggest questions and issues that should be addressed with the woman. In **Brazil**, counseling is an important component of the regulations, and is set out in some detail. Regulations in these countries state that when health professionals provide information, they must ensure that it is received accurately, and that it is understood. In **Colombia**, the regulations specifically include an explicit warning that counseling is voluntary.

In **Norway**, the technical regulations spell out emphatically that the woman must make the final decision about terminating her pregnancy. In principle, counseling consists of the provision of information so that she can make the decision herself. In a situation where the pregnancy could lead to serious difficulties for the woman, she shall be offered information and guidance about the assistance that society can offer her (Art. 2, Act No. 50 concerning Termination of Pregnancy, 1975, with Amendments, 1978).

²⁶ The original text reads: «Integração com outros serviços de promoção à saúde da mulher e de inclusão social às mulheres.»

In **South Africa**, the termination of pregnancy act indicates that the state shall promote the provision of non-mandatory and non-directive counseling, before and after the termination of a pregnancy (Art. 4, [Choice on Termination Act](#) and [Amendment](#), 1996 and 2004). The regulations establish the rules governing the provision of counseling. On the one hand, the Protocol for Termination of Pregnancy Services, Department of Health: Western Cape (Circular H97/2000) indicates that counseling must cover all aspects related to the termination of pregnancy, including options open to the client (Art. 2, Client Assessment and Preparation). On the other hand, the [Guidelines for Pre-Termination of Pregnancy Counselling](#), Department of Health: Western Cape (Circular H97/2000), define the goal of counseling as providing sufficient information for the woman to make an informed decision. It also specifies the minimum elements it must include:

- assuring the woman that services are confidential
- listening to the reasons she is requesting a termination of pregnancy
- discussing available alternatives (for example, continuing the pregnancy or adoption)
- encouraging the client to express her opinions, feelings and concerns
- providing details on the procedure
- provision of information about contraceptive methods available for use after the procedure
- respecting and supporting the woman's decision without judgement (Art. 2)

In **Peru**, the [Manual on Sexual and Reproductive Health Counseling](#) (*Manual de Orientación/Consejería en Salud Sexual y Reproductiva*, 2006), which has been regarded, mistakenly, as promoting legal abortion, includes, among other client's rights in decision making, the right «not to be subjected to any type of pressure to choose or not choose a contraceptive method, especially in stressful situations, such as during childbirth or abortion.» The [Technical Regulations of the Perinatal Maternal Institute](#) (*Norma Técnica del Instituto Materno Perinatal*, INMP) sets out a five-step model for abortion counseling: 1) develop rapport:²⁷ to build a cordial relationship with the patient, notify her that

²⁷ 'Developing rapport' includes various steps: apply the five steps for sexual and reproductive health counseling, provide initial information about the confidentiality of the interview, build a cordial relationship in a location appropriate for the consultation, and observe the patient's reactions and one's own. The health professional may raise two issues to explore with the patient: explore any perception of contradictions. Key question: «How do you feel about the news?» Decision to have an abortion. Key question: «Have you decided if you are going to have an abortion?» Evaluate the patient's response to the consultation: identify her beliefs about abortion and evaluate her knowledge; identify her situation by finding out about her work, family, relationship and housing situation; identify whether her partner is involved in the decision (absent, coercive, supportive); identify the patient's support system: family members, friends, etc; and find out about past contraceptive use and status of contraceptive use when the patient became pregnant. Begin to provide general information about the need to choose a contraceptive method to prevent another pregnancy.

the consultation is confidential, and thoroughly explore her beliefs and knowledge about abortion; 2) provide support:²⁸ to provide comprehensive information about the procedure, during which the health professional must refrain from expressing opinions that could affect the woman's decision; 3) analyze the client's reaction:²⁹ to understand the woman's reaction to the information provided; 4) informed consent; and 5) establish a follow-up appointment,³⁰ so the client feels supported in her decision.

The [Case Management Protocol for Legal Abortion, Belén de Trujillo Hospital](#) (*Protocolo de Manejo de Casos para la Interrupción Legal del Embarazo*), provides counseling guidelines to assist women with decision making, although it is only binding on personnel at that facility. It mandates that counseling be available before, during and after an abortion procedure as an essential aspect of service quality. It mandates that obstetricians provide counseling and that they maintain confidentiality and respect the woman's privacy. Counseling must include psychological, social and legal support, provided by the appropriate professional, although it does not specifically define the content. However, a woman must be informed of other options in addition to abortion, whenever such options do not endanger her life or pose serious or permanent harm to her health. Finally, it states that «information and counseling should culminate in the pregnant woman's informed decision, which must be documented by the woman before the procedure is performed» (Information and Counseling (*Información y consejería*)).

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- 28** 2.a. Provide support in accordance with bioethics: respect the pregnant woman's questions, thoughts and decisions; keep in mind that the opinions of all members of the health team influence the pregnant woman, both in favor and against the recommendation; refrain from making a value judgement about the woman's situation or the decision she makes; think about the importance of preserving her health and life and about the developing life: explain it to her. Do not ignore this fact; and consider immediate consultations with other health professionals such as psychologists, social workers, lawyers, and other professionals.
- 2.b. Support about the diagnosis: provide truthful and comprehensible information that the patient needs to understand: procedures/methods that she may choose to terminate the pregnancy, in accordance with the duration of the pregnancy; possible effects, complications and risks associated with each procedure/method; provide information about symptoms that might indicate a problem: excessive bleeding, intense pain that does not respond to analgesics, fever and foul-smelling vaginal discharge. If these symptoms occur, the patient should return to the hospital; how long the procedure lasts; how pain will be managed; necessary physical examinations; results of clinical and laboratory examinations if administered; evaluate together the patient's concerns, needs and doubts about the procedure or her reproductive health, such as when she can resume normal activity and sexual relations, HIV/sexually transmitted infection prevention; support the woman's decisions; inform the pregnant woman that ending her pregnancy is legal and that she therefore has the right to services at health facilities. Discourage risky practices.
- 29** The goal is for the client/patient to have correct and comprehensible information about her pregnancy and the risks, benefits and reality about continuing it so that she is able to make an informed decision. It is important to discuss how much time she has to make the decision, given her mental and physical health.
- 30** Setting another appointment and keeping in touch with the patient/client, via one member of the health team, are essential to the prevention strategy. When possible, the patient should provide reliable contact information to one member of the health team at the Perinatal Maternal Institute. The woman should be given a telephone number in case of emergency. The client should feel that the facility and its personnel are available at any time to assist her.

In **Colombia**, the technical regulations stipulate that counseling must be voluntary, confidential and provided by a trained individual. Counseling for women with HIV/AIDS includes information about the risks the pregnancy poses to her health, the risks of transmission to her child and preventative measures so that she can make a well-informed decision. When health professionals suspect coercion or pressure, they should talk to the woman alone and refer her for additional counseling. This same step should be initiated in cases of sexual violence to ensure the woman receives appropriate counseling. It is one of the only regulations that includes instructions for specific situations.

The regulations in Colombia emphasize that health professionals must ensure that the woman understands and retains the information so she can make a well-informed decision. In addition, they emphasize that information is a woman's right and a health professional's responsibility: «It should support both a woman's capacity to exercise her reproductive rights and other rights as well as the health professionals' compliance with their ethical obligations.» These criteria are reinforced by international human rights standards in the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and other documents. It is important to emphasize that the Colombian regulations distinguish between the need to provide counseling (to provide emotional support for decision making) and information (which refers to procedures and resources, for example).

Finally, when a woman decides to end her pregnancy, the health professional must explain the legal requirements and provide the woman with enough time to make a definitive decision, even if it means the woman must return at a later date, while reminding her that an early abortion is safer and more effective. If the woman decides to continue the pregnancy or consider adoption, the health professional must provide appropriate information and refer her, if appropriate (Technical Regulations on Care for the Voluntary Interruption of Pregnancy).

In **Brazil**, providing information to women in an appropriate and humane manner is a fundamental component of the support model and the technical regulations. The regulations attempt to provide context, noting that women who seek abortion services may be experiencing many feelings, such as anxiety, anguish or fear of punishment. As a result, support and counseling are key components of humane care. Support includes treatment that respects a woman's dignity; listening, recognizing and accepting differences; respect for women's and men's right to choose; as well as the accessibility and effectiveness of the assistance provided.

In this model, counseling includes a review of the information necessary for the woman – as a recipient of services – to make decisions and care for her health in accordance with the guidelines of the *Sistema Único de Saúde*, Brazil's public health care system.

Counseling should promote self-determination in keeping with the principle of autonomy. In addition, the ability to listen without prejudice or imposing one's own values; the capacity to provide leadership in situations of conflict; to validate complaints; and to identify needs are all basic principles that can encourage women to talk about their feelings and needs. Health professionals must create an environment that encourages dialogue with the woman. The technical regulations in **Brazil** stipulate that this support model should be mainstreamed and utilized at all stages of contact with the woman because it not only includes the obligation to provide information, but encompasses an educational approach that aims to create a new model of care. As a result, health professionals must be trained in this method.

For example, the regulations recommend that social workers or psychologists should be the ones to listen to women's concerns. They suggest that this conversation is a good opportunity to ask questions about motherhood and whether the woman wants or does not want to be a mother, sexuality and her relationship with her partner. In order to prevent repeat abortion, it is important for women to take time to reflect on their experiences, to verbalize their feelings and understand what they mean to their lives, and understand what circumstances led to the unwanted pregnancy. When a woman decides to end a pregnancy that is the result of rape, the health professional must act to facilitate the decision making process and respect the woman and her decisions (3. Support and Counseling).

Health professionals must also respect a woman's decisions about the procedure itself. In the case of elective abortion allowed by law, the woman must have the option to choose the preferred procedure, after appropriate discussion of the advantages and disadvantages of each method, the associated complication rates and adverse effects (4. Medical Aspects).

vii. Services for young people³¹

In general, the research found that very few countries have regulations that recognize the need for special services for adolescents.

Provisions in the **Colombian** regulations address adolescents, services and providing information.

Guyana requires special counseling for young women who have an abortion.

Peruvian regulations address sexual and reproductive rights, but not specifically abortion.

31 'Young people' includes adolescents and young adults up to 24 years of age.

In **Colombia**, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy address the provision of information, stating that those responsible for providing services must «endeavor to develop skills for an integrated approach to adolescent sexuality and respect for their rights.» Since adolescents may find it difficult to share information relating to their medical records, it is important for health professionals to be skilled in obtaining this information; some suggestions include being friendly, asking simple questions in understandable language, repeating questions and suggesting different responses. In order to build trust, it is equally important that the adolescent is told explicitly that the information and the consultation are confidential (6.3 Counseling, Information and Informed Consent (*Asesoramiento, información y consentimiento informado*)).

The same regulations say that ‘adolescent-friendly’ services may be necessary and suggests reorganizing existing services so that the opening hours, locations and costs are accessible to adolescents. It is also important that adolescents are aware that these services exist.

In **Guyana**, the Medical Termination of Pregnancy Act – Legal Supplement B (1995) makes it a condition that when the termination involves a woman younger than 18 years of age, a medical practitioner or authorized medical practitioner and any counselor are required to pay particular attention³² to:

- a. directing her and, where appropriate, her partner to someone who can provide moral guidance
- b. educating her and, where appropriate, her partner on the full responsibility of parenthood
- c. making her and, where appropriate, her partner aware of modern family planning methods (Art. 2.5)

The **Peruvian** [General Plan of the National Health Strategy for Sexual and Reproductive Health](#) (*Plan General de la Estrategia Sanitaria Nacional de Salud Sexual y Reproductiva*), which describes sexual health during different life stages, includes a chapter specifically on adolescents. The description of what should be taken into consideration during this stage includes «Integrated care for abortion and its complications (information, education, counseling and services)» (page 6).

In addition, outpatient care for incomplete abortion and abortion complications is included among services that improve adolescents’ reproductive health. In order to be youth friendly, it specifies that these services must:

³² This measure should be viewed with caution because its application may restrict women’s rights.

- ❑ be in a convenient location with convenient opening hours
- ❑ have short waiting times
- ❑ be private
- ❑ ensure confidentiality
- ❑ not have any restrictions on providing services to adolescents
- ❑ maintain a stable staff
- ❑ seek the community's support (page 2)

Finally, it outlines the need for counseling services specifically for adolescents that emphasize privacy, but does not explicitly address abortion-related counseling (B. Counseling for Adolescents (*Consejería para adolescentes*), page 31).

viii. Models of care for abortion in specific circumstances

All countries with abortion care models for specific circumstances include models of care for cases of rape.³³

In **Brazil**, the [Technical Regulations for the Prevention and Treatment of Injuries Resulting from Sexual Violence against Women and Adolescents \(2005\)](#) address abortion in these circumstances (chapters 9 and 10). In other words, abortion services are classified as part of integral care for victims of violence. The regulations generally spell out different information, counseling and support measures that must be implemented in these cases. The chapter that addresses abortion regulates specific aspects related to the procedure; for example, it recommends establishing the duration of pregnancy through medical examinations in order to determine which procedure to use and any pre-existing conditions that may affect the abortion.

The regulations describe the procedure for misoprostol, vacuum aspiration and curettage. They recommend vacuum aspiration up to 12 weeks and medical abortion after 12 weeks. After 20 weeks, the regulations indicate that a termination of pregnancy is not recommended, and therefore the woman should be told that her request for an abortion cannot be met. She should be provided with prenatal support and adoption counseling if she desires it. The regulations also recommend preserving a sample of the uterine contents for later DNA testing for the judiciary. It states that it is important to set a follow-up appointment to test for sexually transmitted infections, HIV and hepatitis.

In **Colombia**, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy address abortion and sexual violence. They state that general management

³³ Rape and related issues are addressed in the section on Administrative issues, (i) requirements for accessing abortion services.

for rape survivors includes physical and psychological care, emergency contraception, treatment for injuries or sexually transmitted infections, collection of forensic evidence, counseling and follow-up care, in accordance with the Guidelines on Care for Abused Women and Minors (*Guía para la atención de la mujer y el menor maltratado*), laid down by Resolution 412 of 2000 and the regulations that support it, modify it or expand it (6.3 Counseling, Information and Informed Consent).

In **Mexico**, the [Penal Procedures Code \(Código de Procedimiento Penal\)](#) for Mexico City stipulates that after an abortion in situations of sexual violence, health professionals shall provide the necessary counseling and support to encourage personal and familial recovery in order to avoid subsequent abortions (Art. 131 bis). In addition, there is a specific regulation on abortion care in these situations: [Agreement of the Attorney General of Mexico City \(Acuerdo del Procurador General de justicia del Distrito Federal\)](#), which sets out the Order on Legal Termination of Pregnancy Procedures and Emergency Contraception in the Case of Rape (*Instructivo sobre el Procedimiento de la Interrupción Legal del Embarazo y Anticoncepción de Emergencia en los Casos de Violación*, 2006), which regulates administrative aspects of the procedure and support for clients.

According to the regulations, when a woman initially reports a rape, she should be immediately informed of the possibility of obtaining an abortion. Once the report has been filed, the Public Prosecutor's Office must support this right by referring the victim to a medical expert who must provide preliminary information about emergency contraception and legal abortion. After this, the expert must provide a written report to the Public Prosecutor's Office (Art. 3 of the Agreement). If the victim wants to end her pregnancy, her request, included in a file issued by the Public Prosecutor's Office, must be attached to the criminal investigation file together with the medical and psychological expert reports. Once the documentation has been included, the Public Prosecutor's Office will check whether the requirements of Article 131 bis of the Penal Procedures Code for Mexico City are met. If they are, it authorizes a legal abortion within 24 hours. However, in accordance with the new regulations in Mexico City, when an abortion is requested before 12 weeks, it is not necessary to follow this procedure because an abortion must be performed at the woman's request.³⁴

As well as informing the Health Department, the Public Prosecutor's Office must refer the woman to a Support Therapy Center for Victims of Sexual Crimes, where she will be given truthful, impartial, objective and sufficient information about abortion and existing support and alternatives so that she can make a free, informed and responsible decision (Art. 4 of the Agreement).

³⁴ However, for the purpose of pursuing criminal charges in the case of rape, the requirement of filing a legal report should be met.

These regulations also govern the verification process to determine whether the pregnancy is the result of rape. The verification process consists of tests to confirm pregnancy and duration of pregnancy. Once this information has been obtained, the forensic medical expert determines whether the gestational age coincides with the date of the reported crime (Art. 5 of the Agreement). In creating these additional verification processes, the regulations do not fully respect the woman's decision or her word nor do they create conditions favorable to the full exercise of her rights. In addition, it is the Health Department that determines the place, day and time of the procedure and that arranges for a forensic genetics expert, sent by the Public Prosecutor's Office, to verify the victim's identity before the procedure. The expert must also collect biological material obtained during the procedure and send it to the appropriate laboratories for histopathological or genetic testing for inclusion in the criminal investigation (Art. 8 of the Agreement).

ix. Professionals with authorization to perform abortions

Almost all the countries reviewed specify which health professionals may perform abortions, although with different levels of detail. The first group of countries – consisting of **Bolivia**, **Peru** and **Brazil** – simply mention that a physician must perform the procedure, without stipulating a specialty. In these countries, this information is in the penal code.

Norway addresses the issue in a similar manner; it states that abortions must be performed by a medical practitioner, without further specification. However, the requirement is not included in the penal code (Art. 3, Act No. 50 concerning Termination of Pregnancy, 1975, with Amendments, 1978).

In **Panama**, the penal code also states that the procedure must be performed by a physician (Art. 144). [Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion](#) (*Comisión Multidisciplinaria Nacional de Aborto Terapéutico*) adds that the procedure is the responsibility of medical specialists authorized to practice medicine in the country; however, this provision only applies to therapeutic abortion (Art. 7).

The second group of countries requires abortions to be performed by a physician specializing in gynecology and obstetrics. This is the case in **Italy**, as laid down in the Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy (1978).

Mexico allows appropriately trained general surgeons, gynecologists and obstetricians at medical facilities that provide abortion services to perform the procedure (Art. 4 and 4 bis, [General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City, 2007](#)).

In **Guyana**, who performs the procedure depends on the duration of pregnancy. If the abortion is performed before eight weeks by any appropriate method other than a surgical procedure, it may be administered or supervised by a medical practitioner (Art. 5.1); that is, any person registered as a duly qualified general physician under current law (Art. 2). When the pregnancy is more than eight weeks and not more than 12 weeks' duration, the procedure may be administered by an authorized medical practitioner – any physician registered as a duly qualified specialist in obstetrics and gynecology with experience, or a general practitioner trained to perform abortions – and an assistant acting under his or her direction. If the pregnancy is between 12 and 16 weeks, the termination may be performed by an authorized medical practitioner in an approved institution (Art. 6). However, when the termination is to save the life of the woman or to prevent grave permanent injury to her physical or mental health, it may be performed by any medical practitioner (Art. 10, [Medical Termination of Pregnancy Act](#), 1995).

Colombia is unique in that different health professionals may perform the abortion depending on the procedure: vacuum aspiration and dilatation and curettage must be performed by a gynecologist or trained general physician (7.3. Surgical Abortion, Technical Regulation on Care for the Voluntary Interruption of Pregnancy). In general, the regulations do not distinguish between which procedures gynecologists and trained general physicians can perform.

Institutional regulations in **Peru**, such as the Perinatal Maternal Institute Guidelines (2007), do not clearly distinguish the duties of each health professional. However, the human resources section names 'professional medical specialists' (gynecologists, obstetricians, anesthesiologists) and licensed obstetricians or other health professionals trained in counseling for therapeutic abortion (VI Specific Provisions, Human Resources). In contrast, the Hospital Belén de Trujillo Protocol on Abortion Case Management not only states which health professionals may perform the procedure, but also describes the other human resources needed for abortion services: gynecologist-obstetricians trained in surgical and medical abortion procedures, anesthesiologists, intensive care specialists, trained blood bank personnel, nurses, social workers and psychologists (Human Resources).

Finally, **South Africa** is the only country that legally allows registered midwives to perform abortions.³⁵ According to the Choice on Termination Act and Amendment (1996 and 2004), abortion must be performed by a medical practitioner, except abortions performed before 12 weeks, which may be performed by a registered midwife or nurse (Art. 2).

³⁵ «Registered midwife: means a person registered as such under the Nursing Act, 1978 (Act No. 50 of 1978), and who has in addition undergone prescribed training in terms of this Act.»

In **Spain**, the penal code states that only physicians may perform abortions. The Royal Decree does not specify further details, but accreditation requirements for facilities stipulate that they must have a physician specializing in gynecology and obstetrics, nurses, health aides and a social worker.

x. Entities responsible for guaranteeing service provision

This criterion establishes who is responsible for guaranteeing service provision. In many cases this information is found within other criteria. In Brazil and Mexico, the research found that regulations only addressed guarantees for service provision at public health facilities. In Norway, Mexico and Italy, this responsibility belongs to administrative authorities. Colombia is unique in that it involves the entire system.

In **Brazil**, the Technical Regulations for Humane Abortion Care (2005) assign the responsibility to guarantee abortion services to the state, in the abstract, and involve public hospitals by stipulating that it is the state's obligation to maintain professionals who perform abortions at public hospitals (5. Professional Ethics).

Mexico specifically involves public health facilities that, according to the [Mexico City Health Act](#), revised in 2004, shall provide free quality services at the woman's request and respond to her requests even when they involve another public or private health facility (Art. 16 bis).

In **Spain** and **Italy**, governmental authorities are responsible for guaranteeing abortion services. In **Spain**, the health authority in each region is responsible for keeping services necessary for abortion available, including urgent diagnostic techniques that make it possible to perform abortions within the legally established timeframes (Art. 5). In **Italy**, it is the responsibility of the state, the regions and local entities, within the scope of their functions and authorities, to promote and develop social health services for abortion (Art. 1, Regulation for the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

Similarly, in **Norway**, Act No. 50 concerning Termination of Pregnancy (1975), with Amendments (1978), states that county municipalities are required to organize hospital services so that the women in their area may have a pregnancy termination performed at any time, taking into account conscientious objectors (Art. 14). The regulation reiterates the above (Art. 19) and empowers the medical officer, in consultation with the county municipality, to decide which hospital units/institutions shall serve specified geographical areas in the county (Art. 19, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975).

In **Guyana**, the authority responsible for guaranteeing abortion services is not clearly assigned, but the Ministry is ordered to publish in the *Gazette*, the official government register, and a nationally circulated newspaper, the name and address of every approved institution and of the person owning or managing the institution (Art. 4, Medical Termination of Pregnancy Act – Legal Supplement B, 1995).

In **Colombia**, guaranteeing abortion services is the responsibility of all actors in the health system (public and private) and depends on the woman's affiliation to the health system via her insurance. Health Promotion Entities (insurance providers) are responsible for guaranteeing women's access to services, regardless of whether they belong to the national contributory insurance plan or the subsidized insurance plan. For these women, services are provided via the public or private service provider institutions with which the insurance providers are required to have contracts. On the other hand, abortion services for poor and unaffiliated women must be provided by the public or private health service facilities with which the regional authorities have agreements (Art. 1). In any case, regional authorities are required to guarantee real access and timely care for abortion services at all levels of care within the public system in their jurisdictions (Art. 2). Finally, in general, health system administrators are required to guarantee an appropriate number of abortion providers in accordance with the provisions of the decree, the Obligatory System for Quality Assurance and other technical regulations (Art. 2, Regulatory Decree 4444 of 2006). In 2007, an additional obligation was added requiring Health Promotion Entities and Departmental and District Health Offices to send to the Ministry of Social Welfare's General Office on Service Quality information on those facilities within the network authorized to provide low, medium and high level gynecological-obstetric services, and that have professionals willing to provide abortion services. In addition, these entities are required to keep this information updated and available to all clients who need these services, and they must report annually to the General Office with information on the provision of safe abortion services, as decriminalized by law (Art. 1, [External Circular 2137 of 22 May 2007](#)).

xi. Post-abortion counseling and care: complications, access to contraceptives, and other sexual and reproductive health services

Almost all the countries included in the analysis provided information on this criterion, although the information itself and the level of detail provided differed. Access to contraceptives was a recurring issue; Brazil, Colombia and Peru provide highly detailed information, while Italy, Guyana, Norway and Panama simply make brief mention of contraception. Although the South African regulations do not provide very detailed information about access to contraceptives, they are unique in that they require information about contraceptives to be provided to the woman before she is discharged.

Brazil, Peru and Colombia include detailed information about the symptoms of complications and normal post-abortion experiences, while Norway only mentions this topic. In Brazil, South Africa, Colombia and Peru, post-abortion management includes a follow-up appointment to determine whether the procedure has been successful. Italy is alone in requiring that information be provided on how to prevent pregnancies involving fetal malformations when this is the reason for the abortion.

The **Brazilian** regulation includes a section on normal recovery after an abortion and also lists the symptoms that require emergency care: prolonged abdominal pain, prolonged bleeding, bleeding more excessively than a normal period, fever, chills and general malaise, intense or prolonged pain, and fainting.

It also specifies what information should be provided to women during general counseling: personal hygiene routines, resuming sexual activity, return of menstruation, return of fertility, family planning methods, access to contraception, follow-up visit within the following 15 days, what to do and where to go in case of emergency, and possible complications (V Providing Information and Counseling, Technical Regulations for Humane Abortion Care, 2005).

Post-abortion management includes counseling on post-abortion contraception, including emergency contraception. The regulations indicate that a woman must first be informed that fertility returns within a short period of time and of the subsequent need for family planning methods. Women who do not use family planning methods must be told that they are at high risk of repeat abortion. Information must be provided about all contraceptive methods and their effectiveness in preventing pregnancy as well as about dual protection. It is preferable that contraceptive methods are provided at the same time as the procedure.

The **Colombian** regulations are also highly detailed. They require that post-abortion recovery is monitored. During recovery from surgical abortion, health professionals must provide the woman with comfort and support and monitor her recovery. They must also respond to complaints about pain since these may indicate uterine perforation. For surgical abortion, the regulations also require a follow-up visit between seven and 15 days after the procedure for a general health evaluation.

For late abortions, it is important to confirm the size of the uterus through the abdominal wall with a bimanual examination. Moreover, if significant sedatives or general anesthesia were administered, the woman must be informed that her recovery may take longer. Due to the higher risk of hemorrhage and incomplete abortion for abortions after 12 weeks, women who have these procedures must be kept under observation until the fetus and placenta have been expelled.

The regulations address how to manage various situations immediately after the procedure. If there are no complications, women may leave the facility as soon as they feel able to and their vital signs are normal. In cases where it is indicated that a woman should remain under clinical observation for four to six hours after taking a prostaglandin, the attending health professional must confirm expulsion and check for complications.

When a medical abortion cannot be confirmed immediately after the procedure, the regulations state that a follow-up visit must be made within 10 to 15 days in order to confirm that the abortion has been completed and that there are no infections or any other complications. In all cases, clear, simple, oral and written information must be provided about recovery, including normal symptoms (bleeding similar to a menstrual period or for several weeks, bleeding similar to or greater than a heavy period, nausea, vomiting, cramping) and symptoms that require medical care (excessive bleeding, fever that lasts more than one day and abdominal pain). Post-abortion management includes examining the product of conception to verify that it is as expected and to rule out ectopic pregnancy, molar pregnancy or incomplete abortion (Technical Regulations on Care for the Voluntary Interruption of Pregnancy).

Access to contraceptive methods as part of post-abortion management is one of the most important aspects of the regulations in **Colombia**. The regulations require health professionals to ensure that every woman receives information and counseling on post-abortion contraception, including emergency contraception, before she leaves the facility. The regulations make some recommendations about contraception: «After an abortion, all contraceptive methods should be discussed, including IUDs and hormonal contraception, as appropriate for the medical record of each woman and the limitations associated with certain methods, some of which may be started the same day. However, it is important to consider that the benefit of beginning safe contraception immediately may be greater than any associated risks.»

When a woman chooses sterilization, the regulations indicate that health professionals must ensure that the woman has not made this decision in response to the crisis, which she might regret later. The regulations recommend that facilities providing abortions have the capacity to provide family planning methods, and if they are not able to provide the method chosen by the woman, they must provide information about where and how to access it as well as a temporary method. In addition to contraception, they must provide information about preventing HIV and sexually transmitted infections and promote dual protection. In general, services should include post-abortion counseling, family planning counseling, access to effective methods of contraception, prevention of sexually transmitted infections and HIV/AIDS, and all activities that assist a woman to care for her own health (6. Characteristics of Service).

In **South Africa**, the termination of pregnancy act requires the state to promote non-directive and non-obligatory counseling – before and after the procedure (Art. 4, Choice on Termination Act and Amendment, 1996 and 2004). The regulations specify procedures to be included in post-abortion management: check vital signs, bleeding and uterine contractions; inspect the tissue removed from the uterus to ensure completeness; monitor recovery in a comfortable area for one or two hours; check that abdominal pain and bleeding have diminished and the uterus is well contracted; and if the woman is Rh-negative, administer anti-D if necessary.

If the woman's condition is stable, she should be discharged after being provided with the following:

- post-operative counseling and information about signs of normal recovery, taking prescribed medication, about routine personal hygiene, resumption of sexual activity and of menstruation, and signs and symptoms that require immediate emergency attention
- contraceptive counseling and provision
- appointment for counseling with a social worker if it is required or requested
- appointment for a follow-up within two or three weeks at a time convenient to the client

The emphasis on contraception in the regulations is noteworthy. It states that services must include a follow-up appointment to ensure continuing use of contraception and further counseling if it is necessary (2. Client Assessment and Preparation). Similarly, emergency contraception should be provided at the facility before the woman is discharged (4. Applied Pharmacology – Manual Vacuum Aspiration. Protocol for Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

Italy also requires the physician who performs the abortion to provide the woman with information about controlling her fertility. In addition, when fetal malformations or abnormalities are present, the woman should be provided with information about prevention (Art. 14, Regulation for the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

In **Guyana**, the regulations delegate to the Ministry of Health the responsibility for creating pre- and post-abortion counseling guidelines for any woman seeking treatment for the medical termination of her pregnancy and, where appropriate, her partner (Art. 4, Medical Termination of Pregnancy Act, 1995). In addition, the regulations state that after an abortion procedure the medical practitioner or authorized medical practitioner must:

- a. counsel the patient and, when appropriate, her partner about responsible sexual behavior or refer her to any individual or institution approved by the Ministry to provide such counseling
- b. give such advice to the patient and, where appropriate, her partner to enable them to deal with the social and psychological consequences of the termination of the pregnancy

The regulations say that when determining if the partner's participation is or is not appropriate, the medical practitioner or counselor must abide by the desires of the woman who is seeking the termination of her pregnancy (Art. 2).

In **Mexico**, the Mexico City Health Act, amended in 2004, states that the counseling services the government is required to provide to women include general medical support after the abortion, especially for family planning and contraception.

The regulations in **Norway** make it mandatory that women who request contraception must be provided with counseling about the methods (Art. 14, Act No. 50 concerning Termination of Pregnancy, 1975, with Amendments, 1978). The Regulation for the Implementation of the Act concerning Termination of Pregnancy (1975) also says that the medical superintendent responsible for the hospital unit will take the necessary measures to ensure that women receive the necessary post-operative treatment and individual guidance about contraception (Art. 19).

In **Panama**, in the [Provision of Health Services in the Social Welfare System](#) (*Oferta de Servicios de Salud del Sistema de Protección Social*, 2005), the chapter on Health Care for Pregnant Women (*Atención de la Mujer Embarazada*) stipulates that health professionals must be trained to provide appropriate treatment, follow-up and biopsychosocial care to women immediately following childbirth or an abortion. However, it does not indicate what the treatment, appointments or follow-up should consist of.

The Technical Regulations of the Perinatal Maternal Institute in **Peru** also provide for counseling after the procedure, divided into several steps: 1) emotional support, during which the health professional should build a relationship with the client without prejudice or judgement in order to identify her feelings about the procedure; 2) provide contraception and comprehensive information about contraceptives to the woman, explore options and respect her choices; 3) post-abortion care, during which the health professional must inform the woman about caring for her health, signs of normal recovery and symptoms indicating a problem; and 4) follow-up, which should take place at a follow-up visit. Similarly, the Hospital Belén de Trujillo Protocol includes, as part of post-abortion management, monitoring for signs that may indicate complications, such as pain, or even incomplete abortion, to ensure that the procedure has been appropriately performed. In

addition to monitoring, it requires health professionals to provide support to the woman and reinforce information given in preparation for the procedure, including information about contraceptive methods, prevention of HIV and sexually transmitted infections, and symptoms indicating a problem: excessive bleeding, intense pain that does not respond to analgesics, fever and discharge.

xii. Timeframes for service provision

The research found that waiting times range from 24 hours to 10 days, starting from the woman's request to terminate the pregnancy and ending with service provision. In general, this period is used to resolve administrative procedures. One exception to the rule is found in **Italy**, where a waiting time of seven days from the woman's request until the authorization goes into effect is intended as a time for reflection. In most cases, with the exception of Colombia and South Africa, the established waiting times are obligatory.

South Africa does not set a specific time period but indicates that clients who request an abortion before the end of the first trimester must be scheduled for the procedure in an appropriate facility before the end of the 12th week of pregnancy. The referring practitioner should indicate to the booking clerk the date by which the client should be scheduled for an appointment. In the case of a second trimester termination, the client must be given an appointment as soon as possible (Art. 1.7, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

In **Colombia**, [Resolution 4905 of 2006](#), which enacts the technical regulations for abortion, states that the procedure should be performed within a period of five days, but this timeframe is to be followed «to the extent possible,» indicating that it is not obligatory (Art. 5).

Panama does not stipulate a waiting time, but requires administrative procedures and technical issues related to the request for a therapeutic abortion in state facilities to be facilitated so that the greatest number of women may receive services at an early stage of pregnancy (Art. 5). The commission shall meet within the shortest timeframe possible whenever a request for an abortion is made and periodically to issue regulations (Art. 11, Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion).

In **Mexico**, waiting times are governed by various regulations. The Penal Procedures Code regulates the maximum waiting time for the request to the Ministry of Health in cases of sexual violence and non-consensual artificial insemination: requests must be resolved within 24 hours. The Mexico City Health Act specifies a deadline for public health

facilities, which must provide services within five days after the woman's request (Art. 16 bis). However, another regulation also governs timing: the General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City (2006); but these guidelines govern the amount of time between the first appointment at the facility and when the procedure is performed. They require hospital unit authorities to expedite the administrative procedures «necessary for an abortion to be performed as early as possible, providing a resolution for the pregnant woman within a maximum period of ten calendar days from the first appointment at the facility, in order to decrease risks and harm to maternal health, which increase with the length of the pregnancy.» If it is before 12 weeks, the time period is 48 hours (Art. 15, General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City – this item was amended in 2007).

Finally, in **Peru**, the Perinatal Maternal Institute Guidelines (2007) state that no more than 10 calendar days may pass from the date of the request to when the therapeutic abortion is performed. Similarly, the Hospital Belén de Trujillo Protocol indicates that no more than one week may pass from the time of the request to the procedure and, if necessary, should be resolved even more quickly (Administrative Procedures (*Procedimientos administrativos*)).

ii. Service quality: guaranteeing rights and quality standards

i. Informed consent

This section firstly examines general rules about informed consent for all women. Secondly, it examines specific rules for minors younger than 14 years of age. However, the research found that the problem of who can give consent is not solely limited to minors, and includes the issue of consent for those individuals who, according to the laws of each country, cannot directly give consent. The two following questions address this important issue:

1. Who can consent directly to an abortion?
2. Who cannot consent directly, for what reasons and how does a health professional know when consent for abortion has been given?

The age at which a woman is considered to be an adult varies, in some countries no minors under 18 years of age can give consent, and in other countries issues of consent are limited to those under 14. The research also found that the laws regarding consent for women with disabilities constituted a significant variable among the different regulations.

The analysis examines general rules about informed consent and specific rules for minors and women who cannot directly give consent, such as women who have some type of disability. Each point is analyzed separately to identify specific models to address the different situations.

a. General rules for consent

Almost all the regulations explicitly state the goal of free and autonomous decision making. On the one hand, this is expressed in the way the woman's consent must be given: often it must be written, and some regulations include consent forms. On the other hand, it can be expressed via the type of information that must be provided to women to ensure that they understand and are giving their informed consent.

In **Mexico**, for example, the General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City (2007) define informed consent as the «voluntary agreement, in writing, of the woman who requests or requires a legal abortion once the health facility has, as part of its compulsory obligation, provided objective, truthful, sufficient and timely information about the procedures, risks, consequences and effects as well as the assistance and alternatives available so that the pregnant woman can make her decision in a free, informed and responsible manner» (Art. 3). The same regulations later stipulate that «objective, sufficient, timely and understandable information be provided to the pregnant woman who requires a legal abortion about the procedures that will be used and their risks and consequences so that she can make a free and responsible decision to end her pregnancy via informed consent.» Protection for this freedom of choice and respect for her autonomy is based on the principle that individuals have the right to decide freely. This decision involves the voluntary agreement of the individual who, together with her physician, assumes responsibility for the agreement. If the woman does not agree, she assumes responsibility, which must be respected by the team of health professionals (Art. 16).

Although **Peru** does not have a health regulation that addresses abortion, there are two other relevant regulations governing this issue. While the Manual on Sexual and Reproductive Health Counseling (2006) addresses general issues related to sexual and reproductive rights, and is not specifically about abortion, it defines informed consent in the following terms: «The rational agreement to a medical or surgical operation that the client makes by choosing among possible alternatives that satisfy her health needs. This agreement must be free, voluntary and aware, and the client must make this decision after being provided with information, free from persuasion, manipulation or coercion. Agreement is indicated by the client or patient's signature on the form.»

Additionally, the Perinatal Maternal Institute Guidelines, which apply to employees of that facility, reiterate the rights contained in the General Health Act and apply them to cases of therapeutic abortion. This includes the right to «be provided with all information necessary to give informed consent for, or to refuse, any procedure or treatment before it is performed.» The guidelines also establish various rules on how informed consent may be given. As a starting point in the case of therapeutic abortion, the pregnant woman is entitled to decide whether to end the pregnancy since it is her life and/or health that may be affected by continuing the pregnancy. When a woman cannot give consent, it is the responsibility of the legally designated person to do so, except in emergency situations, in which case the physician shall make the decision most appropriate for the life and health of the pregnant woman. The guidelines stress the importance of exploring doubts and possible conflicts with the pregnant woman and of helping her clarify them. At the end of this process, the pregnant woman must fill out a prepared form. It is suggested that the witness be her partner.³⁶ Finally, the guidelines note that «It must be kept in mind that the pregnant woman may change her decision and refuse the procedure, in which case, the consent will not be valid and the pregnant woman's decision must be respected. Health professionals must provide health care for the remainder of the pregnancy» (VI Specific Provisions, Counseling Before or After the Procedure (*Consejería inicial o antes del Procedimiento*), point 5). Additionally, the Appendix includes a form for informed consent. Also in **Peru**, in contrast to the Perinatal Maternal Institute Guidelines, the Hospital Belén de Trujillo Protocol merely requires that the woman's informed consent be verified when the procedure is approved.

In **Italy**, the Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy (1978) indicate only that the request for abortion services must be made in person by the woman (Art. 1).

Similarly, in **Norway**, the termination of a pregnancy must be requested by the woman herself (Art. 4), according to Act No. 50 concerning Termination of Pregnancy, 1975, with Amendments (1978). The regulations also state that the opinions of individuals other than the woman may only be solicited at the woman's request (Art. 5, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975). Moreover, the regulations stipulate that for the termination of a pregnancy for a woman of any

³⁶ The original of Article 4, Informed consent, reads: «After completing the previous steps, the health professional, together with the pregnant woman, will fill out the form provided for informed consent; once completed, the health professional can proceed with the process. Suggest that her partner act as a witness. Keep in mind that the pregnant woman may change her decision and refuse the procedure, in which case, the consent will not be valid and the pregnant woman's decision must be respected. Health professionals must provide health care for the remainder of the pregnancy. It is important to explore doubts and possible conflicts with the pregnant woman and to help her clarify them.»

marital status, although the medical practitioner or authorized medical practitioner may encourage the patient to inform her partner, his consent need not be obtained and he does not need to be informed (Art. 8.4).

In **Guyana**, the Medical Termination of Pregnancy Act (1995) establishes that, except where the pregnant woman is of unsound mind, the medical practitioner or an authorized medical practitioner, as the case may be, may require written or oral consent before administering treatment for the termination of pregnancy.³⁷

In **Spain**, by contrast, the only explicit provision regarding consent in the regulations governing abortion is the exception for emergencies, in which case consent is not required (Art. 4. Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions, 1986). However, the [General Informed Consent Act \(2002\)](#) defines informed consent as «the free, voluntary and aware consent of a patient manifested in the full use of his or her faculties after receiving appropriate information to allow an action that affects his or her health» (Art. 3). This law includes the right to medical information which, in addition to establishing the right to receive complete information, also establishes the right not to receive it:

1. Regarding any actions affecting their health, patients have the right to know all available information, apart from what is excluded by law. In addition, the desire not to be informed is the right of all people and must be respected. Information shall generally be provided verbally, be noted in the medical record, and include at the minimum the purpose and nature of each procedure, its risks and its consequences.
2. Clinical information is a part of all medical actions and shall be truthful and be communicated to patients in a manner that is understandable and appropriate to their needs in order to help them make decisions according to their own free will.
3. The physician responsible for the patient shall guarantee the fulfillment of their right to information. Health professionals who assist during the medical procedure or perform a technique or a specific procedure shall also be responsible for providing adequate information (Art. 4).

The General Informed Consent Act is specific about the minimum level of information that must be provided to the patient:

1. Before obtaining his or her written consent, the physician shall provide the patient with the following basic information:

³⁷ A medical practitioner is any person registered as a duly qualified general physician under current law (Art. 2); an authorized medical practitioner is any physician registered as a duly qualified specialist in obstetrics and gynecology with experience, or a general practitioner trained to perform abortions (Art. 2).

- a. the relevant or significant consequences of the treatment when performed safely
- b. the risks related to the personal circumstances of the patient
- c. the probable risks under normal conditions according to experience and scientific knowledge or directly related to the type of treatment
- d. contraindications (Art. 10)

In **Colombia**, informed consent is governed by the Technical Regulations on Care for the Voluntary Interruption of Pregnancy, which defines it as «the free and voluntary statement of the pregnant woman that she requests and consents to a voluntary and legal termination of pregnancy for which she has received clear, true and complete information about her rights, the procedures, risks and effects on her health and life.»

With regard to the timing and format, the regulations state that «it shall be signed before the abortion procedure and be attached to the medical record.» They include a model informed consent form, which is not obligatory. The regulations add that «The voluntary termination of pregnancy shall require the informed consent of adult women, including those over fourteen years of age. This decision must reflect the women’s desire to receive these services, free from coercion or discrimination and without requiring that the permission, authorization or notification of a third person be obtained» (6.3.3 Informed Consent).

In **Brazil**, the Technical Regulations for Humane Abortion Care (2005), reiterating the Civil Code, say that the woman’s consent is necessary for the procedure except when her life is at risk and she is unable to express her desires (4. Consent). Furthermore, health professionals must ensure that the information provided resolves all the woman’s doubts and concerns in order to guarantee that she makes an informed decision (5. Professional Ethics).

The Choice on Termination Act and Amendment (1996 and 2004) in **South Africa** simply establishes that the procedure must be performed with the informed consent of the woman (Art. 5.1) and adds that no additional consent other than the woman’s shall be required to terminate the pregnancy (Art. 5.2).

Panama requires the woman’s consent to be given in writing, but this requirement is limited to cases of therapeutic abortion (Art. 3, Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion).

Finally, Bolivia and Puerto Rico do not mention informed consent.

As shown, most countries with abortion regulations address the issue of informed consent. However, the level of detail and the rules about how it is expressed vary from country to country.

Countries such as **Mexico** specifically indicate the minimum information that must be provided to the woman in order for her consent to be considered informed. The same is true for the regulations in **Spain** and **Colombia**. In these three countries, the information provided must at least cover the procedures, and their risks and potential consequences. Another important aspect of the regulations in these three countries is that the definitive criterion for consent is the woman's own wishes. From a rights perspective, this implies that anyone else's decisions, opinions and desires can be excluded, and that this exclusion can be enforced.

Peru (in the Perinatal Maternal Institute Guidelines), **Colombia** and **Spain** require consent to be provided in writing; they also provide models for informed consent.

b. Consent of minors

The research found that the age at which women were considered fully able to make the decision to end their pregnancies varied by country. For this reason, the following section reviews the rules for informed consent of minors on a case-by-case basis. These areas of difference, or areas that are problematic, include (i) the value assigned to the minor's wishes in decision making; and (ii) the existence of mechanisms to resolve potential discrepancies between the minor's desires and those of her legal representatives or those holding parental rights. These issues are resolved differently by the various regulations.³⁸

In **Peru**, as mentioned earlier, there is no national law regulating the technical aspects of legal abortion. However, the Perinatal Maternal Institute Guidelines (2007)³⁹ establish that abortion services provided at this facility to adolescent women younger than 16 years of age require the authorization of her parents or her legal representative. In contrast, «pregnant adolescents between sixteen and eighteen years of age may request and authorize the procedure. Adolescents younger than sixteen years of age who are already mothers may also make this decision» (General Provisions, C. Consent by the pregnant woman or by her representative). These guidelines resort to the extreme solution of assigning no value to the minor woman's wish to end the pregnancy as the procedure requires the authorization of a representative and there is no mechanism to resolve possible discrepancies.

38 The requirements for consent of minors do not apply to minors who decide to continue the pregnancy even though pregnancy itself may present health risks. In the latter case, the consent of a family member is not required, only that of the minor.

39 While writing this publication, the Perinatal Maternal Institute suspended this directive and it is no longer being applied.

In **Panama**, Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion, which regulates access to therapeutic abortion, nullifies the desires of minors by stating that they must obtain the consent of their legal representative (Art. 3).

Similarly, in **Spain**, the General Informed Consent Act states that a representative may give consent when a patient who is a minor is not intellectually or emotionally capable of understanding the consequences of the procedure, which may occur at any age. In this case, consent shall be given by the legal representative of the minor after listening to her opinion if she is older than 12 years of age. For minors who are not incapable or incapacitated, and who are legally emancipated⁴⁰ or older than 16 years of age, consent is not given by a representative. However, when medical intervention is necessary because of grave risk, according to the physician's judgement, the parents shall be informed and their opinion shall be taken into consideration as part of the decision making process. This regulation does not explicitly provide a solution for consent of minors younger than 16 years of age, although it appears that consent should be given by a representative. Additionally, this regulation does not provide fully objective criteria such as age, but rather relies on mixed criteria that include other components such as the minor's intellectual and emotional capacity to understand the procedure and the risk it represents as presented by the physician. In this system, the rules for consent can only be determined in each specific case.

Brazil, South Africa and Guyana, by contrast, are at the opposite extreme and assign value only to the minor's wishes, although these countries do allow the involvement of her representatives. In **Brazil**, the Technical Regulations for Humane Abortion Care (2005), in principle, state that adolescents between 16 and 18 years of age must be *aided* by their parents or legal representative who give consent *with* the adolescent. Adolescents younger than 16 years of age must be *represented* by their parents or a representative, who give consent *for* them. However, the regulations state that in any case where the adolescent is able to express her wishes, she shall consent and her wishes must be respected, even if she refuses to have an abortion against the wishes of her representatives. The **South African** regulations establish that if the woman is younger than 18 years of age, a medical practitioner, registered midwife or registered nurse shall advise the minor to consult with her guardian, family members or friends; however, the abortion would not be denied because the minor chooses not to consult them (Art. 5.3, Choice on Termination Act and Amendment, 1996 and 2004).

Similarly, in **Guyana**, the regulations stipulate that for a termination of pregnancy for a girl of any age, although the medical practitioner or authorized medical practitioner

⁴⁰ 'Emancipated' is a legal term referring to minors who have gone through a legal process to become emancipated from their parents and gain the legal rights of an adult.

may encourage her to inform her parents, he is not required either to obtain the consent of her parents or guardian or to notify them (Art. 8.3, Medical Termination of Pregnancy Act, 1995).

Italy requires authorization by representatives with parental rights or guardianship for minors younger than 18 years of age, but has a special mechanism to resolve discrepancies. The mechanism may be applied if the request is made within the first 90 days of pregnancy or in pregnancies of more than 90 days when there is a risk to the pregnant woman's life, when it is not possible to obtain the representative's consent, or if the representative is opposed or claims a conflict of interests. Within seven days of the request, the physician sends the case, with his opinion, to a local judge who supervises guardianships.⁴¹ Within five days, the judge, after listening to the woman and taking her wishes into consideration, may decide to allow the woman to end the pregnancy by means of a legal action for which there are no provisions for a subsequent appeal.⁴² In addition, if it is urgent for the abortion to be performed, the health professional may order the procedure without the consent of the representative and without consulting a judge (Art. 12, Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

In **Norway**, the Termination of Pregnancy Act says that if the woman requesting the abortion is under 16 years of age, the person exercising parental authority shall be given an opportunity to express his or her views, unless there are particular reasons to the contrary. As a result, the representative's opinion is considered but is not given an absolute value (Art. 4). When there is a discrepancy, because the person exercising parental authority has expressed the view that the pregnancy should not be terminated, the termination may be performed only with the consent of the county medical officer (Art. 9).

In **Mexico**, the Agreement of the Attorney General of Mexico City establishes the Order on Legal Termination of Pregnancy Procedures and Emergency Contraception in the Case of Rape, which governs cases where there is a conflict between the decision of the minor and of those holding parental rights. It states that «the social services representative shall ensure that the personnel at the Support Therapy Center for Victims of Sexual Crimes provide the former with truthful, objective and impartial information about the risks and consequences of terminating or not terminating the pregnancy. According to Article 49 of the Rights of Girls and Boys Act of Mexico City (*Ley de los Derechos de las Niñas y Niños en el Distrito Federal*), the social services representative shall serve the

⁴¹ The Italian is «giudice tutelare del luogo.»

⁴² In other words, the decision is not subject to any further judiciary action.

best interests of the minor and take into consideration the minor's decision in order to make a determination in consultation with the appropriate Deputy Attorney General for criminal investigation.» The mechanism therefore consists of a third party decision, but emphasizes the importance of the minor's wishes and protecting her best interests. To that end, it defines the minor's best interests in accordance with international instruments signed by Mexico, indicating that «it consists of that which is most appropriate to her integrated development, prioritizing her rights over any others', providing her with the means to this end as a person holding rights and obligations within her specific circumstances, and which does not mean that some rights should be sacrificed so that others may be exercised, but rather indicates the fundamental exercise of those rights, as an inalienable element of this best interest» (Art. 7).

In **Colombia**, in accordance with the Ministry of Social Welfare's regulations regarding minors younger than 14 years of age, an abortion requires the authorization of the parents, guardians or relatives unless the urgency of the case requires immediate intervention. Although a specific mechanism is not established to resolve discrepancies, it indicates that «In all cases, there must be an attempt to reconcile the patient's right to self determination with protection of health, without impinging on the consent of the fourteen-year-old minor» (6.3.3 Informed Consent, Technical Regulation on Care for the Voluntary Interruption of Pregnancy). These regulations should be interpreted in accordance with case C-355⁴³ and the Children and Adolescent Code (*Código de la Infancia y la Adolescencia*, 2006), especially Articles 8 and 9. Article 9, Prevalence of Rights, establishes that «In every administrative, judicial or other type of action, decision or measure that must be taken in relation to boys, girls or adolescents, their rights shall prevail, especially if there is a conflict between their fundamental rights and those of any other person.» Article 8 defines the best interests of the minor: «The term 'best interests of boys, girls and adolescents' is understood as the imperative that obligates all people

43 Although C-355 of 2006, the Constitutional Court ruling that decriminalized abortion in extreme cases, did not establish specific rules about the decision of minors under 14 to terminate the pregnancy, some sections of the ruling can be used as guidelines. It overturned the law establishing that all abortions performed for minors under 14 years of age must be considered a crime. The basis for this decision was that categorically rejecting the wishes of minors younger than 14, by deeming abortions for minors younger than 14 a crime in all circumstances, nullified «...completely the free development of personality, autonomy and dignity of minors.» In addition, the ruling also recognized «...that minors have the right to make decisions about invasive procedures and prohibited legislators from establishing abortion policies in the future that infringe on minors' wishes...» Constitutional case law has recognized the right of minors to the free development of personality and the possibility of consenting to treatment and surgery that affect their bodies even when they are highly invasive. The ruling «discards the concept that merely objective criteria, such as age, are the only determinants for establishing the extent of freely given consent by minors to authorize treatment and surgery that affect their bodies. On the subject of abortion, the legislator, if he deems it appropriate, shall establish specific rules regarding representation or guardianship for minors or adults unable to give consent without infringing on the consent of minors younger than fourteen years of age.»

to guarantee integral and simultaneous satisfaction of all their human rights, which are universal and interdependent and prevail over other rights.» These provisions must be taken into account to resolve discrepancies as described in the Technical Regulations on Care for the Voluntary Interruption of Pregnancy cited earlier.

Once again, **Puerto Rico** and **Bolivia** do not define rules for the consent of minors.

c. Consent of women who cannot directly give it themselves

The research found that for consent of women who cannot directly give it themselves because of some type of mental disability, the general rule is to require the consent of the woman's representative. However, in all countries except Panama, the regulations require that the woman's wishes be considered. Most countries do not establish mechanisms to resolve differences between the woman and her representative. Spain and Italy establish what to do when the woman does not have a representative. South Africa states that the physician's opinion should determine a course of action, and in Italy it is a judge who makes the decision.

One of the countries that does not have a specific mechanism to resolve differences, but that makes an effort to assign value to the woman's wishes is **Spain**. Article 3 of the General Informed Consent Act (2002) sets out who must give consent via a representative: «patients, who, in the opinion of the physician providing care, are not able to make decisions or whose physical or psychological state does not allow the patient to take responsibility for his or her own situation.» When the woman does not have a legal representative, the regulations indicate that individuals with familial ties or close relationships shall give consent.

Although there is no mechanism for situations where the representative or close family member decides that the abortion should not be performed, the regulations indicate that consent by representatives must be appropriate to the circumstances and health needs and «...in favor of the patient and with respect for her personal dignity.» In addition, the law states that the woman shall participate in the decision to the extent possible (Art. 9).

Finally, the Fourth Additional Provision (*Disposición adicional cuarta*) establishes the power of the heads of state and regional governments within their respective jurisdictions, to issue specific provisions «to guarantee patients or clients with special needs associated with disability the rights to autonomy, information and medical documentation regulated by this Act.»

Similar to Spain, in **Brazil** the Technical Regulations for Humane Abortion Care (2005) establish the same rules for adolescent girls and disabled women via a system that

requires the consent of the representative, but indicating that in any case where the woman is able to express her wishes, she shall consent and her wishes must be respected, even if she refuses to have an abortion against the wishes of her representatives. For the purposes of these regulations, disability refers to women who, for whatever reason, are not able to discern or express their wishes.

In **Norway**, the rules for consent of minors and women who have some type of disability are identical. The law states that if the woman is mentally disabled the guardian shall be given an opportunity to express his or her views, unless there are particular reasons to the contrary. If the woman is suffering from severe mental illness or mental retardation, the guardian may directly submit the request for a pregnancy termination. The woman's consent shall be obtained if it may be assumed that she is capable of understanding the significance of the operation. If the woman has no guardian, the court shall appoint an auxiliary guardian at the request of her medical practitioner (Art. 4). If the guardian has denied consent, the pregnancy may be terminated with the consent of the county medical officer (Art. 9, Act No. 50 concerning Termination of Pregnancy, 1975, with Amendments, 1978).

In **Colombia**, the regulations also set out the same rules for the consent of minors, women who cannot directly consent, and women who are unconscious or mentally incapable: the consent of parents, guardians or relatives is required unless the urgency of the case necessitates immediate intervention. However, the woman's wishes are not completely disregarded; the regulations state: «In all cases, there must be an attempt to reconcile the right of the patient to self determination with protection of health...» (6.3.3 Informed Consent. Technical Regulations on Care for the Voluntary Interruption of Pregnancy).

South Africa does not have a mechanism to resolve conflicts between the wishes of the woman and of her representative, but it states clearly that the latter's wishes are not definitive. Specifically, the wishes – or, more correctly, the opinion – that prevails is that of the physician, but consultation with the representative is urged although not obligatory. The law states that when a woman is severely mentally disabled to the extent that she is completely incapable of understanding and appreciating the consequences of a termination of her pregnancy, or is in a state of continuous unconsciousness and there is no prospect that she will recover in time to make a decision about the termination before the first 12 weeks or between the 13th and 20th week: (i) [the termination may be performed] with the consent of her natural... or legal guardian and (ii) if such persons cannot be found, with the consent of her 'curator personae',⁴⁴ provided that

⁴⁴ Within common law, 'curator personae' refers to a person appointed by a court to manage the personal and health-related affairs of an incapacitated individual.

the pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife or nurse who has completed the prescribed training course consent thereto (Art. 5.4).

It further states that, after consultation with her natural or legal guardian, spouse or 'curator personae', when two medical practitioners or a medical practitioner and a registered midwife or nurse who has completed the prescribed training course agree, they may proceed with the termination even if the guardian or spouse refuses consent in the following cases:

1. Up to the 20th week of gestation, if the health personnel mentioned above are of the opinion that the continued pregnancy would pose a risk of injury to the woman's physical or mental health or there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality.
2. After the 20th week of gestation, if they are of the opinion that it would endanger the woman's life, may result in a severe malformation of the fetus or pose a risk of injury to the fetus (Art. 5.5, Choice on Termination Act and Amendment, 1996 and 2004).

By contrast, in **Italy**, the Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy (1978) delegate the decision to a judicial authority, and the guardian or spouse simply gives his opinion. If the woman's mental state is in doubt, consent may be given by a guardian or a spouse (provided he is not legally separated from the woman). If the spouse or the woman presents the request, the guardian's opinion should be heard. In all cases, the woman must confirm what she wants to do about the pregnancy. Within seven days of the request, the attending physician at the facility or the physician of choice shall send to a judge who supervises guardianships a report containing the details of the request and its source, the woman's illness and guardian's point of view if it has been expressed. After five days, the judge may, having listened to the parties if there has been time, make a decision that is not subject to appeal. The judge's decision is issued as a title – this is an instrument granting the woman the right to request that an abortion be performed.

In **Panama**, Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion, binding only in cases of therapeutic abortion, requires that a legal representative gives consent for a woman who is incapacitated for legal reasons (Art. 3).

In **Peru**, the Perinatal Maternal Institute Guidelines require that women with disabilities⁴⁵ give consent through their legal representative. However, if consent is refused, the

⁴⁵ The guidelines discuss absolute and partial legal incapacity in the following terms. Absolute legal incapacity: minors younger than 16 years of age, except for those acts determined by law; individuals who for whatever

attending physician or the health facility is obligated to communicate with the appropriate judicial body in order to proceed with the actions allowed by law to preserve the life and health of the woman.

In addition, when a woman who has some degree of mental incapacity is involved, the medical board must include a psychiatrist. If the health facility does not have a psychiatrist, a psychologist shall perform this function. The regulations state that the closest family member or the legal guardian shall sign the request for the operation.

ii. Conscientious objection

The research did not find any country that allowed conscientious objection by institutions, and the majority prohibited physicians from invoking conscientious objection when the woman's life or health was in danger. Furthermore, most establish an obligation to refer the woman to a health professional who is able to provide a safe and timely abortion. In general, three areas are regulated: (1) what is conscientious objection; (2) procedures to become an objector; and (3) guarantees for women who encounter a physician who is an objector. Not all countries regulate all areas.

Italy is the only country that regulates all three. **Brazil** and **Colombia** concentrate on defining conscientious objection and establishing guarantees for women, while **Guyana** and **Norway** concentrate on defining conscientious objection and the procedure for a physician to become an objector. **Peru** and **Mexico** only regulate guarantees for women, and **Spain** only partially defines conscientious objection. The regulations in **South Africa** specifically concentrate on allowable restrictions to labor rights in relation to the conscientious objector, as discussed below.

reason are deprived of discernment; and deaf mutes, deaf blind people and blind mutes that cannot express their wishes beyond a doubt. Partial legal incapacity: minors older than 16 and younger than 18, mentally retarded people, people suffering from mental deterioration that prevents them from expressing their wishes; spendthrifts, individuals judged to have acted in bad management, habitual drunks; drug addicts; and individuals whose sentences entail deprivation of civilian rights. This interpretation relies on the laws that govern general incapacity as included in the abortion regulations which, from any point of view, is unjustified. The general laws on absolute and partial incapacity govern whether individuals may enter into legal transactions autonomously. As a result of this type of reliance on other laws, limitations are set on women seeking to terminate their pregnancies even when they possess discernment and are able to make decisions about reproductive issues. For example, a woman who has lost her civilian rights because she was found to be a spendthrift may not enter into legal transactions autonomously because she is lacking the ability to make rational judgements regarding the management of economic resources. However, this woman perfectly understands the consequences of an abortion and may decide effectively and in an informed manner about a termination of pregnancy. Limitations on decision making, such as those linked to absolute and partial incapacity, are only justified when they protect the individual. If there is no reason to impose such protection, the person is entitled to make decisions without restrictions.

In **Peru**, the Perinatal Maternal Institute Guidelines (2007), following the model of Article XII of the General Health Act, state that «...reasons of conscience or belief may not be invoked when such exemption results in risks to women's health.» They add: «The guidelines of the corresponding facility, or, in their absence, the Ministry of Health, must provide or require that the necessary replacements or substitutions be provided within a maximum of forty-eight hours.»

Spain does not regulate the issue of conscientious objection. However, there are various legal texts that allow some rules to be defined. For example, it is addressed, in conjunction with abortion, in the Code of Ethics and Deontology (*Código de Ética y Deontología*) of the Medical Association of Spain (*Organización Médica Colegial*). However, this code does not have the force of law. It is also generally addressed in the Deontology Code (*Código Deontológico*) of the Nursing Association (*Organización Colegial de Enfermería*), which suffers from the same problem. However, the Constitutional Court has recognized that in spite of the lack of regulation «...it is worth noting, in reference to conscientious objection, that it exists and may be exercised independent of whether or not such a regulation has been issued.» (Ruling of 11 April 1985, which revised the law reforming the penal code to allow abortion in some cases. Subsequently, this decision has been reiterated in other rulings.) It is important to mention at least two rules:

- ❑ it may only be invoked by physicians and nurses⁴⁶
- ❑ the transfer of objector personnel to services unrelated to abortion is not discriminatory as long as it does not reduce his or her salary, ranking or residency (Constitutional Court ruling of 20 January 1987)

In **Mexico**, the Mexico City Health Act, amended in 2004, allows conscientious objection based on religious beliefs or personal convictions, but simultaneously establishes the obligation that objectors «...refer the woman to a non-objecting physician.» Additionally, it prohibits conscientious objection in urgent cases and requires facilities to guarantee the presence of non-objecting physicians so that services may always be available: «When the termination of pregnancy is urgent to preserve the health or life of the woman, conscientious objection may not be invoked. It shall be the obligation of public health facilities to guarantee the timely provision of services and the ongoing availability of personnel who are not conscientious objectors in this matter» (Art. 16 bis 7).

⁴⁶ This information is included in guidelines issued by the Ministry of Health that IPPF/WHR was unable to obtain; however, it is cited in [Cebriá García, María \(2003\) La objeción de conciencia al aborto: su encaje constitucional](#) (Conscientious objection to abortion: its constitutional underpinnings). *Anuario de la Facultad de Derecho*. XXI, pp.99–121.

The General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City (2006) further develop the provisions of law regarding these same points and define the circumstances in which women must be referred for abortions, while reiterating the same concepts. «Health professionals may abstain from participating in abortion procedures for reasons of conscience, except in those cases that place the pregnant woman's life at imminent risk. The physician who objects to abortion shall immediately, responsibly and discreetly refer the woman to a non-objecting physician or to a hospital which performs legal abortions using the Referral and Counter-referral Form and with all other important documents of legal importance, such as: results of laboratory or other tests and authorization for the abortion issued by an official of the Public Prosecutor's Office or medical report, according to the case, with the certainty that she shall be provided care to resolve her problem.»

In **South Africa**, the regulations stipulate respect for the right of health care workers to invoke conscientious objection regarding abortion in accordance with the right to freedom of conscience established in the Constitution. However, clients' rights to health services, including abortion, must also be respected. For this reason, if the health provider is an objector, he or she must refer the woman to a non-objecting physician. Public health facilities, however, must ensure the provision of services (Art. 1.13). Conscientious objection may only be expressed by individual staff members and not as a group action (Art. 1.15.1).

It is essential that equitable, accessible and user-friendly comprehensive reproductive health services are provided (Art. 1.14). The regulations state that in order to ensure the availability of sufficient personnel for abortion services, it may be necessary to advertise vacancies with the requirement that the incumbent shall perform abortions (Art. 1.15). Refusal to discharge obligations when faced with a particular task could lead to breach of contract (Art. 1.15.2, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

In **Italy**, health and auxiliary personnel are also permitted to invoke conscientious objection and consequently are allowed to be absent from procedures. However, the objection must be presented in advance and must be communicated to the provincial physician; in the case of personnel affiliated with a hospital or nursing home, it must also be communicated to the health director within the first month after the law comes into effect or of the certification of the facility that will provide these services. Objection may be revoked or invoked outside these conditions, in which case it shall go into effect one month after being submitted to the provincial physician. In all cases, objection does not exempt the objector from providing pre- and post-abortion services. Hospitals and nursing homes must guarantee abortion in the circumstances allowed within their

establishments, as must regions, among others, the availability of sufficient personnel to carry out abortion services. As in all the other countries, conscientious objection does not exempt health personnel from performing the procedure if it is urgent. Finally, objection is understood to be revoked if the health professional takes part in an abortion, unless the case was urgent (Art. 9, Regulation for the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

The regulations in Norway and Guyana also require health professionals to follow a procedure in order to be registered as objectors. In **Norway**, health personnel who, for reasons of conscience, do not wish to perform or assist in pregnancy terminations shall, via the medical superintendent,⁴⁷ give written notification of such a wish, together with a more detailed explanation, to the administrative head of the hospital or institution. The right to conscientious objection applies only to health personnel who either perform or assist in the operation itself, and not to those who assist the woman before or after the operation. The administrative head of the hospital or institution shall, each quarter, notify the county municipality of the number of different categories of health personnel who are conscientious objectors and include the health personnel who are available at any time for pregnancy terminations, as well as the number of vacant posts. A copy of the report shall be sent simultaneously to the county medical officer and to the Directorate of the Health Services. To ensure that there are appropriate personnel throughout the country, the county municipality may, when advertising job vacancies for health professionals, make it a condition for employment that the person appointed to the post must be prepared to carry out the duties and tasks imposed on the hospital unit or institution, including pregnancy termination. Health personnel who apply to facilities where pregnancy terminations may be performed shall make it known whether they wish to be exempted from performing or assisting in pregnancy terminations (Art. 20).

The regulations in **Guyana** state that no one is legally obligated to participate in an abortion if it is against his conscience. However, the regulations warn that in any legal proceedings the burden of proof of conscientious objection shall lie on the person claiming such objection. Such proof may be provided by a statement given under oath or affirmation of conscientious objection to participating in any pregnancy termination authorized by law (Art. 11, Medical Termination of Pregnancy Act, 1995).

In **Colombia**, Regulatory Decree 4444 of 2006 only allows individual – not institutional – conscientious objection, and only for direct providers, not administrative personnel (Art. 5). The Technical Regulations on Care for the Voluntary Interruption of Pregnancy set out rules regarding the guarantees for women requesting abortions when there is an

⁴⁷ From the context, medical superintendent seems to refer to an administrative authority of the health institution.

objection, which attempt to minimize trauma to patients because of the refusal of the professional. The regulations state the following:

When, by exercising conscientious objection, health personnel directly related to providing this service believe that they cannot perform the abortion, they are obligated to follow professional ethical codes, which state that they must refer women to trained colleagues who do not object to legal abortion. In such circumstances, the following rules shall be observed:

- a. Providers and facilities may not refuse to provide or hide information about the woman's rights and abortion nor limit a woman's options in order to change her decision. Neither may health professionals or facilities deny a woman information about therapeutic options or alternatives to the abortion if there are any.
- b. The pregnant woman must be provided with the necessary counseling and be referred immediately to a trained and available non-objecting provider within the same facility or one that is otherwise easily accessible who can guarantee services.
- c. When the objector is the only professional able to provide the service, and/or a timely referral to a non-objecting provider is not possible, or when the pregnant woman's life is in imminent danger, he or she must perform the abortion, as part of the provider's greater obligation to protect the life or health of the woman.
- d. Providers must maintain confidentiality about the identity of the pregnant woman who requests an abortion, without prejudice to subsequent decisions by the Medical Ethics Board about whether the conscientious objection was legitimate and appropriate (6.2. Admission of Pregnant Women (*Admisión de la gestante*)).

In **Brazil**, the Technical Regulations for Humane Abortion Care (2005) reiterate the rules regarding conscientious objection in the Code of Medical Ethics. In general, it is allowed except when the abortion is required to save the woman's life, when there is no other physician who can perform the procedure, when the woman may suffer harm or injury as a result of the absence of the physician or when services for post-abortion complications are needed, which is an emergency situation. The regulations also establish the obligation to guarantee that the procedure is performed by another professional at the facility and the state's obligation to maintain professionals who perform abortions at public hospitals (5. Professional Ethics).

As shown, the regulations are quite uniform in this area and, to a greater or lesser extent, the objective is always the same: (i) objection only by individuals; (ii) prohibition when it would present a risk to the woman, or in emergencies; (iii) obligation to refer to a trained professional; and (iv) obligation always to have available non-objecting personnel at facilities. Several countries limit conscientious objection to medical personnel directly involved in the procedure (**Colombia, Norway and Italy**). **Norway**

explicitly states that it is permissible to require, as a condition for recruitment, that the potential employee is not an objector in order to guarantee coverage for all women throughout the country.

Finally, **South Africa, Puerto Rico, Panama** and **Bolivia** do not have any regulations on this topic.

iii. Confidentiality of services: medical confidentiality

Almost all countries with regulations of this type include confidentiality of services via obligations to maintain medical confidentiality or by restricting access to information about the procedure and the woman's personal information. Across the board, the obligation to maintain confidentiality of information is placed on individuals (such as the physician in charge of the procedure, nurses participating in the procedure or the people responsible for medical files), except in **Colombia**, which also establishes institutional obligations (for example, of the hospital where the abortion is performed). This is important because the person with whom the obligation rests is the person sanctioned for infringements; therefore, when institutions are included, the responsibility for maintaining confidentiality is reinforced.

In **Mexico**, the General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City (2006) obligate the medical and paramedical personnel who are involved in performing legal abortions to provide treatment that respects the patient's dignity, to respect confidentiality and to offer security to the patient during her hospital stay (Art. 9). In contrast, the method used to guarantee individuals' right to confidentiality in the Mexico City penal code is to make the violation of medical confidentiality a crime: «Any person who, without the consent of an individual who has the right to consent, and to their harm, reveals confidential information, which has been made known to or has been confided to that person, or who uses such information for his own or another's gain, shall be imprisoned for six months to two years and fined for the equivalent of twenty-five to one hundred days' labor. If the employee learned of or received the confidential information by means of his employment, position, profession, expertise or trade or if the confidential information was of a technical or scientific nature, the prison term shall be increased by half and he shall be suspended from performing his profession, expertise or trade for six months to three years. When the employee is a public servant, he shall also be dismissed and disqualified from office for six months to three years» (Art. 213).

In **Italy**, restrictions about confidentiality of services are only imposed on hospitals, nursing homes and outpatient clinics that perform abortions, which must delete the

woman's identity from the information they send to the provincial physician regarding the procedure and the documentation that provided the basis for the abortion (Art. 11, Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

Spain, similarly, establishes confidentiality as a restriction on information. Documents – such as medical reports, documents required to legally perform the abortion and documents related to the consent given by the pregnant woman – must be kept in a way that ensures confidentiality (Art. 4, Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions, 1986). The General Informed Consent Act (2002) defines, as part of the right to privacy, the right of all people «to respect the confidential nature of information about their health and that no one may access this information without previous authorization as established by law.» It also establishes that «Health centers shall adopt timely measures to guarantee the rights named in the previous section and shall create, where appropriate, regulations and protocols to guarantee legal access to patient information» (Art. 4).

In **Brazil**, physicians and health professionals are prohibited from revealing to authorities from the police, judiciary or the Public Prosecutor's Office instances of spontaneous abortion or to reveal that an abortion has been performed, except to protect the woman and with her consent. This is based on the ethical and legal obligation to maintain medical confidentiality. Anyone who does not uphold this obligation may be prosecuted criminally or brought before a board of ethics and must pay compensation for all harm caused to the woman. This obligation is established twice for adolescents since it is included in the Children and Adolescent Act and the Medical Ethics Code (5. Professional Ethics). In addition, medical teams must guarantee privacy and confidentiality of information (3. Protection and Counseling, Technical Regulations for Humane Abortion Care, 2005).

In **Colombia**, confidentiality of services is also addressed from the perspective of medical confidentiality. The Technical Regulations on Care for the Voluntary Interruption of Pregnancy, in Characteristics of Service, stipulates that «Any person who is a member of a health team that knows of or provides health care related to abortion is obligated to maintain medical confidentiality and therefore shall observe the confidentiality of the consultation and the diagnosis, the procedure itself and of all information in order to preserve the pregnant woman's rights to privacy and dignity. This means that epidemiological information is confidential and shall only be utilized for statistical purposes. Abortion facilities shall guarantee confidentiality and respect the pregnant woman's privacy and right to privacy» (6. Characteristics of Service).

This regulation addresses not only confidentiality, as it must be observed by each member of the medical team, but also the obligations of facilities that «are obligated

to protect the patient's information and not share it without authorization. They must also ensure that patients who do authorize such confidential information to be revealed to others do so freely and based on clear information» (6.3. Counseling, Information and Informed Consent).

In **Guyana**, any medical professional, authorized medical professional, owner or director of an approved establishment, or any person employed by or working at, or having legal access to an approved facility must maintain confidentiality of the documents and issues relating to the procedure and may not use any information for their own benefit or to benefit another person (Art. 14, Medical Termination of Pregnancy Act, 1995). The regulations specifically state that any information given to the Chief Medical Officer as part of the records that must be kept for each woman shall not be disclosed except:

- a. by the Chief Medical Officer in the performance of his functions under the Act⁴⁸ and these regulations
- b. to a member of the police for the purpose of instituting criminal proceedings under the Act; for the purpose of carrying out scientific research; or to a medical practitioner, authorized medical practitioner or other person, with the consent in writing of the woman whose pregnancy was terminated (Art. 5, Medical Termination of Pregnancy Act – Legal Supplement B, 1995)

In **Norway**, Act No. 50 concerning Termination of Pregnancy (1975), with Amendments (1978), states that despite the statutory obligation to observe professional secrecy, the committee may obtain information regarding the woman's situation from the health, social and insurance standpoints, provided that the woman has given her consent. Everyone participating in the examination of cases is under an obligation to maintain confidentiality concerning anything that has come to his knowledge (Art. 11).

The regulation simultaneously reinforces confidentiality and the need for the woman's consent to obtain information. According to the Act, information concerning the woman's health, social and insurance conditions will normally be subject to confidentiality and may be obtained only with her consent. Information not classified as confidential may also be obtained only with the woman's consent and, in each case, she must be informed of her right to refuse for the information to be obtained (Amendments, Art. 11). The record and the documents in the case shall be kept securely stored at the hospital or institution for at least 10 years (Art. 25, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975).

⁴⁸ Medical Termination of Pregnancy Act.

Finally, **Peru**,⁴⁹ **South Africa**, **Puerto Rico** and **Bolivia** do not have regulations on this topic.⁵⁰

iv. Privacy of services

The only country with regulations on the privacy of services is **Colombia**. The technical regulations require health facilities «...to ensure that facilities provide the highest level of privacy possible, both when speaking with the patient as well as when providing services» (6.3. Counseling, Information and Informed Consent). This obligation is explicitly addressed in Appendix 2 of the regulation, which specifies facility conditions for each procedure. It states that facilities where vacuum aspiration and dilatation and evacuation procedures are performed must, as a minimum, have a private area for counseling and a clean procedure area that provides privacy. For medical abortions, the facility must guarantee a private area for counseling and, when observation is indicated, a private area with chairs where women can wait comfortably after taking the medications; this area must be separate from the area set aside for labor and delivery.

v. Consideration of the client's culture

Only **Brazil** and **Colombia** have regulations that address consideration for the woman's culture. In **Brazil**, although the Technical Regulations for Humane Abortion Care (2005) do not stipulate concrete measures to overcome cultural barriers, the 'support' model does state that physicians must adapt to the client's world view, at least in relation to the language that information is provided in (V. Providing Information and Counseling). In addition, bioethical principles, on which humanized care for abortion is based, include the principle of justice, which requires health professionals to prevent cultural and other prejudices from interfering with their relationships with patients (5. Professional Ethics).

⁴⁹ However, in **Peru**, the General Health Law, Art. 30, states that «a physician who provides medical attention to a person for injuries due to a sharp instrument, a bullet, a traffic accident or any other type of violence that is a prosecutable crime or when the symptoms indicate a criminal abortion is obligated to report such information to the appropriate authority.» In other words, the law does not respect medical confidentiality in these circumstances. In practical terms, this violates women's rights as well as weakens the doctor-patient relationship due to the loss of confidence in the health professional with serious consequences for women's health who, because of this law, may not seek services in a timely manner for fear of being reported.

⁵⁰ Although **Uruguay** was not included among the countries chosen for this analysis, it is important to note the recently issued [Declaration of the Faculty of Medicine of the University of the Republic, the Arbitration Tribunal of the Sindicato Médico del Uruguay and the Ethics Board of the Federación Médica del Interior on confidentiality and medical confidentiality](#), Uruguay, 2007. This Declaration was in response to the prosecution of 16 May 2007 of a young woman for the crime of voluntary abortion after she was reported by the physician she consulted; these associations unanimously issued a statement against this violation of medical confidentiality.

Colombia requires the client's culture to be taken into consideration when information is provided (6.2. Admission of Pregnant Women, Technical Regulations on Care for the Voluntary Interruption of Pregnancy). Both provisions may be understood as the obligation to employ staff who speak the languages of the communities they serve.

vi. Systematic dissemination of information to promote services to the general public

Only **Colombia** and **Mexico** establish measures in this area. The former sets out «collective education and information about sexual and reproductive rights with an emphasis on family planning and abortion» as an important community level action (Appendix 1). In **Mexico**, the most recent reform of the Mexico City Health Act, in 2007, requires the government to promote and apply comprehensive training policies on sexual and reproductive health, reproductive rights and responsible parenthood with the goal of reducing the number of abortions resulting from unwanted or unplanned pregnancies (Art. 16 bis 8). In addition, it requires the Mexico City Legislative Assembly to carry out a broad informational campaign about the reforms (Art. 5 provisional, from the decree amending the Mexico City penal code and adding the Mexico City Health Act).

Although **South Africa** does not stipulate specific actions, the regulations state that unwanted pregnancies must be prevented before women resort to terminations. To this end, every opportunity must be used to persuade sexually active individuals to make regular use of contraceptive methods to avoid unwanted and unplanned pregnancies. In addition, the regulations state that all efforts must be made to promote and provide emergency contraception in cases of method failure or unprotected sexual intercourse (Art. 1.12, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

vii. Content of information provided to individual women

Information at the individual level has two important components: the first addresses the content of the information that must be provided to women, and the second addresses the conditions in which it must be provided, with the goal that this information must be fully understood.

Mexico only regulates the content of information provided to women. Although there are no regulations to address whether or not the information is understood, it is prohibited to introduce bias during information-giving. It is worth noting that two of the three provisions that regulate this area are criminal laws which, by definition, establish crimes

and punishments. This type of categorization is specific to the criminal regulation of abortion, not just in Mexico but in other countries as well – no other penal classification regulates areas other than to define criminal acts and establish punishments. Including legal aspects that are not appropriate to criminal law within penal codes emphasizes how coercive these provisions actually are. It is important to avoid this mix of regulations when creating new abortion provisions.

The Mexico City penal code states: «Physicians shall be obligated to provide pregnant women with objective, truthful, sufficient and timely information about the procedures, risks, consequences and effects as well as the assistance and alternatives available so that the pregnant woman can make her decision in a free, informed and responsible manner» (Art. 148). The Penal Procedures Code of Mexico City states, in a very similar manner, that: «All [public health institutions] shall be obligated to provide women with impartial, objective, truthful and sufficient information about the procedures, risks, consequences and effects as well as the assistance and alternatives available so that the pregnant woman can make her decision in a free, informed and responsible manner. This information shall be provided immediately and shall not intend to influence or delay the woman's decision» (Art. 131 bis). Finally, the Mexico City Health Act, reformed in 2004, states: «Public health institutions shall provide timely and truthful information about other options women may have in addition to termination of pregnancy, as well as consequences to their health» (Art. 16 bis).

In **Spain**, health professionals are also obligated to inform women about the medical, psychological and social consequences of continuing or terminating the pregnancy and about social assistance and family counseling services available to her. They must also inform the woman about the requirements for an abortion specific to her case, the dates and facilities where it may be performed and, if the procedure will not be performed in the facility where it is requested, provide information about another facility (Art. 9, Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions, 1986).

Similarly, **South Africa** simply requires that all women who request an abortion must be informed of their rights according to the Choice on Termination of Pregnancy Act (Art. 6), which must be interpreted in accordance with the obligation to provide non-mandatory and non-directive counseling to women, before and after the termination of pregnancy (Art. 4, Choice on Termination Act and Amendment, 1996 and 2004). Likewise, the regulations establish that if the woman agrees to the abortion, the procedure should be fully explained to the client (Art. 2, Client Assessment and Preparation, Protocol for Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000). In addition, in accordance with the Choice on Termination Act and

Amendment (1996 and 2004), the health professional should inform the woman of her rights under this Act:

- ❑ she may request a termination of pregnancy within the first 12 weeks and, under certain circumstances, between the 13th and 20th weeks
- ❑ only the woman's consent is required for the procedure. A minor should be advised to consult her parents, a family member or a friend, but the termination cannot be denied if she chooses not to
- ❑ pre- and post-termination counseling will be available
- ❑ the locality of the termination of pregnancy services (Guidelines for Pre-Termination of Pregnancy Counselling, Department of Health: Western Cape, Circular H97/2000)

Norway does not explicitly specify the content of the information that must be provided to the woman. It simply establishes the doctor's obligation to provide the woman with information concerning the medical nature and effects of the operation. If she so desires, the doctor shall also provide information concerning the availability of social assistance programs offered by the government (Art. 2), and the doctor shall make sure that she receives this. This guidance may be given in collaboration with a welfare officer, health visitor or other competent person. If the woman wants other guidance, such that she herself is able to make the final decision, the doctor may refer her to another competent agency (Art. 3, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975).

Peru is one of the countries that establishes not only what information should be provided, but also that the information should be understood. Although the Perinatal Maternal Institute Guidelines are binding only on that facility, they reiterate the rights related to information from the General Health Act and apply them to therapeutic abortion, including the right to be given truthful, timely and complete information about the services, any fees and charges, and any other terms and conditions of the services and to be given comprehensible, complete and ongoing information about the process, including the diagnosis and alternative treatments, as well as the risks of, contraindications, precautions and warnings for medicines that are prescribed and administered.

The guidelines also reiterate the rights that must be respected during counseling: the right to complete, truthful, impartial and useful information; respect for dignity, privacy and confidentiality; freedom of conscience and expression; and respect for a woman's wishes and choices (VI Specific Provisions, Information and Counseling).

In **Peru**, the Hospital Belén de Trujillo Protocol also indicates that information is an essential part of service quality, although the scope of the guidelines is less extensive than those described above. It states that information must be complete, precise and easy to understand. Content must include information about sexually transmitted infections

and HIV, the different stages of the procedure and the family planning methods offered by the facility. It also specifies that «Information about abortion procedures must be provided: what will be done during and after the procedure, what may happen (cramps, pain and bleeding such as during menstruation), how long the procedure will last, how the pain will be managed, risks and complications associated with the procedure that will be used, when the patient may resume normal activities and sexual activities, and the need for follow-up.» In addition, information about contraception should be provided. According to the protocol, the goal is for the woman to make an informed decision (Information and Counseling).

In **Guyana**, although the law requires that the woman be provided with information before the abortion, it delegates to the Ministry the responsibility for drafting regulations to provide such information for any woman seeking information about the termination of her pregnancy and, where appropriate, her partner. Unusually, the law states that to facilitate such counseling, the regulations shall provide for a waiting period of 48 hours after the woman has requested the termination of her pregnancy (Art. 4). However, when the termination is to save the life of the woman, or prevent grave permanent injury to her physical or mental health, counseling requirements may be waived (Art. 10, Medical Termination of Pregnancy Act, 1995). In fact, the regulations address this area in depth and list a considerable amount of information that must be provided. It states that before carrying out treatment for the termination of a pregnancy, the medical practitioner shall:

- a. counsel the woman requesting the procedure and, where appropriate, her partner
- b. or ensure that the woman and, where appropriate, her partner have been counseled by a person authorized by the Ministry
- c. and advise the woman and, where appropriate, her partner of the 48-hour waiting period after the woman has made a request for an abortion, so that the woman and, where appropriate, her partner decide whether or not to undertake the procedure

Although the consideration that the partner may also receive information is unusual, and is specific to the Guyanese law, the law also states that in determining whether it is appropriate to involve the partner in counseling, the medical practitioner or counselor shall refer to the wishes of the woman seeking the termination.

The law states what information should be provided and that the person who counsels the woman requesting an abortion or her partner shall:

- a. advise either of them on courses of action that are available as alternatives to the termination of pregnancy
- b. inform either of them of the operative procedures and the possible immediate and long-term effects of the termination of a pregnancy

- c. advise either of them of methods of contraception and the availability of family planning services
- d. advise either of them about sexually transmitted infections, including information about transmission and how to avoid these infections
- e. give such advice that will enable either of them to deal with the social and psychological consequences of continuing the pregnancy or of terminating it
- f. in the case of a woman who decides to continue her pregnancy, advise her about the availability of adoption, fostering or other services
- g. in the case of a woman who decides to terminate her pregnancy, make reasonable arrangements for the continuation of counseling after the termination of pregnancy (Art. 2, Medical Termination of Pregnancy Act – Legal Supplement B, 1995)

In **Colombia**, according to the technical regulations, information is one component of quality services: «The provision of quality abortion services requires the provision of truthful information and timely emotional counseling. The information provided to the pregnant woman shall be complete; clear; true; easily understood; appropriate to her psychological and cultural conditions and educational level; and indicate the procedures that may be used, the risks and effects of those procedures on her life and health, and other information so that she may make an informed decision about the procedure» (6.2. Admission of the Pregnant Woman). As shown, this regulation refers both to the content and characteristics of the information as well as including additional measures to ensure that the information is transmitted effectively; the same regulations later indicate that information «must be complete, precise, easily understood and must be provided in a way that respects the woman’s privacy and confidentiality» (6.3. Counseling, Information and Informed Consent).

The technical regulations also specify what such information must include, at a minimum: what will be done during and after the procedure, symptoms, how long the procedure will last, type of pain management, the risks and complications associated with the method, when the woman may resume normal activity, including sexual relations, follow-up care and information about contraception.

However, **Brazil** may have the most comprehensive regulations about information that must be provided to the client. As its name suggests, the concept of ‘support’ for the pregnant woman who requests an abortion is fundamental to the Technical Regulations for Humane Abortion Care (2005). The emphasis is not just on the information that must be provided, but also on how it is provided, by listening to the woman’s concerns and responding truthfully and openly to them, and on the care given to the woman, who is considered an active participant in a dialogue. For example, the health team’s obligations include being attentive to the woman’s concerns by providing information

that meets her needs and answers her questions, establishing effective communication and paying attention to non-verbal language, as well as adapting to the client's world view. The 'support' system attempts to take seriously women who request an abortion. The regulations state that the woman must also be provided with information about procedures and how they will be performed, the state of the woman's health, test results, self-care to avoid subsequent complications and post-abortion support (V. Providing Information and Counseling).

In this area, **Italy** is a special case because it is the only country whose laws seem to include some bias in the information that must be provided to women, which is aimed at finding solutions to the pregnancy other than abortion. The Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy (1978) describe what assistance family advisors⁵¹ must offer a pregnant woman, some of which include her rights under state and regional law; social, health and welfare services available in her area; and the best way to ensure that the law protecting working women who are pregnant is respected. Family advisors may also assist the pregnant woman – either by acting directly or by requesting her local social services to make a special intervention. Here, the intention would be to help resolve any potential pregnancy or motherhood issues faced by the woman, and to help her overcome any problems that may cause her to seek an abortion. (Art. 2). Clearly, the information given to a woman who requests an abortion seeks, in part, to dissuade her from the procedure.

Puerto Rico, Panama and Bolivia do not define any rules regarding information given to women, either individually or for the general public.

viii. Protocols for surgical and medical abortion^{52, 53}

This section includes provisions or measures that specifically address the technical aspects of providing abortion services. The research found that the countries belonged to one of three different groups: (a) countries with specific protocols for abortion care; (b) countries with legal provisions with a broader purpose (regulating access to abortion services) that

⁵¹ Family counselors.

⁵² It is possible that the laws and regulations analyzed for this chapter do not provide a complete picture of the legal situation in each country. For this issue in particular, it is possible that individual hospitals have their own protocols of care that are not a part of national laws. In general, these types of protocols were not included because it is outside the scope of the research, which is limited to national laws. Peru was an exception to this rule; the hospital protocols were included since the Perinatal Maternity Institute Guidelines were being developed at the time of the research and represented one of the first efforts to respond to the recommendations included in the UN Human Rights Commission's ruling on the case (*K.L. versus Peru*).

⁵³ Refers to protocols that are obligatory.

include relevant information for protocols on abortion care; and (c) countries without any type of provision in this area.

Group (a) includes **Colombia, Brazil, Peru** and **South Africa**. In Colombia, Regulatory Decree 4444 of 2006 requires abortion services to be subject to the administrative provisions issued by the Ministry of Social Welfare, which state which procedures shall be used according to weeks of gestation in the Technical Regulations on Care for the Voluntary Interruption of Pregnancy. Brazil has the Technical Regulations for Humane Abortion Care (2005). In Peru, facilities have developed protocols of care, including the Perinatal Maternal Institute Guidelines (2007) and the Case Management Protocol for Legal Abortion (2006), Department of Gynecology, Belén de Trujillo Hospital. And in South Africa, Circular H97/2000 compiles various circulars and guides on the technical aspects of abortion services.

Group (b) is more diverse. In **Italy, Mexico** and **Norway**, access to abortion is regulated by law, but there are no protocols of care. **Spain** is unique in that the decree that governs abortion only addresses issues related to facilities and health professionals. In **Guyana**, abortion is also regulated by law, and the Ministry of Health is given the authority to define protocols of care (Art. 16).

Puerto Rico and **Panama** are borderline cases within this group. In Puerto Rico, in addition to the penal code, another law addresses requirements for facilities that provide abortion services; this law does not directly establish requirements but, instead, specifies what issues facilities must address in their own regulations.⁵⁴ In **Panama**, a resolution of the National Multidisciplinary Commission on Therapeutic Abortion specifies some requirements for accessing abortion services, but they are only binding in the case of therapeutic abortion.

Bolivia and **Canada** belong to group (c).

Some of the issues related to protocols of care are now examined.

a. **Laboratory tests and ultrasound before an abortion**
(for example HIV/AIDS, syphilis, other blood tests)

Several countries regulate what tests are administered before an abortion. Most countries only require a physical examination; laboratory tests are optional. **Puerto Rico**

⁵⁴ For example, the law delegates organization of the facility, roles and obligations of personnel, procedures and tests required for each patient, initial counseling and training for personnel, biosecurity protocols, rules requiring that a physician remains in the health facility until the last patient has been discharged, and rules requiring that any patient who is not sure she is pregnant to be given a blood pregnancy test by a clinical laboratory that is licensed by the Health Department.

and **Norway** require a physical evaluation of the woman before an abortion; in Puerto Rico this also includes laboratory tests to identify Rh and the presence of antibodies. In **Colombia**, a physical examination is required; except for testing for HIV, which must be offered, tests are not required and should be administered only as needed in each specific case. The Perinatal Maternal Institute Guidelines in **Peru** also require a physical examination; laboratory tests are optional.⁵⁵

By contrast, **Brazil** does not require any test or examination to be performed, only that tests and examinations are offered to pregnant women. Uniquely, **Colombia** is the only country that stipulates that examinations must not become an obstacle to accessing abortion services.

In **Puerto Rico**, although the General Regulations for the Operation of Health Facilities of 1999 (Art. H, Family Planning and Abortion Center) do not directly require any examinations to be performed, they do stipulate that all facilities that provide abortion services should establish regulations to guarantee a physical examination and laboratory tests to all women who wish to terminate their pregnancies. The regulations do not specify which examinations or tests should be carried out. However, they clearly state that tests to determine Rh and detect antibodies should be included (Coombs test).⁵⁶ In **Norway**, the Regulation for the Implementation of the Act concerning Termination of Pregnancy (1975) requires an evaluation of the duration of the pregnancy for terminations before 12 weeks; after 12 weeks, the doctor must examine the woman and evaluate the duration of the pregnancy (Art. 8). In addition, the medical superintendent who is responsible for the hospital unit shall prepare guidelines for the necessary examinations and preliminary treatment of women whose pregnancy is to be terminated (Art. 19); in effect, each hospital may determine what tests are necessary before an abortion.

As mentioned earlier, an evaluation is required in **Colombia**. According to the regulations, during the first consultation the physician must evaluate the woman's health and the biological, psychological and social risk factors associated with abortion. He or she must also confirm that the woman is pregnant, determine the number of weeks of gestation and verify that it is an intrauterine pregnancy (6.4. First General Medical Consultation (*Consulta de Primera Vez por Medicina General*)). The regulations later clarify that the pregnancy should be confirmed and number of weeks of gestation determined by a bimanual pelvic examination, during which the health professional should ascertain if the uterus is anteverted or retroverted or in another position that may affect evaluation

⁵⁵ The laboratory tests are referred to as optional, but are often considered to be a routine part of care.

⁵⁶ The regulations also establish treatment: all women with an Rh-negative result and with sensitivity should be administered anti-D immunoglobulin (RhoGAM) within 72 hours of the abortion.

of the pregnancy or complicate a surgical abortion. The regulations also indicate that the physician should check for signs of sexually transmitted infections or other infections of the reproductive tract, as well as anemia or other diseases (such as malaria) that may require additional procedures or referral to specialized medical care (6.4. 1.2. Physical Exam (*Examen físico*)). The only laboratory test – and subsequent counseling – that must be offered to all women is to screen for HIV (ELISA or rapid test) during the first trimester of pregnancy or the first prenatal check-up. The regulations state that health professionals must always respect a woman’s wishes about voluntary testing for HIV; however, it is vital that testing is offered to all women. At the same time, it is imperative that HIV testing does not constitute a barrier to accessing abortion.

Examinations that may be administered, although they are not obligatory, include hemoglobin/hematocrit (HCT), blood typing and ultrasound (6.4.1.3. Paraclinical Tests, Technical Regulations on Care for the Voluntary Interruption of Pregnancy).

The Perinatal Maternal Institute Guidelines in **Peru** (2007) require health professionals to first conduct a clinical examination that includes a gynecological examination, an examination to identify signs of sexually transmitted infections or other genital and vaginal tract infections, and to confirm the pregnancy, among other measures, for women who request a termination of pregnancy. The guidelines identify the following as optional to the physical examination: measuring hemoglobin or hematocrit; blood typing and Rh; evaluation of coagulation profile; and serologic tests: rapid plasma reagin (RPR), HIV, ultrasound, measuring human chorionic gonadotrophin (HCG), other tests that help to diagnose concomitant diseases and, depending on the case, an evaluation of surgical or anesthetic risk (VI. Specific Provisions).

The Hospital Belén de Trujillo Protocol requires a clinical examination, which includes confirmation of pregnancy and duration of pregnancy, and identification of signs and symptoms of sexually transmitted infections and of pregnancy-related complications (such as hydatidiform mole, ectopic pregnancy). It also lists some optional blood tests, including serologic tests and Rh. The protocol indicates that the clinical examination is an opportunity to do a Pap smear and any other tests that would help to diagnose associated diseases (Clinical Examination and Auxiliary Tests (*Examen clínico y exámenes auxiliares*)).

In **Brazil**, the Technical Regulations for Humane Abortion Care (2005) require health professionals to offer blood typing tests to all women and to administer anti-D immunoglobulin to women who are Rh-negative in addition to a serologic test for syphilis and a test for HIV (4. Medical Aspects).

In **South Africa**, health professionals must also begin with a physical examination, including abdominal palpation, and speculum and bimanual examinations. In addition,

the pregnancy should be confirmed by a urine test, and the woman should be referred for an ultrasound if the duration of the pregnancy is uncertain or an ectopic pregnancy is suspected. Finally, the regulations indicate that relevant investigations should be made: blood grouping (blood typing), HB, RPR, Rh and a Pap smear if necessary. It also requires health professionals to treat symptomatic sexually transmitted infections using the syndromic approach (Art. 2, Client Assessment and Preparation, Protocol for Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

b. Requiring a pregnancy test

Only five countries have regulations that address pregnancy tests; and only in two countries is it a requirement. In **Puerto Rico** and **Colombia**, it is indicated when the existence of the pregnancy is in doubt. In **Mexico**, it is required when a sexual crime is the grounds for the termination of pregnancy; in this case, its purpose is not to verify the pregnancy, but rather to establish its duration to compare with the police report. In **South Africa**, a urine test is always used to verify the pregnancy. In **Peru**, although the Hospital Belén de Trujillo Protocol does not explicitly require a pregnancy test to be administered, it does state that the pregnancy should be confirmed during the clinical examination.

In **Puerto Rico**, facilities have the delegated responsibility to create regulations that require any patient who is not sure she is pregnant to be given a blood test for pregnancy in a clinical laboratory that is licensed by the Department of Health (Art. H, Family Planning and Abortion Center, General Regulations for the Operation of Health Facilities in Puerto Rico, 1991).

Similarly, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy in **Colombia** states that «Laboratory analyses to corroborate pregnancy may not be necessary unless the typical signs of pregnancy are not clearly present or there is no certainty about the pregnancy or when there are inconsistencies between the date of the last menstruation and the physical signs. However, performing such tests should not hinder or delay uterine evacuation.»

The Hospital Belén de Trujillo Protocol in **Peru** requires a uterine pregnancy to be confirmed, but does not indicate a method (Case Evaluation and Preparation before Termination (*Evaluación y preparación del caso antes de la interrupción*)). Later, the protocol is more specific: «Confirm the pregnancy and estimate its duration with a bimanual pelvic exam.»

In **Mexico**, for cases of sexual violence, the Mexico City Penal Procedures Code states that the pregnancy should be confirmed in a public or private health facility as a prerequisite

to authorizing the termination (Art. 131 bis). The purpose of this test is set out in the Agreement of the Attorney General of Mexico City, which established the Order on Legal Termination of Pregnancy Procedures and Emergency Contraception in the Case of Rape (2006). The latter requires the Public Prosecutor's Office to send the woman to a public or private health facility of her choice, so that the appropriate tests may be performed to confirm the existence of the pregnancy and to determine its duration. Once the Public Prosecutor's Office has the results issued by the health facility, the medical forensic expert can use this information to determine whether the gestational age does or does not coincide with the date of the reported crime (Art. 5).

South Africa simply indicates that a urine pregnancy test should be administered (Art. 2, Client Assessment and Preparation, Protocol for Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

c. Pain management

Colombia, South Africa, Peru and **Brazil** are the only countries with identified regulations that address pain management. These four countries all provide information on how to use medications and emotional support to alleviate pain.

In **Colombia**, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy have a chapter on pain management. It includes a component on emotional support, which indicates that counseling and medical attention that is respectful of the woman may reduce fear and, as a result, the perception of pain. For this reason, the regulations require the person performing the procedure, as well as all personnel present at the procedure, to act in a calm and friendly way. They also recommend that, whenever possible, the client should be given specialized support during the procedure.

It is left to the woman to decide, depending on the space constraints of the facility, whether anyone other than the medical personnel should be present to provide emotional support, such as a spouse or partner, a family member or a friend who remains at her side during the procedure.

Together with emotional support, the regulations also mandate medical support, which may not replace the former; pain medication must always be provided. The regulations indicate three types of medications that should be used: analgesics, tranquilizers and anesthesia. «Three types of drugs, either alone or in combination, are used for pain management during abortion: analgesics, which relieve feelings of pain; tranquilizers, which reduce anxiety; and anesthesia. In most cases, analgesics, local anesthesia and/or light sedation together with verbal support are sufficient» (7.2.1. Pain Medication (*Medicación para el dolor*)).

The regulations also have specific recommendations for cervical dilatation:⁵⁷ light sedation and/or local anesthesia for most vacuum aspiration procedures; and light or heavy sedation, analgesics and/or local anesthesia for dilatation and curettage. Finally, they do not recommend the use of general anesthesia, but do note that if the woman requests it, or it is appropriate for her case, the client shall be referred to the appropriate level of care for the complexity of the procedure, in accordance with the regulations of the Obligatory System for Quality Assurance (7.2. Pain Management).

When considering emotional support for pain management, the technical regulations in **Brazil** state that the use of criteria for clinical evaluation; a careful analysis of the procedures that will be used; and warm, empathetic and humanized support foster an environment that makes it possible to avoid administering too many medications, thereby reducing complications and costs. However, similar to the Colombian regulations, the regulations state that pain medication must be offered to all women.

The regulations state that, when conditions are favorable, paracervical anesthesia should be applied and verbal support offered, but associated drugs should be administered when the woman needs them to avoid unnecessary suffering. In most procedures, analgesics or narcotics are sufficient with paracervical anesthesia or sedation. In addition, some women may require tranquilizers if their anxiety is hindering the procedure. Finally, it does not recommend the use of general anesthesia, except in specific cases (III. Pain Management, Technical Regulations for Humane Abortion Care, 2005).

In **Peru**, the Hospital Belén de Trujillo Protocol requires pain management to be used for all manual vacuum aspirations and specifies that medications to be used include analgesics, tranquilizers and anesthetics. It does not recommend general anesthesia, but notes that it may be used if the patient requests it or the provider considers it necessary. As in Brazil and Colombia, verbal support is considered part of the treatment plan to reduce pain. «In most cases, analgesics, local anesthesia and light sedation together with verbal support are sufficient.» The protocol also describes the procedures to administer the medications.

South Africa recommends pain medications according to the level of care:

First level of care:

1. Pre-operative (one of the following):
 - paracetamol 1000mg orally

⁵⁷ To decrease the woman's discomfort when cervical dilatation is required for a surgical abortion, a paracervical block should be used with local anesthesia such as fast-acting lidocaine, injected under the cervical mucosa in the four quadrants of the cervix. Care is needed to avoid injecting the local anesthetic intravenously.

- ibuprofen 400mg orally
- diclofenac 75mg orally
- anxiolytics are indicated as needed: lorazepam 1mg orally or diazepam 5mg orally

2. During the operation:

- paracervical block, if needed (lidocaine)
- good client-provider interaction: 'verbocaine'

3. Post-operative:

- Same as pre-operative

Second level of care:

Same as first level, with suggested alternatives:

- Fentanyl 100µg by intravenous injection (IVI) or Dormicum 5mg IVI (noting that this is an expensive drug)

The circular also offers alternatives in case of respiratory depression (4. Applied Pharmacology – Manual Vacuum Aspiration, Protocol for Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

d. Description of abortion techniques (surgical and medical)

Only **Peru, Mexico, South Africa, Colombia** and **Brazil** regulate abortion techniques, although each does so differently in terms of content and detail. **Colombia** gives the most amount of detail, as it describes various techniques and various methods of using these techniques, as well as studies on the level of effectiveness of each.⁵⁸ Although the procedures are explained, none of these countries mandate the use of a specific method; therefore, the use of one method or another depends on the physician's judgement and the circumstances of each case. However, the chosen method must follow the specific steps set out in the regulations. In all these countries, the stage of the pregnancy determines which methods may be used. Countries also often differentiate between medical and surgical abortion. In **Brazil**, it is worth noting that the woman's potential response or reaction to the physical effects of the procedure is one of the criteria that must be used to decide the most appropriate method. **South Africa** is unique in indicating manual vacuum aspiration in all cases; medical methods are used to prepare for the surgical procedure.

⁵⁸ This section of the Colombian regulation is based on the World Health Organization guidelines for abortion methods, 2003.

In **Colombia**, as stated, the regulations are highly detailed. The regulations recommend manual vacuum aspiration or medical abortion, in conjunction with a surgical method when necessary, for procedures during the first 12 weeks.⁵⁹ At this stage, mifepristone and misoprostol are indicated,⁶⁰ and vacuum aspiration and dilatation and curettage. After the 12th week, the potential for higher morbidity and increased risk of complications that might require hospital care are taken into account. The regulations describe methods using mifepristone, prostaglandin, misoprostol or gemeprost, with an emphasis on surgical methods. Also included are techniques to prepare the cervix⁶¹ (Technical Regulations on Care for the Voluntary Interruption of Pregnancy).

In addition, Resolution 4905 of 2006, which enacted the technical abortion regulations, codifies procedures in the Unified Classification of Health Procedures (*Clasificación Única de Procedimientos en Salud*, CUPS) (Art. 4).

The Technical Regulations for Humane Abortion Care (2005) in **Brazil** also describe various procedures. According to the regulations, abortion methods that may be used include medical abortion methods, vacuum aspiration, and dilatation and curettage (4. Medical Procedures). During the first trimester, acceptable methods include medical abortion, vacuum aspiration and curettage. During the second trimester, the only method permitted is medical abortion, in conjunction with aspiration or curettage, as necessary, to expel the fetus. The regulations indicate that microsurgery should be reserved for exceptional situations (4. Medical Procedures).

59 The regulations provide detailed information on the options given below. They also include possible drug combinations and methods of administration. References to the pertinent sections are provided here, but not the description in its entirety due to its length:

- mifepristone, followed by a prostaglandin (7.4.1.1) accompanied by vacuum aspiration (performed in an examining room, room used for minor surgery, gynecology room, operating room or gynecology-obstetrics operating room. Instruments and procedures are described in 7.3.1)
- misoprostol (7.4.2.)
- dilatation and curettage (performed in an operating room or gynecology-obstetrics operating room; procedure described in 7.3.2.)

60 Mifepristone is not registered in **Colombia**. In 2007, misoprostol was approved (by expanding the indications for which it can be used) for abortions in the three circumstances decriminalized by the Constitutional Court.

61 The regulations restate that mifepristone is not registered in Colombia and list the following recommended techniques for cervical preparation:

- mifepristone followed by repeated doses of a prostaglandin such as misoprostol or gemeprost
- dilatation and evacuation (7.3.3.), using aspiration and forceps (7. Abortion Methods; see description in the regulations)

Cervical preparation is suggested for pregnancies of more than nine full weeks for nulliparous women younger than 18 years and all women with pregnancies of more than 12 full weeks, using:

- vaginal or oral administration of 400µg of misoprostol four to six hours before the surgery is performed
- oral dose of 200mg of mifepristone, 36 hours before the procedure
- vaginal administration of 1mg of gemeprost, three hours before the procedure (7.1. Cervical Preparation).

For first trimester medical abortions, one important point mentioned earlier is that the regulations require the provider to discuss with the woman her response to the procedure and whether she wishes to remain in hospital until the abortion is completed or do so as an outpatient. For second trimester terminations, the woman must remain under observation to determine if a secondary method is needed to complete the abortion.

The regulations describe drug dosages, the equipment necessary for surgical procedures and the steps to follow (Manual Vacuum Aspiration and Curettage).

Mexico, in contrast, does not describe what methods should be used. However, it does say that they may be medical or surgical methods depending on the number of weeks of pregnancy and the judgement of the attending gynecologist-obstetrician or the general surgeon who performs the procedure (Art. 14, General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City).

Finally, in **Peru**, the [Practical Clinical Guide for Emergency Obstetrics](#) (*Guía de Práctica Clínica de Emergencias Obstétricas*, 2007) establishes rules for using methods to evacuate the uterus. However, it is important to clarify that the purpose of these protocols is to provide care for incomplete abortion or abortion complications, and not legal abortions. The guide includes a protocol for uterine curettage (*Legrado Uterino*, Appendix 4) and another for manual vacuum aspiration (*Aspiración Manual Endouterina*, Appendix 5). Both include definitions, indications, requirements, equipment that must be used, step-by-step guide to the procedure, complications and discharge criteria. Furthermore, the Perinatal Maternal Institute Guidelines (2007) establish manual vacuum aspiration or misoprostol as recommended methods until 12 weeks. For methods between 13 and 21 weeks, the guidelines recommend the following: «Apply the therapeutic treatment regimen for misoprostol according to the gestational age of thirteen to fifteen weeks, from sixteen to twenty-one weeks as set out in the guidelines. Once the contents have been expelled, the procedure must generally be completed by evacuating the uterus through curettage.»⁶²

By contrast, the Hospital Belén de Trujillo Protocol, also in Peru, regulates in detail methods to terminate pregnancy, which are associated with the number of weeks of gestation and are divided into two groups: (1) methods up to 12 weeks of pregnancy and (2) methods for use between 13 and 21 weeks.

⁶² This paragraph includes an error in the original, Guideline No.—DG—INMP—2007 of the Perinatal Maternal Institute. The title of the paragraph is «Methods to Empty the Uterus between Thirteen and Twenty-one Weeks,» by which one could assume that misoprostol is only used for this gestational age period, but which contradicts the contents of the paragraph.

Up to 12 weeks of pregnancy, the protocol states that electric vacuum aspiration or manual vacuum aspiration and misoprostol are preferred but, if the equipment is not available, curettage is permitted. The protocol describes the procedure, the instruments required and the techniques for performing the operation. Between 13 and 21 weeks, it recommends admitting the pregnant woman and initiating a medical abortion. It identifies the different doses that must be administered according to weeks of pregnancy.

In **South Africa**, the protocol divides techniques into two groups: Applied Pharmacology – Manual Vacuum Aspiration (Art. 4), which describes the medical procedure to prepare for aspiration, and Surgical Procedure – Manual Vacuum Aspiration (Art. 5), which describes that procedure. As mentioned, medical abortion is indicated only as a preparatory measure, since it is always accompanied by manual vacuum aspiration.

The first section addresses four areas: a) pain management (see section on pain management on page 00); b) preparation; c) Rh treatment; and d) contraception. It notes and even recommends alternatives to the protocol. In section b), preparation for the termination, it recommends that misoprostol is used on site only, if possible. For first trimester terminations performed on site, it indicates the use of two tablets of misoprostol (400µg) orally or vaginally; the procedure may be performed two to three hours later. For second trimester terminations, between 13 and 16 weeks, the protocol states that 400µg of misoprostol should be taken orally, with the dose repeated six hours later depending on the status of the cervix. Between 17 and 20 weeks, it indicates 400µg of misoprostol orally and 200µg six hours later if necessary. In all cases, management should be according to circumstances. The outpatient regimen advises administration of one tablet of 200µg of misoprostol at 16:00 hours and another at 22:00 the day before the procedure. The woman must be informed about symptoms that need emergency care.

The protocol indicates that the patient should be admitted at 08:00 on the day of the procedure. Health professionals should ask the woman about any symptoms that might have occurred with misoprostol use (pain or bleeding), ensure that test results are available, confirm the length of gestation of pregnancy, and perform a vaginal examination to determine if the cervix is prepared. Vacuum aspiration should be performed under light sedation/analgesia. If the cervix is not sufficiently dilated, the procedure can be performed with a paracervical block and cervical dilatation provided the practitioner has the necessary skill; if not, a further dose of misoprostol should be administered. If the cervix is still not prepared, the client should be referred to a secondary level hospital. Intravenous fluids and an ambulance must be available in case of complications. Finally, the protocol states that physicians should continue with methods used in the past, based on their clinical knowledge and competence (5. Surgical Procedure – Manual Vacuum Aspiration, Protocol

for Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).⁶³

e. Prophylactic antibiotics

Antibiotic prophylaxis is only addressed in **Peru**, **Colombia** and **Brazil**, which recommend its use; in Brazil, its use is restricted to cases of sexual violence. The Technical Regulations on Care for the Voluntary Interruption of Pregnancy in **Colombia** state that antibiotics should be used routinely during the procedure because this reduces by half the risk of infection after the abortion; however, they clarify that abortions may be performed without the routine use of antibiotics. The regulations also state that cleanliness and disinfection play an essential role in preventing infections after the procedure. Finally, in cases presenting with clinical symptoms of infection, the regulations require treatment with antibiotics before the procedure (6.4.2.1. Reproductive Tract Infections (*Infecciones del tracto reproductivo*)).

In **Brazil**, the Technical Regulations for the Prevention and Treatment of Injuries Resulting from Sexual Violence against Women and Adolescents (2005) recommend the prophylactic use of antibiotics in cases of sexual violence to reduce the rate of sexually transmitted infections.

In **Peru**, the Hospital Belén de Trujillo Protocol recommends two prophylactic methods: one related to the use of instruments, and the second related to the use of medications. For the former, it notes that to prevent and control infections nothing replaces «the use of biosecurity best practices, implemented continually by the facility.» It specifies disinfection of equipment, clinical spaces and medical attire, and waste management, among other measures. For the latter, it recommends one dose of prophylactic antibiotics and an examination of the tissue after the evacuation (Procedures to Evacuate the Uterus (*Procedimientos para la evacuación del útero*)).

f. Management of complications

Provisions addressing the management of complications appear most frequently and in the most detailed manner in the countries that do not regulate legal abortion care, such as Bolivia and Peru. These provisions tend to address the consequences of unsafe

⁶³ In the Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000, Art. 2, Standardized Guidelines, states that facilities should order their own manual vacuum aspiration equipment at the number indicated in the protocol and that for first trimester terminations of pregnancy, single or double valve syringes may be used. However, double valve syringes are more appropriate for use in terminations of pregnancy at 10 to 12 weeks of gestation (Art. 2.1).

abortion in contrast to the regulations in countries with a framework for legal abortion care, which address deficiencies in procedures that are performed legally. In **Bolivia**, the [Universal Maternal Infant Insurance Program](#) covers the costs of medications and equipment for the treatment of septic abortion with complications.⁶⁴

In **Peru**, various regulations include provisions for the management of abortion complications. In the [Integrated Sexual and Reproductive Health Care Guide](#) (*Guía de Atención Integral en Salud Sexual y Reproductiva*, 2004), there is a section on Measures to Improve Care and/or Prevent Emergency Obstetrics (*Medidas para mejorar la atención y/o prevención de las emergencias obstétricas*), and the section on Management of Obstetric Hemorrhage (*Manejo de las hemorragias obstétricas*) includes Suspected Abortion (*Sospecha de Aborto*).⁶⁵

The [National Health Strategy for Sexual and Reproductive Health General Plan \(2004\)](#), which describes sexual health during different life stages, includes a chapter on adulthood. Considerations during this stage include «integrated care for incomplete abortion and its complications (information, education, counseling and services).» In both the Perinatal Maternal Institute Guidelines⁶⁶ and the Hospital Belén de Trujillo

64 This also covers treatment for incomplete abortion with dilatation and curettage or manual vacuum aspiration (pages 21 to 24), septic abortion complicated by adnexitis, pelviperitonitis due to septic abortion and post-abortion obstetric sepsis (Integrated Consultation for Pregnant Women (*Consulta integral para la mujer embarazada*), Universal Maternal Infant Insurance, Protocols for Pregnant Women Until Six Months After Childbirth (*Protocolos para la mujer embarazada hasta los seis meses posteriores al parto*)).

65 For vaginal bleeding before 22 weeks of gestation, the regulations cover the treatment of incomplete abortion without complications; incomplete abortion with infection that requires hospitalization in a facility with the capacity to provide the necessary treatment; incomplete abortion complicated by septic abortion that requires hospitalization in a facility with the capacity to provide the necessary treatment; incomplete abortion with hemorrhaging or hypovolemic shock that requires hospitalization in a facility with the capacity to provide the necessary treatment; and incomplete abortion complicated by uterine perforation that requires hospitalization in a facility with the capacity to provide the necessary treatment (page 112 and following).

66 «Incomplete abortion: in the case of manual vacuum aspiration it is infrequent. If it occurs, re-empty the uterus. Missed abortion: may occur with manual vacuum aspiration or misoprostol. Requires surgical evacuation under anesthesia. Hemorrhaging: may occur due to retained products of the conception, trauma, cervical tears or uterine perforation. Depending on the cause, it may be necessary to: re-empty the uterus, replace liquids or blood or perform laparoscopy or exploratory laparotomy. Infection: Rare after appropriately performed evacuation. Symptoms include fever, chills, foul-smelling cervical fluid or vaginal discharge, abdominal or pelvic pain, prolonged vaginal bleeding, sensitive uterus and high white blood cell counts. Administer antibiotics and re-evacuate the uterus if the products of conception have been retained. Uterine perforation: Infrequent. Monitor vital signs, control vaginal bleeding and administer antibiotics. If there is damage to the organs, perform an exploratory laparotomy. Anesthesia-related complications: local anesthesia is safer than general anesthesia. When administering general anesthesia, be prepared for possible convulsions and cardiorespiratory complications» (VI Specific Provisions. Managing Complications Related to Evacuation of the Uterus (*Manejo de las complicaciones de la evacuación uterina*)).

Protocol,⁶⁷ care for abortion complications refers to procedural deficiencies: incomplete abortion, hemorrhage, infection, uterine perforation, and so on.

Brazil describes procedures for threatened abortion, complete abortion, inevitable/incomplete abortion, missed abortion, infected abortion and recurrent miscarriage (4. Medical Aspects, Technical Regulations for Humane Abortion Care, 2005).

Colombia details the indications for the following complications: incomplete termination of pregnancy, failed termination, hemorrhage and uterine perforation (7.5. Management of Complications (*Manejo de Complicaciones*), Technical Regulations on Care for the Voluntary Interruption of Pregnancy).

South Africa indicates that manual vacuum aspiration may also be used for incomplete abortion, because it involves huge cost savings (Art. 2.4, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

g. Establishing biosecurity standards

Colombia sets out some biosecurity rules for vacuum aspiration and dilatation and curettage in Appendix 2, which require a receptacle with a cover for disposable materials and a receptacle for sharp objects (with cover).

In the section on indications for prophylaxis, the Hospital Belén de Trujillo Protocol in **Peru** also specifies the general obligation to dispose of materials appropriately and, specifically, to dispose of sharp objects in receptacles designed for such use.

In **South Africa**, biosecurity standards concentrate on establishing guidelines for the reuse of manual vacuum aspiration equipment and making sure that general guidelines are followed. Chapter 2, Policy on the Management of Termination of Pregnancy, Services Department of Health: Western Cape, Standardized Guidelines, states that

⁶⁷ The protocol states: «When procedures are performed by trained personnel, complications are minimal. However, keep in mind possible complications, which are rare in the case of manual vacuum aspiration. If complications occur, re-empty the uterus. May occur with manual vacuum aspiration or misoprostol. Requires surgical evacuation. May occur due to retained products of conception, trauma, cervical tears or uterine perforation. Depending on the cause, it may be necessary to: re-empty the uterus, replace liquids or blood or perform laparoscopy or exploratory laparotomy. Rare after appropriately performed evacuation. Symptoms include fever, chills, foul-smelling cervical fluid or vaginal discharge, abdominal or pelvic pain, prolonged vaginal bleeding, sensitive uterus and high white blood cell counts. Administer antibiotics and re-evacuate the uterus if the products of conception have been retained. Uterine perforation is generally not detected and will resolve itself. If it is detected, often only observation and antibiotics are necessary. If a laparoscope is available a laparoscopy can be performed. If there is damage to the organs, perform a laparotomy. Local anesthesia is safer than general anesthesia. When administering general anesthesia, be prepared for possible convulsions and cardiorespiratory complications.»

syringes and cannulae may be reused until no adequate suction can be produced (Art. 2.2). The guidelines of the protocol for Infection Control and Manual Vacuum Aspiration Instruments Reuse must be followed when reusing instruments (Art. 2.3, Circular H97/2000).

This protocol states that standard infection control practices and universal blood precautions – including hand washing, using barriers (masks, gowns, aprons and gloves), safe waste disposal and protection from needle-stick injuries – should be followed strictly. It also states that cannulae should be sterilized; if sterilization is not available, high level disinfection is the only acceptable alternative method. It describes four basic steps for processing manual vacuum instruments for reuse: decontamination, cleaning, sterilization or high level disinfection, and storage (Guidelines for Infection Control and Manual Vacuum Aspiration Instrument Reuse, Circular H97/2000).

ix. Infrastructure requirements for service provision

Infrastructure requirements can be divided into two types: (1) those that indicate the conditions that must be met by the facility where abortions will be performed (certification); and (2) those that require some form of verification process to demonstrate that the requirements have been met (accreditation). Provisions in Colombia and Mexico are limited to the first type. Peru, Panama and Italy also do not have accreditation mechanisms. In Peru, this is because existing regulations are actually protocols for care that are specific to individual facilities: rather than creating requirements, they describe available conditions. In Panama and Italy, the regulations merely indicate the type of facility, without specifying infrastructure requirements.

Colombia explicitly spells out the obligation of health facilities that provide abortion services to comply with certification standards defined in the Obligatory System for Quality Assurance within the Health Care section of the General System for Healthcare Social Security (SOGCS) (6. Characteristics of Service, Technical Regulation on Care for the Voluntary Interruption of Pregnancy). Appendix 2 specifies the physical requirements and required instruments and medications depending on the type of procedure; it differentiates between requirements for vacuum aspiration and dilatation and evacuation, and for medical abortion. The requirements cover biosecurity, appropriate infrastructure and medicines.

In addition, Circular 0031 of 2007 states that the Health Promotion Entities and the Departmental and District Health Offices shall inform the Ministry of Social Welfare's⁶⁸

⁶⁸ In Colombia, this ministry performs the functions of the Ministry of Health, among others.

General Office on Service Quality about those facilities within the network authorized to provide low, medium and high level gynecological–obstetric care and which have personnel willing to provide abortion services. This information shall be kept current and available for clients who require these services and shall be reported annually to the General Office on Service Quality.

Mexico addresses requirements for the type of facility and medical personnel, establishing that medical facilities that perform legal abortions, whether public or private facilities, must comply with the requirements detailed in the regulation entitled For the Performance of Major Outpatient Surgery (*Para la práctica de la Cirugía Mayor Ambulatoria*), and must have gynecological-obstetric personnel or appropriately trained general surgeons available for the procedure (Art. 4 bis, General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City, 2006).

In **Spain**, by contrast, the law explicitly states that facilities must be accredited. According to the Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions (1986), private health centers or establishments that provide low-risk abortions before 12 weeks must have, at least, a physician specializing in gynecology and obstetrics, nursing staff, auxiliary health personnel and a social worker. It also requires appropriate facilities and health equipment (infrastructure and hygiene requirements as for any health center and physical installations that include areas for reception, offices for information and counseling, rooms appropriate for the procedure, and a waiting and recovery room); basic equipment in addition to specialized equipment, examination equipment, equipment to perform the abortion, and informational and educational materials; facilities for clinical analysis, anesthesia and recovery; blood supplies or plasma volume expanders; and a hospital center to which cases can be referred as necessary.

To be accredited, health centers that perform abortions for high-risk pregnancies or abortions after 12 weeks must have, as a minimum, gynecology or obstetrics units, laboratory analysis units, anesthesia and recovery units, an appropriate blood bank or blood supplies, and nursing and hospitalization facilities (Art. 1).

Accreditation is automatic for public centers or establishments that comply with the requirements; health authorities periodically publish lists of accredited facilities. Private centers or establishments must submit a request to their respective regional government (Art. 2).

In addition, the law states that accreditation is conditional on maintaining these minimum requirements and effective compliance with medical infrastructure requirements necessary to save the life and health of the woman (Art. 3).

In **Guyana**, Article 4 of the Medical Termination of Pregnancy Act – Legal Supplement B (1995) lays down a certification and approval system for facilities, which must comply with a series of requirements and must submit proof of compliance to the authorities as part of the application. It also mentions various situations that will cause the facility to lose its certification.

The law states that the Ministry of Health acting on the advice of the chief medical officer, may grant the person owning or managing an institution approval to provide treatment for the medical termination of pregnancies of more than eight weeks' duration, having given due consideration to:

- a. the training and experience of the medical staff, nurses and technical personnel employed by or working in the institution
- b. equipment and facilities available in the institution

The person owning or managing an approved institution is required to inform the Ministry of any changes that may reduce the safety of providing treatment under the Act. These include any changes in personnel such as medical practitioners, nurses or medical-technical staff, and any deterioration or non-functioning of medical equipment or other clinical arrangements. Such notification must be made as soon as possible but, in any case, within 14 days from the date on which the change, deterioration or non-functioning took place. Failure to provide this information may result in the cancellation of the approval, as discussed below.

Infrastructure and human resource requirements are also detailed in the law. It states that no institution shall be approved:

- a. unless the Ministry is satisfied that termination of pregnancies may be done there under safe and hygienic conditions
- b. unless the following are provided in the facility:
 - i.* an operating table, instruments and supplies for performing abdominal and gynecological surgery
 - ii.* anesthetic equipment, resuscitation equipment and sterilization equipment
 - iii.* drugs and parenteral fluids for emergency use
 - iv.* adequate facilities for recovery from anesthesia

The approval of an institution under these regulations will be valid for two years or a shorter period and may be renewed by the minister. The minister may cancel the approval of an institution:

- a. if anyone employed by the institution or the person owning or managing the institution refuses or fails to comply with or contravenes any provision of the Act or these regulations

- b. if it is not desirable that the institution should continue to be an approved institution because of a change in the above requirements

In the latter case, instead of canceling the entire approval of an institution for all termination of pregnancy procedures, the Ministry may decide to restrict approval to one or more specific medical procedures. The Ministry cannot restrict or cancel the approval of an institution without giving the institution a reasonable opportunity to be heard.

The regulations include application and certification forms. The certificate must be displayed by an approved institution in a prominent place in the institution.

In **Norway**, facilities must not only comply with certain infrastructure conditions, but must also submit proof of compliance to an administrative authority, in this case the county medical officer. The county medical officer may give approval to a nursing home or health center to perform pregnancy terminations before the 12th week of pregnancy if the institution fulfills the following conditions:

- ❑ The permanent staff of the institution must include a doctor who is a gynecological or surgical specialist or who, after having worked in a gynecological or surgical unit, can show evidence of the necessary ability to perform pregnancy termination. The staff of the institution must also include personnel with the necessary experience of administering anesthetics.
- ❑ The institution must have the necessary technical equipment, including equipment to give anesthetics and blood transfusions, and to carry out laparotomies.
- ❑ The institution must have a properly equipped recovery room where outpatients are able to remain for at least four hours after the operation (Art. 18).

To guarantee compliance with these requirements, and also to guarantee availability of abortion services, the county municipality is obligated to publish a list of hospital units and institutions that perform pregnancy terminations (Art. 19, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975).

Similarly, in **South Africa**, under the Choice on Termination of Pregnancy Act and Amendment (1996 and 2004), facilities are required to comply with specific conditions and, except in certain circumstances, must demonstrate proof of compliance to the authorities.⁶⁹ Facilities must have the following:

- ❑ access to medical and nursing staff
- ❑ access to an operating theater
- ❑ appropriate surgical equipment

⁶⁹ The text of the law does not specify what these circumstances are.

- ❑ intravenous and intramuscular injection equipment
- ❑ emergency resuscitation equipment and access to an emergency referral center or facility
- ❑ access to appropriate transport should the need arise for emergency transfer
- ❑ appropriate infection control measures
- ❑ equipment for clinical observation
- ❑ telephone communication
- ❑ equipment for observation and access to in-patient facilities
- ❑ safe waste disposal infrastructure

In addition, facilities must be approved by a member of the Executive Council with a notification published in the *Gazette*, the official government register. However, any health facility that complies with the requirements, provides 24-hour maternity services and termination of pregnancy services up to 12 weeks is not required to obtain the approval of a member of the Executive Council. The person in charge of these types of facilities, however, must notify the administrative authorities that they are offering termination of pregnancy services (Art. 3).

The regulations require all facilities to order their own manual vacuum aspiration instruments from SA Biomedical (PTY) LTD. They also indicate that manual vacuum aspiration should be performed in a private room with two people – a practitioner to carry out the procedure and an attendant to provide emotional support to the client (Art. 5, Surgical Procedure Manual Vacuum Aspiration, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

In **Italy** and **Panama**, the regulations only indicate the type of facility that may perform abortions. In the former, the Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy (1978) merely state what type of facility may perform abortions, indicating that they should be performed by physicians from the gynecology-obstetrics unit in general hospitals. However, they add that abortions may also be performed in specialized public hospitals and other health facilities. They may also be performed in nursing homes before 90 days, if the facility complies with the requirements and is authorized by the regional authority; however, the number of abortions these types of facilities may perform depends on a decree from the Ministry of Health.

The penal code in **Panama** requires therapeutic abortions to be performed in a state health center (Art. 144). Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion adds that the procedure shall be performed in a hospital in the state or health area or region where it is requested (Art. 8).

In **Peru**, both hospital protocols – the Perinatal Maternal Institute Guidelines and the Hospital Belén de Trujillo Protocol – describe their own facilities, including information about infrastructure, equipment and supplies, rather than establishing infrastructure requirements. The former protocol is more detailed.

x. Accreditation mechanisms for professionals

Only **Puerto Rico**, **Guyana** and **Mexico** regulate professional accreditation. In principle, given the accreditation requirements, it is clear that they seek to set out qualifications for health professionals and their training in the specific area of abortion. However, particularly in Puerto Rico, the requirements are not always clearly related to the goal of establishing the professional's qualifications for the actual procedure.

In **Puerto Rico**, the General Regulations for the Operation of Health Facilities (1999) states that any procedure to terminate a pregnancy via abortion must be performed by a physician who fulfills the following requirements:

- i.* license issued by the Puerto Rico Board of Medical Examiners
- ii.* recorded in the Health Professionals Registry of the Department of Health
- iii.* current state and federal narcotics license
- iv.* annual enrollment in an approved cardiopulmonary resuscitation course
- v.* current health certificate
- vi.* copy of the certificate (or diploma) of residency in obstetrics and gynecology or urology (for male sterilization)
- vii.* existence of an individual file for each physician containing the required documents
- viii.* proof of current continuing education according to the Continuing Education Rules of the Puerto Rico Board of Medical Examiners
- ix.* request for privileges approved by the medical faculty and re-evaluated every two years according to the rules in force (Art. H, Family Planning and Abortion Center)

In **Guyana**, Article 3 of the Medical Termination of Pregnancy Act – Legal Supplement B (1995) says that a registered medical practitioner shall satisfy the requirements of the Medical Council of Guyana to be recognized as a medical practitioner if he has undertaken training in gynecology and obstetrics or can demonstrate experience in one or more of the areas listed:

- a. if he has practised gynecology and obstetrics for a period of not less than three years
- b. if he has completed six months of house surgery in gynecology and obstetrics
- c. if he has had experience in obstetrics and gynecology at any hospital for a period of not less than one year

- d. if he has assisted a registered medical practitioner in performing 25 cases of termination of pregnancy in a hospital approved by the Ministry
- e. if he has completed the training provided by the minister to be qualified as an authorized medical practitioner
- f. if he holds a postgraduate degree or diploma in gynecology and obstetrics, the experience or training gained during the course of such degree or diploma

The Ministry, acting on guidelines that may be provided by the Medical Council, shall make provision for such training and supervision required in order for a medical practitioner to qualify as an authorized medical practitioner under paragraphs a, b, c, d or e (Art. 3.2 and 3). The Ministry may from time to time determine what fee is appropriate for such training. The Medical Council of Guyana has the power to determine the experience deemed appropriate for certifying a registered medical practitioner as an authorized medical practitioner. Applications for training are directed to the chief medical officer. When the training provided by the chief medical officer has been completed satisfactorily, the secretary of the Medical Council provides the doctor with certification. The Act includes application and certification forms.

In **Mexico**, the General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City (2006) establish that it is preferable for health professionals who carry out abortions to be physicians specializing in gynecology-obstetrics, which must be proved with documentation issued by an institution guaranteeing that the academic program was completed. In addition, the health professional must be affiliated with a public, private or social health facility (Art. 6). The guidelines also require different accreditation for physicians who are responsible for issuing medical reports documenting risks to the physical or psychological health of the pregnant woman or of genetic or congenital anomalies of the fetus. They need to provide proof of their specialty with documentation issued by an institution guaranteeing that the academic program was completed; in addition, the health professional must be affiliated with a public, private or social health facility (Art. 7).

Although **Colombia** does not explicitly establish an accreditation system for health professionals, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy require health professionals to be appropriately trained «both in medicine and in emotional, legal, ethical and social issues» (Art. 6).

xi. Gestational limits

In certain countries, gestational age limits are part of the specific criteria for legal abortion, linking duration of pregnancy with grounds for the termination of pregnancy.

Such limits are most common in countries where the circumstances for legal abortion are established in health regulations or technical guidelines. In **Italy, South Africa, Guyana** and **Norway**, gestational limits are part of the system of criteria for legal abortion; they are divided into three periods, and the grounds to terminate a pregnancy become more limited as the pregnancy advances.⁷⁰ By contrast, when countries use penal codes to establish the grounds for legal abortion, it is less common to find gestational limits. However, the Mexican and Spanish penal codes, which regulate the grounds for legal abortion, do establish gestational limits for the voluntary termination of pregnancy.⁷¹

Before 2007, the Mexico penal code did not set gestational limits. However, the guidelines that regulated the provision of termination of pregnancy services (General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City, 2006) stated that the duration of the pregnancy may not be more than 20 weeks (Art. 14). Changes to the penal code in Mexico City in 2007 allow abortion on demand before 12 weeks (Art. 144, Penal Code, in effect in Mexico City).

In **Peru**, the penal code does not set gestational limits on abortion. When abortion is permitted, both protocols – the Perinatal Maternal Institute Guidelines and the Hospital Belén de Trujillo Protocol – only specify procedures for the termination of pregnancy up to 21 weeks, which may be a tacit limitation on gestational age.

Finally, it is important to examine the situation in **Colombia**, which does not set gestational limits for abortion, either in the court case that decriminalized abortion in specific situations or in the regulations, although it does state that it is preferable for abortions to be performed in the first trimester.⁷² Something similar occurred in **Canada**, where a Supreme Court ruling (*R versus Morgentaler, 1988*) fully decriminalized abortion. Although the court did not mention this point explicitly, its silence must be interpreted as an intention not to impose gestational limits on abortion and to delegate this task to the legislature. For example, in their opinion, Judges Beetz and Estey stated: «The objective of protecting the fetus would not justify the severity of the breach of the pregnant woman’s right to security of the person which would result if the exculpatory provision of section 251 was completely removed from the penal code. However, a rule

⁷⁰ These examples demonstrate how systems that establish specific grounds for abortion often restrict access to services, particularly for women with more advanced pregnancies.

⁷¹ For more information, see Chapter III, Countries that establish grounds for abortion and duration of pregnancy in non-criminal laws and regulations (page 00) and Countries that penalize abortion except in special circumstances as stated in the penal code (page 00). This section only includes country information that expands on the content of Chapter III.

⁷² However, the technical regulations include a table indicating the most appropriate method according to duration of pregnancy, which goes up to a maximum of 22 weeks.

that would require a higher degree of danger to health in the latter months of pregnancy, as opposed to the early months, for an abortion to be lawful, could possibly achieve a proportionality which would be acceptable under section 1 of the Charter.»

iii. Education and training of service providers

i. Education and training in medical aspects (pain management, abortion methods, post-abortion counseling) and psychosocial aspects of abortion (gender perspective, rights and empowerment) for all health personnel (physicians, midwives, nurses and counselors)

Of the regulations reviewed, only **Italy, South Africa, Brazil** and **Colombia** had specific measures for training medical personnel. In Brazil and Colombia, training addresses medical and psychosocial aspects of abortion, including a sensitization component. In fact, in Brazil, the latter is the most important component. By contrast, in Italy, training encompasses only medical aspects of abortion and related issues. In addition, the research found that the regulations in Brazil and Italy suggest ways to implement training, while Colombia concerns itself only with the content. Italy establishes who is responsible for training and how often it should occur. South Africa specifies what courses must be offered each year and stresses that it is important for personnel to attend them.

In **Italy**, the Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy (1978) require regions, universities and hospital facilities to promote and update training for health personnel and related auxiliary personnel on issues relating to responsible family planning, contraceptive methods, stages of pregnancy, childbirth, and the use of more modern techniques of pregnancy termination that are less harmful to the woman's physical and mental health. In addition, they require regions to promote courses and meetings for health personnel and related personnel who wish to expand their understanding of sexuality education, childbirth and related topics. The regulations suggest that regions should hold an annual training and information program on regional legislation and social, health and welfare services to guarantee that training is implemented (Art. 15).

Consistent with the support model discussed earlier, **Brazil** states that professionals who provide abortion services to women must be appropriately sensitized and trained to provide true support to clients. The goal is to create a new model of care for everyday practice. The regulations suggest activities that may help sensitize health professionals, including group discussions, clinical supervision, confronting attitudes and convictions

implicit in health care, exchange of concerns, and sensitization and training workshops on sexuality and reproductive practices (3. Support and Counseling. Technical Regulations for Humane Abortion Care, 2005).

Finally, in **Colombia**, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy (2006) say that abortion services shall be provided by professionals who are appropriately trained, not just in medicine but also in emotional, legal, ethical and social aspects. To complement this training, the regulations suggest that services shall have the appropriate infrastructure, including essential equipment, supplies and medicines (6. Characteristics of Service).

In **South Africa**, the regulations strongly urge all physicians, nurses and social work personnel to attend relevant training. They add that courses should be offered annually; contact information for organizers of such courses is included (Art. 1.11.1 to 1.11.4). The following training courses are available:

- one-day values clarification workshop
- one-day pre- and post-termination of pregnancy counseling workshop
- 160-hour abortion care course for registered midwives (this includes training on techniques for manual vacuum aspiration)
- training for physicians in abortion care (Art. 1.11)

An important point, addressed only by South Africa, is the requirement for the manager of services to ensure that adequate support is provided for staff involved in the termination of pregnancy and that confidential access to professional counseling is available to personnel who need it (Art. 1.16, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

ii. Ongoing training at health facilities

Colombia is the only country with specific regulations on this issue. Resolution 4905 of 2006, which enacted the technical abortion regulations, requires managers and health facilities to provide ongoing information, training and education for health professionals in order to ensure adequate provision of abortion services (Art. 8).

iii. Emotional support for women and respect for their decisions

Colombia, South Africa, Brazil and **Canada** have regulations on this issue. In **Brazil**, emotional support to clients, and respect for their decisions, form an integral part of the support system. Specific measures to ensure compliance include a number of obligations for the health team: respecting and believing what the woman says, helping her to

express her feelings and life experiences, encouraging confidence, offering solutions to the problems the woman may encounter, while prioritizing her well-being and comfort. Mental health and social services professionals are also involved in this process; their obligations include providing immediate emotional support and offering subsequent support as necessary; reinforcing the woman's importance; respecting her emotional state; adopting an understanding attitude that seeks to encourage self-esteem; investigating the reactions of the social group she belongs to; asking about her relationship with her partner and possible repercussions; and talking about the pregnancy, unsafe abortion, menstruation, sexual rights and reproductive health (3. Protection and Counseling, Technical Regulations for Humane Abortion Care, 2005).

The **Colombian** regulations simply establish the obligation to respect the client's decision to continue a pregnancy even if she has grounds for a legal abortion (6.2. Admission of Pregnant Women, Technical Regulations on Care for the Voluntary Interruption of Pregnancy).

In **Canada**, the Supreme Court case [*Tremblay versus Daigle \(1989\)*](#) showed that the decision to end a pregnancy belongs exclusively to the woman. In this case, a man ended a relationship when his partner was two months' pregnant. She decided she wanted an abortion, and he filed an injunction to stop her. A lower court ordered the woman to continue the pregnancy. The case went to the Supreme Court, which decided unanimously to grant her appeal. The most important arguments were that (i) a fetus is not recognized as a juridical person under the Civil Code of Canada; and (ii) there is nothing in the Quebec legislation or case law to support the argument that the father's interest in a fetus gives him the right to veto a woman's decisions about the fetus she is carrying.

South Africa simply establishes that the woman's decision must be respected and supported without judgement (Art. 2, Guidelines for Pre-Termination of Pregnancy Counselling, Department of Health: Western Cape, Circular H97/2000).

In addition, it is important to note that in some cases information provided to individual women may be specifically intended to encourage autonomous decision making. As a result, the measures in this section should be considered in conjunction with the measures on the provision of information.

iv. Eliminating harmful customary practices

The review did not find any regulations that included measures specifically intended to eliminate harmful customary practices, such as requiring a partner's consent or addressing social and moral sanctions against abortion. The closest measure found that could be interpreted as an effort to account for cultural consideration was in the Technical Regulations on Care for the Voluntary Interruption of Pregnancy in **Colombia**, which state

that the following services should not constitute additional restrictions to timely access to abortion services: management of abortion complications and access to other services such as pre- and post-abortion counseling, family planning counseling, access to effective methods of contraception, prevention of sexually transmitted infections, HIV/AIDS, sexual and reproductive rights and, generally, all actions that aim to increase self-care.

However, many of the measures studied for this analysis may be regarded as actions to eliminate customary practices and barriers, such as prohibitions against requesting the consent of third parties (see page 66), prohibitions against labor discrimination (see page 123) and prohibitions against judging women (see page 49).

v. The role of health sciences faculties

Only **Colombia** has a measure related to this issue. According to Resolution 4905 of 2006, which enacted the technical abortion regulations, institutions of higher education have the power to cover the technical, ethical and legal aspects of providing abortion services within their undergraduate and postgraduate programs (Art. 8).

In addition to highlighting the lack of information about this criterion in existing regulations, it is important to note that in Colombia, the only country that does address the issue, its inclusion in educational programs within academia is optional, not mandatory.⁷³

vi. Creating a multi-disciplinary team to manage unwanted pregnancies

The penal code of **Panama** (Art. 144) may be the only provision that requires the creation of a multi-disciplinary commission. The role of the commission is to authorize therapeutic abortions on the grounds of serious health problems that endanger the life of the woman or of the fetus. Ministry of Health Resolution No. 02007 of 2 August 1988 names the members of the commission.⁷⁴

The commission reserves the right – when necessary – to request the assistance of other health professionals such as infectious disease specialists or psychiatrists who are members of the technical or medical staff at Hospital Santo Tomás. The commission sets its own terms of reference.

⁷³ Other countries may address this issue, but within laws or regulations unrelated to abortion.

⁷⁴ The head of the Ministry of Health's Maternal Infant Program, who coordinates the commission; the head of the Obstetrics and Gynecology Unit at Hospital Santo Tomás; the head of Obstetrics Services at Hospital Santo Tomás; the head of Emergency and Admission Services of the Obstetrics and Gynecology Unit at Hospital Santo Tomás; the head of the Obstetrics and Gynecology Unit at the Hospital Metropolitano Complex of the Social Security Agency (*Caja de Seguro Social*); and a lawyer from the Ministry of Health's Legal Consultancy Department.

The situation in **Norway** is somewhat similar; the medical officer nominates a third member to join the board that considers abortion appeals. The regulation prohibits this person from being a doctor. Instead, the person shall be a trained welfare officer or health visitor with social work experience (Art. 22).

By contrast, **Brazil** requires a multi-disciplinary team to be set up, but not to manage unwanted pregnancies. Its stated purpose is to provide support and humanized abortion-related care: the team includes a social worker, psychologist and nurse (3. Support and Counseling. Technical Regulations for Humane Abortion Care, 2005).

iv. Data collection, monitoring and oversight systems

i. Data management systems, including reporting complications and infections (epidemiological monitoring system)⁷⁵

Only **Colombia, Guyana, Mexico, Norway, South Africa** and **Spain** addressed this criterion. In these six countries, the person who performs the procedure is required to collect information. In Colombia, Guyana and South Africa, this data includes general information about the procedure. Colombia explicitly requires providers to report information about complications. In Norway, the information recorded is more specifically about the procedure. In Colombia and Spain, data is sent to a statistical database, while in Norway and South Africa, it is simply reported to a superior.

In **Colombia**, Resolution 4905 of 2006, which enacted the technical abortion regulations, requires information relating to abortion to be included in national data management systems. This means that this information must be coordinated with the Ministry of Social Welfare's⁷⁶ integrated health information system, and must be reported by all public and private institutions. In addition, all abortion procedures must be reported to the Individual Health Services Delivery Registry (*Registro Individual de Prestación de Servicios de Salud, RIPS*), in accordance with statistics requirements laid down by the Ministry of Social Welfare. Public health monitoring of abortion must be performed in accordance with the specific instruments defined by the Public Health Monitoring System (*Sistema de Vigilancia en Salud Pública, SIVIGILA*). Finally, the resolution specifically requires reporting of abortion-related complications in order to monitor the quality of services and women's real access to abortion services (Art. 6).

⁷⁵ Data management systems described in abortion laws and regulations are examined below. Some countries may have general laws or regulations on this topic that are outside the scope of this project.

⁷⁶ Equivalent to the Ministry of Health.

External Circular 0031 of 22 May 2007, regarding information on the provision of safe abortion services, as decriminalized by law, added to the above provisions. Based on the information in individual data collection systems, it states that Departmental and District Health Offices and Health Promotion Entities shall conduct an analysis and submit a quarterly report that includes: (1) a quarterly summary divided by diagnosis; (2) a summary of the cases in which contraception counseling was provided; and (3) a summary of complications. The first two must indicate age group, town and type of affiliation (contributory/subsidized/exceptions)⁷⁷ or lack of affiliation to the General System for Healthcare Social Security.

In **Spain**, the [Order of 16 June 1986 \(Information and Statistics \(*Información y estadística*\)\)](#) establishes that all terminations of pregnancy must be reported to the health authority which, in turn, must send the information to the Public Health General Office (*Dirección General de Salud Pública*) (Art. 1). Monitoring shall be carried out using an epidemiological monitoring system that collects data nationwide.⁷⁸ This office provides information by province to local authorities every quarter (Art. 5). The website of the Ministry of Public Health and Consumer Affairs indicates that «Annually, the Public Health General Office, once the collected data has been compared, tabulated and analyzed, creates an annual publication with nationwide statistical information and makes available to the health authorities of each official region information about abortion services provided to women residing in their region who had the procedure outside said region.» The data collection form has been modified to include family, socio-economic and work data about the client, reason for the procedure and procedure used.

The Order of 16 July 1986 also states that health authorities must maintain confidentiality of information and ensure that it is not published in any way that might identify individuals. In addition, the resolution requires information about individual clients to be destroyed after it has been used for statistical purposes (Art. 3, [Resolution of 4 February 2000](#), of the Office of the Undersecretary, on statistics and epidemiological information about voluntary terminations of pregnancy performed in accordance with Organic Law 9/1985, of 5 July).

In **Mexico**, the General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City requires files to be created in accordance with NOM-168-SSA-1998 of Clinical Files (*Expediente Clínico*), including the

⁷⁷ Exceptions refer to armed forces personnel, as well as some public sector employees. In effect, they are covered by their own health plans and are not entitled to file claims under the national subsidized health system.

⁷⁸ Ministerio de Sanidad y Consumo: www.msc.es/profesionales/saludPublica/prevPromocion/embarazo/home.htm#datos

following documents: original medical record, medical notes for urgent care, admission form, discharge form, request for and record of surgery, social work investigation, record of services for violence and injuries, referral and counter-referral form, informed consent form for a legal termination of pregnancy, medical reports, authorization for a termination of pregnancy on the grounds of rape issued by an official of the Public Prosecutor's Office Aid to Victims System, as well as the results of diagnostic tests administered to the client, the request for surgery application, and record of the procedure and treatment. The clinical file provides a record of abortion clients (Art. 19).

Norway uses two types of records. The first is a detailed record that provides follow-up to the administrative procedure of each request for an abortion; these records must be sent to the county medical official and to the doctor who was approached by the woman. They must be made available for the Director-General of Health, who may request them at any time. This first set of records is used as a basis for a second set of records, which are more statistical in nature.

The boards and the hospitals or institutions where pregnancy terminations are performed keep separate case records. When a case is considered by the board, the decision is entered in the record, which is dated and signed by the members.⁷⁹

Finally, the law requires records and documents to be kept locked up at the hospital for at least 10 years. An extract of the record is sent to the county medical officer and to the doctor who was approached by the woman. The Director-General of Health Services may request the record at any time (Art. 25).

In addition, the law states that at the end of each quarter, every facility authorized to perform abortions shall submit a report to the county medical officer based on the second set of records. The report shall include specified data from the records, as well as details about individual operations. The county medical officer submits quarterly reports to the Directorate of the Health Services covering the following:

⁷⁹ The following information should be recorded: name of hospital/institution; case number; the date on which the hospital/board received the application; the name and date of birth of the patient; civil status; the number of previous births, and the number of children now living; the number of previous pregnancy terminations and the number that were induced; presumed duration of the pregnancy; the name of the doctor who forwarded the application; the person who submitted the application; whether it was necessary to obtain the consent of the county medical officer; whether or not the operation was performed; and the reason why the operation was not performed if this is the case. When an application is approved by the Primary Board, the record should include the grounds for approval. When an application is rejected by the Primary Board, it should include the grounds for rejection, whether the rejection was unanimous and the grounds of the minority. If it is approved by the Appeals Board, it should include the grounds for approval and the reasons for the point of view of the minority if the decision was not unanimous. If it is rejected by the Appeals Board, it should include the grounds for rejection; whether the decision was unanimous; and the grounds for the minority point of view if the decision was not unanimous.

- information received based on the above
- the number of appeals received and forwarded
- the number of approved cases
- the number of rejections

(Art. 26, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975).

South Africa also establishes the obligation of any medical practitioner, registered midwife or nurse who terminates a pregnancy to record the information and inform the person in charge of the health facility, who shall be notified of every termination of a pregnancy carried out in that facility. Within one month of the termination of a pregnancy, the person in charge of the facility shall send, by registered mail, information about requests for and abortion procedures performed – omitting the name of the woman – to the Department of Health, which will maintain a record of this information. The law states that the woman’s identity shall remain confidential (Art. 7, Choice on Termination Act and Amendment, 1996 and 2004). The regulations state that except for the anonymous copy of the Notification form (Annexure A), the records should be kept in the usual manner in the client’s file (Art. 1.8, Policy on the Management of Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

In **Guyana**, the law states that a record of every termination of pregnancy shall be kept at the facility where the treatment was administered by the medical practitioner, authorized medical practitioner or person managing an approved institution. The record shall include the name, address, treatment, reasons for the termination and any other relevant data (Art. 14). The purpose of such information is not specified. However, the law has a further provision that is binding on all medical practitioners, authorized medical practitioners, the person owning or managing an approved institution or person employed by, or working in, and anyone else with lawful access to the information. The law states that there is no provision to prevent any of these personnel from disclosing any information, document or matter related to the record; nor are they entitled to refuse to disclose, for the purposes of discharging their functions or when lawfully required by any court or by any person having authority to do so under any law or for any legal proceeding in respect of the contravention of any provision of this Act (Art. 14, Medical Termination of Pregnancy Act, 1995).

ii. Monitoring and oversight systems of facilities that provide services

The research found provisions on this topic in **Colombia, Guyana, Spain** and **Italy**. However, there are few similarities among the countries. Colombia requires monitoring and oversight, and Spain requires inspection and oversight. In Italy, by contrast, the

system seems to be a form of political oversight. All three establish who is responsible for oversight. Only Colombia clarifies that specific criteria for monitoring shall be established, although it does not state what the criteria are. Guyana, rather than subjecting facilities to an oversight system, empowers a health system official to visit facilities to verify that they are in compliance with the provisions of the Act that regulate access to abortion services.

In **Colombia**, according to Resolution 4905 of 2006, which enacted the technical abortion regulations, the authority to monitor health belongs to the head of the Ministry of Social Welfare, and the regions within their respective jurisdictions. In addition, monitoring and oversight authorities have the power to issue sanctions for failure to comply with the provisions of the decree (Art. 7, Regulatory Decree 4444 of 2006).⁸⁰

In **Spain**, the law simply requires centers and facilities to submit to inspection and oversight by appropriate health administrations (Art. 3, Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions, 1986).

In **Guyana**, the chief medical officer⁸¹ or any public officer authorized by him in writing may at all reasonable times enter any premises where a medical practitioner administers or supervises terminations of pregnancy, or is reasonably suspected of doing so, or any approved institution, to ascertain whether there has been any contravention of, or failure to comply with, any provision of the Act. The above shall be without prejudice to the powers of the police force that is conducting an investigation. These provisions do not include the power to obstruct any abortion procedures (Art. 15, Medical Termination of Pregnancy Act, 1995). Article 6 of the Medical Termination of Pregnancy Act – Legal Supplement B (1995) sets out additional monitoring measures specifically to ensure implementation of the Act. The Minister of Health shall appoint an Advisory Board to monitor conduct under the Act and its regulations and to advise the minister on securing its effective operation.

The Advisory Board shall be broad-based and balanced, consisting of not more than nine members chosen from non-governmental organizations, such as religious, legal and medical organizations. The board shall assess how the Act and its regulations are working and, from time to time, make recommendations to the minister that may be appropriate to achieve the purposes of the Act, namely:

- a. to reduce the incidence of medical terminations of pregnancies
- b. to reduce the incidence of septic abortions
- c. to improve the standard of maternal health

⁸⁰ More information about sanctions can be found in the section on Administrative issues, sanctions for denying services (see page 124).

⁸¹ From the context, it is understood that this is an administrative authority for the health sector.

The Advisory Board may request data and encourage research as it deems appropriate for assessing the impact of the Act and its regulations.

Finally, **Italy** establishes a form of political oversight of the implementation of abortion provisions. The law requires that before February of each year, the Ministry of Health shall present to parliament a report on the implementation of the law, including prevention. The regions are requested to submit supplementary information to the report. The Department of the Interior presents the report as it relates to its jurisdiction (Art. 16, Regulations on the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

iii. Appeal or review mechanisms when services are denied

Explicit appeal processes for decisions that deny abortion services exist only in Norway, which has a highly detailed description of the procedure and, in Peru, in the Perinatal Maternal Institute Guidelines.

In **Norway**, according to Act No. 50 concerning Termination of Pregnancy (1975), with amendments (1978), when a woman's application is rejected by the board, the woman or her representative must be informed that the decision will be examined by another board unless she withdraws the application within three days after she has been notified of the rejection. In other words, the appeal process is automatic, and the woman chooses whether to halt its action. For this reason, once it has made its decision, the board forwards the documents to the county medical officer who, in consultation with the woman, submits the case to another board for re-examination, unless the woman has withdrawn her application within the time limit stipulated above. In appeal cases, the board includes a third person who is not a doctor, appointed by the county medical officer. The decisions of the board are reached by a simple majority (Art. 8). This procedure is reiterated in the regulations.⁸²

In **Peru**, if the hospital authority does not process the request or exceeds the time limit, or if the medical board has denied a woman's request, she may appeal to the appropriate higher authority, which will respond within 48 hours (VI Specific Provisions, Administrative Requirements (*Requisitos administrativos*) Perinatal Maternal Institute Guidelines, 2007).

iv. Prohibition against employment or social discrimination against abortion providers

Only **Colombia** prohibits discriminatory practices related to abortion in Regulatory Decree 4444 of 2006: «In no case shall conscientious objection, not invoking conscientious

⁸² Art. 13 and 14, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975.

objection or having performed a voluntary termination of pregnancy under the terms of the decree constitute a circumstance for discrimination for the pregnant woman, health professionals or health facilities» (Art. 5).

Along similar lines, the regulations in **Brazil** require health professionals to act in a non-judgemental manner when responding to cases of unsafe abortion.

v. Sanctions for denying services

In general, all the countries, and specifically **Colombia, Mexico, Guyana, Peru** and **Norway**, have developed a broad formula for sanctions for failure to comply with the provisions of law that regulate access to abortion. Only **Brazil** explicitly spells out sanctions for refusing to provide services. **South Africa** sanctions any person who avoids performing a legal abortion. South Africa, Guyana and Norway also sanction violations of confidentiality; and Colombia sanctions the imposition of administrative barriers that delay access to abortion. Only Colombia specifies who may initiate investigations into failures to comply with the law. No country clarifies in its regulations which authority has the power to impose sanctions. Some countries refer to other legal provisions about what sanctions to impose (Colombia and Mexico), order fines (Norway, Guyana and South Africa) or prison (Norway, Guyana and South Africa). Other countries simply establish the type of liability, which may be administrative (Peru), civil (Brazil) or eventually criminal or disciplinary (Colombia, Peru and Brazil). The general rule is individual liability, except in Colombia, Peru and Brazil, which hold institutions liable, although only public hospitals.

Colombia uses a general formula to sanction failure to comply with any of the provisions of the decree. Sanctions are those established in the Obligatory System for Quality Assurance⁸³ and in Article 49 of Law 10 of 1990 and Law 100 of 1993.⁸⁴ The regulations state that a procedure leading to the imposition of sanctions may be initiated *sua sponte* (of one's own accord), at the request of an interested party, by information held by a public official, by a report or complaint presented by any person, or as a result of having taken a security or preventative measure in advance. It also requires notice of such proceedings to be sent to other authorities when the facts constitute a crime or disciplinary infraction

⁸³ The sanctions established by these regulations include warnings; successive fines up to a sum equivalent to 10,000 times the daily minimum wage up to the maximum value established at the time the resolution was issued; seizure of products; suspension or cancellation of registry or license; and temporary or permanent closure of the establishment, building or facility.

⁸⁴ The sanctions established by these regulations include fines up to 200 times the monthly legal minimum wage; intervention in the administrative and/or technical management of the facilities that provide health services for up to six months; suspension or revocation of the legal status of individuals who provide health services; and suspension or revocation of authorization to provide health services.

(Art. 7). The regulations specifically require the imposition of sanctions on managers or health facilities that impose administrative barriers that unnecessarily delay the provision of abortion services (Art. 2, Regulatory Decree 4444 of 2006).

The **Mexican** regulations also use the general formula that failure to comply with the provisions of the guidelines results in sanctions set out in the applicable Mexico City legal instruments (Art. 22, General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City).

Act No. 50 concerning Termination of Pregnancy (1975), with Amendments (1978) in **Norway**, using the same formula, establishes fines or imprisonment for failure to comply with the law, violating observance of professional secrecy and for false information in decision making about an application for the termination of pregnancy (Art. 13).

In **Peru**, the Perinatal Maternal Institute Guidelines (2007) say that failure to comply with its provisions results in administrative liability⁸⁵ for the health professional and general personnel of the National Perinatal Maternal Institute, without prejudice about the legal liability that applies (VIII Final Provisions (*Disposiciones finales*)).

By contrast, **Brazil** clearly states that physicians who refuse to provide abortion services in the circumstances allowed by law may be held liable on civil and criminal grounds for the death of the woman or for the physical or mental harm that she experiences. The regulations also state that if the woman experiences physical, psychological or emotional damage due to negligence on the part of the professionals who provide abortion services, public hospitals and their staff may be held liable individually and institutionally (5. Professional Ethics, Technical Regulations for Humane Abortion Care, 2005).

In **Guyana**, liability is broad and penalties include both fines and imprisonment: (i) when any person for any approved institution refuses to maintain the records or documents required by the law or maintains such a record but it is incomplete or contains any statement which is false, that person or, for an approved institution, the person owning or managing the institution shall be liable to a fine of \$20,000 and imprisonment for six months; (ii) where any statement made by a pregnant woman is intentionally false or misleading, the pregnant woman shall be liable to a fine of \$7,000 and imprisonment for six months; (iii) where any medical practitioner, authorized medical practitioner, or person employed by an approved institution or any other person with lawful access to an approved institution

⁸⁵ The state incurs administrative liability due to the actions of its employees and officials. In this case, the state may be liable for the actions of members of the Perinatal Maternal Institute since they are state employees employed by a public health facility. In most cases, economic indemnification is imposed for administrative liability, although currently there is a trend towards full compensation.

contravenes the rules governing confidentiality of information that person or the person owning or managing the approved institution shall be liable to a fine of \$100,000 and imprisonment for one year; and (iv) any person who contravenes or refuses or fails to comply with any provision of this Act shall be liable to a fine of \$10,000 and imprisonment for three months (Art. 12, Medical Termination of Pregnancy Act, 1995). The law also states that «no medical practitioner or authorized medical practitioner or person authorized by him shall in any way be liable for the carrying out of, or the supervision of treatment to terminate a pregnancy where the pregnant woman has consented to such treatment, unless it was carried out in a negligent manner» (Art. 9).

Finally, the law in **South Africa** states that anyone who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years (Art. 10.c). It also sets out penalties for anyone who does not comply with confidentiality requirements (Art. 10.2, Choice on Termination Act and Amendment, 1996 and 2004).

vi. Management of medical records

Only **Colombia, Peru, Mexico** and **Spain** address the management of medical records. In Colombia and Peru, information that is recorded in the medical record is related to the pregnancy and the abortion procedure, although Colombia is much more detailed about the information required. By contrast, in Mexico, only information relating to the administrative procedure necessary for the abortion should be included. In reality, Spain does not have any specific rules about abortion, but the General Informed Consent Act includes a chapter on general rules for processing medical records.

In **Colombia**, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy regulate in detail the information that must be requested from clients for inclusion in the medical record. Because many women begin to suspect a pregnancy after a delay in menstruation, women should be asked about the first day of their last menstruation – in other words, the first day of bleeding – and if the menstruation was normal.⁸⁶

⁸⁶ It must also include: identification: name, identity document, age, race, socio-economic level, education, civil status, occupation, insurance affiliation, origin (urban, rural), address and telephone number. Personal history: pathologies, surgeries, nutritional information, traumas, allergies (medications given), tobacco use, alcohol use, psychoactive substances, exposure to toxins or radiation, other information. Diseases, complications and treatments during the current pregnancy. Obstetric history: pregnancies: number of pregnancies, time between pregnancies, abortions, ectopic pregnancies, molar pregnancies. Births: number of births, date of last birth. Gynecological history: age of menarche, menstrual cycle pattern, dates of the last two menstrual periods, contraceptive method use and dates of use, history of or current vaginal discharge, sexually transmitted infections and HIV/AIDS, history and treatment of infertility. Family history: chronic hypertension, pre-eclampsia, eclampsia, heart disease, diabetes, metabolic

In **Peru**, the Perinatal Maternal Institute Guidelines (2007) require that a complete medical record be kept,⁸⁷ as does the Hospital Belén de Trujillo Protocol. The medical record should include the first day of the last normal menstruation and whether menstruation is regular or irregular. In addition, it should identify other symptoms, such as breast tenderness, nausea, vomiting, fatigue, change in appetite, frequent urination and pelvic pain.

The General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in **Mexico** City (2006) require that medical records for abortion clients are kept in accordance with the general rules. However, they should include additional information related to the administrative procedure for accessing abortion: informed consent form to authorize a termination of pregnancy on the grounds of rape or non-consensual artificial insemination issued by an official of the Public Prosecutor's Office Aid to Victims System, as well as the results of diagnostic tests administered to the client, the request for surgery application, and record for the procedure and treatment (Art. 19). The guidelines explicitly add that medical records must be managed with absolute confidentiality and that personal information is protected under the fundamental rights to privacy, honor and dignity (Art. 20).

The medical personnel responsible for the procedure are required to include the following in the client's medical record (Art. 8):

- consent for the procedure
- report on the duration of the pregnancy (up to 12 weeks)
- report on the duration of the pregnancy and congenital abnormalities for abortions decriminalized by law (after 12 weeks)
- authorization by an official of the Public Prosecutor's Office if sexual violence or non-consensual artificial insemination are a factor

history, autoimmune system, infections, congenital disorders, epilepsy, mental disorders, multiple pregnancies, tuberculosis, tumors, other. Current pregnancy: probable duration of pregnancy (date of last period, size of uterus and/or ultrasound). Persistent migraines, progressive edema. Symptoms of infections: urinary or cervical-vaginal. Evaluation of psycho-social condition: emotional tension, mood, neurovegetative signs or symptoms, familial support and support from the partner. Other reasons for the examination: initiation and progress of symptoms, previous examinations, treatment received and current status (6.4.4. Anamnesis (*Anamnesis*)). Risk factors for abortion: bleeding disorders, allergies to any medications used during the abortion and information about any medications the woman is currently taking and how they may interact with medications used during the procedure (6.4.2. Pre-existing Conditions (*Condiciones preexistentes*)).

- ⁸⁷ The medical record should at least include the first day of the last normal menstruation; regularity or irregularity of the menstrual cycle; an evaluation of personal, obstetric, surgical and pathology records relevant to the procedure; and the identification of other symptoms: breast tenderness, nausea, vomiting, fatigue, change in appetite, frequent urination and pelvic pain (VI Specific Provisions, Anamnesis (*Anamnesis*)).

Spain does not have any specific regulations on the information that should be included in the medical record. The General Informed Consent Act (2002) specifies the general rules for medical records. The law basically stipulates that the medical record should incorporate all information necessary for a truthful and up-to-date understanding of the patient's health status. This is considered a patient's right with the purpose of facilitating necessary health care⁸⁸ (Art. 15).

South Africa does not have specific regulations in this area, but it does indicate that the medical record should be complete (Art. 2, Protocol for Termination of Pregnancy Services, Department of Health: Western Cape, Circular H97/2000).

v. Funding of services

i. *Service costs: payment*

In general, the regulations do not address the issue of service costs. The inclusion or exclusion of these services from different types of insurance programs provides some indirect information, but it is not sufficient to clarify the source of funding for abortion services. However, some countries have explicit measures according to two different models. Some countries, such as **Mexico**, establish that public sector services are free, while others, such as **Colombia**, establish cost structures that also involve the private sector.

In **Mexico**, the Mexico City Health Act, amended in 2004, requires public health facilities to provide quality abortion services free at the woman's request (Art. 16 bis). In **Colombia**, Regulatory Decree 4444 of 2006 states that abortion services must be available to all women, regardless of their ability to pay or affiliation in the health system (Art. 1); and establishes that services for poor women shall be provided by public facilities (or private facilities with existing contracts) without charge. Subsequently, [Agreement 350 of the National Council on Social Security in Health](#) included the procedure «uterine evacuation by aspiration to terminate a pregnancy» for legal abortion in the Compulsory Health Plan of both the contributory and subsidized insurance programs. As a result, the Colombian health system establishes that for women who belong to the contributory

⁸⁸ Minimum requirements: a) documentation relevant to the clinical statistical form; b) authorization for admittance; c) emergency report; d) anamnesis and physical examination; e) progress; f) medical orders; g) referral/information form; h) additional examinations reports; i) informed consent form; j) anesthesia report; k) report from the operating room or birth registry; l) morbid anatomy report ; m) nursing care progress and plan; n) therapeutic nursing administered; o) vital signs chart; and p) clinical discharge report.

insurance program⁸⁹ services may be subject to a co-payment if the woman who requires the service does not contribute directly to the plan but is the beneficiary of another person. In this case, the payment that the client must make depends on the amount that the affiliated person contributes to the system. However, given the legal changes regarding abortion in Colombia, it is possible that abortion services may be integrated within maternal-infant preventative care programs which, according to the general rules, are exempt from payment. Added to this, the regulations specifically clarify that neither sliding scale fees nor co-payments may become a barrier to access to services; nor may they be used to discriminate, given the risk of illness and death. Medications and paraclinical examinations may be subject to sliding scale fees.

In **Canada**, case law has defined some rules regarding the cost of abortion services. In the case [*Civil Liberties Association versus British Columbia \(1988\)*](#), the Supreme Court of British Columbia ruled on a case filed by the British Columbia Civil Liberties Association against a regulation issued by the Lieutenant–Governor in Council of British Columbia that held that abortion was not ‘medically required’. A previous regulation indicated that services that were not considered ‘medically required’ could not be insured; as a result, abortion services could not be insured. The court ruled that it was inconsistent with the statute for political bodies to decide whether abortion services are ‘medically required’ and that such decisions should be determined by medical professionals. The court’s decision was based on the reasoning that a political body did not have the authority to decide a medical question about whether abortion services were necessary.

More recently, the Prince Edward Island Supreme Court reviewed a case filed by Morgentaler against a regulation issued by the Health and Community Services Agency. Although it included abortion among basic health services, it did so under the condition that the procedure was performed in a hospital when the Agency determines that the services are medically required. This case law is important because services deemed to be basic health services were paid for with public funds. As a result, non-medically necessary abortion services were defunded and women were required to pay. The Supreme Court found that limiting publicly funded abortions to those that are performed in a hospital because they are medically necessary violates the law because the regulation is designed to indirectly prevent legal abortions. The court found the regulation to be ‘unauthorized’ because it did not have any discernible authorized purpose – in other words, it was inconsistent with the purposes of the parent legislation – and created a barrier to women accessing abortion ([*Morgentaler versus Prince Edward Island, 1995*](#)).

89 Women who are not classified as poor pay into the health care system to some extent or are beneficiaries of someone who contributes to the system.

Finally, in **Brazil** (Technical Regulations for the Prevention and Treatment of Injuries Resulting from Sexual Violence against Women and Adolescents, 1998), manual vacuum aspiration procedures are financed by the Unified Health System and admission for legal abortion services is assigned a specific code.⁹⁰

Bolivia, Panama, Puerto Rico, Peru, Italy, Guyana, Norway, Spain, Brazil and South Africa do not have any provisions relating to service costs.

ii. Instruments to identify the socio-economic situation of different populations

No countries had provisions regarding specific instruments or mechanisms to identify the socio-economic situation of different populations specifically for abortion services.⁹¹ However, in **Colombia**, the laws regulating the General System for Healthcare Social Security contain a mechanism, SISBEN,⁹² to identify the socio-economic situation of different populations. This is a survey that analyzes different factors of socio-economic well-being in order to classify the population and identify the poorest sectors; it prioritizes their inclusion in the health system through subsidies or the provision of free health care via the network of public hospitals. Classifications in this system are applied to all services that are provided to the public.

vi. Administrative issues

i. Requirements for accessing abortion services

This may be the most regulated criterion. Of the countries reviewed, only **Puerto Rico** and **Brazil**⁹³ do not include requirements for accessing abortion services in their regulations. Most requirements refer to administrative procedures to access abortion services. Within this broad range of information, it is possible to identify some commonalities among the countries as well as a few unique requirements:

⁹⁰ Ministério da Saúde – [Portaria nº 48 de 13 de Agosto de 2001](#) (Inclusão para reembolso pelo SUS). Ministry of Health – Ordinance No. 48 of 13 August 2001 (Included for reimbursement by SUS).

⁹¹ The research did not find specific provisions in abortion regulations. In some countries, this topic may be included in general or specific laws or regulations on other topics. This limitation is due to the scope of the project. To facilitate access to information, the research team was only able to include more general laws that affect abortion in a few cases.

⁹² Sistema de Identificación de Beneficiarios.

⁹³ The 1998 regulation required women to sign a document stating that she had been raped and attesting to the truthfulness of the statement. It also required a police report.

- a. All countries that establish grounds for abortion in criminal law also establish in the same law some requirements for accessing abortion services associated with those grounds (**Peru, Mexico, Panama** and **Bolivia**).
- b. In countries that have decriminalized abortion, and where grounds for abortion are related to gestational age, requirements for accessing services are determined by the duration of pregnancy (**Norway, South Africa, Guyana** and **Italy**).
- c. Norway has the most detailed procedure, which constitutes the greater part of the body of the regulations. In contrast, South Africa barely establishes requirements.
- d. The most common requirements include:
 - In cases of rape, a police report must be filed. (**Panama, Mexico, Spain, Colombia** and **Bolivia**. **Guyana** requires a statement.)
 - Review of cases by a medical board to verify if the case fulfills the grounds for risks to the health or life of the woman, or fetal malformations. (**Panama**, by a multi-disciplinary board; **Norway**, after 12 weeks and there is an appeal mechanism, that includes a non-medical professional on the board.)
 - Opinion of a physician or a medical board. (**Mexico**, the opinion of two physicians specializing in fetal malformations, and of one, if the risk is to the woman's life; **Spain**, in cases of risk to the mother's life or physical or psychological health; **Colombia**, medical certification is required for risk to the life or health of the woman and fetal malformations. **Italy, South Africa** and **Guyana**, depending on the duration of the pregnancy, certification by one, two or three physicians.)
 - An administrative procedure initiated at the woman's request (**Peru, Norway** and **Italy**).
 - Authorization by a non-medical administrative authority. (**Mexico**, in cases of sexual violence.)
- e. The most unusual requirements include the following:
 - **Spain** requires a medical report from an approved institution with specialized systems to identify malformations for abortions in cases of fetal malformation.
 - **Italy** requires a waiting period of seven days for the woman to reflect before the order becomes effective.
 - In **Colombia**, the requirements to access legal abortion services are stated in a Constitutional Court ruling. The regulations literally reiterate them and prohibit insurers or facilities from imposing new requirements.

Peru is among the countries that define grounds for abortion and related requirements within the penal code. The law requires abortions to be performed by a physician with the consent of the pregnant woman or of her legal representative (Art. 119). However, the Perinatal Maternal Institute Guidelines (2007) also establish requirements for accessing abortion services within that facility. The guidelines specify a procedure beginning with

the provision of information to the woman up to the authorization for the procedure from a medical board.⁹⁴ The Hospital Belén de Trujillo Protocol establishes a similar procedure, but the steps are slightly less complicated.⁹⁵

Panama is also one of the countries that establishes requirements to access abortion services in the penal code; it requires that in cases of rape the crime is reported to the appropriate authority and that the abortion is performed within the first two months of pregnancy. When grave health conditions put the life of the mother or of the fetus at risk, a multi-disciplinary commission appointed by the Ministry of Health determines the grave health risks and authorizes the abortion. In both cases, the abortion must be performed by a physician in a state health center with the woman's consent (Art. 144). In effect, Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion establishes that for abortions for reasons of grave health

94 The procedure includes the following steps: 1. The attending physician informs the pregnant woman about the diagnostic tests and the risk to her life or physical and mental health. 2. The pregnant woman or her legal representative, if she is unable to do so, submits the Request for Therapeutic Abortion Care (Appendix 1) to the attending physician, who forwards it to the chief of Obstetrics or Gynecology-Obstetrics Services or Unit. 3. The pregnant woman or her legal representative, if she is unable to do so, submits the Informed Consent Form (Appendix 2) for a therapeutic abortion. 4. The request and the consent form submitted by the pregnant woman or her legal representative, as appropriate, shall, from this moment, be a part of the medical record and must include the signature and National Identity Document number; if the woman is illiterate and/or undocumented, her fingerprint is sufficient. 5. The chief receives the request and creates a Medical Board; the physician who evaluated the case shall present it to the board. 6. The Medical Board – consisting of three medical professionals – may request the advice of another professional(s) with an appropriate specialization, considers the case – if necessary the medical record may be expanded or the woman re-examined – issues a report on the legal basis or lack thereof of the request, which must be noted in writing in the medical record, and informs the chief of their conclusions. 7. If there are grounds supporting the request, the chief immediately designates a physician to perform the procedure, which shall be scheduled as soon as possible. 8. The time period from the date of the request to the date of the therapeutic abortion must not exceed 10 calendar days. 9. Once the procedure has been performed, the chief shall inform the facility's administration. 10. If the chief does not process the request or exceeds the time limit or if the medical board has denied her request, the pregnant woman may appeal to the appropriate higher authority, which shall respond within a period no greater than 48 hours (VI Specific Provisions, Administrative Requirements).

95 1. After receiving the physician's report on the medical status of the pregnant woman, the procedure is initiated by the woman's request, which must include her reasons for the request for an abortion, to the chief of the Gynecological-Obstetric Unit. 2. The chief of the Gynecological-Obstetric Unit should immediately begin processing the request and create a Medical Board; the physician who initially evaluated the case shall be a member of the board and present the case to his or her colleagues. 3. The Medical Board – consisting of three medical professionals – may request the advice of another professional(s) with an appropriate specialization, considers the case – if necessary the medical record may be expanded or the woman re-examined – issues a report on the legal basis or lack thereof of the request, which must be noted in writing in the medical record. 4. If there are grounds for supporting the request, the attending physician prepares the patient for the abortion. 5. The unit chief designates a physician to perform the procedure (Administrative Procedures). The Medical Board shall consist of three gynecologist-obstetricians, one of whom is the attending physician. The Medical Board may request the advice of another professional(s) with knowledge of the case (Medical Board (*Junta médica*)).

conditions that put the life of the mother or the fetus at risk, which the commission has the authority to authorize, the following are required:

- the woman's written request and consent
- a medical report specifying and substantiating the diagnosis or diagnoses on which the request is based
- laboratory tests and/or other information that confirm the diagnosis (Art. 3)

When necessary, the commission shall request the written opinion of other health professionals who shall collaborate with its members (Art. 4). The chief of the gynecology and obstetrics unit of each hospital in each area or region will analyze the requests there, verify that the requirements are met and send the documents in a timely manner to the National Multidisciplinary Commission on Therapeutic Abortion for its study and final decision (Art. 6). In no circumstances may the authorization be omitted (Art. 9). When the commission decides that the termination is justified, it issues the authorization (Art. 10).

In **Mexico**, in addition to the Mexico City penal code, the Penal Procedures Code for Mexico City establishes the requirements for access to abortion after 12 weeks.⁹⁶ When the pregnancy represents a grave danger to health, the law requires a medical report from the attending physician and states that the first physician should consider a second physician's report when possible and when the delay does not pose a danger. For fetal malformation, the law requires the opinion of two specialists who agree that it is possible that the fetus has genetic or congenital malformations that may result in physical or mental damage to the extent that they pose a danger to the survival of the fetus; the pregnant woman's consent is also required (Art. 148). The Penal Procedures Code establishes an administrative procedure to access legal abortion services when the pregnancy is the result of rape or non-consensual artificial insemination as well as a number of requirements for the abortion to be authorized by the Public Prosecutor's Office, including:

- i.* a police report for the crime of rape or non-consensual artificial insemination
- ii.* the victim's statement that she is pregnant
- iii.* confirmation of the pregnancy by any public or private health facility
- iv.* elements that allow the Public Prosecutor's Office to deduce that the pregnancy is the result of rape or artificial insemination as established in Articles 150 and 151 of the new penal code for Mexico City
- v.* the pregnant woman's request for a termination of pregnancy. Public health facilities in Mexico City shall, at the woman's request, perform an examination that proves the existence of the pregnancy, as well as its termination (Art. 131 bis)

⁹⁶ Under the new laws, abortion must be performed at the woman's request up to 12 weeks of pregnancy.

The General Guidelines on the Organization and Operation of Health Services related to the Termination of Pregnancy in Mexico City (2006) specify what the medical report must include in cases of fetal anomaly: «The medical report on genetic or congenital anomalies shall preferably be based on specific examinations in conjunction with diagnostic tests, including ultrasound or similar procedures, biochemical analysis, cytogenetic analysis and analytical techniques. The diagnosis shall determine presumption of risk and be based on probability criteria» (Art. 5). In cases before 12 weeks, the woman's written request, written consent form and a medical report on duration of pregnancy are required (Art. 4 bis).

In **Spain**, the penal code establishes some medical requirements for abortion, including that it is performed by a physician or under a physician's supervision and in an approved private or public health center or facility (the 'approved' criterion may be omitted in cases of malformation) with the consent of the pregnant woman. However, it also states that certain requirements related to the specific grounds are met; therefore, when the woman's life or physical or psychological health is in danger, the law requires a medical report from a physician other than the one who performs the procedure. This requirement, and the woman's consent, may be omitted in emergency situations. It requires a police report if the pregnancy is the result of rape. If the fetus would be born with serious physical or psychological defects, a facility other than the one where the procedure will be performed must issue a medical report (this requirement may be omitted in certain cases) (Art. 417 bis).

The Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions (1986) specifies who may issue medical reports when they are required. When the abortion is to avoid serious danger to the life or to the physical or psychological health of the woman, the law indicates that physicians with the corresponding specialty are authorized to issue an opinion. For the presumption of physical or mental defects of the fetus, the facility that issues an opinion for the medical report must be authorized by the regional government. This authorization to issue opinions is different from that required to perform abortion procedures. To obtain such authorization, the facility must have the diagnostic equipment required for each type of case (ultrasound or similar equipment to diagnose malformations, biochemical equipment to diagnose metabolic diseases, cytogenetic equipment to diagnose chromosomal abnormalities, specific analytic techniques to diagnose malformations resulting from infections). In addition, it reiterates that the diagnosis shall determine presumption of risk and be based on probability criteria (Art. 6). These requirements for extremely complex procedures may easily create disproportionate burdens for women who seek abortion services.

In **Bolivia**, requirements vary by situation. To terminate a pregnancy that is the result of rape, kidnapping or incest, the law requires a criminal proceeding to be initiated. The

law does not establish full administrative procedures to save the life or health of the woman, but states that there must not be any other measure that will fulfill the same purpose. In all cases, abortions must be performed by a physician with the woman's consent and appropriate judicial authorization (Art. 266, Penal Code, 1972).

In **Colombia**, the penal code does not set out grounds for abortion as in the countries above; the grounds, and related requirements, are established by the court ruling that decriminalized abortion in certain specific circumstances. The decision states: «The crime of abortion has not been committed when, with the woman's consent, the termination of the pregnancy is performed in the following cases: (i) when the continuance of the pregnancy constitutes a danger to the life or health of the woman as certified by a physician; (ii) when a grave malformation of the fetus makes fetal life unviable as certified by a physician; or (iii) when the pregnancy is the result of a duly reported act constituting carnal access or a non-consensual and abusive sexual act or non-consensual artificial insemination or implantation of a fertilized egg or incest» (Constitutional Court, Case C-355 of 2006). As stated earlier, medical certification is required when there is danger to the life or health of the woman and a police report when the pregnancy is the result of sex crimes.

The regulations literally reiterate the court decision and prohibit insurers or health providers from imposing new barriers to services:

- Acceptance of a contraceptive method by the woman may never be a precondition for abortion (6.3.2 Information on Legal Abortion Procedures (*Información sobre procedimientos de IVE*) Technical Regulations on Care for the Voluntary Interruption of Pregnancy).
- Managers and health professionals are prohibited from imposing administrative barriers that unnecessarily delay the provision of abortion services, such as authorization by various physicians, review or authorization by boards, waiting lists or waiting periods and other procedures that may represent an excessive burden on the pregnant woman (Art. 2, Regulatory Decree 4444 of 2006).

On this point, this regulation differs from the provisions in all the other countries examined: in most cases, regulations establish requirements for access, while leaving open the possibility that insurers or health facilities may impose additional requirements, as in Peru, for example.

In **Italy**, the grounds for access to abortion services are not regulated by criminal law. Requirements are established by the technical regulations and depend on the duration of the pregnancy. As a result, if the termination of pregnancy will be performed within the first 90 days, the woman may go to a public medical office, a social health facility or her physician of choice. If the reasons for terminating the pregnancy are related to the

woman's economic, social or familial conditions, possible solutions to the existing problems and possibilities for overcoming the reasons the woman wishes to end the pregnancy must be reviewed with the woman and the father – if the woman agrees – within a framework of respect for the dignity of the woman and the biological father, while maintaining confidentiality, and assistance must be offered to help the woman before and after the birth. If any of the people or facilities described above discovers urgent reasons for the termination to proceed, they must provide the woman with a certificate documenting the urgency of the situation. With this certificate, the woman may go to an authorized facility for the termination of pregnancy. If there is no urgency, the woman must be given a certificate after the consultation that documents the request and the duration of the pregnancy and is asked to reflect for seven days; after that time the woman may go to an authorized facility for the termination of pregnancy.

When the pregnancy is of more than 90 days' duration, and the abortion is for reasons of fetal malformations or abnormalities that endanger the physical or mental health of the woman, or constitute a grave risk to the woman's life, these grounds must be certified by a gynecologist-obstetrician at the hospital where the termination will be performed. The physician may consult with specialists. The director of the hospital must be informed of the certification in order for the abortion to be performed. When the life of the woman is in danger, the procedure to inform the provincial physician may be omitted (Art. 5 to 7, Regulation for the Social Protection of Motherhood and Voluntary Interruption of Pregnancy, 1978).

Guyana also establishes a system where the requirements depend on the duration of pregnancy and the grounds. If the pregnancy is between eight and 12 weeks' duration, the medical practitioner responsible for the treatment shall consider that, in effect, the termination is within one of the grounds for authorization (only for risk to the life or health of the woman, fetal malformation or if the woman is of unsound mind). If the pregnancy is between 12 and 16 weeks' duration, two authorized medical practitioners must make a judgement but based on all the grounds (Art. 6). After 16 weeks, the termination may only be performed if there is risk to the woman's life or to prevent grave permanent injury to the physical or mental health of the woman or her unborn child and is approved by three authorized medical practitioners (Art. 7). In addition, when the termination is necessary to save the life of the woman, or to prevent grave permanent injury to her physical or mental health, these medical opinions may be omitted (Art. 10, Medical Termination of Pregnancy Act, 1995).

As stated above, **Norway** has the most detailed administrative procedure.⁹⁷ Broadly speaking, it is divided into two parts, one for terminations of pregnancy before 12 weeks and the second for terminations after 12 weeks. In both cases, the procedure is initiated at the woman's request; for minors or women with severe mental disabilities or serious

97 The administrative procedure in Norway includes the following provisions for abortion services:

- That there are no serious medical reasons to the contrary (Art. 2).
- Account shall be taken of the woman's ability to provide the child with satisfactory care (Art. 2).
- The application for pregnancy termination after the 12th week of pregnancy has elapsed may be submitted to a doctor or to a board (Art. 5).
- If it is possible to perform the operation before the 12th week of pregnancy, the doctor shall, after the woman has been given information about the procedure, forward the application, together with the written reference, to the hospital unit or other institution where the operation is to be carried out. If in the event that the medical superintendent or his deputy refuses to perform the operation for the reason that there are serious medical grounds to the contrary, the case shall be forwarded immediately to the county medical officer together with a written explanation. The county medical officer shall refer the woman to another hospital or approved institution where it may be possible to perform the operation (Art. 6).
- If it is impossible to perform the operation before the 12th week of pregnancy has elapsed, the doctor shall, when the woman has been given information about the procedure, immediately forward the application, together with the written report concerning the reasons put forward by the woman and the observations that have been made, to a board.
- When the application has been submitted directly to a board, the case shall be decided as soon as it has been fully prepared. If investigations show that it is possible, after all, to perform the operation before the 12th week of pregnancy has elapsed, the board shall immediately refer the woman to a hospital unit or other institution where the operation may be performed. The decision regarding termination of pregnancy shall be reached, after consultation with the woman, by a board consisting of two doctors (Art. 7).
- The decision by the board to authorize or refuse termination of pregnancy shall be substantiated in writing. The woman, or the person acting on her behalf, shall be informed of the reasons for the decision. In special cases, the decision may be communicated verbally. If the application is rejected the decision may be examined by another board (Art. 8).
- In cases where the pregnancy constitutes an impending risk to the woman's life or health, it may be terminated without regard to the provisions of this Act (Art. 10, Act No. 50 concerning Termination of Pregnancy, 1975, with amendments, 1978).
- Before the 12th week of pregnancy [which does not require a board], the application shall be submitted to a medical practitioner. If the woman is suffering from severe mental illness or is mentally retarded to a considerable degree, the application may also be submitted by the guardian. The doctor, in consultation with the woman, shall be responsible for the written formulation of the application unless this has been taken care of by the woman herself (Art. 1).
- The doctor shall make an assessment of the duration of the pregnancy. If the doctor finds that it is possible to perform the operation before the 12th week of pregnancy has elapsed, it is his duty to immediately forward the application, together with a written reference, to the hospital unit or other approved institution where the operation is to be performed (Art. 4).
- It may be necessary to postpone the operation for a shorter [sic] period out of consideration for responsible medical practice (results of laboratory investigations and preliminary treatment of the woman) (Art. 5).
- The medical superintendent or his deputy is responsible for ensuring that the application is dealt with and, in the event of an operation, that this is performed as soon as possible (Art. 5).
- If, on the basis of their examinations, the medical superintendent or his deputy find that the pregnancy has had a duration of more than 12 weeks, the doctor shall forward the application for termination of pregnancy to a board. The woman shall be informed immediately of this, as well as of the further progress of the case (Art. 5).

mental illness, the request may be submitted by her representative. Before 12 weeks, the request should be made to a physician (it does not specify a specialty), who must authorize the termination and refer the woman to a facility where it may be performed. If the physician denies her request, it may be reviewed by an Appeals Board. After 12

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- An application for termination of pregnancy after the 12th week of pregnancy has elapsed shall be submitted by the woman to a doctor or to a board. If the woman is suffering from severe mental illness or is mentally retarded to a considerable degree, the application may be submitted by the guardian. The doctor, in consultation with the woman and/or the guardian, shall be responsible for the written formulation of the application, unless this has been taken care of by the woman herself (Art. 7). The doctor is under an obligation to prepare, in consultation with the woman, a written report on her reasons for termination of pregnancy, unless this has been done by the woman herself. The report shall also include information concerning the observations made, including the status of health of the woman and her life situation. The doctor shall immediately forward the application, together with the written report, to the board (Art. 8).
 - If the woman has directly approached a board, or if the application has been forwarded from a hospital unit or other institution, the board shall itself prepare the case in accordance with the same rules described above for doctors. The board, in consultation with the woman, may entrust the preparation of the case to a doctor not on the board, to a family guidance office, or to another competent agency (Art. 9).
 - If investigations show that it is possible, after all, to perform the operation before the 12th week of pregnancy has elapsed, the board shall immediately forward the application, together with a written reference, to the hospital unit (institution) where the operation may be performed (Art. 10).
 - The case shall be dealt with as quickly as possible. The board is responsible for ensuring that the case is as well elucidated as possible. If it is relevant to the decision, a report may be obtained concerning the woman's life situation. The woman shall be given the opportunity to make her views known to the board either in writing or verbally. She has the right to attend the board accompanied by a legal advisor or other competent person. If the board is of the opinion that a statement by the woman is necessary in order to shed more light on the case, the case shall as a rule be postponed when the available information indicates that the application will have to be rejected. If the available information indicates that the application will be approved, the board shall in its evaluation weigh the consideration for a quick decision against the consideration that there should be as complete a foundation as possible for reaching a decision. If the woman is under 16 years of age or is mentally retarded, the person exercising parental authority or the guardian shall be given the opportunity to express his/her views to the doctor or to the board, unless there are particular reasons to the contrary (Art. 11).
 - The decision shall be reached as soon as possible after the case has been prepared. A decision by the Primary Board to authorize a pregnancy termination must be unanimous. A decision in the Appeals Board is reached by a simple majority. The decision shall be in writing and shall be simultaneously substantiated (Art. 12).
 - The board (the Primary Board or the Appeals Board) shall immediately give the woman, or the person acting on her behalf, written notification of the decision and the reasons for the same. If the application is rejected in the Primary Board, in special cases the notification may be given verbally [...and] the woman shall subsequently receive written notification. If the application is approved, the reasons shall be stated with reference to the grounds in § 2 [...and] the notification shall also state the date and place of admission to hospital [*sic*] (Art. 13).
 - When the application is rejected, the reasons shall include a brief account of the determining factors for the decision. To the extent that it is necessary in order to enable the woman to understand the decision, the grounds for the decision shall also refer to the content of the legislation and the approach to the problem on which the decision is based. It shall also be stated whether the decision was unanimous, and in cases of dissent, what the reasons were for the point of view of the minority. In the event of a rejection by the Primary Board, the notification shall also state that: 1) the application will be presented for an Appeals Board unless she has withdrawn it within three days from the time she has received notification of rejection; 2) she has access, until the time limit of three days has expired, to express a preference as to which board shall examine the appeal; 3) she may provide additional information if she so wishes (Art. 13).

weeks, the request must be made to a board⁹⁸ consisting of two physicians, who may approve or reject the request; rejections are automatically sent to an appeals board. This procedure is included both in the abortion law and the abortion regulations. However, there are no requirements other than this administrative request.

Finally, for terminations between 13 and 20 weeks, **South Africa** simply requires a physician to be of the opinion, after consulting with the woman, that the termination falls within one of the grounds permitting a termination at that stage of pregnancy. After 20 weeks, it requires a general physician, after consulting with another physician or a registered nurse or midwife, to be of the opinion that the termination is within one of the grounds permitting termination at that stage of pregnancy.

ii. Defining and clarifying grounds for abortion

The regulations of most countries do not analyze the grounds for abortion defined in criminal law. At most they literally transcribe the criminal law provisions and, for the most part, the laws that originally establish the grounds for abortion do not explain the meaning of the terms. However, the research found two different methods of defining the grounds for abortion. The first is to define them specifically, as done in the Perinatal Maternal Institute Guidelines and the Hospital Belén de Trujillo Protocol in **Peru**; the second is not to define them but to identify the authority that may do so, as in **Panama**.

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- In cases where the application for termination of pregnancy is approved by the Appeals Board, but where the medical superintendent of the unit where the operation is to be performed, as a member of the board, has voted against the approval, the county medical officer shall ensure that the woman is transferred to another hospital unit where the operation will be performed (Art. 15).
 - If the woman has expressed a wish that the appeal is dealt with by a specific board, this wish should be complied with provided there are no particular reasons to the contrary. As a rule, the appeal shall be examined by a board in the county where the woman is resident (Art. 16).
 - In the event that the woman's application is rejected by the Appeals Board, there is access for a new Primary Board to take up the case for new consideration at the request of the county medical officer. The woman does not have the right to have the case considered anew unless there is fresh information available (Art. 17, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975).

98 Appointment of boards: one member shall be the medical superintendent of the unit where the operation is to be performed, the medical superintendent's permanent deputy, or another doctor attached to the unit and chosen by the medical superintendent. The second member of the board shall be appointed by the county medical officer. The person appointed shall not belong to the staff of the unit where the operation is to be performed. The doctor must have a [sic] knowledge of social medicine. At least one member of the board should be a woman. Deputy members shall be appointed with similar qualifications (Art. 21). The county medical officer shall nominate the member who is to join the board which shall consider the appeal. The person in question, who shall not be a doctor, shall be trained as a welfare officer or health visitor and have experience of social work. At least one member of the Appeals Board shall be a woman. Members of the Appeals Board shall not have considered the application in the Primary Board (Art. 22). Members are nominated for a four-year period. The county medical officer may release a member; members may not be older than 70. Members receive remuneration for their services (Art. 23 and 24).

The Perinatal Maternal Institute Guidelines (2007) attempt to clarify the definitions of the grounds for abortion established in the penal code. It does so in two ways: analyzing the law to gain an understanding of its meaning and, based on this analysis, providing a list of specific situations in which a woman may request a termination of pregnancy. In the first case, the guidelines define two rules relating to the provisions of the penal code: (i) that there are two grounds for abortion that do not both need to be met: (a) saving the life of the pregnant woman; and (b) avoiding grave and permanent harm to the woman's health; and (ii) that the concept of health in the criminal law must be interpreted as including physical and mental health.

In the second case, the guidelines provide a list of conditions that endanger a woman's physical or mental health, compiled from nine Peruvian medical societies, for which she may request an abortion.⁹⁹ However, although the law does not explicitly state that this list is exhaustive, it may constitute a restricted interpretation of health grounds. Similarly, the Hospital Belén de Trujillo Protocol states that it is not necessary for the risk of death to exist for a termination to be performed.¹⁰⁰ The situation in Peru, with different tools determining access to abortion services, is a clear example of how the lack of a national level regulation may result in the proliferation of regulations with distinct content, thereby making it difficult to guarantee the rights of women seeking legal abortion services.

By contrast, Resolution 1 of April 1989 of the National Multidisciplinary Commission on Therapeutic Abortion in **Panama** states that the full commission shall define grave risks to health that merit a request for the termination of pregnancy (Art. 2).

⁹⁹ Advanced kidney failure; women on dialysis; lupus erythematosus with severe kidney damage; chronic hypertension and with evidence of damage to the target organs and/or with associated morbidities (severe hypertension); class III–IV congestive heart failure due to congenital or acquired heart disease (valvular and non-valvular), hypertension and ischemic heart disease; chronic liver failure caused by hepatitis B, hepatitis C, portal-splenic vein thrombosis with esophageal varices; malign gastro-intestinal neoplasia that requires surgery, radiotherapy or chemotherapy; demonstrated history of post-partum psychosis that does not respond to psychiatric treatment due to the risk of homicide or suicide; respiratory failure demonstrated by partial pressure of oxygen under 50mm and blood oxygen saturation of less than 85 per cent; unruptured ectopic pregnancy; chorioamnionitis; severe ovarian hyperstimulation syndrome resistant to treatment; invasive cervical cancer; other gynecological cancers that require radiotherapy or chemotherapy; partial hydatidiform mole with hemorrhaging posing a risk to the pregnant woman; advanced diabetes mellitus with organ damage; and malign neoplasias in the central nervous system.

¹⁰⁰ According to the protocol, abortion is justified in the following cases: congenital or acquired heart disease with heart failure; advanced multi-drug-resistant pulmonary tuberculosis; severe respiratory failure; hemorrhagic disorders; severe chronic renal failure; chronic hypertension with evidence of damage to the target organs; malign neoplasia in the reproductive organs that requires surgery, radiotherapy or chemotherapy; epilepsy that does not respond to treatment; severe hyperemesis gravidarum resistant to all treatment; and partial hydatidiform mole with severe hemorrhaging. In addition, the protocol notes that other clinical processes may justify the termination of pregnancy; a Medical Board shall issue a report documenting that they endanger the life and health of the pregnant woman (Indications for Legal Abortion (*Indicaciones para la Interrupción Legal del Embarazo*)).

iii. Availability of abortion drugs

The research found little information in the regulations about the availability of medications. Only three countries made some reference: in two (**Peru** and **Brazil**), to indicate their availability and, in the third (**Colombia**), to state that they were not available for abortion. Misoprostol was the only drug mentioned. It is also important to clarify that in Peru it is not the regulations that mention the availability of medications, but rather a technical report from the body responsible for authorizing medications, in reference only to missed abortion and incomplete abortion, not legal abortion.

In **Peru**, [Technical Report 23–2005 \(Informe Técnico 23–2005\) of the Executive Office of Access to and Use of Medications \(Dirección Ejecutiva de Accesos y Uso de Medicamentos\)](#) was issued in response to a request from the Perinatal Maternal Institute regarding the use of misoprostol for treatment of missed abortion, treatment for uterine hemorrhage due to uterine atony and use for cervical preparation. The report concluded: «For the reasons described above, the General Office of Medications, Supplies and Drugs (*Dirección General de Medicamentos, Insumos y Drogas*) finds that the acquisition of misoprostol 200µg tablets, authorized by the Pharmacological Commission of the Perinatal Maternal Institute: a. may be used for missed and incomplete abortion, and b. may not be used to treat post-partum uterine hemorrhage nor to prepare the cervix to induce childbirth in the third trimester of pregnancy.» In addition, [Executive Resolution No. 1988 SS/DIGEMID/DERD/DR](#) of 20 February 2003, authorized the use of misoprostol under the commercial name Prostokos in Peru.¹⁰¹

The Technical Regulations for Humane Abortion Care (2005) specifically state that misoprostol and oxytocin are available in **Brazil** (4. Medical Procedures).

In **Colombia**, the Technical Regulations on Care for the Voluntary Interruption of Pregnancy (2006) indicate that at the time the regulations were issued misoprostol was available in the country, but gynecology-obstetrics was not among the indicated uses. The regulations add that mifepristone and gemeprost were not on the health registry (Medical Abortion Methods (*Métodos médicos de ILE*)). In 2007, the Ministry of Social Welfare requested the [Specialized Section on Medications and Biological Products \(Sala Especializada de Medicamentos y Productos Biológicos\) of the Review Committee of the National Institute for Drug and Food Surveillance](#)¹⁰² to expand the indication of the active ingredient misoprostol for use in voluntary terminations of pregnancy as allowed by law. In response to the request submitted by the Ministry of Social Welfare,

¹⁰¹ This resolution is currently not in effect because the laboratory that requested the registration has not brought it into the country; it is attempting to revalidate this authorization.

¹⁰² Review Committee of the National Institute for Drug and Food Surveillance (INVIMA).

and after considering the medical community's understanding of the pharmacological profile of misoprostol, the Specialized Section on Medications and Biological Products of the Review Committee ruled that this active ingredient may be used as an oxytocic in the specific circumstances established in Case C-355 of 2006, in accordance with the provisions of Decree 4444 and Resolution 3905 of the same year. In other words, it is possible to use misoprostol in Colombia for legal terminations of pregnancy.

iv. Grounds for denial of services

Only **Norway** explicitly establishes in its regulations the grounds on which services may be denied. Act No. 50 concerning Termination of Pregnancy (1975), with amendments (1978), establishes two grounds: (1) after 18 weeks if there are reasons to consider that the fetus is viable (Art. 2); and (2) if the medical superintendent or his deputy consider that there are serious medical grounds contrary to performing the procedure (Art. 6).¹⁰³

At the same time, the Regulation for the Implementation of the Act concerning Termination of Pregnancy (1975) establishes in detail how the latter grounds for refusal of services operates. It states that it is only the medical superintendent or his deputy who has power to deny the operation on serious medical grounds. It adds that 'serious medical grounds' means conditions that are of such a nature that, due to the status of the woman, an operation must be assumed to present a serious risk to her life or health. The ministry may issue more detailed guidelines about the medical criteria that form the basis for this evaluation (Art. 6).

Moreover, in Norway, this system of specific grounds for refusal of services is complemented by a comprehensive appeals process.

Some conclusions

As shown in this chapter, the regulations issued by the countries included in the comparative analysis vary widely, not only in number but also in the level of detail, thereby creating great differences among countries. As a general rule, in countries where abortion is not criminalized, some type of regulation exists. Such is the case in South Africa, Guyana, Norway and Italy. However, it is important to emphasize that in those countries, regulations are primarily concerned – although not exclusively – with issues

¹⁰³ In this situation, the case shall be forwarded immediately to the county medical officer together with a written explanation. The county medical officer shall refer the woman to another hospital or approved institution where it may be possible to perform the operation (Art. 6).

specifically related to access (for example administrative procedures for access, informed consent, conscientious objection) and do not include issues relating to protocols of care (for example abortion methods, biosecurity standards, tests). Of the countries that belong to this first group, only South Africa has protocols for care.

By contrast, in most countries where abortion is a crime except in certain circumstances, regulations are limited or concentrate on abortion complications. In other words, the regulations do not guarantee access, but rather attempt to reduce the effects of complications. In Panama, Bolivia and Peru, the national level regulations on access to abortion are quite limited. However, both Peru and Bolivia have extensive regulations on abortion complications. Colombia and Mexico are the exceptions to this rule. Colombia has detailed regulations on all aspects of abortion. Mexico City has the most liberal abortion regulations of the countries researched in Latin America and the Caribbean, which allow abortion at the woman's request until 12 weeks of pregnancy; to a significant extent, these regulations have greatly improved access to legal abortion services.

Regionally and worldwide, it is important to note that the judiciary is gradually taking an interest in the issue of access to safe abortion. The research found several cases where judges took the lead in guaranteeing women's access to safe and legal abortion. In Colombia and Canada, constitutional courts reviewed laws banning abortion and found that absolute criminalization was contrary to their respective constitutions. In Canada, the courts have made other decisions relating to funding and the extent of women's right to choose. In Brazil, the Supreme Court has played a definitive role in access to safe and legal abortion in cases of fetal malformation incompatible with life. In Peru, it was not a domestic court but rather the United Nations Human Rights Committee that ordered the state in 2005 to issue appropriate regulations on women's access to safe therapeutic abortion.

Within this panorama, some issues are not addressed sufficiently, including the establishment of guiding principles, appropriate service networks (including referral and counter-referral systems), comprehensive models of care for abortion services, youth-friendly services, privacy of services, dissemination of information to the general public, education and training of health professionals, biosecurity standards, and data collection, monitoring and oversight systems, among others.

By contrast, other issues have received much more attention, and these regulations provide examples for the proposed model described in the next chapter. Some of these issues include provisions related to counseling, information provided to individual women, post-abortion care, requirements for access, sanctions for refusal of services, and other issues. An in-depth analysis was conducted of provisions for informed consent (in general, and for minors and for women with disabilities), conscientious objection and medical confidentiality in order to address these topics effectively in the model.

Finally, in all areas related to protocols of care (laboratory tests, pain management, management of complications, and so on) the comparative analysis clearly demonstrates the importance of following the recommendations of international institutions, such as the World Health Organization, whose guidelines attempt to guarantee rights to service provision within varying legal contexts and disparate political, cultural and social conditions in an effort to standardize all processes relating to access to safe and legal abortion services.

In general, the trend in regulations is moving towards reducing barriers and improving women's access to safe abortion. In a few cases – although these were in the minority – the research found regulations with measures that clearly constitute barriers to access. These included mandatory waiting periods between the authorization for the procedure and when the procedure is performed, or excessive infrastructure demands for facilities where abortions are performed. Requirements for access were identified as the most frequent barriers to safe abortion services – occurring in almost all countries – ranging from the requirement of a police report in cases of sexual violence to long and difficult administrative procedures for obtaining authorization, with the burden on the woman to complete these procedures.

For many reasons, incorporating these different issues into the proposed model discussed in the next chapter is of the utmost importance. The model takes into consideration recommendations from international organizations and highlights the provisions analyzed in this document that are most conducive to promoting a rights perspective.

V. Recommendations for developing regulations that guarantee access to abortion services

One of the most important motivations for undertaking this comparative analysis was the prospect of creating a model proposal and recommendations for developing abortion regulations, based on an in-depth review of existing national health regulations as well as recommendations issued by international bodies and/or experts on the subject.

As shown in the previous chapter, the health measures adopted by different countries are intended, with only a few exceptions, to guarantee timely access to legal abortion services within a rights framework and therefore provide an important basis for this model. However, the regulations reviewed do not include all the components that they ideally should incorporate; therefore the model recommendations in this chapter seek to provide a more comprehensive catalog of these components that can serve as a guide for developing regulatory frameworks that guarantee women's timely access to abortion services. Since these recommendations are based on the regulations reviewed in the analysis, each category included in the model has a footnote referencing the relevant sections of the previous chapter.

This proposal was developed to advance the following three goals:

- to encourage conditions favorable to the exercise of sexual and reproductive rights and to improve sexual and reproductive health in all aspects of abortion services
- to establish measures to reduce or eliminate barriers to access at different levels of care
- to minimize risks to health and encourage comprehensive, high quality legal abortion services

Each category includes recommendations on measures that should be incorporated within regulatory frameworks, in accordance with the context and opportunities in each country. The aim is to eliminate or reduce barriers to access. **The model begins by looking**

at the different types of barriers women may face when accessing abortion services and then turns to identifying key components and recommendations for addressing these barriers.

These recommendations should form part of a comprehensive package of sexual and reproductive health care policies that seek to provide the necessary services for women facing unwanted or unplanned pregnancies and to implement measures to prevent future unwanted pregnancies. In the area of prevention, there are two important areas of action: implementation of quality sexuality education, and promotion of and access to contraceptive methods, including dual protection. In relation to the management of unwanted pregnancies, the full range of options that best respond to a woman's reproductive health needs should be available: termination of pregnancy in cases allowed by law (medical and surgical abortion), promotion of harm reduction strategies for unsafe abortion, outpatient care for incomplete abortion, adoption counseling and referral to related services, and finally, for those women who decide to continue the pregnancy, provision of integrated care for pregnancy, childbirth and post-partum with appropriate social support.

While this publication has emphasized the positive role of abortion regulations, it is important to bear in mind that the creation of health regulations and guidelines may have a potential negative impact. Excessive regulation can often hinder rather than promote access to specific services by creating additional bureaucratic requirements for health care providers or clients. In addition, detailed regulations can prevent the flexibility needed for health institutions and providers to more broadly interpret regulations in an effort to provide adequate care. That said, it is also clear that the absence of such guidelines and regulations inhibits the provision of services as providers lack clarity about their responsibilities and clients are unaware of their rights and what they should expect from their health care system. IPPF/WHR believes that well-designed health regulations can not only remove barriers to care, but can actively promote access and **create conditions favorable to the exercise of women's rights, particularly within the context of abortion-related services.**

The involvement of health professionals from the start is a fundamental part of creating effective health regulations. Such involvement helps to create a strong base of allies within the medical community who understand the importance of such regulations, and the role they play in shifting the way health systems treat women. To achieve this, it is essential that health institutions and governments provide adequate opportunities for training in order to ensure proper interpretation and implementation of the regulations and to prepare health professionals to provide quality care that respects women's dignity and autonomy.

i. Barriers

Women who decide to end their pregnancies face many types of barriers to care. These range from difficulties with paying for the abortion, to accessing services in a timely manner because of geographic location, to resistance from friends, family, partners and community or from health professionals who should be providing care and respecting a woman's decision.

Access therefore encompasses a comprehensive process that addresses a range of issues from ensuring the effective entry of women into the health system (including insurance and benefits coverage as a basic component) to appropriate care for all women – regardless of their race/ethnicity, age, education level, place of origin, language, ability to pay and so on – with services of the highest quality, under the best technical conditions and in the most humane environment that can be provided by health professionals. It also requires the acceptance of abortion to the extent that the general population actively demand and encourage access to these services, in part by monitoring the actions of the government in this domain. Abortions must be provided within a framework of full protection for sexual and reproductive rights and with the guarantee of timeliness and security.

Because barriers have many different sources, it is important that regulations address all the factors that are necessary to eliminate them. For ease of analysis, these barriers have been divided into five categories: organization of services; quality of care and exercise of rights; data collection, monitoring and oversight systems; funding; and administrative issues.

Barriers related to the organization of services

Multiple barriers arise at this level and any analysis must address considerations such as where the population is located, whether the location is rural or urban, and its division into departments, states or municipalities outside the largest cities. Any of these factors can pose a barrier to access as **abortion services may be concentrated in areas with the greatest number of health professionals and where the procedure may be less stigmatized**, in other words, in the urban areas of the most important or largest cities.

These types of barriers are also related to the lack of service networks at all geographic levels (local or municipal, departmental or state, and national) and at all health care levels (primary, secondary, and tertiary), as well as the lack of appropriate definition and operation of referral and counter-referral systems. Likewise, they are related to the lack of integrated models of care, including the provision of counseling and support

services for clients, which are particularly important for addressing the specific needs of adolescents.

Barriers may be created within this category by the failure of the regulations to adequately define various elements that are fundamental to the organization of services:

- the types of professional(s) who are authorized to perform these procedures (avoiding stipulating specialized care when it is not necessary)
- appropriate provision of surgical and medical methods
- facility/clinic operating hours
- post-procedure management and care
- provision of services for other areas directly related to abortion services, such as gender-based violence and HIV/AIDS

Finally, even when measures to reduce the barriers mentioned above are implemented, several other considerations may need to be addressed that may also act as obstacles to women's access to services. These include, for example, the lack of social support networks that serve an important role in providing women with information about where to access legal abortion services, or the 'informal' involvement of other actors, such as pharmacies. If pharmacists and their staff are not appropriately trained to provide information and referrals to health facilities, it may put at risk the quality of information and support provided during and after the procedure. One final consideration in this category is **the lack of coordinated and systematic efforts among sectors outside the public health arena to address the issue of unsafe abortion and unwanted pregnancy; for example, the lack of action by the educational system, the media and the legal system to raise awareness about the social and health impact of unsafe abortions and unwanted pregnancies.**

Barriers related to quality of care and the exercise of rights

The concept of service quality is very broad, and practically all regulatory measures have an impact on this issue. However, in addition to traditional standards or parameters, this category includes components related to a more substantive aspect of quality – the exercise of rights. Ensuring quality of care and guaranteeing rights within health services are fundamentally linked; barriers related to service quality frequently manifest in violations of women's rights, including but not limited to the right to health, the right to information, and the right to bodily integrity, among others.

The issue of **informed consent**, which includes establishing consent for minors or women who for various reasons have difficulty giving it, is one of the most common barriers related to quality of care and protection of human rights. Barriers arise when

a procedure is performed on a woman without her full consent, when the unnecessary consent of a third party is required of her, or when the woman's decision has not been preceded with all the necessary information or the information that has been provided has been manipulated.

Another significant source of barriers in this category is **conscientious objection**, which must be regulated so that it does not provide a cover for those who deny services to women or who delay care. Similarly, **confidentiality** is essential to service provision. Violations of confidentiality cause women to delay seeking services out of fear or to seek services from untrained providers, and as a result, they are often exposed to potential complications from abortion services performed under riskier conditions. In addition, respect for confidentiality is one of the highest obligations for physicians within their professional ethical responsibilities. Finally, as with any highly stigmatized service such as abortion, the lack of **privacy for abortion-related services** can create barriers to access, since absolute privacy is essential for protecting women from any associated social and cultural stigma.¹⁰⁴

Moreover, the lack of systematic and collective actions to make the public aware of abortion services (including through communications campaigns and community work) is responsible for the primary barrier related to information: women often do not know about services even when they are available, and in addition, very often, neither women nor providers have accurate information about abortion laws. This barrier is critical: it must be addressed in order to increase women's awareness of their rights and ensure that if they need an abortion they can request one within the legal framework of their country. It is also important to look at barriers to information on the individual level, which are created when the information provided is not sufficient, is not trustworthy, is not clear or does not respect the woman's decision.¹⁰⁵

A woman's understanding of all the information provided to her during counseling and when receiving services is a key part of the process, and therefore language must not be allowed to constitute an additional barrier.

Although it is very difficult for health facilities to implement measures in this area, **information must help to break down the unequal power relations between**

¹⁰⁴ In general, poor quality of care in the formal health system becomes a barrier to access as women share their experiences of poor treatment with other women in their community. As a result, upon hearing these experiences, other women are more likely to seek out untrained or unqualified providers rather than requesting services from providers in the formal health system.

¹⁰⁵ Given experiences in the United States and other countries, it is important to be aware that some informational campaigns that purport to provide information to women have resulted in misinformation; for example, 'scientific' information has been used to persuade the public that abortion risks include breast cancer or high mortality rates.

women and men in society by addressing, for example, issues related to gender-based violence. It is also important to try and understand the decision making and negotiation skills needed by women facing an unwanted pregnancy who are in a relationship where they do not have the power to negotiate their sexual needs or contraception.

In the area of quality standards, the lack of standardized, evidence-based technical procedures often means that women do not receive care under optimal conditions for preserving health and well-being in the broadest sense of the term. In some cases they are subjected – in the name of science – to excessive requirements in order to have an abortion. This is often due to the lack of clear service delivery guidelines that seek to establish integrated services at the least complex level of care possible. For example, requiring a test or certain type of examination can sometimes create new barriers – including economic ones – for women. In other cases, examinations to diagnose fetal malformations or other diagnostic tests for conditions that endanger the woman’s life or health are delayed.

Barriers resulting from the preparation and accreditation of facilities also belong in this category: for example, instituting infrastructure requirements for abortion care that are unnecessary for simple procedures, or failure to carry out technical procedures appropriately in accordance with biosecurity measures that guarantee women and health professionals optimal conditions for the provision of care.

Finally, the most critical aspect of the entire process may be **the human warmth with which health professionals (not just the medical staff) provide quality care** to women who request abortion services. A lack of human warmth can easily result in women failing to ‘listen’ to the recommendations of health professionals and can – with even graver consequences – result in women not accessing health services or not accessing them early enough.¹⁰⁶ Stereotypical attitudes and prejudices held by individual providers often solidify into habitual practices within an institution and these can undermine women’s rights.

These quality of care problems are often related to the failure of universities to address these subjects adequately and the failure (or belated entry into this area) of health sciences faculties and medical schools to take an active role in systematically addressing women’s sexual and reproductive health from a rights perspective, including comprehensive abortion care. When medical associations (particularly obstetric and

¹⁰⁶ Deborah Maine (Columbia University), for example, has analyzed delays leading to maternal death. [Thaddeus, S and Maine, D \(1994\) Too far to walk: maternal mortality in context. *Social Science and Medicine*. 38\(8\), pp.1091–110.](#)

gynecological associations) and other health professionals do not favor the exercise of these rights, it can result in greater obstacles to service provision.

These problems are also linked to **the lack of initial training or inadequate refresher training for all health professionals** on the medical and psychosocial aspects of safe abortion services, including training with a gender, rights, empowerment and values clarification perspective. This training cannot be limited to doctors only, but must extend to midwives, nurses, social workers, counselors and all other professionals who are involved in providing health care. In addition, those in charge of health services and institutions must ensure that such training takes place.

These gaps in education and training also affect other aspects of health care, such as pain management techniques, abortion management and, in particular, emotional support for the client with full respect for her decisions. Often the lack of inter-disciplinary health teams limits this type of integrated service.

Another barrier related to training is the lack of appropriate post-abortion counseling to reduce or avoid future unwanted or unplanned pregnancies and to promote healthy sexual behaviors in general, including the use of contraceptive methods and emergency contraception.

Barriers related to data collection, monitoring and oversight systems¹⁰⁷

Data collection and health statistics are a fundamental part of decision making within the health sector and therefore the absence of systems to make factual information available in a timely manner causes many difficulties. Lack of data obscures the magnitude of a problem and impedes health facilities' compliance with

107 Oversight functions may have different names in different countries, but generally refer to the power of health authorities (which also vary by context) to order sanctions to correct a critical or irregular situation (legal, financial, economic, technical, administrative–scientific) in which any entity or individual under its authority is involved and to punish those actions that depart from the law, whether by action or omission. These functions are closely related to inspection (activities and actions related to monitoring and evaluation of health institutions) and monitoring (warning, preventing, orienting, assisting and guiding the bodies responsible for financing, insuring and providing health care and services, and involving civil society and all other bodies subject to monitoring to ensure that they comply with the regulations governing health systems in each country). These definitions are adapted from Colombian Law 1122 of 2007 «which modifies some aspects of the General System for Healthcare Social Security and establishes other provisions.» Lastly, monitoring also refers to epidemiological activities, in which case it is the systematic, ongoing, timely and reliable collection of relevant and necessary information about specific health conditions of the population. Analysis and interpretation of data should be the basis of decision making and should also be used to disseminate it (Pan American Health Organization). All these components depend on sound and timely information systems.

laws and regulations, quality of care standards (for example detecting complications) and, above all, timeliness in providing abortion services.

Similarly, problems are created when monitoring and quality of care evaluations do not take into account the perspective and opinion of clients, and when they do not involve evaluations of the providers, including revisions of the quality of information contained in the medical records.¹⁰⁸ Problems also stem from the paucity of research focusing on the experiences of women who request abortion services (such as the obstacles they encounter, or the conditions giving rise to the unwanted pregnancy), on the complexity of abortion services, on other aspects that are critical for decision making and, above all, on the prevalence of unsafe abortions. Information on cost-benefit analyses of services or conscientious objection claims and other related topics is also scarce.

In addition to these problems, the absence of oversight is an enormous barrier because many regulations are simply not followed or implemented, without any type of repercussion for facilities or providers that should be providing these services. Lack of oversight often commonly manifests in the absence of systems to establish specific time periods or time limits for service provision in response to an abortion request and corresponding sanctions on facilities that do not comply. In addition, the lack of appeal mechanisms for an abortion that has been denied is also a barrier.

Economic barriers

Paying for services is often one of the first barriers mentioned by women who seek to terminate their pregnancies; due to the absence of clear regulations establishing obligations for service provision in public facilities, women often resort to using private services, which frequently exceed their capacity to pay. This situation is particularly critical for adolescents who, because they are often dependent on their parents' health plan or insurance, must obtain parental approval in order to receive services, with all the difficulties that entails, especially when parents are not supportive. Economic barriers are further exacerbated by the lack of government tools to identify which sectors of the population must receive free services. In addition, many public and private health insurance plans do not cover the costs of abortion services.

In addition, measures related to costs continue to be applied only to public facilities, while private entities do not fall under governmental oversight systems, leading to segmentation of pricing and services.

¹⁰⁸ Although the information included in medical records is confidential, there should be mechanisms in place to analyze the quality of the information recorded and of the care provided.

Guaranteeing access to affordable services is an important mechanism for increasing women’s awareness about their rights, and ensuring that decision makers and providers are sensitized to the reality of women’s lives and their decisions about pregnancy and abortion. This increased awareness facilitates a process of change that is essential for successful efforts to expand access to legal abortion.

Administrative barriers

Women who request abortion services are often disproportionately subjected to an array of administrative measures that create enormous barriers. These measures run the gamut from the involvement of the judicial (legal) system as a prerequisite to abortion in certain circumstances, to the participation of more than one medical professional or of a highly specialized professional – for example the head of an institution – as a requirement to obtain authorization for the procedure. Although many of these barriers may be related to the organization or quality of services, they have been divided into a separate category because they often manifest in the practices of health facilities (as administrative procedures) or of institutions outside the health sector.

This category includes the (often restricted) definitions of specific grounds for an abortion, for example in attempts to interpret the extent of health or economic hardship exceptions. It also includes measures (often administrative) imposing gestational limits on abortion requests in addition to the grounds under which the woman is seeking an abortion, as well as measures that restrict the availability of drugs (such as misoprostol), which are well known to be highly effective in inducing abortion early in pregnancy. Similarly, the judicial system commonly imposes additional requirements on women, or even refuses to hear their petitions, which in some places is necessary to authorize an abortion.

This category also includes barriers stemming from the failure to define appropriate maximum time limits for facilities to respond to service requests, lack of mechanisms to appeal against service denials and excessive requirements on medical professionals who perform abortions.

Barriers of this type also arise out of legal ambiguities or the lack of protection for health professionals who perform abortions to prevent employment or social discrimination, which may exert a powerful force for the denial of abortion services.

ii. Recommendations

As demonstrated by the analysis presented in previous chapters, it is clear that in order to craft regulations that protect sexual and reproductive rights and guarantee timely

access to safe abortion services, it is necessary to establish and adopt measures on a variety of issues to reduce and eliminate the barriers women face when attempting to access these services.

The measures included in the model are divided into six categories: organization of services; quality of care and exercise of rights; education and training of health professionals; data collection, monitoring and oversight systems; funding; and administrative.

The recommendations in each category should be included in an administrative act at the highest possible level of the administrative structure overseeing the health sector in each country.¹⁰⁹ This will avoid the proliferation of guidelines from different entities, which often contradict one another and can cause enormous confusion for women and providers. However, it is important to note that in the absence of national regulations, guidelines created by health facilities can provide a provisional solution.

Furthermore, it is important to clarify that this model includes an exhaustive list of ‘ideal’ recommendations as it is intended to be a resource for drafting regulations in many different countries. In this respect, incorporating these measures can be a gradual process eventually culminating in a comprehensive regulatory framework that provides certainty to health professionals and helps to eliminate barriers to access without creating disproportionate burdens on women. This process can be enhanced by using the proportionality test.¹¹⁰ This is a tool to foster critical thinking that aims to determine whether or not a measure affects the right to equality. The test can also be used in a wider context to resolve conflicts between rights and principles and is used to gauge whether a measure is proportional to its effect on each fundamental right or principle. The basic steps in the test are:

1. Identify the purpose of the measure (the right it seeks to guarantee).
2. Identify the rights that will be negatively affected by the measure.
3. Judge whether the impact on the rights in conflict is justified by the protection that the measure will provide.

This model has been created in the belief that regulations should aim to reduce barriers and promote access to care, not become a source of new barriers.

¹⁰⁹ Whenever possible, these provisions should not be part of penal codes; they should be part of health regulations.

¹¹⁰ The proportionality test has different degrees relating to the rigor of the judgement. For example, if a measure imposes limitations related to a characteristic that is surmountable (such as age), the judgement should be lenient, while if the restriction is related to characteristics that are not surmountable (such as race or gender) the test should be strict.

Guiding principles

The recommended measures for reducing barriers to access to legal abortion services must be considered within a framework of basic principles¹¹¹ that should be clearly articulated in the regulations and should serve as the guiding force in service delivery. These principles establish guidelines that serve as the basis of decision making for health facilities and providers whenever a conflict arises. Currently there is a trend towards including in rights documents an explicit clause establishing that the most favorable interpretation of a specific right should be applied. As a result, when the meaning of a regulation or its application is in doubt, this respect for rights obligates the provider or facility to adopt the interpretation or application best in keeping with the protected rights. This is called the *pro homine principle*. This principle is increasingly being included in regulations that clarify rights, together with specific applications to ensure adherence to the principle and to assist facilities and providers to act to guarantee these rights. Consequently, it is recommended that abortion regulations include a specific principle directed at administrative, judicial and medical personnel, mandating that they must adopt the course of action that best favors women's rights whenever there is doubt about a regulation or its application.

While these guiding principles are described in more detail below, it is important to point out the relationship between these principles and the ethical and human rights framework.

Of these principles, there are some that belong to the realm of ethics and others that relate to the protection of human rights. The first group includes the principles of justice, autonomy, beneficence and nonmaleficence, which from an ethical perspective should guide the decisions of health professionals and service providers when doubts or conflicts arise over situations related to legal abortion services.

The second group of principles, which includes favorable interpretation of rights, respect, confidentiality, privacy, integration, timeliness, promptness, continuity, security, co-responsibility and solidarity, provides a framework to protect human rights.

The principles of confidentiality and privacy are closely tied to the right to privacy; the application of these principles seeks to ensure that the privacy of clients seeking legal abortion services is safeguarded in all their interactions with the health system. On a similar note, the principle of respect reinforces the protection of the right to autonomy and the right to freedom from arbitrary interference that would impede, delay or complicate the implementation of a woman's request for legal abortion services.

¹¹¹ The comparative analysis of this issue is on page 43.

The principles of integration, timeliness, promptness, continuity and security are fundamental to protect women's right to health and well-being; these principles interact to guarantee effective access to the necessary health services for legal abortion and ensure conditions that protect health, minimize risks and promote well-being. The principle of co-responsibility is also connected to the protection of the right to health given that effective access to services is dependent on a concurrence of financial and institutional conditions that facilitate the implementation of services in all contexts permitted by law.

Finally, the principle of solidarity is deeply embedded in the right to equality, and the need to reduce economic disparity among women so that all women have equal opportunity and access to safe and legal services.

The most important guiding principles that should be included in abortion regulations¹¹²

- ▣ favorable interpretation of rights
- ▣ justice¹¹³
- ▣ autonomy
- ▣ beneficence
- ▣ nonmaleficence
- ▣ respect¹¹⁴
- ▣ confidentiality
- ▣ privacy
- ▣ integration
- ▣ timeliness
- ▣ promptness
- ▣ continuity
- ▣ security
- ▣ co-responsibility¹¹⁵
- ▣ solidarity

¹¹² See **Colombia** and **Brazil**, which define principles for service provision.

¹¹³ Justice, autonomy, beneficence and nonmaleficence are defined on page 43. **Brazil**.

¹¹⁴ Both for the client's decisions and for confidentiality.

¹¹⁵ Although the state is responsible for public health, in countries where other sectors are involved in service provision, all involved sectors, including the private sector, must contribute resources for abortion services.

Favorable interpretation of rights: When the meaning of a regulation or its application is in doubt, the interpretation or application best in keeping with women's rights must be adopted.¹¹⁶

Confidentiality: This principle is founded on the obligation to maintain professional confidentiality. As a condition of their employment, anyone who is directly or indirectly given explicit or implicit information about a termination of pregnancy, or the private or intimate life of a woman who has terminated her pregnancy, is obligated to use all available methods to ensure that such information is not divulged and is prohibited from using it for their own benefit or from divulging it.¹¹⁷

Privacy: Abortion services must ensure respect for women's privacy. This includes at least: (i) adapting the physical space in facilities to provide privacy for women seeking abortion services, including pre- and post-abortion care; (ii) creating conditions to guarantee the privacy of the information provided by the woman and of the information included in her medical record; and (iii) providing training and information to all employees so that they understand their obligation to respect the privacy of information and of women in relation to abortion services.

Integration: Abortion services shall be provided in an integrated manner and include education, information, prevention, diagnosis, treatment, rehabilitation and all other services and activities to preserve the woman's life and maintain the highest possible level of health.¹¹⁸

Timeliness: Abortion services must be provided at the time that a woman or her provider requests the termination of pregnancy or when it is necessary to save her life, maintain her health or prevent complications. All individuals involved in providing abortion services, including pre- and post-abortion care, are prohibited from being evasive and from keeping the patient in suspense or in a state of uncertainty.¹¹⁹

¹¹⁶ In the Childhood and Adolescence Code of Colombia, Law 1098 of 2006 articulates the use of this principle as applied to children.

¹¹⁷ The following sources were consulted for the definition of this principle: Rodríguez Almada, H (2002) *Iniciativas médicas contra el aborto provocado en condiciones de riesgo: fundamentos médico legales* (Medical initiatives against unsafe abortion: forensic medical foundations). Montevideo: Faculty of Medicine, University of the Republic, Uruguay (www.mednet.org.uy/dml/actividades/archivos/inmed-pay030614.ppt#256,1) and Bruno, A and Bosco, M *La práctica pericial psiquiátrica y su contexto ético* (Expert psychiatric practice and the ethical context) (www.aap.org.ar/publicaciones/forense/forense-10/tema-1.htm)

¹¹⁸ Law 100 of 1993 of **Colombia** was consulted for the definition of this principle.

¹¹⁹ The following sources were consulted for the definition of this principle: **Colombian** Law 266 of 1996, «which regulates the nursing profession in Colombia and establishes other provisions» and Case T-881 of 2003 (Hon Rodrigo Escobar Gil).

Co-responsibility: The state and all other levels of government shall work together to provide financing for and to guarantee the provision of abortion services.^{123, 124}

Solidarity: In order to achieve universal access to abortion services, pricing policies shall promote systems in which those individuals with greater resources subsidize those with fewer resources.¹²⁵ In no circumstance shall a woman's inability to pay prevent her from accessing abortion services, and services must be provided in accordance with her need and not her ability to pay.

I. Measures to reduce barriers related to the organization of services

1. Create and/or consolidate service networks throughout the country at all levels of care and with appropriate referral and counter-referral systems¹²⁶

This recommendation includes the availability of services throughout the country,¹²⁷ in urban and rural areas, which entails, but is not limited to, measures that promote access for the most isolated populations. These measures may include educational and health brigades¹²⁸ and reliance on community leaders to improve access in areas where women need services. The involvement of community leaders is also critical for populations that have difficulties accessing services for other transitory reasons: displaced populations, migrants in general and migrants in crisis situations, for example in the wake of a natural disaster. In addition, service consolidation can be based on the expansion of social support networks, including actions to promote social and cultural change.

¹²³ The following sources were consulted for the definition of this principle: Proposed constitutional text, **Bolivia** (<http://constituyenteyautonomias.enlared.org.bo/Archivo/Docs/TEXTO%20CONSTITUCIONAL%20ultimo%20del%20MAS.doc> and <http://canciller.blogia.com/2007/050601-principios-de-coordinacion-concurrencia-y-subsidiaridad.php>).

¹²⁴ The usefulness of this principle depends on the geopolitical organization of each country, the level of autonomy of the actors and the health insurance system.

¹²⁵ The following sources were consulted for the definition of this principle: *Las reformas de salud en América Latina y el Caribe: su impacto en los principios de la seguridad social* (Health reforms in Latin America and the Caribbean: impact on social security principles); Economic Commission for Latin America and the Caribbean, Project Documents (www.eclac.cl/publicaciones/xml/8/24058/LCW63_ReformasSalud_ALC_Cap2.pdf). Remarks by José Luis Machinea, Executive Secretary of the Economic Commission for Latin America and the Caribbean (ECLAC), at the official launch of the Commission on Social Determinants of Health (ECLAC, Santiago, Chile, 18 March 2005) (www.eclac.cl/prensa/noticias/discursossecretaria/3/20963/DeterminantesSalud18MarzoFinal.pdf).

¹²⁶ [The comparative analysis of this issue is on pages 44-48.](#)

¹²⁷ Health services should follow administrative divisions (generally corresponding to geographic divisions) of each country. The names of these divisions differ by country: for example municipalities, boroughs, departments, states.

¹²⁸ 'Brigades' refer to a system of providing health services extramurally. In other words, health teams travel to areas that are very isolated, where the population's mobility is severely limited or where several communities with limited access to health services are concentrated.

Regulations must include the obligation to clearly establish who is responsible for providing services in the public and private spheres and which facilities provide these services in different geographic areas of the country.¹²⁹

Because abortion is a simple procedure, in most cases, it is important to note that services should be provided by lower level care facilities,¹³⁰ preferably in outpatient settings, to encourage terminations to be performed in the first trimester. However, capacities must be developed at all levels of care, including appropriate referrals across levels of care when necessary because of complications or abortions later in the pregnancy.

These measures must include appropriate hours of operation that take into account the fact that women are responsible for tasks in and/or outside the home. They should also include services that are available for women living in remote or rural areas.

Finally, developing referral and counter-referral systems is critical to removing barriers to access. These systems must include the health system as well as other sectors.¹³¹ Within the health sector, the goal of referrals is to guarantee the timely transfer of a woman to higher levels of care when an additional risk to her health has been determined or when the necessary treatment capacity does not exist at the woman's point of entry into the health system. In addition to this conventional concept of referrals, it is important to create mechanisms that allow pharmacies to play a role in abortion care and to make timely referrals to the appropriate facility.

Likewise, counter-referrals are a fundamental part of integrated care; their goal is to ensure that abortion services do not end with the procedure when it has been performed at a higher level of care and that women receive the necessary counseling and services to prevent unwanted pregnancies in the future. These types of services are generally provided at lower level care facilities. This system must also assist women who decide to continue their pregnancies in order to guarantee them access to necessary care.

Other sectors involved in this system may include social service organizations (for example, when a woman chooses adoption) or organizations that interface with the legal system (when its involvement is required, for example to transfer police reports or to take forensic medical evidence).

¹²⁹ See **Colombia** and **Norway**. Service networks at all levels, organization of services.

¹³⁰ «The initial priority might be to train and equip staff in lower level facilities including those in rural areas, at least to provide first-trimester procedures and effective referral for more complicated cases.» World Health Organization (2003) *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO.

¹³¹ See **Norway**.

The following key factors are considered in the model proposal and recommendations:¹³²

- ❑ Ensure that services and certified facilities, authorized by the health sector, are available throughout the country.
 - ❑ Create mechanisms to make available lists of facilities that provide services in the different geopolitical divisions of the country.¹³³
 - ❑ Strengthen social support networks.
 - ❑ Involve community leaders in developing health care models.
 - ❑ Include mobile health units.
 - ❑ Provide services in an outpatient setting, where possible.¹³⁴
 - ❑ Ensure availability of mid and high level care institutions to manage complications or for cases that need specialized care.
 - ❑ Appropriate hours of operation for all facilities.
 - ❑ Referral and counter-referral systems.¹³⁵
 - ❑ Alliances with pharmacies for timely referrals of clients.
 - ❑ Implement coordinating mechanisms across the public and private sectors.
 - ❑ Involvement of the judiciary.¹³⁶
 - ❑ Involvement of social service sectors.¹³⁷
2. Adopt integrated care models for abortion services within a framework of sexual and reproductive health policies, with attention to special situations (violence, HIV/AIDS) and populations (adolescents) as well as post-abortion care¹³⁸

Comprehensive care has two essential components: services for other sexual and reproductive health-related issues (favoring the inclusion of health promotion measures) and the inclusion of counseling and support as a central part of the model.¹³⁹ Services for other sexual and reproductive health-related issues that can be provided in conjunction with abortion care include screening for cervical cancer (Pap

¹³² In general, the bullet points in each category synthesize the most important measures or criteria that should be considered when creating a regulation, as proposed by this model.

¹³³ The term 'geopolitical division' refers to the administrative and geographic organization of the territory of a country, which differs by country: municipalities, boroughs, regions, departments, states.

¹³⁴ See **Colombia**.

¹³⁵ **Mexico, Spain, Puerto Rico, Brazil** and **Colombia** establish referral systems. **Colombia** and **Guyana** also establish counter-referral systems for counseling on contraceptive methods and preventing unwanted pregnancies.

¹³⁶ See **Italy**.

¹³⁷ **Brazil**, for example, provides for referrals to feminist non-governmental organizations and women's groups if health providers cannot meet the client's needs.

¹³⁸ [The comparative analysis of this issue is on pages 48-57.](#)

¹³⁹ An important element of **Brazil's** support model is that it establishes that one of the objectives of counseling is to guide women receiving health care in decision making and self-care.

smear)¹⁴⁰ and breast cancer, testing for HIV and other sexually transmitted infections, and support services for gender-based violence. With respect to counseling and support models, these services should encourage women's autonomous and voluntary decision making and not seek to dissuade them from any particular course of action.

In no circumstances should the provision of these types of services become an additional barrier to access or a prerequisite for abortion services.

Legal abortion services should be provided within a framework of comprehensive sexual and reproductive health policies that support the prevention of unwanted/unplanned pregnancies, and include provisions for other issues that, in conjunction with the need for abortion services, require models of specialized care. Gender-based violence and HIV are examples of such issues.¹⁴¹

These models must promote health and include counseling and support that encourage women's autonomous decision making and do not seek to dissuade women. They must also provide options ranging from safe termination of pregnancy and risk reduction for unsafe abortion,¹⁴² to health care for pregnancy and childbirth, and adoption if the woman decides to continue the pregnancy. Although discussion of what content should be included in the counseling is essential, at no time should it be assumed that this format is the only format or a rigid one; the assistance provided by a professional must prioritize the needs of each woman in order to provide adequate care.¹⁴³ Finally, it

¹⁴⁰ For example, the Protocol of Hospital Belén de Trujillo establishes that the medical examination before an abortion is an opportunity to take a Pap smear and conduct other tests that aid in diagnosing sexual and reproductive health issues.

¹⁴¹ Countries with models of care for abortion in situations of violence: **Brazil, Mexico and Colombia**. Brazil's model is especially detailed.

¹⁴² Some countries are implementing initiatives to reduce risks associated with unsafe abortion in order to decrease maternal mortality, irrespective of the legal framework. The harm reduction project initiated in **Uruguay** by a group of health professionals (Iniciativas Sanitarias) is a pioneering example of such efforts. Iniciativas Sanitarias seeks to empower women and communities through increasing the commitment of health professionals to provide comprehensive care to women with unplanned and/or unwanted pregnancies. In 2004, the Uruguayan Ministry of Health included this initiative in its regulations via a resolution mandating that physicians in the public and private sectors provide counseling to women who decide to end their pregnancies. This decision aims to decrease the number of deaths due to unsafe abortion, the main cause of maternal mortality in Uruguay and in Argentina. The regulations include the provision of information and counseling to help women explore different options. If the woman decides voluntarily to end her pregnancy, a medical team meets with her to discuss safe and unsafe methods of abortion, as well as other issues such as prophylactic administration of antibiotics 24 hours before the procedure. The goal is to bring women with unwanted or unplanned pregnancies into the health system and ensure that they receive the necessary care both before and after an abortion procedure, including access to contraception. The ultimate goal of the counseling service is to decrease the number of unwanted pregnancies in the future and consequently the need for abortions. Ministry of Public Health, **Uruguay**. *Normativa de Atención Sanitaria y Guías de Práctica Clínica* (Health care regulations and clinical practice guidelines). Ordinance 369 of 2004.

¹⁴³ See **Brazil's** and **Peru's** models.

is important to differentiate between the need to provide counseling (which relates to emotional support in the decision making process) and information (which relates, for example, to procedures and resources), as discussed later.

Because service provision for adolescents and young people has many particular aspects associated with it, abortion services should be provided within a model of care specific to this population. This is not only because of their status as autonomous rights holders (which is often limited in health systems) but also because of their specific needs for health care appropriate to their stage of development.

These models of care require special training for professionals and consideration of the characteristics specific to the developmental stage of adolescents and young people: these include the difficulties of preventing unwanted or unplanned pregnancies (often associated with other risks common during this stage of development), the difficulties about negotiating contraceptive use, the difficulties of speaking openly in a health care setting or with parents, and other related factors.

Considerations when providing services to this population must take into account not only the model of care, but also issues related to costs and other barriers to access arising out of their status within health systems. Adolescents are usually the beneficiaries of adults who can interfere in their decisions – not always in a positive way – when they decide to seek counseling and health care.

Finally, within the integrated care model, women should receive post-abortion counseling (to prevent future unwanted/unplanned pregnancies)¹⁴⁴ as well as contraceptive counseling, and should also be referred for consultation and treatment if warranted by certain situations (for example, support services for gender-based violence or management of HIV, or other appropriate services).

Post-abortion counseling should also include a space to address any lasting psychological or emotional issues to ensure that women receive the support they need.

The following key factors are considered in the model proposal and recommendations:

- Sexual and reproductive health policies that include abortion services and the prevention of unsafe abortion.
- Comprehensive models of care that provide a wide range of options for unwanted pregnancies and promote prevention and care for sexual and reproductive health issues.
- Inclusion of abortion care in special cases as part of comprehensive care models:

¹⁴⁴ See *Norma del Instituto Materno Perinatal* (Regulations of the Perinatal Maternal Institute) of Peru.

- i. Incorporate abortion services in comprehensive care models for sexual violence.¹⁴⁵
 - ii. Incorporate abortion services in comprehensive care for HIV.
- Provision of a comprehensive counseling and support¹⁴⁶ model, that includes counseling for women during the decision making process.¹⁴⁷
- Model of care for adolescents: accessible locations and appropriate hours.¹⁴⁸
- Protection for adolescents as rights holders within health systems.¹⁴⁹
- Counseling for adolescents that includes an explicit explanation about confidentiality of information and of the consultation in order to build trust.
- Care and treatment of other problems related to sexual and reproductive health for adolescents.¹⁵⁰
- Availability of a wide range of contraceptive methods (temporary and permanent) after the abortion, including information on emergency contraception,¹⁵¹ avoiding whenever possible postponing the decision about a contraceptive method for a later consultation.
- Psychosocial support.¹⁵²

3. Appropriate professionals to perform abortions¹⁵³

In order to guarantee the provision of abortion services, it is necessary to have a sufficient number of health professionals (adequately located across geographic areas) who are well-trained and who comply with the relevant requirements.¹⁵⁴ Regulations should explicitly state who can provide abortion services and in what circumstances.

The World Health Organization has stated that the medical personnel who provide abortion services should include nurses, medical aides, midwives and general physicians. In other words, it is not necessary in any circumstances to restrict abortion services to

¹⁴⁵ See **Brazil**.

¹⁴⁶ The *Manual de Orientación y Consejería en SSR* (Sexual and reproductive health counseling manual) of **Peru** (2006) includes one of the most detailed approaches.

¹⁴⁷ See **Peru, Colombia, Norway, South Africa** and **Brazil**.

¹⁴⁸ See, for example, **Colombia**, which establishes the option of developing 'adolescent-friendly services'.

¹⁴⁹ See, for example, the integrated care model for sexual and reproductive rights in **Peru**.

¹⁵⁰ **Colombia**, for example, includes prevention of sexually transmitted infections and HIV/AIDS, among others.

¹⁵¹ See **Brazil, Colombia, Peru, Italy, Guyana, Norway** and **Panama**.

¹⁵² See, among others, the psychosocial support provided to women in **Guyana** and, at the woman's request, to her partner to offer a better understanding of the procedure.

¹⁵³ [The comparative analysis of this issue is on page 57.](#)

¹⁵⁴ See obligatory provisions in **Norway** and **Colombia** on entities that provide abortion services.

physicians or specialized physicians.¹⁵⁵ In addition, the ideal strategy is to create multi-disciplinary teams that can respond not only to women's physical needs but also to their emotional needs, before, during and after the procedure, and that can even help to evaluate women's socio-economic situation. Some specific cases, for example a high-risk situation, may require the presence of a gynecologist.

The following key factors are considered in the model proposal and recommendations:

- ❑ Establish who can provide abortion services: general physicians and/or appropriately trained nurses, medical aides and midwives for cases without complications and for medical abortion.^{156, 157}
- ❑ Include gynecologists and obstetricians when necessary.
- ❑ Ensure that the multi-disciplinary team includes non-medical professionals:¹⁵⁸ psychologists, social workers and other appropriate professionals.

4. Promptness in providing services¹⁵⁹

Regulations must include **clearly defined maximum time limits¹⁶⁰ within which facilities must provide services to women. These time limits should not create additional obstacles to access and must be obligatory.** Whenever services are not provided in a timely manner, the reasons for the delay must be included in the medical record. Above all, it is important to recognize that timeliness in service provision is critical to evaluating the quality of care.

¹⁵⁵ Health personnel [...who] have demonstrated ability to perform a bimanual pelvic examination to diagnose signs of pregnancy and to perform a transcervical procedure such as IUD insertion, can be trained to perform vacuum aspiration (Freedman et al (1986), Greenslade et al (1993). From World Health Organization (2003) *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO. p.60.

¹⁵⁶ In **South Africa**, for example, a registered and appropriately trained nurse or midwife is allowed to perform an abortion before 12 weeks.

¹⁵⁷ Medical abortion with mifepristone and misoprostol provides a new perspective on service provision that is centered on appropriate pre-abortion counseling and appropriate supervision of the abortion process by personnel trained in recognizing symptoms of complications, but who do not necessarily need to have the same level of training as for surgical abortion procedures. Mid level providers can meet this need perfectly well with the support of a specialist. Rodolfo Gómez Ponce de León, ObGyn, MSPH, PhD. Senior Health System Advisor, Ipas. 2007.

¹⁵⁸ **Brazil's** 'support' model provides for multi-disciplinary teams that include social workers and psychologists.

¹⁵⁹ [The comparative analysis of this issue is on page 65.](#)

¹⁶⁰ **Panama, Mexico** and **Colombia** emphasize the importance of providing care to women in the early stages of pregnancy.

I. Measures to reduce barriers related to the organization of services

1. Create and/or consolidate service networks throughout the country at all levels of care and with appropriate referral and counter-referral systems
2. Adopt comprehensive care models for abortion services within a framework of sexual and reproductive health policies, with attention to special situations (violence, HIV/AIDS) and populations (adolescents) as well as post-abortion care management
3. Appropriate professionals to perform abortions
4. Promptness in providing services

II. Measures to eliminate barriers related to service quality: guaranteeing rights and quality standards

This group of measures related to guaranteeing a robust quality of care process and adequate service delivery norms and guidelines is intended to demonstrate that the quality of care process must go beyond conventional standards of quality to ensure the protection of women's fundamental human rights. Ensuring quality of care and guaranteeing the rights of clients within health services are inherently linked – each of the measures described below for reducing barriers related to quality are grounded in fundamental rights necessary to sustain a high quality of care.

As such, measures related to informed consent, and the systematic dissemination of information about services to clients – both at the level of public awareness raising campaigns and at the individual level – respond to the fundamental right of clients to information and autonomy. Clear, truthful and timely information is essential to ensure that clients can make informed and autonomous decisions about their health.

In addition, the rules about conscientious objection, the adoption of protocols or service delivery guidelines and infrastructure requirements, as well as training and accreditation for health professionals, are measures closely linked to the protection of the right to health and life. Such measures ensure that the services required for legal abortion are delivered in a timely and effective manner by well-trained professionals using adequate clinical techniques.

Finally, measures related to protecting confidentiality and privacy are essential components to ensure clients' right to privacy. This right extends, for example, to women who have abortions in countries where abortion is legally restricted or is illegal: their rights to

confidentiality must still be preserved and any information discussed between the client and the provider remains strictly private and confidential. Taking account of cultural considerations is an important part of protecting the right to equality, particularly the right to receive treatment that corresponds to the particular situation of each client.

5. Informed consent¹⁶¹

The basis of all abortion services must be the informed consent of the woman. Consent must be an action by which the woman makes a free and fully informed decision on the basis of factual, timely and complete information about the procedure as well as other topics that form part of comprehensive care.

The Mexico regulations define consent as the voluntary agreement, in writing, of the woman who requests or requires a legal abortion once the health facility has, as part of its compulsory obligation, provided objective, truthful, sufficient and timely information about the procedures, risks, consequences and effects as well as the assistance and alternatives available so that the pregnant woman can make her decision in a free, informed and responsible manner. For the consent of minors or women who are not able to give consent, it is important to determine the value assigned to the desires of the minor or woman with a disability in the decision making process and to refer to existing mechanisms to resolve a possible discrepancy between the desires of the minor or disabled woman and the desires of her representatives.

A useful tool to regulate the consent of minors is the concept of ‘evolving capacities’. This concept was recognized by international law in article 5 of the 1989 Convention on the Rights of the Child.¹⁶² This concept recognizes that children’s acquisition of increasingly greater competencies must, in turn, increase their capacity to assume responsibilities and to make decisions themselves affecting their lives and – as a result – that the need for counseling and guidance becomes reduced. The concept helps to establish a point of equilibrium between the recognition of children as rights holders and their autonomy balanced with the obligation to protect them as children.

The recognition of children’s autonomy implicit in this concept requires that alternative systems to regulate decision making be considered that include factors in addition to

¹⁶¹ [The comparative analysis of this issue is on page 66.](#)

¹⁶² Article 5: States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

age and take into account the maturity of the minor in each case.¹⁶³ The report, *The Evolving Capacities of the Child*, published by the UNICEF Innocenti Research Centre, suggests some alternative regulatory models:

- ❑ «Removal of all age-limits, substituting a framework of individual assessment through which to determine competence to exercise any particular right. Alternatively, the law could introduce a presumption of competence with the onus on adults to demonstrate incapacity in order to restrict a child's rights.
- ❑ Introduction of a model that includes age-limits but entitles a child who can demonstrate competence to acquire the right at an earlier age.
- ❑ Legal differentiation among specific rights and the establishment of age limits only for those rights that are at risk of being abused or neglected by adults, and introducing a presumption of competence with respect to other rights.»¹⁶⁴

Within the sexual and reproductive rights field, the concept of evolving capacities finds that minors who are sexually active, and seek information and ways to protect themselves from unwanted pregnancies, AIDS and sexually transmitted infections, are acting in a responsible manner to prevent risks to their health to which they are exposed. These children therefore have the capacity to enjoy their sexual and reproductive rights and choose, among other things, the number and spacing of their children.¹⁶⁵

For women with some type of disability,¹⁶⁶ the system regulating informed consent should respect at least the following minimum rights: (i) information must be provided

¹⁶³ The publication, *The Evolving Capacities of the Child*, by the UNICEF Innocenti Research Centre, notes that one of the main limitations to applying this concept is the lack of trained personnel and of appropriate definitions of competency. It suggests several that could be adopted eventually as criteria to evaluate specific cases and to establish if a minor has the capacity to make a decision relating to the termination of her pregnancy:

- ❑ **«Ability to understand and communicate relevant information.** The child needs to be able to understand the available alternatives, express a preference, articulate concerns and ask relevant questions.
- ❑ **Ability to think and choose with some degree of independence.** The child needs to be able to exercise a choice without coercion or manipulation and be capable of thinking through the issues for themselves.
- ❑ **Ability to assess the potential for benefit, risk and harm.** The child must be able to understand the consequences of different courses of action, how they will affect him or her, the risks involved and the short and long-term implications.
- ❑ **Achievement of a fairly stable set of values.** The child needs to have some value base from which to make a decision.» p.xi.

¹⁶⁴ Landsdown, G (2005) *The Evolving Capacities of the Child*. Florence: UNICEF Innocenti Research Centre. See page 12 for an extended analysis of these four alternatives. See page 71 and following for the advantages and disadvantages of each model.

¹⁶⁵ [Center for Reproductive Rights \(2006\) *Gaining Ground. A Tool for Advancing Reproductive Rights Law Reform*. New York: Center for Reproductive Rights, Chapter X: Adolescents' Reproductive Rights.](#)

¹⁶⁶ The [United Nations Convention on the Rights of Persons with Disabilities \(2006\)](#) defines some of the rights that must be considered when establishing rules for decision making for women with disabilities in relation to abortion. Article 3, which establishes **General Principles**, states: «(a) Respect for inherent dignity, individual autonomy

to women with disabilities in a form most appropriate to their limitations, ensuring that the information is understood, that the procedures, effects and alternative treatments are clear; (ii) providers must first attend to determining whether the disabled woman desires to terminate or continue the pregnancy, and all possible measures must be exhausted to enable her to express her desires regarding the pregnancy; (iii) if it is impossible for the woman to express her will, the person designated by law to provide consent for her (a doctor who is not a conscientious objector, family member, guardian or spouse) must take into consideration the circumstances of the situation, the alternative which is most in accordance with the woman's right and her clinical condition. Under no circumstances may the designated person be someone who is in direct conflict with her interests.

The following key factors are considered in the model proposal and recommendations:

- ❑ In relation to issues of consent, the woman's desires are paramount (in writing is sufficient), except in urgent situations where a professional may make a decision to save the woman's life.¹⁶⁷
- ❑ The individual situation must be taken into consideration; for example, in the case of minors, the pregnant adolescent should be recognized as a rights holder and her desires should be accepted.¹⁶⁸ Every attempt should be made so that the

including the freedom to make one's own choices, and independence of persons...» Article 6 **defines rights particular to women with disabilities to ensure the full enjoyment of the rights and freedoms to which they are entitled:** «1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms» and «2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.» Additionally, Article 12 of the Convention directly alludes to disabled persons' decision making abilities. This article, titled **Equal recognition before the law**, states in paragraph 4: «States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.» Reinforcing article 12, article 23 provides for respect for the autonomy of persons with disabilities to make decisions relating to sexual and reproductive health. This provision, entitled **Respect for the home and the family**, states: «1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that... (b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to exercise these rights must be provided...»

¹⁶⁷ See the **South African** regulations, which explicitly prohibit requesting additional consent other than from the woman.

¹⁶⁸ See **Brazil, South Africa** and **Guyana**, where minors are the ones to make the decision.

involvement of parent(s) or guardian serves to reinforce the provision of education and information in order to avoid future unplanned or unwanted pregnancies. Wherever possible, adults should also attempt to identify whether the adolescent is a victim of violence.

- 169 Establish a special mechanism to resolve discrepancies between the consent of the minor and of her representative.¹⁶⁹
- 170 Establish a clear procedure to obtain the consent of individuals who are not able to provide it.¹⁷⁰

6. Conscientious objection¹⁷¹

In order for regulations to guarantee services to women who have voluntarily decided to end their pregnancies, regulations must, without exception, include concrete measures to address conscientious objection, which is recognized by many constitutions as the right of individuals. Because this issue is complex, and is one of the most critical barriers to women's access, this section defines both the concept of conscientious objection as well as the main elements that should be addressed in abortion regulations.

Firstly, «freedom of conscience must be understood as the faculty of all people to assert their individual criteria – within the basic laws governing coexistence, which establish that one person's rights extend to the point where another's begin – and their principles over all legal or social considerations governing their circumstances. Conscientious objection is the mechanism whereby this freedom is put into effect... It cannot be emphasized enough that the concept of conscience does not depend on adherence to any religious creed and therefore no political or religious organization can abrogate the 'certification' of the arguments that any individual professes in order to abstain from complying with the mandates of the law due to the dictates of his or her conscience, regardless of how removed such arguments are from the concept of conscience of the person evaluating them.»¹⁷²

In Case C-355, which decriminalized abortion in three circumstances in Colombia, it is important to note that neither the state nor legal entities have the right to conscientious objection. It is the right only of natural persons;¹⁷³ therefore clinics, hospitals, health centers

¹⁶⁹ See Italy.

¹⁷⁰ In this situation, responses should be obtained to the following questions, at least: Can anyone besides the woman request the abortion? What happens if the woman does not have legal representation? Who can make a decision about abortion and how has that person been designated? Does the opinion of the woman's legal representative or of the person who cares for the woman carry more weight? How much weight should be given to the attending physician's opinion? How will severe disabilities be handled?

¹⁷¹ [The comparative analysis of this issue is on page 78.](#)

¹⁷² [Castillo, E \(2005\) Objeción de conciencia \(Conscientious objection\). Espacio Libre, No. 10. Bogotá: PROFAMILIA.](#)

¹⁷³ In Mexico and other countries the term 'individuals' is also used.

or any other entity, regardless of what it is called,¹⁷⁴ cannot claim conscientious objection with regard to abortion. For natural persons, it is worth mentioning that conscientious objection refers to a well-established religious conviction, and therefore is not a question of whether or not the physician agrees with abortion nor does it permit ignorance of women's fundamental rights. Therefore, if a physician professes conscientious objection, he or she must immediately refer the woman to another professional who can perform the abortion, without subsequent prejudice as to whether the conscientious objection was legitimate and relevant according to the mechanisms established by the medical profession.¹⁷⁵

To ensure, as much as possible, that there are appropriate personnel throughout the country, each level of government¹⁷⁶ can, when advertising job openings for health professionals, make it a condition of employment that new employees are prepared to comply with the obligations and tasks required by the hospital unit or facility, including provision of abortion procedures. Medical professionals who apply to facilities that provide abortion services must indicate their desire to be exempt from performing or assisting with these procedures.¹⁷⁷

The following key factors are considered in the model proposal and recommendations:

- ❑ Conscientious objection applies to natural persons.¹⁷⁸
- ❑ Conscientious objection cannot be invoked when a woman's life is in danger.¹⁷⁹
- ❑ Facilities must guarantee an appropriate number of health professionals who are not conscientious objectors.¹⁸⁰
- ❑ When a health professional is a conscientious objector, he or she is required to refer the woman in a timely manner to a professional who is not a conscientious objector within the same facility or to an appropriate facility.¹⁸¹
- ❑ Providers and facilities may not refuse to provide information about women's rights and abortion nor hide information nor limit a woman's options in order to change

¹⁷⁴ Health facilities or even groups such as professional associations or universities.

¹⁷⁵ From Case C-355 of 2006 of the Constitutional Court of Colombia. The Constitutional Court of Colombia recently issued a new decision clarifying the legal duties of providers, hospitals and health care systems relating to conscientious objection, stating that hospitals, clinics and other institutions have no rights of conscientious objection (Decision T-209 of 2008). See also regulations in **Colombia** and **Mexico**.

¹⁷⁶ County, state, departmental, etc.

¹⁷⁷ See **Norway**.

¹⁷⁸ See **Italy** and **Colombia**.

¹⁷⁹ See **Mexico** and **Brazil**.

¹⁸⁰ **Norway** allows employment conditions to stipulate that medical personnel may not be conscientious objectors in order to comply with the requirements on service availability in different parts of the country.

¹⁸¹ A **Colombian** regulation establishes the guarantees granted to women in response to conscientious objection.

her decision. Neither may professionals or facilities deny a woman information about therapeutic options or abortion management alternatives if there are any.

- II Individuals who are not directly involved in the procedure cannot invoke conscientious objection.¹⁸²
- II Conscientious objection does not extend to pre- or post-abortion activities.¹⁸³
- II Regulations must include a formal procedure, in writing, to register as a conscientious objector within a facility;¹⁸⁴ however, the facility should not promote this option.
- II Create guidelines to make available a list of public and private facilities that are authorized to provide abortion services.¹⁸⁵ This mechanism must help to maintain an appropriate number of physicians who are not conscientious objectors at facilities so that services are consistently available to women.

7. Confidentiality, medical confidentiality and privacy of services¹⁸⁶

Maintaining confidentiality of information and, most critically, physician-patient confidentiality, is one of the most important elements to ensure that women seek services in a timely manner. Here, it is the ethical and legal obligation of a physician to maintain in confidence all information originating from the professional relationship with their clients. Revealing this information violates women's rights¹⁸⁷ to privacy and

¹⁸² Norway, Italy and Mexico.

¹⁸³ Norway.

¹⁸⁴ See Italy and Norway. Without these procedures, a physician can invoke conscientious objection immediately before a case he or she might attend, instead of having to indicate in advance his or her reasons behind the objection. This gives facilities some control over personnel and guides them about whether their personnel are or are not conscientious objectors.

¹⁸⁵ Spain, Norway, Guyana and Colombia have provisions along these lines. Spain requires health authorities to periodically publish lists of accredited abortion centers (Art. 2, Royal Decree on Accredited Centers and Mandatory Reporting for the Performance of Legal Abortions, 1986). Norway has established the obligation of county municipalities to publish a list of the hospital units and facilities that perform abortions (Art. 19, Regulation for the Implementation of the Act concerning Termination of Pregnancy, 1975). Guyana requires the Ministry of Health to list in the official Government register, the Gazette, and in a Guyanese newspaper, the name and address of all approved institutions and the owner or director of the institution (Art. 4, Medical Termination of Pregnancy Act, Legal Supplement B). The same regulation requires the certificate granting approval to perform abortions to be displayed in a prominent place in the facility. Finally, in Colombia, the Health Promotion Entities and the Departmental and District Health Offices must refer to the Ministry's General Office on Service Quality those facilities within the network authorized to provide low, medium and high complexity gynecological-obstetric services and those that have personnel willing to provide abortion services. This information must be kept current and available for clients who require these services and should be reported annually to the Ministry's General Office on Service Quality (Order 0031 of 2007).

¹⁸⁶ [The comparative analysis of this issue is on pages 83-86.](#)

¹⁸⁷ More information on clients' rights can be found in [International Planned Parenthood Federation \(2004\) *Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services*. Third edition. London: IPPF. Chapter 1.](#)

health as recognized by international human rights instruments.¹⁸⁸ It is important to note that all health professionals, not just physicians, are required to maintain patient confidentiality.¹⁸⁹

Because confidentiality also applies to documents containing private information about the patient, it is important to have guidelines for the management of medical records. At the same time, there must be a mechanism that allows access to records as needed to provide judicial evidence, where required, and there must also be a mechanism that permits monitoring and evaluation of the quality of medical records.

All health services should be provided in private, in a designated separate area where patients feel safe and which guarantees privacy. In the case of abortion, it is especially important to provide services separately from services for pregnancy and childbirth as a mark of respect for the woman and her decision to end the pregnancy. Privacy should be offered in a way that inspires the woman's confidence in the physical facilities and in the professional who is providing the service. Privacy is particularly important in the case of rape because of the many implications it could have on a woman's life.

The following key factors are considered in the model proposal and recommendations:

- ❑ Maintain confidentiality.¹⁹⁰
- ❑ Create an explicit obligation on physicians not to reveal or report any information that may expose a patient to criminal prosecution or cause a patient any other type of harm.¹⁹¹

¹⁸⁸ [Ipas \(2004\) *Entre la espada y la pared: el secreto profesional y la atención posaborto* \(Between a rock and a hard place: confidentiality and post-abortion care\). Managua: Ipas.](#)

¹⁸⁹ **Norway, Guyana, Brazil** and **Colombia** have provisions along these lines. **Norway** has established that each and every person involved in examining abortion cases is required to observe confidentiality of all the information acquired (Art. 11, Act No. 50 concerning Termination of Pregnancy, 1975, with amendments, 1978). **Guyana** requires any medical professional, authorized medical professional, owner or director of an approved establishment, any person employed by or working at, or having legal access to an approved facility to maintain confidentiality of the documents and issues relating to the procedure and that these individuals may not use any information for their own benefit or to benefit another person (Art. 14, Medical Termination of Pregnancy Act, 1995). In **Brazil**, confidentiality applies to physicians and health professionals (II. Professional Ethics and Legal Aspects of Abortion, 5. Professional Ethics, Technical Regulations for Humane Abortion Care, 2005). In **Colombia**, confidentiality applies to «Persons who are members of the health team that are aware of or provide health care for abortion procedures» (Art. 6, Characteristics of Service, Technical Regulation on Care for the Voluntary Interruption of Pregnancy).

¹⁹⁰ See **Mexico, Brazil, Guyana** and **Norway**.

¹⁹¹ This point and the following are from the Declaration of the Faculty of Medicine of the University of the Republic, the Arbitration Tribunal of the Sindicato Médico del Uruguay (Medical Union of Uruguay, SMU) and the Ethics Board of the Federación Médica del Interior (Domestic Medical Federation, FEMI) on confidentiality and medical confidentiality. **Uruguay**. 2007. This Declaration was in response to the prosecution of 16 May 2007 of a young woman for the crime of voluntary abortion after she was reported by the physician she consulted. See also the

- ❑ In addition to maintaining confidentiality, physicians and medical professionals who provide services to a patient must ensure that the entire team of medical professionals respects confidentiality and facilities must issue instructions to this effect.
- ❑ Establish ethical and administrative sanctions if confidentiality is violated.¹⁹²
- ❑ Maintain medical records appropriately while, at the same time, not preventing access to evaluate service quality or for other legitimate reasons.
- ❑ Establish that facilities are responsible for confidentiality of information,¹⁹³ which must be appropriately protected so that individuals who are not obligated to maintain confidentiality cannot access it.¹⁹⁴
- ❑ Make use of examination rooms separate from other areas to provide privacy for conversations between a woman and provider.¹⁹⁵
- ❑ Abortion services should be physically separate from obstetrics.
- ❑ Privacy is an essential part of the model of care for rape victims.

8. Cultural considerations¹⁹⁶

Guarantee the availability of professionals who can communicate in the patient's language for specific communities or ethnic groups.¹⁹⁷

9. Systematic dissemination of information to promote services to the general public and provision of information to individual clients¹⁹⁸

A basic premise of public health is the prevention of health problems and their complications. In the context of abortion, the main objective of providing information to women is to raise awareness about their rights under the laws of each country. Access to such information is a key responsibility of the state to ensure that women know their rights and have access to mechanisms for exercising those rights within the health system. Women – and health professionals – must be made aware that abortion is not a crime in certain circumstances, and this awareness must lead to the creation of a rights framework that ensures that the necessary services to guarantee access in those circumstances are available. Information

decision of the Inter-American Court of Human Rights on confidentiality and criminalization of medical acts (*De la Cruz Flores versus Peru*, 18 November 2004, FJ 96-103).

¹⁹² South African, Guyanese and Norwegian models.

¹⁹³ In Guyana, for example, in addition to those who have contact with the patient, all employees, including the director or owner of the establishment, are required to maintain confidentiality of information.

¹⁹⁴ See footnote 188. Uruguay Declaration.

¹⁹⁵ See Technical Regulation on Care for the Voluntary Interruption of Pregnancy, Appendix 2. Colombia.

¹⁹⁶ [The comparative analysis of this issue is on page 86.](#)

¹⁹⁷ See Brazil, Technical Regulations for Humane Abortion Care.

¹⁹⁸ [The comparative analysis of this issue is on page 87.](#)

provided to the general public must include information about services and in which circumstances services are available. It must encourage women to seek services in a timely manner and must help to reduce the risks of unsafe abortion and its complications. Public information campaigns must be conducted in conjunction with campaigns targeting health professionals (as discussed below) that foster an appropriate response to women's needs, thereby contributing to women's empowerment.

The consultation between a health professional and an individual woman is critical to the entire process of care and offers a unique opportunity to provide reliable, timely and quality information. This opportunity exists both when the physician or other medical professional performing the procedure provides information, and when counselors, who are an essential link in the provision of comprehensive abortion care, perform their duties effectively.

There are two important considerations when providing information: guaranteeing a rights focus and ensuring that the basic information is provided.¹⁹⁹ In relation to the first consideration, providing information about the abortion procedure can offer an important opportunity to address unequal power relationships between women and men, which often manifest in gender-based violence, problems about negotiating contraceptive use and other related issues. Using information as a vehicle for change, health care facilities can help to dismantle the gender inequalities that constitute an enormous cultural barrier for women's sexual and reproductive health.²⁰⁰ The basic information provided to women must address, at a minimum, the procedures, risks, consequences of those risks and what to expect after the procedure.

The following key factors are considered in the model proposal and recommendations:

- ❑ Policies should include public health activities directed at the general public.²⁰¹
- ❑ Campaigns on sexual and reproductive rights emphasizing legal abortion and the availability of services.²⁰²
- ❑ Mass media and public awareness activities.

¹⁹⁹ The **Peruvian** regulations establish not only what information should be provided, but also that the information should be understood (Perinatal Maternal Institute Guidelines).

²⁰⁰ The **Colombian** regulations require that counseling includes specific information for women with HIV/AIDS or in a violent situation. There is also a **Brazilian** abortion regulation addressing women victims of violence.

²⁰¹ In **Mexico**, the government is required to promote and implement integrated training policies on sexual and reproductive health, reproductive rights, and responsible motherhood and fatherhood.

²⁰² With the recent decriminalization of abortion in **Mexico**, it is mandatory for the Assembly to conduct outreach campaigns about the new law in Mexico City. In **Colombia**, nationwide mobilization activities are being conducted that focus on sexual and reproductive health, and emphasize legal abortion.

- Community activities to raise awareness about rights and increase use of services early in pregnancy.
- Activities to strengthen social support networks.
- Actions to generate public support for legal change.

The provision of information on an individual basis must guarantee:

- Respect for a woman's decisions.²⁰³
- Timely and truthful information about the procedure and its after-effects, including information about temporary and permanent contraceptive methods, condoms and emergency contraception.
- Identification of the minimum amount of information that must be provided. Emphasize the obligation of other sectors of society to provide information about legal abortion services, for example, representatives of the legal system that women come into contact with in cases of rape.
- Establishment of counseling models that encourage women's empowerment.²⁰⁴
- Understanding of women's cultural²⁰⁵ and intellectual situations.

10. Adopting protocols or technical guidelines for care²⁰⁶

The best way to guarantee compliance with minimum requirements for care is to implement technical guidelines for health professionals specifying the most appropriate abortion procedure according to weeks of pregnancy, pain management, pre- and post-abortion examinations, antibiotic prophylaxis, post-abortion counseling (including access to information and contraceptive methods)²⁰⁷ and other issues. Guidelines should also indicate what type of health professional is recommended for different procedures, level of care, and so on.

In 2003, the World Health Organization published guidelines, *Safe Abortion: Technical and Policy Guidance for Health Systems*, which explores all these issues and is an important starting point for creating protocols:²⁰⁸

²⁰³ In **Brazil**, one component of counseling is respect for the woman's decisions, no matter what they may be.

²⁰⁴ See **Brazil's** support model.

²⁰⁵ **Brazil's** support model encourages providers to adapt to the woman's cultural frame of reference.

²⁰⁶ [The comparative analysis of this issue is on pages 92-106.](#)

²⁰⁷ More information on contraceptive methods can be found in International Planned Parenthood Federation (2004) *Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services*. Third edition, London: IPPF.

²⁰⁸ Protocols should address the following topics, as a minimum: pre-abortion care (medical history, physical examination, laboratory tests, ultrasound, pre-existing conditions, infections, ectopic pregnancy, isoimmunization/Rh status, Pap smear, information and counseling), abortion methods (preparation of the cervix, pain management, surgical abortion, vacuum aspiration, dilatation and curettage, dilatation and evacuation, other methods, tissue analysis, medical abortion), other issues related to abortion procedures (control and prevention of infections, management

- ❑ Implement technical guidelines for care.²⁰⁹
- ❑ Include information on abortion procedures, pre-abortion examinations, pain management, antibiotic prophylaxis, levels of care, which health professionals can perform procedures, managing complications and post-abortion care. For pain management it is important to provide a chart that combines medication and emotional support to alleviate pain.²¹⁰
- ❑ Gestational limits must take into account the different reasons that women request abortions.²¹¹ For example, in cases of fetal malformation, or when the woman's life is in danger, gestational limits can become an additional barrier. For this reason, it is important to determine, according to weeks of gestation, which methods are most appropriate and what needs each procedure should meet as abortions at different stages of pregnancy entail different levels of risk.²¹²
- ❑ These guidelines must be mandatory for everyone involved in providing health services in the country, in both the public and private sectors.
- ❑ In no circumstances should any test be required in order to perform an abortion.²¹³

Regarding laboratory testing, the World Health Organization has stated: «in most cases, providers only require the information obtained from the woman's record and from a physical examination to confirm the pregnancy and estimate its length. Laboratory testing for pregnancy may not be needed, unless the typical signs of pregnancy are not clearly present and the provider is unsure whether the woman is pregnant. However, obtaining such tests should not hinder or delay uterine evacuation. Measuring haemoglobin or haematocrit levels to detect anaemia in areas where it is prevalent enables the provider to initiate treatment and be prepared if haemorrhage occurs at the time of or following the abortion procedure. Tests for ABO and Rhesus (Rh) blood group typing should be provided where feasible, especially at higher level referral centres, in case of complications that might require blood transfusion.... Ultrasound scanning is not necessary for the provision of early abortion (RCOG 2000). Where it is available, ultrasound can aid the detection of ectopic pregnancies beyond about six weeks of pregnancy. Some providers

of complications), follow-up (recovery), service implementation (type of services, referral mechanisms, decision making), provider training and performance, monitoring and evaluation. World Health Organization (2003) *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO.

209 For detailed care guides: World Health Organization (previous footnote), **Colombia, Brazil and Peru**.

210 **Colombia, Peru and Brazil**.

211 See **Colombia**, which does not establish gestational limits. For systems that consider the circumstances, see **South Africa** and **Guyana**.

212 See World Health Organization (2003) *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO. Chapter: Abortion Methods.

213 An explicit prohibition such as this is found in the **Colombian** regulation.

find the technology helpful before or during abortion procedures at later stages of pregnancy.»^{214, 215}

Guidelines for care must also include biosecurity protocols.²¹⁶ The most important of these include:²¹⁷

- i. Hygiene guidelines for personnel before and after the procedure.
- ii. Antisepsis before the procedure.
- iii. Disposal of needles, syringes and other sharp objects.
- iv. Decontamination of reusable instruments.
- v. High level disinfection – sterilization.
- vi. Storage of instruments and other materials.
- vii. Personnel's use of protective garments (gloves, goggles, masks, gowns).
- viii. Cleaning and disinfection areas.
- ix. Elimination of contaminated waste.

11. Determining the infrastructure necessary to provide services, mechanisms for the accreditation (certification) of professionals and content of the accreditation system based on the proposed educational requirements^{218, 219}

The World Health Organization has stated that, in general, abortion is a simple procedure when it is performed by appropriately trained professionals. Consequently, a large number of abortions (especially during the first weeks of pregnancy, when there are no complications) can be performed in outpatient facilities²²⁰ that comply with minimum

²¹⁴ World Health Organization (2003) *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO. p.24.

²¹⁵ Some countries require certain tests. In **Colombia**, it is obligatory to provide the option of an HIV test and for blood typing in case a transfusion is required: administering anti-D immunoglobulin for Rh-negative women is recommended, but not the test to determine Rh (Art. 6.4.1.3 and 6.4.2, Technical Regulation on Care for the Voluntary Interruption of Pregnancy). **Brazil**: offering blood typing, syphilis and HIV testing (4. Clinical Abortion Care, Technical Regulations for Humane Abortion Care). **Puerto Rico** requires an Rh and antibody test (Art. H, General Regulations on the Operations and Functioning of Health Facilities in Puerto Rico).

²¹⁶ **South Africa**, for example, has developed a guide on the reuse of manual vacuum aspiration equipment and recommends following international standards on the use of gloves, masks, etc.

²¹⁷ International Planned Parenthood Federation/Western Hemisphere Region (2007) *Promoting Real Options: A Multi-country Project to Address the Integrated Management of Unwanted Pregnancy and Abortion in Latin America and Caribbean. Evaluating the Quality of Comprehensive Services for Unwanted Pregnancy*. New York: IPPF/WHR.

²¹⁸ This requires mechanisms to monitor compliance.

²¹⁹ [The comparative analysis of this issue is on pages 106-112.](#)

²²⁰ Outpatient services are those services that do not require a hospital infrastructure. Some health services certification systems use the term to refer to the method of care for a group of services that do not require 'admission' of the individual, such as consultations, therapies, imaging, urgent care, laboratory tests, and so on. According to some

requirements similar to those required for other outpatient sexual and reproductive health services.

II. Measures to eliminate barriers related to service quality: guaranteeing rights and quality standards

5. Informed consent
6. Conscientious objection
7. Confidentiality, medical confidentiality and privacy of services
8. Cultural considerations
9. Systematic dissemination of information to promote services to the general public and providing information to individual clients
10. Adopting protocols or technical guidelines for care
11. Determining the infrastructure necessary to provide services, mechanisms for the accreditation (certification) of professionals and content of the accreditation system based on the proposed educational requirements

III. Measures to eliminate barriers related to the education and training of health professionals

12. Medical and psychosocial training/education²²¹

In order to provide integrated care that truly encourages the exercise of rights, all health personnel involved in providing abortion services should receive specialized education and training – not only on abortion procedures but also on the delivery of health care with a gender and rights perspective that encourages women’s empowerment and that addresses ethical and social issues. Education should be provided at various levels and can also help to eliminate stereotypes and cultural barriers.

The two most important types of education include education at the university level and ongoing training at the facilities where medical professionals work.²²² Professional

definitions, admission means entrance into a hospital to receive medical and/or surgical treatment for a period greater than 24 hours. If the time period is less than 24 hours, it is considered outpatient care.

²²¹ [The comparative analysis of this issue is on page 114.](#)

²²² Continuing training is the responsibility of facilities that provide abortion services.

associations are ideal for these types of initiatives.²²³ Education and training must ensure that the professionals who provide abortion services meet medical accreditation requirements.

As a minimum, technical training must include abortion procedures (surgical and medical), pain management, managing complications, antibiotic prophylaxis, pre-abortion examinations and post-abortion counseling (including contraceptive counseling and provision). As these recommendations make clear, abortion services require the involvement of a range of professionals organized in multi-disciplinary teams.

In addition, physicians, midwives, nurses, counselors, social workers and administrative staff should receive training on gender, rights, bioethics and empowerment. Training can help to reduce or eliminate gender stereotypes in health care but must also sensitize personnel so that they can detect and address special situations such as gender-based violence. A rights and gender focus should ensure that personnel provide women with counseling on different options for unwanted pregnancy, emotional support and with respect for a woman's decision. Requiring a husband or partner's consent, or making moral judgements about a woman's decision to end a pregnancy, are just two of the stereotypes and harmful customary attitudes and practices that education and training can help to eliminate.

The following key factors are considered in the model proposal and recommendations:

- Ongoing education at the facilities where professionals work.
- Municipalities and other departmental divisions, in collaboration with universities and hospitals, must encourage continuing education and training for health professionals.²²⁴
- Education and training must include a gender and rights focus as well as technical aspects.²²⁵
- Education must prepare health professionals to provide emotional support to women.
- Training must help to eliminate attitudes and practices that are harmful or limit women's exercise of their rights.
- Encourage the creation of multi-disciplinary teams to provide services.
- Involve faculties of medicine so that they incorporate sexual and reproductive health and comprehensive abortion care in their academic programs.²²⁶

²²³ Professional associations should play an important educational role in many areas on this issue: academic debate, scientific argument, defining criteria for provider certification, training providers, monitoring compliance with regulations, writing reports for Congress, and so on.

²²⁴ **Italy**: Regulation for the Social Protection of Motherhood and Voluntary Interruption of Pregnancy (1978).

²²⁵ See personnel training in **Brazil**, which emphasizes sensitization.

²²⁶ The **Italian** regulations identify universities, among others, as responsible for training health personnel.

III. Measures to eliminate barriers related to the education and training of health professionals

12. Medical and psychosocial training/education

IV. Measures to eliminate barriers related to data collection, monitoring and oversight systems

13. Data management²²⁷

Good public health decisions can only be made when they are based on high quality and current data. Given this concern, and the difficulties of collecting data relating to abortion, it is crucial that abortion-related statistics are included in the existing health care data collection systems in each country. Data management must include mechanisms – as part of the epidemiological monitoring system – for codifying procedures and reporting complications in order to monitor service quality and the timeliness of services provided to women. However, reporting should not be reduced to statistics on procedures and complications; it should also include comprehensive information on barriers to service provision and socio-demographic client data.

Data management must also draw on other sources, including service quality evaluations, which are critical in this field. In an area of service provision as complex as abortion, and its attendant dilemmas, service quality is crucial and abortion regulations must address quality of care issues and the evaluation of both facilities and providers. Although quality of care evaluations may be a routine practice at health facilities (for example, oversight of data collection, appropriate management of medical records, and so on), including the client's evaluation of the health care she has received is an essential component of evaluating abortion services.

Finally, research should be encouraged as an essential tool to expand knowledge about abortion and, in particular, to determine how timely access to legal services can help to reduce complications. Research on the costs and benefits of safe abortion services, the circumstances of the women who request abortions, the magnitude of the problem of rape and its relationship to abortion, as well as other issues, are just some of the areas of enquiry that would undoubtedly help to improve abortion care. All information – whether from medical records, evaluations or research – should be used to improve services and

²²⁷ [The comparative analysis of this issue is on page 118.](#)

as a tool to create change on various levels, including improvement of regulations and compliance mechanisms, improved quality standards, and improved conditions for the exercise of rights, among others.

Key elements of information management systems include the following:

- System for collecting abortion service data.²²⁸
- Reporting complications²²⁹ and infections to monitoring systems.
- Information should be sent to a central statistical system²³⁰ for timely decision making.
- Public dissemination of this information on a regular basis.²³¹
- Ensure that information available to the public is transparent, reliable and accurate.
- Systems to ensure that facilities comply with quality standards.
- Provider evaluations of quality: how they view their working conditions, and how they evaluate themselves and the quality and timeliness of services, including full respect for women and their decisions.
- Client evaluations of provider quality and overall services.
- Implement systems for appropriate management of medical records, including what information is recorded (so that it is complete and legible), monitoring and clinical audits.

14. Monitoring, compliance and oversight systems of individual facilities²³²

Regulating the technical and psychosocial aspects of abortion services is an extremely important requirement for the provision of abortion services. However, regulations are useless without effective mechanisms to guarantee compliance from all individuals and entities within the health system. Senior level health officials must, therefore, put mechanisms in place that ensure compliance with the regulations and, in particular, guarantee timely access to legal abortion services.

The following key factors are considered in the model proposal and recommendations:

- Establish data management systems to periodically collect information on compliance of activities and requirements related to abortion services.
- Establish which entities or officials will conduct oversight activities.²³³

228 Colombia, Guyana, Spain, South Africa and Norway.

229 Including maternal deaths.

230 Spain (Order of 16 June 1986, Art. 1). Colombia (Circular 0031 of 2007).

231 See Spain, where the format is annual reports.

232 [The comparative analysis of this issue is on page 121.](#)

233 Guyana, Colombia and Spain have done so.

- ❑ Be vigilant in preventing the imposition of additional administrative requirements that would delay services.
- ❑ Monitor timeliness of service provision.
- ❑ Create mechanisms within health facilities to appeal against decisions that deny services²³⁴ with higher authorities, up to and including the highest health officials or other governing board as the body of last resort.
- ❑ **Establish measures to eliminate employment or social discrimination against abortion providers.**²³⁵
- ❑ Create mechanisms for community monitoring of health services and facilities.
- ❑ Create mechanisms to establish obligatory reporting to the parliament²³⁶ or other legislative body as a way to maintain oversight over the Ministry of Health.
- ❑ Define penalties for denial of services or failure to comply.²³⁷
- ❑ Establish mechanisms to begin proceedings to impose penalties.²³⁸

Penalties should be defined by law and address failure to provide services,²³⁹ unnecessary delay and the imposition of requirements other than those allowed by law or which create a disproportionate burden on women. These penalties must also address violation of confidentiality, which should be prohibited by medical ethics boards.²⁴⁰

IV. Measures to eliminate barriers related to data collection, monitoring and oversight systems

13. Data management

14. Monitoring, compliance and oversight systems of individual facilities

²³⁴ **Norway** has the broadest appeal mechanism. One of its most interesting aspects is that it is automatic: when an abortion is denied, the case is immediately sent to a superior.

²³⁵ See Decree 4444 of 2006. **Colombia**.

²³⁶ **Italy**.

²³⁷ See **Mexico, Guyana, Colombia, Peru, Brazil** and **Norway**.

²³⁸ **Colombia**. Art. 7 of Decree 4444 of 2006.

²³⁹ See the **Colombian, Guyanese, Norwegian, Brazilian** and **Mexican** models.

²⁴⁰ See note 188. [Uruguay Declaration](#).

V. *Measures to reduce barriers related to costs: funding*

15. Create a fee policy²⁴¹

Because abortion services have a high cost-benefit relationship,²⁴² they should be free for women at the lowest socio-economic levels,²⁴³ and in no circumstance should payment (fees, coupons, sliding scale fees, co-pays, vouchers)²⁴⁴ be a barrier to access.²⁴⁵ Services should ideally be free to all, although sliding scale fees and cross-subsidization that require women with greater resources to subsidize women with fewer resources is an option.

The fee policy must apply to the public and private sectors – as allowed in each country – and should establish fees, if any, in accordance with ability to pay and not based on the medical needs of the clients – in other words, clients should not be charged more if they require more expensive care. Payment policies for adolescents should also be revised to guarantee free services to adolescents and to create mechanisms that recognize them as rights holders in matters of sexual and reproductive health.

The following key factors are considered in the model proposal and recommendations:

- Provide free services for the poorest women.
- Provide free services for adolescents.
- Create mechanisms to recognize adolescents as sexual and reproductive rights holders.
- Develop mechanisms to prevent costs from becoming a barrier to access.
- Any fees should be on a sliding scale in accordance with ability to pay and not the medical needs of the clients.²⁴⁶

²⁴¹ [The comparative analysis of this issue is on page 128.](#)

²⁴² Timely and safe abortion care has numerous positive impacts both on health systems and on women. In contrast, care that is not provided in the timeliest manner creates enormous costs. Failing to act in a way that creates positive impacts results in what is called ‘costs of the omitted action’: those costs are the result of failing to act in order to avoid greater costs at various levels. Consequently, providing abortion care results in the protection of human lives (by avoiding deaths due to unsafe abortions) and a reduction of costs for the health system (by reducing complications). Cristovan Buarque, Former Governor of Brasilia, Brazil, and Professor of Economics at the University of Brasilia. From a speech given at the World Bank, Washington DC, 2000.

²⁴³ **Mexico** and **Colombia** specifically provide free services for poor women at public hospitals.

²⁴⁴ These are some of the terms used for the (out-of-pocket) payments women must make in return for services.

²⁴⁵ These recommendations on costs should also be applied to the provision of contraceptive methods after an abortion in order to decrease unwanted or unplanned pregnancies, repeated abortions and complications.

²⁴⁶ This is a basic principle of health sector reforms that seek to increase equity.

16. Creating and implementing instruments to identify the socio-economic situation of different populations^{247, 248}

These instruments should be used to identify specific populations' capacity to pay in order to give preference to women who cannot afford to pay for services. As an example, the cost of abortion services in Colombia is based on a population's ability to pay as determined by a system called SISBEN.²⁴⁹ This system identifies which populations should receive free services and which should pay for services. These mechanisms do not need to specifically classify the population receiving abortion services, but should be general mechanisms used for providing health care.

V. Measures to reduce barriers related to costs: funding

15. Create a fee policy

16. Creating and implementing instruments to identify the socio-economic situation of different populations

VI. *Measures to reduce administrative barriers*

Although laws govern when women can access abortion services, both national health authorities and health institutions issue administrative provisions to regulate access to services. These measures often attempt to restrict the legal grounds for abortion or make them more complex by using 'scientific' arguments to limit access to services. Abortion regulations must therefore prevent these types of situations from occurring and facilitate an environment that does not attempt to impose additional barriers to services or disproportionate burdens on women.

17. Avoid additional requirements for abortion services²⁵⁰

Additional requirements may include filing criminal charges (when abortion is not legal), judicial authorization, forensic medical examinations, authorization by a number of medical professionals, creating ethics committees and third party consent, to name just

²⁴⁷ The usefulness of this measure depends on the performance of the health system's financing system in each individual country.

²⁴⁸ [The comparative analysis of this issue is on page 130.](#)

²⁴⁹ See Chapter IV of the comparative analysis for the definition of SISBEN on page 130.

²⁵⁰ [The comparative analysis of this issue is on page 130.](#)

a few.²⁵¹ In all cases, it is important to favor the implementation of simple procedures and requirements and avoid the involvement of multiple professionals or boards that delay the provision of services.

During the first 12 weeks, an abortion should be performed at the woman's request, without any other requirements.

18. Avoid restrictive interpretations of the grounds for abortion, when such grounds are required for a legal abortion²⁵²

Interpretations of the health exception often become a list of pathologies that may not look at a woman as a whole or be in accordance with the World Health Organization's definition of health as a state of physical, mental and social well-being and not merely the absence of illness.²⁵³

It is therefore important to define criteria that help health professionals to interpret health or socio-economic grounds (the latter may be structural or temporary) in a broad and comprehensive manner from a human rights, social justice and gender equality perspective. The objective of such criteria should be to allow for a broader application of these grounds.

19. Create conditions for the use of medications recommended for abortion by the World Health Organization, particularly misoprostol and mifepristone²⁵⁴

In countries where these medications are not registered, mechanisms should be established to begin the registration process on public health grounds. Although individual health facilities cannot make this decision, it is clear from the experiences of various countries that when a medication (misoprostol, in many countries, for example) is registered, but its indicated usages do not include gynecology and obstetrics, health authorities should initiate the necessary mechanisms to expand the indication and guarantee its availability

251 Colombia's model is one of the simplest in terms of the requirements established by the court case: medical certificate (without specifying specialization) or a police report in cases of rape.

252 [The comparative analysis of this issue is on page 139.](#)

253 In Peru, for example, the Protocol of Hospital Belén de Trujillo and the Perinatal Maternal Institute Guidelines include definitions on health grounds that are restrictive according to the World Health Organization's broader definition of health.

254 [The comparative analysis of this issue is on page 141.](#)

for abortion procedures.²⁵⁵ Indicated usages should include the general management of obstetrics-related hemorrhage.²⁵⁶

Both the Federación Latino Americana de Sociedades de Obstetricia y Ginecología (Latin American Federation of Obstetrics and Gynaecology Societies/FLASOG) and the World Health Organization support this recommendation. FLASOG, in the latest edition of *Use of Misoprostol in Obstetrics and Gynecology*, stated: «There is no doubt that misoprostol is currently in wide use by gynaecologists and obstetricians in Latin America.²⁵⁷ In a survey on use of misoprostol conducted in three countries, physicians replied that they used it to evacuate the uterus in case of intrauterine fetal death (61%), in case of missed abortions (57%) and to induce labour (46%). Its popularity may be accounted for by the fact that it is cheap, heat-stable and effective in producing contractions of the uterus.... [However,] use of drugs for indications other than those approved is fairly common practice, and is accepted, for example, by the United States Food and Drug Administration, which has stated that: ‘Good medical practice and the best interests of the patient require that physicians use legally available drugs... according to their best knowledge and judgement. If physicians use a product for an indication not in the approved labelling, they have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain records of the product’s use and effects.’»

The World Health Organization has included misoprostol on the complementary list of essential medicines.²⁵⁸ «The **complementary list** presents essential medicines for priority diseases, for which specialized diagnostic or monitoring facilities, and/or specialist medical care, and/or specialist training are needed. In case of doubt medicines may also be listed as complementary on the basis of consistent higher costs or less

²⁵⁵ In **Colombia**, the Review Committee of the National Institute for Drug and Food Surveillance (INVIMA), at the request of the National Public Health Office in the Ministry of Social Welfare, authorized the use of misoprostol for abortion in the circumstances provided for in Case C-355, which decriminalized abortion in some circumstances. The Ministry’s request was based on public health reasons and used the concept of broadening the indication of a product registered previously by a laboratory for purposes other than gynecology/obstetrics. Act 20 of 2007. INVIMA.

²⁵⁶ The use of this medicine should be encouraged for gynecology/obstetrics indications other than abortion, such as obstetrics-related hemorrhage.

²⁵⁷ [Faúndes, A \(ed\) \(2007\) *Use of Misoprostol in Obstetrics and Gynecology*. Second Edition. Latin American Federation of Obstetrics and Gynaecology Societies/ FLASOG.](#)

²⁵⁸ In the Explanatory Notes, the [World Health Organization Model List of Essential Medicines](#) (revised March 2005) defines the two types of lists classifying medicines. The **core list** presents a list of minimum medicine needs for a basic health care system, listing the most efficacious, safe and cost-effective medicines for priority conditions. Priority conditions are selected on the basis of current and estimated future public health relevance, and potential for safe and cost-effective treatment. The complementary list defined in these notes is also managed by the World Health Organization.

attractive cost-effectiveness in a variety of settings.» Misoprostol (vaginal tablet of 25µg), and mifepristone and misoprostol (composed of 200mg and 200µg respectively), appear on the Oxytocics complementary list (Number 22.1) in section 22, Oxytocics and Antioxytocics.²⁵⁹ Health professionals should be trained in the use of all medicines that are included on the World Health Organization's list of essential medicines.

20. Establish mechanisms and strategies to convert pharmacies into allies that provide accurate information and timely referrals to an appropriate health facility for women seeking services. Health authorities should conduct information campaigns targeting pharmacies in order to strengthen their role in prevention efforts
21. Involve and coordinate with other key sectors, including education, media, and the judiciary

VI. Measures to reduce administrative barriers

17. Avoid additional requirements for abortion services
18. Avoid restrictive interpretations of the grounds for abortion, when such grounds are required for a legal abortion
19. Create conditions for the use of medications recommended for abortion by the World Health Organization, particularly misoprostol and mifepristone
20. Establish mechanisms and strategies to convert pharmacies into allies that provide accurate information and timely referrals to an appropriate health facility for women seeking services. Health authorities should conduct information campaigns targeting pharmacies in order to strengthen their role in prevention efforts
21. Involve and coordinate with other key sectors, including education, media, and the judiciary

²⁵⁹ It is worth noting that it is the only medicine to appear with the notation: «Where permitted under national law and where culturally acceptable.»

Final note

Establishing effective health regulations or improving existing ones requires a clear commitment from health officials to support women's sexual and reproductive rights and to create the conditions that enable timely access to safe abortion services. This commitment is often strengthened when there is social and political pressure to address these issues within the public health agenda.

For this reason, it is important to ensure that health officials have access to information that will encourage favorable policy-making. It is equally critical to work closely with civil society groups and to establish clear advocacy strategies, which should include developing alliances with local professional associations of doctors, nurses and other health care providers.

This publication aims to serve as a reference tool for decision makers by providing clear information on regulations in other countries, highlighting their best features as well as those that serve as barriers or create disproportionate burdens on women. In addition to the information provided in the comparative analysis, this tool also includes a model with recommendations on the many measures that should be considered when creating health regulations for abortion services: **measures to help eliminate barriers and promote access, to ensure that women can exercise their sexual and reproductive rights, and to provide certainty and a solid framework for providers.**

With respect to advocacy strategies, this publication can serve as a resource for groups in the region seeking to expand the breadth of women's rights in the area of sexuality - rights that are not limited to reproduction. Groups that are working towards the implementation of comprehensive abortion regulations must analyze the situation in each country to determine the level of political commitment for creating and enforcing compliance with such regulations. In addition, it is important to discuss different strategies to advance women's rights in order to avoid false divisions, particularly between strategies for the legalization of abortion and strategies that foster access to abortion in circumstances where it is decriminalized.

Some key elements in any advocacy strategy include the following steps:

- Analyze the country context and establish a path for securing health regulations that encourage the exercise of rights.
- Map the characteristics of the different actors involved and determine who can influence the issue based on at least two levels: the extent of the actor's influence and his or her position on abortion regulations.

- Foster coordination among those parts of the women's movement that work on the medical aspects of access and those that work on legal aspects to decriminalize abortion; emphasize public health, not the penal code, as the focus of the debate.
- Involve legal professionals interested in high impact litigation to respond to claims of negligence or denial of abortion services.
- Involve health professionals' associations (including midwives and obstetricians) in efforts to advocate for the implementation of abortion regulations.

IPPF/WHR encourages decision makers and advocates committed to supporting women's right to safe and legal abortion to use these tools.

Index of laws and regulations

Index of laws and regulations

Country	Law or regulation	Source	Topic
Bolivia ¹	Penal Code (1972)	Government	Establishes conditions for access
	Seguro Universal Materno Infantil (2002)	Congress	No information relevant to the topic
	Protocolo para la Atención de la Mujer Embarazada	Ministry of Health	Incomplete and septic abortion care
	Paquete de Servicios Mujer Embarazada	Ministry of Health	Incomplete and septic abortion care
Brazil ²	Norma técnica: Atensão humanizada ao abortamento (2005)	Ministry of Health	Medical care for all types of abortions, including legal abortion: consent, procedures, privacy, etc
	Norma Técnica: Prevenção e tratamento dos agravos resultantes da violência sexual contra mulheres e adolescentes (2005)	Ministry of Health	Medical care for abortion in cases of sexual violence
	Norma Técnica: Prevenção e tratamento dos agravos resultantes da violência sexual contra mulheres e adolescentes (2002)	Ministry of Health	Medical care for abortion in cases of sexual violence
	Portaria nº 48 de 13 de Agosto de 2001 (Inclusão para reembolso pelo SUS)	Ministry of Health	Includes manual vacuum aspiration procedures for reimbursement
Canada	R versus Morgentaler (1988)	Supreme Court of Canada	Decriminalization of abortion
	Tremblay versus Daigle (1989)	Supreme Court of Canada	Women's autonomy
	Civil Liberties Association versus British Columbia (1988)	Supreme Court of British Columbia	Economic issues
	Morgentaler versus Prince Edward Island (1995)	Supreme Court of Prince Edward Island	Economic issues
Colombia	Decreto que reglamenta Aspectos de Salud Sexual y Reproductiva (2006)	Ministry of Social Welfare	Availability of services, establishes that technical regulations are compulsory, conscientious objection, prohibition against discrimination, sanctions
	Resolución que adopta Norma Técnica (2006) con Anexos	Ministry of Social Welfare	Enacts the technical regulations, codifies procedures, data collection, oversight and professional education
	Norma Técnica IVE (2006)	Ministry of Social Welfare	Methods, intake and follow-up
	Acuerdo CNSSS que incluye procedimientos (2006)	National Council on Social Security in Health	Includes procedures in the health system
	Circular 031 de 2007 con Información sobre la provisión de servicios seguros de interrupción voluntaria del embarazo, no constitutiva del delito de aborto (2007)	Ministry of Social Welfare	Reporting of approved and available institutions, clarifies some data collection issues
	Acta de aprobación uso de medicamentos (2007) See point 2.9.39	National Institute for Drug and Food Surveillance (INVIMA)	Approves misoprostol
Guyana	Medical Termination of Pregnancy Act (1995)		All aspects of termination of pregnancy
	Medical Termination of Pregnancy Regulations (1995)		Counseling, approval of facilities, medical authorization, data
Italy ³	Norme per la tutela sociale della maternita' e sull'interruzione volontaria della gravidanza (1978)	Congress	Access, privacy, gestational limits
Mexico	Penal Code (2004) – see amendments below		Requirements in accordance with grounds for abortion and right to information
	Modificación Código Penal (2007)	Mexico City Legislative Assembly	Allows abortion before 12 weeks
	Código de Procedimiento Penal (2004)		Permission in cases of rape or non-consensual insemination and right to information
	Ley de Salud Pública (2004) – see amendments below	Mexico City Legislative Assembly	Access to services at public facilities, informed consent, conscientious objection
	Modificación Ley de Salud Pública (2007)	Mexico City Legislative Assembly	Clarifies that services are free, sexual and reproductive health policies

Index of laws and regulations

Country	Law or regulation	Source	Topic
	Lineamientos Generales de Organización y Operación de los Servicios de Salud relacionados con la Interrupción del Embarazo en el Distrito Federal (2006) que modificó una circular anterior (2002) – see amendments below	Mexico City Health Department	Requirements based on grounds for abortion, medical personnel, conscientious objection, facilities, procedures, informed consent, relationship to other departments
	Reforma Lineamientos Generales de Organización y Operación de los Servicios de Salud relacionados con la Interrupción del Embarazo en el Distrito Federal (2007)	Mexico City Health Department	Defines some concepts, requirements to access abortion, reports, requirements for facilities, waiting times, medical files, confidentiality
Norway	Acuerdo para Procedimiento en caso de Violación (2006) que reformó acuerdo anterior (2002)	Attorney General of Mexico City	Procedure to obtain permission from the Ministry in cases of rape, procedure for minors not in agreement with parents
	Termination of Pregnancy Act (1975, amended in 1978)		Grounds and duration of pregnancy, facility and professional that may perform abortions, informed consent, administrative procedures, conscientious objection
	Regulation for the Implementation of the Act concerning Termination of Pregnancy (1975)		Administrative procedure for abortions
Panama ⁴	Penal Code (1982)	Congress	Requirements for abortion: grounds, professionals, permission from the National Multidisciplinary Commission on Therapeutic Abortion
	Oferta de Servicios de Salud del Sistema de Protección Social (2005)	Ministry of Health	Post-abortion treatment, oversight and follow-up (does not indicate what care consists of)
	Resuelto N° 02007 de agosto 2 de 1988 del Ministerio de Salud (1988)	Ministry of Health	Orders the creation of the National Multidisciplinary Commission on Therapeutic Abortion
Peru ⁵	Resolución 1 de abril de 1989 de la Comisión Multidisciplinaria Nacional de Aborto Terapéutico (1989)	National Multidisciplinary Commission on Therapeutic Abortion	Requirements for abortion access, consent, waiting times, professionals that may perform abortions, facilities where abortions may be performed, when the commission meets and its powers
	Penal Code (1924)	Congress	Grounds for abortion, requirement for informed consent and that a doctor performs the abortion
	Guía de Atención Integral en Salud Sexual y Reproductiva (2004)	Ministry of Health	Post-abortion care (treatment of obstetric hemorrhages associated with abortion), treatment of incomplete abortion with different complications (includes family planning counseling), also includes treatment for women with incomplete abortion
	Manual de Orientación/Consejería en Salud Sexual y Reproductiva (2006)	Ministry of Health	Post-abortion counseling, content of counseling (p.23), specialized counseling for adolescents that does not explicitly include abortion (p.31)
	Plan General de la Estrategia Sanitaria Nacional de Salud Sexual y Reproductiva (2004)	Ministry of Health	Chapter on adolescents' sexual and reproductive rights, including integrated abortion care with specific services (p.6); care for adults, which only includes post-abortion care (p.7); one objective is to improve incomplete abortion care (p.8); special sexual and reproductive health services for adolescents, which only includes incomplete abortion and complications
	Estrategia Sanitaria Nacional de Salud Sexual y Reproductiva	Ministry of Health	Does not address abortion
	Directiva del Instituto Materno Perinatal (2007)	National Perinatal Maternal Institute (repealed)	Therapeutic abortion
	Protocolo de Manejo de Casos para la Interrupción Legal del Embarazo (2006)	Hospital Belén de Trujillo Gynecology Department	Therapeutic abortion
	Informe técnico Misoprostol	General Office of Medications, Supplies and Drugs	Approves purchasing of medications by the Pharmacological Commission of the Perinatal Maternal Institute for missed and incomplete abortion

Index of laws and regulations

Country	Law or regulation	Source	Topic
	Resolución Directorial 1988 (2003)	General Office of Medications, Supplies and Drugs, Ministry of Health	Authorization of Prostokos
	Guía de Práctica Clínica de Emergencias Obstétricas, según nivel capacidad resolutive (2007)	Ministry of Health	Procedures for complete abortion, inevitable/incomplete abortion, missed abortion and infected abortion relating to equipment, tests and procedures, manual vacuum aspiration protocol; post-abortion counseling (although it does not address legal abortion, only incomplete abortion)
Puerto Rico ⁶	Reglamento General para la Operación y Funcionamiento de las Facilidades de Salud en Puerto Rico (1999)	Government of Puerto Rico, Health Department	Requirements for medical facilities and doctors, availability for emergencies, facilities' authority to create their own protocols, anesthesia, tests)
	Ley de Facilidades de Salud (1965)		Authority of the Health Department to regulate 'places where abortions are performed'
	Proyecto para Reglamentar el Licenciamiento, Operación y Mantenimiento de Facilidades de Salud Ambulatorias (Centros de Planificación Familiar y Terminaciones de Embarazo)	Health Department	Health facility licenses, facilities' statistics, inspection, internal organization and regulations, medical personnel, tests, requirements for health facilities, infection control, program to improve quality, and data collection and management
South Africa	Choice on Termination of Pregnancy Act (1996)	Parliament	Circumstances and conditions when pregnancy can be terminated, places where abortions can be performed, personnel authorized to perform abortion, information, consent of minors
	Amendment (2004)	Parliament	Authorities and personnel that can perform abortions
	Circular H97/2000 (2000)	Health Department	Primary care, referrals, information, procedures, conscientious objection, medical personnel, post-abortion management, counseling, infection control, biosecurity standards, information systems
Spain ⁷	Penal Code (1985)	Congress	Gestational limits, specialists, consent, authorization
	Ley General de Consentimiento Informado (2002)	Congress	Informed consent
	Real Decreto sobre Centros Acreditados y Dictámenes Preceptivos para la Práctica de Abortos Legales (1986)	Ministry of Health	Requirements for access
	Orden de 16 de junio de 1986 sobre Estadística e Información Epidemiológica de las Interrupciones Voluntarias del Embarazo realizadas conforme a la Ley Orgánica 9/1985 (1986)	Ministry of Public Health and Consumer Affairs	Collection of abortion data
	Resolución de 4 de febrero de 2000, de la Subsecretaría, sobre Estadística e Información Epidemiológica de las Interrupciones Voluntarias del Embarazo realizadas conforme a la Ley Orgánica 9/1985, de 5 de julio (2000)	Ministry of Public Health and Consumer Affairs	Forms for data collection

¹ Abortion is legal in cases of sexual violence, incest, rape, health or life of the woman. Maternal infant insurance (SUMI) is a comprehensive medical care package.

² Abortion is legal only to save the life of the woman and in cases of rape or incest. Authorization is on a case by case basis when fetal malformations incompatible with life are present.

³ Before 90 days for health, life of the mother, familial socio-economic conditions, circumstances of the conception or fetal problems. After 90 days: life of the mother and fetal malformation.

⁴ In Panama, there are two important health laws – the Health Code and the Health Policy – which could possibly address termination of pregnancy but do not include any provisions on the topic.

⁵ In Peru, there are extensive health regulations on sexual and reproductive health, especially emergency contraception.

⁶ Abortion is legal in the same circumstances as in the USA. Services are free in cases of rape or incest.

⁷ Abortion is allowed to save the life or health of the woman, fetal malformations or rape.

Index of documents

Index of documents

Title	Author	Topic
Health systems and the right to health: an assessment of 194 countries. <i>The Lancet</i> . 372(9655), pp.2047–2085 (2008).	Backman, Gunilla; Hunt, Paul; Khosla, Rajat; et al.	Right-to-health features of health systems, health service indicators
Invoking Conscientious Objection in Reproductive Health Care: Evolving Issues in Latin America. Thesis for the degree of Master of Laws, Graduate Department of Law, University of Toronto (2005).	Casas, Lidia C	Conscientious objection in Latin America
Objeción de conciencia médica. Bogotá (2005).	Castillo Vargas, Elizabeth	Conscientious objection in Colombia
La objeción de conciencia al aborto: su encaje constitucional.	Cebriá García, María	Conscientious objection in Spain
Gaining Ground. A Tool for Advancing Reproductive Rights Law Reform. Chapter X: Adolescents' Reproductive Rights (2006).	Center for Reproductive Rights	Sexual and reproductive rights and adolescents
Implementing Adolescent Reproductive Rights Through the Convention on the Rights of the Child (1999).	Center for Reproductive Rights	Sexual and reproductive rights, adolescents and access to services
Transparency in the delivery of lawful abortion services. <i>Canadian Medical Association Journal</i> . 180(3), pp.272-273 (2009).	Cook, Rebecca	Government obligations, transparent access to legal abortion services
Human rights dynamics of abortion law reform. <i>Human Rights Quarterly</i> . 25, pp.1-59 (2003).	Cook, Rebecca and Dickens, Bernard	Abortion law reform, health and human rights
Declaración sobre secreto médico. Uruguay (2007).	Faculty of Medicine of the University of the Republic, the Arbitration Tribunal of the Sindicato Médico del Uruguay (SMU) and the Ethics Board of the Federación Médica (FEMI)	Reiteration of obligation on physicians and health personnel to maintain medical confidentiality
Uso del Misoprostol en obstetricia y ginecología. Federación Latino Americana de Sociedades de Obstetricia y Ginecología (2007).	Faúndes, Anibal (editor)	Misoprostol use in Latin America
Uso del Misoprostol en Obstetricia y Ginecología. Federación Latino Americana de Sociedades de Obstetricia y Ginecología (2007).	Federación Latino Americana de Sociedades de Obstetricia y Ginecología	Misoprostol doses in different cases
Instructions for Use of Misoprostol for Treatment of Incomplete Abortion and Miscarriage. Gynuity Health Projects and Reproductive Health Technologies Project (2004).	Gynuity Health Projects and Reproductive Health Technologies Project	Misoprostol doses
Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services (2004).	International Planned Parenthood Federation	Sexual and reproductive health issues: contraception, sterilization, fertilization, HIV, safe abortion and others
Entre la espada y la pared: el secreto médico y la atención pos aborto. Ipas Centroamérica. Nicaragua (2004).	McNaughton, Heathe Luz; Padilla, Karen Z; Hernández, Emilia; de Hernández, Patricia; Ramírez, Patricia	Physicians reporting women who have abortions in El Salvador
Misoprostol use in obstetrics and gynecology. <i>Outlook</i> . 21(4) (2005).	PATH. Herdman, Cristina (editor)	Misoprostol in the United States
Penal Code Norway (1902).		Legal classification of sexual abuse
Too Far to Walk: Maternal Mortality in Context (1994).	Thaddeus, Sreen and Maine, Deborah. Published in <i>Social Science and Medicine</i>	Study on factors that affect maternal mortality in developing countries
The Evolving Capacities of the Child (2005).	UNICEF Innocenti Research Centre	Comprehensive study on the concept, application and models on the evolving capacities of children to encourage them to make their own decisions
Convention on the Rights of Persons with Disabilities (2006).	United Nations	Declaration of the rights of persons with disabilities
Safe Abortion: Technical and Policy Guidance for Health Systems. Geneva (2003).	World Health Organization	Abortion care protocol
WHO Model List of Essential Medicines, 14th edition (March 2005).	World Health Organization	List of essential medications
Challenges and possibilities for innovative praxis in health and human rights: reflections from Peru. <i>Health and Human Rights</i> . 6(1), pp.35-62 (2002).	Yamin, Alicia Ely	Human rights approach to service delivery

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