DISCUSSION DOCUMENT

BROADENING THE GROUNDS ON WHICH ABORTION IS LEGAL: EFFECTS ON SEXUAL AND REPRODUCTIVE HEALTH INDICATORS

DISCUSSION DOCUMENT

BROADENING THE GROUNDS ON WHICH ABORTION IS LEGAL: EFFECTS ON SEXUAL AND REPRODUCTIVE HEALTH INDICATORS

Catriona Ida Macleod (Rhodes University)

Anna Maria Speciale (UNFPA)

Richard Delate (UNFPA)

July 2022

Citation: Macleod, C.I., Speciale, A., & Delate, R. (2021). *Broadening the grounds on which abortion is legal: effects on sexual and reproductive health indicators*. Makhanda and Johannesburg: Rhodes and UNFPA

CONTENTS

SUMMARY

What are the effects on sexual and reproductive health indicators of broadening the grounds on which abortion may be legally granted?

1

Comparative research within countries that broadened the grounds[1] for legal abortion since 1990 shows that there was a **decrease** in:

- abortion-related deaths;
- maternal mortality.

2

Twenty-seven countries have broadened the grounds for legal abortion since 2000. Data from these countries show that in:

- 21 countries there was a **reduction in the maternal mortality ratio**[2];
- 22 countries there was an **increase in contraceptive prevalence rates**[3];
- 24 countries there was a **reduction in the fertility rates amongst 15 to 19-year-olds**;
- 20 countries the **reduction in adolescent-specific fertility rates**[4] **was higher than the reduction in crude birth rates**.[5]

3

The proportion of all abortions considered least safe[6] **decreases substantially** as grounds under which abortion is legal become less restrictive. Countries with less restrictive legislation have a **lower maternal mortality rate** – by 45 per 100,000 live births – than countries with more restrictive legislation.

"It is only after careful evaluation of the evidence and the professional and ethical obligation to protect women's health and lives that an organization such as FIGO [International Federation of Gynecology and Obstetrics] can publicly declare to be in favour of women's access to safe abortion." (Faúndes & Shah, 2015, p.257)[1]

4

Restrictive abortion legislation **does not reduce the number of abortions** performed in a country.

5

Legislative change is embedded within health systems responses; broadening the grounds on which abortion is legal should be rights-based, and accompanied by **careful systems and services planning**.

DEFINITIONS

(1) Broadening grounds:

Refers to any legal change that includes additional reasons for granting an abortion. These changes include: from very restrictive legislation (abortion being completely illegal), to abortion being permitted under certain circumstances (e.g. rape; health) through to being permitted on request. In this document, it does not refer to gestational limits, third party authorization, or decriminalization.

(2) Maternal mortality ratio (MMR):

The number of maternal deaths during a given time period per 100,000 live births during the same time period.

(3) Contraceptive prevalence rates (CPR):

Percentage of people of reproductive age (15 to 49) using contraception.

(4) Adolescent-specific fertility rates (ASFR):

Births per 1000 women aged 15 to 19 years.

(5) Crude birth rates (CBR):

Number of live births per 1000 population.

(6) Safe abortions:

Abortions are **safe** when they are carried out by a person with the necessary skills, using a WHO-recommended method appropriate to the pregnancy duration, **less safe**, when done using outdated methods like sharp curettage even if the provider is trained or if women using tablets do not have access to proper information or to a trained person if they need help, **least safe** when they involve ingestion of caustic substances or untrained persons use dangerous methods such as insertion of foreign objects, or use of herbal and other concoctions.

DISCUSSION:

THE EFFECTS OF BROADENING THE GROUNDS ON WHICH ABORTION IS LEGAL

What are the effects on broadening the conditions under which abortion is legal on sexual and reproductive health indicators? In this discussion document we draw on longitudinal and cross-sectional evidence to answer this question.

The following longitudinal evidence is presented:

1. The recorded effects on maternal mortality of countries that have expanded abortion legislation in the last 30 years. This information is based on peer-reviewed publications in academic journals. As such, a limited number of countries are represented. As the measures used in various studies differ, we repeat the authors' wording for the sake of accuracy.
2. The estimated maternal mortality ratio (MMR) (2000 and 2015), adolescent-specific fertility rate (ASFR) (2000—2005 and 2015—2020), and the contraceptive prevalence rate (CPR) (2020 and 2019) of all countries that expanded legislation between 2000 and 2015. These data are drawn from *The Lancet* [2] and United Nations statistics.[3] [4]

Cross-section evidence consists of:

3. Percentages of safe and unsafe abortion in relation to the restrictiveness of the conditions under which abortion is legal.
4. Comparisons of countries with varying degrees of restrictiveness in relation to conditions under which abortion is legal.

1 PEER-REVIEWED EVIDENCE OF IMPACT ON MATERNAL MORTALITY

Table 1 summarises the results from studies published in peer-reviewed academic journals concerning the effects of broadening the grounds on which abortion is legal within countries and its impact on maternal mortality. These were sourced through a search on Google Scholar, Health Source (Nursing/Academic Edition), MedLine PsycInfo, and PsycArticles.

Table 1: Changes in MMR following legislative changes broadening the grounds for legal abortion

Country/ Region	Date of change	Legal conditions changed from	Legal conditions changed to	Recorded impacts
Ethiopia	2005	Threat to life (two physicians' recommendations)	Rape and incest, lethal congenital malformation, physical health and mental health	Between 1980 and 1999, 31% of maternal deaths were caused by abortio-related complications. Between 2000 and 2012, this figure reduced to 10%.[5] Decreased trends of abortion-related maternal mortality were identified in a university hospital.[6]
Mexico City	2007	Rape; threat to life; severe foetal impairment	<12 weeks gestation on request	A sharp fall in the rate of maternal deaths, by 9% to 16% for women aged 15-44 and by 15% to 30.%[7] for teenagers.[8]

Nepal	2002	Rape or incest; danger to life or health; foetal impairment	<12 weeks gestation on request; < 18 weeks for rape or incest; With a physician's approval at any stage of pregnancy to protect mental or physical health and in cases of foetal impairment	A significant downward trend in the proportion of abortion-related serious infections, injuries, and systemic complications in women and girls presenting at public referral hospitals.[9]
Romania	1989 (restrictive law repealed) 1996 (new law)	Severe mental/ physical risk to pregnant person or foetus; pregnant person over 45; pregnant person has 5 or more children	<12 weeks gestation on request; >12 weeks gestation for therapeutic reasons (physical, mental health; foetal impairment; rape or incest; social or economic reasons)	Annual abortion-related mortality ratio dropped from a high of 148 deaths per 100,000 live births in 1989 to 58 per 100,000 in the year immediately following. By 2006, the overall maternal mortality ratio dropped to 15 per 100,000 live births, and the abortion-related mortality ratio fell to 5 per 100,000 live births.[10]
South Africa	1996	Severe mental/ physical risk to pregnant person or foetus; rape or incest	<12 weeks gestation on request; >12 weeks gestation for therapeutic reasons (physical, mental health; foetal impairment; rape or incest; social or economic reasons	In 1994, complications from unsafe abortion accounted for 32.69 deaths per 1,000 abortions. By 1998, 0.80 deaths per 1,000 were reported. A drop of 91% in deaths related to unsafe abortion in the 1998-2001 period was reported. In the period 2005—2007, abortion-related deaths accounted for 3% of all maternal deaths annually.[9] Significant decrease in proportion of cases with signs of infection on hospital admission for incomplete abortion, especially in younger women.[11]

Country/ Region	Date of change	Legal conditions changed from	Legal conditions changed to	Recorded impacts
Uruguay	2012	Husband's honor was at stake; threat to life; extreme poverty	Voluntary termination of pregnancy (VTP) is a non-punishable offense under the following conditions: if the woman is a Uruguayan citizen and gestational age is no more than 12 full weeks or 14 full weeks in cases of rape.	Maternal mortality fell from 25 deaths/100,000 live births (1990—2001) to 14/100 000 live births (2013—2015). Proportion of maternal deaths due to unsafe abortion fell from 37% of all maternal deaths (1990—2001) to two maternal deaths due to unsafe abortions conducted outside the health-care system (2013—2015).[12]

2

SEXUAL AND REPRODUCTIVE HEALTH INDICATORS

Maternal Mortality Ratio (MMR); Contraceptive Prevalence Rates (CPR); Adolescent-Specific Fertility Rates (ASFR)

This section examines the impact of broadening the legal grounds for abortion on maternal mortality, contraceptive prevalence rates and adolescent-specific fertility rates.

Maternal Mortality Ratio (MMR)

Between 2000 and 2015, 27 countries broadened the grounds on which abortion may be legally performed. The details of these changes are contained in Appendix 1. These details can be read in conjunction with the information below.

In Table 2 the MMR across two time periods are presented for each country that broadened the grounds on which abortion is legal. The **relative changes in MMR** are represented in percentages with the following key:

- MMR decreased by 1-25%: Purple background;
- MMR decreased by 25-50% Blue background;
- MMR decreased by >50% Yellow background;
- MMR increased Orange background.

Table 2: MMR for countries that broadened conditions under which abortion is legal since 2000 [Data Source: Center for Reproductive Rights [13] unless indicated; MMR source: WHO Global Health Observatory [14]]

Country	MMR 2000	MMR 2015	Relative change in MMR (%)
Australia [15]	7	6	14
Benin	520	421	19

Country	MMR 2000	MMR 2015	Relative change in MMR (%)
Bhutan	423	203	52
Central African Republic	1280	912	29
Chad	606	550	9
Chile	31	14	55
Colombia	94	53.8	43
Eritrea	1280	518	60
Eswatini	580	435	25
Ethiopia	1030	446	57
Iran	48	17	65
Kenya	708	353	50
Lesotho	614	574	7
Luxembourg	10	5	50
Mali	836	620	26
Mauritius	59	73	-24
Mozambique	798	318	60
Nepal	553	236	58
Niger	813	555	31
Portugal	10	9	10
Saint Lucia	86	115	-34
Somalia	1210	855	29
Spain	5	4	20
Switzerland	7	5	29
Thailand	43	38	12
Togo	489	398	19
Uruguay	26	18	31

Of the 27 countries, **25 saw a reduction in MMR** between 2000 and 2015. The two exceptions are St Lucia and Mauritius, which experienced an increase in MMR. Of those that saw a reduction in MMR, eight experienced a reduction of between 1 and 25%, nine between 25 and 50% and eight above 50% reduction (Bhutan, Colombia, Eritrea, Ethiopia, Iran, Kenya, Mozambique, Nepal). It is important to note that there are variables, other than reform of the conditions under which abortion is legal, that could also contribute to a change in MMR. These may include antenatal care, contraception services and health outreach.

Contraceptive Prevalence Rates (CPR)

In Table 3 the contraceptive prevalence rates (CPR) across two time periods are presented for each country that broadened the grounds on which abortion is legal. The **relative changes in CPR** are represented in percentages with the following key:

- CPR increased by 1 – 25% Purple background;
- CPR increased by 25- 50% Blue background;
- CPR increased by >50% Yellow background;
- CPR decreased Orange background.

Table 3: CPR for countries that broadened conditions under which abortion is legal since 2000 [Data Source: United Nations [3]]

Country	CPR 2000	CPR 2019	Relative change in CPR (%)
Australia[15]	59	58	-1
Benin	20	16	-20
Bhutan	20	38	93
Central African Republic	19	22	19
Chad	4	6	56
Chile	43	62	45
Colombia	53	63	20
Eritrea	6	8	51
Eswatini	29	53	87
Ethiopia	5	27	407
Iran	49	58	20
Kenya	29	46	57
Lesotho	27	52	89
Luxembourg	No data	No data	No data
Mali	8	16	96
Mauritius	46	42	-8
Mozambique	14	24	69
Nepal	28	42	50
Niger	9	15	80
Portugal	59	61	3

Country	CPR 2000	CPR 2019	Relative change in CPR (%)
Saint Lucia	39	48	23
Somalia	7	15	108
Spain	57	60	6
Switzerland	72	72	0
Thailand	52	56	7
Togo	19	23	21
Uruguay	51	57	11

The CPR, as recorded in 2000 and 2019, has, for the most part, **increased in countries that have broadened** the grounds on which abortion is legal. **Only three out of the twenty-seven countries saw a decrease in CPR** during this timeframe. One country, Switzerland, saw no change, and for another, no data were available. The remaining 22 countries saw an increase in CPR. For 11 of these countries the increase was above 50%. This finding refutes the notion that broadening the grounds for legal abortion will lead to people opting out of using contraception.

Adolescent-Specific Fertility Rates (ASFR)

Table 4 presents the ASFR for two five-year periods (2000—2005 and 2015—2020) in the relevant countries. The figures below show the **change in ASFR** from 2000—2005 compared to 2015—2020. A number **below one** shows a **decrease** in this specific fertility rate, while a number **above one** shows an **increase**. Similar calculations are shown for the **crude birth rate (CBR)**. Seen next to each other, the two columns show whether the ASFR and CBR are following the same or different trends (i.e. whether fertility amongst 15 to 19-year-old women are increasing or decreasing relative to the fertility of women across all reproductive ages). The following key is used in the table:

- ASFR decreased Purple (ratio below 1);
- ASFR increased Orange (ratio above 1);
- Ratio of ASFR decreased **relative** to ratio of CBR Blue (CBR ratio higher than ASFR ratio);
- Ratio of ASFR increased **relative** to ratio of CBR Yellow (CBR ratio lower than ASFR ratio).

Table 4: ASFR compared to CBR for countries that broadened conditions under which abortion is legal since 2000
[Data Source: ASFR and CBR source: United Nations [3]]

Country	ASFR 2000-2005	ASFR 2015-2020	Ratio ASFR (2015-2020/2000-2005)	Ratio CBR (2015—2020/2000—2005) compared to ratio ASFR
Australia[15]	16.9	11.7	0.69	1.01 (0.69)
Benin	115.7	86.1	0.74	0.88 (0.74)

Country	ASFR 2000-2005	ASFR 2015-2020	Ratio ASFR (2015-2020/2000-2005)	Ratio CBR (2015—2020/2000—2005) compared to ratio ASFR
Bhutan	69.2	20.2	0.29	0.71 (0.29)
Central African Republic	148.0	129.1	0.87	0.84 (0.87)
Chad	209.7	161.1	0.77	0.84 (0.77)
Chile	57.0	41.1	0.72	0.81 (0.72)
Colombia	95.5	66.7	0.70	0.72 (0.70)
Eritrea	82.4	52.6	0.64	0.88 (0.64)
Eswatini	104.7	76.7	0.73	0.84 (0.73)
Ethiopia	106.0	66.7	0.63	0.79 (0.63)
Iran	32.8	40.6	1.24	0.70 (1.24)
Kenya	106.0	66.7	0.63	0.74 (0.63)
Lesotho	87.9	92.7	1.05	0.87 (1.05)
Luxembourg	11.7	4.7	0.40	0.86 (0.40)
Mali	186.3	169.1	0.91	0.86 (0.91)
Mauritius	36.5	25.7	0.70	0.77 (0.70)
Mozambique	181.2	148.6	0.82	0.85 (0.82)
Nepal	104.9	65.1	0.62	0.70 (0.62)
Niger	215.5	186.5	0.87	0.88 (0.87)
Portugal	20.2	8.4	0.42	0.72 (0.42)
Saint Lucia	54.6	40.5	0.74	0.76 (0.74)
Somalia	127.4	100.1	0.79	0.88 (0.79)
Spain	10.2	7.7	0.75	0.84 (0.75)
Switzerland	5.3	2.8	0.53	1.02 (0.53)
Thailand	41.9	44.9	1.07	0.77 (1.07)
Togo	93.6	89.1	0.95	0.84 (0.95)
Uruguay	64.7	58.7	0.91	0.88 (0.91)

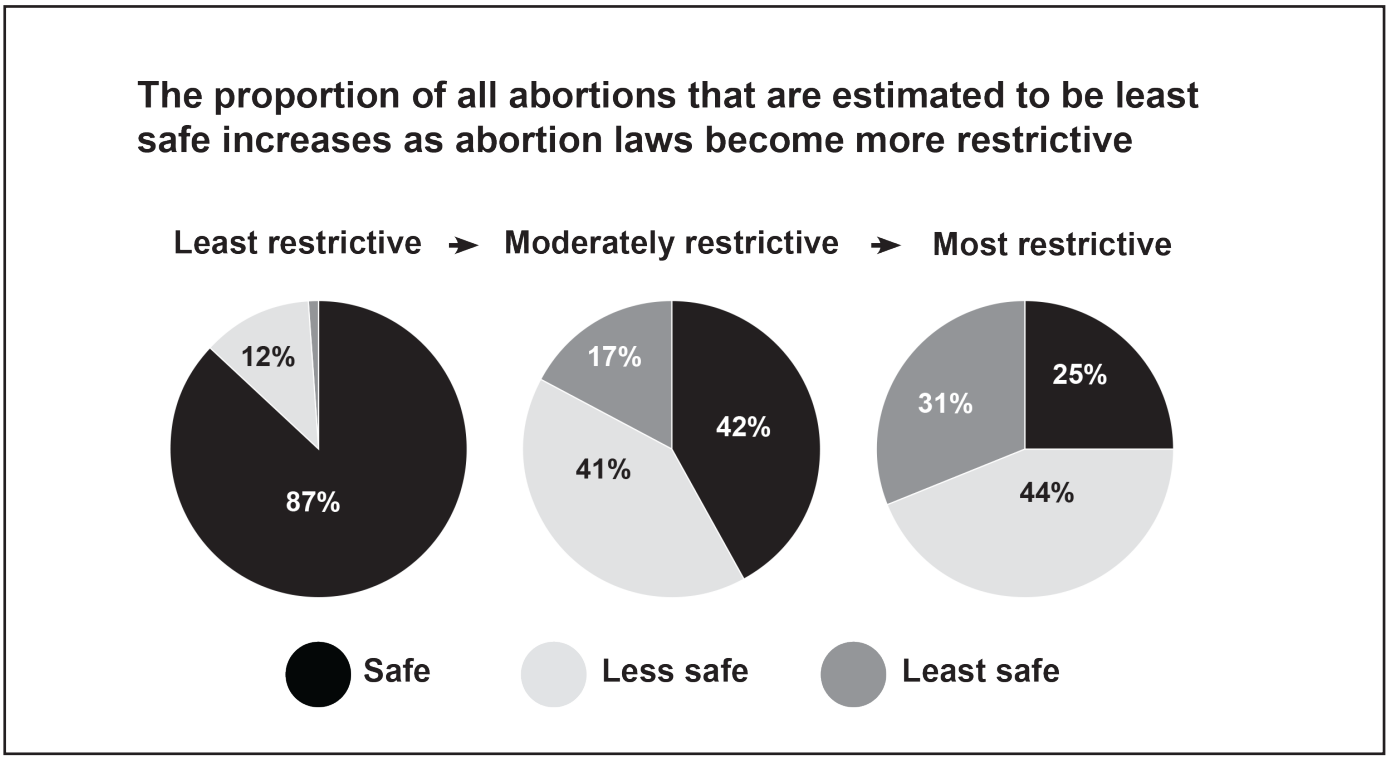
The ASFR (births per 1000 women) for 15 to 19-year-olds, as recorded in 2000-2005 and 2015-2020, **decreased in all** but three countries: Iran, Lesotho and Thailand. The CBR (births per 1000 of the population) also declined in all these countries during these time periods, except for Australia (up marginally from 12.8 to 12.9), Iran (up from 17.4 to 19.1) and Switzerland (up marginally from 10.1 to 10.3). This indicates that for most countries, fertility amongst 15 to 19-year-olds has followed a **general decrease in fertility**. However, comparing the ratio of ASFR for 15 to 19-year-olds (2015—2020/2000—2005) with the ratio of CBR (2015—2020/2000—2005) shows that in 20 of the 27 countries, **fertility decreased to a greater extent amongst women aged 15 to 19** than for all women of reproductive age between the periods 2000—2005 and 2015—2020. The exceptions are Central African Republic, Iran, Lesotho, Mali, Thailand, Togo, and Uruguay.

3 CROSS-SECTIONAL COMPARISONS

Cross-sectional comparisons of data across countries are useful to determine variables in differing contexts. Figure 1 shows the proportion of abortions estimated to be performed under safe, less safe and least safe conditions in relation to the nature of abortion laws (least restrictive = upon request; moderately restrictive = health, life, socio-economic; most restrictive = health, life). The graphic clearly shows that the **most unsafe abortions occur in countries with the most restrictive abortion legislation**: 87% of abortions performed in countries with legislation that allows abortion on request are safe, whereas only 25% are safe in countries that allow abortion in cases of threat to the pregnant person's life or physical health.[12]

Latt and colleagues[16] compared 162 countries to assess the association between abortion laws and maternal mortality. A flexibility score of abortion laws (Score 0–7) was calculated by adding together the number of reasons for which abortion is legally allowed in each country. The results showed that countries with a score ≥3 (i.e. more conditions under which abortion is legal) had a lower MMR – by 45 deaths per 100,000 live births – than countries with a score <3.

Figure 1: Safety of abortions according to abortion laws [Source: Singh et al. (2018)[17]]



4

CONCLUSION

This discussion paper sought to offer insight into the question: "What are the effects on sexual and reproductive health indicators of broadening the conditions under which abortion is legal?"

"Unsafe abortion continues to be a major cause of maternal death; it accounts for 14.5% of all maternal deaths globally and almost all of these deaths occur in countries with restrictive abortion laws."

(Faúndes & Shah, 2015, p. 56) [1]

While the findings cannot be assumed to demonstrate a causal relationship, they do show that in 25 of 27 countries studied, a decrease in maternal mortality was observed after broadening legal access to abortion. In addition, the adolescent-specific fertility rate, crude birth rate and contraceptive prevalence rate showed positive changes in many countries after expanding the grounds on which abortion is legal. This demonstrates the possible sexual and reproductive health harm reductions that could be expected after expanding the legal provisions against which women can have an abortion.

While this discussion paper looked at abortion legislation as it relates to maternal mortality, among other factors, it cannot be ignored that survival (the absence of maternal mortality) is in no way a proxy for good health (physical or emotional). There is a dearth of information relating to maternal morbidity in general, and more so when examining maternal morbidity as it relates to abortion. Nor is there an abundance of literature that addresses the physical, social, economic and emotional costs that may be experienced. No matter the level of restriction, unwanted pregnancies will continue to be addressed through abortions. In restrictive environments the costs of hidden abortion, save mortality, are less easily detected and studied. These remain very important topics for continued research.

As noted by the Guttmacher Institute researchers, abortions occur as frequently in countries with restrictive legislation as in countries with that allow abortions without restriction as to reason (37 and 34 per 1,000 women, respectively[12]). The findings presented above must be viewed in light of the fact that pregnant individuals with unwanted or unsupportable pregnancies will resort to abortion no matter the legal status thereof and illegal abortions are often unsafe.

Unsafe abortion, however, leads to increased mortality and morbidity, prompting the International Federation of Gynecology and Obstetrics[1] and others[18] to support women's access to safe abortion.

Legislative change regarding abortion, while necessary, is not sufficient for the full health effects: policy stipulations and health systems responses play an important role.[2,3] Interpretation and implementation of the law are key to expanding access to safe abortion. While some laws may be restrictive, but allow for permissive interpretations and increased access, the inverse may also be true. Legal and clinical systems that impose restrictive interpretations of less-restrictive abortion legislation may have the same practical effect as restricting the conditions under which abortions may legally be permitted. Additionally, it is important to note that this paper focused on the broadening of the grounds for which abortion is permitted. Decriminalization of abortion may have a similar effect. This has been observed in Uruguay[19] and Nepal.[20]

Similarly, it must be recognized that legal abortion is not synonymous with safe abortion, unless supporting conditions exist. Factors facilitating the expansion of services include the use of a public health framework, situating abortion as one component of a comprehensive reproductive health-care package. Additionally, country-based health, women's rights, youth-focused organizations, medical and other professional societies, international agencies and non-governmental organizations should be included in the design, roll-out and monitoring of services.[21] Utilizing multiple cadres of health workers as outlined in WHO's *Abortion care guideline*[22] is important for increasing coverage and access to abortion services. Similarly, removing potentially dangerous methods such as dilation and curettage to focus on manual vacuum aspiration and medical abortion, which additionally require less infrastructure, are important for rapid establishment of safe services. While taking into consideration various factors, political will is the key factor in establishing or expanding access to safe abortion services.

Although increasing access is dependent on multiple factors, this paper has shown that broadening the grounds on which abortion is permitted is undoubtedly an important first step. The WHO *Abortion care guideline*, however, recommends against laws and regulations that restrict abortion by grounds. In addition, "until they [grounds] are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law".

REFERENCES

1 Faúndes, A. & Shah, I. S. Evidence supporting broader access to safe legal abortion. *Int. J. Gynecol Obstet.* 131, s56–s59 (2015).

2 Kassebaum, N. J. *et al.* Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *The Lancet* 388, 1775–1812 (2016).

3 United Nations Department of Economic and Social Affairs Population Division. World Population Prospects 2019. https://population.un.org/wpp/ (2019).

4 United Nations Department of Economic and Social Affairs Population Division. Estimates and Projections of Family Planning Indicators 2020. https://population.un.org/dataportalng/home (2020).

5 Berhan, Y. & Berhan, A. Causes of maternal mortality in Ethiopia: a significant decline in abortion related death.*Ethiop. J. Health Sci.* 24, 15–28 (2014).

6 Gebrehiwot, Y. & Liabsuetrakul, T. Trends of abortion complications in a transition of abortion law revisions in *Ethiopia. J. Public Health (Bangkok).* 31, 81–87 (2009).

7 The range reflects different statistical specifications

8 Clarke, D. & Mühlrad, H. *The Impact of Abortion Legalization on Fertility and Maternal Mortality*: New Evidence from Mexico. vol. 2473 https://cinch.uni-due.de/fileadmin/content/research/workingpaper/1602_CINCH-Series_clarke_muehlrad.pdf (2016).

9 Henderson, J. T. et al. Effects of Abortion Legalization in Nepal, 2001-2010. *PLoS One* 8, (2013).

10 Benson, J., Andersen, K. & Samandari, G. Reductions in abortion-related mortality following policy reform: Evidence from Romania, South Africa and Bangladesh. *Reprod. Health* 8, 1–12 (2011).

11 Jewkes, R., Rees, H., Dickson, K., Brown, H. & Levin, J. The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change. *BJOG An Int. J. Obstet. Gynaecol.* 112, 355–359 (2005).

12 Briozzo, L. From risk and harm reduction to decriminalizing abortion: The Uruguayan model for women's rights. *Int. J. Gynecol. Obstet.* 134, S3–S6 (2016).

13 Center for Reproductive Rights, Abortion worldwide: Twenty years of reform. Briefing Paper. (2014). 50.9https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/20Years_Reform_Report.pdf

14 WHO Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births)

15 In Australia, abortion is legislated state by state. The following dates for legislative change are relevant: 1998 West Australia, 2002 Australia Capital Territory, 2008 Victoria, 2013 Tasmania

16 Latt, S. M., Milner, A. & Kavanagh, A. Abortion laws reform may reduce maternal mortality: An ecological study in 162 countries. *BMC Women's Health* 19, 1–9 (2019).

17 Singh S et al., Abortion Worldwide 2017: Uneven Progress and Unequal Access, New York: Guttmacher Institute, 2018, URL: https://www.guttmacher.org/report/abortion-worldwide-2017.

18 Okonofua, F. E. Contribution of anti-abortion laws to maternal mortality in developing countries. *Expert Rev. Obstet. Gynecol.* 3, 147–149 (2008).

19 Leonel Briozzo,From risk and harm reduction to decriminalizing abortion: The Uruguayan model for women's rights,*International Journal of Gynecology & Obstetrics*, Volume 134, Supplement 1, 2016, Pages S3-S6,

20 Krishnan Shweta, Decriminalization of abortion in Nepal Part 3. Posted on 26 September, 2012 URL: https://asap-asia.org/blog/decriminalization-of-abortion-in-nepal-part-3/.

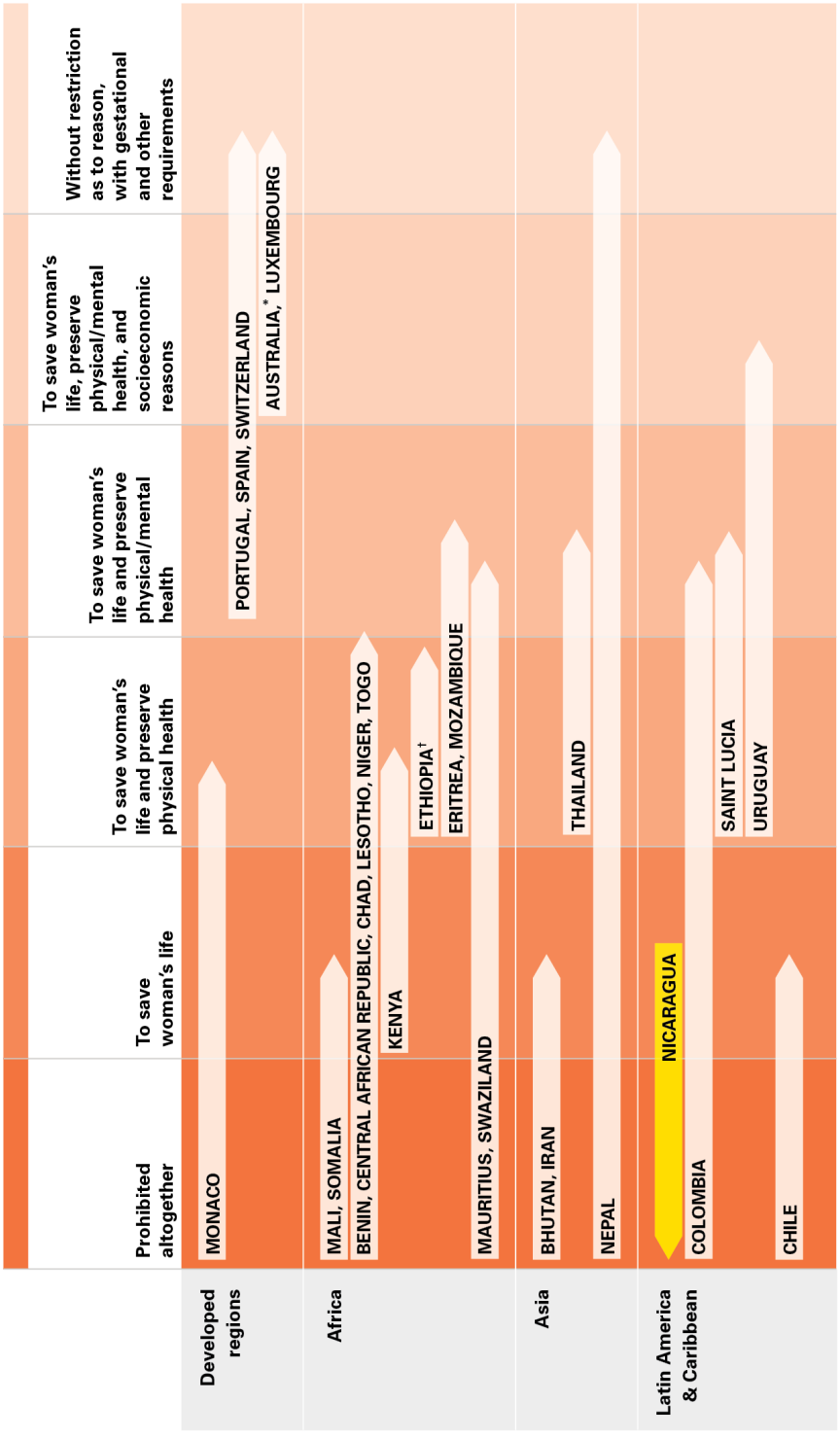
21 Chavkin, W., Stifani, B. M., Bridgman-Packer, D., Greenberg, J. M. S. & Favier, M. Implementing and expanding safe abortion care: An international comparative case study of six countries. *Int. J. Gynecol. Obstet.* 143, 3–11 (2018).

22 World Health Organization. *Abortion Care Guideline*. Geneva: World Health Organization; 2022. https://apps.who.int/iris/handle/10665/349136.

APPENDIX 1

Countries that broadened grounds on which abortion is legal. Reproduced from Singh S et al., Abortion Worldwide 2017: Uneven Progress and Unequal Access, New York: Guttmacher Institute, 2018, https://www.guttmacher.org/report/abortion-worldwide-2017.

FIGURE 3.3 **All countries that have changed categories within the legal continuum since 2000 have broadened criteria for legal abortion, with the sole exception of Nicaragua.**



NOTES TO FIGURE 3.3 *For Australia, a country that decides abortion law at the state rather than federal level, we reclassify the country on the basis of the Northern Territory's 2017 legal reform, which meant that the majority live where abortion is available without restriction as to reason. †Ethiopia's penal code was amended in 2004 to broaden the existing health criteria, which led to expanded access to safe and legal abortion services. The new code specifying permissible abortions used the language of "grave or imminent danger" to the woman, which was described as physical health only, so it does not fit the standard six categories of this spectrum. Thus, the total of 28 countries that moved out of one category to another does not include Ethiopia. *Sources:* references 54, 56, 59, 79 and 89; Republic of Mozambique, Lei nº 35/2014, Lei da revisão do Código Penal, Artigo 168, Aborto não punível, Maputo, Mozambique, 2014; and Journal Officiel de la République Centrafricaine, Loi No. 06.005 du 20 juin 2006 Bangayassi relative à la santé de reproduction, Sept. 2007.

www.guttmacher.org

This discussion document was produced by the
Critical Studies in Sexualities and Reproduction,
Research Programme, Rhodes University
and UNFPA

RHODES UNIVERSITY
Where leaders learn