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Abortion as Health Care

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Acknowledgements:
This resource was prepared by the O'Neill Institute for National and Global Health Law and the State Innovation Exchange (SiX). Support was provided in part by the Robert Wood Johnson Foundation. The views expressed do not necessarily reflect those of the Foundation.

Abortion as Health Care

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1. Introduction

The concept of "abortion as health care" is grounded in the fundamental understanding that abortion is essential health care and a human right.[1]

In countries where abortion is not treated as health care or integrated into primary care, pregnant people face significant legal barriers to accessing safe, high-quality, and timely care — all or most of which do not apply to accessing other essential health services. As part of the abortion exceptionalism phenomena, medically unnecessary regulations and restrictions may target abortion procedures and medications, health professionals and institutions, pregnant people's decision-making, and funding for and insurance coverage for abortion.[2] Failing to treat abortion as a health care service and, instead, subjecting it to burdensome laws and policies can result in unsafe abortions, delayed care, and poor health outcomes.[3]

According to the Guttmacher-*Lancet* Commission, an essential package of sexual and reproductive health interventions includes access to safe abortion care and services.[4] The World Health Organization (WHO), the United Nations agency focused on global public health, has embraced a rights-based and normative approach to abortion as health care in both its 2012 and 2022 abortion care guidelines. In 2012, the guideline stressed that "all abortion laws should protect health and human rights, and that policy barriers 'that hinder access to and [the] timely provision of safe abortion care should be removed.'"[5] In its 2022 guideline, WHO recommended legal and policy interventions focused not only on improving the accessibility, affordability, acceptability, and quality of abortion care, but also on integrating abortion care into primary health care to achieve universal health coverage.[6] 'These elements are all included in the WHO's model for an 'enabling environment' for quality abortion care (see image on next page). Notably, WHO's abortion guidelines have been highly influential in countries worldwide, prompting or shaping many of the positive reforms discussed throughout this report.

This report compiles and analyzes how international organizations and decision-makers in various countries have developed laws, policies, and regulations to include abortion in health care broadly. While not intended to be comprehensive, this report seeks to lift up and increase visibility of some of the approaches select countries have taken to improve the accessibility, affordability, acceptability, and quality of abortion care.

Part 2 examines how some countries have moved away from or eliminated medically-unnecessary requirements placed on the institutions and individuals that provide abortion care.

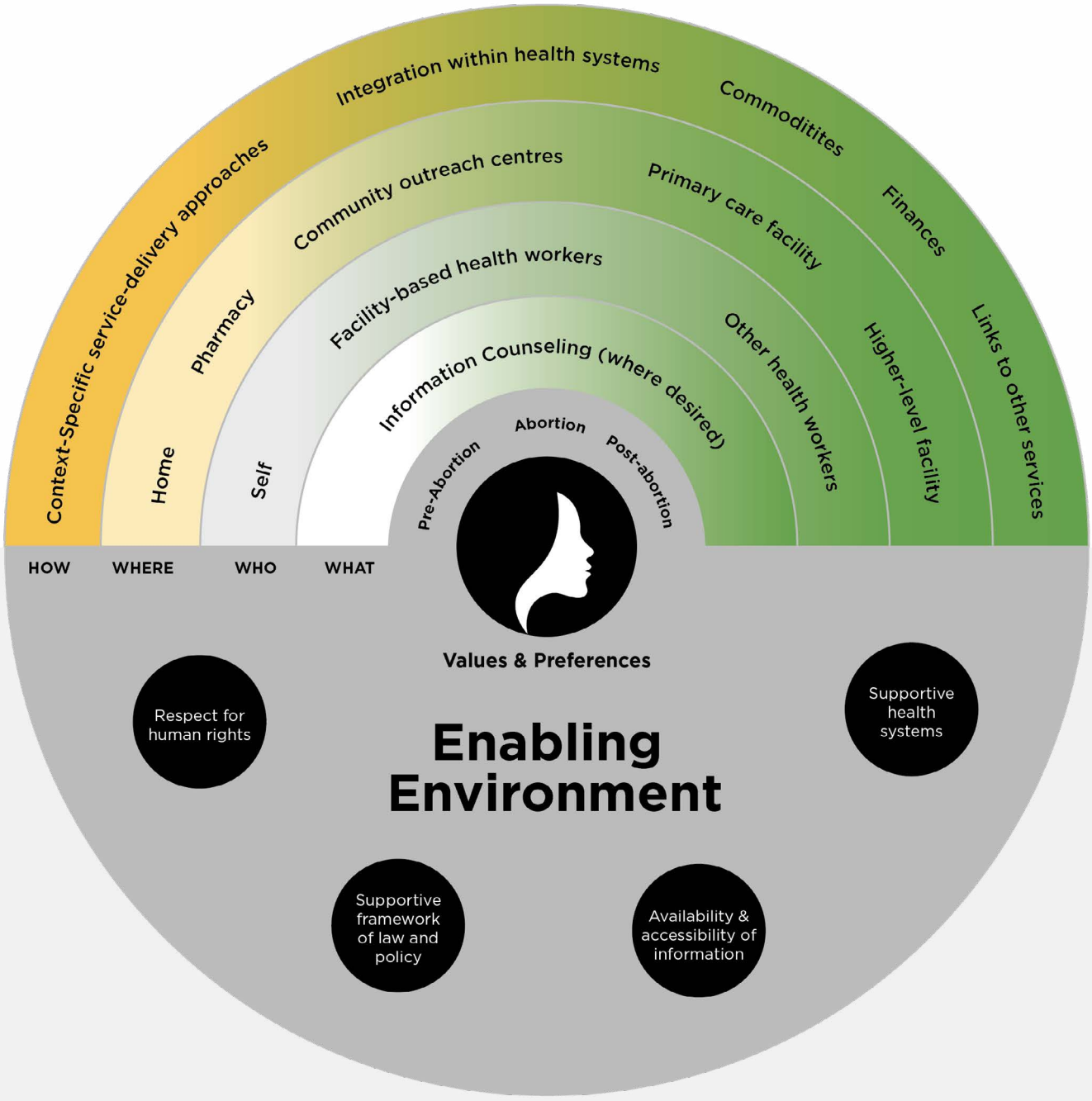
Part 3 explores efforts to improve access to medication abortion, whether by removing place-based requirements, effectively regulating telemedicine abortions, or adding abortion medications to essential medicines lists.

Part 4 considers how other countries have approached the regulation of abortion counseling in a way that protects and advances autonomous decision-making.

Parts 5 and **6** consider other countries' approaches to financing and reducing stigma around abortion care, respectively.

Part 7 offers policy proposals and additional resources for advocates and decision-makers in the United States seeking to integrate these arguments and approaches into their local law and policy reform efforts.

Image 1: WHO's Enabling Environment for Abortion



Graphic based on "Figure 1.1: Conceptual framework for abortion care" in WHO's 2022 Abortion Care Guideline"[7]

2. Facilities and Providers

In the United States, "targeted regulation of abortion providers" or TRAP laws impose additional and burdensome requirements on abortion facilities and providers that go beyond what is imposed on other health care services and required to ensure patient safety. While they vary widely in severity, TRAP laws generally increase the cost and reduce the availability of abortion care. Some TRAP laws, moreover, are intended to be so expensive or otherwise burdensome that they shutter clinics that provide abortion care.[8]

Under international human rights law, TRAP laws conflict with the right to health's four essential elements established by the UN Committee on Economic, Social, and Cultural Rights (ESCR Committee): availability, accessibility, acceptability, and quality (collectively known as the AAAQ framework).[9] The ESCR Committee has applied this framework to sexual and reproductive health broadly, including abortion care. TRAP laws are inconsistent with the element of *availability*, which requires governments to have an adequate number of functioning health care facilities and services, as well as trained and skilled providers, to provide a full range of sexual and reproductive health services, including abortion.[10] They also run counter to the element of *accessibility*, which requires abortion care to be available to all individuals "within safe physical and geographical reach for all."[11]

The WHO has characterized restrictions on the type of facilities or settings where abortion care can lawfully be provided, as well as on the type of health workers that can lawfully provide services, as impermissible barriers to abortion care.[12] While TRAP laws are not unique to the United States, many other countries have removed these types of restrictions from their abortion laws or adopted regulations that seek to reduce medically-unnecessary barriers to care.

This section examines two key approaches for reducing the impact of TRAP laws on abortion care provision:

1. Integration of abortion services into primary care facilities
2. Expansion of task-sharing and prescribing authority

a. Primary Care Facilities

The WHO has stressed that integrating abortion into primary care is essential for achieving Universal Health Coverage (UHC), ensuring that abortion is treated as an essential health care service. As part of its 2022 technical recommendations on abortion, the WHO recommended that to achieve UHC and have access to abortion as part of UHC, "abortion must be centred within primary care, which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed."[13]

> UHC means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.[14]

In the **United States**, however, the vast majority of abortions are provided outside of the primary care setting. Abortion clinics provide nearly all (96%) abortions.[15] These clinics are not integrated into the larger health system; the majority (55%) are independent and community-based, with the remainder (45%) affiliated with organizations like Planned Parenthood.[16] Abortion clinics in the United States are the subject of numerous TRAP laws. Currently, **14 states** impose facility structural requirements that essentially apply the same standards for ambulatory surgical centers, such as procedure room size or corridor width, to abortion clinics.[17] **Nine states** require abortion facilities to have transfer agreements with hospitals, and **seven states** specify a maximum distance between abortion facilities and hospitals with which they have transfer agreements.[18] The transfer agreement requirement, for example, can be particularly difficult to meet in rural areas or other places where there is a scarcity of hospitals.

One way in which other countries have pushed back against the targeted regulation of abortion facilities is by formally integrating abortion care into primary care in accordance with WHO recommendations.

In **Canada** abortion has been removed entirely from the country's Criminal Code and is regulated exclusively as health care. The Canada Health Act guarantees access to abortion upon request without any gestational limit across all territories and provinces.[19] Each province adopts its own approach to integrating abortion care into its respective primary and secondary health care.[20] For instance, in Quebec, each region in the province is required to have at least two facilities where abortion can be accessed (e.g., hospitals, women's health centers, community health centers), with most regions meeting or exceeding that standard.[21]

Mexico's Supreme Court decriminalized abortion towards the beginning of pregnancy and under various exceptions after that point. In the wake of the decision, the country has adopted various federal laws and policies to regulate the provision of abortion care. Under the federal Ministry of Health's Technical Guidelines for Safe Abortion Care, first-trimester abortions can be provided at outpatient facilities, either using medication abortion or manual uterine aspiration. The guidelines note that, given the demonstrated safety and efficacy of medication abortions, they can be provided in outpatient, primary care settings.[22] While medication abortion is recommended for first-trimester abortions, patient preferences and health conditions, as well as the capacity of the facility, are taken into consideration.[23] The guidelines also stress the importance of integrating abortion into primary health care to ensure access for specific patient populations, such as young people.[24] In Mexico City, under the local Legal Abortion Program (PILE), abortion care are provided in 14 medical units,[25] which are part of the local public primary health care system.

In **Ireland**, following the repeal of the 8th Amendment, the legislature passed the 2018 Health (Regulation of Termination of Pregnancy) Act, which allows for abortion during the first 12 weeks of pregnancy. The Department of Health and Health Service Executive collaborated with clinicians providing care at various levels to develop a model for abortion care — resulting in the Irish "Model of Care for the Termination of Pregnancy Services." Under this model, primary care physicians and general practitioners in women's health centers provide medication abortion through the first nine weeks of pregnancy.[26] As long as the patient does not have a clinical indication, the entire process — which includes two in-person consultations under Irish law — can be completed within the patient's local community.[27] Patients between 10-12 weeks of pregnancy are referred to hospitals for medication or procedural abortion within a secondary care setting.[28]

South Africa's 1996 Choice on Termination of Pregnancy Act (CTOP) guarantees abortion as a human right and integrates it into primary care.[29] Abortion is available upon request up to 13 weeks of gestation and under certain circumstances after that point in the pregnancy.[30] The 2021 Termination Pregnancy Guidelines establish that pregnancy can be terminated at most health care facilities, including in the primary care context, as long as the facilities fulfill a set of criteria aimed at protecting patient safety.[31] As a means of removing barriers to abortion care in the first trimester, the CTOP guidelines specifically state that 24-hour maternity units, which are commonly attached to community health centers, do not need formal approval by provincial executive councils to provide abortion up to and including 12 weeks of gestation.[32]

In **Vietnam,** the 1989 Law on the Protection of Public Health permits abortion through 22 weeks of pregnancy, establishing women's rights to abortion "at medical institutions" broadly.[33] Women can obtain abortion care at primary (district and commune-level) health care centers, secondary (province-level) health care facilities, specialized abortion care public facilities, private health care clinics, and centers for disease control.[34]

*It is important to note that simply having laws and policies that formally integrate abortion care into primary or secondary care settings does not mean that it is always accessible. Various barriers remain, even in the least restrictive settings (e.g., Canada).[35] However, calling for abortion care to be provided as primary medical care (and not only available in abortion clinics) is an important step to confronting TRAP laws.

b. Task-Sharing and Prescribing Authority

Restrictions on who can provide abortion care are common in the **United States**. The TRAP laws discussed above also encompass requirements imposed by **seven states**' laws mandating that providers have admitting privileges at nearby hospitals.[36] In addition, **32 states** only allow physicians and, in some cases, specialist physicians to provide abortions.[37] These types of requirements and restrictions shrink the pool of providers such that abortion becomes less accessible for patients, especially in rural and underserved areas where provider-to-patient ratios are already low. Some states have attempted to address this problem. At least **16 states** allow certain non-physician practitioners (e.g., advanced practice registered nurses, nurse-midwives, or physician assistants) to provide both medication and procedural abortions; **three** states (Delaware, New Mexico, and Rhode Island) allow specified non-physicians to provide only medication abortions.[38] For example, in 2022, Maryland lawmakers passed a bill to expand the classes of health practitioners allowed to provide abortion beyond physicians, which now include nurse practitioners, midwives, and physician assistants.[39]

The WHO recommends that countries adopt laws enabling abortion care to be shared between specialists and mid-level providers, including nurses, nurse practitioners, and midwives, based on evidence that mid-level practitioners can safely provide medication abortion in primary care settings.

The WHO recommends that countries adopt laws enabling abortion care to be shared between specialists and mid-level providers, including nurses, nurse practitioners, and midwives, based on evidence that mid-level practitioners can safely provide medication abortion in primary care settings.[40] Countries around the world are using legislation to either formalize task-sharing in abortion care or broaden prescribing authority among both physicians and non-physician practitioners. The WHO has also established "the knowledge and skills required to provide quality abortion care" as an essential training competency of health workers.[41] Other countries have recognized the importance of equipping providers with the skills to provide reproductive health services, including abortion, through comprehensive training programs.

Outside the United States, countries in nearly every region have embraced task-sharing in the context of abortion, permitting health workers other than specialist physicians to provide such care.

Table 1: Task-Sharing related to Abortion

	Generalists	Nurse Practitioner	Registered Nurse	Nurse Midwife	Midwife	Other
Chile[42]	X				X	
Nepal[43]			X	X		
New Zealand[44]	X	X	X		X	
South Africa[45]	X		X		X	
Sweden[46]					X	
Vietnam[47]	X				X	X

Information included in table based on research carried out by the O'Neill Institute.

Some countries, like **South Africa** and **Chile,** continue to limit the provision of second and third trimester abortions to physicians or specialist physicians, respectively.[48] In countries like **Chile** and **Sweden**, task-sharing occurs between physicians and midwives because only physicians are authorized to prescribe abortion medications. Midwives in both countries are able to administer the medication under the supervision of a physician; however, in practice, many midwives in Sweden administer medication abortions independently without risk of sanction.[49] Non-physicians, moreover, provide support services and post-abortion care in many countries.[50]

3. Medication Abortion

The WHO characterizes medication abortions as a safe and effective method for ending early pregnancies and endorses self-management of medication abortion in appropriate settings. Globally, nearly 100 countries have approved mifepristone, and medication abortion accounts for over half of all abortions in many high-income countries.[51]

Like other types of abortion, medication abortion has historically been subject to onerous regulations — many of which have proven to be medically unnecessary in recent decades. Laws that require one or more in-person visits to receive care, for example, can make medication abortion difficult to access, particularly in areas with few providers and among patients who already face structural barriers to care. These types of place-based requirements are still relatively common at the state level in the United States, even when they contradict standards adopted by the U.S. Food and Drug Administration (FDA). In the wake of *Dobbs*, moreover, some states have subjected abortion medications to even more extreme restrictions. Louisiana has passed legislation to reclassify mifepristone and misoprostol as Schedule IV Controlled substances, with Texas, Missouri, and Kentucky introducing similar legislation. This classification subjects the medications to stringent tracking requirements, which could lead prescribers and pharmacists to be hesitant in prescribing them and, ultimately, affect patient access.[52]

While formal approval of a drug for a specific use can help facilitate access in practice, it does not guarantee it and is, in some cases, not necessary. For example, "off-label use" of misoprostol for various obstetrical and gynecological purposes, including abortion, occurs in both the United States and other parts of the world.[a] As a result, human rights bodies, like the ESCR Committee, have stressed the importance of ensuring the availability of essential medicines, including abortion medications.[53] The ESCR Committee, moreover, has cautioned against actions like the Trump administration's review of mifepristone's approval status in the United States, characterizing the removal of reproductive health medications from national drug registries as an impermissible retrogressive measure.[54]

The following section explores how other countries have increased access to medication abortion by eliminating place-based requirements for care, effectively regulating telemedicine abortions, and adding abortion medications to national essential medicines lists.

a Misoprostol is commonly approved only for treating gastric ulcers and used off-label to induce labor, treat postpartum hemorrhage, and terminate pregnancies.

a. Removal of Place-Based Requirements

In the **United States**, the FDA has historically limited access to telemedicine abortion through a Risk Evaluation Mitigation Strategy (REMS) on mifepristone, requiring the abortion medication to be dispensed only by certified clinicians in-person within a health care setting. In 2023, the FDA permanently removed the in-person dispensing requirement, allowing pharmacies to dispense the medication. However, **13 states** continue to require the physical presence of the prescribing physician.[55]

On the global level, eliminating place-based requirements for medication abortion has paved the way for alternatives to in-person visits for care. As recently as 2024, **France** eliminated its in-person visitation requirement for medication abortions.[56] Similarly, **New Zealand** rolled back requirements that abortion be provided by medical doctors on licensed premises (typically hospitals).[57] Other requirements that, in effect, require in-person visits for care include physician-only dispensation or administration requirements and mandated ultrasounds. **Canada** has eliminated the requirement that physicians observe initial doses of mifepristone.[58]

While **New Zealand** only recommends an ultrasound prior to first- and second-trimester abortions, **Canada** has eliminated the ultrasound requirement altogether for early medication abortions.[59] **Colombia**, moreover, does not require providers to determine Rh status or administer anti-D immunoglobulin for pregnancies under 12 weeks.[b] [60]

Removing place-based requirements has facilitated pharmacists' greater involvement in the distribution of abortion medications. In both **Canada** and **France**, pharmacists can dispense abortion medications prescribed to patients via telemedicine.[61] **Canada** has also removed requirements that pharmacists be trained, certified, and registered with the medication's manufacturer, further facilitating access for patients.[62]

b. Regulation of Telemedicine Abortions

In 2022, the WHO recommended telemedicine abortion for the first time, urging countries to provide "the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion care in whole or in part."[63] The recommendation specifically endorses extending telemedicine to cover the assessment of eligibility for medication abortion, counselling and/or instruction relating to the abortion process, instructions for and active facilitation of the administration of medicines, and follow-up post-abortion care.[64]

In the **United States**, the FDA's modification of the REMS in 2023 paved the way for telemedicine abortions. While **six states** continue to ban the use of telehealth for abortion,[65] others have taken steps to make telemedicine abortion care more accessible, such as by providing Medicaid coverage of such services.[66]

During and in the wake of the COVID-19 pandemic, several countries began allowing and, as a result, regulating the provision of medication abortions via telemedicine.[67] Countries that decriminalized abortion in the early 2020s, as a result, are some of the first to adopt abortion laws that address the regulation of telemedicine abortions. **Colombia** regulates telemedicine abortions not only through its 2010 general telemedicine law (Law 1419), but also through its 2023 abortion regulations (Resolution 051). Law 1419's main objective is to promote telehealth through the national health system according to the principles of efficiency, universality, solidarity, comprehensiveness, unity, and quality, among others.[68] It requires insurers and service providers within the national health system (i.e., the General Social Security System) to offer the option of telemedicine as appropriate and ensure its availability, effectiveness, and accessibility to patients.[69] Under Resolution 051, medication abortions can be accessed as an outpatient service during the first trimester of pregnancy. Patients can access counseling and information related to medication abortion through interactive telemedicine or synchronous tele-expertise.[70] In cases of telemedicine abortion, health care providers can send medications to patients via national courier services. Providers must confirm the gestational age and screen for contraindications before initiating treatment and can assess the need for follow-up care in cases of incomplete abortion.[71]

b "Rh status" refers to the presence of a protein on the surface of one's red blood cells. A pregnant person can have a different Rh status than their fetus, which can lead to complications during pregnancy if left untreated by a medication called immunoglobulin.

France, similarly, included provisions regulating telemedicine as of its 2022 abortion law, Decree 2022-212. This provision places a seven-week gestational limit on telemedicine abortions and requires the doctor or midwife to issue the prescription, register the prescription with a recognized health care establishment (public or private), and deliver the medication via community pharmacy.[72] Notably, the Ministry of Health has developed guidelines on medication abortion, which include information on how to self-administer mifepristone and misoprostol at home.[73]

Other countries — particularly those that decriminalized abortion before the widespread use of medication abortion or telemedicine — do not have legislation that explicitly regulates telemedicine abortions. For example, in **Canada**, the federal government released a general policy framework for telemedicine in 2021, which failed to reference abortion care.[74] However, in practice, telemedicine has been a part of Canada's medication abortion model of care since 2019 but without any type of formal regulation.

Since 2005, WHO's model list has included both mifepristone and misoprostol, and both medications have since moved to the core list in 2019.

c. Essential Medicines Lists

Ensuring that the drugs used to terminate a pregnancy are part of a country's "essential medicines list" is another means of increasing the availability of abortion medications and reducing barriers to high quality care. National essential medicines lists include medicines that satisfy the priority health care needs of a country's population. The WHO has developed a Model List of Essential Medicines, which includes the minimum medicines needed for a basic health care system and lists the most efficacious, safe, and cost-effective medicines for priority conditions.[75] Since 2005, WHO's model list has included both mifepristone and misoprostol, and both medications have since moved to the core list in 2019.[76]

Countries have added mifepristone, in particular, to their national essential medicines lists as a means of improving access to medication abortions. In 2017, at least 16 countries have included mifepristone in their essential medications lists.[77] In 2022, **Bolivia's** Ministry of Health added mifepristone to the country's national list of essential medicines from 2022 to 2024.[78] In 2024, the government then added mifepristone to a separate list of medicines that are not produced domestically but must be purchased by the state for distribution by the public health system. While **Ireland** does not have an essential medicines list, it does have a "List of Interchangeable Medicinal Products," which includes medicines "to ordinarily be accessible by members of the public." Ireland's list includes abortion medicines, guaranteeing their coverage.[79]

4. Patient Decision-Making

Compared to medical decision-making related to other health services, patient decision-making related to abortion care is subject to even more requirements.

While all medical decision-making must comply with informed consent requirements, some abortion laws require abortion seekers to participate in mandatory or biased counseling, comply with waiting periods, and undergo medically unnecessary ultrasounds. Others require third parties (e.g., parents or spouses) to be involved in abortion decision-making or facilitate their (e.g., unlicensed pregnancy centers[c]) influence over an abortion seeker's decision to access care. These types of requirements aim to deter people from getting an abortion or to compel them to reconsider their decision — ultimately undermining patients' autonomous decision-making.[80]

Requirements that interfere with pregnant people's decision-making regarding abortion also constitute human rights violations. The ESCR Committee, for example, characterizes third-party authorization requirements, biased counselling, and mandatory waiting periods in the context of abortion as procedural and practical barriers to care that violate state obligations to respect and protect the right to health.[81] The committee has also stated that the right to health's element of *accessibility* includes the right to evidence-based information regarding safe abortion and post-abortion care.[82] In a case involving a child rape victim who was given misinformation to dissuade her from obtaining an abortion, the Inter-American Commission on Human Rights established that "women cannot fully enjoy their human rights without having a timely access to comprehensive health care services, and to information and education in this sphere."[83]

This section considers how other countries have approached regulating not only the content of, but also the nature of abortion counseling, as part of an effort to advance autonomous patient decision-making. It also examines how some countries have adopted regulations that seek to minimize third parties' involvement in abortion seekers' decisions about abortion care.

a. Content of Information and Counseling

The WHO emphasizes the importance of providing patients with accurate, unbiased, and evidence-based information and counseling as a part of abortion care.[84] Yet, in the **United States**, **nine states** require providers to share inaccurate information about the risks and potential complications of abortion as part of the counseling, such as claims of a link between abortion and breast cancer, infertility, mental health problems, or future pregnancy complications.[85]

c Facilities that represent themselves as reproductive care clinics, but aim to dissuade pregnant people from having abortions.

Countries around the world have regulated the content of the information provided as part of abortion counseling, requiring that it be scientifically-accurate and evidence-based or prohibiting it from being misleading or inaccurate. In **Mexico**, the Technical Guidelines for Safe Abortion Care require that counseling include objective, clear, accurate, and evidence-based information.[86]

South Africa's abortion guidelines also specify that counseling should provide "sufficient information for a woman to make an informed choice."[87]

In **Colombia,** for example, the 2023 Resolution No. 051 establishes that health care providers are legally obligated to provide standardized information and counseling on abortion.[88] Such standardized information should be "accurate, credible, accessible, scientific and up-to-date."[89] The resolution, moreover, explicitly prohibits health providers from providing misleading or false information about abortion and denying or withholding information about abortion care, as the latter would violate the person's constitutional rights.[90]

Colombia's 2023 Resolution explicitly prohibits health providers from providing misleading or false information about abortion and denying or withholding information about abortion services, as the latter would violate the person's constitutional rights.

b. Nature of Information and Counseling

According to the WHO, abortion care, including information and counseling, should be provided in a "non-judgemental and nondirective way, allowing individuals to lead the decision-making about their own care."[91] The WHO further provides that counseling must be voluntary and not mandatory and that "[t]he right to refuse counseling when offered must be respected."[92]

Globally, approaches to regulating abortion seeker's decision-making vary. However, mandatory counseling still remains common. In Europe, for example, receiving counseling prior to an abortion is mandatory in 12 countries.[93] Some of these countries (e.g., **Germany** and **Hungary**) either allow or require biased and directive counselling, rather than unbiased and evidence-based information.[94] In the **United States**, **roughly half of all states (26)** require patients to receive "counseling" prior to an abortion that goes beyond typical informed consent requirements,[d] and **15 of those states** require the counseling to be in-person.[95]

Countries have also regulated the nature of the abortion counseling, requiring that it be non-directive, non-mandatory, or both. In **Norway**, the 2025 Abortion Act seeks "to ensure that pregnant women have the opportunity to make independent decisions about their own bodies and their own private lives based on objective and neutral information and without being subjected to pressure."[96] **South Africa**, similarly, requires abortion counseling to be non-directive to preserve autonomous decision-making. **New Zealand**'s 2020 Abortion Act requires health practitioners to advise the pregnant person of the availability of counseling services when the patient inquires about abortion care, but prohibits them from requiring the patient to attend pre- or post-abortion counseling in order to receive that care.[97]

Colombia's resolution requires that the information provided as part of abortion counseling to be relevant and objective.[98] The information, moreover, cannot be dissuasive and must be free from health professionals' and third parties' "personal, ideological, religious or axiological" beliefs.[99] The purpose of counseling, according to the resolution, is not to advise, judge or indoctrinate, but to offer accurate and complete information so that the patient can make an autonomous and informed decision.[100] **Mexico**'s guidelines similarly stress that counseling should not include the values, beliefs, and opinions of health providers.[101]

d Every state requires that patients provide informed consent before undergoing any medical treatment, including abortion. A component of informed consent is the provision of adequate and appropriate information about the procedure to understand the risks and benefits, and provide agreement.

c. Regulation of Interference by Third Parties

The number of unlicensed pregnancy centers in the **United States** is on the rise, particularly in the wake of the *Dobbs* decision. Unlicensed pregnancy centers, also known as crisis pregnancy centers (CPCs), are clinics or mobile vans that present themselves as health centers, but are typically run by anti-abortion activists with the primary goal of dissuading pregnant people from having abortions, often by sharing misinformation.[102] Several states, moreover, have introduced or passed legislation to increase financial support for unlicensed pregnancy centers. In 2023, **12 states** passed 25 bills to provide these centers with over $250 million.[103] In Florida, government spending for unlicensed pregnancy centers increased from $4.5 million in 2022 to $25 million in 2023.

In contrast, countries like **Canada** and **South Africa** have taken measures to prevent third parties from interfering with a pregnant person's access to abortion. In **Canada,** the federal government proposed a bill in late 2024 that would require crisis pregnancy centers to disclose whether they also offer abortion and birth control services or referral for those services.[104] Under the proposed legislation, organizations failing to comply with the requirements of disclosure would be at risk of losing their non-for-profit status. Additionally, the Canadian government's abortion website (Abortion in Canada) includes a warning message about crisis pregnancy centers, stating that:
"Crisis pregnancy centres are usually run by anti-abortion organizations. They often look like clinics or support centres, but they are designed to discourage people from getting an abortion."[105]

In **South Africa**, the Choice on Termination of Pregnancy Act (CTOP) penalizes interference with access to abortion care.[106] Any person who is found to have prevented a lawful abortion procedure, or to have obstructed access to an abortion facility, is guilty of an offence and subject to a fine or up to 10 years imprisonment.[107]

The Canadian government's abortion website (Abortion in Canada) includes a warning message about crisis pregnancy centers, stating that: "Crisis pregnancy centres are usually run by anti-abortion organizations. They often look like clinics or support centres, but they are designed to discourage people from getting an abortion."

5. Financing

Abortion as health care requires ensuring that abortion (like any other essential health service) is available to those who need it without prohibitive financial barriers.

In contexts where abortion is legal, it may remain inaccessible due to the cost of the medication or procedure itself or expenses associated with accessing care (e.g., travel, accommodations, childcare, etc.). Affordability, notably, is a component of the right to health's accessibility element. Accordingly, the ESCR Committee provides that sexual and reproductive health services must be affordable for all people in both public and private facilities.[108] The WHO recommends that "financing of abortion care should take into account costs to the health system while ensuring that services are free or affordable and readily available to all who need them, in support of the goal of achieving UHC."[109]

This section considers how various countries have reduced financial barriers to abortion care — particularly for marginalized pregnant people — by guaranteeing government funding and prohibiting patient cost-sharing for abortion.

a. Government Funding for Abortion

Globally, whether the government itself provides funding for abortion care is a major factor affecting abortion's financing and affordability. According to a WHO survey, approximately 45% of countries with national health benefits packages (as a part of universal health coverage) include abortion care in their benefits packages.[110] Notably, the vast majority of countries (at least 75%) that adopted liberal or liberally interpreted abortion laws and policies in the last 30 years fully cover the cost of abortion care.[111] Twenty-two percent of countries include mifepristone in their national health benefits packages, and 42% of countries include misoprostol.[112]

Another study found that, of 41 countries with data available, 17 require coverage (public or private) for abortion for all individuals, and 12 require coverage for all individuals seeking abortion under certain indications, such as risks to health of the pregnant person or fetal anomaly.[113] In 10 countries, coverage is required for certain individuals. For example, **Israel** requires abortion coverage for patients under 18, regardless of whether it is sought for medical or nonmedical reasons, and **Germany** requires abortion coverage for those with an economic disadvantage.[114]

In the **United States**, government funding for abortion is severely restricted at the federal level. The federal Hyde Amendment, a legislative provision attached to every appropriations bill since 1976, bans the use of federal funds for abortion, except in pregnancies that endanger the life of the pregnant person or result from rape or incest.[115] The Hyde Amendment greatly limits federal funding for abortion through Medicaid, the joint federal and state program that provides health coverage for low-income individuals and families. The majority of states have a similar policy, with only **17 states** allowing the use of state funds to pay for abortions under Medicaid.[116]

The approaches taken by other countries to finance abortion care vary, depending on how their health system is structured. Several countries fully fund or heavily subsidize abortion, particularly countries with public health care or single-payer systems. For example, in **Norway,** abortion is fully covered by the state's public health care system up to a gestational limit of 18 weeks.[117] In **Spain**, the full cost of abortion care is covered under the National Health System.[118] **Canada**, similarly, mandates full coverage of all abortion care, abortion medications, and abortion counseling.[119]

Some countries also create dedicated federal funds or budget allocations that help cover abortion care and related costs, particularly for lower-income populations that might not otherwise be able to afford it. In **Nepal,** the Safe Motherhood and Reproductive Health Rights Act requires the federal government to allocate a portion of its annual budget to motherhood and reproductive health services at each level of government (i.e., provincial and local levels).[120] Local governments are required to spend allocated funds to support access to motherhood and reproductive health services, including abortion, among lower-income women.[121]

In **Canada**, the federal government maintains a federal "Sexual and Reproductive Health Fund" to strengthen access to abortion for underserved populations across the country.[122] The 2021 and 2023 federal budgets included $45 million and $36 million investments for the fund, respectively.[123] This fund has financed projects supporting access to various support services (e.g., transportation, accommodations, and meals), public awareness, and provider trainings.[124]

b. Limits on Patient Cost-Sharing

Another factor affecting abortion's financing and affordability is whether a country's abortion regulation addresses the extent to which insurers or medical providers can charge patient fees or require other forms of cost-sharing.

In the **United States**, **10 states** prohibit private insurance policies sold within the state from covering abortion, and **25 states** have a law prohibiting plans sold on state Affordable Care Act (ACA) Marketplaces from covering abortion.[125] In states with these restrictions, patients with applicable plans would have to pay for abortion care out-of-pocket (or through an alternative source of funding). Alternatively, **12 states** require that Medicaid, private, and ACA Marketplace group and individual plans cover abortion; **9 of these states** require no cost-sharing for abortion, such as the Maryland's 2022 law.[126]

Several countries likewise have laws that prohibit or limit patient cost-sharing. For example, in **South Africa,** the CTOP mandates that abortion costs must be fully covered in public and primary health care facilities accredited by the National Department of Health, including medications, services, post-abortion care, and counselling.[127] In **Ireland,** the 2018 Health (Regulation of Termination of Pregnancy) Act mandates that abortion care, including medical abortions, procedural abortions, and midwifery services, must be provided without cost to the patient.[128]

Nepal's Safe Motherhood and Reproductive Health Rights Act (discussed above) specifies that health institutions receiving government grants must provide free reproductive health services, while private, non-government, and community health institutions may charge fees as prescribed.[129] Notwithstanding, the act further specifies that when charging fees, private, non-governmental, and community health institutions must make services affordable and provide free services to people who are unable to pay the charge.[130]

Finally, in **Colombia,** the Ministry of Health's 2022 Decree 1652 ensures universal and free access to abortion care, which includes consultations with various specialties, such as gynecology, general medicine, and psychology, as well as relevant diagnostic tests and surgical interventions.[131] The 2023 Resolution No. 051 also explicitly exempts all abortion care from co-payments and user fees, regardless of the patient's health insurance plan.[132]

6. Destigmatization

Abortion-related stigma is created by cultural norms and reinforced by restrictive laws and policies, which "create and reinforce the unfounded and unsubstantiated exceptionality of abortion, the perception that abortion is morally wrong, and the shaming of abortion patients and providers."[133]

In commenting on the right to life, the Human Rights Committee has provided that States must "prevent the stigmatization of women and girls who seek abortion."[134] Similarly, the ESCR Committee has called upon State parties to take action to prevent and eliminate "stigmatization and negative stereotyping that hinder access to sexual and reproductive health."[135] The WHO has stressed that stigma remains a significant barrier to the delivery of abortion care.[136] By subjecting abortion care to onerous and medically unnecessary regulations, both those who seek and those who provide abortion care face stark stigmatization.[137]

While there is no one approach to tackling stigma through law (and, therefore, no globally available data on norms on anti-stigma measures), a select number of jurisdictions have implemented unique and innovative legal approaches to reducing stigma associated with abortion care — thus strengthening the enabling environment for such care.

This section considers a handful of approaches, ranging from creating buffer zones around abortion facilities to protect seekers and providers from protests to legalizing paid leave from work for abortion care to adopting anti-discrimination provisions related to abortion.

a. Safe Access Zones

Efforts to prevent or dissuade abortion seekers and providers from entering facilities that provide such care generate a significant amount of stigma. In the **United States**, the U.S. Department of Justice announced in 2025 that it would limit enforcement of the Freedom of Access to Clinic Entrances Act, a federal law designed to protect access to reproductive health care facilities from intimidation and violence.[138] Some states, however, have enacted state-level protections for abortion clinics and patients, with the Supreme Court declining to review a case on whether such laws violate free speech rights in 2025.[139]

In **Canada,** several provincial governments have passed "bubble" or "safe access zone" legislation to ensure that abortion care can be provided and accessed without harassment or intimidation.[140] While the radiuses vary, safe access zone laws in Canadian provinces typically prohibit protests within a radius of 50 to 150 meters of facilities that provide abortion care, the homes and offices of health professionals who provide abortion care, and the homes of abortion clinic staff.[141] The legislation's ultimate aim is to ensure that health professionals and clinic staff can provide abortion health services without interruption, and that patients are able to access abortion care without harassment. The provinces of Alberta, British Columbia, Newfoundland and Labrador, Ontario, and Nova Scotia have each passed a provincial bill protecting safe access zones.[142]

b. Paid Medical Leave for Abortion

In the **United States**, there is no federal law requiring employers to provide paid medical leave, whether for abortion or other health care. **Thirteen U.S. states and D.C.** have enacted paid family and medical leave laws. Though no states have laws specifically designating paid leave for abortion, some may provide for it under more general paid family and medical leave.[143]

Spain's Organic Law 1/2023 (which modified an earlier Law 2/2010) on sexual and reproductive health and voluntary termination of pregnancy regulates the provision of abortion.[144] The law establishes fundamental guarantees for abortion up to 14 weeks of gestation, and up to 22 weeks of gestation in cases where there is a serious risk to the life or health of the pregnant woman, or risk of severe fetal anomalies.[145] It guarantees women the right to take medical leave in the event of a voluntary or involuntary termination of pregnancy that leads to the employee being unable to work.[146] Under the law, an abortion qualifies as an "illness unrelated to work," except in cases where the termination is the direct result of a workplace harm or disease.[147] Where leave is requested using this mechanism, employers are required to pay the employee's full salary for the first day of absence, with the remainder being paid out by social security.[148]

c. Anti-Discrimination Provisions

Nepal includes protections for "disability-friendly service" and specifically prohibits discrimination under sections 28 and 29 of the Safe Motherhood and Reproductive Health Rights Act.[149] Specifically, it guarantees that services under the act, "including family planning, reproductive health, safe motherhood, safe abortion, emergency obstetric care and newborn care, reproductive health morbidity, shall be adolescent and disabled friendly."[150] Further, it prohibits discrimination in the provision of these services.

> "[F]amily planning, reproductive health, safe motherhood, safe abortion, emergency obstetric care and newborn care, reproductive morbidity, menstrual care on the ground of origin, religion, color, caste, ethnicity, sex, community, occupation, business, sexual and gender identity, physical or health condition, disability, marital status, pregnancy, creed, state of being suffering from any disease or infected with virus or vulnerable to such infections, state of reproductive morbidity, personal relationship or any other such grounds."[151]
>
> —*Nepal's Safe Motherhood and Reproductive Health Rights Act*

7. Toolkit for Using the Law to Treat Abortion as Health Care in the United States

In the United States, abortion is treated differently than other essential health services in various ways — resulting in significant legal and practical barriers for those seeking or providing safe, high-quality, and timely abortion care. States have a primary role in determining how abortion is regulated within their respective contexts, particularly in the wake of the *Dobbs* decision. As state lawmakers in the United States explore opportunities to frame and regulate abortion as health care, they can look to the global standards developed by international organizations and human rights bodies and the laws, policies, and regulations adopted by other countries.

a. Policy Proposals

1. Eliminate all **facility requirements** that go beyond what is necessary to ensure patient safety (e.g., ambulatory surgical centers' requirements) and other legal barriers to integrating abortion into **primary care** settings.

2. Expand the **pool of providers** who can provide first-trimester abortions beyond physicians (or in some cases, specialist physicians) to include nurse practitioners, midwives, and physician assistants, including through **task-sharing** and expanded **prescribing authority**.

3. Eliminate **place-based requirements** for medication abortions so that patients can access the medications through the mail or their local pharmacies.

4. Repeal bans on and regulate the provision of medication abortions via **telemedicine**.

5. Ensure that the law treats abortion medications as **essential medicines**, and not as controlled substances.

6. Ensure that **abortion counseling** is not only non-mandatory and non-directive, but also includes information that is accurate, unbiased, and evidence-based.

7. Adopt measures to limit **third parties'** (e.g., crisis pregnancy centers, parents, and legal guardians) influence over abortion decision-making, such as disclosure requirements.

8. **Reduce the costs** of abortion care borne by patients, including through the elimination of state funding restrictions, prohibition of cost-sharing, and state budget allocations for abortion care.

9. Adopt measures to **reduce stigma** related to abortion care, including around abortion facilities (e.g., safe access zones) and time off for care (e.g., paid medical leave).

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