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Trends in Abortion Policies in Low- and Middle-Income Countries

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Abstract

The decision to terminate a pregnancy is not one that is taken lightly. The need for an abortion reflects limited sexual autonomy, ineffective or lack of access to contraceptive options, or a health indication. Abortion is protected under human rights law. That notwithstanding, access to abortions continues to be contested in many parts of the world, with vested interests from politically and religiously conservative states, patriarchal societies, and cultural mores, not just within local contexts but also within a broader geopolitical context. Criminalization of a women's choice not to carry a pregnancy is a significant driver of unsafe procedures, and even where abortions are provided legally, the policies remain constrained by the practice or by a lack of coherence. This review outlines the trends in abortion policy in low- and middle-income countries and highlights priority areas to ensure that women are safe and able to exercise their reproductive rights.

PROLOGUE

I (Allotey) undertook a study some years ago in a rural community in West Africa to explore the impact of tropical diseases in pregnancy. A 28-year-old woman who was assisting me with community engagement activities discovered she was pregnant—for the 6th time in the 11 years she had been married. She had four daughters and a son; her husband, however, counted only one child (the son).... At the time she realized she was pregnant, she was still breastfeeding a 7-month-old baby girl. I facilitated her access to the primary health care service—her very first visit ever to the health center. She otherwise could not have attended the health center without the presence of, or explicit permission from, her husband. She was given information about her range of options for the current pregnancy, as well as future contraceptive choices but no specific treatment or procedure until she returned with her husband. When I saw her 2 days later, she had been visibly physically assaulted. It turned out that one of the nurses' aides at the clinic was a relative of her husband's and had reported to him that she had gone to the clinic in an attempt to procure an abortion (1).

INTRODUCTION

Terminating a pregnancy is never an easy decision. The need for an abortion often reflects limited sexual autonomy as well as ineffective or lack of access to family-planning and contraceptive options. An abortion can also be indicated even when a pregnancy is intended. To carry a pregnancy to term has profound implications on the health, well-being, and life of the mother, through gestation and beyond, and, where relevant, on her partner and other relationships. By right, this decision must be made and owned by the woman, with control and agency over her body and her life. Abortion is protected under the rights to life; liberty; privacy; equality and nondiscrimination; and freedom from cruel, inhuman, and degrading treatment (2, 13). However, reproductive choices continue to be contested in many parts of the world, with vested interests from politically and religiously conservative states, patriarchal societies, and cultural mores playing a significant role in the decision. This contestation is further complicated by individual, but powerful politicians, health officials, and religious and autocratic leaders (7). The policies that result from these different interests, including criminalization, have an impact on access to safe, affordable, and respectful reproductive health services.

Abortion rates are based on estimates that draw on often unreliable data. However, a recent study developed a new model for such estimates. The study used a Bayesian framework to simultaneously estimate abortion and unintended pregnancy (5). Over the last three decades, rates of unintended pregnancies have declined, suggesting better access to sexual and reproductive health services (5). Globally, between 2015 and 2019, there were an estimated 121 million unintended pregnancies per year, a rate of 64 unintended pregnancies for every 1,000 women of reproductive age. This finding demonstrates a reduction from 79 per 1,000 estimated between 1990 and 1994. However, the decline in low-income countries was slightly less than in middle- and high-income countries (5).

Not all unintended pregnancies result in terminations. The proportion of abortions performed for unintended pregnancies has increased from 51% to 61% over the 30-year period from 1990 to 2019. The differences are again evident across country income groups. The most recent estimates report 15 abortions per 1,000 women in high-income countries, 44 per 1,000 women in middle-income countries, and 38 per 1,000 women in low-income countries (5).

Low- and middle-income countries (LMICs) account for approximately 88% of worldwide abortions (15). Unsafe abortions occur almost exclusively in LMICs (97%), including in countries that have liberal abortion laws (38). Beyond the laws and policy environment, therefore, there also

needs to be access to information about choices, services to reduce maternal morbidity and mortality, and advocacy for longer-term sexual and reproductive health of women and their families. The complex contexts in LMICs—which influence the types of laws, policies, and available services and how these are applied to different population groups—are an important consideration and are often overlooked, limiting the effectiveness of interventions to enable access to abortion for population groups that often suffer multiple marginalization. The woman in the opening example resided in a setting in which, legally, she could have procured an abortion. However, the odds were otherwise stacked against her.

In this review, we provide an overview of trends in abortion policies, over the past three decades, across several LMICs where data are available, outlining not only the local contexts but also the impact of the global geopolitical landscape on realizing women's sexual and reproductive health rights in general and access to abortion in particular. The precariousness of access is borne out by the removal of abortion services from essential services lists with the advent of the coronavirus disease 2019 (COVID-19) pandemic. We highlight the reasons why, despite significant policy gains since the 1990s, abortion services still remain out of reach for many women in LMICs, especially those from the most marginalized groups. We incorporate specific case examples to illustrate the intersections of social, cultural, religious, and economic factors in women's lives and the impact that legal, political, and health systems in contemporary society have on these women.

ABORTION IN LOW- AND MIDDLE-INCOME COUNTRIES IN CONTEMPORARY GLOBAL HEALTH DISCOURSE

An extensive body of literature on abortion has been built over at least the 25 years since the Beijing Declaration and Call to Action (65). Data from LMICs show that approximately 50% of induced abortions are unsafe, placing women at significant risk of mortality or permanent disability (59). Poor data sources, underreporting, clandestine procedures, and the range of public, private, and self-care interventions for pregnancy termination make both legal and illegal abortions difficult to estimate (51). In LMICs, in particular, data are often restricted to individuals with complications who present to health facilities, deaths, and public health services used; therefore, a range of methods are used to calculate estimates. In Tanzania, for each woman treated in a facility for induced abortion complications, an estimated six times as many women had an abortion but did not receive care (40).

Available data, despite their shortcomings, list abortion as one of the top four causes of maternal mortality (44). Countries in sub-Saharan Africa still record some of the highest maternal mortality rates globally, and unsafe abortion remains one of the leading causes (40). It is noteworthy, however, that mortality from unsafe abortions between 1990–1994 and 2010–2014 decreased by 42%. Estimates show that in 2010–2014, Africa had the highest case fatality rates from abortion with 141 deaths per 100,000 women of reproductive age, followed by Asia (62 per 100,000) and Latin America (22 per 100,000). Studies also show that while morbidity following unsafe abortions continues to be significant, the proportion of severe complications has declined (60).

Unlike access to any other health service, access to safe abortion is highly politicized. It is a service that only women need and is regulated by laws in a majority of the world's countries. Criminalization and other legal restrictions on abortions do not reduce the rates; rather, they serve to increase incidences of unsafe, clandestine procedures.

Countries are classified into five categories on the basis of the circumstances under which abortion is permissible. Category I countries impose a total prohibition on abortion with no mitigating circumstances. In 2019, 26 countries, accounting for 5% of the world's women of reproductive age, were in this category. Category II countries permit abortion if it is required to save the life of the

woman. Thirty-nine category II countries account for 22% of women of reproductive age globally. Category III comprises 56 countries (14% of women). Abortion is permitted to save the life of the woman as well as for health reasons. Twenty-five of the 56 countries explicitly mention potential injury to mental health as grounds for permitting abortion. Category IV countries (14 countries) are those where abortion is legal on broad social and economic grounds. Sixty-six category V countries account for 36% of the world's women; in these countries, abortion is available on the woman's request but with limits on gestational age. With the exception of category I countries, most countries also permit abortion on additional grounds such as pregnancy resulting from rape or incest and in the case of fetal impairment (12). Only 48 out of 148 countries in developing regions permitted abortion on 5 grounds or more (to save the woman's life, health grounds, pregnancy resulting from rape or incest, fetal impairment, social and economic reasons), whereas 41 out of 49 countries in the developed regions did so (64).

Religion is a strong legacy of the colonial past of many LMICs and continues to retain a foothold, particularly in countries in sub-Saharan Africa. Even in countries such as Ethiopia, which have relatively liberal abortion laws, religious norms constrain implementation and service provision (19). In many of the Muslim countries in the Global South, the interpretation of Islam allows abortion with a four-month gestational limit on the broad reasoning of mother's physical health. However, the rules and implementation rely heavily on how the laws are interpreted by clerics, all of whom are men. An in-depth study of Islamic scholars noted that the sex of the fetus had to be an important consideration in the decision, with secondary concern for the women's experiences and needs (30).

The Sustainable Development Agenda, with its imperative to leave no one behind, has opened up the opportunity to engage more directly in sexual and reproductive health (SRH) for women and girls (73). Initiatives such as Every Woman Every Child (EWEC) and the Partnership for Maternal, Newborn & Child Health (PMNCH) have helped to retain some focus on the unfinished agenda from the Millennium Development Goals (52), including the right to abortion.

Expanding access to and influence of social media has improved the availability of information and provided a significant tool for advocacy, both for and against abortion. The global trend toward the liberalization of abortion laws has been fueled by social movements created through social media (SheDecides, #MeToo movement) (33), but there is a strong contextual effect to the impact of these campaigns (6, 16, 35, 54). The gendered inequalities in access to information and technology for women in the Global South are clearly documented (21, 23, 47). The strength of campaigns led by the Global North may resonate with the educated elite in the Global South but leave the majority of women behind.

Information about and access to services for adolescents present a significant challenge. Sexual activity outside marriage remains highly stigmatized in many developing countries. With little access to comprehensive sexuality education and to contraceptive information and services, unmarried adolescents in developing countries are at a high risk of unintended pregnancies. Legal restrictions on abortion services and, even where abortions are available for a broad range of indications, the requirement for parental consent and the likelihood of negative health provider attitudes leave adolescents in developing countries with few options besides unsafe abortions. Studies from developing countries indicate that when compared with women aged 20 and above, adolescents were more likely to self-induce or seek abortion services from untrained providers, often resulting in multiple attempts to terminate a pregnancy (27). Adolescents also had a relatively higher probability of seeking second trimester abortions for reasons such as delays in recognizing the pregnancy, difficulties in locating a suitable provider, and the challenge of paying for the abortion. Adolescents account for between one-fifth and one-third of the approximately seven million women with complications from unsafe abortions who were admitted to hospitals (27).

The World Health Organization (WHO) recommends that laws and policies should enable adolescents to obtain safe abortion services; that adolescents should have access to postabortion care as a life-saving medical intervention, regardless of whether the abortion or attempted abortion was legal; and that interventions to prevent unplanned pregnancies be put in place, including sexuality education, contraceptive services, and prevention of sexual violence (69).

Despite these initiatives, abortion has remained politically sensitive. For LMICs in particular, there is pressure for governments to conform to particular ideologies with conditions tied to development assistance. In 1984, a policy introduced by US President Ronald Reagan forced many governments and nongovernment service providers who rely on funding from the US government to choose between continuing to provide safe, legal abortion and losing US government funding and the ability to operate. In addition, funding was contingent on the avoidance of any advocacy for abortion law reform (Mexico City policy, also known as the global gag rule). Under this policy, organizations were ineligible to receive US funding if they also received alternative sources of funding for abortion-related activities. In 2017, US President Donald Trump expanded the global gag rule with the Protecting Life in Global Health Assistance policy. This policy covered the withdrawal of funding from health systems strengthening, HIV and AIDS programming, and water, sanitation, and hygiene programs. A hospital that provided access to abortion, advice, or information could no longer receive US funding for any of its other programs, which effectively imposed US domestic policy on bilateral funding agreements. The Mexico City policy (and the subsequent derivatives) has had strong partisan support in the United States and has therefore been systematically repealed by US Democratic party governments and reinstated by conservative Republican governments. A 2019 study of the trends and impacts of this policy on unintended pregnancies and abortions has shown a systematic rise of approximately 40% in abortion rates in countries highly exposed to the policy relative to periods when the policy was rescinded (11).

ABORTION LAWS AND POLICIES IN LOW- AND MIDDLE-INCOME COUNTRIES: RECENT PROGRESS

The years since the International Conference on Population and Development (ICPD) in 1994 have seen some progress in terms of laws governing abortion access. As of 2019, 47 countries, 40 of these in developing regions, have expanded the grounds for legal abortion (**Table 1**). Unfortunately, in at least three developing countries—the Dominican Republic, Nicaragua, and Papua New Guinea, where in 1994 abortion was permitted to save the life of the woman—abortion is now totally prohibited under all circumstances (64, 72).

There have been a range of drivers for change in abortion policies. For the most part, concerted advocacy has built on local events. In Ghana, for instance, the criminal law that restricted access to abortion was inherited from the British colonial government. The military dictatorship in the 1980s and 1990s targeted colonial and religious influences, and a revision of the law in 1985 opened up access to abortion for cases of rape, incest, and fetal abnormalities or where the pregnancy is a risk to the woman's physical or mental health as exceptions within the criminal code (3). However, until recently, abortion services have been provided largely by the private sector, making them unaffordable and therefore provided largely by clandestine, unsafe practitioners. While services are increasingly available, the rise in Christian fundamentalism has led to an increase in the conscientious objection among health care providers (50). Similar challenges have been reported in other countries in sub-Saharan Africa (4, 31).

At a regional level, there has been a more concerted adoption and adaptation of international human rights norms and standards. UN human rights treaty monitoring bodies have regularly impressed upon states the need to decriminalize abortion as a means to reduce maternal mortality

Table 1 Liberalization of abortion laws since 1994: developing countries

Abortion law category[a] in 1994	Abortion law category[a] in 2019	Number of countries
I	II	5
I	III	10
I	V	2
II	II with additional grounds[b]	4
II	III	3
II	V	2
III	III with one or more additional grounds	5
III	IV	2
III	V	5
IV	IV with one or more additional grounds	1
IV	V	1
TOTAL		**40**

Table constructed on the basis of data from Reference 12.
[a]Definitions: I, prohibited under all circumstances; II, to save the woman's life; III, health grounds; IV, social and economic grounds; V, on request.
[b]Additional grounds: pregnancy resulting from rape/incest; fetal impairment or other additional enumerated grounds.

from unsafe abortions. They have also urged that abortion laws be decriminalized at a minimum when the pregnancy poses a risk to the life and health of the woman; when pregnancy is the result of rape or incest; and in cases of severe fetal impairment. In 2013, the Child Rights Committee urged states to decriminalize abortion to ensure that girls had access to safe abortion services. In the same year, the Committee on the Elimination of Discrimination Against Women (CEDAW) directed states to ensure that sexual and reproductive health care included safe abortion services (20).

A number of regional human rights instruments have also upheld women's right to access safe abortion services in specific circumstances. General comment (2)(c) of Article 14 of the Protocol to the African Charter on the Rights of Women (Maputo Protocol) enjoins States Parties to take appropriate measures "to protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus" (49). Forty-nine out of the 54 African member states have signed the protocol; 37 have ratified it, making it legally binding within their national laws, notwithstanding local protests from religious groups. This protocol is the first human rights treaty to recognize abortion as a human right. The African Commission on Human and Peoples' Rights has moved further to use the protocol for advocacy recognizing the weakness of human rights protections despite CEDAW and other international instruments (48).

ABORTION POLICY IN PRACTICE

Having the right policies in place, in and of themselves, may not be sufficient to guarantee choice and access. Research has documented instances of a lack of policy coherence. In addition, there may be a lack of fidelity in the operationalization of the policy in practice.

The following case illustrates a context in which the policies are implemented. India makes for a good case study of how a relatively "liberal" abortion law may be unable to ensure access to abortion services for some of the most vulnerable women and girls.

India's Medical Termination of Pregnancy (MTP) Act of 1971 permits abortions to be performed not only on therapeutic grounds, but also in cases of fetal anomalies, for humanitarian

reasons such as pregnancy resulting from rape, or from contraceptive failure. Termination of pregnancy is also permitted for social reasons, "where actual or reasonably foreseeable environment" (social/economic) would lead to "risk of injury to the health" of the mother (22, section 3.3). However, the law is mired in shortcomings and legal loopholes. Furthermore, implementation of the law is confounded by other legislation meant to prevent gender-biased sex selection and child sexual abuse.

The first limitation of the MTP Act is that the law does not allow for abortion on request by the woman. It bestows exclusive power on service providers to decide who satisfies the indications specified in the law and who does not. Thus, the service provider decides if the woman seeking an abortion is at risk of injury to physical or mental health, including for social reasons. Some of the early reports indicate that providers viewed women as irresponsible and incapable of making judicious decisions about pregnancy termination (41, 43). The law permits abortion in the case of contraceptive failure only for married women, which excludes access to safe abortion for a large number of sexually active young and/or unmarried women. In violation of the rights of persons living with disabilities, the MTP Act of 1971 requires that pregnancy in a "mentally ill person" shall not be terminated "except with the consent in writing of her guardian" (22, section 3.4.a).

The MTP Act also specifies where the abortion can be provided and by whom. Mid-level providers, medical graduates of the allopathic system who are not specially trained to provide abortion services and even medical professionals who are not specialists in obstetrics and gynecology, are excluded from providing abortion services. In a country where the number of doctors of allopathic medicine per 1,000 total population (0.77 per 1,000) falls below the WHO-recommended minimum of 1 per 1,000, and where the majority of doctors practice in urban metropolitan centers, this limitation on providers makes abortion services beyond the reach of millions of rural women (70).

Significant attempts at litigation for abortion in India have sought judicial intervention to obtain abortion services beyond the approved gestational limit of 20 weeks. The gestational limit is arbitrary and is not backed by scientific evidence. In countries with liberal abortion laws such as Vietnam, and countries such as Bolivia and Burkina Faso where abortion is permitted only to save the woman's life, no gestational limits have been imposed for abortion services (14). The imposition of a gestational limit effectively cuts off access to the most vulnerable populations of women (67). These include women who have to negotiate with their spouses before they can seek an abortion; women who need time to put together the resources needed to seek abortion from a distant facility; and, most importantly, survivors of sexual assault, including children, who have been unable to recognize or acknowledge their pregnancies or do so at a later gestational age than others (17, 62).

Particularly poignant cases relate to pregnant child rape survivors who have petitioned courts seeking permission to terminate their pregnancies beyond the gestational limit of 20 weeks. The courts, usually based on the recommendations of expert committees of doctors, have ruled against terminations in many instances, forcing children as young as 12 years old to undergo high-risk pregnancies, childbirth, and motherhood as a child. Between 2016 and 2019, various high courts of India rejected 12 of 78 petitions, as did the Supreme Court in 2 of 5 petitions, for terminations of late pregnancies in child rape survivors (56).

Gender-biased sex selection and selective abortion of female fetuses are major gender issues in India and significant complicating factors in the negotiation for abortion rights. Feminist groups successfully advocated for national legislation, known as the Pre-Conception and Pre-Natal Diagnostics Techniques (Prohibition of Sex Determination) (PCPNDT) Act, to prevent the misuse of prenatal diagnostic tests for sex detection (9). While the legislation includes punitive action only for providers who engage in sex detection, in practice, abortion providers, who may or may

not know of the sex selection motive, are also subject to legal action. Because sex detection using ultrasonography is possible only in the second trimester, one of the major consequences of this law has been the near nonavailability of second-trimester abortion owing to providers' fear of legal action (26).

More recently, misconceptions about individual obligations and adolescents' rights in the context of the Protection of Children from Sexual Offences (POCSO) Act of 2012 (25) and the MTP Act (24) have adversely affected adolescents' access to abortion services. The POCSO Act mandates reporting by health service providers in cases of minors seeking abortion services. The Act explicitly overrides provisions under other laws, such as the MTP Act, which guarantees privacy and prohibits disclosure. Unaware of the fact that they can first provide the abortion services and then notify the child protection officers, many service providers resort to denying abortion services to all adolescents (36, 45).

Given these major barriers to accessing abortion services, a vast majority of abortions in India (78%) are estimated to take place outside a health facility and, except for a small minority, use medical abortion services without consulting an approved abortion service provider (61).

Finally, we come to the most critical legal challenge of all. Women who resort to abortions outside the purview of the MTP Act are criminals (and so are their providers, if the abortion was not self-induced) under Section 312 of the Indian Penal Code (22). Abortion has not been decriminalized in India, and the MTP Act merely outlines the circumstances under which abortion will not be considered criminal. Thus, women in India face the double burden of limited access to safe and legal abortions and being criminalized if other safe means are used.

PRESSING CHALLENGES

Despite the progress made in liberalizing abortion laws and policies, recent events highlight the fragility of the conviction for the protection of reproductive choices and the need for ongoing monitoring and vigilance. In April 2020, the Guttmacher Institute estimated that the COVID-19 pandemic could result in an additional 15 million unintended pregnancies over the course of the year, assuming that there was a 10% decline in the use of reversible contraceptive methods in LMICs, owing to disruptions in the supply chains. Furthermore, assuming that there would be a 10% increase in unsafe abortions owing to restrictions on travel and the noninclusion of abortion services among essential services to be guaranteed during the pandemic, an additional 3.3 million unsafe abortions would occur in LMICs over the course of a year, contributing to an additional 1,000 maternal deaths (57).

Information compiled by the International Campaign for Women's Right to Safe Abortion since the end of March 2020 suggests that the situation thus far has not been as bad as was feared. In countries where abortion is legal, services have been included among essential care. Where abortion services were discontinued in the chaotic initial months of the pandemic, efforts have been made to reopen them (8). In addition, the WHO has included abortion as an essential public health service in the interim guidance issued for health services (71). The extent to which this recommendation has been adopted by LMICs is not clear. The guidance also proposes the use of telemedicine and self-management for safe abortion, ensuring access to a trained provider if needed (71, p. 29). Telemedicine and self-management approaches would not only help overcome many of the pandemic-related barriers to safe abortion access, but could also expand access to safe abortion services even after the pandemic recedes.

Several other policy challenges call for urgent attention. We list here the most prominent of these. First is the continuance of laws criminalizing abortion in many countries, including countries where abortion is permitted for a wide range of circumstances. For example, in many

countries that were under British rule, abortion is a crime, for which there are some exceptions (as, for example, in India). It is time that lawful abortion is the default position, except under circumstances that would make any medical procedure unlawful or criminal (10).

The second policy challenge is the imposition of gestational limits for abortion services, which are not based on scientific evidence and create major barriers to women's access to safe abortion. Experiences from countries that have not imposed gestational limits show that late abortions (beyond second trimester) are rare (about 1% of all abortions) and are perfectly safe when conducted by skilled providers (28, 29).

A third issue relates to conscientious objection by providers to the provision of abortion. Professional bodies of obstetricians and gynecologists have taken the position that a professional may decline to provide abortion services for reasons of conscientious objection only if s/he informs the patient that abortion is an available service and refers the patient to another professional who can provide the service (39). Laws and policies should explicitly spell out the obligations of providers who resort to conscientious objection in order to protect women from being turned away from an abortion facility without any recourse.

In addition to these areas that call for immediate changes at the level of formal policies, several de facto policies are imposed at the level of implementation. These include denial of abortion services to adolescents and young people, requirement for spousal or parental authorization, restriction of the range of abortion methods offered, and not including abortion services in health benefits packages or essential health service packages under universal health coverage.

Furthermore, the ideological nature of abortions has resulted in a predominant focus on the legality, or illegality, of abortion as a procedure. Less considered, particularly in the context of LMICs, is a more comprehensive management and development of pre- and postabortion quality of care (18, 55). A study in Kenya, for instance, demonstrated that any considerations of quality of postabortion health care are constrained by law and government policy (46). The problems related specifically to the negative attitudes of staff, borne both of fear of possible repercussions and of prejudice against women seeking abortions. There is also a dearth of evidence on the provision of psychosocial support and counseling that is culturally appropriate (63). The lack of prioritization also extended to women who sought abortions on the basis of possible congenital malformations and other reasons that related to health and well-being, particularly in LMICs—a situation that was manifest during the recent Zika outbreak (66).

The lack of consideration of abortion as an essential service within a comprehensive package of sexual and reproductive health services has a negative impact on rural women. In several countries where abortion policies are considered liberal, access is constrained by the requirement that the procedure is performed by specialists to the exclusion of mid-level providers who are more likely to be available (34). The lack of trained specialists in rural health facilities means that most women cannot obtain abortion within the 10-week gestational limit (58). This limitation pushes rural women back to the routes of unsafe abortions, which puts their risk of death at 208 deaths per 100,000 procedures. This figure is four times higher than if the abortion is performed in medical clinics (34).

There are also challenges in abortion policy implementation as it relates to policy intersections (gender, disability, and experiences of violence, often resulting in unwanted and unexpected health outcomes, such as HIV and sexually transmitted infections; discrimination; and accessibility). For vulnerable populations, there is a lack of policy enforcement, limited budget allocation for disability issues, limited skills among health providers to provide adapted services (lack of cultural competence, lack of accessible mass education, and weaknesses among elected bodies, including disabled officials, to promote and protect the rights of people with disabilities). These policy

implementation gaps had a direct impact on the experiences of vulnerable populations when using SRH services (42).

A further challenge worth noting is the need for a clear policy environment on pregnancy in humanitarian crisis settings (53). This area has received recent attention in policy discourse, although implementation and practice remain unclear (53). The WHO (68) estimates that 51% of low-income countries, 34% of middle-income countries, and 14% of upper-middle-income countries are classified as fragile and conflict-affected states. Six percent of the world's population lives in fragile and conflict-affected states. A significant number of women and girls are at risk of carrying to term an unwanted pregnancy that resulted from war rape. Women and girls in armed conflict are entitled to nondiscriminatory medical care, which includes safe abortion services. However, national restrictive abortion laws and policies often (erroneously) override international humanitarian law, which otherwise entitles women and girls to broader, more inclusive access to safe abortion. Funding complications arise particularly through international aid from the United States, which does not allow for any form of abortion-related medical services (32). Countries such as the United Kingdom, the Netherlands, and France have reviewed and changed their humanitarian aid policy to include safe abortion policies for those protected under international humanitarian law.

CONCLUSION

Significant progress has been made globally, supported by evidence, human rights law, regulatory frameworks, access to and sharing of information, and advocacy, to address women's right to abortion (37). Online trackers and policy monitors provide updates on changes in laws and policies (see, for instance, **https://abortion-policies.srhr.org/** and **https://reproductiverights.org/worldabortionlaws**).

For the most part, the policy environment is intended to ensure the sexual and reproductive health and rights of women in LMICs, including access to abortion services should they be required. The critical message, however, is that abortion rights need to be part of an overall package of sexual and reproductive health and rights. The need to terminate a pregnancy may not arise if the pregnancy is planned and does not jeopardize the life, health, and well-being of the mother. Furthermore, the policy environment needs to be coherent and supported by enabling regulatory environments.

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