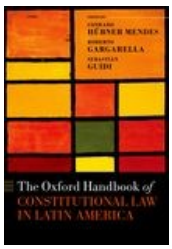

The Oxford Handbook of Constitutional Law in Latin America

Conrado Hübner Mendes (ed.) et al.

https://doi.org/10.1093/oxfordhb/9780198786900.001.0001

Published: 2022 **Online ISBN:** 9780191829048 **Print ISBN:** 9780198786900

CHAPTER

46 Abortion: More Than Criminalization, Not Yet Women's Constitutional Right

Agustina Ramón Michel

https://doi.org/10.1093/oxfordhb/9780198786900.013.57 Pages 799–831

Published: 13 January 2022

Abstract

This chapter is about abortion law in Latin America. Latin America abortion law is often categorized as seriously restricted. And this is so, partially. Abortion is criminalized if it does not fit in the legal indications (e.g. health risk, rape) contemplated. However, the region is in a process of examining some of their laws and implementation. The chapter argues that we should go beyond the more classic discussion in comparative constitutional law and engage in constitutional discussions in which we check thoroughly the persistent criminalization of abortion in most of the world, and the (health) regulations on abortion that put doctors, not women, at the centre and hinder access to safe abortion. If the law recognizes an abortion right to women, thus, it needs to deliver regulations that fit that purpose. The second part of the chapter analyses these regulations, as they burden women's rights and overstep constitutional governmental discretion to regulate this practice.

Keywords: Latin America, abortion law, constitution, women's rights, criminalization, abortion regulations

Subject: Constitutional and Administrative Law, Comparative Law, Law

Series: Oxford Handbooks

Collection: Oxford Handbooks Online

46.1 Introduction

Latin America abortion law is often categorized as seriously restricted. And this is so, partially. Abortion is criminalized if it does not fit in the legal indications (e.g. health risk, rape) contemplated. These indications have not only been one of the most innovative areas to expand access to legal abortion in the region in the last years—including rulings of high courts—but they also question the typical classification of Latin America as an extremely legal constrained setting. In fact, if we look closely at the world legal map, we find that only two countries have absolutely ruled out the use of criminal law to deal with voluntary abortion (Canada and some jurisdictions in Australia) while the rest persist in its deployment. That is, the basic framework for regulating abortion worldwide is still criminal. Therefore, what differs is the degree and forms of (partial) decriminalization, both in the letter of the law and practice.

From this point of view, there is the total penalization model, the indication model, the periodic model, and the mixed model (a combination of the time and indication criteria). The last two, in place in almost all of northern hemisphere countries, are usually depicted as more liberal as they seem to give women control over the abortion decision for at least an initial time during pregnancy.[1] The indication model, prevalent in Latin America, on the other hand, has been portrayed as a rather restrictive model because its main rules come from criminal laws, because it was the regime that was in force in a large part of the northern countries until, starting in 1960, they changed to the periodic model (conceived as more 'liberal'). Another reason is because most countries with this model have had, in practice, an absolute penalization due to the lack of implementation of the 'legal indications', and ↳ lastly because the constitutional arena has remained mostly soundless about 'a right to abortion' under this model until recently.

p. 800

At the beginning of the twenty-first century, however, the legal landscape in Latin America began to experience some changes: a gradual and uneven liberalizing trend with constitutional arguments and discourses. This constitutionalization of abortion has not only focused on more progressive legislation, but it has also drawn attention to the enforcement of the already existing legal indications for abortion contained in penal codes since the 1920s. Indeed, this process led by some high courts has resulted not only on an evolving appreciation of women's rights and new proportionality tests, but also on an understanding of the importance of securing certain conditions that make rights real. The first part of this chapter underscores some features of this development (46.2).

But abortion constitutionalization has left aside, at least until now, a topic I consider central to enhance real access to legal and safe abortion: regulations. Indeed, legal restrictions not only come from the criminalization framework (still in place) but also from regulations which aim at implementing abortion health services. The problem is that regulations governing abortion place doctors both as the health guarantors and gatekeepers of women's right to abortion layering several restrictions. The justice system expects physicians to guarantee the safety of the legal abortion procedure—as they embody health guardians—and, at the same time, ensure that women only practice abortion within the confines of the law—as they also serve as legal custodians.

Doctors, thereby, turn simultaneously into allies and enemies of women, in an always misleading dynamic that carries a certain degree of inaccessibility.[2] Moreover, as explain later, this particular arrangement has led to over-regulation of abortion-health services, arbitrariness in the certification of the indication or gestational period, breach of confidentiality, conscientious objection abuse, resistance against scientific advances that makes easier to terminate pregnancy, concentration of power on obstetricians and gynaecologists, among other barriers.

These regulations, which I call 'doctor-based regulations', have been able to survive even the more liberalized laws around the world, but have developed with strength under the shadow of the indication model in Latin America. Regulations help to shape the ways in which women experience their right to have

an abortion, they can even place undue and unnecessary restrictions. And these regulations nowadays not only come from criminal laws but also from health regulations that are supposed to lay down the conditions to guarantee women's right.

Latin America is in a process of examining some of their laws and implementation, in some cases supported by constitutional arguments and forums; the overall trend regionally is toward more progressive laws. My argument is that we should go beyond the more classic discussion in comparative constitutional law, not only in Latin America but also around the world, and engage in constitutional discussions in which we check thoroughly the persistent criminalization of abortion in most of the world and the (health) regulations on abortion that put doctors, not women, on the centre and hinder access to safe abortion. If the law ↳
p. 801 recognizes an abortion right to women, thus, it needs to deliver regulations that fit that purpose. Thus, the second part of the chapter analyses these regulations, as they burden women's right and overstep constitutional governmental discretion to regulate this practice (46.3).

46.2 The Criminal and Constitutional co-existence on Abortion Legal Environment

In this part, I first provide a panoramic view of abortion laws in Latin American countries (46.2.1). Then, I outline some recent constitutional episodes (46.2.2).

46.2.1 The Abortion Legal Landscape in Latin America

The standard classification in comparative law talks about four models of abortion legislation: the total penalization model, that criminalizes the practice with no exception; the indication model, that decriminalizes abortion under certain circumstances (e.g. health risk of the woman, rape, foetal anomalies); the periodic model, that decriminalizes abortion within a gestational period; and the mixed model, which combines the time and the indication criteria. Finally, there is a model that drops penalization completely, regulating abortion by health laws, professional laws, etc. While the indication model predominates in Latin America, Africa, Middle East, and South-East Asia, the mixed regime prevails in Europe, the United States of America, Oceania, and Central Asia. Only in Canada, and in two Australian jurisdictions—Australian Capital Territory and Victoria—criminal law is discarded. To sum up, in almost all countries there is still some degree of criminalization combined with some degree of legalization under different models.

Thus, from one point of view, it would be correct to say that Latin America penalizes abortion as a rule, since all countries maintain the criminalization of induced abortion for some or many circumstances. But from another point of view, by looking more at the permissions given by the law, it could also say that in almost all Latin American countries there is partial decriminalization, either under an indication model or mixed model. Hence, much of the last ten years of abortion politics the region could be described as a dispute between the criminalization paradigm—that still considered abortion, as a rule, a crime against life, a moral wrong, and a behaviour against expected female behaviour regarding sexuality and reproduction—and the constitutional paradigm—that underlines women's rights to access to a practice that is partially decriminalized.

Indeed, as Table 46.1 indicates, twenty-six Latin American countries have at least one or two indications under which abortion is permitted. Six countries still uphold absolute criminalization: Dominican Republic, Haiti, Honduras, Suriname, El Salvador, and Nicaragua (Chile was part of this group until very recently), while five countries and one city, Cuba, Guyana, French Guiana, Puerto Rico, Uruguay, and Mexico City follow a mixed model.

Table 46.1

Country	Model of decriminalization	Indications/Time	Requirements	Women's penalization for illegal abortion[1]
Argentina	Indication Criminal Code (art. 86) 1921	Life Health Rape	The risk can't be avoided through other means Intervention of a physician No need of a police report in case of rape (National Supreme Court)[2]	1–4 years Criminal Code (art. 88)
Bahamas	Indication Criminal Code (art. 334) 1924	Life Physical health	Good faith	Up to 10 years Criminal Code (art. 315)
Bolivia	Indication Criminal Code (art. 266) 1972	Life Physical health Mental health Rape Incest Kidnapped (without subsequent marriage)	A physician Unless it can be avoided through other means No need of judicial authorization or a police report (Supreme Court)[3]	1–3 years Criminal Code (art. 263)
Brazil	Indication Criminal Code (art. 128) 1940 Federal Supreme Court[4] 2016	Life Rape Severe foetal anomalies (Federal Supreme Court)[5]	It can't be avoided through other means	1–3 years Criminal Code
Chile	Absolute penalization Criminal Code 1874	——-	——-	Minimum security prison with maximum period of time Extenuating circumstance: honour (art. 344)

Colombia	Indication Supreme Court[6] 2006	Life Health Serious foetus malformation with incompatibility with life Rape or non-consensual sexual act Incest Non-consensual artificial insemination or transference of ovules	A physician Complaint	1–3 years Extenuating circumstances: Rape or non-consensual sexual act or artificial insemination or transference of fertilized ovules Exemption of punishment: when the abortion was made in extraordinarily abnormal motivating conditions the legal officer could pardon the punishment Criminal Code (art. 122 and 124) 1980
Costa Rica	Indication[7] Criminal Code (art. 121) 1970	Life Health	A physician (or an obstetrician under exceptional circumstances) Unless it can be avoided through other means	1–3 years Extenuating circumstances: abortion made before 6 months of pregnancy[8]; honour Criminal Code (art. 119)
Cuba	Periodic model Health Statutory 1965	First 10 weeks of pregnancy	A physician Abortion practice at a health service After 12 weeks of pregnancy it requires authorization of health authorities Parents' permission for minors under 16	———[9]
Ecuador	Indication Criminal Code (art. 447) 1971	Life Health Rape of a mentally disabled woman	A physician Unless it can be avoided through other means	1–5 years Extenuating circumstances: honour Criminal Code (art. 444)
El Salvador	Absolute penalization Criminal Code Reform 1997[10]	——-	——-	2–8 years Criminal Code (art. 133)

French Guiana[11]	Mixed model French Law (75-17) 1979	First 10 weeks Health Foetus malformation	Serious health condition Incurable malformation Two physicians Waiting time	6 months–2 years and Economical sanction French Law 75-17 (1979)
Guatemala	Indication Criminal Code (art. 137) 1973	Life	Two physicians Unless it can be avoided through other means	1–3 years Extenuating circumstances: mental disturbance Criminal Code (art. 134)
Guyana	Mixed model Medical indication of pregnancy act (art. 6) 1995	From 8 up to 12 weeks Life Physical health Mental health	Serious damage to health Authorized by health service One physician	———[12]
Haiti	Absolute penalization[13] Criminal Code 1826	——-	——-	No specification Criminal Code (art. 262)
Honduras	Absolute penalization[14] Criminal Code Reform 1997	——-	——-	1–6 years Criminal Code (art. 128)
Jamaica	Indication Judicial decision[15] 1938	Life Physical health	No specification	Prison for life Act of Crimes against People (art. 72)
Mexico States	Indication State Criminal Codes	Rape Life Consequence woman's negligence	See Bergallo and González Vélez (2012) and GIRE website	6 months to 3 years in average

México City	Mixed model Criminal Code (art. 148) 2007	Up to 12 weeks Health Serious foetus malformation with life incompatibilities Rape or non-consensual sexual act Non-consensual artificial insemination or transference of ovules	Serious health risk (for the indication) Certification of a physician with consultation with another physician	3–6 months prison or 100–300 days of community work Criminal Code (art. 145)
Nicaragua	Absolute penalization Criminal Code 2007	——-	——-	1 to 2 years Criminal Code (art. 143)
Paraguay	Indication Criminal Code (art. 109 inc. 4) 1937/2008	Life	One physician	Up to 2 years Criminal Code (art. 109 inc. 3)
Panama	Indication Criminal Code (art. 142) 2007	Life (of the woman) Life (of the foetus) Physical health Rape	Judicial investigation (rape) Up to 12 months (rape) Interdisciplinary committee (all indications) Serious risk (health)	1 to 3 years Criminal Code (art. 139)
Peru	Indication Criminal Code (art. 119) 1924	Life Health	Permanent and serious risk The risk can't be avoided through other means	Up to 2 years and community work Criminal Code (art. 114) 1991
Puerto Rico	Mixed model U.S. Supreme Court[16] (1973)	Life Health Rape Up to 12 weeks of pregnancy	Up to viability of the foetus At least one physician	6 months to 3 years Criminal Code (art. 112) 2004

Dominican Republic	Absolute penalization Criminal Code 1948	——-	——-	6 months to 2 years Criminal Code (art. 317)
Surinam	Absolute penalization Criminal Code	——-	——-	Up to 3 years
Venezuela	Indication Criminal code (art. 433) 1915	Life	Physician' decision	6 months up to 2 years Criminal Code (art. 430)

1 Unless any clarification, the punishment is imprisonment

2 Supreme Court of Argentina, case of *FAL s/Medida autosatisfactiva*, March 12, 2012.

3 Constitutional Plurinational Court of Bolivia, *Decision 0206/2014*, February 5, 2014.

4 Federal Supreme Court of Brazil, *ADPF 54/DF*, April 12, 2012.

5 Ibid.

6 Constitutional Court of Colombia, *Decision C-355/06*, May 10, 2006.

7 Besides article 193 establishes legal pardon.

8 There will be a punishment of six months to two years, if the fetus has not reached six months of intrauterine life.

9 There will be no criminal punishments for women, there will only be punishments for abortions without the consent of the woman and other third party behavior, like having practiced the abortion for economic reasons outside governmental institutions or by people without medical authorization. Criminal Code, articles 267 to 271.

10 No causes of punishment existed before the criminal reform.

11 The French legislation is applied.

12 There is no information

13 According to the principle of necessity, the abortion to save a pregnant woman's life is permitted

14 The Criminal Code approved in 1997 repealed the causes for the non-existence of punishment. Notwithstanding, the Code of Medical Ethics admits abortion in case of risk of life for the pregnant woman, requiring a certification from a medical committee and the consent of the husband or closest relative.

15 Since Jamaica is a party to the Commonwealth the case *Rex v Bourne* is implemented in the country.

16 *Roe v Wade* (1973).

p. 802 ↳
p. 803
p. 804 ↳
p. 805 ↳
p. 806 ↳
p. 807 ↳

p. 808

Most Latin American rules on abortion date back to the beginning of last century, during the codifying period. The fact that abortion is determined by criminal law entails material and symbolic effects. Certainly, the indication model is tied up to the structure, principles and practice of criminal law. For instance, in Central America and Paraguay abortions under legal indications are still granted as 'exceptions' to the general rule of criminalization. Moreover, health professionals tend to take all kind of self-safeguards, including refusal to treat women, which also explains the huge problems to implement abortion-care services. In other words, the indication model is haunted by the criminal framework.[3]

As Table 46.1 shows, on average, the penalty given to women who interrupt pregnancy is nine months to three years. Uruguay has the lowest penalty for women, while Bahamas and El Salvador the highest; the latter has even accused, prosecuted and imprisoned women believed to have medically self-induced an 'illegal abortion', either voluntary or spontaneous.[4] An estimated 129 women in El Salvador were charged with self-inducing an abortion between 2000 and mid-2011, and at least twenty-six were convicted of homicide (including a woman who was sentenced to forty years in prison for aggravated homicide after suffering a miscarriage and going to the hospital for medical attention); however, some of these women declared that they did not know they were pregnant or that they miscarried without attempting to self-induce.[5]

In relation to the structure of indications, Guatemala, Paraguay, and Venezuela have the lowest degree of permissiveness, allowing decriminalization only when life is at risk, which in practice results in a complete ban. The most common indications are risk to health and rape. Practically no law specifies the scope of the health indication (also known in some countries as 'therapeutic abortion'), probably because criminal statutes (where these indications are included) were passed when health had neither been defined as a right nor had it acquired an integral scope. Just Panama and Bahamas explicitly limit the ground to physical health, while Colombia and Guyana, who have had recent reforms, define health in integral terms, as both physical and mental. So, nowadays in countries like Argentina, Colombia, and Peru, where some important steps have been taken towards access to abortion, much of the legal dispute is to broaden the interpretation of this health indication. Finally, Ecuador, Costa Rica, and Chile still have the 'honour' of the woman as a specific mitigating factor for the crime of abortion when the judge considers that the woman terminated her pregnancy because of 'honour' reasons.

Almost all countries that adopted the periodic or mixed model have a distinct political status: Puerto Rico, Guyana, and French Guyana,[6] all connected by a political and legal dependence on countries with liberal legislations, or the case of Cuba, which has a strong socio-economic policy, structured under a communist/socialist regime (in 1965 it became the first country in the region to reform its abortion law and recognize the right of women to abortion on request up to the tenth week of pregnancy through the national
p. 809 health system; it is criminalized only if it is without the consent of the pregnant woman, is unsafe, or is provided for profit). Only Uruguay and Mexico City who have a new and more liberalized statutory respond to direct social mobilization and Congress favourable reaction.

Certainly, parliaments in the region have been a quite unreachable, conservative, forum to call for changes in the abortion matter. As I pointed out, the only more progressive reforms coming from the Congress have been México City, Uruguay, and more recently Chile, which in fact repealed a total criminalization law and passed a moderate set of indications. On the other hand, in the last twenty years, El Salvador (1998), Honduras (1997), and Nicaragua (2006)[7] outlawed all abortions, and just this year Dominican Republic Senate rejected, for the second time in the decade, the observations made by the Executive Power to the Penal Code who recommended legalisation when the pregnancy puts the woman's life at risk, in case of rape, incest, or foetal anomalies.[8] In Venezuela during the process of criminal reform, the organization Movimiento Amplio de Mujeres, members of the House of Representatives, among others, claimed to

incorporate new grounds for decriminalization into the restrictive abortion legislation, and submitted a proposal to the National Assembly, which was hardly discussed and then rejected. Similarly, in Peru, the possibility of having a legal reform insinuated during the reform of the criminal code; in 2009, the Special Commission, in charge of reviewing the code, suggested the addition of new grounds such as rape and serious foetal anomalies, but at the end it did not find support, and the law from 1926 was kept in force.[9] One of the last episodes took place in Ecuador, where the National Assembly started debating a more liberal law, but the conservative and dogged position of the former President Correa put to sleep any real chance of change.[10]

Furthermore, it is a distinct feature of Latin America that nearly all of the formal measures to enhance access to abortion have come from administrative and health regulations. That is the case of Argentina, Bolivia, Brazil, Colombia, Peru, some states from Mexico and Panama, which have issued guidelines to guarantee health-care in cases of legal abortions under the indication model. Colombia passed guidelines almost immediately after sentence C-355[11] was issued (both of them subject to contest later on), that is, the regulating norm was an immediate and direct cause of judicialization, while in Argentina, Brazil, Peru, Costa Rica, and Bolivia the strategy to claim for abortion guidelines aim at dismantling the structures of inaccessibility of legal indication for abortions enacted almost 100 years ago.

Finally, High Courts have gradually become involved, with different attitudes in the abortion arena, as explained below.

46.2.2 Constitution and Abortion

Together with the criminal framework, around 2005 a constitutional perspective emerged, even institutionalized in both legislative and judicial decisions. As Siegel expresses, it would be a mistake to assume the existence of constitutional law on abortion. Rather, there are processes under which it is constitutionalized.[12] While constitutional judgements about abortion in several northern countries date back to the 1970s, Latin American rulings are fresh, with its common and distinct traits. In this section, I briefly present this development, specifically landmark decisions of national high courts.[13]

Latin American constitutional reforms since 1980—as part of the return to democracy after authoritarian governments—have resulted in favour of a more equal perspective on women's rights, including an integral right to health, clauses of equality between men and women, with other human rights. Moreover, Mexican Federal Constitution[14] and Ecuador 2008 Constitution[15] explicitly recognize reproductive rights. This expansion of constitutional rights plays a key role in the constitutionalization of abortion among other topics; as Brinks and Blass put it, 'the increasing centrality of constitutional rights and constitutional courts in politics is partly based on the considerable expansion, over the last forty or fifty years, of the constitutional provisions that define the sphere of constitutional justice'.[16]

Notwithstanding, constitutional reforms have also been an opportunity to introduce prenatal protections clauses in attempts to extend a right to life before birth, not only to ban abortion but also to restrict in vitro fertilization and contraception (CDR, 2012). During the 1994 Constitutional Conventional in Argentina, women's movement had to quickly organize and negotiate to block the initiative to include a recognition of prenatal legal personhood in the new text (Gutierrez, 2004). In other countries, attempts were more successful. In Guatemala, the 2002 reform included a constitutional right to life before birth, likewise in Chile (1980), Honduras (1982), El Salvador (1983), and Dominican Republic (2010). Similarly, since 2008, sixteen Mexican states have amended their constitutions to protect the right to life from fertilization (CDR, 2012). Of course, the constitutional protection of life before birth does not demand, not even justify, a ban on abortion or any other health reproductive service, as the Interamerican Court in *Artavia Murillo v Costa*

Rica (2012) held.[17] Still, almost all of the constitutional judgements about abortion since 2005 have had to deal with this apparent dilemma between competing interests and rights.

p. 811 On occasions, abortion has been the 'ghost' behind other reproductive policies debates, such as assisted fertilization, emergency contraception, and even some less obvious topics like the ratification of the Protocol of CEDAW. The Costa Rican affair regarding the ban to assisted fertilization which ended in a case against the State in front of the Interamerican Court perfectly reflects this dispute.[18] Furthermore, in many Latin American countries, emergency contraception has been the prelude to the battle around the status of prenatal life.[19] More recently, a Brazilian case concerning stem cell research also brought into debate the status of embryos.[20]

For most of the twentieth century, abortion laws in the region remained untouched. Only recently—in the early 2000s—there have been some relevant changes, which came through constitutional and human rights arguments. High courts have played a key role in this process, assessing the constitutionality of criminal laws regulating abortion, supporting law changes, but also in some instances bringing legal conditions to make effective the right to have an abortion under the indication models set since the begging the twenty century but with almost no implementation.[21]

In 2005, the Constitutional Court of Colombia ruled that abortion should be permitted for three specified indications: when the life or health of the woman is at risk; when pregnancy is a result of rape or incest; when the foetus has serious anomalies. It was the first progressive judgment on abortion in the region, accompanied by more than fifteen other judgments of the same court in the following years.[22] After the reform of the abortion legislation in México DF, in 2008, the National Supreme Court had to define if this change was constitutional.[23] In 2012, the Supreme Court of Brazil ruled that abortion in cases of anencephaly was exempt from criminal penalties.[24] That same year, the Argentine Supreme Court confirmed that abortion on grounds of rape was constitutional and already decriminalized by the penal code of 1922.[25] In February 2014, the Highest Court of Bolivia ruled that women seeking a legal abortion after rape or incest do not need a previous judicial approval.[26] And more recently, in 2016, the Brazilian Supremo Tribunal Federal ruled that abortion is not a crime when performed in the first trimester of pregnancy.[27]
p. 812 Finally, in 2017, Chilean Supreme Court backed the bill that leaves behind the total ban of ↳ abortion and replaced it with a moderate set of legal indications.[28] But, there has been also rulings maintaining status quo: Costa Rica (2004)[29] and El Salvador (2007)[30] courts upheld the constitutionality of criminal abortion laws and understood, in general, that the decision regarding the use of criminal law to regulate abortion, even to ban it, was part of the legislative discretion.[31]

But there is more than judicialization. Constitutional arguments have also found expression in few, but still, new pieces of legislation.[32] As pointed out, Mexico City and Uruguay repealed the indication model and passed laws with a mixed regime.

In what follows, I will analyse in more detail some constitutional episodes in abortion: the Mexican City episode (both the 2007 legislative and 2008 judicial decisions), and the judicial decisions of Argentine (2012) and Brazilian (2016) Supreme Courts, as I believe they allow, first, to show dimensions of the discussions and challenges, second to give a fair account of the differences among countries in the so-called 'constitutionalization' of abortion in the region.[33]

The Mexican Legislative Assembly decision was taken in a political environment with strong and organized progressive groups (feminist, health-providers' organizations, etc), a new party ruling the city after seventy years of PRI domination, and supported by the *Pauline Case* in the Inter-American Commission on Human Rights.[34] It was the first legislation in this new liberalizing trend in Latin America that recognizes women's right to terminate pregnancy during the first twelve weeks of pregnancy. Once passed, the law was challenged by the Attorney General of Mexico and the president of the National Human Rights Commission,

and sent to the Supreme Court to be reviewed, and in August 2008 it was found constitutional.[35] It will take almost five years for another legislature in Latin America to address and pass a new progressive law (Uruguay in 2012).

The landmark Mexican legislation called on the federal constitutional provision that guarantees: 'All
p. 813 persons have the right to choose in a free, responsible, and informed manner ↳ the number and spacing of their children'.[36] It is a distinctive and quite explicit clause. But the Supreme Court, when deciding the challenges to the abortion law reform, managed somehow to ignore it. The Court's judgment focused on technical aspects of the criminal law, leaving aside the substantive issue of women's rights.[37] Likewise, Pou pointed that it was a lost opportunity to further develop a constitutional interpretation of women's rights and reproductive rights as enshrined in the constitution.[38]

Indeed, having the opportunity to lay the constitutional foundations of the most liberal rule in the region, the Court did not develop a specially sophisticated balance test and neither did it provide a substantial argument based on autonomy, not even having a provision like Article 4.[39] The judgment revolved mostly around the objection placed by the plaintiffs regarding the unborn life status. The Supreme Court understood that unborn life is a constitutionally protected right, but this does not mean an explicit mandate to criminalize abortion; instead, there is a margin of appreciation for defining the type and scope of abortion regulation:

> [t]he Legislative Assembly of the Federal District has the power to determine, by a majority of its members and through open debate, which behaviours should or should not be reproached by criminal law, and in the absence of an express constitutional obligation, it has the duty to weigh the various events, issues and rights that may be in conflict.[40]

So, the ruling was based more in analysing the duties, prohibitions, and powers of democratic lawmakers to criminalize and decriminalize abortion than in asserting women's right to privacy, autonomy or equality. Yet, as Bergallo and Ramón Michel point out, the court's assertion that the legislative margin of appreciation encompassed the option to eliminate the criminalization of abortion in the early stages of pregnancy probably represents a promising approach to the constitutionalization of abortion across Latin America.[41]

The implementation of the laws that establish legal indications is the *missing link* of the abortion public policy in most countries in Latin America. The Argentine case reflects quite clearly how the Supreme Court got involved in this pervasive problem. In Argentina, abortion has been decriminalized in certain cases since the enactment of the Penal Code in 1921. The termination of pregnancy is considered legal when the woman's life or health is at risk, and when the pregnancy is a product of rape, specifying that in the case of 'mentally retarded' women their legal representative must consent to the abortion.[42] For almost 90 years this regime was unenforced. Only in the last twelve years has this situation begun to change. One of the
p. 814 primary factors that explain this lack of access has been the frequent, ↳ controversial, and restrictive interpretation of the legal text, particularly with respect to the indication for the risk of health and the severity of that risk, as well as whether the exception for rape refers only to women with mental disabilities or whether it refers to any woman who has been raped.

In 2012, in *F.A.L.*, the Supreme Court confirmed that the Penal Code decriminalizes abortion in case of rape and held that it was a woman's right. The Court tackled three issues: first, the constitutionality of Article 86 challenged by the plaintiff arguing that it violates the right to life, second, the scope of the rape indication, and finally, procedural aspects of the implementation of the indication model.[43]

Regarding the constitutional objection of Article 86, the Argentine Supreme Court did not address directly the classic discussion about the legal status of prenatal life but it reviewed the state obligations under the

Constitution and Human Right Treaties. Regarding the provisions established in Article 1 of the American Declaration of the Rights and Duties of Man as of Article 4 of the American Convention on Human Rights, the Court held that 'there is no obligation to interpret in a restrictive way the scope of article 86…because the relevant norms of these [human right] treaties were expressly restrained in their formulation so that they would not result in the invalidity of an abortion case such as in this case.[44]

The Court also addressed Article 4.1 of the American Convention on Human Rights, that states

> Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.[45]

It has been argued that this provision is the constitutional basis for granting unborn life status as a person, and thus a justification for abortion ban. The Argentine Court replied to this argument by resorting to the Inter-American Commission decisions.[46] The Supreme Court recalled that in the case of *Baby Boy v United States*, the Commission stated that the expression 'in general' of Article 4.1 was just included so that countries would not have to change their abortion legislation, especially those that at that moment had already partial decriminalization of abortion.

After revising this and other human right treaties, usually deployed as arguments against liberalizing and in favour of a total protection of the unborn life, the Argentine Court concluded that there were not any constitutional barriers to decriminalized abortion under the indication model. Furthermore, international human rights treaties require governments to respect women's rights, including the right to terminate abortion after sexual violence. Moreover, the Court explicitly recognized that Article 86 granted a woman right to access abortion. In this line, noticeably, the Argentine judges laid down a series of procedural guarantees for the implementation of the abortion. For instance, until that moment, all of the health guidelines and local regulations required a police report or judicial complaint as proof of the sexual crime to
p. 815 access to the rape indication. The *F.A.L.* ruling changed this and ↳ established that neither of these procedures were required to access legal abortion. Rather, the woman's statement will be enough in the health service declaring that she had been raped and as a result of the assault she was made pregnant.

Abortion is legal in Brazil only in cases of rape, when necessary to save a woman's life, or when the foetus suffers anencephaly, but in practice, there are huge problems of access.[47] Federal Supreme Court has been called into the abortion discussion in the last decade. In 2012 it issued an important judgment on abortion in a claim involving foetus anencephaly, where the Court in fact avoided judging the claim as a challenge to the criminal regulation on abortion and instead it treated the case as induction of labour.[48] In 2008, six of the court's eleven judges upheld a 2005 law allowing embryonic stem cell research, hence, not granting legal rights to embryos.[49] Another decision was a Habeas Corpus in 2016, which will be described in more detail below. That same year the National Association of Public Defenders challenged the punitive laws in the context of the Zika virus epidemic, arguing that pregnant women experiencing mental health impacts from contracting the virus during pregnancy, and, at beginning of 2017, the Socialism and Freedom Party filed a separate case challenging the criminalization of abortion in the first twelve weeks of pregnancy.[50]

A ruling on a Habeas Corpus issued by the majority of the Supreme Court on 2016, ordered the release of five health-care providers who had been arrested, in a clandestine clinic in the greater Rio de Janeiro area, for the alleged provision of illegal abortion services and for the crime of formation of a gang.[51] In this judgment, the three-judge majority held that the criminalization of abortion until the first trimester is incompatible with the Brazilian Constitution based on women's fundamental rights and the principle of proportionality. Although this ruling just applies to the case in discussion, it sets a precedent that eases future constitutional discussion regarding women's abortion rights.[52]

Judge Luis Roberto Barroso, who wrote the opinion for the majority, was the one that brought into the case the question regarding decriminalizing abortion. The decision resorted explicitly to women's rights, specifically autonomy, sexual and reproductive rights, physical and psychological health, and gender
p. 816 equality. Indeed, Barroso pointed out that ↳ making abortion illegal does not reduce the number of abortions but actually increases women's deaths due to unsafe abortion procedures. Moreover, he argued that a complete ban violates women's reproductive rights, sustaining that as women carry the full burden of reproduction, 'there will be full equality only if they are recognized as having the right to decide'.[53] He also argued that women's health and safety should be ensured without interference, 'having a child determined by the Criminal Code constitutes a serious violation of the physical and psychological integrity of a woman'.[54] In this equality line of reasoning, Barroso also considered that penalization of abortion disproportionately affects poor and marginalized women.

The majority also sustained that the criminalization violates the proportionality principle, in different ways. First, criminalization is not effective in protecting the life of the foetus: it has no impact on the number of abortions performed but it blocks women's access to it in a safe way. Second, the State can protect prenatal life and prevent abortions in more effective and rights-compliant ways, such as reproductive health education and health services, social assistance to women, among other policies. Finally, penalization causes social costs (health problems, including the death of women) that override its alleged benefits.

Although this judgment is not a binding legal precedent, and that most sure the conservative Congress will try to block moves toward liberalizing legislation, it represents a step forward into putting women and their rights in the centre of the debate and arguments. It is a necessary step in the constitutionalization process of abortion not only for Brazil but for the region as a whole. As Deborah Diniz, co-founder of Anis—which has campaigned to liberalize Brazil's abortion law—expressed, this ruling has greater political than legal significance, however 'it is a clear and strategic message by Justice Luis Roberto Barroso that some Justices are ready to tackle the fundamental question in abortion cases, which is: should abortion be considered a crime, given the Brazilian Constitution's provisions on gender equality, dignity, and the right to health?'.[55] Furthermore, the trend in the Brazilian Federal Court seems to be in support of expanding women's right to safe, legal abortion, as this case, the one of anencephaly and the one declaring embryonic stem cell research constitutional suggest.[56]

As we explained with Bergallo, in Latin America High Court's interventions:

> [Have] implied the establishment of limits on the extent to which congresses have been deemed authorized to use criminal law to restrict abortions. Although criminal law continues to be the preferred tool for the regulation of abortion, its use has been constrained through limits hard to imagine in the past. As a result of these limits, in the countries studied throughout this chapter, abortion arguments no longer revolve around the constitutional and categorical mandate of totally criminalizing abortion, a mandate that used to be interpreted as a default rule in most of the
> p. 817 region's past debates. Instead, current conversations on the use of ↳ criminal law have been reoriented towards the definition of situations in which punishment is waived, or situations in which abortions are considered legal under what is known as indication model. Moreover, most of the region's high courts have understood that constitutional and human rights treaty provisions mandate the adoption of, at least, an indication model that should contain certain legal grounds for abortion. Secondly, another trait in the constitutionalization of the region's legal discourse on abortion stems from decisions such as those from Argentina or Colombia, where the constitutions have been found to require not a mere model of formal requirements, but rather a regulatory framework that effectively ensures access to and provision of legal abortion services. In these decisions, Latin American courts have made original contributions regarding the institutional context of the supply of abortions services, as well as the individual duties of healthcare

> professionals and public officials for ensuring the right to a legal abortion. Finally, the constitutionalization of the criminal treatment of abortion has also yielded more complex judicial arguments about the constitutional status of unborn life and the duty to balance it against increasingly elaborate conceptions of dignity, autonomy, and equality between the sexes.[57]

46.3 Doctor-Focused Regulations: Also a Constitutional Issue

Although a legal reform is vital where abortion is highly restricted, barriers remain even in settings where is legal and most socially accepted, spawned by specific regulations of this practice. In this second part of the chapter, I will describe and conceptualize what I have called 'doctor-based' regulations giving a range of country-based examples not only of Latin America but also worldwide as this type of regulatory choices are typical of almost all legal regimes, even of those featured as more liberal.[58]

The shape of abortion regulations, including their constitutional dimensions, is different worldwide. Yet, as mentioned above, almost all countries retain some degree of criminalization. Moreover, this pervasive criminalization framework is usually complemented by doctor-focused regulations, that is, physicians as gatekeepers of legal abortion, which, I argue, should draw more 'constitutional' attention as they hinder access to safe abortion, fail to acknowledge moral judgment of women, thus affecting all kinds of rights.

Abortion was legally restricted in almost every country by the end of the nineteenth century.[59] Since then, each step towards some sort of access to 'legal' abortion (progressive abortion law reform) has convoyed less (but not drop of) criminal law and a propagation of doctor-focused regulations, contributing to define abortion as a 'practice that should be authorized'—by someone different than the woman–, reinforcing some kind of 'permission framework'. And this framework has not changed with the constitutionalization
p. 818 of much of the debate, strategies, rulings, and other institutional decisions. Moreover, for more than a ↳ decade now, the political underpinnings of abortion liberalization in Latin America have been strongly linked to constitutional law, and every time high courts have granted some sort of abortion right to women they have also placed physicians as the last word in the access to legal abortion, together with a right to conscientious objection.

Conscientious objection is a hint of doctor-based regulations but not the only one. In fact, these regulations entail a series of dynamics and consequences such as physicians becoming the 'last word' in abortion procedures (e.g. physician deciding when there is a health risk that justifies interrupting pregnancy); over-regulation of abortion health services as well as out of date or unreasonable requirements (e.g. compulsory ultrasound or waiting periods); a huge gap between legal requirements and advances in reproductive technologies (namely, self-use of abortion with pills by women), among others.

In countries that adopt the indication model—like most Latin American ones—doctor-based regulations are quite noticeable. Basically due to the way in which, despite the differences that the practice might show, women who require an abortion are subjected to the scrutiny of physicians who certify the 'health risk', 'rape', 'foetal anomalies' and so on.[60] This delegation of power to physicians is exposed in the legal norms that define abortion access. Take for example Article 137 of Guatemala's Penal Code, that states:

> Therapeutic abortion is not punishable abortion performed by a physician, with the consent of the woman, after a favourable diagnosis of at least one other doctor, if performed…for the sole purpose of avoiding a risk for the life of the mother, properly proven after exhausting all the scientific and technical exams.[61]

In Panama, for instance, the intervention of an interdisciplinary committee is mandatory to examine and determine the life risk and, therefore, to perform the pre-trial procedures for the rape ground.[62] Similarly,

p. 819 Article 86 of the Argentine Penal Code illustrates this clearly: ↳ 'The abortion performed by a licensed physician with the consent of the pregnant woman is not punishable…'.[63] In other words, physicians' involvement is necessary for an abortion to become a legal abortion, which currently entails, as explained below, a series of challenges, especially due to abortion pills.

One if not the most relevant feature of the indication model is that it does not stipulate specific circumstances on which abortion should be legal but it rather leaves a judgement as to legality to doctors. As Kristin Luker puts it: 'No laws defined precisely when a woman's life was at stake: For example, must the threat be immediate or can it be long term?'.[64] The author suggests that the ambiguity in the concept 'life' was deliberate. Life could mean physical life in the narrow sense of the word (life or death), or it could mean the social, emotional, and intellectual life of a woman in the broad sense (style of life).[65] Therefore, 'saving a life' may mean saving the woman only from imminent death, or it may mean protecting the process and quality of her daily life. Physicians still now usually ignore the complexity of real women's lives. 'What does it mean to save a woman's "life", in the context of an untenable pregnancy?'[66] During the period 1900 to 1960, U.S. physicians performed abortions under 'life' and 'therapeutic' exceptions for reasons including rape, maternal health or foetal indications, and even economic or 'social' conditions.[67] This suggests that physicians had a broader conception of 'life', and that they 'never believed that embryos had an absolute right to life.[68] However, the contemporary conservative view of what it means to include a 'life exception' for the woman has strongly narrowed.[69] Actually, health providers in Argentina have also mentioned this shift in physicians' willingness: how before the 1990s physicians working in public and private hospitals used to perform abortions when the foetus had severe malformations (mainly anencephalic) or when the pregnancy undermined woman's health because she was already facing a disease.

But when the law specifies the indication, there are other problems. The Peruvian case is prominent in this regard. Recently, in 2014, as a way to enforce permitted grounds for abortion and after a case against the State in front of the CEDAW Committee, the Health Ministry of Peru issued a guideline for the provision of legal abortion services. According to CEDAW's recommendations, this guideline ought to protect both women's physical and mental health, but the guideline only mentions women's health in quite medical terms and it does not cover situations related to mental health.[70] Of course, this guideline is better than nothing and it has been helping health services to consider the rights and needs of women case by case, but it grants physicians with the power to decide by themselves if and in which basis a woman will access to a
p. 820 legal abortion; for instance, a woman might suffer ↳ mental health pain as a result of carrying an unwanted pregnancy, but not only is this distress not specified in the text, but there are no guarantees left in the guidelines that the physician will address the woman's suffering, and will take into account her words, feelings, and thoughts.

Also, some regulations entitled doctors to verify if women had reported the rape to police or judicial authorities as a requirement to access legal abortion on sexual abuse grounds. That is the case in Mexico. Until 2013, in almost all Mexican states, the prosecutor's office had to record the crime of rape before authorizing the abortion.[71] Moreover, in Latin America, almost all statutory with rape indication require a previous police report, except in Argentina, Brazil, Ecuador, and Paraguay.[72] These sorts of requirements are supposedly meant to protect physicians from potential criminal complaints against them (within a criminal framework that includes certain legal indications), but not to guarantee women's well-being.

However, the delegation of power to physicians is not an exclusive feature of the indication model. The legal statutory that liberalizes abortion under the periodic or mix models[73] also implements doctor-focused regulations. In fact, Uruguay stands as the typical case of a mixed legal regimen with doctor-based regulations. In 2012, it became the first South American country to decriminalize abortion within the twelve-week period of gestation. According to Law 18.987, 'voluntary termination of pregnancy shall not be penalized…in the event of a woman complying *the requirements established in the following articles* and it takes place within the first twelve weeks of the pregnancy'.[74] This is a liberal law for Latin America, yet it

also entails an archetypal doctor-based regulation, which set limits to the liberalization promise by the law. First, abortion is decriminalized under the terms, assumptions and conditions determined by law, yet it maintains criminalization when the practice is held out of those limits—with the possible appliance of
p. 821 sanctions from 1938's Criminal Code.[75] ↳ Second, the participation of healthcare providers has not been reduced, as evidenced by the interdisciplinary commission intervention. Third, it gives a prominent role to gynaecologists. Fourth, legal abortions can only be provided by the National Integrated Health System institutions, thus, other options as non-governmental organizations services or self-medication (with pills) are ruled out. Fifth, it requires an appointment with a three-health-provider committee and a mandatory waiting period.[76] Finally, after a claim of a group of physicians, a court granted the right to conscientious objection to all healthcare professionals involved in abortion health-care.[77]

What the Uruguayan case reflects is that even in more liberal laws, there are regulations centred on women or doctors depending on where decision-making power leans. It also depends on what role physicians get, their type of participation in the different instances, and the number of requirements an abortion must sort out to be qualified as 'legal'.

Distrust of woman's moral judgment, one of the major traditions in reproductive policies, has probably had a strong influence on the development of doctor-focused regulations.[78] This tradition has fostered a pervasive ambivalence towards women, and has affected the way both law and policies recognizes sexual and reproductive autonomy. *Roe v Wade*, the well-known U.S. Supreme Court landmark decision on abortion, embrace this tradition regarding women's lack of 'judgmental capacity'.[79] In fact, *Roe* and its companion decision, *Doe v Bolton*,[80] represent the perfect combination of doctor-based foundational legal framework. Under *Roe* women were granted the right of abortion while 'the physician…is constitutionally required to lead the decision-making process'.[81] *Doe* confirmed this role of doctors as gatekeepers and laid down the basis of future conscious objection clauses—that would undermine U.S. reproductive policies in the following decades.[82]

Even though many regulations claimed to protect women's health, several features of these norms—thus their health justification—are out of date considering the advances in reproductive technologies.[83] Moreover, despite the liberalization trend, legal barriers to abortion care mount.[84] Marge Berer puts it quite straightforward:

> the plethora of convoluted laws and restrictions surrounding abortion do not make any legal or
> p. 822 public health sense. What makes abortion safe is simple and irrefutable—when it is ↳ available on the woman's request and is universally affordable and accessible. From this perspective, few existing laws are fit for purpose.[85]

Indeed, current regulations create unnecessary restrictions on access to safe abortion, and hinder the participation of non-medical health professionals, among other problems.

In what follows, I will focus on the existing gap between abortion regulations and the options offered by different reproductive technologies, specifically medical abortion/abortion with pills, as it clearly reveals how keeping doctors as gatekeepers of the right to abortion has serious problems, even of reasonability, that requires applying scrutiny due to the burdening impact it has on women's fundamental rights.

Medical abortion is different from the surgical method. It consists on the use of a drug or a combination of drugs to terminate pregnancy. When used from the time a woman first misses her period until up to approx. Sixty-three days since the first day of the last menstrual period this method is more than 95 per cent effective, and the earlier it is used, the closer to 100 per cent effective it is.[86] The method consists of two kinds of medication: *Misoprostol* and *Mifepristone*. *Mifepristone* followed by *Misoprostol* is the most effective regimen, the 'gold standard', although both are effective individually.[87]

Medical abortion has expanded and changed practices as well as the options of lots of women.[88] In places where abortion is legal, options were amplified: according to the evidence, women often resort to medical abortion to avoid a surgical abortion; they thought medical abortion was less painful, easier, and safer.[89] In legally restrictive settings, it means a less risky and less expensive, and a private way of early termination of pregnancy (i.e. the administration of *Misoprostol* at home).[90] As Winikoff and Sheldon point put, where it is available, medical abortion has reduced women's dependence on medical systems, providing them with greater autonomy and control over their most important reproductive decisions.[91] But medical abortion has not only enhanced women's access to safer abortion, but it is also an excellent option for health professionals; with this method they can help women in restrictive contexts, they can prescribe or provide the medication for home administration, and eventually place it vaginally—if a woman prefers it.[92]

Since the 1980s, women in Latin America have used *Misoprostol* to self-induce abortions, despite the lack of
p. 823 approval of this medication and other legal and informal restrictions.[93] ↳ Along with the transmission of information by word of mouth, women in the region obtained information from the internet, through printed materials, face-to-face meetings, telemedicine, and direct telephone hotlines, most of them supported by feminist groups.[94].The result has been substantial declines in abortion-related morbidity and mortality, and lower costs of treating complications.[95]

As Winikoff and Sheldon put it, medical abortion is the most important advance in reproductive health since the discovery of oral contraceptives.[96] Nevertheless, *Misoprostol* and *Mifepristone* availability and accessibility have not been without drawbacks. Since its appearance, medical abortion has been marked by political and administrative turmoil and resistance.[97]

Misoprostol is widely approved: ninety countries have already registered *Misoprostol* for at least one of their obstetric uses.[98] But that is not the case in Latin America where in most of the countries it is rather not approved for obstetric use or its access is increasingly limited by regulations and cost.[99] Similarly, *Mifepristone*: with more resistance as it is known as 'the abortion pill', more and more drug national agencies have registered it but not in Latin America, which together with and Africa are regions with the lowest proportion of approvals.[100]

In addition to the lack of registration, one of the greatest difficulties on the use of medical abortion are the constraints imposed by regulations. Although there is abundant and reliable evidence that women can safely self-administer *Mifepristone* out of the health-care facility, most guidelines require *Misoprostol* and
p. 824 *Mifepristone* to be administered by health ↳ services.[101] Only France, Armenia, Georgia, Azerbaijan, Scotland, Vietnam, Sweden, Australia, and Norway allow women to obtain *Mifepristone* in health services and self-administer it outside the clinic.[102] Meanwhile, in the rest of the world, medical abortion is hindered by unnecessary requirements.[103]

There are several benefits in allowing women to use *Mifepristone* outside of health services. As Gold and Chong explain, allowing women to self-administer *Mifepristone* (if that is the option the woman prefers) would allow them to better schedule their bleeding and cramping, as well as manage their other responsibilities.[104] Self-administration of *Mifepristone* allows greater autonomy and privacy. Finally, eliminating the requirement of taking *Mifepristone* in the health service or doctor's office helps to combat the idea that there is something dangerous about this drug that requires it to be taken in the presence of a provider. If all these benefits exist, why is this misconception about medication abortion so prevalent? According to Gold and Chong, several factors are involved.[105] First, many providers (including women) continue to believe that abortion is risky, and therefore, women should be supervised during the process because they 'will not be able to handle it' on their own. In addition, several people still consider abortion medication as a 'procedure' that must be 'performed' by a provider, when in fact it is a treatment with medication. Third, a large number of professionals are outdated, and lots of clinical guides and professional associations remain silent or delay the adoption of their recommendations according to new evidence.[106]

Finally, the distribution and dispensing mechanisms of *Mifepristone* create confusion about what is and is not permissible. This, added to the contentious environment in which abortion is performed, causes many professionals to be reluctant to do something outside of what is specifically written in the clinical guidelines, even when in other practices they usually follow off-label indications.

Resistance, even moral panic, to make abortion a simple procedure along with restrictions coming from in regulations that insist on institutional abortion are illustrated in online telemedicine. Telemedicine for abortion was popularized by Women on Web, which since 2006 has provided services to thousands of women in at least 88 countries.[107] Brazil, Canada,[108] and the U.S.[109] have used this technology to help women
p. 825 access *Mifepristone* and ↳ *Misoprostol* in countries, rural, and suburban areas with no safe care for termination of pregnancy, registering around 93 per cent of success among the women that used it.[110] But telemedicine initiatives have also faced backlash. In the U.S., nineteen States ban telemedicine as they require that doctors must be in the physical presence of the patient when prescribing abortion-inducing drugs.[111] Some States even challenged the already outdated FDA's guidelines that order that *Mifepristone* must be administered by doctors in their offices.[112] More recently, in February 2017, the Guatemalan Army blocked a Women on Web boat (flying a Dutch flag) that was offering pills for abortions meaning they could not carry out any terminations at that time.[113]

A case in the United Kingdom—where there is a pretty liberal implementation of the indication abortion law—sheds light on the tensions between the advances in reproductive technologies, and doctor-focused and other out-of-date regulations, as well as their endurance and reluctance from governmental actors to make changes in this matter. In Britain, abortion has been legal and almost always available since 1967 as a result of the Abortion Act 1967, as amended by the Human Fertilization and Embryology Act 1990.[114] Section 1(3) of the Abortion Act 1967 stated that a 'registered medical practitioner' must carry out 'any treatment for the termination of pregnancy'. In February 2011, a High Court judge rejected a case brought by the British Pregnancy Advisory Service (BPAs) against the Secretary of State for Health.[115] The plaintiff argued[116] that the norms that regulated the 1967 Abortion Act, which say that the practice of abortion must be provided in hospital and should be modified to allow women to administer a final dose of tablets for early medical
p. 826 abortion themselves at home. Despite the rejection, the judge recommended (based on the ↳ evidence provided by BPAs) the government to amend the regulations, which were written at a time when all abortions were surgical procedures and carrying them out in hospital premises was intended to remove them from unsafe abortions in the backstreets. According to the Act, the treatment of an early abortion (gestations of nine weeks or less) requires women taking *Mifepristone* in the presence of a doctor or nurse, go home and come back twenty-four or forty-eight hours later to get the *Misoprostol* pills, which are inserted in her vagina at the clinic or taken buccal, and then she has to wait about five hours for the abortion to happen in the clinic (if they have the facilities for this) or go home again. In some cases, if she goes home again, she may well experience anxiety and worry as a result of the bleeding which sometimes occurs.[117] As Ann Furedi from BPAs has expressed, the change would have allowed doctors to give the woman the tablets to take once she got home—if this is what she wanted. 'In our experience, this is what most women want. Only exceptionally do women wish to stay at the clinic for an unpredictable number of hours until their miscarriage is complete.' She added: 'It is wrong to compromise women's care through unnecessary restrictions imposed by officials who fear criticism from those who oppose abortion in principle.'[118]

Many of the laws that partially decriminalized abortion occurred during the 1920s and 1970s, years in which the safest method to terminate a pregnancy was the surgical procedure practised by a trained professional with adequate infrastructure and supplies. This could partially explain the doctor-based requirements for labelling abortion as legal. But it is an imperfect explanation. The newly regulations such as the Uruguayan law, the reformed laws of Denmark and Bosnia-Herzegovina, insist on this physician over-representation, and as the United Kingdom shows, there is also the reluctance to chance out of date regulations.

These technological, practical and health services' organizational gaps synthetized in the regulations not
p. 827 only generate access barriers but also criminal concrete problems. For ↳ instance, since the most renowned liberal ruling, *Roe v Wade*, a number of women have been prosecuted in the U.S. for self-inducing abortion under a variety of state statutes.[119] Jennie Linn McCormack is a test case. In late 2010, McCormack, unemployed single mother of three children, found herself pregnant again. She took the *Mifepristone* her sister ordered over the Internet.[120] She used the pill after realizing she 'had neither the time nor resources to seek an abortion from one of Idaho's legally authorized abortion clinics (I could only find two of these after a fairly thorough Internet search)'.[121] McCormack was charged when police began investigating after finding a foetus in a box.[122] Certainly, the case had all the uncomfortable facts.[123] And as such, the case raised also some uncomfortable questions: 'Should a woman be able to have a self-induced abortion?... When is the foetus viable and when can it feel pain?...Should the abortion pill be prescribed to women from doctors or even made as easy to order online?'[124]

McCormack was charged under the criminal law of Idaho for ending her pregnancy with abortion pills.[125] Despite the fact that *Mifepristone* is legal and the foetus was not yet 'viable', Idaho has a statute from 1972—never before enforced—that considers self-induced abortion a felony (with five years in prison and a $5,000 fine).[126] The case was dismissed for lack of evidence—but left open the possibility for prosecutors to refile.[127]

In September 2012, McCormack sued the federal court alleging the unconstitutionality of at least three statues: Idaho law of 1972 just mentioned, the foetal pain law of 2012 banning abortions after twenty weeks of pregnancy; and the requirement that first-trimester abortions be performed by a physician in a staffed office or clinic.[128] McCormack claimed the right for self-medical abortion and for doctors' rights to prescribe such drugs, becoming the first woman to bring a case like that in the United States. The District Court Judge B. Lynn Winmill declared unconstitutional the three provisions and argued that: 'historically, abortion statutes sought to protect pregnant females from third parties providing dangerous abortions...As a result, most states' abortion laws traditionally criminalized the behaviour of third parties to protect the health of pregnant women—they did not punish women for obtaining an abortion. By punishing women, Idaho's abortion statute is therefore unusual'.[129]

In Uruguay, there was a similar case. In 2012, after a (progressive) law reform, three women and two men were charged with the crime of abortion, 'for having practiced the abortion outside the conditions enabled or, as in the case of the husband of the deceased girl, for not knowing that in the act of reporting the doctor who had performed the abortion practice, was involving himself in the crime'.[130] The three women who faced the charges were a twenty-one-year-old woman—a sex worker from Maldonado—who, with the
p. 828 assistance ↳ of the mother and another woman, interrupted her pregnancy in a safe way. The prosecution was requested by a Prosecutor arguing that it was a five-month pregnancy and that the abortion was done 'clandestinely and in an unhygienic environment'.[131]

Additionally, doctor-focused regulations become a major access problem when we take into account the movement towards the legal recognition of conscientious objection in Latin American countries where the most important advances in access to safe and legal abortion have taken place. When the Colombian Constitutional Court (2006) and Argentine High Court (2012) ruled in favour of the liberalization of abortion under the indication model, they also recognized the right to conscientious objection for health providers. This is not a special feature of Latin America constitutionalization of abortion, though. A few months after *Roe* was decided, the U.S. Congress passed the Church Amendment (1973), which prohibits public authorities from requiring individuals or institutions to perform abortions or sterilizations if they have religious or moral objections to doing so. Actually, the endorsement of conscientious objection can be found in one of the 1973 Supreme Court decisions on abortion. In *Roe*, the Court quoted a brief resolution of the American Medical Association (AMA) House of Delegates of 1970: 'no party to the procedure should be required to violate personally held moral principles.'[132] But when ruling *Doe* that same year, the majority of the

Supreme Court went a step further and held, 'nothing in this section shall require a hospital to admit any patient under the provisions hereof for the purpose of performing an abortion, nor shall any hospital be required to appoint a committee such as contemplated under subsection (b) (5)'.[133]

More notable, in *Doe* Justice Harry Blackmun—the judge who wrote the vote for the majority in *Roe*—held:

> a physician or any other employee has the right to refrain...for moral or religious reasons, from participating in the abortion procedure. These provisions obviously are in the statute in order to afford appropriate protection to the individual and to the denominational hospital.[134]

Therefore, while congress or courts have legalized abortion they have also kept some degree of criminalization and set forth doctor-based regulations, all of which undermine not only policies but daily access to abortion, under a dynamic that could be synthesized as a 'making rules, unmaking choices',[135] all of which should be part of our contemporary constitutional discussions, at least in terms of judicial scrutiny of these regulations to determine the burden on right to autonomy, privacy, and to enjoy the benefits of scientific progress of women.

46.4 Conclusion

p. 829

World laws still embrace a criminalization paradigm. So, what we have in comparative law is total criminalization, different partial decriminalization models and the exceptional case of Canada. Most of Latin America adopt the indication model, a partial decriminalization one.[136]

Latin American countries have undergone relevant changes in abortion law for more than a decade. The progressive modifications have been sustained by constitutional arguments, alongside some high court's rulings. The less of these changes are conservative, coming from some countries in Central America.

One might argue that one of the most important contributions to the comparative constitutional law and even to the abortion global landscape of this process is the emphasis on making effective the law in the books, by, for example laying down specific rules for abortion health services. This contribution is directly connected to one of the major problem in the abortion arena in this region: even though most of Latin American countries have had the indication model (one of the models of partial decriminalization) since the begging of the twentieth century, the enforcement has been extremely weak, almost none. This started changing around 2005 in South America countries and Mexico, where a combination of (few) law reforms and (more) constitutional judgments, and public health guidelines have helped to improve access to safe abortion for women. Some of these changes went a step further, allowing abortion on request in the first trimester of pregnancy in Mexico City and in Uruguay. Chile is now one step away from passing a new law that decriminalize abortion under certain grounds, leaving behind the total ban of abortion put into force by Pinochet in 1989. In Argentina, Bolivia, Brazil, and Colombia, high courts have been key to interpret the constitutionality and scope of specific indications. Furthermore, in countries such as Argentina, Bolivia, Colombia, and Peru, guidelines issued by health authorities have enhanced access to the permitted abortions.

As previously mentioned, most of these legal challenges have been built on constitutional and human rights arguments, and mainly viewed as a way to enforce the already 'legalized' abortions and, at the same time, as a path towards a more liberalized regulatory framework, typically, the mix model (as the total penalization is almost a dream even in less conservative countries around the world). In this environment, new cases discussing the constitutionality of criminal laws on abortion arose. In addition to the emphasis placed on implementation, various high courts have also started to develop different balance tests to deal with the perennial tension between women's rights and prenatal life. The high courts of Costa Rica, Colombia, El

Salvador, Mexico, Argentina, Bolivia, and Brazil began to take part of the dispute addressing the so-called 'clash' between the right/interest/value of prenatal life and women' rights, applying different proportionality tests. From more restrictive rulings, such as El Salvador, to those of the progressive Constitutional Court of Colombia, all courts were encouraged to assess the constitutionality of the various models of criminal regulation of abortion.[137] Despite the significant changes, they did not reach to the point
p. 830 to question the ↳ criminalization but limits of the criminalization and State obligations to assure women some degree of access to legal abortion.

Nonetheless, the changes are uneven in the region. Indeed, in many countries (i.e. Central America and Venezuela) restrictive punitive laws have remained intact; moreover, in Salvador, where abortion is currently banned, women were not only prosecuted but imprisoned for having an abortion, even women who are merely suspected of having induced an abortion, but in fact had suffered miscarriages.[138] In these punitive settings but also in those with legalize but restrictively regulated services, or in those with progressive changes in law in the books but with still huge problems of implementation or hostile environment, women have resorted to other options. Indeed, new reproductive technology, namely abortion pills, have allowed women to self-induce abortions in an effective, safe, and private way, radically changing abortion practices.

Besides the prevalence of the indication model, the legislation of abortion in the region is characterized by an over-representation of physicians along with restrictions on self-abortions and other uses of *Misoprostol* and *Mifepristone* (medical abortion) which can improve access to safe abortion.

The law regulates abortion; that is, it is not a free practice for women. While the regulated condition of abortion dates back centuries, the shape of this regulation varies by country, and has changed through different dynamics of legal production. Yet, one critical feature of most statutory is that they place physicians as gatekeepers of legal and safe abortion, and women as supplicants (or challengers), thus helping to define abortion as a 'practice that should be authorized' even when a right to abortion has been granted to women by Congresses or Courts. Indeed, even when they are upholding reproductive rights, courts, health ministries, and legislatures, 'have consistently expressed [their] ambivalence by struggling to parse the degree of control which [they] hold must be allocated to the woman'.[139]

In other words, underlying doctor-focused regulations there are normative assumptions about women's autonomy which have practical consequences on access to abortion. Therefore, regulations on abortion, besides the traditional discussion on the degree and type of decriminalization, should become a real constitutional issue as they involve a far-reaching legal assault on women's rights.

Delegating power to physicians is not an exclusive feature of the indication model. Periodic or mixed regimes—usually depicted as the most liberal—also contemplate rules focused on doctors, whether in primary law—which defines the legal status of abortion—or procedural regulations that determine the access to the practice. Of course there are regulations that are more deferential to women's decisions than others. A prohibitionist regime, such as the Nicaraguan, declares that the government has a monopoly on the decision not the woman. More flexible legislation—in countries such as Colombia, Peru, Nepal, Germany, and the U.K.—offers a series of slightly different answers: 'the woman has the decision according to the gestation term'; 'the woman has the option after the certification process'; 'the woman can have the abortion depending on the doctor diagnosis'; 'the woman can require an abortion depending on the cases'; etc. Yet, and despite the differences, the delegation to another actor different from the woman operates in almost all of these laws.

p. 831 Consequently, besides the traditional classification (indication, time, mix models) world regulations should also be classified, analysed, scrutinized whether it is the woman or another person the one that decides the continuation or termination of the pregnancy and how to safely practice it.

Even the most liberal law does not ensure by itself a respectful regulation of women's autonomy as doctor-based regulations showed. These regulations encompass a series of problematic consequences such as displacement of women's decision, over-regulation and contentious dynamics around norm-making (e.g. conscientious objection clauses, severe requirements to health facilities), lack of incorporation in the regulation of new technologies that contribute to women's control of their bodies (e.g. pills), reluctance to incorporate other health providers.

Doctor-based regulations whose claimed aim is to guarantee women's health are illegitimate and discriminatory insofar as they are unaware of their autonomy, degrade their ability to make decisions regarding their health, and show contempt to use the advances of scientific development and make the corresponding regulatory arrangements. Currently, medical abortion (with pills) departs in significant ways from the traditional ways to have an abortion. Nowadays, it more like a treatment with medication, that makes an early abortion safe and easier. So, why do regulations still embrace an old paradigm that violates women's constitutional right to autonomy, privacy, dignity and health? In recent times, a number of restrictions have proliferated and become more extreme, driven by the opponents to women's right to abortion, who have sought in numerous ways to regulate, and restrict, the provision of abortions. But there are also settings where one could not trace special conservative incidence but still there are legal barriers to abortion care, or even the unwillingness to accommodate regulations to the technological advances, like the U.K. case. These regulations are not in the best patients' interest; rather, they make access to abortion more difficult, sometimes impossible, and the experience more upsetting.

By highlighting the over-representation of physicians in laws I do not mean rejecting their role. Rather, I suggest an accommodation. Women should have the opportunity to obtain information about the different methods of abortion, their legal status, advantages, possible complications, and any other technical aspects of the procedure. They should also have, if wanted, the opportunity to address their feelings. They should be able to obtain the surgical method performed by a health provider in a facility if they preferred so (e.g. some women suffering domestic violence in Argentina have chosen to have the abortion take place in a hospital). Or to opt out for a medical abortion, acceding to the pills by prescription, from the health insurance, or the public hospital with the help of a health provider (not necessarily a physician). Pills should be made available through national drug registration and health service provision. Also, sometimes women can become nervous or have some questions, and might want someone to talk to, so an abortion phone line should be an important part of the provision of this method. Moreover, as there are (low) probabilities that things may go wrong with an early abortion with pills, access to medical treatment is essential. Women can also prefer to turn to other women to obtain information from, for example, hotlines, and also support and counselling. Finally, women with second or third term pregnancies who require abortion should be able to resort to a health facility.

To sum up, I believe it is important to explore how regulations redistribute competencies between doctors and women to complement the classic typology of abortion legislative models. This work implies readjusting current constitutional discussion to focus on both these regulatory traits (roles assigned to doctors and women, requirements needed to an abortion 'be legal', etc.) and the persistence of the criminal paradigm (even in those countries that are known to have a periodic or mixed model).

Notes

1 Reva Siegel, 'The Constitutionalization of Abortion' in Michel Rosenfeld and Andras Sajo (eds), *The Oxford Handbook of Comparative Constitutional Law* (OUP 2012).

2 Agustina Ramón Michel and Mercedes Cavallo, 'El principio de legalidad y las regulaciones de aborto basadas en los médicos' in Paola Bergallo; Isabel Jaramillo Sierra, and Juan Vaggione (eds), *El aborto en América Latina. Estrategias jurídicas para luchar por su legalización y enfrentar las resistencias conservadoras* (Siglo XXI Editores 2018).

3 Additionally, in this type of legislations the physician is an unavoidable figure, as she is entitled to 'certify' the indication for an abortion to become legal (see 46.3).

4 Center for Reproductive Rights, 'The Total Criminalization of Abortion in El Salvador' (Center for Reproductive Rights 2015) <www.reproductiverights.org/sites/crr.civicactions.net/files/documents/GLP_FS_ElSalvador-Final.pdf> accessed 1 December 2019.

5 Guttmacher, 2015.

6 They are all connected by a political and legal dependence of countries with liberal legislations on abortion.

7 In 2007 the ruling party, Frente Sandinista de Liberación Nacional, passed a law banning therapeutic abortion. Ten years before, in Honduras (1997) and in El Salvador (1998) abortion was banned.

8 See Ramón Pérez Reyes, 'Senado Mantiene Penalización del Aborto' *Listin Diario* (Santo Domingo, 1 June 2017) <www.listindiario.com/la-republica/2017/06/01/468302/senado-mantiene-penalizacion-del-aborto-rechaza-observaciones-del-presidente> accessed 1 December 2019.

9 Promsex, 'Comisión Especial Revisora del Código Penal Aprobó la Despenalización del Aborto Eugenésico y Por Violación' (*Promsex*, 11 October 2009) <http://promsex.org/index.php?option=com:k2&view=item&id=1162:comision-especial-revisora-del-codigo-penal-aprobo-la-despenalizacion-del-aborto-eugenesico-y-por-violacion&Itemid=696> accessed 1 December 2019.

10 See Soraya Constante, 'Ecuador, Una Nueva Ley del Aborto que no Gusta a Nadie' *El País* (Quito, 7 March 2014) <https://elpais.com/sociedad/2014/03/07/actualidad/1394211311_298099.html> accessed 1 December 2019.

11 Constitutional Court (10 May 2006), Ruling C–355.

12 Siegel, 'The Constitutionalization' (n 1).

13 In this chapter, I don't analyse international or regional cases, which have been very important role in shaping the legal arena of abortion in both regional and national settings. See Johanna Fine, Katherine Mayall, and Lillian Sepúlveda, 'The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally' (2017) 19(1) *Health and Human Rights Journal* 69.

14 Political Constitution of the United Mexican States 1917 (Constitución Política de los Estados Unidos Mexicanos) art 4.

15 Constitution of the Republic of Ecuador 2008 (Constitución de la República del Ecuador) arts 10 and 32.

16 Daniel Brinks and Abby Blass, *The DNA of Constitutional Justice in Latin America: Politics, Governance and Judicial Design* (CUP 2018) 7.

17 Inter-American Court of Human Rights, *Artavia Murillo and others ('In Vitro Fertilization') v Costa Rica* (28 November 2012) Series C no 257, Preliminary Objections, Merits, Reparations and Costs.

18 Ibid.

19 Rocío Villanueva Flores, *El Debate Legal en América Latina: La Anticoncepción Oral de Emergencia* (Tomo 3, Instituto Interamericano de Derechos Humanos 2008); Maria Alexandra Cardenas 'Banning Emergency Contraception in Latin America: Constitutional Courts Granting an Absolute Right to Life to the Zygot' (2009) 6 *American Comparative Law Review* 3; Bergallo, 2011.

20 Debora Diniz and Daniel Avellino, 'International perspective on embryonic stem cell research' (2009] 43(3) *Revista de Saúde Pública* 541.

21 Paola Bergallo and Augustina Ramón Michel, 'Abortion' in Roberto Gargarella and Juan González Bertomeu (eds), *The Latin American Casebook: Courts, Constitutions, and Rights* (Routledge 2016).

22 Constitutional Court (10 May 2006), Ruling C–355.

23 Supreme Court of Justice of the Nation, Plenary (28 August 2008) Acción de Inconstitucionalidad 146/2007 y 147/2007.

24 Supreme Federal Court (12 April 2012) ADPF 54/DF.

25 Supreme Court of Justice of the Nation, *FAL s/Medida autosatisfactiva* (12 March 2012) F.259.XLVI, CSJN Fallos 335:197.

26 Constitutional Plurinational Court of Bolivia (5 February 2014) Decision 0206/2014.

27 Supreme Federal Court, *1°Turma* (29 November 2016) HC 124.306/RJ.

28 See Piotr Kazak, '"A Triumph of Reason": Chile Approves Landmark Bill to Ease Abortion Ban' *The Guardian* (Santiago, 22 August 2017) <www.theguardian.com/global-development/2017/aug/22/chile-abortion-bill-michelle-bachelet-a-triumph-of-reason-ease-abortion-ban> accessed 1 December 2019.

29 Supreme Court of Costa Rica, Constitutional Chamber (17 March 2004) Decision 02792–04.

30 Supreme Court of El Salvador (20 November 2007) Decision 18/98.

31 For a detailed account of Latin American constitutional judgments about abortion, see Bergallo and Ramón Michel (n 21).

32 Siegel, 'The Constitutionalization' (n 1).

33 The Colombian Constitutional judgment has been sufficiently analysed.

34 'Paulina was 13 years old when she was raped in 1999 and subsequently denied a legally permitted abortion by state health and law enforcement officials. In 2002, the Center for Reproductive Rights and two Mexican human rights groups filed a petition on Paulina Ramirez's behalf with the Inter-American Commission on Human Rights, alleging violations of

her legally guaranteed rights under Mexican law, as well as her rights to physical and psychological integrity and health, among others…In 2006, the Center and its partners reached a landmark settlement with the Mexican government, in which the government agreed to, among other things, pay reparations to Paulina, provide her and her son significant compensation for health care and education, and issue a decree regulating guidelines for access to abortion for rape victims': Center for Reproductive Rights, '*Paulina Ramírez v Mexico*' (Center for Reproductive Rights 2008) <www.reproductiverights.org/case/paulina-ram%C3%ADrez-v-mexico-inter-american-commission-on-human-rights> accessed 1 December 2019.

35 Supreme Court of Justice of the Nation, Plenary (28 August 2008) Acción de Inconstitucionalidad 146/2007 y 147/2007.

36 Political Constitution of the United Mexican States (n 14).

37 Alejandro Madrazo, 'The Debate Over Reproductive Rights in Mexico: The Right to Choose vs the Right to Procreation' (Paper 74, Yale Law School SELA Papers, 1 January 2009) <http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1073&context=yls_sela> accessed 1 December 2019.

38 Francisca Pou Giménez, 'El aborto en México: el debate en la Suprema Corte sobre la normativa del Distrito Federal' (2009) 5 *Anuario De Derechos Humanos* 37.

39 Bergallo and Ramón Michel (n 21).

40 Supreme Court of Justice of the Nation, Plenary (28 August 2008) Acción de Inconstitucionalidad 146/2007 y 147/2007, 180, cited in Bergallo and Ramón Michel (n 21)

41 Bergallo and Ramón Michel (n 21).

42 Argentine Penal Code 1984 arts 86.1 and 86.2.

43 Supreme Court of Justice of the Nation, *FAL s/Medida autosatisfactiva* (12 March 2012) F.259.XLVI, CSJN Fallos 335:197.

44 Ibid 10.

45 Ibid. 3.

46 Together with the Inter-American Court, they are the organizations in charge of monitoring and interpreting the content of the American Convention, that is, authoritative interpretations of the Treaty.

47 Kali, 2016; Human Rights Watch, 'Brazil: Court Reviewing Criminalization of Abortion' (*HRW*, 25 April 2017) <www.hrw.org/news/2017/04/25/brazil-court-reviewing-criminalization-abortion> accessed 1 December 2019.

48 Luís Roberto Barroso, 'Bringing Abortion into the Brazilian Legal Debate' in Rebecca Cook, Joanna N Erdman, and Bernard M Dickens (eds), *Abortion Law in Transnational Perspective: Cases and Controversies* (University of Pennsylvania Press 2014).

49 Supreme Federal Court (12 April 2012) ADPF 54/DF. The Brazilian Law on Biosafety was passed on 2005. That same year, the Attorney General filed a case challenging the constitutional grounds of Article 5 that allows the use of embryonic stem cells in research and therapies obtained from surplus human embryos from techniques of in vitro fertilizations. See Diniz and Avelino, 'International perspective' (n 20).

50 Human Rights Watch, 'Brazil' (n 47); Sarah Boseley, 'Zika Emergency Pushes Women to Challenge Brazil's Abortion Law' *The Guardian* (19 July 2016) <www.theguardian.com/global-development/2016/jul/19/zika-emergency-pushes-women-to-challenge-brazil-abortion-law> accessed 1 December 2019.

51 Supreme Federal Court, *1°Turma* (29 November 2016) HC 124.306/RJ.

52 It is important to recall that the jurisprudence of the STF does not allow the declaration of unconstitutionality of any law adopted prior to the 1988 Constitution, and the punitive provisions are set in the Penal Code passed in 1940. See Beatriz Galli, 'Abortion Rights in Brazil: A Big Step Forward' (IPAS 8 December 2016) <www.ipas.org/en/News/2016/December/Abortion-rights-in-Brazil-A-big-step-forward.aspx>.

53 Supreme Federal Court, *1°Turma* (29 November 2016) HC 124.306/RJ, para 29.

54 Ibid.

55 Diniz interviewed by Sirin Kale, 'Brazil Takes Historic First Step Towards Decriminalizing Abortion', *Vice* (2 December 2016) <www.vice.com/en/article/ywmgex/brazil-takes-historic-first-step-towards-decriminalizing-abortion> accessed 1 December 2019.

56 Beatriz Galli, 'Los efectos de las restricciones jurídicas relacionadas a la penalización del aborto y otras barreras jurídicas al acceso de las mujeres a la salud sexual y reproductiva' (IPAS, 31 December 2012) <www.ipas.org/es-MX/Resources/Ipas%20Publications/Los-efectos-de-las-restricciones-juridicas-relacionadas-a-la-penalizacion-del-aborto-y-otr.aspx>.

57 Bergallo and Ramón Michel (n 21).

58 This section is a partial reproduction of Ramón Michel and Cavallo (n 2).

59 Marge Berer, 'Discussion: Abortion Law and Policy Around the World: In Search of Decriminalization' (2017) 19(1) *Health and Human Rights Journal* 13.

60 See Paola Bergallo, 'Aborto y Justicia Reproductiva: una Mirada sobre el Derecho Comparado' (2010) 7 *Revista de Derecho Penal y Procesal Penal* 1139; Laurenzo Copello (2011); Galli, 'Los Efectos' (n 56); Agustina Ramón Michel, 'El Fenómeno de

Inaccesibilidad al Aborto no Punible' in Paola Bergallo (ed), *Aborto y Justicia Reproductiva* (Editores del Puerto 2012); Sabrina Cartabia, 'El Derecho a la Salud y al Aborto: El Punto Ciego' (2014) 3(8) *Revista Derechos Humanos* 31; CIDH (178/15); GIRE, 'Violencia sin interrupción' (GIRE 2016) <http://aborto-por-violacion.gire.org.mx/#/> accessed 1 December 2019; Viviana Bohórquez Monsalve and Laura Castro Gonzalez, 'De los Derechos a los Hechos: Diez Años Continuos de Acompañamiento a las Mujeres' in Ana Cristina González Velez (ed), *Las Causales de la Ley y la Causa de las Mujeres. La Implementación del Aborto Legal en Colombia: Diez Años Profundizando la Democracia* (Mesa por la vida y salud de las mujeres 2016); Paola Bergallo, 'Litigio estratégico y derecho al aborto' in Rebecca Cook, Joanna Erdman, and Bernard Dickens, *El Aborto en el Derecho Transnacional* (FCE-CIDE 2016); Luis Campoverde Vera, 'Situación de la Provisión de Abortos Legales en los Servicios Públicos de Salud del Ecuador' (Primer encuentro latinoamericano de prestadores públicos de abortos seguros y legales, Buenos Aires, 11–12 August 2016) <https://clacaidigital.info/bitstream/handle/123456789/876/Sit.prov.abortos.Ecuador.pdf?sequence=5&isAllowed=y>; Garay Zarraga (2016).

61 Guatemala Penal Code 1973 art 137. The emphasis is mine.

62 However, it also occurs in other regions. In Albania with mixed regime, a health commission has to authorize therapeutic abortions. Similarly, in Bosnia and Herzegovina abortive practices after the week tenth shall be authorized by a multidisciplinary committee. In Denmark, the same law that establishes a broad ground regulation regime also requires commissions to grant permission for abortion on adolescents and women with mental disabilities, as well as cases that exceed the twelve-week period. All these legislations come from the mid-1990s onwards; furthermore, Denmark and Bosnia and Herzegovina's are from 2008.

63 Argentine Penal Code 1984 art 86.

64 Kristin Luker, *Abortion and the Politics of Motherhood* (University of California Press 1985).

65 Ibid.

66 Caitlin Borgmann, 'The Meaning of "Life": Belief and Reason in the Abortion Debate' (2009) 18(2) *Columbia Journal of Gender and Law* 551, 593.

67 Luker (n 64).

68 Ibid.

69 Borgmann (n 66).

70 CRIN, 'Perú: Abortion Guidelines Established after 90-year Delay' (CRIN 2016) <www.crin.org/sites/default/files/lcv.peru_.pdf> accessed 1 December 2019.

71 GIRE (n 60).

72 Paola Bergallo and Ana Cristina González Vélez, *Interrupción del Embarazo por la Causal Violación: Enfoques de Salud y Jurídico* (La Mesa por la Vida y la Salud de las Mujeres 2012). Countries like Ecuador and Paraguay represent the typical settings where abortion laws are highly restrictive, access to legal abortion even under indications is almost non-existent, and is completely unregulated. So, it is not clear where they would stand in this classification regarding requirements to access abortion on rape grounds if they would issue a guideline.

73 A specific problem of the periodic model is that it almost always tends to be under-inclusive or over-inclusive to their proponents' goals. As Borgmann (n 66), notices, once the law draws the line and assigns different responses to unwanted pregnancies, it leaves out many abortions that some of us would consider morally acceptable and/or even compelling, while it will not ensure morally commendable responses to unwanted pregnancy, 'much less ensure moral conduct in a host of other, equally weighty circumstances…it does not help someone else's life but spoils it to force values upon him he cannot accept but can only bow before out of fear or prudence'. The under-inclusive or over-inclusive effect is in large part due to the fact that legality is determined by some criterion external to women. Moreover, the periodic model is criticized for leaving out those most vulnerable women, who seek an abortion in the second or third semester. Marge Berer, 'Medical Abortion in Britain and Ireland: Let's Join the 21st Century!' (*Reality Check*, 16 February 2011) <https://rewire.news/article/2011/02/16/medical-abortion-britain-ireland-let-join-21st-century/> accessed 1 December 2019; Tamar Pitch, *Un Derecho Para Dos: La Construcción Jurídica de Género, Sexo y Sexualidad* (Trotta 2003).

74 Law 18.987 of 2012, art 12.

75 Sonia Correa and Mario Pecheny, *Abortus interruptus: política y reforma legal del aborto en Uruguay* (MYSU 2016).

76 My translation.

77 Dispute Tribunal, *Alonso, Justo and Others v Executive authority* (11 August 2015) Invalidity action: No 586.

78 Paula Abrams, 'The Tradition of Reproduction' (1995) 37 *Arizona Law Review* 453. For other probable reasons see Luker (n 64).

79 Scott Moss and Douglas Raines, 'The Intriguing Federalist Future of Reproductive Rights' (2008) 88 *Boston University Law Review* 175; Hendricks, 2009.

80 *Doe v Bolton*, 410 US 179, 192 (1973).

81 Erin Daly cited by Hendricks (2009) note 19.

82 I will further develop this point at the end of the section.

83 Beverly Winikoff and Wendy Sheldon, 'Use of Medicines Changing the Face of Abortion' (2012) 38(3) *International Perspectives on Sexual and Reproductive Health* 164.

84 Guttmacher (n 5); Marji Gold and Erica Chong, 'If We Can Do It for Misoprostol, Why Not For Mifepristone? The Case for Taking Mifepristone out of the Office in Medical Abortion' (2015) 92 *Contraception* 194; Berer, 'Discussion' (n 59).

85 Berer, 'Discussion' (n 59) 13.

86 WHO, 2003.

87 Ibid; World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd edn, World Health Organization 2012).

88 Ilana G Dzuba, Beverly Winikoff, and Melanie Peña, 'Medical Abortion: A Path to Safe, High-Quality Abortion Care in Latin America and the Caribbean' (2013) 18 *The European Journal of Contraception & Reproductive Health Care* 441; Winikoff and Sheldon (n 83); Agustina Ramón Michel and Sonia Ariza, 'Entre la Indolencia y el Sesgo: El Derecho de las Mujeres a Beneficiarse de los Avances Científicos en Materia Reproductiva' (CLACAI, February 2017).

89 María Mercedes Lafaurie and others, 'Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and Peru: A Qualitative Study' (2005) 13(26) *Reproductive Health Matters* 75; Pak Chung Ho, 'Women's Perceptions on Medical Abortion' (2006) 74(1) *Contraception* 11; Stephanie Teal and others, 'Efficacy, Acceptability and Safety of Medication Abortion in Low-Income, Urban Latina Women' (2009) 80(5) *Contraception* 479.

90 Winikoff and Sheldon (n 83).

91 Ibid.

92 Dzuba, Winikoff, and Peña (n 88); Berer, 'Medical Abortion' (n 73).

93 Nina Zamberlin, Mariana Romero, and Silvina Ramos, 'Latin American Women's Experiences with Medical Abortion in Settings Where Abortion is Legally Restricted' (2012) 21(3) *Reproductive Health* S32; Henry Espinoza and others, 'Medicamentos para la interrupción de la gestación: una revisión de la literatura y sus posibles implicaciones para México y América Latina' (2002) 138(4) *Gaceta Médica de México* 347; Regina Barbosa and Margareth Arilha, 'The Brazilian Experience with Cytotec' (1993) 24 *Studies in Family Planning* 236.

94 Ramón Michel and Ariza (n 88).
Feminist groups put into motion telephone hotlines and women support services, considering access to information and pills a political strategy that seeks to make women regain control of their own lives, bodies and even the abortion practice itself: Zamberlin, Romero, and Ramos (n 93). They challenge the monopoly held by health professionals and state regulations. Perú (e.g. Colectiva por la Libre Información para las Mujeres); Ecuador (eg Jóvenes por despenalización del aborto); Argentina (e.g. Feministas y Lesbianas por la Decriminalización del Aborto;); Chile (e.g. Red de Lesbianas y Feministas por el Derecho a la Información); Uruguay (e.g. Mujeres en el Horno); México (e.g. Las libres); and Venezuela (e.g. Línea aborto: información segura) are some of the countries in which women's organizations have established phone number lines, accompaniment for women who want to proceed the pregnancy interruption, and that have developed and disseminated information about medical abortion.

95 Dzuba, Winikoff, and Peña (n 88).

96 Winikoff and Sheldon (n 83).

97 Adele Clarke and Theresa Montini, 'The Many Faces of RU486: Tales of Situated Knowledges and Technological Contestations' (1993) 18(1) *Science, Technology and Human Values* 42; Marge Berer, 'Inducing a Miscarriage: Women Centered Perspectives on RU486/prostaglandin as an Early Abortion Method' (American Society for Law and Medicine Conference, Arlington, 6–7 December 1992); Julie Hogan, 'The Life of the Abortion Pill in the United States' (Third Year Paper, Harvard University 2000) <https://dash.harvard.edu/bitstream/handle/1/8852153/Hogan,_Julie.pdf?sequence=1> accessed 1 December 2019.

98 Gynuity Health Projects, 2014a. 'Map of Misoprostol Approval' (Gynuity Health Projects 2014) <https://gynuity.org/resources/map-of-misoprostol-approvals>.

99 i.e. its distribution is solely in-hospital, exclusive institutional presentations, and the sale is subject to special or stored prescriptions, among others: Ramón Michel and Ariza (n 88).

100 Gynuity Health Projects, 'Map of Mifepristone' (Gynuity Health Projects 2014) <https://gynuity.org/assets/resources/mapmiso__en.pdf >.

101 Gold and Chong (n 84); Yael Swica and others, 'Acceptability of Home Use of Mifepristone for Medical Abortion' (2013) 88 *Contraception* 122.

102 UK Parliament, 'Select Committee on Science and Technology Written Evidence: Submission from Reproductive Health Matters' (Memorandum 24, 2007) <www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045we25.htm> accessed 1 December 2019; Berer, 'Medical Abortion' (n 73); Ann Furedi, 'Let's Make it Easier to Take the Abortion Pill' *Spiked* (London, 13 January 2011) <www.spiked-online.com/newsite/article/10078> accessed 1 December 2019; Gold and Chong (n 84); Daniel

Grossman and Philip Goldstone, 'Mifepristone by Prescription: A Dream in the United States But Reality in Australia' (2015) 92(3) *Contraception* 186.

103 Winikoff and Sheldon (n 83).

104 Gold and Chong (n 84).

105 Ibid.

106 See the American College of Obstetricians and the National Abortion Federation's Clinical Policy Guidelines; the International Planned Parenthood Federation and its First Trimester Abortion Guidelines and Protocols.

107 Rebecca Gomperts and others, 'Provision of Medical Abortion Using Telemedicine in Brazil' (2014) 89 *Contraception* 129; Sara Larrea, Laia Palencia, and Glória Perez, 'Aborto Farmacológico Dispensado a Través de un Servicio de Telemedicina a Mujeres de América Latina: Complicaciones y su Tratamiento' (2015) 29(3) *Gac Sanit* 198.

108 Willow Women's Clinic.

109 NYT, 2014.

110 Daniel Grossman, Kate Grindlay, and Todd Buchacker, 'Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine' (2011) 118 *Obstetrics & Gynecology* 296; Erica Chong and others, 'A Prospective, Non-Randomized Study of Home-Use of Mifepristone for Medical Abortion in the US' (2015) 92(3) *Contraception* 215; Rebecca Gomperts and others, 'Using Telemedicine for Termination of Pregnancy with Mifepristone and Misoprostol in Settings Where There is no Access to Safe Services' (2008) 115 *BJOG* 1171; Abigail Aiken, Rebecca Gomperts, and James Trussell, 'Experiences and Characteristics of Women Seeking and Completing At-Home Medical Termination of Pregnancy Through Online Telemedicine in Ireland and Northern Ireland: A Population-Based Analysis'. National Center for Biotechnology (2016) *BJOG* <www.ncbi.nlm.nih.gov/pubmed/27748001> accessed 10 September 2019.

111 Guttmacher Institute, 'State Facts About Abortion: Utah: National Background Context' (Guttmacher Institute 2017).

112 Grossman, Grindlay, and Buchacker (n 110); Gold and Chong (n 84); Elizabeth Nash and others, 'Laws Affecting Reproductive Health and Rights: 2014' (State Policy Review, Guttmacher Institute 2015) <www.guttmacher.org/laws-affecting-reproductive-health-and-rights-2014-state-policy-review> accessed 10 September 2019.

113 Editorial, 'Guatemala Army Blocks Dutch Boat Offering Abortions' *BBC* (London, 24 February 2017) <www.bbc.com/news/world-latin-america-39073367> accessed 10 September 2019.

114 When the Act was passed in 1967, the normal method of abortion used was surgical abortion. But then, the reform of 1990 incorporated medical abortion, and in 1991 the government licensed the drug *Mifepristone*.

115 *BPAs v Secretary of State for Health* [2011] EWHC 235.

116 BPAs sought a declaration that stated: 'For the purposes of section 1 of the Abortion Act 1967, a pregnancy is "terminated by a registered medical practitioner" where the registered medical practitioner prescribes an abortifacient drug with the intention of terminating a pregnancy and the administration of that drug to the pregnant woman is not "any treatment for the termination of pregnancy"': *BPAs v Secretary of State for Health* [2011] EWHC 235.

117 Berer, 'Medical Abortion' (n 73); *The Guardian*, 2011.

118 Furedi (n 102). Restrictions on the use of medicaments do not end there. There are health protocols and registrations of *Mifepristone* that limit the use of *Misoprostol* and *Mifepristone* at a determined gestational age, with no update according to new scientific evidence. This is the case of the United States, where the current *Mifepristone*'s label approved by the FDA limits its use to up to forty-nine days of gestation, indicating a 600 mg dose (higher than recommended according to the updated and best evidence available), forbid its sale in pharmacies and require patients to make at least three visits to the medical office in order to receive the medication and complete an extensive follow-up procedure: see Gold and Chong (n 84). In spite of the clear safety and efficiency of the updates regimes based on evidence regarding medical abortion, some states require the service providers to follow this FDA protocol, restricting the access to safe abortion: Kelly Cleland and Nicole Smith, 'Aligning Mifepristone Regulation with Evidence: Driving Policy Change Using 15 Years of Excellent Safety Data' (2015) 92(3) *Contraception* 179; Grossman and others, 2014. Some of these cases were brought to court and their results were dissimilar. For instance, Oklahoma passed an Act that makes the FDA's outdated protocol mandatory, but a lawsuit suspended its application. A similar case of Arizona is waiting for the Supreme Court's decision. On the other hand, a Federal Appeal Court upheld a similar Texas law and so did the North Dakota Supreme Court: Nash and others, 'Laws' (n 112); Grossman and others, 2014. In 2016, the FDA updated the *Mifepristone* protocol, incorporating a regime that seems to be beneficial for women: Guttmacher Institute, 'State Facts' (n 111). Other restrictions, such as exclusive distribution within health services and requirements like post-use medical visits, show how complex the regulatory environment needed to expand access to safe abortion is, and suggest government resistance to align regulations with available evidence: Gold and Chong (n 84); Dzuba, Winikoff, and Peña, 'Medical Abortion' (n 88); Cleland and Smith (n 118); and Grossman and Goldstone (n 102).

119 Guttmacher (n 5).

120 Nancy Hass, 'The Next *Roe v Wade*?: Jennie McCormack's Abortion Battle' *Newsweek* (New York, 12 December 2011) <www.newsweek.com/next-roe-v-wade-jennie-mccormacks-abortion-battle-65831> accessed 10 September 2019.

121 Meredith Jewitt, 'The Case We Need' *Duke Chronicle* (16 September 2012) <www.dukechronicle.com/article/2012/09/case-we-need>.
122 Ibid.
123 Ibid.
124 Hass (n 120); Murray, 2012; Jewitt (n 121).
125 Hass (n 120); *Idaho Press Tribune*, 2012.
126 Hass (n 120).
127 Kathryn Smith, 'Idaho Abortion Law is Struck Down' *Político* (3 August 2013) <www.politico.com/story/2013/03/idaho-fetal-pain-abortion-law-is-struck-down-088596>.
128 Ibid.
129 Ibid.
130 Correa and Pecheny, *Abortus Interruptus* (n 75) 20 (my translation).
131 See Editorial, 'Maldonado: Dos Mujeres a Prisión Por Aborto Ilegal' *El País* (17 March 2015) <www.elpais.com.uy/informacion/maldonado-mujeres-prision-aborto-ilegal.html> accessed 1 December 2019.
132 *Roe v Wade*, 410 US 113 (1973).
133 *Doe v Bolton*, 410 US 179, 205 (1973) *7 (e)*
134 *Doe v Bolton*, 410 US 179, 197–98 (1973) *2*.
135 White, 2010.
136 Ramón and Michel Cavallo (n 2).
137 Bergallo and Ramón Michel (n 21).
138 Center for Reproductive Rights, 'The Total Criminalization' (n 4).
139 Abrams (n 78) 454.