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Examining implementation of health exception laws in six countries

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Abstract

Exceptions to abortion restrictions on the grounds of protecting life or health enable essential care for pregnancy complications but are often underutilized or inconsistently applied. Through a narrative study, Global Doctors for Choice (GDC) aimed to identify barriers and facilitators to implementing these exceptions. We conducted literature and desk reviews and 15 semi-structured interviews (May-August 2025) with physicians, lawyers, and advocates from six countries: Colombia, Ghana, Ireland, Peru, Rwanda, and South Korea. Interviews were transcribed, de-identified, and analyzed for common themes. Implementation depended on disparate, often narrow or incorrect, interpretations by clinicians and institutions. Barriers included lack of training, geographic obstacles, personnel and supply constraints, stigma, and logistical delays, which push patients toward unsafe abortion. Facilitators involved comprehensive training with values clarification, patient awareness campaigns, unambiguous guidelines, and committed advocacy. Ultimately, clear legal frameworks, provider education, advocacy, and patient empowerment could improve access in diverse clinical and legal settings. *(Afr J Reprod Health 2026; 30 [9]:26-45).*

Keywords: Abortion; Health exception; Reproductive health policy; Access to abortion care; Maternal health; Unsafe abortion

Résumé

Les exceptions aux restrictions légales de l'avortement fondées sur la protection de la vie ou de la santé permettent de fournir des soins essentiels en cas de complications liées à la grossesse, mais elles demeurent souvent sous-utilisées ou appliquées de manière inégale. À travers une étude narrative, Global Doctors for Choice (GDC) a cherché à identifier les obstacles et les facteurs facilitant la mise en œuvre de ces exceptions. Nous avons réalisé une revue de la littérature et une analyse documentaire, ainsi que quinze entretiens semi-structurés (mai–août 2025) avec des médecins, des juristes et des acteurs du plaidoyer issus de six pays : Colombie, Ghana, Irlande, Pérou, Rwanda et Corée du Sud. Les entretiens ont été retranscrits, anonymisés et analysés afin d'identifier des thèmes récurrents. La mise en œuvre dépendait d'interprétations divergentes, souvent restrictives ou erronées, de la part des cliniciens et des institutions. Les obstacles identifiés comprennent notamment le manque de formation, les contraintes géographiques, les limitations en personnel et en ressources, la stigmatisation sociale ainsi que des retards logistiques, qui peuvent orienter les patientes vers des avortements non sécurisés. Les facteurs facilitants incluent des programmes de formation complets intégrant des démarches de clarification des valeurs, des campagnes de sensibilisation destinées aux patientes, des directives claires et sans ambiguïté, ainsi qu'un plaidoyer soutenu. En définitive, l'existence de cadres juridiques explicites, le renforcement des capacités des prestataires, le plaidoyer et l'autonomisation des femmes pourraient améliorer l'accès aux soins d'avortement dans des contextes juridiques et cliniques variés..*(Afr J Reprod Health 2026; 30 [9]: 26-45).*

Mots-clés : Avortement; Exception sanitaire; Politiques de santé reproductive; Accès aux soins d'avortement; Santé maternelle; Avortement non sécurisé.

Introduction

Preventable maternal mortality and severe maternal morbidity remain pressing public health challenges, particularly in low- and middle-income countries (LMICs). Sub-Saharan Africa accounts for approximately 70% of global maternal deaths, with unsafe abortion contributing significantly to this burden.[1,2]The World Health Organization (WHO) has identified comprehensive abortion care as an essential health service and delayed or denied access as a public health and human rights concern, with significant health system and societal costs.[3–6] Despite international calls for rights-focused law,

abortion regulation most commonly follows a grounds-based approach. "Grounds," sometimes called "exceptions" or "exceptional grounds," are stipulated circumstances in which abortion is allowed by, not contrary to, or explicitly permitted or specified by law.[7] Exceptions are often made in cases of risk to the life or health of the pregnant woman, rape, incest, sexual violence, severe or lethal fetal diagnosis, or socioeconomic justification.[7]

Despite inclusion of Health and Life Exceptions (HE/LE) in the legal frameworks of 91 countries – 47 for health grounds and 44 for life-saving indications[8] – these provisions are frequently underutilized, inconsistently applied, or impeded by ambiguous legal interpretation. While some jurisdictions allow abortion on broad therapeutic grounds, others limit it to narrowly defined physical threats, omitting mental or social health considerations. Generally, countries do not place a gestational limit on their HEs, reflecting the reality that health risks requiring termination of pregnancy may emerge throughout gestation. Prior work by Global Doctors for Choice (GDC) elucidated how few countries provide clear regulatory guidance or oversight for the implementation of HE/LE exceptions, and highlighted missed opportunities to protect maternal health.[9] However, no systematic, multi-country research to date has examined how these laws function in practice or whether they achieve their intended health outcomes.

Through a six-country qualitative study, we sought to (1) identify systemic and remediable barriers to the effective use of HE/LE laws, (2) document promising practices that have expanded access to safe and legal care, and (3) inform clinical, legal, and policy strategies for improving patient life and health.

Methods

We employed a narrative approach, consisting of a literature review, desk reviews, and key informant (KI) interviews. Colombia, Ghana, Ireland, Peru, Rwanda, and South Korea were chosen as study countries as they are geographically and culturally diverse and have adapted varied policies: Colombia and Ghana have expanded interpretations of HE/LE to broaden access to safe care; Rwanda and South Korea are in the midst of policy change; Peru's policy remains constant, and Ireland has successfully changed the law and services for first trimester abortion, but has left HE/LE unchanged and highly restrictive. Co-authors' experiences in study countries informed study design and interview instrument development.

Literature review

A comprehensive literature review was completed on January 1, 2025, to examine the medical and legal landscapes of the six focus countries. The search strategy included PubMed, using the terms "(abortion) AND (health OR life) AND (exception)" to identify biomedical literature. For country-specific sources, ScienceDirect was queried using "(abortion) AND (health OR life) AND (exception) AND (law OR policy) AND (indications OR qualifying conditions) AND (country name)." Retrieved documents were screened independently by two reviewers using predefined inclusion and exclusion criteria.

Desk reviews

Country desk reviews were completed on April 21, 2025, to examine relevant HE/LE laws, policies, and interpretation using health databases and gray literature.

Key informant interviews

Data collection

KI interviews were conducted from May to August 2025. Semi-structured interview questions explored country-specific procedures, outcomes, and barriers related to the implementation of HE/LE laws. We used a standardized semi-structured interview guide organized around eight thematic areas: (1) interpretation and scope of HE/LE laws, (2) existence and content of medical policies or guidelines, (3) provider knowledge and decision-making processes, (4) approval pathways and additional requirements, (5) denials and any appeals mechanisms, (6) monitoring and data collection on HE/LE use, (7) process barriers such as training, resources, and stigma, and (8) recommendations for improving access and support for clinicians. Interviewers followed the guide using open-ended questions and probes to clarify and deepen responses

while maintaining consistency across interviews. Eligible participants included professionals based in the country with demonstrated expertise in healthcare policy, clinical practice, legal frameworks, or advocacy related to abortion care. We aimed to interview two to five KIs per country (total N=15), as prior research suggests that between nine and 17 interviews are typically needed to reach thematic saturation in qualitative studies.[10] KIs were recruited through snowball sampling, facilitated by in-country contacts. Interviews were conducted virtually on Zoom after informed consent had been obtained and were conducted in English, Spanish, and Korean, scheduled for 30 to 60 minutes, recorded on a password-protected local device, and stored securely. All interviews were carried out by three members of the research team (E.F., C.R.S., and L.S.) who had prior experience with qualitative interviewing and worked under the supervision of the senior investigators.Fifteen KI interviews were conducted, with one informant each from Colombia and Ghana, two participants from South Korea, Peru, and Ireland, respectively, and seven from Rwanda. The majority of participants (53.3%) were physicians in the private sector. Three lawyers, three advocates, and a minister of health also participated.

Data analysis

Interview recordings were transcribed, de-identified and uploaded into Dedoose for qualitative coding and thematic analysis. Researchers developed the codebook through iterative analysis and open coding to identify emerging themes. After coding all transcripts, the team determined that thematic saturation had been achieved. Researchers developed a conceptually ordered matrix by country for comparative analysis. Prominent themes were selected based on frequency and relevance, and representative quotations were included to illustrate key findings.

Ethical approval

The study received ethical approval from the Research Ethics Committee of the University of Health and Allied Sciences in Ho, Volta Region, Ghana (IRB UHAS-REC A.5 [8] 24-25), which covered the multi-country KI component conducted virtually across all six settings under a single coordinating protocol. All participants gave informed consent, were reminded that participation was voluntary, and they were asked to speak only in their professional capacity. Participants de-identified data was stored on secure, password-protected servers. Columbia University determined the study IRB exempt due to low potential risk for harm to participants (Columbia IRB-AAAV6545).

Results

Literature review

Some countries allow broader access to abortion based on physical and mental health risks, while others restrict HE to physical health only. For example, Great Britain,[11,12] Spain,[13] and Ghana[14] explicitly permit abortion in cases of threat to both physical and mental health. Even within a country, national- and sub-national policies may diverge. For instance, Nigeria[15] by has a strict life-only exception on the national level, while Lagos[15] state has exceptions for life and physical health. The converse pertains to Mexico, where not all states endorse the WHO definition of health as "a state of complete physical, mental, and social well-being," although Mexico does nationally.[13] In the U.S., 22 states[16] restrict abortion to physical health grounds, and most of these explicitly exclude psychiatric exceptions.[17–20] Other definitions and exceptions, or lack thereof, also exist. For example, Poland's[21] law does not define health. Many countries and states have exceptions for rape and incest, despite longstanding judicial[22–24] and moral[25,26] debate about rape as a qualification.

Laws with vague HE/LE definitions and those requiring additional steps for a patient to qualify, often lead to delays that obstruct access to care and aggravate poor health outcomes.[9,11,27–29]

Poorly defined and restrictive HE/LE laws can also lead to provider confusion, distress, and decreased safe abortion utilization.[9,28,30] Opinions of providers on the morality of abortion care and conscientious objection have been reported to limit practical utilization of HE/LE laws in Argentina, Costa Rica, Poland, Ethiopia, and Ghana.[14,30–33] Public and provider opinion about the acceptability of abortion also influences whether abortion is perceived as legitimate HE/LE care after rape.[25,34–36]

Table 1: Legislation and policy surrounding HE/LE by study country[40,63,64]

Country	On request	Phy. health	Mental health	Intellectual disability	Rape	Incest	Fetal impairment	Social/economic	Gestational limit
Colombia	Yes (≤24 wks)	Yes	Yes	No	Yes	Yes	Yes	No	24wks (court ruling)
Ghana	No	Yes	Yes	No	Yes	Yes	Yes	No	28wks (guideline)
Ireland	Yes (≤12 wks)	Yes	Yes	No	No	No	Yes	No	Viability ~22–24 wks
Peru	No	Yes	Yes	No	No	No	No	No	22wks (guideline)
Rwanda	No	Yes	Yes	No	Yes	Yes	Yes	No	22wks (ministerial order)
South Korea	No	Limited	Limited	Limited	Limited	Limited	Limited	No	≤24wks w/ approval

Finally, geographic distribution of care,[31,37,38] lack of public funding for abortion care,[12] limitations on the cadres of providers allowed to perform abortions,[39] and a lack of abortion training for providers[30,31,37,38] all contribute to an inability to access abortion care, even when explicitly permitted by HE/LE laws.

While the vague wording of HE/LE laws can constrain access, liberal interpretation can increase access to abortion care and ensure protection of health and life.[14,21,40,41] Court cases upholding liberal interpretations of HEs are associated with increased accessible care.[9,40,42] High-profile maternal deaths from three cases of delayed and denied care following preterm premature rupture of membranes – Izabela[43] and Dorota Lalik[44] in Poland, and Andrea Prudente[45] in Malta – galvanized public and international pressure, which led to court proceedings that exposed the life-threatening consequences of restrictive abortion laws and to criminal charges of negligence for the Polish physicians.

Clinicians report that robust guidelines from medical authorities clarifying conditions requiring lawful terminations are helpful[9,20]; Ethiopia[31] has used these to increase abortion for medical complications. The explicit inclusion of mental health as a permitted exception, as in Great Britain and Colombia[12], has been associated with increased utilization of abortion care under HE/LE. Training clinicians to provide safe abortion has been shown to increase access to HE/LE abortion in Ethiopia[31], Ghana[37], Colombia[40], and Great Britain.[12]

Grounds-based, HE/LE legislation combined with efforts to generate public awareness, ultimately led to liberalizing legislation beyond HE/LE in Argentina[38], Colombia[40], and Ireland.[46]

Desk reviews

The supplementary material presents the country-specific desk reviews and relevant health and mortality data and thus provides country-specific health status and policy context to ground the analysis of HE implementation.Table 1 offers baseline knowledge of the relevant legal landscapes and current legislation of study countries discussed at length in the desk reviews.

Key informant interviews

Systemic barriers to effective HE implementation

Despite varied cultural, resource, and legal policy settings, similar themes emerged from the interviews. Access to abortion was inconsistent, despite laws allowing abortion in the instance of a threat to life or health. Many participants cited the lack of clarity about HE laws to explain varied interpretations by providers. As one KI from Rwanda explained:

There's often a fear of legal liability and there's also a lot of … moral judgement … because [the law] is unclear, that allows people to interpret it in different ways and leads to reduced access. RW7

This KI proceeded to explain how some providers endorse narrow, incomprehensive definitions of health:

…when physicians.. are looking at the HE, they look at an immediate risk to the mother… focusing on immediate physical threats, ignoring the mental and social health part of it. RW7

In particular, the threat of criminal prosecution of provider or patient, as well as perceived societal stigma, contributes to limited access. As one participant in Ireland detailed, this creates:

a climate of if in doubt, say no. IR1

A similar situation prevails in South Korea and Peru, where clinicians default to outdated laws, perpetuating fear and the association of abortion with criminality. Thus, care under the HE becomes reliant on those committed providers willing to face risks. In self-defense, providers may not document that a patient was seeking abortion care under the HE:

We know that in many hospitals you can get a therapeutic abortion, but they will not record it as such … doctors don't want to expose the pregnant woman to the burden associated with [HE] abortion … [saying] let's use incomplete miscarriage. PE1

Hospitals and providers, in part due to misconceptions about the law, often enact additional policies that are not explicitly required. In Rwanda,

for example, many clinicians continue to refer all patients seeking abortion, even those who may qualify under the HE/LE exception clause, to clinics specializing in gender-based violence, Isange One Stop centers, under the misguided belief that court approval is still necessary for abortion care:

Some of the doctors … provide the services only to the women who have gone through the Isange One Stop center ... it is like a shortcut to [the court system]. RW1

Limited access to abortion care under the HE has detrimental effects on patients, including death. Participants remembered:

I saw 2 cases of women who were denied the service and then came back with septic shock with peritonitis. RW3

This patient [was] diagnosed with leukemia … in early pregnancy … but the most famous hospital for leukemia care is a Catholic hospital… [so] she had an abortion at a private clinic … Post procedure complication (bleeding) was severe because she had leukemia … She had to tell her doctors [at the Catholic hospital] that she had miscarried. SK1

This woman tried to access abortion and was denied even though the fetus had died 2 days prior … this denial of care did result in her death. RW4

Doctors wait until their patients are in a critical condition before they address the issue. There is one case of a woman who had lupus, and because she was pregnant, they stopped her medicine. Her health deteriorated. They gave her an abortion when her health was already in a critical state. She died a month later. PE2

Care barriers

Common barriers included multi-physician approval requirements, personnel and supply shortages, logistical constraints, limitations in personal agency, deficient provider awareness and competence, stigma from both providers and society, the public–private divide, and unsupportive key stakeholders.

Multi-physician sign-off to qualify for the HE delays care, as noted by participants in Rwanda, Peru, and Ireland. In contexts of provider scarcity, inability to secure a second physician's approval can result in outright care denial.

Workforce barriers were common in all countries but limited-resource countries experienced them more frequently and severely. In Ghana, for example, a participant explained how brain drain exacerbates existing abortion provider shortages and diminishes capacity to administer medications, monitor patients, and complete procedures:

We have very few doctors… (and) migration of healthcare workforce. Last year, 4000 nurses left Ghana to either US, Canada, UK, whatever. GH1

Participants in Rwanda, Peru, Colombia, South Korea, and Ghana explained that personnel trained to provide abortions reside disproportionately in cities, requiring rural patients to travel long distances, pay more to receive care, and face heightened stigma prevalent in rural areas.

Similarly, supply barriers, such as difficulty securing mifepristone for medication abortion and manual vacuum aspiration (MVA) kits, were prevalent, and were especially acute in resource-limited countries.

Logistical barriers may manifest when resource constraints meet scheduling difficulties against the background of a gestational age limitation, as illustrated by this KI from Rwanda:

The day will end before [the patient is] seen … because it's a domestic worker, they have to find another time to ask for permission to go to the hospital. And then you'll find they're waiting another week before they can get another day off ... we've seen as high as four weeks [before they can be treated] ... if they wait the four weeks and they're outside of the gestational age that it's allowed, they can't get (abortion) anymore. RW7

This example also demonstrates how limited personal agency significantly deters care under the HE. In addition to an individual's occupation, citizenship can influence access. In Ireland, for instance, recent immigrants are not eligible to receive NGO funding available to Irish citizens seeking care that requires travel:

Many of the cases after 12 weeks under HE are women who do not have residency papers in place… asylum seekers … that could be very difficult because they don't necessarily have the right to travel. IR1

An additional Irish KI emphasized how social and economic vulnerabilities further restrict HE access for marginalized groups:

There's no recognition at all in the current legislation or definitely by practitioners that [social and economic needs] need to be considered … real life implications of an unwanted continued pregnancy for someone who's … on the edge of poverty or experiencing homelessness or facing [issues with] immigration status. IR2

A common belief among KIs was that most providers continue to follow outdated, restrictive guidelines, as in South Korea and Rwanda. While younger physicians are more informed about the law, limited training curtails policy awareness and provider availability. For example, in Rwanda, a participant stated:
I think it's [difficult to qualify for the HE] because [physicians], they don't… receive trainings on it. RW1

Even when physicians were adequately trained and comfortable providing care under the HE, other members of the care team could present barriers, increasing burden on providers and contributing to delays in care:
[Even] if the medical doctor is comfortable to give safe abortion and the midwife or nurses are not comfortable, that will automatically break the chain of giving safe abortion services. You find yourself educating and giving information to those midwives or nurses to get comfortable to give those medications. RW2

Provider stigma can manifest as deliberately misinforming patients or withholding legal information, as discussed in Colombia, Peru, and Ireland, or mistreating patients who seek abortion care under the HE, as detailed in Colombia, South Korea, and Rwanda:
The only way that they have nowadays to prevent abortions is discouraging women at the services … they mistreat them. They tell them it's still a crime. They tell them they are going to call their families. So, they leave. CO

Mentioned by all participants, societal stigma was also believed to contribute to a lack of agency, poor awareness of the law, and fear in patients, sometimes resulting in unsafe abortion. For example, a participant in Rwanda mentioned:

Either because of a lack of awareness of it or just not wanting to do the whole process, [patients] won't go through [attempting appeal] … when they have been refused at hospital or denied safe abortion under the HE … they end up going through the unsafe abortion route. RW7

Participants from all countries cited the divide between public and private hospitals as an enabler of inconsistent HE implementation between sectors. Private hospitals vary in their provision of abortion care, with some offering services more liberally at high cost, while others – particularly those with religious affiliations – refuse HE care even when legally mandated.
Medical societies, governmental organizations, and public officials play salient roles in abortion legislation and policy, sometimes creating care obstacles. For example, in South Korea, some medical societies seek to prevent medication abortion legalization, presumably based on lost personal profit:
The Association of Obstetricians and Gynecologists in South Korea are urging the government not to allow the medical abortion pills … Because if the government allows the medical abortion pills they might lose some (expensive) surgical abortions. SK2

Moreover, in Ireland, one participant noted that legalizing abortion up to 12 weeks gave health officials a sense of progress that stalled further reforms (IR1).

Promising practices and care facilitators

Facilitators included stigma-combatting awareness for patients and providers, clear guidelines promoting provider protection, clinical training programs, and key players committed to access.
Governments, court systems, and advocacy organizations can all play critical roles in promoting expansive interpretation of HE/LE. Participants called for evidence-based clinical guidelines from governments and medical societies, not lists of qualifying health conditions, which are predictably inadequate, to bolster providers' sense of personal security when giving care. In Colombia, a participant

relayed that government policy, paired with Court interpretation, delineated a clear and expansive HE definition.

Participants cited collaboration with governments and NGOs as helpful, especially in buttressing provider training. One Rwandan KI discussed building networks across allied health and advocacy organizations on the ground that are vital to generating public pressure:

All SRH [sexual and reproductive health] groups are also active … it's very important to partner with the local organizations also advocating for changing practice. RW6

Values clarification training has been demonstrated to transform attitudes on abortion. For example, Rwanda's Ministry of Health and Medical Doctors for Choice Rwanda jointly implemented such a training program:

[we] trained almost 600 young physicians in the last year. The training was about the legal, the medical aspects of abortion, but also values clarification. And later I could call a physician from anywhere because 600 people, when they are deployed, eventually go to almost all the district hospitals in the country … these young people are more willing to provide services than the older providers. RW1

Similarly, in Colombia, increased training was associated with less stigma and more positive provider attitudes:

At first those trainings were very difficult … [participants said] How can you sleep at night when you have murdered so many babies? But little by little, all of those trainings [with a values clarification and HE component] … the example was set … every year it was less hard, I could feel it. CO

Although one participant disagreed:

rather than prioritizing education and changing attitude or behaviors among individual healthcare providers … the priority should be on the legal and policy form because we can't … change individuals' belief systems. SK1

Participants called for strengthening national and international partnerships to discuss strategies to broaden access, encourage evidence-based medicine, facilitate training, and provide supplies and educational material. A participant in Ghana reiterated the purpose of international collaboration is to:

Encourage best practices and…to learn from each other sharing of best practices changes…between different countries. GH

This KI clarified that collaboration was most effective when also paired with:

national champions to be able to advocate [and have a] bit of voice. GH

KIs identified goals to reduce barriers to patient care and increase patient awareness of policy. One group in Rwanda is attempting to accomplish this by creating a cellphone application that connects patients to providers who provide timely, safe HE abortion care. Some Rwandan providers have started implementing optional consultation with

Psychologists as well as midwives or nurses…to comfort [the patient] and then to let her know that safe abortion is like other treatment that you can get at the hospital. RW2

Several participants felt widespread public health awareness campaigns are the best way to target patients and increase agency:

Public awareness campaigns with both the duty bearers and the rights holders or legal rights and safe options could go a long way. RW7

A participant described what set Colombia apart from other countries, and enabled an interpretation of the HE that resulted in the ultimate legalization of abortion:

in a lot of places, they tell me … people are going to get scared … and not help us implement legal abortion … We were always open and clear about what the HE had to be about. And we were not afraid of people rejecting legal abortion as a whole because we were interpreting the HE too widely. So, I think that it takes kind of courage, but also consistency. CO

Discussion

Together, the literature review, desk reviews and KI interviews point to significant barriers that hamper HE/LE implementation and result in significant delays in care. These delays have been associated with higher rates of unsafe abortion and maternal morbidity and mortality in varied contexts.[47–50]

Spotlight: Rwanda

We focus on Rwanda, as the country is in the midst of significant policy change regarding abortion. In 2003, because of poor reproductive health outcomes across Africa, the African Union released the Maputo Protocol, which affirmed the right to abortion in cases of rape, incest, and threat to the health of the woman.[57] Subsequently, seven African countries, including Rwanda, have changed their laws to include an HE/LE clause.[58] In 2012, Rwanda explicitly affirmed the HE in law, but required patients to obtain court approval; this requirement was removed in 2019 by Ministerial Order.[59] A new 2025 law removes parental consent requirements for contraception in adolescents 15 and older, further expanding access.[60] Despite liberalization of the law, our analysis confirms continued inaccessibility of abortion under the HE/LE for many in Rwanda. Yet there have been significant advances, such as training on legal and medical aspects of abortion, values clarifications, development of telemedicine, the expansion of a physician workforce that now includes roughly 600 willing providers, and task-sharing with midwives to bolster provider capacity. Barriers that persist include conscientious objection and inadequate recognition of physical and mental health as legitimate grounds for HE. KIs suggest implementing consistent, nationally institutionalized training for all healthcare workers, including pharmacists (RW2), and integrating "E-governance" systems for abortion reporting to ensure real-time accountability and reduce record manipulation (RW1). Monitoring and enforcement could be achieved by building on Rwanda's existing nationwide maternal death audit.

This analysis confirms that HE abortion laws often do not effectively utilize the WHO's holistic definition of health.[12] All six countries permit abortion when there is a threat to mental health, but most fail to extend this to social health threats. Lack of guidelines or clarity about the interpretation of HE/LE laws has resulted in preventable harm, as seen in Rwanda and Ireland, where mental health is often excluded, and in Ireland, where fear of criminalization drives non-provision for those with complications past 12 weeks gestation.

The consequences for patients reported by KIs mirror those found in quantitative investigations of the effects of abortion bans, such as those in the U.S., reporting associations between restrictive laws and maternal[50–53] and infant[29,54,55] mortality. Globally, unsafe abortion, which many of our informants believed was increased with unclear and restrictive HE/LE policy, accounts for 13% of global maternal mortality, and disproportionately affects those living in developing countries with restrictive abortion laws.[56]

Common barriers and facilitators emerged from the interviews despite varied cultural and resource contexts. LMICs experienced material and personnel shortages and geographic limitations to a more severe degree. Aligning with the literature, barriers to HE/LE care disproportionately affected disadvantaged communities, including immigrants, within all countries.[34] Oftentimes, informants discussed how access reflected gendered and income-driven power dynamics that limited patient autonomy and agency, similar to how researchers have situated abortion access within the broader context of structural inequality.[61,62]

Promising practices that support legal and safe abortion noted by KIs build upon existing literature and include provider training with values clarification, supportive government and advocacy engagement, as well as technological initiatives for patient awareness and ease of care. Collective action by stakeholders on local, national, and global scales yields the potential to generate an exchange of clinical, legal, and policy strategies to improve patients' health and well-being via expanded abortion access and strengthened HE enforcement.

Strengths

To our knowledge, this is the first study to include advocates as KIs on this topic, adding a unique and important perspective. Interviews with KIs from diverse countries revealed commonalities despite varied local contexts.

Limitations

Although study subjects reported on their perceptions of patient experiences, we did not interview patients directly and thus have a limited understanding of affected individuals' experiences. The sample is not representative, and purposeful recruitment of interviewees may have led to a sample of those attuned to the limitations of current HE/LE laws. While translators were offered to participants, interviews conducted primarily in English may have led to simplification or misunderstanding.

Policy implications

These findings offer models for countries and advocates seeking to improve access to abortion using HE laws and policies. Successful strategies may provide a framework for tangible action, which can then be adapted to a country's political, legal and social landscape. For example, the Ministries of Health in Colombia and Rwanda, created guidelines, rather than lists of eligible health conditions; this has increased provider willingness to deliver care. In Colombia, the explicit inclusion of mental health as a permitted exception has boosted care utilization[12]. Colombia, Ghana, and Rwanda also found that clinical and values clarification trainings for providers were associated with a rise in provider willingness and workforce supply, and the development of new reproductive health champions. The most successful interventions demonstrate deep understanding of and responsiveness to country-specific context paired with a willingness from public and private sector advocates to adapt to changing environments. For example, the inclusion of telehealth to increase patient awareness in Rwanda following COVID-19 and provider efflux, indicated a clear understanding of unmet need and a creative solution to improve access.

Conclusion

Subsequent studies should seek to improve data surveillance on HE/LE care in countries, follow up outcomes and quantify HE/LE abortions and denials.Patient experiences with HE/LE care should be included to assess additional barriers to care. Special attention should be given to recruiting participants from countries where abortion is highly stigmatized to understand their experiences with the HE/LE. Facilitators such as clear legal guidelines, provider training with values clarification, supportive government and advocacy engagement, and patient awareness initiatives have shown promise in expanding safe, timely, and equitable care that could reduce maternal mortality and morbidity. Sustained collaboration among national and international stakeholders, encouraging best practices and sharing successful strategies, could be instrumental in ensuring that HE/LE laws fulfill their intended role in protecting patients' lives and health.

Colombia

In 2006, the Constitutional Court decriminalized abortion in cases of rape and incest, health and/or life risk, and lethal fetal abnormalities[40]. This decision, a direct result of advocacy by feminist groups framing abortion through a human rights lens,[63] paved the way for the *Causa Justa*[64] movement and the 2022 Constitutional Court ruling which decriminalized abortion for any reason up to 24 weeks, with exceptions at later gestational ages for rape/incest,health/life, and fetal abnormality.[40] Now an example of one of the least restrictive abortion policies in Latin America, it has become commonplace for those seeking abortion from neighboring countries with restrictive abortion legislation, such as Venezuela, to travel to Colombia for termination of pregnancies.[65] Both medication and surgical abortion are legal, provided by both physicians and midwives, and are free of cost[49] through EPS services that insure 98% of the country's population.[66] However, Colombia is not immune to opposition that has gained momentum in Latin America following the 2022 overturning of *Roe v. Wade* in the United States;[67] the backlash comprises proposed legislation and legal complaints seeking to restrict abortion access.[68,69] While geographic barriers and provider and patient stigma serve as significant barriers to care, efforts like telemedicine services seek to improve access.[70–72]

Ireland

In 2018, the Irish public voted via referendum to overturn the Eighth Amendment, a 1983 amendment that had allowed abortion only when the life of the pregnant woman was directly threatened.[73] Following the referendum, abortion became free and legal in Ireland up to 12 weeks, with exceptions at later gestational ages in instances of danger to health or life and fetal abnormalities.[74] Thus, while first-trimester abortion care has become widely available, after 12 weeks, abortion is permitted only in instances of fetal abnormalities that are "likely to lead to the death of the foetus either before, or within 28 days of birth"[75] or health or life endangerment of the pregnant woman and requires sign-off from two medical practitioners (in many instances hospitals require multi-disciplinary team meetings with additional providers).[76] However, abortion under the HE is difficult to obtain. Due to fear of liability and conscientious objection from providers and significant logistical challenges causing delays, many require continued travel to the UK to receive HE/LE care.[74,75]

While infrastructure exists to support abortion care before 12 weeks, abortion care after 12 weeks, when the health and life exception is applied, is lacking. In 2020, only 10 out of 19 maternity care centers (centers qualified to perform abortions beyond 12 weeks)[77] in Ireland were offering abortion services. While this number has improved,[78] logistical challenges remain. Statutes require conscientious objectors to arrange care through another provider,[75] objectors are not required to register under current laws or guidelines,[77] limiting effective enforcement. The current law also requires a three-day waiting period.[74] Despite vast expansions to abortion access in Ireland following the 2018 referendum, significant challenges, including provider beliefs, and logistic challenges,[77] prevent accessibility of abortion care after 12 weeks through the HE.

Peru

Peru remains an exception to Latin America's "Green Wave"[79] which has seen liberalized abortion in several countries. Legal abortion in Peru, referred to as therapeutic abortion, is allowed only when the health or life of the pregnant woman is at risk.[80] Despite significant restrictions, abortion in Peru remains common. 19% of women in Peru across socioeconomic status have an abortion at some point in their lives[81] and 48% of all unintended pregnancies are estimated to result in abortion.[82] Many are conducted unsafely, however, contributing to an estimated 16% of maternal mortality in Peru.[83] Restrictive hospital policies, limited authorized and trained providers, geographic, and financial constraints, often prevent utilization of legal avenues.[84,85] The influence of U.S.-based religious organizations in anti-abortion lobbying and conscientious objection by providers is another significant care barrier.

In response to two landmark international court decisions centering inaccessibility of HE/LE abortion care, KL v. Peru[86] and LC v. Peru,[87] and recommendations from the United Nations Human Rights Committee, the Peruvian government released the 2014 Therapeutic Abortion Guidelines,[88] seeking to clarify exceptions under the law. The guidelines detail medical indications for legal abortion, such as ectopic pregnancy and hydatidiform moles. Despite UN recommendations, Peru has not expanded access to rape, incest, or fetal abnormalities. Of note, the guidelines do allow for medication abortion in the first 12 weeks of pregnancy under the health and life exception; however, challenges to consistent enforcement and cost limit access.[89] In 2023, the Peruvian Congress passed the "Law Recognizing the Rights of the Conceived Child"[90] which many fear will threaten access to abortion under Peru's already restrictive legal landscape.[91]

Ghana

In 1985, Ghana amended the Criminal Code[92] of 1960 to decriminalize abortion under specific circumstances, including rape, defilement, or incest, risk to the woman's life or physical or mental health, or substantial risk of serious physical abnormality or disease to the child. The amendment mandated that a registered medical practitioner in a government or registered private hospital or clinic perform the abortion. Because "registered medical practitioner" was undefined, it was interpreted as doctors only; a 2006 operational directive expanded eligibility to

nurse-midwives, community health workers, and medical assistants, but poor dissemination has left many of these potential providers unaware.[93] As a result, of 200,000 abortions[94] that occur annually, 71% are considered illegal,[94] often due to being performed outside approved medical settings or by untrained individuals. Unsafe abortions account for 11% of maternal deaths[95] in the country. Data from the 2017 Ghana Maternal Health Survey, which employed a large, nationally-representative sample, indicate that 69% of women[96] had a surgical-based procedure, while 31% used herbal or medication-based methods. Safe abortion costs can be prohibitively high, especially in private facilities;[92] Ghana's National Health Insurance Scheme, which covers over half of the population, does not include abortion costs.[94,96] Stigma is also a barrier; a Global Doctors for Choice-Ghana study found that over 50% of trained healthcare providers in public, private, and faith-based facilities objected to providing legal abortion services, often due to moral or religious beliefs, linking conscientious objection to unsafe abortion-related mortality and higher patient volumes for non-objecting providers.[97] Additionally, anti-abortion hospitals administrators neither facilitate training nor procure supplies and equipment for other providers to perform abortions.

Rwanda

As of 2018, abortion is legal in five specific exceptions: rape, incest, forced marriage, risk to the health of the pregnant person or fetus, or if a child is pregnant and less than 22 weeks' gestation.[8] Ministerial Order No. 002/MoH/2019 removed the need for court approval, easing access;[98] however, barriers to implementing abortion under the health and other exceptions endure. Two recognized medical doctors – one being an OB/GYN – must confirm that a risk to health applies.[99] While midwives are the primary providers in many areas via internal task sharing, they are not eligible abortion authorizers under the Ministerial Order.[99] A 2024 Ministerial Order revision further extended access from hospitals and polyclinics to approved health centers.[99] Despite reforms, nearly half of abortions[100] are performed by untrained individuals. Of poor rural women, 74% resort to unsafe methods,[100] leading to an estimated 300–400 maternal deaths annually.[101] From 2018-2023, health facilities recorded 5,748 safe abortions, with 45% occurring in Kigali and a majority due to rape (62%).[102] Providers are clustered in urban areas although the majority of the population is rural.[101] Disparities persist in districts served by faith-based hospitals, which refuse to provide abortions, even under the HE, but may offer postabortion care.[102,103] Additional delays are imposed due to the Community-Based Health Insurance system's requirement for patients to first visit a health post for the abortion to be covered, increasing travel, gestational age, and medical risk. Mifepristone remains unregistered (albeit anecdotal evidence suggests its limited use at public hospitals),[104] while misoprostol is included in national protocols.[105] Proactive initiatives to protect health include implementing nationwide maternal death audits[106] and strengthening provider capacity through local medical doctor networks, including OB/GYN societies[107–109] and international partnerships.[110] Not all hospitals provide comprehensive abortion training; instead, trainees rotate at specific hospitals to gain this experience.[111]

South Korea

Barriers to abortion access in South Korea are not unique to implementing a HE. Only recently did steadfast advocacy by a few progressive, human rights- and public health-focused professional groups[112] prompt the South Korean Constitutional Court's 2019 ruling that the country's abortion ban was unconstitutional.[113] The National Assembly subsequently failed to pass any of the seven bills proposed to regulate abortion post-decriminalization, leaving providers with no formal gestational limits or structured guidelines for providing care, regardless of life- or health-threatening pregnancy complications.[113] Many physicians default to the outdated 1973 Mother and Child Health Act, which had permitted abortion only in cases of serious maternal health or life exception, rape, incest, communicable infectious disease risking the embryo, and parental heritable disease or disability up to 24 weeks gestational age with male spousal approval.[114] In practice, abortion services are primarily provided by urban private clinics for

profit.[115,116] Although official data on abortion-related deaths is lacking, 169,000 abortions were estimated to have been performed in 2010.[117] Medication abortion remains limited, as mifepristone is unapproved and access to platforms like Women on Web is blocked.[118,119] Despite these restrictions, roughly 8% of women aged 15–40 reported using abortion pills in 2019 voluntarily, sourcing them from clinics, domestic sellers, or international providers.[118,120] The country's physician shortage- 2.5 doctors per 1,000 people- and lower density of emergency facilities in rural regions delay critical care access.[121] National health insurance excludes abortion, allowing private providers to charge market rates with no ceiling: over half of patients reportedly pay more than 800,000 won per procedure.[122] Conscientious objection is common among Christian providers,[123] and up to 30% of OB/GYNs[112] reportedly refuse to provide abortions, even when a patient's health is in jeopardy.

Poland and Malta

Poland and Malta serve as important case studies where public pressure to change restrictive abortion laws has been notable. Poland permits abortion only when a woman's life or health is at risk or when the pregnancy results from a criminal act such as rape or incest. It is one of only four countries in the world to have recently rolled back abortion rights, abolishing the provision that allowed termination for grave, irreparable fetal defects in 2020. In September 2024, the UN CEDAW Committee denounced Poland's restrictive law as a severe human rights violation, noting that legal abortion is almost impossible to obtain, leaving women in dire circumstances.[124,125] Women have died after being denied critical, life-saving care, illustrating the dangers of these laws. The Committee called for comprehensive reform, including decriminalization, an immediate moratorium on abortion-related penalties, improved access to safe services, and expanded sexual and reproductive healthcare.

Despite popular support for liberalization, reform efforts have stalled. Polish Prime Minister Donald Tusk promised to allow abortion up to 12 weeks, but the proposal failed in parliament. In August 2024, the Health Ministry issued new guidelines allowing a single specialist's recommendation as sufficient grounds for legal abortion, but implementation remains uneven. Health Minister Izabela Leszczyna acknowledged that most doctors and hospitals still seek additional opinions, delaying care. To improve compliance, hospitals that deny abortion to women with valid referrals may now face fines of up to 500,000 zlotys (about €115,000) or lose their National Health Fund contracts.[126]GDC previously described the emblematic case of Alicja Tysiąc, who in 2000 was denied an abortion despite risk of severe vision loss.[9] In 2005, Tysiąc and the Center for Reproductive Rights brought her case before the European Court of Human Rights, which in 2007 ruled that Poland had failed to meet its obligations under Article 8 of the European Convention on Human Rights.

The year after fetal anomalies were removed as grounds for abortion, the 2021 death of Izabela, a 30-year-old hospitalized at 22 weeks with PPROM and confirmed fetal defects, triggered nationwide protests.[43] Doctors confirmed fetal anomalies and delayed termination; she died of septic shock within 24 hours. In July 2025, a Polish court sentenced two doctors to prison and gave a third a suspended term for endangering her life. In 2023, another woman, Dorota Lalik, died under similar circumstances after her 20-week pregnancy ruptured membranes; admitted to a Catholic hospital, she was treated "conservatively" – observed without medical intervention – becoming septic and dying.[44]

In Malta, American tourist Andrea Prudente experienced ruptured membranes at 16 weeks in 2022. Because even life-saving abortion was illegal under the HE, she could not be treated and was transferred to Spain for termination. Public outcry led to Bill 28, which permits abortion only in life-threatening complications with approval from three specialists, or from a single doctor in emergencies.[45] While this represents legal change, its restrictive wording raises concern. Monitoring implementation in both Poland and Malta will be essential to assess whether narrow interpretations continue to result in preventable deaths.

Conflict of interest

Team members have no conflicts of interest to report.

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Contributions of Authors

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Supplementary Table 1: Country-specific health and mortality data by most recent data (Year)[40,63,64]

Country	Maternal Mortality Rate	Infant Mortality Rate	Physicians /10k	Nurses & midwives /10k	Healthy life exp. At birth	Gov. health exp. As % of GDP (%)	Skilled birth (%)	Family Planning needs met (%)	Abortion rate/ 1K ages 15-49
Colombia	75 (2020)	7 (2020)	24.5 (2021)	14.5 (2021)	65 (2021)	19 (2021)	98 (2021)	86.6 (2015)	27 (2015–2019)
Ghana	263 (2020)	21 (2020)	1.4 (2022)	37.9 (2022)	57.9 (2021)	8.2 (2021)	88 (2022–23)	49 (2022)	37 (2015–2019)
Ireland	5 (2020)	2 (2020)	40.6 (2021)	143.4 (2022)	70 (2021)	21 (2021)	100 (2020)	94 (2023)	Unavailable
Peru	69 (2020)	8 (2020)	16.2 (2022)	26.6 (2022)	63 (2021)	16.9 (2021)	95 (2023)	67.2 (2023)	42 (2015–2019)
Rwanda	259 (2020)	17 (2020)	1.2 (2019)	9.3 (2019)	58.7 (2021)	9.5 (2021)	94 (2019–20)	72.1 (2019)	28 (2015–2019)
South Korea	8 (2020)	1 (2020)	25.2 (2021)	89.1 (2021)	72.5 (2021)	14.8 (2021)	100 (2021)	74.1 (2021)	21 (2015–2019)

Notes:

*Maternal mortality rate, as calculated by the WHO: The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period.

**For Ireland, the percentage of reproductive-age family planning needs mmet was calculated by subtracting the percentage of unmet family planning needs recorded in the European Contraception Policy Atlas from 100; the WHO did not report this metric for Ireland