Abortion Governance in Legal Permissive Frameworks: The promise of abortion decriminalization

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Abstract

English: The literature on abortion politics closely follows trends in legislative change, celebrating the victories of feminist social movements and warning against potential backsliding. While most countries have some type of law governing abortion, rarely does the abortion literature consider which legal frameworks would be best at ensuring abortion access. This thesis addresses this gap by comparing legal frameworks from countries that demonstrate a desire to allow access to abortion care, that is Australia, Canada and Ireland. Through a normative comparative case study analysis and process tracing, I determined two metrics to evaluate access to abortion care: accessibility and stigma. As a result, this thesis argues that, compared to abortion liberalization and partial decriminalization, full abortion decriminalization, based on the Canadian case, is the most promising regulatory framework to guarantee abortion access. This thesis not only contributes meaningfully to academic debates but also offers actionable insights for policymakers and advocates seeking to expand reproductive rights globally. Canada's experience, though unique, shows potential to enhance abortion access without direct legislative intervention, effectively challenging the traditional legal paradigm.

French: La littérature sur la politique de l'avortement suit de près les tendances des changements législatifs, célébrant les victoires des mouvements sociaux féministes et mettant en garde contre les risques de régression. Bien que la plupart des pays disposent de lois régissant l'avortement, la littérature sur ce sujet considère rarement quels cadres juridiques seraient les plus efficaces pour garantir l'accès à l'avortement. Cette thèse comble cette lacune en comparant les cadres juridiques de pays qui manifestent une volonté de permettre l'accès aux soins liés à l'avortement, à savoir l'Australie, le Canada et l'Irlande. À travers une analyse normative comparative de cas et de "process tracing", j'ai identifié deux critères pour évaluer l'accès aux soins d'avortement : l'accessibilité et la stigmatisation. En conséquence, cette thèse soutient que, comparée à la libéralisation de l'avortement et à la décriminalisation partielle, la décriminalisation complète de l'avortement, basée sur le cas canadien, constitue le cadre réglementaire le plus prometteur pour garantir l'accès à l'avortement. Cette thèse contribue non seulement de manière significative aux débats académiques, mais offre également des recommandations concrètes aux décideurs politiques et aux défenseurs des droits cherchant à élargir les droits reproductifs à l'échelle mondiale. L'expérience canadienne, bien que singulière, démontre le potentiel d'améliorer l'accès à l'avortement sans intervention législative directe, remettant en question de manière efficace le paradigme juridique traditionnel.

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List of abbreviations (in order of appearance)

US: United States

SMA: Self-managed abortion

NCS: Normative Case Study

ARC: Abortion Rights Campaign

TFY: Together For Yes

ACT: Australian Capital Territory

WA: Western Australia

FQPN : Fédération du Québec pour le planning des naissances

PLDPA: Protection of Life During Pregnancy Act

WHO: World Health Organization

PPSN : Personal Public Services Number

GPs: General Practioners

MVA: Manual Vacuum Aspiration

HSE: Health Service Executive

WoW: Women on Web

WHW: Women Help Women

NSW: New South Wales

TGA: Therapeutic Goods Administration

NT: Northern Territory

SA: South Australia

PBS: Pharmaceutical Benefits Scheme

EMA: Early medical abortion

TAC: Therapeutic Abortion Committee

ARCC: Abortion Rights Coalition of Canada

AB: Alberta

MN: Manitoba

ON: Ontario

SK: Saskatchewan

BC: British Columbia

NB: New Brunswick

PEI: Prince Edward Island

QC: Quebec

1. Introduction

Over the past five decades, the issue of abortion has prominently featured in political debates, the media, and the agendas of both national and international organizations advocating for women's reproductive rights (Rebouché 2014). Seeing the recent backsliding of reproductive rights in the United States (US), Poland, El Salvador and Nicaragua, there is a pressing urgency to monitor abortion trends around the world. For example, the *Dobbs v. Jackson's Women Health Organization (2022)* US Supreme Court decision that the US Constitution does not protect the right to abortion ushered in a new era of uncertainty around reproductive rights in the US. The recent reelection of Donald Trump is likely to reignite contention around the topic. The literature plays a fundamental role by closely following legislative changes. Additionally, it informs the general population, on one hand warning against potential backsliding (Ehsassi 2023; Kubal 2023; Brysk 2024) and, on the other hand, celebrating the victories of feminist social movements (Hurst 2020; Bohn et al 2022; Braine 2023; Daby and Moseley 2023). Yet, the literature seldom examines the legal foundations underpinning these changing regulations to assess how effectively they provide comprehensive abortion care. Thus, this thesis is guided by the question: Which current model of abortion governance best guarantees pregnant individuals' comprehensive access to abortion care?

This thesis makes the normative argument that abortion decriminalization, as seen in Canada, is preferable to other liberal frameworks, that is abortion legalization and partial decriminalization. This will be demonstrated through a normative comparative study analysis of three countries with permissive legal frameworks: Australia for its unique partial decriminalization, Canada as the only long-lasting case of full decriminalization, and Ireland for its recent legalization of abortion. This thesis takes on the project of examining the limitations of

the law as women may fail to meet standards of care, experience stigma and face criminal sanctions, even if abortion is legal. It also evaluates in detail the 'counterintuitive' framework of decriminalization, which challenges conventional assumptions by demonstrating that abortion care can be safely and effectively provided without the formal legal oversight typically considered necessary for ensuring accessibility and safety. By removing abortion from the criminal code, as seen in Canada, this approach relies on existing health regulations to ensure professional standards (Dwyer et al 2021), contrary to the traditional legal paradigm that frames abortion as requiring dedicated legislation. As such, I assert that protections under health law are more than enough to regulate abortion care as they already ensure patient safety, professionalism, and clinical best practice. Additionally, I argue that other legal frameworks are detrimental to abortion access, especially to women seeking abortions, but also to everyone assisting in the delivery of the care. Even if these countries have a desire to guarantee access to the care, the criminal regulations specific to abortion found in these legal frameworks contribute to abortion exceptionalism, imposing unnecessary restrictions, creating a chilling effect on providers and further exacerbating abortion stigma (Shah and Jacob 2023). In brief, this thesis defends that abortion decriminalization is a promising avenue for policymakers and advocates working to expand abortion access globally, suggesting that a shift away from punitive legal structures toward decriminalization could better serve women's reproductive health and autonomy.

This project is grounded in the well-established (and yet normative) position that abortion access is a social and political good. By abortion access, I mean that women and individuals with

the capacity to become pregnant[1] are entitled, first, to make an independent decision regarding their pregnancy and, second, to obtain the according health services. Consequently, if the termination of pregnancy is desired, individuals should have access to safe, legal, and affordable abortion care. Abortion access also includes the autonomy and privacy of individuals in making choices and getting quality services related to their reproductive health.

My work makes four contributions to the literature on abortion politics. First, this research will be the first to present a comparative analysis of Australia, Canada, and Ireland based on their abortion regulatory framework. Second, this proposal will make an empirical contribution by contrasting how abortion legalization, partial decriminalization, and full decriminalization guarantee the provision of abortion access. Third, this project also makes a theoretical contribution by scrutinizing the relationship between the law and abortion access in practice. Fourth, this proposal makes a political contribution by analyzing ways to enforce abortion outside the norm of regulating abortion through the law. I argue that abortion decriminalization is the best framework to regulate abortion. It is a promising avenue for other countries and for pro-abortion movements advocating to enhance access.

This thesis is structured as follows. First, I will start by outlining the literature on abortion politics. I will identify the three predominant regulatory models of abortion governance: abortion prohibition, abortion legalization, and abortion decriminalization. I will focus on how the literature informs us about the ways in which these legal frameworks impact access to abortion care and address various gaps. Second, I will lay out my methodological choices. I

[1] I acknowledge that abortion access is not an issue exclusive to women. As non-binary and trans people can also be pregnant, they are subjected to the same legislations. However, they may be overlooked in abortion debates. Nonetheless, this thesis will mostly refer to the category of people subject to abortion laws as "women" because I follow the same feminist argument as Briggs (2018) and Browne and Calkin "that the laws intended to restrict reproductive freedoms target women as a social group and as a means of sexual control" (2020, 4).

chose a comparative case study approach to demonstrate how abortion decriminalization best regulates abortion. Three cases were selected due to their different liberal legal systems: Ireland for its abortion legalization, Australia for its partial decriminalization, and Canada for its full decriminalization. I will trace the process through which each of these legal frameworks came to be and pay attention to two specific metrics: accessibility (i.e., health regulations, cost and geography) and stigma. Third, I will present the research findings. Each case will be examined according to these metrics in the following order: Ireland, Australia and Canada. Fourth, I contribute to the growing scholarship advocating for the full decriminalization of abortion by arguing that it represents a superior model of abortion governance. By removing abortion from criminal law and treating it like other healthcare services, decriminalization enhances access and supports reproductive autonomy. My work builds on the arguments of Gordon and Johnstone (2024), emphasizing that Canada's unique experience offers valuable insights for other countries. Beyond serving as a regulatory framework, Canada's model can also be leveraged as a powerful advocacy tool to advance sexual and reproductive rights globally.

2. Literature review

The literature on abortion has focused namely on morality (Thomson 1971; Boonin 2003; Greasly 2017; Walbert and Butler 2021; Schoen et al 2022), historical context (McBride 2008; Hildebrandt 2015; Stettner et al 2017; Muldoon 2021), access expansion through feminist social movement victories (Staggenborg 2000; Fischer 2020; Duffy 2024) and backsliding (Śledzińska-Simon and Wójcik 2024). There has been limited focus on examining the legal approaches to regulate abortion. Most countries have some form of abortion law dictating the provision of abortion care. Some focus on restricting access, while others aim at allowing access to care. However, rarely are legal frameworks evaluated and compared to determine which best

guarantees comprehensive care. This thesis addresses this gap in two ways. First, it examines the three main approaches to abortion governance: abortion prohibition, legalization (varies from exceptions to liberalization) and decriminalization, demonstrating how their regulatory framework impacts access. Second, it turns to the growing literature on abortion decriminalization based on Canada's alternative, non-legal approach to regulate abortion.

2.1. Problems of abortion prohibition

Numerous countries have adopted a regulatory framework that completely bans abortion. Examples include Egypt, El Salvador, Malta, Nicaragua, and Poland. However, there is a consensus in the literature that the prohibition of abortion, namely by making abortion a criminal act, causes tremendous harm. First, this legal framework marks assisting, receiving, or providing an abortion will be followed by criminal sanctions for either or both women and providers. Prohibition of abortion often pushes women to obtain illegal care, as is the case in El Salvador (Smyth 2020). When experiencing miscarriages or complications due to unsafe care, women are brought to hospitals where they are questioned by law enforcement without proper legal representation. In the past 20 years, more than 180 Salvadorian women in this situation have been sentenced to up to forty years in prison for having had abortions (Elbaum and Chiwaya 2022). Most of these women were from poor and uneducated backgrounds, showing how socioeconomic inequalities further endanger those without the means of bypassing these restrictive legal systems. In the United States, the reversal of *Roe v. Wade* in the *Dobbs v. Jackson Women's Health Organization* Supreme Court decision in June 2022 has led to 14 states prohibiting the provision of abortion. The repercussions on women are immense, forcing them to travel across state lines and increasing their concerns about the legal issues they could encounter. In the United States, "at least 61 people were prosecuted for allegedly trying to self-manage

abortion between 2000 and 2020" (Marshall 2024). We can only imagine how that number will increase after the *Dobbs v. Jackson Women's Health Organization* decision as state laws get stricter. Joanna N. Erdman and Rebecca J. Cook, in their piece on the influence of international human rights law on abortion regulations, argue that this type of legal framework is discriminatory according to human rights standards as it criminalizes a health procedure that is only needed by individuals who can carry a fetus, mostly women (2020, 19). Further, it restricts these individuals from exercising reproductive autonomy and attaining full gender equality. It instrumentalizes and politicizes pregnant bodies by moving their right to terminate a pregnancy into the hands of the state. In fact, it reinforces feminine ideals of motherhood, hinting that individuals with the capacity to carry a fetus can only freely exercise their sexuality when they intend to procreate (Browne and Nash 2020).

Second, there is also a consensus that abortion prohibition does not stop abortions from being practiced. Evidence shows that legal regulations that criminally penalize women accessing abortion and/or physicians providing abortion care do not eliminate the practice of abortion; instead, they go through illegal means to terminate their pregnancy, such as travelling abroad, illegally importing abortion pills, contacting underground networks, among others. Indeed, in Poland, following the abortion ban, illegal pathways emerged through 'underground' clinics and the distribution of abortion pills (Calkin and Kaminska, 2020). In Malta, even with the continued ban on abortion, its occurrence through means such as travel or online purchase of abortion pills, demonstrates that abortion is effectively taking place in practice (Harwood 2023). In many countries with restrictive frameworks, including Poland, transnational networks of pro-choice activists also facilitate travel to other countries (Duffy 2020). Emma Campbell, Maureen Mansfield and Fiona Bloomer confirm that while the illegality of abortion and the risk of

criminality increase the challenges in accessing abortion, it does not prevent anyone from seeking it (2022, 150).

2.2. Abortion legalization

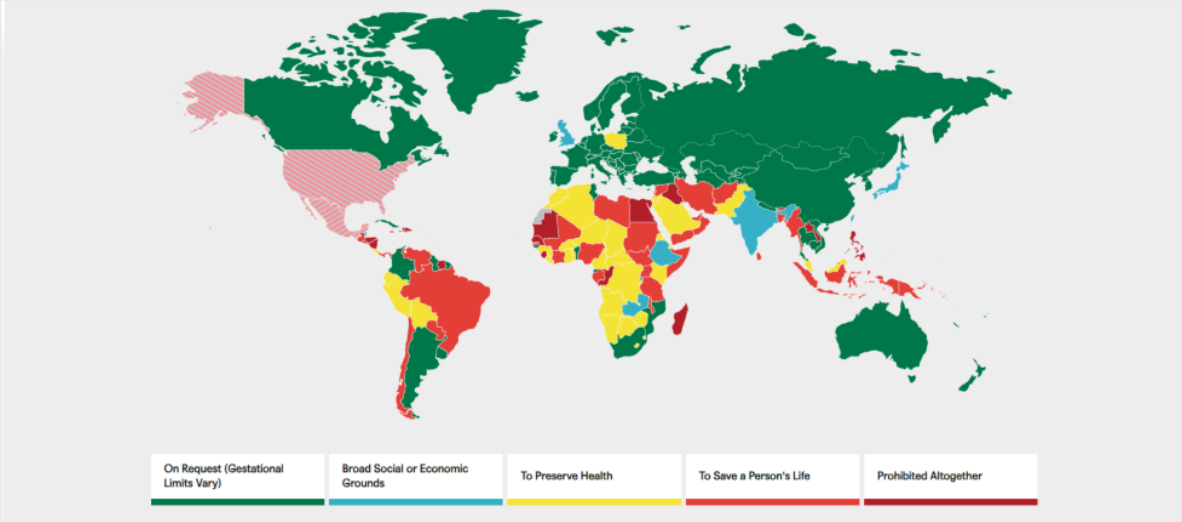
The literature informs this project on abortion legalization in different ways. On one hand, the ongoing criminalization of abortion limits women's reproductive autonomy, puts individuals at risk of criminal penalties and produces stigma around the procedure. On the other hand, abortion legalization can support abortion access when liberal by increasing opportunities for women to obtain the procedure, namely by extending gestational limits, lowering costs and increasing medical training. This project will further investigate the links between abortion access and this legal mode of governance, as it is still not clear whether liberalized laws truly guarantee access, as promised by the medico-legal paradigm.

Abortion legalization is the most popular legal framework to regulate abortion around the world. The vast majority of countries have some form of abortion law that dictates who is eligible for an abortion, who is allowed to perform or prescribe an abortion, where and when an abortion can be procured, at what cost, for what reasons, etc. (Assis and Erdman 2022). Therefore, there is a ton of variation within this legal framework, from highly restrictive to very liberal models. Organizations like the Center for Reproductive Rights tend to categorize the countries within this framework based on the reasons for which they allow abortion. As seen in the map below, countries are classified as follows: prohibited altogether (abortion prohibition, see earlier section), to save a person's life, to preserve the person's health, on broad social and economic grounds, and on request[2]. As abortion legalization refers to the process of making

[2] The United States and Mexico are in different categories here, because their regulations change from one state to another, some allowing and others restricting access.

abortion legally permissible under specific conditions, the last four categories are part of the abortion legalization framework.

Figure 1. World map based on abortion laws



Source: Center for Reproductive Rights (2024)

The literature tends to organize the legalization framework by their degree of restriction: restrictive, moderate, and liberalized abortion laws. The first subcategory includes all countries that allow abortion on very limited grounds such as rape, incest, and to save the person's life. The second subcategory allows abortion on all the previous grounds plus what are called social and economic grounds (e.g., poverty, enough children, etc.) as well as to preserve the health of the pregnant person (sometimes including mental health) and in cases of certain fetal abnormalities. The third subcategory is also called abortion liberalization. It grants abortion access on request up to a certain number of weeks (i.e., gestational limit), and afterwards, allows it on the previous grounds with the approval of medical professional(s). A succinct summary table that outlines key features and examples of each framework can be found in the appendix (see Table 1).

Mostly located in Africa, South America, and South-East Asia, countries with restrictive abortion laws barely permit the provision of abortion. For example, in Brazil, abortion is only legal in in cases of rape, incest, to save a woman's life, and, since 2012, in the case of anencephaly – a type of fatal fetal abnormality (Malta et al 2019). However, under legalization, there is often a disconnect between the law's provisions and the practical realities of accessing abortion. Despite the restrictive measures, the Brazilian National Abortion Survey of 2021 shows that abortion remains widespread (Diniz et al 2023). Brazil experiences one of the highest estimated abortion rates globally, with an estimated 44 abortions per 1 000 women—compared to the lowest rate of 17 abortions per 1 000 women in the United States and Canada (Sedgh et al., 2016). Recent studies estimate that approximately 250,000 women are hospitalized annually in Brazil due to complications from illegal abortions, accounting for nearly 50% of all estimated illegal abortions each year (Diniz et al., 2019). These high rates are explained by unmet needs for birth control, limited information on sexual and reproductive health, and significant barriers to accessing such healthcare services, which fuel the need for abortion care (Diniz et al., 2019). Additionally, individuals undergoing illegal abortions may face up to 3 years in prison, while those performing abortions may be sentenced to up to 4 years. In brief, as shown by the Brazilian example, restrictive abortion laws do not reflect the actual landscape of abortion provision; women obtain abortions regardless of its limited legality and suffer tremendous consequences.

Countries with more moderate abortion laws include Japan, India and some African countries, among others. For example, in Japan, abortion is allowed until 22 weeks if the health of the pregnant woman is endangered, if she suffers physical or economic hardship, incest or rape. Abortion is a crime, but the exceptions to the law are broad enough that it is widely accepted and practiced (Osumi 2022). Nonetheless, barriers of cost and spousal consent remain,

as abortion is not covered under Japanese health insurance and needs approval from the spouse if the woman is married[3] (Nakagawa 2021). In India, abortion laws have been amended to increase access but still rely heavily on medical control. For instance, the *Medical Termination of Pregnancy Amendment Act* legislates that the gestational limit for terminating a pregnancy is 20 weeks, but in all cases, it requires the opinion of one doctor, then two doctors from 20 to 24 weeks, and a full medical board past the 24 week-limit (Center for Reproductive Rights 2021). Singh et al's study on the incidence of abortion and unintended pregnancy in India shows that 15.6 million abortions took place in 2015, the abortion rate standing at 47 abortions per 1000 women aged 15–49 years, even higher than Brazil. The Center for Reproductive Rights further indicates that 800,000 unsafe abortions occur in India every year (2021). Thus, the literature shows that, even in countries with more moderate abortion laws, women suffer from the criminal framework restricting access, pushing them towards more timely accessible options which are illegal and frequently unsafe.

According to the Center for Reproductive Rights, more than 60 countries have liberalized their abortion laws over the past three decades, representing notable victories of activists in nearly every continent (2024). For example, Argentina's Congress legalized abortion in 2020 after mass mobilizations at *La Plaza de Mayo*, extending the legal provision of abortion to 14 weeks. On 21 February 2022, the Constitutional Court of Colombia legalized abortion on request up to 24 weeks. As such, abortion liberalization has expanded access to abortion in these countries, progressively achieving the goals of feminist social movements. This framework regulates abortion in a way that recognizes women's need to access legal abortion services and

[3] The rule doesn't apply if the woman is in a broken marriage, suffering abuse, or other domestic issues. Nonetheless, doctors often demand the signature of the person believed to have made the woman pregnant for fear of getting into legal troubles, even if she is unmarried.

thus amends criminal law to allow it without legal penalty in certain contexts. By broadening the circumstances under which abortion is permitted, this approach reduces procedural barriers, successfully allowing more individuals to access abortion care. Compared to the previous frameworks among abortion legalization, abortion liberalization represents a crucial step toward dismantling oppressive structures, lowering fear of prosecution and enhancing access by prioritizing equity, safety, and autonomy in reproductive healthcare.

However, abortion liberalization shows some imperfections. The model follows a logic called the medico-legal paradigm, that is the state establishes a legal framework under which abortions are provided by medical experts, signaling that they will undoubtedly be safe. Abortion liberalization regulates abortion under a broader set of circumstances and/or gestational limits that usually stem from a desire to offer access to care under certain circumstances. However, the legal framework still places abortion under criminal law. Since abortion is a crime, women and abortion providers can be criminally convicted if they do not respect the conditionalities of the law, for example, if an abortion is provided past the gestational limit. State regulations on abortion, even in liberal settings, often come with many restrictive requirements such as gestational limits, approval from spouses, parents and/or doctor(s), ultrasounds, waiting periods, among others (Cook 2014). Thus, as seen in both abortion prohibition and legalization, the criminalization of abortion restricts the reproductive freedoms of one specific social group: women.

For decades, the United States were the example to liberalize abortion. “Roe became a global symbol of abortion rights that encouraged legislative liberalization around the world” (Rebouché 2014, 99). However, the world has also witnessed what happened in the country when *Roe v. Wade* was overturned in June 2022, ending the constitutional protection that had

been upheld since 1973. Legal frameworks are reversible; they can progress towards liberalization but also regress to prohibition.

Moreover, there seems to be another disconnect between the law and the practice. For instance, in Tunisia, where abortion has been liberalized and is offered on request free of cost during the three first months of the pregnancy, the country still faces issues. A shortage of abortion pills has forced many women to turn to illegal markets to buy the pills. Additionally, despite the law, more health professionals are illegally denying women access to safe abortion. Already in 2013, according to the study "Denial of Abortion in Legal Settings", Hajri and collaborators estimated that 26% of women seeking safe and legal abortion in Tunisia and Nepal were denied their rights. Consequently, women with financial means seek services at private clinics to ensure safe abortions while avoiding societal judgment. Additionally, medical facilities are experiencing a severe shortage of staff. For instance, Tunis has 8 obstetrician-gynecologists for every 10,000 women, whereas Tatouine has fewer than one doctor per 10,000 women (*ibid)*. It thus seems that liberal abortion laws do not always guarantee access when facing issues of shortages of trained providers and abortion pills, objections to care, or tight regulations (e.g., medical approval, gestational limits).

In sum, the literature informs us in great detail about the world's evolving trends in terms of abortion regulations. While the benefits of abortion liberalization are greatly emphasized, some of the literature still leans towards the traditional stance that safe abortions require significant oversight through legal frameworks and medical authority. This project addresses this gap by examining the potential of abortion decriminalization as a model for abortion advocacy and governance in other countries, compared to other legal frameworks.

2.3. Abortion decriminalization

The decriminalization of abortion is a growing area of study. While many countries continue to liberalize their abortion laws (e.g., Argentina, Colombia, Ireland, Thailand), other countries consider non-legal avenues, that is to completely remove abortion from penal/criminal law. Indeed, full abortion decriminalization entails repealing all existing abortion laws. It ensures that "there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors" (WHO 2022, 24). Some countries such as New Zealand (2020), Australia (2002–2023), South Korea (2021) and Mexico (2023) are currently all exploring different levels of abortion decriminalization. For instance, Australian jurisdictions have progressively removed criminal penalties for pregnant individuals seeking abortion care. However, the removal of criminal penalties is only applicable for a limited time period (e.g., 22 weeks) and criminal penalties remain for other actors involved in the provision of abortion (e.g., medical practioners), thus preventing Australia from qualifying for full abortion decriminalization. As such, the country's legal framework is categorized as partial decriminalization. This framework differs from abortion legalization because, instead of amending criminal laws to allow abortion under specific circumstances, it has repealed criminal penalties for a specific time period, effectuating a partial shift towards the decriminalization of abortion.

For now, Canada is a global exception as the only country that has fully decriminalized abortion. Since the 1988 Supreme Court decision in *R. v. Morgentaler*, Canada has no criminal abortion law. The literature describes Canada's case of abortion decriminalization as an accident that surprisingly turned out to be a great model (Gordon and Johnstone 2024). Still, its uniqueness has led to the case being understudied. Worse, its framework is rarely considered to

govern abortion, as the dominant logic presumes that the combination of regulated legal and medical oversight is the optimal path to ensure safe and accessible abortion care (Assis and Erdman 2022).

The current literature has named some advantages to this mode of governance especially in comparison to abortion legalization. First, since abortion is removed from criminal law, individuals are no longer convicted for receiving, providing or assisting in an abortion (Shah and Jacob 2023). Second, abortion decriminalization is said to increase legal clarity and comfortability for health providers. In his book chapter on the advancement of reproductive rights in Australia, Sifris explains that when abortion was criminalized but simultaneously available, practitioners declared that they were extremely confused (2023). Abortion laws were sparsely implemented to punish the provision of abortion, which was widely available and even publicly funded across the country (*ibid*). After the progressive abortion reforms in all of Australian jurisdictions that partially decriminalized abortion, medical providers were satisfied to obtain clear health guidelines to perform abortion, avoiding the previous ambiguity that they feared might lead to criminal penalties (even if they vary across states and territories) (Baird 2017; Keogh et al. 2017; Sifris 2023). Keogh and collaborators further argue that this abortion reform "d[id] affect the practice of doctors and their willingness to provide abortion services" in a positive way (2017, 19). Canada, the only longstanding case of full decriminalization, similarly had positive effects for medical practitioners in terms of clarity. However, the same cannot be said about the general public. Gordon and Johnstone admit, from their experiences are researchers and professors in Canada, that most people are generally unaware that Canada has fully decriminalized abortion (2024). Consequently, legal ambiguity is still present for individuals that are inadequately informed about the absence of criminal regulations. However,

Shah and Jacob indicate that South Korea has experienced a different situation than Australia, where partial decriminalization has instead led to confusion and fear of prosecution for pregnant individuals and abortion providers (2023). In April 2019, the Constitutional Court of South Korea deemed unconstitutional the criminal provisions on abortion in the Criminal Act. The court demanded that the country amend the law to adjust its constitutionality by the end of 2020. Since the country failed to adopt new abortion provisions, South Korea now has no abortion law in place since the start of 2021. Human Rights Watch indicates that it created an enduring legal gray zone which the government maintains as it affirmed its disregard for women's rights issues (2024). In this context, decriminalization has not been proven to enhance clarity or access.

The literature also mentions some disadvantages of abortion decriminalization. First, the removal of abortion from criminal law does not automatically mean better access (Baird 2017). In Canada, abortion decriminalization is pushed beyond its simple definition. In addition to removing abortion from criminal statutes, the country treats abortion like healthcare. Protected under the *Health Act*, abortion is promoted as regular healthcare and managed under the same quality standards (Johnstone 2017). In their case study of Canada, Shaw and Norman demonstrate that abortion care has been safely and effectively integrated as a standard part of routine medical care (2020). However, that is not the case everywhere. Abortion decriminalization does not immediately infer that abortion is integrated into healthcare to guarantee access. In fact, while some countries' populations are in favor of abortion provision, without strong political will and institutional support, abortion services may not be prioritized or adequately funded within the healthcare system. Governments or healthcare authorities may stop at decriminalization, without committing resources to make abortion accessible. It takes large effective of trained and voluntary providers, reallocated funding, increased resources and

available infrastructure, among other positive measures, to offer comprehensive abortion care, which go beyond abortion decriminalization. Second, decriminalization does not offer protections or rights to pregnant individuals. For example, it does not prevent activists from picketing outside abortion clinics and obstructing the entrance to abortion clinics. Legislation providing safe access zones around clinics has been introduced in many countries, but it does not always protect women in their decision to terminate their pregnancy.

Nevertheless, there are still gaps in the literature to be further researched. While many countries aim to broaden access to abortion care, they take varied approaches, and their legal frameworks are seldom analyzed to determine which most effectively achieves this goal. Consequently, this project's first contribution is to comparatively analyze different liberal models of abortion governance, that is a liberal model of abortion legalization, partial decriminalization and full decriminalization in relation to their provision of abortion care. Second, this project will thoroughly examine the relationship between abortion and the law. The recent interest in abortion decriminalization disputes the legal paradigm, questioning whether the law is the best means to guarantee abortion access. While the predominant assumption presumes that liberalization protects pregnant individuals because legal and medical control would guarantee safe abortions, this thesis demonstrates how the absence of legal regulations has proven to be incredibly safe in Canada. In fact, this thesis aims at moving away from the criminalization of abortion to embrace a healthcare framing that strives to guarantee access. Third, this project will contribute to the emerging literature on abortion decriminalization, studying its potential in enhancing abortion access and furthering reproductive justice. In all cases, abortion decriminalization is a promising avenue that has been understudied, which this project aims at remedying.

3. Research design

3.1. Case study

This project employs a normative comparative case study analysis to explore abortion governance in Ireland, Australia and Canada. In political science, case studies are widely valued for their capacity to delve deep into specific phenomena, events, or individuals. They are particularly effective in examining complex issues within real-world contexts, especially when researchers have limited influence over the events being studied (Yin and Campbell 2018). Traditional qualitative case studies typically aim to establish causal, interpretive, or descriptive inferences, focusing on broad empirical questions. In contrast, normative case studies, as outlined by Thacher (2006) and Taylor (2024), tackle moral and ethical questions, combining empirical analysis with normative assessment to reimagine public values and address societal dilemmas. This approach, based on the work of Gordon and Johnstone (2024), diverges from King, Keohane, and Verba's (1994) traditional comparative framework by prioritizing normative reasoning over causal analysis.

Normative case studies (NCS) are based on and contribute to existing normative theory (Thacher 2006). They allow the researcher to have a more engaged stance than regular case studies. In this case, the normative argument about the desirability of abortion access is a well-established one in the literature on abortion politics. This normative ideal guides my research, allowing me to contribute to the growing body of literature on abortion decriminalization. This methodology is particularly relevant for exploring abortion governance, where existing legal frameworks often impose barriers. By analyzing real-life cases, such as Canada's decriminalization model, this research evaluates existing regulatory frameworks and highlights the potential of non-legal approaches to abortion governance, demonstrating how they can enhance accessibility and reproductive freedoms. For instance, it critiques the widespread belief

that legal oversight is a prerequisite for safe abortion access, instead demonstrating that the absence of such regulations, as seen in Canada's model, can address issues inherent in other regulatory frameworks, proposing it as a better approach to abortion care. Furthermore, this study offers transferable insights that support the formulation of alternative, policy-oriented strategies for governing abortion outside the law. The findings not only address theoretical questions but also have practical implications, suggesting that decriminalization, as seen in Canada, could serve as a transformative model for global abortion governance.

Empirically, this project traces the process through which each country experienced judicial and legislative changes, culminating to their contemporary regulatory framework. Process tracing is a renowned qualitative method in political science that examines sequences of events, decisions, or actions within a case to establish causal mechanisms that explain specific outcomes (Collier 2011). However, using process tracing to demonstrate how abortion decriminalization is the most effective abortion governance framework focuses less on establishing causal mechanisms and more on evaluating outcomes and comparing effectiveness. In this context, process tracing can systematically assess the implementation and consequences of each legal framework by tracking specific indicators related to access.

I determined two metrics to evaluate access to abortion care: accessibility and stigma. Accessibility considers facilitators and barriers within the legal and health care system such as legal restrictions (e.g., gestational limits, waiting periods, medical approval, etc.), cost (e.g., travel, transport, time commitments, cost of service, etc.) and geography (e.g., repartition of services, providers, telemedicine, etc.). Stigma refers to the negative attitudes, beliefs, and perceptions that lead to the discrimination, marginalization, and shaming of individuals, in this case anyone seeking or providing abortions. When applied to the specific sexual and

reproductive health care experience of abortion, stigma has been conceptualized as, a negative attribute that marks individuals, "internally or externally, as inferior to ideals of womanhood" (Kumar et al., 2009) and based on a "… shared understanding that abortion is morally wrong and/or socially unacceptable" (Norris et al. 2011). The construct of abortion stigma explores the various levels - individual, societal, institutional – that interact and reinforce each other to create an environment where abortion stigma is perceived, experienced and internalised when receiving or providing the care (Kumar et al. 2009; Cook 2014; Hessini 2014). At the societal level, for example, the influence of religious and cultural beliefs about the morality of abortion can be analyzed to determine how stigma shapes access. The same process is operationalized at the individual and institutional levels, where the state's choice of language to regulate abortion, for example, can perpetrate stigmatized views of abortion care. As such, stigma has far-reaching consequences, directly and indirectly impacting abortion access and contributing to the barriers women face when seeking reproductive healthcare. By examining how these elements change at each stage of policy implementation across our three countries, process tracing helps pinpoint which framework(s) meet key criteria for successful abortion care governance. It serves as a tool for outcome-based analysis, systematically showcasing the strengths and limitations of each governance model in real-world settings. As such, this method provides clear evidence of how decriminalization functions in practice, supporting the argument that it is the most effective approach to governing abortion.

3.2. Case selection

The objective of this research is to demonstrate how abortion decriminalization, compared to other liberal modes of abortion governance, guarantees more comprehensive access to abortion care. As demonstrated in the literature review, three main frameworks exist:

prohibition, legalization and decriminalization. However, as abortion prohibition does not align with my research objectives nor my normative argument that abortion access is preferable, this legal framework will not be included in the selection of cases. Further, out of the three frameworks of legalization, only liberalization strives to offer comprehensive abortion care. Hence, three cases, each with a different regulatory framework, will be compared to illustrate abortion decriminalization's promising avenues. First, the case of Ireland will be mobilized for its recent liberalization of abortion laws. Second, Australia has been chosen for its hybrid regulatory framework that has elements of both decriminalization and liberalization, which we will define as partial decriminalization. Third, Canada will be the final case in order to examine abortion decriminalization.

The first case that will be analyzed is Ireland. The country liberalized its abortion laws in January 2019 after the population voted "Yes" in the referendum for the repeal of the 8th Amendment in May 2018. The literature is extensive on the pro-abortion campaigns that were mobilized by the arts (Calkin 2019; Enright 2020), the doctors (Bergen 2022) and the grassroots activist organizations such as the Abortion Rights Campaign (ARC) (Carnegie and Roth 2019) and the Together for Yes (TFY) campaign (Fletcher 2018; Kennedy 2018). It also accounts for anti-abortion activism, emphasizing the role of religion and the Catholic Church (Calkin and Kaminska 2020; Campbell et al. 2022), the demonstration of heteroactivism (Browne and Nash 2020), and the stigmatization of abortion (Cullen and Korolczuk 2019). There are a lot of countries that have liberalized their abortion laws in recent years, but I have chosen the case of Ireland for three reasons. First, Ireland underwent a dramatic transformation in abortion policy, moving from a strict constitutional ban to a more liberalized framework after the 2018 referendum repealing the Eighth Amendment. This historical shift provides a distinct lens

through which to examine the impacts of major societal and political movements on reproductive rights, unlike countries with more gradual liberalization processes. Further, Ireland's abortion reform was largely driven by public opinion and a high-profile referendum, making it a compelling case for understanding how democratic mechanisms can influence or expedite legal changes in reproductive healthcare. This focus on public engagement contrasts with top-down policy changes in other countries, enriching the analysis of policy reform through democratic participation. Second, Ireland's strong Catholic heritage once heavily influenced its restrictive abortion laws. Studying Ireland allows for an exploration of how deeply rooted religious and cultural values interact with and shape national policies on reproductive rights, offering insights that may not be as prominent in secular contexts like New Zealand or the United Kingdom. Third, Ireland provides a unique opportunity to observe how a healthcare system adapts to newly integrated abortion services. This allows for examination of the challenges and successes involved in rapidly implementing access to abortion within an existing healthcare infrastructure. In sum, I believe that the case of Ireland provides great nuances as a country with a history of restrictive abortion laws now embracing a liberal model of governance.

The second case that will be analyzed is Australia. The country is an interesting case to consider because of its unique variation visible in its states (Petersen 2014; Gleeson 2023). Australia is a Commonwealth federal state that takes more from the US than Canada, as states and territories are responsible of all the domains that are not specified in the Australian Constitution, which includes several sectors of health care. As the country has no federal law on abortion, each state has introduced different policies to regulate abortion. Authors have long considered Australia as displaying a "marble-cake federalism", in which jurisdictional responsibilities are interwoven, often encompassing two or three levels of government at the

same time (Duckett 2016). While Ireland's liberal model of abortion legalization establishes a formal legal framework with specific conditions for abortion access, Australia's partial decriminalization model opts for less rigid legal oversight. Abortion is removed from criminal law in some jurisdictions, instead governed through specific health regulations. However, violations of these health regulations, such as exceeding gestational limits or bypassing mandatory counseling, can lead to criminal prosecution of offenders (except for pregnant individuals), highlighting that Australia has not fully decriminalized abortion. In fact, Australian Capital Territory (ACT) is the only jurisdiction in Australia that qualifies as achieving full decriminalization by having no health regulations specific to abortion while Western Australia (WA) is the only state that has legalized abortion, that is where a criminal framework remains. The remaining states have removed abortion from criminal law but have added these new health regulations regarding gestational limits, medical practitioners, conscientious objections, etc., leaving a residual criminalization (Baird and Millar 2024). Australia will thus be considered in the analysis for its unique mix of regulations, which I will refer to as partial decriminalization.

Lastly, Canada is the only country that has fully decriminalized abortion. In 1988, Canada ruled unconstitutional the criminal restrictions to abortion, thus removing abortion from criminal law (Johnstone 2017). The Fédération du Québec pour le planning des naissances (FQPN), a feminist pro-abortion organization in Quebec argues that “there is no law legislating this health service just like there is none for cancer treatments” (2023), emphasizing the uselessness of an abortion law. From a judicial perspective, abortion is health care, and access to health care is protected by the federal *Health Act*. Besides Canada, few countries have opted for this type of abortion governance. South Korea has since the beginning of 2021, but the case is extremely recent and does not qualify for full decriminalization as the mandate of male consent

for abortion prevails (Moon et al. 2023). New Zealand recently modernized their abortion legal framework. However, though newspapers and even the Ministry of New Zealand refer to decriminalization (BBC 2020; Ministry of Health NZ 2023), it is not the case. To replace the *Crimes Act* of 1961 and the *Contraception, Sterilisation, and Abortion Act* of 1977 (CSA Act 1977), New Zealand implemented the *Abortion Legislation Act* in 2020. Even if it grants unrestricted access to abortion to women before they reach 20 weeks of pregnancy, abortion specifically is still regulated within a legal framework, thus qualifying for abortion liberalization.

The three countries are comparable in other ways. They all present a desire to guarantee access to abortion care; what varies is the way they achieve it. Further, they are all states characterized by federalism, active social organizations, and Commonwealth democracies. They all have a public health care system through which abortion can be accessed. Variation in factors determining abortion access will be further analyzed to observe how abortion governance factors in the achievement of abortion care in terms of availability, accessibility, acceptability, and quality.

The next section will present the research findings by country, beginning with Ireland, then moving to Australia, and concluding with Canada. Each case study is organized in three parts. The first part details important court cases, activist efforts and legislation that culminated into each country's contemporary legal frameworks. The second and third parts evaluate how their contemporary legal frameworks impact the outcome of interest: access to abortion care. The first metric focuses on accessibility, considering factors such as legal restrictions, cost, geography, repartition of services, etc. The second metric evaluates how abortion stigma at the individual, community and institutional levels shapes access to care, emphasizing the influence religious, cultural and personal beliefs in the stigmatization process.

4. Abortion Liberalization: The Case of Ireland

This section focuses on the case of Ireland and is divided into three parts. First, I trace the evolution of Ireland's abortion law, from the 1861 British law until the 2018 referendum that caused the removal of the Eight Amendment and the liberalization of abortion in the country. Then, I analyze the implementation of Ireland's new *Health (Regulation of Termination of Pregnancy) Act 2018*, discussing how the new abortion law has changed access to care. In this second part, I turn to accessibility factors such as legal guidelines, cost, and geography of services, showing that while liberalization has enhanced access, the country relies heavily on medical control and legal restrictions to regulate abortion. The third part scrutinizes how Ireland's abortion law continues to promote abortion stigmatization through criminalization, language and moral beliefs.

4.1. Historical context

Ireland's abortion laws have historically been shaped by a complex interplay of religious, cultural, and legal influences that evolved significantly over time. Following independence in 1922, Ireland retained the *British Offences Against the Person Act of 1861*, which criminalized abortion under any circumstances, a law reflective of the prevailing conservative Catholic values and the role of the Church in Irish society (de Londras 2023). Similar policies were enacted for other reproductive and sexual matters such as contraception, which was also banned in the mid-1930s (Bergen 2022). This foundation persisted for decades, reinforced by a societal and constitutional commitment to idealized views of motherhood and procreation, reflecting a deeply conservative moral framework around women's reproductive rights (Browne and Nash 2020).

4.1.1. Safeguarding morality: The Eight Amendment

The international landscape began shifting in the 1960s and 1970s, with countries like the United Kingdom, Canada, and the United States liberalizing abortion laws. Ireland experienced

to a lesser degree the trend with the Irish Supreme Court affirming the right to privacy in marital affairs by ruling in favour of a woman using contraceptives to avoid a future pregnancy that could endanger her life in 1974[4] (Earner-Byrne and Urquhart 2019; Ralph 2020). However, fearing the demands for abortion liberalization, anti-abortion organizations felt a sense of urgency to make sure Ireland would not fall for this sinful trend. Consequently, they decided to entrench their moral values in the Constitution. Mobilizing the Catholic Church, which was very influent on various reproductive concerns (Barry 1988; Cullen and Korolczuk 2019; Earner-Byrne and Urquhart 2019; Calkin and Kaminska 2020), anti-abortion efforts culminated in the 1983 *Eighth Amendment*, a constitutional provision recognizing an equal right to life for the mother and the unborn, further solidifying the prohibition of abortion except when the mother's life was in immediate danger. The amendment, passed by popular referendum, institutionalized Ireland's anti-abortion stance and made any future legislative change to this position nearly impossible without further referendum (Carnegie and Roth 2019). The abortion ban forced pregnant individuals to travel outside of the country to receive an abortion.

4.1.2. Challenging the abortion ban: the path towards liberalization

Judicial challenges in the 1990s, particularly the X Case (1992)[5], began to expose the limitations and human rights implications of Ireland's rigid abortion laws[6]. In this landmark case,

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[4] The ruling was made with the idea that married couples have a right to privacy when making decisions about their family. In this context, a married woman followed the health directives from her doctor, that is to avoid another pregnancy in her marriage so to protect her life. This ruling was followed by the 1979 Health (Family Planning) Act which "made doctors responsible for deciding if a couple had a bona fide family planning or medical reasons for using birth control" (Earner-Byrne and Urquhart, 2019, 61).

[5] Attorney General v X [1992] IESC 1, [1992] 1 IR 1

[6] Other examples include the case of *Open Door and Dublin Well Woman v. Ireland*, the plaintiffs claimed that the injunction they received for distributing information on abortion to women in Ireland violated the right to transmit and receive information per Article 10 of the European Court of Human Rights' (ECHR) Convention, which Ireland ratified. Though the ECHR admitted that there was indeed a violation, it was found permissible as the Eight amendment was a domestic law that acted in the protection of morals (see Article 10(2) in the Convention). As such, the judgment granted the Irish state a lot of control over the information that could be communicated on abortion travelling in the aim of protecting the life of the unborn.

a 14-year-old rape victim (named "X") received an injunction from the Irish Attorney General forbidding her to travel to the UK in order to receive an abortion. The Supreme Court overturned the decision and ruled in favor of allowing abortion in instances where the mother's life was at risk from suicide. Gathering plenty of public attention, this ruling prompted three referenda in 1992, ultimately enabling women to travel abroad for abortion services and access information on these services outside of Ireland, although the constitutional ban on abortion in Ireland remained intact (Oaks 2002). However, tragic cases continued to happen because of the prohibition of abortion. For example, Savita Halappanavar, a 31-year-old dentist, died of septicemia in 2012 after being denied an abortion due to the detection of a fetal heartbeat (Boylan 2013; Bergen 2022). Her death is what many authors consider to be a turning point in Irish abortion politics (Lentin 2013; Enright 2018; Earner-Byrne and Urquhart 2019; Drążkiewicz-Grodzicka and Ní Mhórdha 2020; Ralph 2020; Taylor, Spillane and Arulkumaran 2020), further igniting public outcry and intensifying calls for reform. Her case highlighted the life-threatening consequences of the strict abortion ban, bringing the conversation into the global spotlight. This and similar cases, such as the *A, B and C v. Ireland*[7], underscored the amendment's failure to adequately protect women's health and wellbeing, fueling momentum toward legislative change.

Starting in 2012, an annual March for Choice was organized by the ARC. The status quo on abortion was no longer acceptable (McDonnell and Murphy 2019) and citizens urged the

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The Attorney General (at the relation of S.P.U.C Ireland Ltd.) v. Open Door Counselling Ltd and Dublin Well Woman Centre Ltd [1988] I.R. 593.

[7] The *A, B and C v. Ireland* case in 2011, demonstrates that three women - referred to as A, B and C - who travelled to the UK to obtain abortion suffered inhumane conditions, where their life was avoidably endangered, because of the state's lack of clarity on the legal status of abortion. The ECHR's 17 judges ruled unanimously that these three women were treated unfairly and while Ireland had a sovereign right to restrict abortion access, it violated the rights of C, who was undergoing chemotherapy and faced serious health risks from her pregnancy. The court thus demanded that the state legislate on the matter (Ralph 2020).

government to reform abortion laws. Consequently, in 2013, the Oireachtas passed the *Protection of Life During Pregnancy Act* (PLDPA). The act still criminalized abortion, making it illegal except for risk to the mother's life (including suicide grounds). However, the law was still unpractical; the cases of *Amanda Mellet v. Ireland*[8] and *Whelan v. Ireland*[9] reiterated the need for abortions to be accessible in Ireland rather than exported to the UK, especially in the case of fatal fetal abnormality. These cases also showed that Ireland was continuously breaching its international obligations. It favored the unrealistic broadcasting of a country with superior morals, claiming the absence of abortion provision on its lands made Ireland better than its promiscuous neighbor, United Kingdom.

By 2016, the Citizens' Assembly, a body representing a cross-section of Irish society, was convened to examine the *Eighth Amendment*. The Assembly's recommendations[10], supported by public opinion and the ensuing political discourse, led to the 2018 referendum, in which a significant majority (66.4%) voted to repeal the amendment. This repeal marked a historic shift, allowing the enactment of the *Health (Regulation of Termination of Pregnancy) Act of 2018.* Effective on January 1, 2019, the law allowed abortion on four different grounds: Section 9 allows it if two medical practitioners, including an obstetrician, determine a serious risk to the life or health (physical or mental) of the pregnant woman; Section 10 permits emergency abortions with one medical practitioner's assessment of immediate risk to the life or

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[8] The UNHRC ruled that Ireland had violated Amanda Mellet's human rights by denying her access to abortion services after being informed her pregnancy involved a fatal fetal abnormality.
See 9th June 2016, UN Doc CCPR/C/116/D/2324/2013.

[9] The UNHRC Committee held that by prohibiting Ms. Whelan from accessing abortion services in Ireland, the state subjected her to severe mental anguish and suffering. As a result, the Committee found that Ireland had violated Ms. Whelan's rights to freedom from cruel, inhuman or degrading treatment, to privacy, and to equality before the law as protected by Articles 7, 17 and 26 of the International Covenant on Civil and Political Rights (ICCPR).
See 12th June 2017, UN Doc CCPR/C/119/D/2425/2014.

[10] Citizens' Assembly, Final Report on the Eighth Amendment of the Constitution (Dublin: Citizens' Assembly, 2017) https://www.citizensassembly.ie/en/The-Eighth-Amendment-of-theConstitution/Final-Report-on-the-Eighth-Amendment-of-the-Constitution/Final-Report-on-the-EighthAmendment-of-the-Constitution.html

of serious harm to the pregnant woman's health; Section 11 authorizes termination when two practitioners reasonably conclude that a fetal condition will result in the death of the fetus before or shortly after birth (28 days); and Section 12 allows abortion within 12 weeks of pregnancy with proper certification.

This historical journey of Ireland's abortion laws illustrates the gradual transition from a framework rooted in conservative Catholic doctrine to one reflecting contemporary human rights standards. The changes were heavily influenced by pivotal court cases, public opinion shifts, and advocacy campaigns that highlighted the urgent need to prioritize women's health and autonomy, culminating in a redefined legal approach aligned with broader international standards.

4.2. Accessibility

Ireland's new regulations governing abortion care have been life-changing for pregnant individuals, who are now able to obtain an abortion in their own country. However, while aimed at providing access, these regulations still impose significant legal restrictions that hinder women's ability to exercise reproductive autonomy. These restrictions are particularly evident in time limits, vague legal language, logistical and geographical barriers that disproportionately affect women living in rural areas, in poverty and facing complex medical conditions.

4.2.1. Section 12: Strict gestational limit

In Ireland, Section 12 of the *Health (Regulation of Termination of Pregnancy) Act* provides access to abortion on request up to 12 weeks of pregnancy[11]. However, the real-world accessibility of this provision is limited by several factors. First, the legal requirement to ensure

[11] See Table 2 in the appendix for the number of terminations notified in Ireland by section of the Act in the year 2023.

that a pregnancy is within the 12-week limit causes institutional burdens, particularly for medical practioners who now may need timely access to ultrasound equipment to make sure they deliver legal abortion services (McMahon and Ní Ghráinne 2019). Compared to other countries with liberal abortions laws, where gestational limits usually vary from 16 to 24 weeks, Ireland's 12-week limit is unnecessarily strict. This time limit can be problematic for women who learn of their pregnancy at a later stage. Further, through this regulation, the state shows a lack of trust in women to evaluate themselves their pregnancy stage (as accurately as possible) by relying so much on medical oversight.

Second, there is a three-day waiting period required for all pregnant individuals who would like to terminate a pregnancy. This leads women to needing many appointments, a costly and time-consuming institutional barrier for most women. The mandatory waiting period may be extended to four or five days if it coincides with weekends or public holidays. Overall, it creates delays that may push women beyond the legal limit for abortion. Donnelly and Murray add that "there is no health rationale for the waiting period", plus it is contrary to the World Health Organization's (WHO) Safe Abortion Guidance (2020, 78). This requirement also tells us a lot about preconceived ideas the state holds towards women, as if women were unable to make rational decisions on their terms and within the timeframe that works for them (Ralph 2020). This problem is exacerbated by the fact that women may struggle to secure multiple appointments or if previous treatment to terminate the pregnancy fails. For marginalized women, including those in rural areas and those with complex medical conditions, the combination of logistical barriers and legal restrictions poses a significant challenge. They contribute to the continued trend of women forced to continue their pregnancy, to illegally import abortion pills or

to travel abroad for abortions, despite the liberalization of abortion services within Ireland (Enright 2018).

4.2.2. Sections 9, 10 and 11: Vague legal language

Additionally, the vagueness in the language of the law poses significant barriers to access. Sections 9, 10 and 11 make health professionals determine whether the risk of harm or the fetal abnormality is urgent or severe enough for a woman to obtain an abortion. However, the absence of clear health guidelines has a chilling effect on medical practioners who adopt defensive medical practices to avoid potential risks of prosecution. In Section 9, abortion is permitted after 12 weeks only if a woman's health is at risk of "serious harm." However, there are no medical guidelines that determines the “” threshold of risk”, “serious harm”, or the extent to which the risk has to be averted” (O’Shea 2023, 8), leaving medical practitioners uncertain about how to interpret and apply the law in practice (McMahon and Ní Ghráinne 2019). This ambiguity leads to cautious, risk-averse decision-making, referred to as "defensive medicine" (Taylor, Spillane and Arulkumaran 2020). As a matter of fact, section 23 makes ending the life of a fetus outside the provisions of the Act an offence punishable by a fine or imprisonment of up to 14 years (Donnelly and Murray 2020). This lack of clarity is particularly problematic in cases involving mental health, cardiac risk, or complex conditions like cancer, where the threshold for intervention remains unclear (O’Shea 2023). Moreover, the lack of a standardized clinical pathway for implementing sections 9 and 10 exacerbates these challenges. Medical practitioners report that the absence of clear guidance on how and when to apply these sections makes it difficult to provide care, particularly in complex cases (ibid). As a result, some women who have a legitimate right to abortion under these provisions are denied care, further restricting their reproductive autonomy (Mullally et al 2020; O’Shea 2023). Section 11, in which abortion is

allowed in cases of fatal fetal anomalies, is similarly vague and difficult to implement. The term "fatal fetal anomaly" is not medically defined, and there is no definitive list of conditions that qualify. This lack of clarity creates confusion for medical professionals, particularly in cases where the condition may be associated with severe morbidity or disability rather than certain death. The subjective interpretation of this section, combined with the risk of criminal sanctions, further encourages defensive medical practices, leading to the denial of abortion care even in cases where it is legally permissible (ibid).

4.2.3. Cost and geography

In terms of accessibility, Ireland did nail something: the free provision of abortion care. As Carnegie and Roth mention, “Ireland does not have a universal health care system and offers relatively few universal health benefits, so the government’s decision to make abortion free is especially impressive” (2019, 116). However, access is limited to individuals with a Personal Public Services Number (PPSN). Migrants, asylum seekers, undocumented residents, and those on temporary visas may lack a PPSN, which requires them to pay out-of-pocket for abortion services. For marginalized populations, including those experiencing homelessness or living in abusive situations, this cost barrier can be insurmountable (Side 2020; Mishtal et al. 2022). Furthermore, individuals without a PPSN are often excluded from state-subsidized care, compounding the financial strain (Carnegie and Roth 2019). Irish feminist activists successfully advocated for free abortion services as part of the Repeal campaign, but legal reforms have not adequately addressed the needs of non-citizens. Moreover, these individuals often face additional obstacles to travel, such as the need for state permission to leave and re-enter the country, which limits their ability to seek care abroad (Side 2020). As Side affirms, “it remains a significant oversight that recent legal reforms overlook immobility that impinges on rights to health, privacy

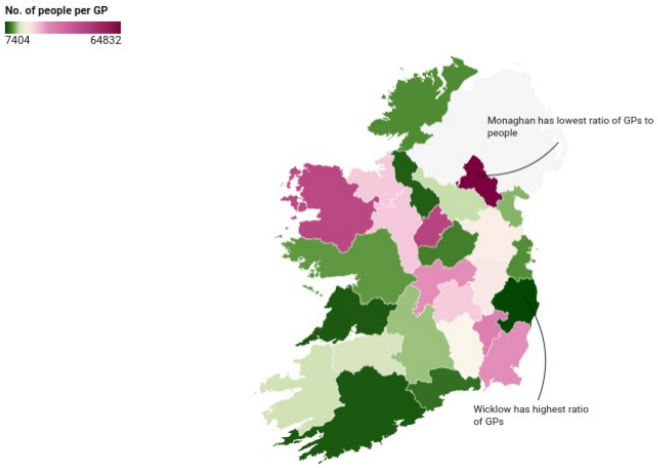
and bodily autonomy" (2020, 22). The criminalizing framework targets these groups characterized by geographic limitations, leading to inequalities between Irish citizens and non-citizens, despite evidence showing that maternal deaths are way higher for women part of marginalized and ethnic groups (MERJ 2018).

Another positive change brought by Ireland's abortion liberalization is legal access to medical abortion. Medical abortion, specifically using abortion pills, is available up to 9 weeks (including the three-day waiting period), after which women must seek care in hospitals. The liberalization of medical abortion in Ireland has shifted the abortion landscape from one of secrecy to one where women have greater autonomy (Calkin 2020). However, the medico-legal paradigm still over-medicalizes abortion care within the healthcare system, maintaining control with general practioners (GPs) being the only professionals legally able to prescribe it (de Londras and Enright 2020; Bergen 2022). Medical abortion is the most common method for early termination of pregnancy, namely because it is accessible and practical but also because surgical options are limited. Only six of Ireland's 11 hospitals offering abortion services provide manual vacuum aspiration (MVA), a surgical option which may be preferable to some women (O'Shea 2023). Medical abortion may not correspond to all women's preferences and situations, namely those who are minors or endure domestic violence. This limited availability of surgical abortion highlights the ongoing resource constraints in Irish healthcare and prevents women from accessing comprehensive care.

One of the most pressing issues is the uneven geographic distribution of abortion providers, which disproportionately affects individuals in rural areas. Providers are concentrated in urban centers, particularly around Dublin with five clinics, while regions such as the south-east, north-west, midlands, and border counties have fewer available providers. This requires

women in rural areas to travel considerable distances, often relying on poor public transportation (Carnegie and Roth 2019). Although there are approximately 422 primary care providers, there are only 11 of 19 maternity units or hospitals providing comprehensive services, which exacerbates these geographic disparities (O'Shea 2023) - see table 3 in the appendix for more detailed numbers of providers by county.

Figure 2. GP contracts for termination of pregnancy by county in Ireland



Source: Bray (2023). https://www.irishtimes.com/politics/2023/04/27/nine-counties-have-fewer-than-five-gps-providing-abortion-care/

Combined with the problem of conscientious objection, provision is limited to the few willing providers, increasing the risks of burnout and making the service less sustainable (ibid). The Health Service Executive (HSE) has identified conscientious objection as a key factor slowing the rollout of services, particularly in hospitals, where some staff refuse to offer even basic abortion care. Ireland's legal framework also contributes to the complexity of abortion access, namely by limiting abortion provision to medical practitioners, excluding nurses, midwives, and other healthcare workers, despite evidence that they could safely do so, which would address problems of access particularly in rural and underserved areas (Naughton et al. 2012; Side 2020). Recruitment of willing providers in hospitals has been shown to be effective,

but the service is led by consultants, making the process very slow (O'Shea 2023). Given the historic restrictions on abortion, there is a crucial lack of training on abortion care in Ireland. However, education and training are required to become an abortion provider. Training started shortly after the repeal of the Eight Amendment, knowing the service would start in January 2019. While primary care workers felt supported, many health professionals felt unprepared and expressed concerns regarding their training (O'Shea 2023). As such, training needs to be ongoing and extended to non-GPs, so that access is enhanced. The HSE does in fact invest in workforce training annually, but it still seems insufficient. Consequently, these restrictions add to the shortage of providers and places additional strain on GPs and hospitals.

The Covid-19 pandemic has been a source of worry for many pregnant women, not knowing whether they could access care. However, the Department of Health granted more flexibility by allowing first consultations via telemedicine. Though not as prevalent as in other countries, telemedicine helped decentralized access from hospital settings. However, this resource is still mostly unknown to women. An option to obtain information on abortion services is to call the national free helpline MyOptions; the national initiative allows women to receive the name and phone number for two to three specific providers near them (Mishtal et al. 2022). MyOptions has been a successful information resource and point of entry for abortion services, but individuals who bypass the helpline often encounter unreliable referrals from their local GPs (Carayon et al. 2020). Those who do not utilize MyOptions can experience more convoluted patient journeys, encountering non-providing GPs – despite the obligation - and even rogue agencies posing as pro-choice organizations (Duffy et al. 2022). MyOptions, though widely promoted in the early stage of liberalization, remains less visible in rural areas, leaving many people unaware of this critical resource (*ibid)*.

In sum, Ireland's abortion regulations, while marking considerable progress from the past, continue to impose barriers that restrict access to care, particularly for marginalized groups. Vague legal language, the paternalistic three-day waiting period, the uneven repartition of services and the logistical challenges in accessing services before the 12-week deadline all contribute to ongoing abortion travel and delayed care. These barriers disproportionately affect rural women and those with complex medical conditions, perpetuating class, disability and geographical inequalities in reproductive healthcare access. The government's attempts to balance legal access with restrictive measures rooted in moral judgment ultimately limit women's reproductive autonomy, highlighting the need for further abortion law reform to ensure equitable access in Ireland.

4.3. Stigma

Ireland's transition from prohibiting to liberalizing abortion laws has significantly expanded access to abortion care. However, the liberal reforms have not normalized abortion as a routine healthcare service. Instead, the framework perpetuates abortion stigma through criminalization, exceptional regulations, and religious, cultural and social beliefs, namely stemming from the enduring influence of the Catholic Church. These factors collectively undermine women's access to care, leaving abortion stigmatized and marginalized.

4.3.1. Institutional barriers: Abortion criminalization and medical monopoly

Although Ireland now permits abortion under certain conditions, the criminalization of the procedure remains a cornerstone of its legal framework. This criminalization fuels stigma by framing abortion as a deviant or morally questionable act, creating barriers for individuals seeking to terminate a pregnancy (Taylor, Spillane, and Arulkumaran 2020). Drawing from Link

and Phelan's model of stigma production (2001), Cook shows how abortion as a criminal act generates abortion stigma (2014). As shown by these five steps, criminalization first

> "marks those seeking and providing abortion as different [...]. Criminalization links those differences to undesirable characteristics through stereotyping, the second component. Linking the labeled persons to criminal deviance separates labeled persons from the dominant culture, the third component. The separation justifies a loss of status in, or even discrimination against, the labeled persons, the fourth component. Through each of these components of stigma production, the criminal law allows the labeling agents to exert power over the labeled persons, the fifth component." (ibid, 354)

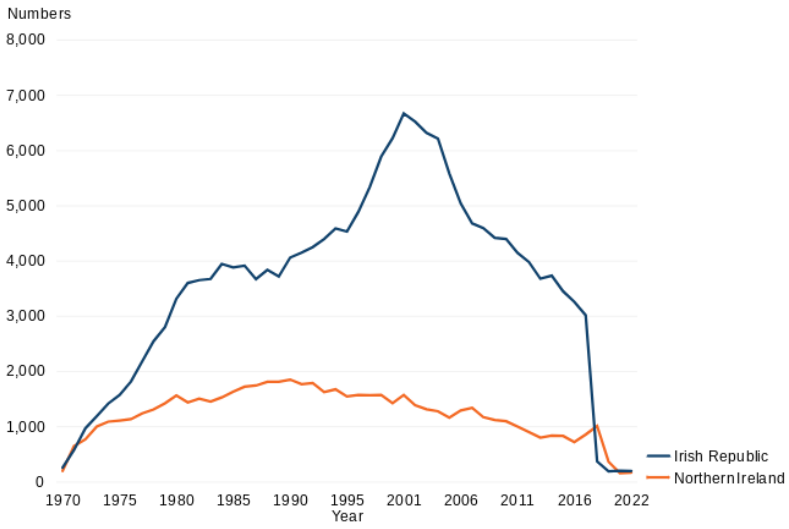
Consequently, the stigma stemming from criminal law poses a clear barrier to access, making the experience more difficult for women from accessing care. Even Ireland's *Health (Regulation of Termination of Pregnancy) Act* employs language that reinforces stigma by avoiding the term "abortion" and instead describing the procedure as the "termination of pregnancy." This linguistic choice humanizes the fetus while subtly invoking a sense of moral wrongdoing. By framing abortion as an exception to healthcare rather than an integral part of it, the law perpetuates the notion of abortion as quasi-criminal (Carnegie and Roth 2019), which exacerbates societal judgment and marginalization.

The perception of abortion as a criminal act deters healthcare providers from offering services due to fear of legal repercussions. This fear has a chilling effect, causing providers to adopt defensive medical practices or outright deny care, resulting in widespread service shortages (Carnegie and Roth 2019; Side 2020; O'Shea 2023). Ireland's strict legal framework has reasons to instill fear in providers since the country has a long history of interpreting and applying abortion laws in a highly restrictive fashion (McMahon and Ní Ghráinne 2019), a behaviour that is expected to continue even with the implementation of the new abortion law. Moreover, the vague language in current legislation continues to instill apprehension among providers, hindering access and creating disparities, particularly in rural areas.

In addition to criminalization, another institutional barrier within the liberal framework that stigmatizes abortion are the specific regulations that govern abortion outside of healthcare. For instance, the law dictates that only GPs can prescribe abortion and that they must go through a particular training to be able to do so. However, experts indicate that abortion, especially medical abortion, is a relatively simple procedure (O'Shea 2023). First, there is no reason to limit abortion provision solely to doctors. It undermines the role that nurses and midwives could play in offering safe, accessible abortion care. They already play a significant role in primary care by transmitting information and facilitating transfers to abortion providers. Expanding abortion provision to non-doctors in all three countries could alleviate the stigma stemming from Irish institutions while ensuring access for women in need of care (de Londras and Enright 2020). Second, GPs are already constrained by heavy workloads. They may hesitate to provide abortion services if additional training is mandatory (*ibid*). This overregulation – typical of abortion legalization - stigmatizes it, as other comparable healthcare procedures do not demand the same levels of training and qualifications.

Additionally, even as women now mostly access care in their home country rather than travel overseas, the clear limitations to access stemming from criminal law (e.g., strict gestational limit, waiting period, fatal fetal abnormality) forces women to consider alternative or illegal routes to abortion, namely importing pills and travelling to other countries. In 2019, 375 women travelled from Ireland to England and Wales, 194 in 2020 despite the COVID-19 pandemic travel restrictions, 206 in 2021 and 201 in 2022 (UK DoH 2020, 2021, 2022, 2024).

Figure 3. Number of abortions in United Kingdom and Wales for residents of Northern Ireland and the Irish Republic, 1970 to 2022



Source: United Kingdom Department of Health and Social Care (2024)

To be refused care in your own country leads women to feeling distressed and unsupported, exacerbating stigma (Mishtal et al. 2022). Experts report that when abortion services are accessed outside of the official health channels, abortion care is delegitimized and further stigmatized (Taylor 2015; WHW 2016; Sheldon 2018). In sum, whether women access care within their own country, they experience abortion stigma because of its continuous criminalization and exceptionalism that prevents the care's full integration into healthcare.

4.3.2. Conscientious Objection and Provider Stigma

Another major mechanism reinforcing stigma in Ireland is conscientious objection. Conscientious objection is the possibility for healthcare providers to refuse to perform abortions based on their moral, personal or ethical beliefs. While conscientious objection is legal, its impact is profound, especially when providers fail to offer timely referrals. In Ireland, the legal framework allows GPs to object, but it also mandates them to minimize harm to the patient, such as informing patients of their right to seek care elsewhere and facilitating the transfer of care (Donnelly and Murray 2020). Despite these guidelines, gaps remain, such as the absence of

statutory requirements for referrals in emergencies. The ambiguity in laws governing conscientious objection has led to inconsistencies in care and a rise in "convenient objections" among clinicians who refuse to offer abortion care due to personal biases and/or workload concerns (Donnelly and Murray 2020; O'Shea 2023). Additionally, it appears that many GPs who conscientiously object have not only refused to refer but have actively tried to obstruct or delay a woman's access to care by providing misleading information and have been able to do so with impunity (O'Shea 2023). These institutional shortcomings further delay access to legal abortion services, exacerbating the stigma and reinforcing a culture where abortion is viewed as an exceptional or morally questionable choice. Nonetheless, we must underline the efforts of the HSE, which initiated measures to overcome barriers to access caused by conscientious objection such as arranging values clarification sessions in hospital settings (which has been shown to be effective) (ibid).

4.3.3. Religious, cultural and social beliefs

Ireland's historical Catholic identity continues to shape societal attitudes toward abortion. For much of the 20th century, abortion was illegal under the 8th Amendment, which granted equal rights to the fetus and the pregnant woman. The influence of the Catholic Church permeated Irish society, dictating social norms surrounding sexuality, gender roles, and reproductive rights (Lentin 2013; Kennedy 2018; Calkin and Kaminska 2020). The Catholic Church's teachings framed abortion as a moral sin, reinforcing a culture of shame that stigmatized women who sought the procedure. Religious stigma in Ireland was not merely a private matter but was codified into law, reinforcing a conservative Catholic sexual and gender order that positioned women primarily as mothers (Browne and Nash 2020). Any deviation from this norm—such as seeking an abortion—was met with moral condemnation. As many experts

argue, scandals in the 1990s (Lentin 2013; Calkin, de Londras and Heathcote 2020), the release of the Ryan Report into clerical child sex abuse in 2009 (Ralph 2020) and the death of Savita Halappanavar in 2012 (Holland 2012; Berer 2013) eroded the Church's moral authority, paving the way for legal reforms (Cullen and Korolczuk 2019). Even after the 2018 repeal of the 8th Amendment, remnants of this moral framework persist, with societal acceptance often contingent on the "moral deservingness" of the reason for seeking abortion (e.g., cases of rape or fatal fetal abnormalities over intentional terminations) (Enright 2020). Further, the psychological impact of religious stigma endures, particularly for Catholic women, who may internalize shame or guilt, deterring them from seeking abortion care.

Cultural norms further stigmatize abortion by framing it as incompatible with traditional gender roles that center women as mothers. Women seeking abortions are often stereotyped as selfish, irresponsible or immoral, resulting in psychological distress and social isolation or alienation from their families, communities, and social networks (Cullen and Korolczuk 2019). This stigma deters open discussions about abortion, and as Cook explains, may lead to women delaying or avoiding terminating pregnancies or accessing post-abortion care (2014). GPs may also face stigma and discrimination for providing abortions, particularly in rural areas where they are more recognizable (Enright 2018; Donnelly and Murray 2020). Fear of social judgment discourages some providers from participating in abortion care, perpetuating shortages in underserved regions. Anti-abortion activists targeting abortion providers with intimidation tactics have proven to exacerbate these challenges (Hogan 2019).

Stigma is also perpetuated by the broader societal image of abortion as a controversial or morally dubious act. In Ireland, abortion was historically framed as a moral issue tied to national identity. The narrative of an "abortion-free Ireland" was part of the geopolitical discourse that

positioned Ireland as morally superior to other countries, particularly the United Kingdom, by exporting abortion-seeking women to jurisdictions where the procedure was legal (Lentin 2013; Calkin 2019; Fischer 2019). Its legacy persists as the state keeps tight control of abortion access.

In brief, while the 2018 legislation marked a significant expansion of abortion access in Ireland, its framework perpetuates stigma by criminalizing abortion, imposing exceptional restrictive regulations, and maintaining cultural and religious barriers. Women remain subjects of the law, their reproductive autonomy limited by institutional controls. Providers, too, operate within a system that exceptionalizes abortion care, facing societal and professional stigma. These conditions reveal that the liberal reforms have not fully integrated abortion into mainstream healthcare. Instead, the law reinforces abortion's status as an exceptional, stigmatized act, limiting its accessibility and normalcy in Irish society.

Decriminalization would be a great first step to enhance abortion access. Regulating abortion outside the law would eliminate the problems caused by the vague legal language and the fear of criminal prosecution for all actors involved in abortion care, leading to less defensive medical practices. Under full decriminalization, some regulations specific to abortion could fall under health statutes such as the medical approval of one or multiple health professionals. Other regulations such as gestational limits would be fully removed, meaning that, at any stage of the pregnancy, a pregnant woman could not be criminally prosecuted for obtaining an abortion. Full decriminalization would also repeal criminal penalties for women who self-manage their abortion, for example, by buying abortion pills on the internet. Organizations like Women on Web (WoW) and Women Help Women (WHW) have been instrumental in providing abortion

pills and offering support to women in Ireland, even before legalization (Sheldon 2018)[12]. Self-managed abortion (SMA) – not proven to pose risks to the health or life of pregnant women[13] – contradicts the medical paternalism that has been characterizing abortion provision in Ireland, allowing women to obtain abortion care without experiencing legal hurdles or breaching their privacy. Decriminalization allows for SMA, decentralizing abortion provision and increasing women's reproductive autonomy. Decriminalization would also contribute to the destigmatization of abortion, as it would no longer be considered a crime. Negative cultural, religious and moral beliefs about abortion would remain as preconceived ideas take longer to change than legislation. However, the combination of full decriminalization and the provision of free abortion services shows a recognition of abortion as an essential service in reproductive healthcare, shifting the focus from compliance to care. Removing punitive legal structures to prioritize a health approach empowers individuals and providers to make informed decisions. This approach has facilitated greater accessibility, including through innovations like telemedicine, and reduced stigma by treating abortion as a routine aspect of healthcare. By centering the needs of individuals rather than adhering to restrictive legal frameworks, decriminalization advances a transformative vision of reproductive health governance.

5. Partial Decriminalization: The Case of Australia

The case of Australia shows how court cases in certain states and territories set legal precedents, allowing for the partial decriminalization of abortion across the country. Access to abortion in the country varies depending on each state's legislation, creating geographical and

[12] It is 5,650 women that requested abortion pills to WoW between 2010 and the end of 2015, a significant part being from Ireland (Sheldon 2018).
[13] "The Irish government has [had] direct, judicial confirmation that WoW's service meets the standards expected of medical practice within another EU state" (Sheldon, 2018, 840).

financial disparities amongst women. The criminal restrictions were transferred to the health department, where regulations around gestational limits, counselling and accreditation still dictate the rules of access. The legal reforms contributed to lowering abortion stigma, but the residual criminalization and the legacy of religious and moral beliefs still maintain a culture of shame and secrecy around the care. Australia's fascinating mixed model offers lessons for both liberalized and fully decriminalized frameworks, as it provides insights into how removing criminal sanctions can enhance access and underscores the need for supportive healthcare policies and infrastructure to fully realize the benefits of decriminalization.

5.1. Historical context

The legal history of abortion in Australia reflects a gradual evolution from strict criminalization to broader healthcare access, shaped significantly by court rulings and activism. Like Ireland, colonial laws criminalized abortion based on English statutes, such as the *Offences Against the Person Act of 1861* (Baird 2017). Over time, legal precedents and feminist advocacy played crucial roles in reshaping abortion governance, with each state developing distinct frameworks.

5.1.1. A series of legal challenges

The first major legal change in abortion governance was set by the 1938 *Bourne case* in England, which established that abortion was permissible under the doctrine of necessity to preserve a woman's life, including psychiatric factors (Gleeson 2023). This influenced subsequent legal interpretations in Australia. A pivotal moment came in 1969 with the case of *R. v. Davidson*[14] in Victoria, where the Supreme Court ruled that abortion could be lawful if judged necessary to protect a woman's physical or mental health. The judgment allowed for broader

[14] R v Davidson [1969] VicRp 85; [1969] VR 667 (3 June 1969)

interpretations of what constituted harm to a woman's health. This ruling was a turning point in the liberalization of abortion laws in Australia, setting a precedent for interpreting existing abortion laws more leniently. Shortly after, South Australia became the first state to reform their abortion laws by enacting the *Criminal Law Consolidation Act Amendment (Abortion) Act* (1969). Though innovative, the Act legalized abortion under strict conditions, including medical oversight and hospital settings. Further liberalization occurred in 1971 with the case of *R. v. Wald* in New South Wales (NSW). This case broadened the criteria for legal abortions, considering social, economic, and medical factors for valid reasons to obtain an abortion. Similar principles were applied in Western Australia's *S. v. the Queen* (1971), solidifying a trend toward leniency based on the Davidson precedent. These rulings galvanized feminist networks, prompting increased advocacy for reproductive rights.

The 1970-80s were a period marked by heightened activism by organizations such as the Abortion Law Reform Association and feminist groups. Their efforts highlighted the inadequacies of restrictive laws and laid the groundwork for legislative reforms. However, the conservative political climate of the 1990s introduced setbacks, such as the 1996 ban on the abortifacient RU-486, driven by political deals involving Senator Brian Harradine (Petersen 2010). Although the ban was lifted in 2006, the drug was not registered by the Therapeutic Goods Administration (TGA) until 2012, and overregulation persisted past that date, effectively limiting access to medical abortions (O'Rourke, Belton and Mulligan 2016).

Critical court cases continued to shape the legislative landscape of abortion. For example, the 1995 *CES v. Superclinics Australia Pty Ltd* case[15] was a landmark decision by the NSW

[15] CES and Anor v Superclinics (Australia) Pty Ltd and Ors (1995) 38 NSWLR 47.

Court of Appeal. A woman (CES) sued a clinic for negligence after they failed to inform her of her pregnancy in time for her to consider an abortion (Henry 1995). The court ruled in her favor, emphasizing that medical practitioners have a legal duty to provide accurate and timely information regarding pregnancy options, including abortion. This case underscored the importance of informed consent in reproductive healthcare and reinforced the obligation of doctors to adhere to professional standards, with potential legal consequences for failing to do so. In 2002, the Supreme Court of Queensland ruled in *Attorney-General (Qld) v. T*[16] that a pregnant 12-year-old girl could lawfully have an abortion. This ruling gave legal clarity for cases involving minors and victims of sexual violence, especially since abortion was still illegal in Queensland. More importantly, the case galvanized reproductive rights activism in the province, leading to increased calls for legislative reform to decriminalize abortion in the state.

5.1.2. Legal reforms: the partial decriminalization of abortion across the country

Since there are no federal laws on abortion, states and territories are left to decide their legal framework. In Western Australia, the *Criminal Code Amendment (Abortion) Act of 1998* legalized abortion up to 20 weeks, setting clear guidelines and affirming women's autonomy. Similarly, the Australian Capital Territory adopted the *Crimes (Abolition of Offence of Abortion) Act* in 2002, removing abortion from criminal codes and shifting its governance to healthcare regulation. In Victoria, the *Abortion Law Reform Act* of 2008 removed abortion from the criminal code, legalizing it up to 24 weeks with provisions for later-term abortions. Tasmania followed in 2013 with the *Reproductive Health (Access to Terminations) Act*, permitting abortions up to 16 weeks on request. These legislative milestones reflected growing public support for reproductive rights.

[16] R v T; ex parte Attorney-General of Queensland [2002] QCA 132

Recent years have also seen noteworthy progress. After legal and activist pressures, Northern Territory passed the C*riminal Code Amendment (Medical Termination) Act,* liberalizing abortion up to 23 weeks of pregnancy. However, the legislation was deemed insufficient, and, in 2021, was reformed to remove barriers such as mandatory counseling and waiting periods. Queensland legalized abortion up to 22 weeks under the *Termination of Pregnancy Act* 2018, and NSW followed in 2019 with the *Reproductive Health Care Reform Act.* In 2021, South Australia adopted the *Statutes Amendment (Abortion Law Reform) Act*, allowing abortions to be performed until 22 weeks and six days[17]. These reforms were victories for feminist and reproductive rights groups. The changes signaled a nationwide shift towards recognizing abortion as a healthcare issue rather than a criminal matter (Haining et al. 2023). By 2021, all states had enacted safe access zone legislation to protect women and providers from harassment at clinics.

In sum, Australia's abortion law history illustrates a complex interplay of judicial decisions, legislative reforms, and feminist activism. Early cases like Davidson and Wald set critical legal precedents, while later legislative efforts partially decriminalized abortion and improved access. Although significant strides have been made, ongoing challenges highlight the need for continued advocacy to ensure equitable reproductive healthcare nationwide.

5.2. Accessibility

The partial decriminalization of abortion has extended the rules of access, increasing gestational limits, expanding access to medical abortion and allowing abortions on request for women. However, there are still many legal and health challenges that limit access. First off, the

[17] The different technicalities on abortion governance for each state and territory in Australia are illustrated in the appendix (see table 4).

country's marble-cake federalism impacts the jurisdictions' health systems, relying on a heavily privatized model of healthcare provision. Then, even if abortion was decriminalized for women seeking abortion, the legal regulations specific to abortion in the criminal code were transferred to healthcare, overregulating the care and instilling fear among providers. Further, the uneven geographic availability and high financial costs of abortion services result in a system that disproportionately disadvantages women from low socioeconomic backgrounds and rural areas.

5.2.1. Australia's marble-cake federalism

The structure of abortion governance in Australia reflects the country's "marble-cake federalism," where responsibilities are intertwined between federal and state governments (Wiltshire 2008). Since there are no abortion laws, abortion legislation, funding, and regulation are primarily state and territory responsibilities, leading to considerable disparities in access across the country. At times, this marble-cake federalism has obstructed the creation and implementation of effective policies to address modern health challenges, including the rising costs of healthcare (Duckett 2016). Public hospitals, funded by state budgets with some Commonwealth support, often fail to offer extensive abortion services due to funding limitations. This has created a patchwork system where access depends heavily on state policies and the financial resources allocated to abortion care. For example, jurisdictions such as the Australian Capital Territory (ACT), Northern Territory (NT) and South Australia (SA) integrate abortion services into public hospitals, whereas in others like Queensland, less than 1% of abortions are provided by public hospitals (Children by Choice, 2024a). Even if Australia has a universal public health insurance program (Medicare), many public hospitals are generally unwilling to provide abortion services (Baird 2017). Considering the unreliability of the public healthcare system in some states, paying for private health insurance becomes incredibly attractive for those

who can afford it. Indeed, almost half of Australians buy private insurance to pay for private hospital care, dental services, and other services (Commonwealth Fund 2020). Consequently, private clinics dominate in these states, making abortion care inaccessible for women who rely on Medicare to fund their abortion in a public facility. The federal government's diminished funding role— covering about 45% of costs (Duckett 2016) —has compounded this issue, with states struggling to meet growing healthcare demands. The division of responsibilities also complicates interstate abortion access. Different regulations and the absence of a national strategy create logistical and financial hurdles for women seeking care, particularly those in underserved areas. This lack of coordination perpetuates inequalities, reflecting a broader structural issue within Australia's healthcare system.

5.2.2. From criminal code to health regulations

The removal of abortion from the criminal codes of Australian jurisdictions signaled a significant shift in framing abortion as a healthcare matter (Petersen 2014; Keogh et al 2017; Sifris 2023). Feminist and pro-choice advocates celebrated this change as a step toward aligning with human rights principles (Baird 2017). However, the partial decriminalization of abortion has moved the legal restrictions to the realm of healthcare, meaning that abortion remains overregulated compared to other healthcare services, perpetuating its exceptionalism.

The legal reforms in Australian jurisdictions decriminalized abortion for women seeking abortion care within the designated gestational limits. This step was crucial in increasing the law's clarity and lowering women's past fear of prosecution. Australian women have been able to feel empowered and confident when asking for abortion care. However, the story is different for abortion providers. Medical doctors, the only legal abortion providers, still experience the residual effects of abortion criminalization because of the incomplete decriminalization of

abortion (Baird and Millar 2024). Residual criminalization remains for “unqualified people” who provide or assist in abortions as well as for professionals that do not respect gestational limits or violate other procedural technicalities (e.g., counselling). This legal environment instills fear among healthcare providers and discourages participation, further limiting service availability. Additionally, doctors may practice defensive medicine, cautious of providing abortion services out of concern for legal ramifications. This overly cautious approach can result in the denial of abortion services or delays in care, echoing the criminal law barriers seen in Ireland.

Moreover, there are still key health regulations that pose risks to medical providers and exceptionalize the procedure. First, all states and territories (except the ACT) impose gestational limits ranging from 16 to 22 weeks. While these limits exceed Ireland’s 12 weeks, they undermine the whole “health positive” approach by pressuring women to make rushed decisions and creating barriers for those in remote areas or facing complex situations. They are inconsistent, leading to interstate “abortion tourism” for those who can afford it. Sifris adds that gestational limits contribute to abortion exceptionalism as other medical procedures simply require informed consent and professional ability to be done (2023, 138). Second, some jurisdictions, like NSW, SA, and WA, mandate that doctors provide information about counseling services, implying that women cannot make independent decisions (Millar 2022) and leading to uncomfortable discussions between the patients and the doctors. Women frequently face scrutiny over their reproductive decisions. Rather than being trusted, states such as NSW impose further restrictions, including bans on abortions motivated by “sex selection” (Baird and Millar 2024). This legal restriction is completely unreasonable as it does not rely on any scientific evidence, nor does it reflect the contemporary abortion landscape. Third, only medical doctors can legally perform abortions or prescribe abortion medications. Further, they must

undergo special registration to prescribe abortion medication, creating disincentives for providers (Sifris 2023). This health regulation follows the medico-legal paradigm by reaffirming legal and medical control over abortion care. It is said to prevent "backyard abortions", which no evidence has shown to be happening in Australia nowadays (*ibid*). Abortions are already provided by qualified professionals as ensures health law. This irrelevant condition contributes to abortion exceptionalism and creates an unnecessary fear among providers, who risk between five and ten years of imprisonment. Additionally, this legislation also excludes midwives and nurses from providing care despite their qualifications, preventing the procedure from becoming more accessible. Altogether, the legal infrastructure around abortion remains cautious, reinforcing the medicalization of the process and power dynamics that limit women's autonomy in their reproductive choices.

In sum, the residual criminalization of abortion and the specific health regulations governing abortion such as gestational limits, counselling requirements and provider restrictions continue to reduce access to care. These regulations frame abortion as an exceptional procedure rather than standard healthcare, limiting its integration into the public healthcare system and undermining women's autonomy.

5.2.3. Cost and geography inequalities across the country

The cost of abortion services in Australia varies significantly across states and between private and public providers, creating disparities in access. The introduction of abortion pills such as mifepristone and misoprostol on the Pharmaceutical Benefits Scheme (PBS) in 2013 helped reduce the cost of medical abortion, bringing it down to under AUD$15 for healthcare card holders and under AUD$50 for Medicare card holders who access medical abortion in the public healthcare system (Children by Choice 2024b). However, private clinics dominate

abortion care provision. In Victoria, a medical abortion can range from AUD$6.10 for disadvantaged women in public facilities to over AUD$440 in private clinics (Sifris and Penovic 2021). In other regions, the costs are even higher. For example, a medical abortion in a private clinic in Perth can cost AUD$650, and in regional Queensland, the cost can soar to AUD$770 (ibid). The lack of affordable options, especially in NSW, Queensland and WA, forces many women to either delay care or seek services in other states, adding travel costs to an already expensive procedure.

Public hospitals, which could provide more equitable access, often fail to deliver abortion services due to funding constraints or opposition from religious organizations managing healthcare facilities. For example, the Catholic Calvary Group in the ACT refuses to offer abortion services, leaving women in those areas with very few, if any, local alternatives for abortion care. Consequently, geographic location is a key factor, with rural and remote areas particularly underserved. The closure of clinics and the reluctance of some public hospitals to provide abortions leaves many women in these areas with few options, forcing them to travel across state lines or rely on costly private clinics, creating a form of "reproductive tourism" where access is dictated by one's ability to pay and travel. This privatized model disproportionately affects women in rural and remote areas, who face additional travel costs and logistical challenges to access care. Some states offer better public access; for example, NT has public hospitals in Darwin and Alice Springs that provide abortions. Even when public sector care is available, it may not be easily accessible due to delays in public hospital availability and the limited distribution of early medical abortion (EMA) services in primary care (Dwyer et al. 2021). Despite these exceptions, the predominance of private healthcare in abortion provision highlights broader systemic issues in Australia's healthcare model, where out-of-pocket expenses

are among the highest in developed countries (Duckett and Kempton 2012). This financial burden exacerbates inequality, particularly for low-income and rural women.

Nonetheless, Australia has made significant changes in improving access to medical abortion through telemedicine, particularly in rural and remote areas (Sifris and Penovic 2021). The Tabbot Foundation, established in 2015, pioneered telehealth services for medical abortion in Australia, enabling women to obtain abortion pills remotely. While this has increased access, particularly during early pregnancy, telehealth abortion remains tied to medical professionals, often requiring ultrasounds and/or the proximity to emergency medical services, which can be challenging for women in remote areas (Baird and Millar 2024). Moreover, the residual criminalization could be used to penalize collective networks, just like this foundation, that make abortion pills accessible (*ibid*).

In brief, Australia's partial decriminalization of abortion represents progress in reframing the procedure as healthcare rather than a crime. Medical abortion has facilitated access to abortion services, especially for women in remote or rural areas. Combined with telemedicine, it decentralizes healthcare from clinical settings and challenges traditional medical and legal paradigms. However, the persistence of overregulation, residual criminalization, and fragmented responsibilities across government levels undermine access. The high costs and geographic disparities in service provision disproportionately disadvantage women in rural and underserved areas. Addressing these systemic issues requires not only the full decriminalization of abortion but also the creation of a coordinated national strategy to ensure equitable and affordable access to abortion as an essential healthcare service.

5.3. Stigma

Australia's partially decriminalized abortion framework has shifted the procedure from criminal law to healthcare regulations. However, this shift has not eliminated stigma (Sifris 2023). Women seeking abortion continue to face various forms of stigma at individual, community, and institutional levels, perpetuating barriers to care.

5.3.1. Social and religious stigma

At the individual level, women seeking abortions often internalize societal attitudes that frame abortion as immoral or sinful. As Hughes indicates, "a woman who terminates a pregnancy is the cultural target of stigma because she embodies opposition to deeply held cultural beliefs about female sexuality, motherhood and the nurturing nature of women" (2017, 237). These views label women who terminate pregnancies as careless or selfish (Sifris 2023). This internalized stigma fosters feelings of shame, secrecy, and guilt, discouraging women from openly discussing or accessing abortion care (Cook 2014).

While abortion laws have been secularized, religious groups continue to exert influence on public opinion and women's reproductive choices, portraying abortion as morally wrong. Religious stigma plays a significant role, particularly in rural and conservative regions with strong evangelical or Catholic communities. Religious opposition to abortion in Australia often manifests through political lobbying by religious groups and public protests at abortion clinics. While the transfer of abortion laws to healthcare regulations in Australia has diminished the legal influence of religious institutions over reproductive rights, women from religious backgrounds may experience heightened internal conflict, as they navigate the tension between legal entitlement to abortion services and the moral teachings of their faith. This psychological toll often results in delayed care and emotional distress.

5.3.2. Anti-abortion activism

At the community level, social stigma manifests through anti-abortion activism and societal judgment. Protesters outside clinics frequently use social constructs around motherhood and fetus-centered arguments to shame women and healthcare providers, intimidating those seeking or offering abortion care (Cannold 2000; Keogh et al. 2017; Sifris 2023). This activism perpetuates the narrative that abortion is morally reprehensible and isolates women from their social networks. Misleading stereotypes also exacerbate stigma. As Statham and Ringrow point out, the "political arguments which present the threat of dystopian outcomes often succeed because they are highly emotive yet require no statistical proof" (2022, 548). For example, claims that women use abortion as contraception lack evidence but convey a strong image in which women are immoral and selfish because they treat abortion like a commodity freely available, disrespecting their "nature" as women and future mothers (Browne and Nash 2020). These narratives reinforce secrecy and guilt among women and hinder open conversations about reproductive health.

5.3.3. States regulations and medical exceptionalism

Institutional stigma stems from the overregulation of abortion compared to other healthcare procedures. In Australia, healthcare professionals must obtain special accreditation to perform abortions or prescribe medical abortion drugs, even though these are straightforward medical processes. These regulations add unnecessary burdens on providers and delay care for women. Further, this institutional approach to regulating abortion stigmatizes it, as other comparable healthcare procedures do not demand the same levels of accreditation. Gestational limits, present in all states and territories except the ACT, further restrict access. While these limits are more permissive than in other countries, they pressure women to make rushed decisions and reflect abortion's exceptional status in healthcare. Requirements for providers to

offer counseling in some jurisdictions reinforce the notion that women are incapable of making rational and autonomous decisions about their reproductive health. Conscientious objection is another institutional mechanism that reinforces stigma. In Australia, approximately 15% of providers conscientiously object, refusing abortion services based on moral or ethical beliefs (Sifris and Penovic 2021). Although all Australian jurisdictions legally require objecting providers to refer women to alternative services, this process still causes delays (Sifris 2023). This situation increases the emotional and logistical burden on women and heighten their sense of stigma surrounding abortion, as they must navigate a healthcare system where some providers' personal beliefs impede access.

The partial decriminalization of abortion has definitely helped women change their mindset about obtaining abortions. No longer considered a crime, abortion has been increasingly normalized. However, as Sifris indicates, "the shift from a criminal law approach to a health law approach does not automatically lead to a complete eradication of stigma" (2023, 128). In the Australian context, this can be largely explained by the residual criminalization that persists for medical providers. In fact, they face potential prosecution for breaching procedural technicalities, such as gestational limits, reinforcing a culture of defensive medicine. This legal environment deters providers from offering comprehensive abortion care and limits access in underserved areas. This incomplete shift towards full decriminalization has thus not led to the destigmatization of abortion. Keogh et al's (2017) study of Victoria showcases this situation, where the partial decriminalization has reduced stigma by shifting the perspective towards the preservation of health, but it has not really improved access, because the legal reform was incomplete. First, it did not fully decriminalize abortion and, second, it was not followed with

positive measures such as a strategic planification of services and a full integration in the healthcare system, which would target other forms of stigma and barriers to access.

While Australia's shift to a healthcare-focused abortion framework has reduced criminal law stigma for women seeking care, it has not for medical providers. Further, other forms of stigma remain deeply entrenched. Women endure individual shame and guilt, community judgment fueled by activism and stereotypes, and institutional barriers created by overregulation, conscientious objection, and residual criminalization. Addressing these challenges requires the full decriminalization of abortion and a comprehensive strategy that includes service integration into healthcare, public education, and policies to ensure equitable and stigma-free access to abortion care.

In sum, the partial decriminalization of abortion has brought significant improvements in Australia. The increased legal clarity for providers has created a better delivery environment, where abortion is considered as a healthcare matter rather than a crime. Australia's partial decriminalization highlights the benefits of removing some criminal penalties, but its incomplete shift towards full decriminalization leaves a residual criminalization that disproportionately penalizes abortion providers and women seeking later-term abortions. These lingering punitive measures create barriers that undermine the full potential of treating abortion as a routine aspect of healthcare. Moving toward full abortion decriminalization, as seen in Canada, could address these shortcomings by repealing all criminal penalties, including those tied to gestational limits, ensuring that no woman faces prosecution for obtaining an abortion at any stage of pregnancy. If the country implemented abortion decriminalization based on the Canadian model, where abortion is treated like other essential healthcare procedures, Australian medical providers would no longer fear criminal prosecution as long as they offered quality care as indicated by their legal

professional standards. The Canadian experience shows the unnecessity of the law to govern abortion, considering the extensive protections under health statutes (Shaw and Norman 2020). Additionally, decriminalization would allow current collective networks to administer abortion pills for women to self-manage their abortion without fear of prosecution or state seizure. This shift would lower legal control, prioritize women's autonomy, and further destigmatize abortion, framing it firmly within the sphere of public health and reproductive justice.

However, full decriminalization alone cannot address systemic issues within Australia's public healthcare system, which remains unreliable in certain states. There are non-legal barriers that need to be solved before better access can be achieved (Sifris and Penovic 2021), namely a better allocation of funding for the public provision of abortion. I could not agree more with Baird's argument that "it is only when public health departments take responsibility that equitable access will be delivered" (2017, 198), especially as costs and geography are still the main barriers for women seeking abortion in Australia. The country's fragmented implementation underscores the need for a comprehensive nationwide approach to abortion delivery.

6. Abortion Decriminalization: The Case of Canada

The case of Canada will reveal the circumstances that allowed for the decriminalization of abortion in 1988. Unlike other countries where the legal reforms were mostly the result of pro-choice activism, Canada's full decriminalization happened unintentionally through a series of judicial challenges by Dr. Morgentaler, the adoption of the Charter of Rights and Freedoms, and an unexpected legislation change. After laying out the historical context, the next part will evaluate access, showing how the absence of legal regulations and the full integration of abortion in a functioning public healthcare system have proven to guarantee safe access to abortion in the

country. The last part will show the interplay between stigmatization and decriminalization, reflecting on the remaining influences that still stigmatize abortion.

6.1. Historical context

Canada's evolution of abortion laws is deeply rooted in its evolving legal, social, and political landscape. Initially, abortion was entirely criminalized through the 1869 adoption of Britain's 1861 *Offences Against the Person Act*. Incorporated into the 1892 Criminal Code, this prohibition included severe penalties for anyone involved in abortion (Haussman 2002). The rigid laws were part of broader restrictions on reproductive health, including a ban on contraception. While prosecutions were rare (Burnett 2019), the threat of criminal penalties had a chilling effect on doctors and women, forcing abortion into the shadows for nearly a century.

In the mid-20th century, a wave of social liberalization influenced global attitudes toward reproductive rights. In Canada, the 1960s and 70s saw significant activism surrounding issues like divorce, homosexuality, and contraception. Responding to these shifting norms, Pierre Trudeau's Liberal government introduced the 1969 *Criminal Law Amendment Act*, which fully legalized contraception and partially legalized homosexuality and abortion. The new law on abortion – Section 251 of the Criminal Code – allowed abortions if they were "performed in an accredited or approved hospital and approved by a three-physician therapeutic abortion committee (TAC) from that hospital as necessary to protect the woman's life or health" (Brown and Sullivan 2005, 287). These measures would make sure to legally protect medical practitioners from potential prosecutions (Johnstone 2017). This reform would further reinforce a medicalized approach, placing decisions about abortion in the hands of (predominantly male) doctors rather than women themselves.

6.1.1. Dr. Henry Morgentaler

Dr. Henry Morgentaler, a Polish immigrant and Holocaust survivor who settled in Montreal, became the central figure in Canada's abortion rights movement. Trained as a physician, Morgentaler opened an abortion clinic in Montreal in 1968, openly defying Canada's restrictive laws. His aim was to challenge the legal framework by inviting prosecution, thereby forcing public and judicial scrutiny of the abortion law. Morgentaler's trials became pivotal moments in the debate. Despite repeated acquittals by juries, appellate courts overturned these decisions, leading to his imprisonment in 1975 (Arthur 1999). Public outrage over his incarceration, coupled with the political support he garnered, led to the adoption of the Morgentaler Amendment, which limited appellate courts' ability to overturn jury verdicts (Johnstone 2017). Furthermore, considering his numerous acquittals, the Parti Québécois, when governing the province of Quebec, declared that they would no longer prosecute Morgentaler for practicing abortions. The political party made a major declaration, in reality legalizing abortion in the province. At the time, abortions were then already integrated in the healthcare insurance plan, that is fully funded by the provincial program, at the exception of clinic fees (*ibid*).

Morgentaler's persistent legal battles, including Supreme Court appearances in the 1970s, highlighted the limitations of existing laws. His advocacy galvanized feminist networks and abortion rights activists across Canada, who demanded comprehensive reforms to ensure reproductive justice. His actions also spotlighted the inequalities and inefficiencies of the therapeutic abortion committee (TAC) system, where approval for abortion was inconsistent, especially for marginalized women. As Johnstone indicates, "the TACs operated at the discretion of hospitals, of which only one in five across Canada chose to establish them" (2017, 56), creating unequal access to care.

6.1.2. The Charter of Rights and Freedoms and the Morgentaler Decision

A significant turning point came with the adoption of the Canadian Charter of Rights and Freedoms in 1982 (Gordon and Johnstone 2024). The Charter enshrined individual rights and freedoms into Canada's Constitution, offering a robust framework for challenging discriminatory laws. As Smith argues, using the courts to challenge the law at this moment led to judicial empowerment for certain social movements, especially those who are "dedicated to liberal rights-claiming" (2005, 347). Feminist groups leveraged the Charter, particularly Section 7, which guarantees the right to life, liberty, and security of the person, to argue against the restrictions imposed by Section 251 of the Criminal Code.

In 1988, the landmark *R. v. Morgentaler* decision struck down Section 251. The Supreme Court ruled that the law violated women's rights under Section 7 by imposing undue burdens and delaying or denying access to abortion. This decision effectively decriminalized abortion in Canada, marking a watershed moment in the country's legal history. While the ruling did not establish a positive right to abortion, it removed the procedure from the criminal code, leaving regulation to healthcare systems.

6.1.3. Post-Decriminalization Landscape

Following the 1988 decision, the federal government attempted to reintroduce abortion restrictions through Bill C-43, which sought to criminalize abortions unless a doctor determined that the woman's life or health was at risk. The bill narrowly passed the House of Commons but was defeated in the Senate (with a tie). This failed attempt left Canada without an abortion law, a status that remains to this day. As such, Canada's lack of abortion law was anything but intentional. Since then, federal governments have avoided discussing abortion. Still, considering the public opinion polls consistently showing strong support for abortion rights (Forum Research

2012), the government maintained the status quo by tacitly recognizing a negative right to abortion.

After the decriminalization of abortion, the legal situation was ambiguous. Judicial rulings in the years following decriminalization provided much needed clarifications while also further solidifying women's reproductive autonomy. In *Tremblay v. Daigle*[18] (1989), the Supreme Court ruled that a father could not prevent a woman from obtaining an abortion, reinforcing the principle of a woman's right to choose, even against her partner's wishes. However, the flaw in Daigle's victory, in legal terms, was that it failed to recognize her rights, focusing instead on procedural concerns (2017). Other cases, such as challenges to fetal rights and the legal status of healthcare providers[19], consistently brought clarifications to the Morgentaler decision and reinforced the legal framework supporting abortion rights. Meanwhile, attempts by anti-abortion activists to use the courts to re-criminalize abortion, such as the Borowski case[20], were largely unsuccessful. Moreover, even if no government has attempted to legislate the procedure, more than forty-five unsuccessful attempts to introduce bills meant to restrict or re-criminalize abortion have been suggested since 1987 (ARCC 2023a). Their failure has solidified the decriminalized status of abortion.

The decriminalization of abortion has had profound implications for Canada. It established a healthcare-oriented approach to reproductive rights, integrating abortion services into the public system. The focus has shifted toward improving service delivery rather than revisiting criminalization. Today, Canada's unique status as the only country without abortion-

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[18] Tremblay v. Daigle, 1989 CanLII 33 (SCC), [1989] 2 SCR 530

[19] R. v. Sullivan, 1991 CanLII 85 (SCC), [1991] 1 SCR 489
Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.), 1997 CanLII 336 (SCC), [1997] 3 SCR 925
R. v. Levkovic, 2013 SCC 25 (CanLII), [2013] 2 SCR 204

[20] Borowski v. Canada (Attorney General), 1989 CanLII 123 (SCC), [1989] 1 SCR 342

specific laws reflects the enduring legacy of the Morgentaler decision and the societal consensus around reproductive rights. Public support for abortion remains high, and political parties continue to avoid reopening the debate. However, this approach has the troubling side effect of effectively absolving the House of its responsibility to actively participate in safeguarding women's constitutional rights. The story of Canada's abortion laws underscores the power of activism, judicial intervention, and societal change in shaping progressive legal frameworks.

6.2. Accessibility

The full decriminalization of abortion in 1988 significantly changed reproductive healthcare. The absence of legal regulations has proven that protections under health law were sufficient to ensure quality care and professionalism. Abortion's widespread availability has facilitated access, even if geographical and citizenship-based inequities remain. Further, the lack of federal enforcement of the *Health Act* has allowed some provinces to continuously violate its terms by not offering, or even restricting, access to abortion. While decriminalization has not created a perfect system of abortion provision, it exemplifies how the consistent availability of care at no cost in a public health system complements the removal of abortion from the criminal code for enhanced access.

6.2.1. The absence of criminal law on abortion

Canada has fully decriminalized abortion, removing it entirely from the realm of criminal law and eliminating the risk of prosecution for both patients and medical providers. The only remaining legal risks for medical professionals are those that apply to all healthcare practices and are not specific to abortion. By fully integrating abortion into the healthcare system, it is now regulated like any other medical service, with health law ensuring the delivery of safe and quality care (Shaw and Norman 2020). This framework dismantles the notion of abortion as an

"exceptional" procedure, allowing decisions about it to remain strictly between patients and healthcare providers. In contrast to countries that maintain some level of criminalization, Canada's approach provides much-needed legal clarity and removes the threat of prosecution for all parties involved in abortion care. This decriminalization marks a significant shift, reframing abortion as a critical public health issue rather than a private or moral concern. The fact that no matter in which province or territory a Canadian pregnant woman is, counselling, assessments and follow-up are available at no cost is a great step towards accessibility. By prioritizing public health and treating abortion as essential reproductive healthcare, Canada's model advances reproductive justice.

Since there is no federal criminal law on abortion, there are no legal restrictions specific to the provision of abortion. For instance, there are no requirements regarding gestational limits, waiting periods, counselling or ultrasounds - just to name a few - which usually limit access in other countries. In fact, enacting some of these regulations would conflict with the *Charter of Rights and Freedoms* and the *R. v. Morgentaler* decision that decriminalized abortion in the first place. Overall, this framework allows for more streamlined access to abortion services, as women can make decisions about their reproductive health without unnecessary legal or medical hurdles.

6.2.2. Limits to abortion decriminalization

While abortion decriminalization has done a lot to enhance access to abortion, there remain limits to access, namely provincial disparities, non-conformity to the *Health Act,* and cost and geography inequalities. Since healthcare is a provincial responsibility, the availability of abortion stems mainly from provincial health regulations. Each jurisdiction sets its own guidelines for how abortion services are delivered and funded, including the availability of

facilities. Regardless, healthcare in Canada is remarkedly consistent (Fierlbeck and Palley 2016), leading to steady and accessible care to abortion. For instance, medical abortion is an area of abortion delivery that has shown uniformity in access. The approval of Mifegymiso (Mifepristone and Misoprostol pills) in 2017 for medical abortion has enhanced access, allowing pregnant individuals to obtain the medication in their local health facility with a prescription. The decentralization of services through telemedicine programs has also made it easier for women to access abortion care, particularly in rural areas where physical clinics may be scarce. Telemedicine enables women to obtain prescriptions for abortion pills after virtual consultations with physicians or nurse practitioners, reducing the need for travel and in-person visits. However, disparities persist due to the limited availability of telemedicine.

Still, the provincial variation in abortion administration can create confusion, especially for individuals seeking care in a jurisdiction different from their home province. For instance, while there are no national gestational limits, individual clinics and hospitals often impose their own limits based on staff, local resources, technology, and expertise. This means that while early abortion care is generally accessible across the country, access to later-term abortions may be restricted to specialized facilities in major urban centers. For example, hospitals and clinics in New Brunswick, Newfoundland and Labrador, Nunavut and Prince Edward Island offer surgical abortions between 12 and 15 weeks (maximum) (ARCC 2024c; Vitalité 2024). Women are likely to experience increased stress and financial burden if they cannot make it before these deadlines and are forced to travel to other provinces. As such, individuals living in these areas, or in provinces with fewer specialized abortion providers may face significant challenges. The logistical and financial burden of this travel can act as a barrier to timely access, disproportionately affecting marginalized communities, including low-income individuals, non-

English or French speakers, Indigenous people, and young people (Shaw 2013). Another area where provincial variation affects access to abortion is the regulation of minors' consent. Different provinces have differing rules about the age at which minors can consent to an abortion without parental involvement, which can lead to confusion and delays in access for young people.

As long as provinces offer abortion care within the guidelines of the *Health Act*, access should be guaranteed. Further, the federal government has the power to enforce universal access to essential health services, including abortion, namely by stopping federal health transfers until compliance. However, for many years now, it has been failing to hold provinces accountable when they violate the Act by restricting access to abortion services. Most provinces uphold their share of responsibilities, offering extensive care. Nevertheless, two provinces have been intentionally limiting access to care. First, New Brunswick had enforced regulations that limit publicly funded abortions to hospitals (Johnstone 2017). The newly elected Liberal government recently eliminated the legal restriction, which is a clear victory for women in the province (Poitras 2024). Second, Ontario has been refusing to extend funding to four private abortion clinics, even if it does fund four others (ARCC 2022a). The status quo of abortion in politics has made the federal government reluctant to raise the matter and implement concrete sanctions. Additionally, conflicts between the federal and provincial governments over healthcare funding and jurisdiction have at times hindered the provision of abortion services (Vickers 2010). The hesitance of the federal government to confront provinces that fail to comply with the Canada *Health Act*'s principles of universal, comprehensive, and equitable healthcare access, is thus very complicated. Still, it has been a long promise of the Trudeau administration to guarantee abortion access; during a one-on-one interview organized by the Up for Debate campaign, [Justin]

Trudeau "committed to engaging provinces in discussions regarding their compliance with the Canada Health Act so as to ensure all individuals have access to essential health services, including abortion" (Action Canada 2015). Since being in office, however, his government has taken little direct action on abortion, except to remove the restrictions put in place by the previous government that blocked funding for the performance of abortions overseas (Akin 2016). This is one of the reasons that has pushed the Abortion Rights Coalition of Canada (ARCC) to write a letter to current NPD leader, Jagmeet Singh, on December 12, 2022. The letter criticizes the inaction of the current Liberal government, particularly towards provinces that have been breaching the *Health Act* for decades now. It also addresses some of the challenges in access stemming from the conservative nature of provincial governments (AB, MN, ON, SK) that tend to do very little for abortion accessibility. In sum, some provinces' lack of accountability towards the *Health Act* complicates the uniform delivery of abortion services, leading to inequalities across regions. Still, there is potential for improvement. ARCC advocates argue that tying federal health transfers to provincial compliance with these principles could enhance abortion access across the country (ARCC 2022a). Canada has a public healthcare system that provides abortion services at no cost, and all provincial health insurance plans cover the cost of abortion medication. The recipe for enhanced access is right under our eyes, the federal government must then enact their powers to keep provinces accountable.

Issues due to cost and geography are also limits that abortion decriminalization has not solved on its own. For instance, for those living in rural or remote areas, the lack of nearby facilities or available providers often requires traveling to another province or city, incurring significant costs related to transportation and accommodation (ARCC 2024c). For all provinces, except Quebec, Ontario, and British Columbia (BC), women have to travel long distances to

larger urban centers for care, particularly for second-trimester abortions since many smaller or remote clinics may not offer the service (ARCC 2022a). This is not surprising considering the large size and low population of the country. This situation is especially true for second-trimester surgical abortions, which are performed either in hospitals or specialized clinics, since the level of risk during and after the procedure may be heightened. Obtaining a later abortion due to health complications or fetal anomalies can expand these existing delays and costs, which exacerbates women's already more fragile emotional and physical well-being. For instance, in Alberta, the main clinics, located in Calgary and Edmonton, perform more than 75% of abortions in the province (ARCC 2024b). Therefore, positive measures that target these problems of cost and geography must be implemented by each province with the help of the federal government.

Furthermore, while abortion is free to patients with provincial health insurance, non-citizens must pay out-of-pocket costs for private care. Non-citizens such as migrants, international students, asylum seekers, among others, do not necessarily own a health insurance card, are thus excluded from the benefits of Canada's free abortion provision. However, this is not an issue unique to abortion. The reliance on citizenship (or permanent residence or other arrangements) to obtain health insurance is common to access all health services. Despite efforts to make abortion universally accessible, geography and cost continue to pose significant barriers for many individuals, especially those in rural or underserved provinces. The absence of a systematic and periodic method of data collection on abortion provision – or reproductive healthcare more largely - is a critical oversight in Canada. Effective monitoring and evaluation are essential to measure quality and trends, and to inform policy and decision-making to further improve service delivery and quality.

6.3. Stigma

Canada's full decriminalization of abortion in 1988 has played a pivotal role in lowering stigma at all levels. While societal and religious beliefs still contribute to abortion stigma, the absence of legal restrictions has significantly reduced the institutional and criminal law-related stigma that impedes access in other countries, as seen in Ireland's liberal abortion legalization and Australia's partial decriminalization.

6.3.1. Deconstructing internalized stigma

Even in a decriminalized framework, individuals in Canada may still internalize societal attitudes framing abortion as immoral or sinful. Traditional gender roles, cultural norms, and religious doctrines often depict women as nurturers, stigmatizing those who seek abortions as selfish or irresponsible (Johnstone 2017). These perceptions can lead to feelings of guilt, shame, and psychological distress, particularly among women from devout religious backgrounds. The decriminalization of abortion, even after more than 30 years, has unfortunately not fully deconstructed centuries of moral beliefs around female sexuality and motherhood.

However, Canada's decriminalized approach helps mitigate these pressures by treating abortion as a standard healthcare service. Unlike countries where abortion remains regulated by criminal law or subject to restrictive conditions, Canadian women experience fewer external barriers, reducing the likelihood of secrecy and emotional strain. This secular legal framework allows women to access care without the added burden of legal judgment, fostering greater acceptance of abortion as a legitimate choice.

In fact, public support for abortion in Canada has steadily increased over the years. In 1975, nearly three-quarters of Canadians supported abortion when a woman's health was at risk, and by 1988, 69% believed abortion decisions should be made solely between a woman and her

doctor (Brodie et al. 1992). By 2012, polling showed that 90% of Canadians supported some form of legal abortion, with 60% advocating for its legality under all circumstances (Forum Research 2012). This growing consensus highlights the broad and enduring public approval for reproductive rights in Canada, reducing abortion stigma over time as its vitality to reproductive justice is emphasized.

6.3.2. Community-level judgment

Anti-abortion activism in Canada, while present, has less impact on abortion access compared to countries with restrictive laws. Protests and campaigns by anti-abortion groups in Canada differ from the "traditional portrait" of anti-abortion activism, actually moving away from religious appeals, fetal-centric arguments and anti-woman discourses (Saurette and Gordon 2016). For example, the arguments about the sanctity of the life of the fetus do not appeal much the masses in Canada considering the secularization of the population and the numerous legal decisions (e.g., *Tremblay v Daigle* (1989), *Winnipeg Child and Family Services v. DFG* (1997), and *Dobson v Dobson* (1999)) that deny fetal rights. Instead, the movement has rebranded itself using pro-woman anti-abortion rhetoric - such as the argument that abortions harm women - to attract more support (Gordon and Saurette 2020). Anti-abortion activists have also been using various intimidation tactics to shame abortion providers and pregnant individuals alike (Johnstone 2017). Yet, because Canada's legal framework does not align with these narratives, their influence is largely confined to personal beliefs and localized community attitudes, having more repercussions at the individual and community levels. Furthermore, Canadian provinces have progressively added legal protections for safe access zones around abortion facilities. All inspired by BC's first law on safe access zones: the *Access to Abortion Services Act* passed in 1995, other provinces passed similar legislation in the mid-2010s, with Newfoundland and

Labrador in November 2016, Quebec in December 2016, Ontario in October 2017, Alberta in May 2018, Nova Scotia in March 2020, and Manitoba in June 2024 (ARCC 2024b). While three provinces remain without safe access zones legislation (Saskatchewan, Prince Edward Island, and New Brunswick), the federal government announced in January 2022 the implementation of Bill C-3, which amends the Criminal Code to make it illegal to intimidate healthcare workers or patients, or obstruct access to healthcare services at any facility, including abortion clinics. Initially prompted by anti-vaccine protests, the law extends to all healthcare providers and locations, including homes and online spaces. It imposes harsher penalties than existing provincial laws and may help deter abortion protests in the other provinces without specific safe access zone laws for abortion facilities. Still, the safe access zones legislation is not without its challenges; though it has been shown to work well in BC and Quebec, Ontario and Alberta's governments still limit the legislation's application. In Ontario, only the original eight private abortion clinics are covered by the law, thus excluding other hospitals and facilities. In Alberta, the lack of law enforcement even after court injunctions were obtained led to increased protests and disruptions which physically restricted women's access to abortion (ibid). Yet, the legal protections offered by the state and the provinces further support abortion as essential healthcare, invalidating anti-abortion efforts.

While Canada's secular legal framework excludes religious influence from abortion policy, religious stigma persists within certain communities. Some Catholic and Evangelical groups continue to oppose abortion, shaping societal attitudes and contributing to internalized shame among religious women. However, since religious groups in Canada are much less politicised and politically organised (Farney 2012; Malloy 2009), their influence is limited to personal and community beliefs rather than institutional policies, reducing their overall impact

on abortion access. The absence of religious interference in Canada's legal framework contrasts sharply with countries like Ireland, or even Australia, where religious groups have historically shaped laws and public opinion. This secularization ensures that abortion access in Canada is less affected by external pressures, though personal struggles with religious beliefs can still affect individual experiences. However, their effects are less pronounced in a system that offers broad access and normalizes abortion care.

6.3.3. Institutional practices

Institutional stigma remains a challenge in Canada due to uneven policies on conscientious objection. Two provinces, Ontario and Nova Scotia, mandate effective referrals when providers refuse to perform abortions, while most provinces (NB, PEI, QC, SK, AB) only require referrals to information sources, causing delays and enforcing abortion as exceptional (ARCC 2022b; 2023b). The lack of consistent enforcement mechanisms for ensuring that providers adhere to these referral policies reflects lingering institutional barriers that position abortion as a contentious healthcare service. The refusal of care, coupled with inconsistent referral practices, positions abortion as an exceptional service subject to moral debate, further complicating access and marginalizing women seeking care. Such policies, combined with the lack of centralized monitoring of abortion access, contribute to systemic inequalities in reproductive healthcare across the country.

Despite these challenges, Canada's decriminalized framework promotes abortion's integration into the healthcare system. Unlike Australia, with its ongoing residual criminalization, Canadian healthcare providers do not face abortion-specific criminal liabilities, reducing the stigma of offering care. The full decriminalization of abortion was followed by meaningful efforts to normalize abortion care within the public health system. For example, the

lack of legal restrictions such as mandatory counseling or heightened accreditation requirements ensures that abortion is treated like any other medical procedure, empowering both patients and providers. Still, a last institutional barrier to dismantle would be to not restrain the prescription of abortion medication solely to physicians and nurse practioners (Government of Canada 2024), but to extend it to all qualified health professionals, including pharmacists and midwives[21]. The medicalization of abortion in Canada has lasting effects, limiting the decentralization of care. However, unlike other legal frameworks, full decriminalization has been critical in eliminating criminal law stigma. Without federal restrictions, abortion is no longer framed as a morally or legally exceptional act. This legal environment fosters a patient-centered approach, where providers can focus on women's healthcare needs without fear of legal repercussions. By removing abortion from the Criminal Code, Canada has established a precedent for destigmatizing abortion at an institutional level.

To conclude, Canada's full decriminalization of abortion has significantly reduced stigma at institutional and criminal law levels by treating abortion as a routine healthcare procedure. While individual and community-level stigmas persist, often influenced by cultural and religious beliefs, the absence of legal barriers has minimized their impact on access. This legal framework underscores the critical role of decriminalization in normalizing abortion and supporting women's reproductive autonomy.

7. Conclusion

To summarize, this thesis underscored the limitations of liberal models of abortion legalization and partial decriminalization, advancing the normative argument that full

[21] Quebec is the only exception that allows abortion pills to be prescribed by midwives.

decriminalization represents the most effective regulatory framework for ensuring safe, accessible, and affordable abortion care. Through a comparative analysis of Australia, Canada, and Ireland, the study explored how permissive legal frameworks influence access to abortion care. It examined the interplay between legal frameworks and two metrics of access: accessibility in healthcare delivery, and abortion stigma. The findings demonstrated that while liberal abortion legalization and partial decriminalization have expanded abortion access, these frameworks often retain procedural and legal barriers, including criminal sanctions and restrictive health regulations, which hinder access and perpetuate stigma. Even within these permissive systems, their persistent entanglement with criminalization negatively affects women seeking care and the healthcare professionals involved in its provision.

Therefore, drawing on the Canadian experience, this thesis argues that abortion decriminalization addresses these challenges in two ways. First, abortion decriminalization requires repealing any existing criminal abortion laws, and second, mandates that abortion must be treated like any other essential health service. By evaluating the "counterintuitive" framework of decriminalization, the research identified its potential to enhance abortion access without direct legislative intervention, highlighting the paradox of the law. Canada’s approach demonstrates that decriminalization can shift abortion governance from punitive legal frameworks to a public health model, prioritizing accessibility and destigmatization.

Overall, this project contributes to the emerging literature on abortion decriminalization, revealing its potential to reduce the unfair burden placed on women by traditional legal structures, particularly in settings like Canada and Australia, where telemedicine and self-managed abortion (SMA) have already begun to reshape access. Even if the Canadian trajectory

to abortion decriminalization is unique, the advantages of abortion decriminalization can be transferred to other countries, namely Ireland and Australia.

Abortion decriminalization constitutes the first step towards better access and destigmatization. Nonetheless, it does not magically solve all issues related to the provision of abortion care. Other positive measures are necessary to guarantee full access to free, safe and available care. Challenges such as geographical disparities and financial barriers to accessing care persist, particularly for women in rural or remote areas. Although abortion is free for those with public healthcare coverage in Canada, travel costs and logistical burdens remain significant obstacles, as do limitations on local provider/facility availability for late-term abortions. Yet, these challenges characterize most countries, regardless of their abortion governance model.

Furthermore, while decriminalization shifts abortion governance away from criminal law, it does not inherently guarantee equitable access, particularly in countries lacking universal healthcare systems (Luna 2020). As Gordon and Johnstone (2024) explain, while decriminalization in Canada did not come with a positive right to abortion, the large public approval and the nature of the Canadian healthcare system have reinforced the perception that abortion services are a guaranteed and universally available component of medical care. However, in countries without such strong and long-lasting social attitudes towards abortion, decriminalization could create a false sense of security. Additionally, integrating abortion into healthcare may lead to its depoliticization, as observed in Canada, where federal inaction has tempered debates on abortion access over the years (Erdman 2017). Full decriminalization is a drastic legal change for countries used to governing abortion within criminal law. Incremental reforms, as seen in Ireland, may then be prized for minimizing backlash but they fail to align with the broader normative argument that criminal abortion laws must be repealed to achieve

reproductive justice. Overall, the potential of abortion decriminalization outweighs a liberal framework that governs abortion within criminal law.

Despite these limitations, abortion decriminalization holds many promises for improving abortion care globally. Adopting decriminalization as a governance model for abortion has several global policy implications, emphasizing a shift toward more equitable reproductive healthcare. Over 35 years of decriminalization in Canada have shown that it is effective in providing comprehensive care and that protections under health law were enough to ensure quality care and professionalism (Shaw and Norman 2020; Dwyer et al 2021). This framework challenges traditional legal control over abortion, reframing it as an essential reproductive healthcare service rather than a private moral issue (Sheldon and Wellings 2019; Gordon and Johnstone 2024). Consequently, this shift helps governments prioritize women's health, safety, and autonomy. It can also facilitate better allocation of resources, including funding for comprehensive abortion services and training healthcare providers. In fact, countries adopting decriminalization may also face the need to address broader healthcare and social policies, such as ensuring universal healthcare access, combating structural inequalities, and strengthening protections for reproductive rights. As Canada shows, the absence of criminal sanctions fosters a more supportive environment for reproductive justice. International organizations and advocacy groups may leverage these examples to promote global standards for reproductive healthcare and challenge restrictive abortion laws worldwide. In brief, decriminalization has shown that women can make autonomous and informed decisions about their bodies in a positive environment prioritizing healthcare, instead of being confined to criminality.

This research aligns with the growing literature on reproductive justice, which examines the intersections of race, class, gender, disability, and economic inequality in shaping access to

reproductive healthcare (Chrisler 2012; Luna and Luker, 2013; Ross and Solinger 2017; Luna 2020). It also agrees with emerging trends like self-managed abortion and telemedicine, which have empowered women to make autonomous reproductive decisions outside traditional legal frameworks (Shaw and Norman 2020). This thesis not only contributes meaningfully to academic debates but also offers actionable insights for policymakers and advocates seeking to expand reproductive rights globally. As such, this study highlights the promise of full decriminalization as a critical step toward reproductive justice, autonomy, and equity. By removing abortion from punitive legal systems, decriminalization provides a framework for addressing barriers to care and ensuring that reproductive rights are upheld as an essential component of public health.

8. Appendix

Table 1: Summary of abortion governance models

Abortion frameworks	Legal frameworks	Summary of characteristics	Examples
Abortion prohibition		Complete ban on abortion. No exceptional conditions.	El Salvador, Nicaragua
Abortion legalization	Restrictive legalization	Abortion is allowed in very few circumstances such as rape and incest.	Brazil
	Moderate legalization	Abortion is allowed on the previous grounds and in a few more circumstances (e.g., social grounds, fatal fetal abnormalities, risk to the life of the pregnant woman, etc.)	India, Japan
	Abortion liberalization	Abortion is allowed on request until a certain gestational limit (e.g., 12 weeks). After, abortions are allowed on certain grounds with the approval of one or multiple medical practioners.	Colombia, France, Tunisia, Ireland
Abortion decriminalization	Partial decriminalization	Criminal laws on abortion are repealed and abortion governance is transferred to health regulations. Still, abortion is legislated and allowed on request until a certain gestational limit (e.g., 12 weeks), after which medical approval is necessary.	Australia
	Full decriminalization	Criminal laws on abortion are repealed and abortion governance is integrated into healthcare under health law. There are no regulations that are specific to abortion such as gestational limits.	Canada

Table 2. Number of abortions notified in Ireland in 2023 by section of the Act

Section of the Act	Number of terminations notified
9 – Risk to life or health	21
10 – Risk to life or health in an emergency	7
11 – Condition likely to lead to death of foetus	129
12 – Early pregnancy	9876
Total	**10033**

Source: Department of Health (2024). https://www.gov.ie/pdf/?file=https://assets.gov.ie/297473/336a1c59-9628-46df-aebf-0fdc6e99e35d.pdf#page=null.

Table 3: Number of GPs providing abortions per county as of 2022

County	Population (2022)	Number of GPs	Ratio (as seen in graph)
Carlow	61 931	2	30 966
Cavan	81 201	6	13 534
Clare	127 419	15	8 495
Cork	581 231	69	8424
Donegal	166 321	15	11 088
Dubin	1 450 701	130	11 159
Galway	276 451	24	11 519
Kerry	155 258	11	14 114
Kildare	246 977	13	18 998
Kilkenny	103 685	6	17 281
Laois	91 657	4	22 914
Leitrim	35 087	4	8772
Limerick	205 444	14	14 675
Longford	46 634	1	46 634
Louth	139 100	11	12 645
Mayo	137 231	3	45 744
Meath	220 296	12	18 358
Monaghan	64 832	1	64 832
Offaly	82 668	3	27 556
Roscommon	69 995	3	23 332
Sligo	69 819	3	23 273

Tipperary	167 661	13	12 897
Waterford	127 085	13	9 776
Westmeath	95 840	9	10 649
Wexford	163 527	6	27 255
Wicklow	155 485	21	7404

Source: Bray (2023). https://www.irishtimes.com/politics/2023/04/27/nine-counties-have-fewer-than-five-gps-providing-abortion-care/.

Table 4: Summary of abortion governance in Australia per state and territory

State or territory	Abortion legal framework	Details
Australian Capital Territory	Decriminalized	No gestational limit. Must be provided by medical doctor. Health Minister may set 50 meters exclusion zones for protests.
New South Wales	Partially decriminalized	Accessible up to 22 weeks. Beyond 22 weeks, legal with two doctors' approval. Safe access zones are set at 150 meters around abortion clinics.
Northern Territory	Partially decriminalized	Accessible up to 24 weeks. Beyond 24 weeks legal with two doctors' approval. Safe access zones of 150 meters provided around abortion clinics.
Queensland	Partially decriminalized	Accessible up to 22 weeks. Beyond 22 weeks legal with two doctors' approval. Safe access zones of 150 meters are provided around abortion clinics.
South Australia	Partially decriminalized	Accessible up to 22 weeks and 6 days. Beyond this, legal with two doctors' approval. Safe access zones of 150 meters provided around abortion clinics.
Tasmania	Partially decriminalized	Accessible up to 16 weeks. Beyond 16 weeks, legal with two doctors' approval. Safe access zones of 150 meters provided around abortion clinics.
Victoria	Partially decriminalized	Accessible up to 24 weeks. Beyond 24 weeks, legal with two doctors' approval. Safe access zones of 150 meters provided around abortion clinics.
Western Australia	Partially decriminalized	Accessible up to 23 weeks. Beyond 23 weeks legal with two doctors' approval. Safe access zones of 150 meters provided around abortion clinics.

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