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Received: 12 December 2024 | Revised: 12 December 2024 | Accepted: 12 December 2024 | Published online: 22 December 2024

DOI: 10.1002/ijgo.16119

International Journal of GYNECOLOGY OBSTETRICS FIGO WILEY

ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Gynecology

Legal challenges in expanding the provider base for abortion in Asia

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Abstract

In Asia as elsewhere, strict regulations on who is authorized to provide abortion services and to prescribe or dispense medical abortion adversely impact access, especially for marginalized persons and residents in remote areas. The WHO's 2022 Abortion Care Guideline provides an important framework for states to formulate and implement policies to serve sexual and reproductive rights of access to abortion services. The Guideline calls for decriminalization of abortion services to increase authorization to provide abortion services and to promote self-managed medical abortion. This review examines the legal and policy frameworks of Bangladesh, India, Indonesia, Malaysia, and Nepal against the WHO Guideline. Legal and policy reforms successfully introduced in Bangladesh and Nepal to grow the provider base allow healthcare systems to expand safe abortion. This review outlines further challenges where the WHO Guideline on decriminalization and availability of medical abortion is disregarded and advocates a reproductive justice approach promoting egalitarian access to services even among the most marginalized.

KEYWORDS
abortion provider base, Asian abortion laws, medical abortion, reproductive justice, safe abortion, WHO abortion care guideline

1 | INTRODUCTION

In many South Asian and Southeast Asian countries, public health care is underfunded, and only expensive and inaccessible abortion services may be available in private healthcare facilities.[1] The inability of public health care institutions to provide timely, affordable, and good-quality services, including abortion services, is apparent by the many pregnant persons who either carry unwanted pregnancies to term or resort to unsafe abortion methods.[2] WHO has recorded that 45% of abortions undertaken globally are unsafe,[3] showing that systemic changes in the healthcare sector are imperative to improve abortion access. In many countries, the legal frameworks allow only specific medical practitioners to provide abortion services, thereby restricting the overall availability of healthcare practitioners to provide abortion services.[4] However, improving access to healthcare services requires empathetic, sensitive, and trained healthcare practitioners, as well as comprehensive public healthcare infrastructure, especially in remote areas.

Access to safe and legal abortion remains a critical issue around the world, with varying degrees of availability and restrictions in different countries. A key factor contributing to the lack of access to safe abortion services and increased incidence of unsafe abortions is the global shortage of skilled healthcare providers. Per WHO estimates, the shortage of skilled healthcare providers is likely to increase to 12.9 million at a global scale by 2035. The most significant effects of this shortage are felt by resource deficient countries and

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rural areas.[5] To address this issue, it is essential to consider ways to expand the provider base to increase access to abortion services. This can involve increasing the number of trained healthcare providers who are able to offer abortion care, as well as expanding the types of providers who can legally provide abortion services. Additionally, ensuring that providers are properly trained and supported in offering abortion care is crucial to ensuring that patients receive high-quality and compassionate care throughout the process.

These restrictions around abortion services are inconsistent with the WHO's 2022 Abortion Care Guideline.[3] Recommendation 1 seeks the full decriminalization of abortion services, calling for the removal of offenses and penalties enacted against persons who access abortion services, service providers, and people who assist in access or management of abortions, sometimes even including information providers. Recommendation 21 recommends against regulation on who can provide abortion services, noting that such restrictions are arbitrary in nature, result in delays, and impose a burden on pregnant persons.

Recommendation 28 read with Recommendation 50 of the WHO Guideline suggests using misoprostol either by itself or in combination with mifepristone for pregnancies up to 12 weeks of gestation to promote self-managed medical abortion. Recommendation 50 (self-management of medical abortions at <12 weeks) calls for expansion of the provider/prescriber base to include community health workers, pharmacy workers and pharmacists, traditional and complementary medicine professionals, auxiliary nurse-midwives (ANMs), nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners, and specialist medical practitioners. Therefore, removal of penalties, increasing the provider base and promoting medical abortions are all concretized in the WHO Guideline. This is supplemented by significant evidence-based research, which shows that expanding the provider base for abortion services can facilitate access to safe abortion and prevent instances of unsafe abortion.[6]

One such national success story showing a direct correlation between an expanded provider base and access to safe abortion can be seen in Bangladesh. In 1978, the state introduced menstrual regulation policies that allowed the removal of uterine contents before a positive pregnancy test. These policies allowed an expanded provider base, including midlevel healthcare service providers, to provide early treatment with minimal infrastructure in the most remote areas.[7] This in turn greatly expanded access to safe, affordable, and timely abortions in the country.[8] Nepal has also expanded its provider base by allowing midlevel healthcare providers to conduct abortions up to 12 weeks of gestation[9] with positive results.[4]

International human rights law has come to a consensus that abortions must be available and accessible—and not just legal[10]—to ensure that reproductive rights are upheld, including the rights to equality, dignity, life, security of the person, and freedom from torture, cruel, inhuman, and degrading treatment or punishment. States are obligated according to the principles of international human rights law to ensure that any abortion regulation is evidence based and proportionate.[11] Where restrictions on the provider base for abortion care are arbitrary and disproportionate, states have an obligation to remedy the impacts of such restrictions.[12]

2 | OVERVIEW

This article aims to show that expanding the provider base for abortion services is necessary to mitigate current barriers to abortion services in various South and Southeast Asian countries, many of which restrict access to abortion through criminalizing laws and grounds-based restrictions. This article further examines the legal and policy frameworks regarding the WHO Guideline, evidence-based research and/or success stories from Bangladesh, India, Indonesia, Malaysia, and Nepal to explore the distinct challenges to safe abortion services, and the critical need to expand the provider base to combat some of these challenges.

I first briefly examine the legal and policy frameworks that influence access to abortion directly or indirectly—through criminalizing laws, jurisprudence, and/or state policies—for each country. I then apply relevant recommendations of the WHO's 2022 Abortion Care Guideline[3] to the outcomes of these frameworks to develop an understanding of the effects of provider restrictions, considering evidence from the applicable human rights standards. Finally, I make a case for the decriminalization of abortion using a reproductive justice framework.

3 | FINDINGS

This section looks at the legal frameworks of Bangladesh, India, Indonesia, Malaysia, and Nepal and evidence-based research in these jurisdictions to identify the current status of abortion care as well as the unique challenges to abortion access. Bangladesh and Nepal have expanded their provider bases, which is seen to improve access to abortion services and overall sexual and reproductive health (SRH) outcomes.

3.1 | Bangladesh

In Bangladesh, the Penal Code of 1860 allows abortion only when it is necessary to save the life of the pregnant woman. In 1978, Bangladesh introduced menstrual regulation policies, aimed at promoting abortion as a segment of national family planning efforts, available in public hospitals and decentralized family planning complexes, up to 12 weeks from the last menstrual period.[13] Midwives, nurses, and other healthcare specialists could receive menstrual regulation training in recognized facilities.[7] Further, the 2015 Guideline on Menstrual Regulation with Medication allows medical abortions using a combination pack of mifepristone and misoprostol in approved facilities, which can be done by seven types of healthcare professionals.[14]

3.2 | India

The United Nations Population Fund (UNFPA) noted in a 2022 study that from 2007 to 2011, 67% of all abortions in India were unsafe.[15]

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Abortion access in India has historically been regulated by the Indian Penal Code (IPC) of 1860, recently replaced by the Bhartiya Nyaya Sanhita, 2023 (BNS) (Sections 88–94), which is India's primary criminal statute since July 1, 2024. Section 88 of the BNS criminalizes abortion unless done in good faith to save the pregnant woman's life, bearing penalties ranging from fines to imprisonment. The Medical Termination of Pregnancy (MTP) Act 1971 was enacted as an exception to the criminal provisions under the Criminal Code, allowing abortions under specified circumstances. The amended MTP Act 2021 provides for abortion services under certain conditions with the assent of one Registered Medical Practitioner (RMP) for pregnancies up to 20 weeks and two RMPs for pregnancies between 20 and 24 weeks of gestation for 'certain categories of women'.[16] The MTP Act was amended in 2002 to include medical management of abortion with pills to facilitate abortions for early-stage pregnancies. It was further revised in 2021 to extend the availability of medical abortion pills up to 9 weeks.[17] In September 2022, the Supreme Court of India while upholding the decisional autonomy of a pregnant person expanded the scope of the MTP (Amendment) Act 2021 and RMPs must acknowledge abortion seekers' material circumstances when deciding whether or not they are eligible for an abortion. The Court noted that the Act must not be restricted to cisgender women and must include transgender and gender-diverse persons.[18]

The MTP rules provide that: (a) for RMPs registered at the state level before the MTP Act's enactment, they must have gynecology and obstetrics practice experience of not less than 3 years; and (b) for RMPs registered in any state medical register after the enactment of the law, they need (i) 6 months of house surgery in gynecology and obstetrics experience at a hospital for not less than 1 year; or (ii) they should have assisted an RMP in 25 abortion cases of which they performed at least five independently in a government-approved hospital.[17,19] Only if RMPs meet the above criteria, can they provide abortions up to 20 weeks of gestation, and an RMP may provide abortions only up to 12 weeks if they have only trained at an institute. These rules significantly restrict the provider base authorized to terminate pregnancies in India.[17]

3.3 | Indonesia

Indonesia's abortion laws have seen considerable change over time. Initially, the 1992 Health Law No. 23 permitted abortion only in medical emergencies. In 2009, the regulations expanded slightly, allowing abortion within the first 6 weeks under specific conditions. The most recent legislation, Health Law No. 17 of 2023, extends this access further, permitting abortions up to 14 weeks in cases involving sexual violence, as detailed in Section 463(2) of the amended Indonesian Criminal Code. This latest law reinforces the importance of individuals' rights to a safe and protected reproductive life but is unlikely to be implemented before 2026.[2]

The Indonesian Criminal Code criminalizes abortion subject to certain exceptions; for example, for pregnancies resulting from sexual violence or rape. Islamic Shariah law is applied in the Aceh Province. The law in Aceh province recognizes that couples have the basic right to decide when and how many children to have, and abortion is allowed upto 40 days under certain conditions.[20,21] There is also legal conflict between the Criminal Code and the Health Law, as the former categorizes abortion as a criminal act, except under specific circumstances such as life-threatening conditions to the pregnant person or rape, as per Articles 346–349; and the latter recognizing women's right to safe and accessible reproductive health services, including safe abortion services as per Article 15.[21] The Health Law can therefore improve access to safe abortion services in Indonesia by allowing for “legal” abortions, but provider base restrictions and legal ambiguities continue to deter healthcare providers from providing abortion services, fearing prosecution.[20]

3.4 | Malaysia

The Malaysian Penal Code of 1936 criminalizes abortion services. The 1989 Amendment to the Malaysian Penal Code was designed to expand access to abortion services. This amendment introduced a new exception according to which the section does not apply to medical practitioners registered under the Medical Act of 1971 who terminate a pregnancy. The exemption applies if the medical practitioner, acting in good faith, believes that continuing the pregnancy would pose a greater risk to the woman's life or her mental or physical health than terminating it. Malaysia's legal framework on abortion reflects a nuanced and comparatively permissive stance. Governed by the Malaysian Penal Code as of 2017, abortion services in Malaysia are subject to specific regulations that are more progressive than those in many other countries.[2] Most importantly, in 2012, Malaysia implemented universal access to health care, extending SRH services to all healthcare facilities nationwide. Malaysia's dual legal system has Sharia law, which allows abortion up to 120 days of gestation for Muslim persons, if there is a risk to the pregnant woman's life, or if fetal anomalies are detected.[22]

The Guideline on Termination of Pregnancy for Hospitals in the Ministry of Health recognizes both medical and surgical abortion methods.[23] However, mifepristone is not registered in the country, and misoprostol is used only for the treatment of gastric ulcers and deregistered for abortion use. The nonavailability of legitimate and safe abortion pills has resulted in a rise in illegal sales of pills, often online, which have in turn exacerbated abortion-related complications due to improper doses of medication or even contaminated pills.[22]

3.5 | Nepal

Nepal criminalized abortion under its historical Penal Code. In 2002, Nepal amended the law to allow abortions up to 12 weeks of gestation, up to 18 weeks on grounds of rape or incest, or without any gestational limit for fetal anomalies or if the pregnancy threatens the life or health of the pregnant woman.[24]

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The Safe Motherhood and Reproductive Health Rights (SMRHR) Act of 2018 allows abortions up to 28 weeks in cases of rape, incest, fetal anomalies, or risks to the pregnant woman's health.[2] Abortion services may be provided only by licensed healthcare professionals in recognized healthcare institutions, with prior consent of the pregnant woman. In 2009, the Supreme Court in *Lakshmi Dhikta v. Nepal* stated that abortion is a constitutionally protected fundamental right and that women hold the right to decisional autonomy in respect of their reproductive health, free from coercion or unnecessary interference.[25] The court highlighted the importance of affordability and accessibility of abortion for marginalized groups and the need to construe abortion as a health issue rather than a criminal act. Further, the 2009 Medical Management of Abortion initiative allowed ANMs to administer abortion pills up to 8 weeks of gestation, significantly expanding the provider base.

4 | CROSS COUNTRY APPROACH TO EXPANDING PROVIDER BASE

This article shows that abortion is criminalized in Bangladesh in contravention of Recommendation 1 of the WHO Abortion Guideline. However, significant state efforts to build provider capacities have improved the availability of reproductive health services in the country.[14] Expanding the provider base through paramedic and menstrual regulation training programs is in tune with Recommendation 28 of the WHO Abortion Guideline, which seeks to facilitate accessibility to quality abortion services without undue delays or burdens on abortion seekers. Furthermore, menstrual regulation training programs are consistent with both Recommendations 21 and 28 of the Abortion Guideline, advocating for medical abortions using the key drugs until a gestational age of 8 weeks, even though the WHO Guideline recommends 12 weeks for the use of these drugs, as indicated per Recommendation 28 in conjunction with Recommendation 50. A 2020 study found that more than three-quarters of menstrual regulation facilities have trained staff and 85% of these facilities are in the public sector, successfully expanding access to abortions among marginalized persons.[14]

In India, a 2017 study showed that only one million qualified doctors serve a population of 1.3 billion, with a public sector shortage of obstetricians and gynecologists (ob/gyns).[26] Further, a 2021 study highlighted provider shortages of over 80% among ob/gyns in the country.[27] Research in 2018–19 also found that medical abortion pills are over-regulated, with fear of prosecution deterring chemists from stocking them.[28,29] These factors restrict the provider base authorized to provide abortion services in India,[17] inconsistently with Recommendation 21 of the WHO Abortion Care Guideline.[3] The complex web of prosecution caused by the Indian legal framework runs contrary to Recommendation 1 of the Abortion Guideline. The overregulation of medical abortion pills decreases the provider base and is contrary to Recommendations 28 and 50 of the Guideline. This legally fueled provider shortage hinders access to safe abortion services, forcing many pregnant persons to seek abortion services through unsafe means. The effects are disproportionately felt by marginalized groups, impacted by poverty, geographical location, caste and indigenous identities, religion, education, and/or age.[17]

In Indonesia, the abortion provider base is restricted, with midwives being compelled to deny abortion services to vulnerable groups like survivors of sexual violence owing to a fear of prosecution and the lack of clarity in regulations.[30] According to data collected in 2023, of the 5270 ob/gyns registered in Indonesia in 2023, 65.7% are male. Abortions are predominantly provided by ob/gyns who mostly are male and less sensitized to sexual and reproductive health needs.[31]

In Malaysia, abortion continues to be criminalized despite exceptions, running contrary to Recommendation 1 of the WHO Abortion Guideline. An estimated 90 000 abortions are provided annually in Malaysia with 240 clinics in the country providing the services. The restrictions on provider base and requirement for authorization from one or two doctors, as the case may be,[22] result in a situation that runs contrary to Recommendation 21 of the WHO Guideline, which calls for expansion of the provider base to facilitate easy access to services. Provider restrictions are also coupled with barriers like high costs for procedures, sociocultural norms and stigma, poor information dissemination, and no awareness around SRH. Malaysia has made some efforts to improve its public healthcare infrastructure and abortion laws are largely lenient, but access to safe abortions is still challenging, especially in remote and rural regions of the country.[2]

In Nepal, the SMRHR Act differs from the Criminal Code for abortions, showing the need for legal harmonization to ensure access to safe abortion services.[2] Further, the *Lakshmi Dhikta* decision led to comprehensive abortion care services being introduced at district hospitals and primary health care centers.[25,32] Midlevel providers like ANMs are well equipped to administer first-trimester medical abortions, even in underserved areas[8] and ANM-provided abortions currently constitute about half of the total abortions in the country. In 2016, the Nepal Demographic Health Survey noted that out of 492 respondents, 71% had received abortion services from a doctor, nurse, or an ANM, 19% from a pharmacist or a medical shop, and 5% from a health assistant or other health worker in the past 5 years. About half of the respondents availed of abortion services at authorized facilities, with 27% of abortions still being performed at home.[33]

5 | EXPANDING PROVIDER BASE: KEY TO ACCESS

Many Asian countries have legal restrictions on who is authorized to provide abortion services. For instance, Bhutan and Myanmar restrict abortion services to the ob/gyns' domain, effectively restricting the provider base. Ipas Development Foundation conducted a study on training outcomes of midlevel providers in nine countries, which showed that 70% of abortions in primary healthcare facilities are provided by these midlevel providers.[33] The shortage of skilled healthcare providers globally is reflected in WHO estimates, which predict that such shortage will increase to 12.9 million by 2035, with disproportionate effects on countries that have insufficient provider bases.[5]

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The WHO Abortion Guideline contains significant evidence-based research that supports the decriminalization of abortion. Recommendation 1 (decriminalizing abortion) reviewed evidence from 22 studies in 14 countries, which showed that criminalization consistently had a poor impact on pregnant persons' health and well-being.[34] Most present-day abortion laws are inconsistent with Recommendation 1, including the countries surveyed, as abortion is still criminalized with exceptions for specific circumstances. A study of abortion laws in 182 countries showed that 181 countries criminalized abortion, and 159 countries had provisions to penalize abortion abettors and providers.[34] Evidence confirms the link between criminalization and unsafe abortions and highlights the "chilling effect" of criminalization on healthcare practitioners, resulting in delays or refusal to provide legal and safe abortion services and unavailability of medical abortion pills.

WHO Recommendation 21 is "against regulation on who can provide and manage abortion that is inconsistent with WHO guidance".[3] Evidence from seven studies in four countries shows that increasing midlevel care providers who can provide abortion services improves access to safe, affordable, and timely abortions.[6] Recommendation 50 calls for "self-management of the medical abortion process in whole or any part" within 12 weeks of gestation.[3] The recommendation underscores that abortion does not need to be conducted in a solely clinical setting, but can be successfully and safely self-managed, granting the abortion seeker decisional autonomy over their care.

Further, international human rights law outlines state obligations to enact/revise laws to ensure women do not have to undergo unsafe abortion, to reduce maternal morbidity and mortality, and to protect women and girls from risks associated with unsafe abortion.[35] The United Nations Convention on Elimination of All Forms of Discrimination against Women (CEDAW), under Article 12, protects the right to health for all women, calling on state parties to eliminate discrimination against women in the domain of health which also includes reproductive health. Article 16 grants women the freedom to decide the number and spacing of children while also having access to information and services to exercise the said right.[36] In its General Recommendation 24, CEDAW notes that the right to health during pregnancy and childbirth is intricately linked to the right to life. State parties must respect and protect this right by ensuring there are no impediments to women accessing reproductive health services, especially in life-threatening circumstances.[36] Further, both the CEDAW Committee and the Committee on Social, Economic and Cultural Rights have noted that principles of equality and nondiscrimination require that states protect SRH rights by increasing access to education and contraception and eliminating barriers to access to reduce the incidence of unsafe abortion.[37] Thus, state regulation of abortion must not risk pregnant persons lives, cause or facilitate physical or mental pain or suffering constituting torture or cruel, inhuman, or degrading treatment or punishment, entail discrimination, nor cause arbitrary interference with their privacy.[38] Notably, all five countries—Bangladesh, India, Indonesia, Malaysia, and Nepal—are parties to CEDAW and the expansion of the provider base for abortion can thus be a key pathway to combat some of these challenges while also adhering to international obligations.

Evidence-based research shows that provider restrictions negatively impact access to quality abortion services and exacerbate delays that condition pregnant persons to resort to unsafe abortion. Trained midwives, nurse practitioners, clinical officers, physician assistants, and family welfare visitors can provide safe abortion services. Further, expanding the abortion provider base can reduce maternal deaths. By expanding the scope of abortion services to be afforded by various providers, countries can improve abortion accessibility and safety, improving overall SRH outcomes and reducing maternal mortality, leading to better enjoyment of the right to sexual and reproductive health.[34]

The trend of progressively decriminalizing abortion and reducing restrictions on provider bases can be seen across the world. For instance, Ethiopia liberalized its abortion law in 2005, by allowing for abortions in limited circumstances, including rape, incest (on the word of the pregnant person), and "fetal impairment", as well as persons with disabilities and minors unprepared for childbirth.[39] In 2006, the Federal Ministry of Health issued technical guidelines for safe abortion care that empowered nurses and midwives to provide first-trimester abortion services, thereby Ethiopia expanded the provider base. These were amended in 2014 to include medical abortion, second-trimester abortions, and post-abortion contraceptive services.[40] In Vietnam, task-sharing is common with midwives providing abortions at the primary healthcare level,[9] and Ghana introduced reproductive health guidelines that expanded the provider base.[41] Ghana's 2012 task-sharing policy allowed community health officers, midwives, medical assistants, medical practitioners, nurses, and ob/gyns trained in midwifery and able to perform reproductive health-related clinical procedures to perform abortions, and pharmacists are allowed to dispense misoprostol and mifepristone if presented with prescriptions.[41]

South Africa implemented the Choice on Termination of Pregnancy Act in 1996, which focused on expanding the abortion provider base and harnessing existing public healthcare infrastructure to improve SRH outcomes.[9] Section 2 of the Act did allow specifically trained registered midwives to provide first-trimester abortion services, and a 2008 amendment allowed trained and registered nurses to provide abortion services, further expanding the provider base and reducing mortality from unsafe abortions.[42] In 2023, Spain amended its abortion law to state that "public services shall always be organized in such a way as to guarantee the necessary health personnel for effective and timely access" to abortion care.[38]

Training a broader range of healthcare providers to provide abortion services allows more pregnant persons to access these services closer to their communities, minimizing the need for costly and logistically challenging travel. This approach is essential for ensuring safe procedures and reducing complications associated with unsafe abortions performed by unskilled practitioners or through self-induced methods. Finally, increasing the provider base for abortion helps to destigmatize and normalize the procedure within the healthcare system. In societies where abortion remains taboo or

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controversial, restricting abortion services to a narrow group of specialists can perpetuate stigma and adverse judgment. Authorizing a diverse group of healthcare professionals to provide abortions sends a message that abortion is a legitimate aspect of reproductive health care. This normalization empowers pregnant persons to make informed choices about their reproductive health without fear of judgment or discrimination, fostering a supportive environment within healthcare facilities.

Therefore, legislative reforms and progressive jurisprudence are imperative, but these must be followed by institutional and systemic reforms including expansion of provider base for medical and surgical abortion services. Such provider expansion can drive transformative change in SRH outcomes by highlighting capacity building and specialized skill development initiatives, rather than enforcing an arbitrary, inefficient, and rights-disregarding grounds-based abortion authorization framework.[43] Such reforms to abortion laws and policies that expand the provider base need to be founded on a reproductive justice framework, which was forged by Black feminists, highlighting the criticality of examining reproductive rights issues from a lens of intersectionality.[44]

One limitation of this article is that I look at international human rights law and the national legal frameworks to assess the provider base sufficiency, which may overlook some local and nonlegal and policy-unrelated contexts that influence the provider base as well.

6 | CONCLUSION

This article identifies evidence of the impact of provider restrictions on people seeking to access abortion and on abortion providers. When considered alongside international human rights law, this evidence points clearly to how restrictions have negative implications for health outcomes, health systems, and human rights. This is especially so as international guidance provided by the WHO indicates best practice in provision and management of abortion and shows clearly that undue provider restrictions are not justified by reference to the nature and complexity of abortion.[3,45] Given this, and as international human rights law enjoins evidence-based regulation, where they exist, provider restrictions should operate to maximize health outcomes, health system efficiency, and human rights enjoyment.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest related to this research.

ACKNOWLEDGMENTS

I am deeply grateful to Rebecca Cook for inviting me to contribute to this journal and for her invaluable guidance throughout the development of this article. My heartfelt thanks also go to Bernard Dickens and Charles Ngwena for their thoughtful and insightful editorial feedback. I deeply appreciate Krithika Balu for her thorough review, Disha Chaudhari for her research assistance during the initial drafting process, and Ahana Bag for her meticulous editorial support. Lastly, I extend my gratitude to ARROW for supporting my earlier study on access to abortion services in Asia, which provided critical insights into the region's legal frameworks and key challenges.

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How to cite this article: Jain D. Legal challenges in expanding the provider base for abortion in Asia. *Int J Gynecol Obstet*. 2025;168:1345-1351. doi:10.1002/ijgo.16119

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