DOI: 10.1002/ijgo.15333

SUPPLEMENT ARTICLE

International Journal of Gynecology & Obstetrics FIGO WILEY

The role of healthcare providers in expanding legal abortion: Qualitative insights from Argentina, Ireland, and South Korea

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Funding information
KIT Knowledge Investment Fund

Abstract

Abortion laws are key in creating an enabling environment that facilitates the advancement of people's sexual and reproductive health and rights. Around 50 countries have liberalized their abortion laws in the last decades by adding new grounds allowing abortion. The road toward the expansion of legal abortion is a long, highly sensitive, and difficult process. The specific role of healthcare providers in influencing abortion law reforms has been scarcely studied. With the objective to better understand their (potential) roles, a qualitative study was conducted in 2021 focusing on three countries that had recently liberalized their abortion regulations: Argentina, South Korea, and Ireland. For each country, key informant interviews were conducted with actors in advocacy for legal change, the majority with healthcare providers. The study results indicate that healthcare providers can contribute to the expansion of legal abortion through their influence on public and legal debates. Healthcare providers were found to be scientifically credible and trustworthy. Their voice and argumentation counteracted anti-rights arguments and addressed information gaps, by providing specific clinical experiences and medical information. Healthcare providers amplified women's experiences through their testimonies and had entry points within governmental bodies, which facilitated their advocacy. These healthcare providers often functioned as individual operating obstetrician/gynecologists or general practitioners who were engaged in networks of health professionals or had previous advocacy experience. In a global context of social and political contention around abortion, extending the engagement of healthcare providers in law and policy deliberation on abortion appears to be useful. This requires recognizing the diversity of roles that healthcare providers can take up, creating a safe environment in which they can operate, equipping them with skills that go beyond the medical expert role and facilitating strategic partnerships that seek complementarity between multiple stakeholders, building on the uniqueness of each stakeholder's expertise.

KEYWORDS
abortion law reform, abortion rights, advocacy, Argentina, healthcare providers, Ireland, South Korea

[French and Spanish] translations are available in the Supporting Information.

1 | INTRODUCTION

Legal frameworks regulating access to safe abortion have been progressively liberalized around the world over the last century in line with a wider recognition of access to safe and legal abortion as a public health and human rights imperative.[1,2] There is strong evidence of the importance of abortion laws and regulations in creating an enabling environment that facilitates the advancement of people's sexual and reproductive health and rights and well-being.[3,4] Abortion occurs across countries regardless of its legal status but is more likely to be unsafe in restrictive settings.[3] In countries with stronger legal restrictions to access abortion, unintended pregnancy rates have increased and the proportion of unintended pregnancies ending in an abortion is higher than in countries where there is better access to sexual and reproductive health services in general, including abortion and contraception services.[4]

International and regional human rights bodies have increasingly pronounced the need for reforming highly restrictive laws on abortion, characterizing restrictive abortion laws as a form of discrimination against women.[5–7] Treaty body jurisprudence states that the denial of access to safe abortion can lead to violations of the right to health,[8] privacy,[9] and in some cases also the right to be free from cruel, inhumane, and degrading treatment.[10] The Human Rights Committee affirms that no measure to regulate voluntary termination of a pregnancy should violate the right to life of a pregnant person or any of their other human rights.[11] More recently, the World Health Organization (WHO), in its updated abortion care guideline, provided law and policy recommendations based on robust evidence and human rights principles that support full decriminalization of abortion and reject laws and other regulations that restrict abortion by grounds and gestational age limits, among others.[12]

Globally, around 50 countries have liberalized their abortion laws in the last decades by adding new circumstances under which abortion is permitted within certain gestational limits. The most common grounds for abortion are to save the woman's life, to preserve the health of the pregnant woman, or other specific enumerated grounds like rape, incest, or fetal impairment.[2,13] However, fewer countries have transitioned to allowing abortion upon request.[1] As abortion is one of the few health procedures that is regulated by penal codes and penalized as a criminal conduct, a legal reform concerning abortion is often a contested process evidencing the diverse and conflicting views toward safe and legal abortion. The space to reform depends on a complex interplay of sociocultural, political, legal, juridical, and health system-related factors.[6,14]

The articulation of public health and rights-based approaches, building a critical mass of support, and a strategic engagement of multiple stakeholders such as legal experts, parliamentarians, healthcare providers, grassroots feminist organizations, and women have been identified as key elements for effective legal reform efforts.[4,15] Various studies that described abortion advocacy initiatives discussed the engagement of healthcare providers in efforts to expand legal abortion, with healthcare providers highlighted as having played important roles in Ethiopia,[14,16,17] Argentina,[18] Uruguay,[19] Ghana,[20] and more recently in Ireland.[21] The exact form of engagement differed greatly, but when healthcare providers took a prominent role, their support was seen as essential and highly valuable,[14,20,22] as their professional credibility contributed to legitimize safe abortion as a public health matter.

While healthcare providers have been recognized as key health advocates, including for sexual and reproductive health and rights and access to safe abortion,[23,24] the specific role of healthcare providers in influencing abortion law reforms should be further studied to effectively mobilize these key players in the field. This study explored the experiences of healthcare providers who played a role in abortion law reform in three countries that recently liberalized their abortion law, to better understand and identify the role that healthcare providers and organizations can play in national initiatives aiming to expand legal abortion.

2 | MATERIALS AND METHODS

A qualitative study was conducted in 2021 with a focus on Argentina, South Korea, and Ireland. These three countries were selected as illustrative cases for having recently (2018–2020) liberalized their abortion laws; all of them removing any restrictions for the first 12–14 weeks of gestation. For later gestational ages, abortion was legalized on certain grounds. The study investigated the type of roles healthcare providers and organizations played, what facilitated or hindered their engagement, and how their contribution was perceived by themselves and by collaborators.

A technical working group (TWG) comprising experts on safe abortion advocacy and the three countries (academics, representatives of medical societies, healthcare providers organizations, women's organizations) guided the study. Members of the TWG provided feedback on the research proposal, contributed to the selection of study participants, provided input into the preliminary analysis of each of the three case studies, as well as on the overarching cross-country analysis, and contributed to the writing of this article. Ethical clearance was granted by the Research Ethical Committee of KIT Royal Tropical Institute.

Key informant interviews were conducted in each of the three selected countries (11–12 per country; 36 in total). The topic guides for the interviews were based on the study objectives and key issues that were identified with support from a literature review (see Supporting Information S1).

The key informants were purposively selected by the TWG based on their individual role or engagement in law reform and/or their representation of a national, transnational, or international key organization that played a role in national initiatives or efforts to expand legal abortion. Interviews were conducted face to face or by phone by four of the authors (NM, SP, NZ, SK), experienced researchers with contextual knowledge of the country's abortion environment. Written consent was obtained (in person or via email) and interviews lasted 1 h on average. Most key informants were healthcare providers including general practitioners (GPs), obstetrician/

gynecologists, professional midwifes, nurses, and pharmacists. Some were involved in networks or organizations of health professionals, and a few had also been involved with other types of civil society organizations. Interviews were also conducted with activists or members of civil society organizations or networks that had been advocating for the expansion of grounds for legal abortion. An overview of the interviews conducted per country is presented in Supporting Information S2.

The interviews were recorded, transcribed, and coded with NVivo 13 software (NVivo, Denver, CO, USA). A coding framework was developed, based on the topic guide, used with a deductive approach and further adapted for each country when new codes emerged. Interviews conducted in Korean were transcribed and coded both in Korean (by SK) and in English (by IV). For the interviews with stakeholders from Argentina and Ireland, the interviews were conducted, transcribed, coded, and analyzed in the original language (Spanish by LJ and English by NM respectively). The data for each country were first analyzed separately by the same researchers who conducted the coding and preliminary results were presented, discussed, and validated in three subsequent TWG meetings. Subsequently, a cross-country analysis was done by LJ, IV, and NM for an overarching interpretation of the main results.

3 | RESULTS

3.1 | Argentina: A new law on access to the voluntary termination of pregnancy

In Argentina, a new law came into force in January 2021 (law 27 610) that expanded rights related to the interruption of pregnancy. Based on this law, women and people with other gender identities have the right to interrupt their pregnancies until week 14 of gestation without having to explain the reasons for the decision. From week 15 onward abortion is also allowed when the pregnancy is the result of rape or if the life or health of the pregnant person is at risk. This milestone resulted from a strong and growing social and feminist movement that had been calling for the expansion of the legal framework on safe abortion for decades. The movement had given rise to the National Campaign for Legal, Safe and Free abortion launched in 2005, and proved to be a central and catalytic factor in making the legal reform in Argentina possible. Throughout the years, this National Campaign led demonstrations, national congresses, and bill proposals, including the Voluntary Termination of Pregnancy Bill that had been passed by the congressional Chamber of Deputies in 2018, but had been rejected by the Senate. As argued by study participants, the consolidation of the National Campaign as a well-known massive social movement acted as a driving force to progressively involve multiple actors from different sectors, including the health sector. The success of the Campaign was linked to its intellectual rigor, as well as to effective communication of a clear slogan and messages and a dissemination strategy that successfully used a green scarf as a symbol for legal and safe abortion.

Many medical associations and societies made public statements regarding the voluntary termination of pregnancy bill.[25] These pronouncements did not explicitly endorse or reject the bill but laid out evidence-informed argumentation, such as the importance of legal abortion in prevention of unsafe abortions and maternal deaths, the recognition of unsafe abortion as a public health issue, the importance of having clear laws with unambiguous gestational age limits, the vulnerability of the poorest and youngest who had less access to quality services, and that access to information and contraceptive services decreases unintended pregnancies but does not prevent unsafe abortions. The pronouncements also referred to the evidence that decriminalization does not increase the total number of abortions but rather reduces unsafe abortions and leads to better abortion registration and data. Many of these pronouncements were made at the stage of discussion of the bill and some stakeholders argued that these should have come earlier to be more useful.

> Later it seems to me that the tide was so great that all the medical societies ended up making a statement. The Faculty of Medicine, including its board of directors, made a statement from the University supporting, I mean, the change of the law. But it was late, it was when the facts were almost consummated. I do not underestimate that contribution, but it seems to me that it was not substantial.
>
> (Medical Doctor Arg4)

The Network of Healthcare providers for the Right to Decide (Red de Profesionales de la Salud por el Derecho a Decidir) was one of the few to institutionally support approval of the bill emphasizing its importance and referring to the National Campaign slogan "comprehensive sexuality education to decide, contraception to prevent abortions and legal abortion to not die."

Key informants highlighted that while certain known healthcare providers with strong voices advocated for the legalization of abortion in Argentina, collective efforts or institutions of healthcare providers did so less. This was attributed to the wide diversity of views among healthcare providers on abortion. Study participants also speculated that healthcare providers may feel distant from political engagement or feminist movements but, rather, identify more with technical and medical roles, such as the provision of services, resolving (emblematic) cases, or building capacity of other healthcare providers. Nevertheless, these roles were also seen as important to progressively address stigma and contribute, in the longer term, to the creation of a momentum for legal reform with clinical evidence to inform the debate. General practice doctors were considered to be closer to the abortion debate than were specialists such as gynecologists.

> There were recognized individual voices of health professionals. More than the positions of scientific societies or professional groups, it seems to me that from the outset, the recognition, the push, was more

> linked to people from the health teams with strong voices reaching the media and who are part of some organizations that were not necessarily medical.
>
> (Medical doctor Arg4)

The voices and testimonies of healthcare providers were perceived to have influenced the debate on the voluntary termination of pregnancy bill in the National Congress as some deputies referred to the testimonies of healthcare providers spread through the Campaign "Let's Save Thousands of Lives" (*Salvemos miles de vidas*). Based on an analysis of audiences, the campaign sought to fill gaps in the existing discourses and narratives around safe abortion to reach groups that were undecided or in the middle concerning the liberalization of the abortion law. According to people interviewed, the effectiveness of this public health campaign can be explained by the combination of emotional stories of ordinary women amplified by direct testimonies of health professionals, who were perceived as credible. Moreover, interventions of healthcare providers in the parliamentarian debate highlighted scientific evidence and the public health angle and served to counteract the arguments of anti-rights groups. In the end, as the following quote illustrates, it was the sum of voices, discourses, and actions from various sectors, including and particularly the feminist movement and the medical community learning from the movement, which facilitated the approval of the law.

> It seems to me that going hand in hand, those of us who have an activist role and provide services, we are finding a place. I believe that activism alone is not enough, and neither are health professionals alone. I think that the synergy of both is what led to the result (law).
>
> (Gynecologist Arg9)

The role and perceived contribution of those healthcare providers who played a role in the abortion law reform in Argentina point to the relevance of complementing discourses and narratives that reach wider population groups, the value of scientific evidence and data in debates, the importance of the constant service provision, and the existence of networks like the Network of Healthcare Providers for the Right to Decide that facilitate healthcare providers' engagement. This was all leveraged by the militancy and activism that pushed for legal changes from outside of public institutions. In the words of one interviewed participant: *Not to think all the same but to push, to think that things can be different*.

3.2 | Ireland: Repeal of the Eighth Amendment and new Health Act 2018

In 1983, through a referendum, the Irish public had voted in favor of the Eighth Amendment of the Constitution (Article 40.3.3), which equated the right to life of the unborn with that of the pregnant woman. In May 2018, the Irish public voted to repeal this Amendment; it was replaced with a new Article 40.3.3, which states that "provision may be made by law for the regulation of termination of pregnancy." The Health (Regulation of Termination of Pregnancy) Act 2018, signed into law in December 2018, permits access to abortion services in the first 12 weeks provided a 3-day waiting period has occurred, or in later gestation in cases of risk to a woman's life, serious harm to her health, or fatal fetal abnormality.

The repeal of the Eight Amendment was a historic success for abortion rights advocates throughout the country. The shift in the discourse around abortion, from fetal rights to an issue of women's health, was considered to be critical to the success of the law reform.[26] Both women and healthcare providers, specifically GPs, played a crucial role in mediating this change. Advocacy organizations had been articulating the discourse over decades, including healthcare providers' organizations such as Doctors for Choice from its founding in 2001. These long-standing voices were further leveraged in the more recent "Together for Yes" Campaign, the national campaign to remove the Eight Amendment co-directed by Abortion Rights Campaign, the National Women's Council of Ireland, and the Coalition to Repeal the Eighth Amendment.

> The campaign for Repeal identified that there were two significant issues in terms of communication. One was the patient voice, the voice of the women who'd taken sort of an abortion journey, should be heard. And the other one—and this was in terms of what the population, the voting public trusted—the second one was the doctor voice, that the doctor voice articulating that patient voice was the other trusted source.
>
> (General Practitioner Ire1)

GPs were in the unique position of being a local, trusted source of information within their communities. They were not only able to provide medical expertise on the issue, but also provided stories from their practices that affirmed the stories told by women patients and showed that the need for access to safe abortion was an everyday and normal need:

> I think what became apparent to me is that the voice of the family practitioner, the general practitioner, was quite powerful (…), I think when people heard GPs talking about an issue, they realized this is local. This is ordinary. And this is something that affects our families, our friends, our cousins and so on. So, I think it normalizes—it localized us because we could have been talking about anybody. (General Practitioner Ire2)

In order to share their patient stories and expertise, healthcare providers engaged in a number of public activities. These activities were either organized and carried out by healthcare providers themselves or in response to requests from the "Together for Yes" Campaign for engagement. Healthcare providers organized and were involved in social media campaigns, notably on Twitter which was found to be particularly effective in reaching different target

audiences (such as the general public and different members of parliament). They were also involved in drafting policy statements, produced fact sheets on frequently asked questions, joined radio and television debates, and spoke at a significant number of public events. Furthermore, in the run-up to the referendum, over 1000 doctors from across Ireland signed a declaration, organized by Doctors for Choice, pledging to vote yes to repeal the Eighth Amendment. Healthcare professionals, such as midwives and GPs, made themselves available to the general public by contributing to canvassing efforts and also standing at information booths wearing their uniforms in busy shopping streets:

> We were in a couple of different kind of projects, one of them was ask a midwife. We put on our midwife gear, and we headed to (…) two of the busiest streets [in Dublin], and we presented ourselves there on the busiest days shopping and we had people saying, come and ask us anything you want to know, and we'll gladly answer. (Midwife Ire7)

The study found that healthcare providers who engaged in national advocacy activities, did so mostly of their own accord and in their personal time. Interviewees shared that within national healthcare provider associations and organizations, such as the Institute of Obstetricians and Gynecologists (IOG) and the Irish Nurses and Midwives Organization, there was internal opposition to liberalizing the abortion law and, therefore, controversy around professional associations who made public statements regarding the referendum. The IOG issued a press release stating that they "support the recommendations of the Joint Committee on the Eighth Amendment to the Constitution that Article 40.3.3 be removed from the Constitution" and, as a result, the chair of the Institute received an internal petition calling for her resignation, although she maintained her position. The IOG then joined advocacy efforts toward Repeal. Healthcare providers who were active in the public sphere as abortion advocates also shared mixed experiences in their workplaces. Some interviewees reported having avoided discussing their public advocacy work with colleagues, while others shared that they had felt very supported by their colleagues. For healthcare providers who were active abortion advocates, the support of international organizations such as the British Pregnancy Advisory Service (BPAS), the British Society of Abortion Care Providers (BSACP), Global Doctors for Choice, and the WHO was found to be invaluable due to the capacity building, peer-to-peer support, and credibility that they were able to provide.

Healthcare providers who were engaged in advocacy efforts started or joined existing groups such as Doctors for Choice, which rebranded as Doctors for Repeal and finally Doctors Together for Yes as part of the national campaign. These groups allowed healthcare providers to be represented and to have a voice regardless of their professional organizations' stance. The importance of having these different "for Choice" groups for healthcare providers was recognized by several interviewees with one sharing: "*we knew that there was a power in the brand of Doctors for Choice*." This "power" related to the strength in having many doctors, publicly speaking out in favor of repealing the Eight Amendment, and the kind of message that sent to the public. Those who functioned as public representatives of these "for Choice" groups also had specific responsibilities, which included staying true to evidence-based facts and not reacting to anti-rights tactics:

> If you became a representative of Doctors for Choice, you had to agree that you were never going to say nasty things and you were never going to react. You were going to stay within all the professional parameters of what traditionally being a doctor looks like. And you were going to look like a doctor, and you were going to sound like a doctor. (General Practitioner Ire1)

Involved advocates learned from conducting a comparative study of other countries[27] how collaboration with the in-country Chief Medical Officer and Department of Health, national feminist grassroots organizations, labor unions, and academic colleges was incredibly important. The importance of undertaking an early mapping exercise that identified not just those in government and the Department of Health who would be central to legislative decision making, but those who would also be central to the introduction and implementation of any new service, was recognized and acted on. In retrospect, study participants acknowledged that this could have been even more detailed and focused. Some of the important strategic connections were acknowledged by study participants to have occurred by happenstance of individual connections rather than by design and could have been further strengthened; the connections and influence developed before the vote were found to be particularly important once the service implementation phase began.

Within the context of Ireland, healthcare providers, and GPs in particular, had a clear role and perceived contribution to the abortion law reform. The experiences and knowledge shared by healthcare practitioners shaped the national discourse around abortion. They cultivated the position they had in society to ensure there was a supportive medical voice and they were active in building networks for support and developing relationships with key stakeholders.

3.3 | South Korea: Abortion ban ruled as unconstitutional

In April 2019, the South Korean Constitutional Court ruled the abortion ban of 1953 to be unconstitutional and ordered the law's revision by the end of 2020. The draft legislation proposed by the government in October 2020 would permit abortion up until 14 weeks and, in some circumstances, up to 24 weeks. However, the law was not voted on by the deadline of 31 December 2020, leaving South Korea without law, but having established the decriminalization of abortion. It was a huge victory for the South Korean women's rights movement, after years of campaigning and an unsuccessful

previous ruling in 2012. Kim et al.[28] described how collective advocacy by the Joint Action for Reproductive Justice (later referred to as Joint Action) played a crucial role in influencing the Court's decision and emphasized the state's responsibility to ensure every individual's reproductive health and rights, breaking with a tradition where the state had controlled reproductive rights for decades, including for population control. Various health professional organizations or collectives, including the Association of Physicians for Humanism (APH), the Pharmacists for Healthy Society (Geonyak), the Center for Health and Social Change, and Doctors of Korean Medicine for Health Rights supported the Joint Action. These groups comprised individual progressive (sometimes feminist) health professionals with specific interests in human rights and public health that were, according to study participants, not addressed by the more clinically focused professional associations such as the Korean Society for Obstetrics and Gynecology or the Korean Pharmaceutical Association. Although most participants in our study indicated that the support of healthcare providers was small and mainly on an individual basis, they also indicated that their growing role had made a difference in contrast to the previous unsuccessful effort in 2012. While the previous debate had focused more on the "prolife versus prochoice" dichotomy, and relied on abstract stories from abroad and international guidelines, the recent debate emphasized Korean women's health, the responsibility of the state, and contextualized stories of women living in South Korea, showing the gap between law and reality. As this nongovernmental organization (NGO) representative, who was involved with the movement since the start, indicated:

> There were a few medical professionals who participated then [ruling of 2012], but it was limited to bringing out global cases and the global legal system. In 2010, the focus was on international examples such as up to how many weeks France and Germany allows abortion. However, in 2016, more medical personnel cooperated and the frame leading the discussion changed. The discussion concentrated on specific clinical experiences, professional medical knowledge, and medical information, such as clinical results on the usage of pills to abortion, helped the activists to respond to the issues with more medical basis.
>
> (NGO representative SK8)

In addition to bringing out clinical stories, physicians contributed to public hearings, issued statements, provided accurate evidence-based information on the safety of abortion procedures, and 1000 healthcare workers submitted their signature on a written opinion. A study participant explained how the Pharmacists for Healthy Society had studied the drug Mifegyne for medical abortion, released statements about its safety and efficacy, and are now consulted as experts on the drug by other institutions, such as the Korean Pharmaceutical Association, the Ministry of Health and Welfare, and the Ministry of Food and Drug Safety.

Despite these roles being taken up by some individual professionals, over the years the mainstream professional groups of physicians, especially obstetrician/gynecologists, appeared to have been motivated to engage in the abortion debate in order to protect their own autonomy. When in 2018 the medical service act was amended to reinforce the punishment of medical doctors who performed illegal abortions, doctors opposed the anti-abortion law as it affected their autonomy and safety. After the decriminalization, the arguments shifted and resulted in low support for a new law and system for legal services, as physicians had previously benefited from providing clandestine services for high fees. In the Korean context, physicians are mostly self-employed and need to financially protect their businesses. As this physician explains, this self-protective mechanism is also a reason why obstetricians have not supported the provision of medical abortion provided by other cadres of providers and continue to focus on surgical abortions:

> About 3 out of 10 ob/gyns go against abortion. Some don't do it because they are Catholic, some because they think a physician should respect life, and some because they feel guilty about performing the operation. The other seven do the operation for their economic interest. Because abortion is not covered by medical insurance, they can earn a lot of income if you keep it confidential. The general medical fee is about 10 000 won [8 USD] per patient, but if you do the operation for abortion, you can get about 300 000–500 000 won [250–400 USD]. Also, they do it because they know how desperate the patients are about it, when they think from a woman's point of view.
>
> (Obstetrician/gynecologist SK5)

The financial incentives and costs have led to discussion as to whether abortion services should be covered in the insurance system and can be identified as essential medical services. Providers have a strong influence on the Ministry of Health to oppose this development as they fear it will affect their income. According to various study participants, a drastic change is needed in the medical systems and curricula so that it both protects doctors' rights and income, but also strengthens/endorses a commitment to public health and human rights in health.

> There's no concept of public healthcare [in medical school]. Several dimensions are intertwined… The Korean education system, the difficult process of becoming a doctor, and the right to survive after becoming a doctor are all connected. It's hard to solve one thing.
>
> (Obstetrician/gynecologist SK3)

The South Korean case demonstrates the complementary role healthcare providers can play in existing successful movements like Joint Action in extending the legal grounds for abortion. However, the current situation where there is no law, nor policies and guidelines despite

decriminalization, may further emphasize the importance of their role in the transition period.

> Last year, the government proposed a revision of the Mother and Child Act, which was far from the civil society's demands, and even it was a retreat that did not meet the Constitutional Court decision. So, during the legislative notice period (2020), APH submitted expert opinions on what should be improved in the government's revision from a medical perspective. In addition, we have been working together with Joint Action for Reproductive Justice on various issues related to the abortion system.
>
> (General Practitioner SK7)

Future steps of the advocacy movement focus on providing education and training on safe and legal abortion within a public health and human rights framework for doctors and medical students, reorganization of the healthcare system, including provision of health insurance coverage, and further legislation following the decriminalization.

4 | DISCUSSION

This study explored the role of advocating healthcare providers in expanding legal abortion with insights from Argentina, Ireland, and South Korea. It has identified which specific roles healthcare providers and organizations played, what facilitated or hindered their engagement, and how their contribution was perceived.

The study is not without limitations. The three illustrative case studies are based on a limited number of interviews conducted at one single time point with participants who were generally in favor of the expansion of legal frameworks on safe abortion. Therefore, rather than a comprehensive analysis of the historical processes behind each country's experience to reform their legal framework, the resulting insights into the specific role that healthcare providers can play reflect the perspectives of those interviewed. Moreover, the study does not have a comparative aim but intends to collect insights from very different contexts—from three continents—to identify commonalities in what works and further substantiate this with insights from other academic literature.

The study results show that healthcare providers and organizations can play an important complementary role to activist movements in the expansion of legal frameworks on safe abortion, as shown in the three cases presented from Argentina, Ireland, and South Korea and has been previously described for Chile,[29] Colombia,[30] Ethiopia,[14,16,17] Ghana,[20] and Uruguay.[19] Although the form and time of involvement in the described cases differed based on individual and contextual realities, the voices, testimonies, and narratives of healthcare providers and organizations were perceived to be relevant across countries due to their influence in public and political spheres. Their narratives bring scientific evidence and credibility to national deliberations as the healthcare providers are trusted as technical, professional, and independent voices detached from political actors or activist groups. Moreover, the testimonies of their day-to-day service provision serve as an amplifier of the diversity of women's experiences that link the debates on safe abortion to the reality of the general population. The combination of the scientific arguments with the real stories of women who requested or went through an abortion make healthcare providers' perspectives crucial in legislative processes. They can effectively counteract false, biased, or inconsistent arguments and myths around abortion, and in highly polarized contexts may effectively reach groups with ambivalent or undeveloped opinions regarding proposed legal reforms. At the same time, it is known that the political and social contention around abortion can hinder the engagement of healthcare providers and organizations in political and law-making processes.[14,23,29,31–33] Hostility against frontline health workers and advocates, particularly those working for sexual and reproductive health and rights such as safe abortion, is a reality.[34] Hence, healthcare providers can fear negative reactions, personal attacks, and stigmatization as a consequence of their engagement. Visible actions of health professionals that are commonly highlighted as decisive in legislative processes, such as interventions during parliamentary debates or participation in public campaigns, imply public exposure and were therefore also in this study often taken up by individual healthcare providers who have previous experience as health advocates or leaders. Being engaged in networks of healthcare providers, the support of their direct social environment, and collaborating with communication experts seemed to facilitate this type of engagement. For healthcare professional organizations however, the contention and hostility around abortion seems sometimes a reason to shy away from stronger engagement in policy and law reforms, while a lack of consensus among members often makes it harder to raise an institutional voice for expanding legal grounds for abortion, as is also shown in previous studies.[23,35] Wood et al.[19] point out that sometimes the false assumption of adverse public opinion led to avoidance of public participation, while in fact this public opinion may be more nuanced. Healthcare providers often emphasize the magnitude of maternal mortality and morbidity as a result of unsafe and clandestine abortions and the needed revision of abortion law to reduce this, as shown in this as well as previous studies.[14,16,20,22,32] Such evidence-based advocacy proved to be highly strategic; in this manner, abortion and law reform could be addressed and legitimized as a public health matter[14,16,19,20,22] or as a matter of social justice[19] rather than as a moral or religious issue.[19,32] In addition, some healthcare providers can also fear the consequences that political and legal changes may have on their clinical and financial autonomy,[14,35] as described in the case of South Korea. Hence, an enabling respectful system in which healthcare providers can operate and engage in law and policy reforms requires ensuring their ability to do their work without fears of discrimination and hostility within a medical system that supports their professional autonomy and fair remuneration. Fair and appropriate payment contracts for GPs, which

were negotiated between the Irish Medical Organization and the Health Service Executive, were also seen as an important aspect of the community care model in Ireland. The negotiations were supported by healthcare provider advocacy organizations such as Doctors for Choice and the Southern Task-Force on Abortion and Reproductive Topics (START), demonstrating the need for ongoing advocacy during abortion policy implementation.[36]

The study also reveals that the common understanding that healthcare providers' main role is service provision and quality of care can hinder their engagement in law and policy reforms and debates. Some healthcare providers and organizations feel distant from advocacy or communication roles, seeing those as unlinked to the medical profession—an engagement reluctance that has also been identified in other studies.[37] They also lack knowledge, skills, or experience in these types of work and actions. In recent years, there has been increasing attention to supporting and encouraging the health advocacy role of healthcare providers and organizations.[38–40] Health advocacy is also receiving increased attention in medical education programs, particularly in those following competency-based approaches such as the Canadian Medical Education Directions for Specialists framework (CanMEDS).[41–43]

The empirical evidence presented in this study demonstrates that there is an ample diversity of roles that healthcare providers and organizations can take up to shape law and policy reforms around abortion. These roles and actions entail different degrees and types of (public) exposure, some specific to a moment of political and social momentum, and others more continuous and sustained in time. In addition to the abovementioned interventions in parliamentarian debates and participation in public campaigns, some examples include generating, sharing, and publishing scientific evidence; writing and signing public statements; sharing news or participating in interviews in traditional media channels; supporting the interpretation of emblematic cases; providing technical input and review to policy and legal documents; developing and facilitating multiple stakeholder partnerships; or participating in demonstrations. The specific examples from the case studies can be added to previous described efforts. In Chile, for example, healthcare providers engaged in a public hearing on abortion law liberalization.[29] The Ethiopian Society of Obstetricians and Gynecologists (ESOG) publicly articulated the need for the abortion law and conducted research on the prevalence of unsafe abortion and related maternal morbidity and mortality.[14,17] In Argentina, Ghana, and Ethiopia, healthcare providers were involved in developing policies and guidelines for abortion provision.[14,20,31] Lastly, WHO's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" has been cited by healthcare providers in Argentina, Ghana, and Chile as a ground for broad interpretation of health and subsequent wider provision of legal abortion services.[18,20,29]

The recognition of the diversity of potential roles of healthcare providers is key to ensure and extend their engagement in law and policy-making processes, which is of clear importance to effectively expand regulatory frameworks on abortion. The polarized debates around safe abortion require the perspective and involvement of the medical community. Besides programs and initiatives that provide technical and financial support to strengthen and amplify the role of healthcare providers and organizations, strategic multisectoral and multistakeholder partnerships and collaborations are crucial. These partnerships can facilitate the complementarity of different expertise and skills, for example, medical discourse and strategic public communications. Multistakeholder partnerships are one of the commonly recognized central factors in making abortion law reforms possible.[14,19,32,44] The significance of the role of healthcare providers is part of the interplay of forces and strategies of the multiple actors engaged in those partnerships. These partnerships can be steered by a national campaign put in place explicitly for an abortion law reform, as was the case in the studied countries, and further substantiated by examples in the literature where oftentimes healthcare providers and organizations operated in partnerships with women's organizations and activist movements or broader advocacy networks, such as the Gambian Sexual and Reproductive Rights Network[32] and the Ethiopian Reproductive Health Working Group,[14] in addition to strategic alliances or collaborations with the government or Ministry of Health, which was the case in Uruguay,[22] Ethiopia,[14] Ghana,[20] and Colombia.[45] The particularities and uniqueness of each type of actor are important, including healthcare providers and organizations who may not always turn into activists themselves but who can still contribute with their medical expertise and emphasize the public health impact.

Finally, just as important as law or policy reform is its implementation, as demonstrated in South Korea that has been deadlocked since abortion was decriminalized but the new law and regulations are not established. The multiple strategies and factors that lead to a law or policy change need to be sustained to ensure its adequate implementation.[36,46] The role and engagement of healthcare providers is also key in transitioning to ensuring quality service provision after a successful law reform not only by expanding service provision, but also by training the medical community, communicating about the legal change, developing technical guidelines for its implementation, including the space for self-administration and task-shifting in line with international guidelines, recording data on the new service provision, and ensuring the availability of needed medical abortion commodities. Again, these roles require a safe work environment and supportive medical system, a diverse set of skills and competencies, and strategic partnerships.

5 | CONCLUSION

The study shows how, in various countries across the world, healthcare providers have played contributing roles in the expansion of legal abortion. In a global context of social and political contention around abortion, the engagement of healthcare providers in abortion law reforms is crucial but requires addressing the hostilities and negative reactions healthcare providers can face and ensuring they operate within a supportive medical system. Recognizing and supporting the diversity of the potential roles that healthcare providers

can play would facilitate the engagement of a wider group of healthcare providers. More attention is needed to equip healthcare providers with a broad set of skills that go beyond the medical expert role and to facilitate strategic partnerships that seek complementarity between multiple stakeholders building on the uniqueness of each stakeholder's expertise.

AUTHOR CONTRIBUTIONS

Lisa Juanola van Keizerswaard: Conceptualization, data curation, formal analysis, funding acquisition, methodology, project administration, resources, supervision, writing-original draft. Irene de Vries: Conceptualization, data curation, formal analysis, funding acquisition, methodology, resources, supervision, writing-original draft. Nicole Moran: Conceptualization, data curation, formal analysis, funding acquisition, investigation (data collection in Ireland), methodology, resources, writing-original draft. Saskia Poorter: Investigation (support data collection in Ireland), methodology. Maryse Kok: Supervision, writing—review and editing. Nina Zamberlin: Conceptualization, formal analysis, investigation (data collection in Argentina), validation, writing—review and editing. Sunhye Kim: Conceptualization, formal analysis, investigation (data collection in South Korea), validation, writing—review and editing. Mary Favier: Conceptualization, validation, writing—review and editing. Wendy Chavkin: Conceptualization, validation, writing—review and editing.

FUNDING INFORMATION

This study was funded by the KIT Knowledge Investment Fund.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Juanola van Keizerswaard L, de Vries I, Moran N, et al. The role of healthcare providers in expanding legal abortion: Qualitative insights from Argentina, Ireland, and South Korea. *Int J Gynecol Obstet*. 2024;164(Suppl. 1):21-30. doi:10.1002/ijgo.15333