Interuniversitair, multidisciplinair en onafhankelijk comité belast met de studie en de evaluatie van de praktijk en de wetgeving inzake vrijwillige zwangerschapsafbreking

Comité interuniversitaire, multidisciplinaire et indépendant en charge de l'étude et de l'évaluation de la pratique et de la loi relatives à l'interruption de grossesse

Studie en evaluatie van de abortuswet en -praktijk in België

Etude et évaluation de la loi et de la pratique de l'avortement en Belgique

Bijlagen van het academisch rapport op verzoek van de "Vivaldi" meerderheid op federaal niveau

Annexes au rapport académique à la demande de la majorité "Vivaldi" au niveau fédéral

Préambule

Les documents disponibles dans cette section des annexes sont de plusieurs types.

L'annexe I reprend les questions qui accompagnaient la saisine du Comité scientifique par les députés de la majorité Vivaldi ainsi que les chapitres et paragraphes du rapport où se trouve la ou les réponse à la question posée.

L'annexe II reprend la composition des groupes de travail.

L'annexe III regroupe les notes de procès-verbal des auditions effectuées par le Comité Scientifique et ouvert aux membres des groupes de travail.

L'annexe IV présente les rapports issus des travaux préparatoires des groupes de travail qui ont servi de base à l'élaboration du rapport principal « Etude et évaluation de la loi et de la pratique de l'avortement en Belgique » par le Comité scientifique. L'anglais ayant fait office de langue de travail, tandis que chaque membre et chaque personne entendue avait l'occasion de s'exprimer dans sa propre langue, c'est en anglais que sont rédigés la plupart des documents ci-annexés. Les données et contenus de ces rapports intermédiaires ont été retravaillés, et affinés ensuite, ce qui explique des divergences avec le rapport principal.

L'annexe V reprend intégralement un texte sur les valeurs d'autonomie, d'égalité et de justice reproductive produit par deux membres du Groupe de travail IV « Ethique et droit ».

Ces documents ne font donc pas partie du rapport proprement-dit mais permettent de documenter le processus d'élaboration de celui-ci.

Voorwoord

Deze bijlagen bevatten verschillende soorten documenten.

Bijlage I bevat de vragen die de leden van de Vivaldi-meerderheid aan het Wetenschappelijk Comité hebben voorgelegd, alsook de hoofdstukken en paragrafen van het rapport waar de antwoorden op de gestelde vraag of vragen te vinden zijn.

Bijlage II bevat de samenstelling van de werkgroepen.

Bijlage III bevat de notulen van de hoorzittingen die door het Wetenschappelijk Comité zijn gehouden en voor de leden van de werkgroepen werden opengesteld.

Bijlage IV bevat de verslagen afkomstig van de voorbereidende werkzaamheden van de werkgroepen die hebben gediend als basis voor de opstelling van het hoofdrapport "Studie en evaluatie van de abortuswet en -praktijk in België" door het Wetenschappelijk Comité. Aangezien Engels als werktaal werd gebruikt en elk lid en elke gehoorde persoon de mogelijkheid had om zich in zijn eigen taal uit te drukken, zijn de meeste van de bijgevoegde documenten in het Engels geschreven. De gegevens en de inhoud van deze tussentijdse verslagen zijn vervolgens bewerkt en verfijnd, wat verschillen met het hoofdrapport verklaart.

Bijlage V herneemt integraal een tekst opgesteld door twee leden van werkgroep IV "Ethiek en recht" over de waarden van autonomie, gelijkheid en reproductieve rechtvaardigheid.

Deze documenten maken dus geen deel uit van het rapport zelf, maar laten toe het proces van de opstelling ervan te documenteren.

Annexe/bijlage I : Questions from the representatives of the Vivaldi government to the Scientific Committee 4

Annexe/bijlage II : Composition of the Scientific Committee and the four working groups ... 12

Annexe/bijlage III : Experts hearings 13

a) Dr. Patricia A. Lohr (Medical Director of British Pregnancy Advisory Service (BPAS)) 13

b) Dr. Raïna Brethouwer (Medical coordinator Beahuis & Bloemenhovekliniek – Heemstede) 19

c) Bérangère Marques-Pereira (Emeritus professor of political sciences, Université Libre de Bruxelles) 30

d) Dutch-speaking abortion centers representatives 52

e) French-speaking abortion centers representatives 70

f) Hospital associations representatives 91

g) National Evaluation Commission : Sylvie Lausberg and Mario Van Essche (co-presidents) 103

h) INAMI/RIZIV representatives 109

Annexe/bijlage IV : Reports from the working groups 115

a) Working group 1 : Current functioning and potential improvements in centers and hospitals regarding elective termination of pregnancy within the current gestational age limit, including prevention and follow-up issues. 115

b) Working group 2 : Termination of pregnancy for medical indication 154

c) Working group 3 : The issue of elective abortion requests beyond 12 weeks, including the analysis of international comparison. 179

d) Working group 4 : Abortion law – ethical and legal aspects 220

Annexe/bijlage V : « Les valeurs d'autonomie, d'égalité et de justice reproductive » by Guy Lebeer and Florence Caeymaex 260

Annexe/bijlage I : Questions from the representatives of the Vivaldi government to the Scientific Committee

Questions from the members of the Parliament to the Scientific Committee		Elements of answer to be found in chapter(s) :
1	Combien de femmes décident de ne pas avorter après l'expiration du délai d'attente ou du délai de réflexion ? Les raisons de leur choix sont-elles connues ? *Hoeveel vrouwen melden zich aan in ziekenhuizen en abortuscentra en zien alsnog af van een zwangerschapsonderbreking na de bedenktijd/wachttijd en waarom?*	3.1.3. 5.2. 6.1.
2	A quel moment, en moyenne, la plupart des avortements sont-ils pratiqués en Belgique ? Combien d'avortements sont pratiqués en Belgique chaque année, et comment peut-on les ventiler en fonction de l'âge de la femme et du nombre de semaines de grossesse ? *Na gemiddeld welke termijn worden de meeste abortussen in België uitgevoerd? Hoeveel abortussen worden er elk jaar in België uitgevoerd, en hoe kunnen deze worden opgesplitst volgens de leeftijd van de vrouw en volgens het aantal weken zwangerschap?*	5.2. 6.1.
3	Les équipes psychosociales et médicales suivent-elles l'évolution de la décision de la femme ? Quelle est l'analyse de ces examens ? *Volgen de psychosociale en medische teams hoe de beslissing van een vrouw evolueert? Hoe luidt de analyse van dergelijke onderzoeken?*	3.1.3.4. 5.2. 5.2.5.
4	Est-il possible d'estimer combien d'avortements pratiqués par voie chirurgicale dans un hôpital auraient pu être évités si le délai d'attente/de réflexion avait été plus court ? *Is het mogelijk in te schatten hoeveel abortussen die zijn uitgevoerd door een chirurgische ingreep in een ziekenhuis vermeden hadden kunnen worden als de bedenktijd/wachttijd korter was geweest?*	3.1.3.4. 5.2. 6.1.
6	L'accès et l'amélioration de l'accès aux contraceptifs ont-ils un impact sur l'acceptation des interruptions volontaires de grossesse et sur le nombre d'avortements ? *Hebben de toegang en de verbetering van de toegang tot voorbehoedsmiddelen een impact op de aanvaarding van vrijwillige zwangerschapsafbrekingen en op het aantal abortussen?*	5.2. 6.1.2. 7.1.
7	Est-il possible de déterminer un impact des résultats des tests et analyses NIPT sur les décisions des femmes ? *Kan men een impact van de resultaten van NIPT-tests en -analyses op de beslissing van de vrouw vaststellen?*	4.1.5. 5.2.4.
8	La commission nationale d'évaluation de l'IVG relève l'augmentation de recours à l'IVG par des femmes sans papiers, sans lieu de résidence fixe. Certaines de ces femmes vivent dans la coercition et la violence, sont sous pression. Il faut peut-être accorder une attention particulière à ces demandes, à comment mieux comprendre ces femmes ; à proposer une aide intégrée ?	5.2.3. 5.2.4. 5.2.6.

	NEZ geeft aan dat er steeds meer blinde vlekken zijn: vrouwen zonder papieren, zonder vaste verblijfplaats. Er is sprake van dwang en geweld. Vrouwen staan onder druk, zeggen niet echt wat ze willen. Hoe kunnen we hier beter zicht op krijgen? Wat drijft deze vrouwen? Hoe kan hen geïntegreerde hulp worden geboden?	
9	Les femmes en situation d'extrême vulnérabilité, qui ont recours à l'interruption de grossesse sous pression, doivent-elles bénéficier d'un soutien et d'informations supplémentaires pour prendre une décision autonome en matière d'interruption de grossesse ? Si c'est le cas, comment ces femmes peuvent-elles bénéficier d'un soutien ou d'un accompagnement supplémentaire ? *Moeten vrouwen die zich in uiterst kwetsbare omstandigheden bevinden, en die een toevlucht nemen tot zwangerschapsafbreking onder druk, extra ondersteund en geïnformeerd worden bij het nemen van een autonome beslissing inzake zwangerschapsafbreking? Zo ja, hoe kunnen deze vrouwen extra worden ondersteund of begeleid?*	5.2.3. 5.2.4. 5.2.6.
10	Combien de femmes demandent un avortement après 12 semaines ? Une durée plus longue du délai légal permettrait-elle d'aider ces femmes ? *Hoeveel vrouwen vragen een abortus aan na 12 weken? Zou een langere termijn het mogelijk maken deze vrouwen te helpen?*	6.
11	Wat zijn de oorzaken van een late ontdekking van een niet-gewenste zwangerschap? *Quelles sont les causes de la découverte tardive d'une grossesse non désirée ?*	6.1.1. 6.1.2.
12	Pour quelles raisons certaines femmes décident-elles d'interrompre leur grossesse après 12 semaines ? *Om welke redenen besluiten bepaalde vrouwen de zwangerschap af te breken na 12 weken?*	6.1.3.
13	Aux Pays-Bas, l'avortement est possible après 12 semaines : y a-t-il plus de problèmes psychologiques et médicaux chez les femmes ? Ces femmes devraient-elles bénéficier d'un soutien médical et psychologique post-avortement plus important que les femmes qui ont avorté avant 12 semaines ? *In Nederland is abortus mogelijk na 12 weken: worden daar meer psychologische en medische problemen vastgesteld bij vrouwen? Moet bij deze vrouwen na de abortus meer medische en psychologische begeleiding voorzien worden dan bij vrouwen die een abortus ondergaan voor 12 weken?*	6.
14	Y a-t-il un sous-estimation, une minimisation du nombre des interruptions de grossesse par les médecins, en particulier après le délai légal de douze semaines ? *Is er een onderraportering van zwangerschapsafbrekingen door artsen, in het bijzonder nadat de wettelijke termijn van twaalf weken overschreden is?*	6.1.
15	Quel est le profil des femmes qui se rendent à l'étranger - par exemple aux Pays-Bas, au Royaume-Uni et au Luxembourg - pour se faire avorter après le délai légal en Belgique ? *Welk profiel hebben de vrouwen die naar het buitenland trekken – naar Nederland, Groot- Brittannië en Luxemburg - om een abortus te laten uitvoeren na het verstrijken van de wettelijke termijn in België?*	6.1.

16	Comment explique-t-on la diminution du nombre de femmes qui se rendent aux Pays-Bas chaque année pour recourir à une IVG après 12 semaines ? Cette tendance est-elle la même en Grande-Bretagne et au Luxembourg ? *Wat is de reden van de dalende cijfers van de vrouwen die naar Nederland trekken? Is deze tendens gelijklopend voor Groot-Brittannië en Luxemburg ?*	6.1.
17	Quels sont les aspects socio-économiques et les conséquences de la prise en charge des avortements réalisés à l'étranger ? *Wat zijn de socio-economische aspecten en gevolgen van de behandeling voor abortussen die in het buitenland zijn uitgevoerd?*	6.1.
18	Combien d'interruptions de grossesse pour raisons médicales sont pratiquées en Belgique ? *Hoeveel zwangerschapsafbrekingen om medische redenen worden er in België uitgevoerd?*	5.3.1.
19	Combien de femmes viennent en Belgique pour avoir une telle intervention ? Quel est leur profil ? *Hoeveel vrouwen komen er naar België om een dergelijke ingreep te laten uitvoeren? Wat is hun profiel?*	5.3.1.
20	Quels sont les motifs d'une interruption tardive de grossesse pour raisons médicales lorsqu'il est probable que l'enfant à naître est atteint d'une affection particulièrement grave et reconnue comme incurable au moment du diagnostic ? *Wat zijn de ingeroepen motieven voor de late zwangerschapsafbreking om medische redenen als het waarschijnlijk is dat het ongeboren kind aan een bijzonder ernstige aandoening lijdt die als ongeneeslijk wordt erkend op het ogenblik van de diagnose?*	5.3.2.
21	Combien de femmes choisissent de garder leur enfant même s'il est atteint d'une maladie grave ? Quels sont les troubles concernés ? Comment les femmes vivent-elles cette expérience (parfois des années plus tard) ? *Hoeveel vrouwen kiezen ervoor om hun kind toch te houden ook al heeft het een ernstige aandoening? Over welke aandoeningen gaat het dan? Hoe ervaren de vrouwen dit (soms jaren later)?*	5.3.4.
22	Les progrès médicaux en matière de viabilité du foetus ont-ils un impact sur la législation relative à l'avortement ? *Heeft de medische vooruitgang in de levensvatbaarheid van foetussen een impact op de VZA- wetgeving?*	4.1.4. 4.2.3. 5.3. 6.3.
23	L'évolution du développement du foetus après 12 semaines est-elle significative par rapport à la sensibilité et à la viabilité du foetus ? *Is de evolutie van de ontwikkeling van de foetus na 12 weken significant met betrekking tot de gevoeligheid en levensvatbaarheid van de foetus?*	4.1.4. 4.2.3. 6.3.
24	Quels diagnostics sont posés pour autoriser un avortement -pour raisons médicales au regard des risques encourus par la mère ou l'enfant à naître ? *Welke diagnoses worden gesteld om een abortus om medische redenen toe te laten – ten aanzien van de risico's die de moeder of het ongeboren kind loopt?*	5.3.
25	La terminologie relative à la certitude du diagnostic d'une affection extrêmement grave et reconnue comme incurable au moment du diagnostic est-elle appropriée ?	5.3.1. 5.3.6.

	Is de terminologie met betrekking tot de zekerheid van de diagnose van een uiterst zware kwaal die als ongeneeslijk wordt erkend op het ogenblik van de diagnose geschikt?	
26	Peut-on déterminer l'impact des tests et examens permettant de connaître le sexe de l'enfant à naître sur les demandes d'avortement ? Faut-il envisager de ne pas divulguer le sexe de l'enfant pendant les semaines où un avortement est autorisé ? *Kan er worden vastgesteld welke invloed tests en onderzoeken om het geslacht van het ongeboren kind te kennen hebben op de abortusaanvragen? Moet er worden overwogen het geslacht van het kind niet bekend te maken tijdens de weken waarin een VZA is toegestaan?*	4.1.5. 5.2.4.
27 + 28	Évolution de la grossesse et de l'avortement : quelles sont les techniques utilisées en fonction du stade de la grossesse ; semaine par semaine, et quels sont les risques médicaux encourus ? Existe-t-il des contre-indications médicales à la prolongation de la durée du délai au-delà de 12 semaines ? *Evolutie van de zwangerschap en abortus: : welke technieken worden gebruikt afhankelijk van de fase van de zwangerschap; week per week, en welke medische risico's zijn daaraan verbonden? Zijn er medische contra-indicaties tegen de verlenging van de termijn na 12 weken?*	4.2.6. 5.1.
30	Faut-il examiner les critères psychosociaux pour pratiquer un avortement tardif ? *Moeten er psychosociale criteria voor het uitvoeren van een late abortus om medische reden worden onderzocht?*	4.2. 6.2.
31	Le développement continu de tests de diagnostic plus complets a-t-il une incidence sur l'impact psychologique du choix ? Comment faire face à cette situation ? Comment les femmes vivent-elles leur choix par la suite (parfois des années plus tard) ? *Heeft de steeds verdere ontwikkeling van meer uitgebreide diagnostische testen een gevolg voor de psychologische impact bij de keuze? Hoe kan dit opgevangen worden?Hoe ervaren vrouwen hun keuze achteraf (soms jaren nadien)*	3.1.3. 5.2.3. 5.2.4. 5.3.4.
32	Quel est l'impact de la période d'attente/de réflexion sur l'autonomie des femmes et sur leur sentiment d'autonomie ? *Welke impact heeft de wachttijd/bedenktijd op de zelfbeschikking van de vrouw en op het gevoel van autonomie van de vrouw?*	3.1.3. 5.2.3. 5.2.4. 5.3.6.
33	Comment les femmes peuvent-elles être renforcées dans leur autonomie de choix/décision ? *Hoe kunnen vrouwen versterkt worden in het maken van een autonome keuze?*	5.2.4. 5.2.6. 5.3.4. 5.3.5. 6.
34	Comment garantir la liberté, comment s'assurer de la liberté des femmes à faire un choix autonome ? Avons- nous connaissance de l'existence et de l'étendue de pressions que subissent les femmes de la part de leur entourage ou de leur médecin au moment de prendre leur décision ? Peut-on mesurer l'influence d'un milieu culturel, social ou religieux ? *Weet men hoeveel vrouwen onder druk worden gezet door hun omgeving of arts wanneer ze een beslissing nemen? Kan de invloed van een culturele, sociale of religieuze achtergrond gemeten worden?*	5.2.4. 5.2.6. 5.3.4. 5.3.5. 6.

38	Quelles informations sur les aspects médicaux et les alternatives à l'avortement sont et doivent être apportées aux femmes par les équipes médicales et psychosociales ? Les équipes considèrent-elles que ces informations sont suffisantes et nécessaires ? *Welke informatie over de medische aspecten en de alternatieven voor een abortus wordt er en moet er worden verstrekt aan de vrouwen door de medische en psychosociale teams? Vinden de teams deze informatie voldoende en noodzakelijk?*	3.1.3. 5.2. 5.3. 6.2.
39	Un soutien (et un suivi) médical et psychologique suffisant est-il offert ? *Wordt er voldoende medische en psychologische ondersteuning (en opvolging) geboden?*	3.1.3. 5.2. 5.3. 6.2.
40	Les conséquences du refus d'une interruption de grossesse sur la santé mentale de la femme ont-elles été étudiées et existe-t-il une approche particulière de cette question ? *Zijn de gevolgen voor de mentale gezondheid van de vrouw van een weigering om een einde te maken aan de zwangerschap onderzocht en bestaat hier een bijzondere aanpak voor?*	3.1.3. 5.2.3. 5.2.5.
41	Comment les femmes vivent-elles le processus décisionnel qui précède ce choix? Quel regard portent-elles après coup (parfois des années plus tard) sur le fait d'avoir gardé l'enfant ou d'avoir pratiqué une interruption de grossesse ? Quelle est la situation des enfants si leur mère a choisi de les garder ? *Hoe beleven vrouwen het beslissingsproces voorafgaand aan deze ingrijpende keuze? Hoe kijken ze nadien (soms jaren later) terug op het behoud van het kind, dan wel de zwangerschapsafbreking? Wat is de situatie van de kinderen indien hun moeder ervoor koos om hen te houden?*	3.1.3. 5.2.3. 5.2.4.
42	La période d'attente minimale de 6 jours entre la première consultation et l'avortement a- t-elle des conséquences psychologiques et médicales ? *Heeft de minimale wachttijd/bedenktijd van 6 dagen tussen de eerste consultatie en de abortus psychologische en medische gevolgen?*	3.1.3. 5.2.3. 5.2.4. 5.3.6.
43	Les équipes médicales et psychosociales considèrent-elles que la période d'attente/de réflexion de 6 jours est nécessaire ? Comment cette période d'attente/de réflexion est-elle évaluée ? Une période d'attente/de réflexion plus courte présente-t-elle des avantages ou des inconvénients ? *Vinden de medische en psychosociale teams de wachttijd/bedenktijd van 6 dagen noodzakelijk? Hoe wordt deze wachttijd/bedenktijd geëvalueerd? Heeft een kortere wachttijd/bedenktijd voordelen of nadelen?*	3.1.3. 5.2.3. 5.2.4. 5.3.6.
45	Comment répondre aux demandes de soutien psychologique des femmes qui sont parties à l'étranger pour se faire avorter ? *Hoe te reageren op aanvragen voor psychologische ondersteuning van vrouwen die naar het buitenland zijn getrokken voor een abortus (>12 weken)?*	6.2. 6.3. 6.4.
46	Quelle est votre appréciation de la loi et de l'application de la loi sur l'interruption volontaire de grossesse, abrogeant les articles 350 et 351 du code pénal, modifiant les articles 352 et 383 du même code et modifiant diverses dispositions légales ?	2. 3.1. 3.4.

	Hoe beoordeelt u de wet en de toepassing van de wet betreffende de vrijwillige zwangerschapsafbreking, tot opheffing van de artikelen 350 en 351 van het Strafwetboek, tot wijziging van de artikelen 352 en 383 van hetzelfde Wetboek en tot wijziging van diverse wetsbepalingen?	
47	Les membres du personnel médical qui pratiquent des avortements en dehors du cadre légal pourraient-ils être poursuivis et faire l'objet de sanctions pénales et/ou disciplinaires si les articles spécifiques relatifs aux sanctions dans la loi sur l'interruption volontaire de grossesse étaient supprimés ? Des sanctions pourraient-elles encore être imposées au personnel médical, aux femmes ou à des tiers ? *Kunnen leden van het medisch personeel die een abortus uitvoeren buiten het wettelijke kader vervolgd worden en onderworpen worden aan strafrechtelijke en/of disciplinaire sancties als de specifieke artikelen over de sancties in de wet betreffende de vrijwillige zwangerschapsafbreking worden geschrapt? Zouden er nog sancties kunnen worden opgelegd aan het medische personeel, vrouwen of derden?*	3.1.5. 3.4.
48	Comment concilier le fait qu'il est punissable d'empêcher une interruption volontaire de grossesse avec la liberté d'expression ? *Hoe kan het feit dat het strafbaar is een vrijwillige zwangerschapsafbreking te verhinderen worden verzoend met de vrijheid van meningsuiting?*	3.1.5. 3.4. 4.2.
49	Dans quelle mesure les femmes et la vie à naître seront-elles protégées par le droit pénal si la loi sur l'interruption volontaire de grossesse est intégrée dans la loi sur les droits des patients ? *In hoeverre worden vrouwen en het ongeboren leven strafrechtelijk beschermd als de wet betreffende de vrijwillige zwangerschapsafbreking wordt opgenomen in de wet betreffende de rechten van de patiënt?*	3.4.
50	Quelles sont les conséquences si l'interdiction de l'avortement pour des raisons liées au sexe de l'enfant à naître est intégrée dans la loi ? *Wat zijn de gevolgen indien het verbod op abortus wegens redenen die te maken hebben met het geslacht van het ongeboren kind wordt opgenomen in de wet?*	4.1.5.
51	Quelles adaptations au niveau institutionnel sont jugées nécessaires par le corps médical quand il s'agit d'interruption de grossesse ? *Welke aanpassingen op instellingsniveau worden er vanuit de medische wereld als noodzakelijk geacht wanneer het gaat over zwangerschapsonderbreking*	3.4. 6. 8.
52	Quel contrôle de qualité interne et externe supplémentaire des centres d'avortement et des hôpitaux est nécessaire en matière d'interruption de grossesse afin d'améliorer la qualité des soins ? *Welke interne en externe kwaliteitsbewaking van abortuscentra en ziekenhuizen is er extra nodig wanneer het om zwangerschapsafbreking gaat, teneinde de kwaliteit van de zorg te verbeteren?*	5.2.3. 5.2.4. 5.2.6. 5.3.4. 5.3.5. 6.2. 6.3. 6.4. 7.3.
53	Quel est le délai maximal pour la réalisation d'un avortement dans la législation des pays occidentaux ? Existe-t-il un consensus (scientifique, social, ...) sur un certain délai maximal ?	4.1. 4.2.

	Wat is de maximale termijn voor het uitvoeren van abortussen in de wetgeving van westerse landen? Bestaat er een (wetenschappelijke, maatschappelijke, …) consensus over een bepaalde maximale termijn?	
54	Quel serait l'impact de la prolongation du délai de réalisation des avortements dans les autres États membres, tant sur la pratique et le nombre d'avortements réalisés que sur l'acceptation sociale de cette modification de la loi ? *Welke impact zou een verlenging van de termijn voor het uitvoeren van een abortus in andere lidstaten hebben op zowel de praktijk en het aantal abortussen dat wordt uitgevoerd als de maatschappelijke aanvaarding van deze wetswijziging?*	6.1.4. 6.3.
55	La Cour européenne des droits de l'homme offre aux Etats une large marge d'appréciation pour trouver un équilibre entre les droits des femmes et les intérêts de l'enfant à naître. Comment cet équilibre peut-il être abordé d'un point de vue juridique et bio-éthique ? *Het Europees Hof voor de Rechten van de Mens biedt aan de staten een ruime beoordelingsmarge om een evenwicht te vinden tussen de rechten van de vrouw en het belang van het ongeboren kind. Hoe kan dit evenwicht worden benaderd vanuit juridisch en bio-ethisch perspectief?*	3.2. 4.
56	D'un point de vue bioéthique, quel est le lien entre le droit de la femme à l'autonomie et le cadre légal des interruptions volontaires de grossesse, les évolutions scientifiques dans le domaine de la viabilité du foetus, le sexe de l'enfant à naître, etc. *Wat is vanuit bio-ethisch standpunt het verband tussen het recht op zelfbeschikking van de vrouw en het wettelijke kader voor vrijwillige zwangerschapsafbrekingen, de wetenschappelijke ontwikkelingen op het vlak van de levensvatbaarheid van foetussen, het geslacht van het kind dat nog niet geboren is …?*	4.
57	Quelle influence les facteurs religieux, sociaux et culturels ont-ils sur l'acceptation sociale de l'avortement ? Dans quel sens exercent-ils une influence sur le choix de la femme de se faire avorter ? *Welke invloed hebben religieuze, sociale en culturele factoren op de maatschappelijke aanvaarding van abortus? In welke zin oefenen ze een invloed uit op de keuze van de vrouw om tot abortus over te gaan?*	3. 4. 5.1. 5.2.4. 5.3.4. 6.1.2. 6.2.
58	Des enquêtes et/ou des études montrent-elles que les femmes subissent des pressions pour des raisons religieuses, sociales ou culturelles ? *Blijkt uit enquêtes en/of onderzoeken dat vrouwen onder druk worden gezet om religieuze, sociale of culturele redenen?*	5.2.4. 5.2.6. 5.3.4. 5.3.5. 6.
59	Peut-on établir une frontière intrinsèque, essentielle et fonctionnelle pour déterminer quand il n'est plus possible d'interrompre une grossesse pour des raisons autres que médicales ? *Kan er een intrinsieke, essentiële, functionele grens worden vastgesteld die bepaalt vanaf wanneer het niet meer mogelijk is een zwangerschap af te breken om andere dan medische redenen?*	4. 6.

60	La Cour européenne des droits de l'homme offre aux Etats une large marge d'appréciation pour trouver un équilibre entre les droits des femmes et les intérêts de l'enfant à naître. Comment cet équilibre peut-il être abordé d'un point de vue juridique et bio-éthique ? *Het Europees Hof voor de Rechten van de Mens biedt aan de staten een ruime beoordelingsmarge om een evenwicht te vinden tussen de rechten van de vrouw en het belang van het ongeboren kind. Hoe kan dit evenwicht worden benaderd vanuit juridisch en bio-ethisch perspectief? (Ook in focusgroep juridische aspecten)*	3. 4.
61	Est-il question d'une saturation ou une charge émotionnelle chez les gynécologues et les soignants, tant à cause de la pratique de l'avortement qu'en raison de l'incapacité à répondre à la demande d'avortement ? Comment soutenir les gynécologues ou les soignants à cet égard *Is er sprake van emotionele verzadiging of belasting bij gynaecologen en hulpverleners, zowel wegens het uitvoeren van abortus, als het niet tegemoet kunnen komen aan de vraag tot abortus? Hoe kunnen gynaecologen of hulpverleners in dit kader worden ondersteund?*	5.3.4. 7.3.
	Q du GP: Comment voyez-vous la structure idéale de prise en charge des interruptions chez des femmes qui demandent une IVG après 12 semaines (médicamenteuse ou chirurgicale). *V van SG: "Hoe ziet de ideale structuur eruit voor de uitvoering van abortus bij vrouwen die een abortus aanvragen na 12 weken (medicamenteus en chirurgisch) ?"*	6.4.

Composition of the scientific Committee and the working groups

	WG/GT1	WG/GT2	WG/GT3	WG/GT4
Voorzitterschap/Présidence	Patrick Emonts (ULg)	Luc Roegiers (UCL)	Yvon Englert (ULB)	Eva Brems* (UGent)
	Anne Verougstraete (VUB)	Maryse Bonduelle (UZBrussel)	Kristien Roelens (UGent)	Yvon Englert (ULB)
Expertleden / Membres experts Naam en affiliatie - Nom et affiliation				
	Heidi Mertes (UGent)	Ellen Roets (UZGent)	Ann Buysse (UGent)	Eva Brems (UGent)
	Caroline Lecocq (Planning Familial St Josse)	Myriam Israel (Erasme ULB)	Sylvie Lausberg (Commission Nationale d'Evaluation/Nationale Evaluatiecommissie)	Guy Lebeer (ULB)
	Chaïma Ahaddour (KUL)	Roland Devlieger (UZLeuven)	Uschi Van den Broeck (UZLeuven)	Pascal Borry (KUL)
	Carine Vrancken (LUNA)	Maryse Bonduelle (UZBrussel)	Eric Boss (Gynaikon)	Gily Coene (VUB)
	Johan Goiris (LUNA)	Antoon Mulder (UZA)	Bettina Blaumeiser (UZA)	Charlotte De Mulder (UA)
	Mathieu Luyckx (Saint-Luc UCL)	Corinne Hubinont (Saint-Luc UCL)	Pierre Bernard (Saint-Luc UCL)	Jean-Marc Hausman (UCL)
	Claudine Mouvet (Planning Familial Louise Michel)	Bruno Fohn (Citadelle Liège)	Thérèse Locoge (ULB)	Florence Caeymaex (ULg) (replacing Nicole Gallus* (ULB))

Leden van het Wetenschappelijk Comité in de WG / Membres du Comité Scientifique dans le GT				
	Patrick Emonts (ULg)	Luc Roegiers (UCL)	Yvon Englert (ULB)	Yvon Englert (ULB)
	Anne Verougstraete (VUB)	Yves Jacquemyn (UA)	Kristien Roelens (UGent)	Martin Hiele (KUL)

Universitaire onderzoekers/Chercheuses universitaires
Aurélie Aromatario (ULB)
Fien De Meyer (UA)

* Resignation from the working group during the abortion evaluation project, for reasons unrelated to the project.

Annexe/bijlage III : Experts hearings

a) Dr. Patricia A. Lohr (Medical Director of British Pregnancy Advisory Service (BPAS))

Interuniversity Steering Committee Evaluating the Belgian Abortion Law and Practice

Expert hearing: dr. Patricia A. Lohr – 5 September 2022

Powerpoint presentation sent to members of the committee by e-mail

- ***Summary of Q&A:***

> *Q: Based on the statistics from 2021 that were mentioned at the beginning of the presentation: are there any data available about the philosophical or ethnic background of the women who had an abortion?*

PL: Women requesting an abortion in the 2nd trimester tend to be younger, less privileged, and more often from ethnic minority groups. Data is collected through required reporting to the Department of Health, but it is always possible to opt out from the questions related to the demographic parameters. Routine annual data and numbers are available online (https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021) but specific data requests can be made for more detail to the statistical team.

> *Q: Do you have a comparison available on the outcomes of medical v. surgical abortion in terms of long term effects, such as pre-term births or miscarriages for further pregnancies ?*

PL: There are some smaller studies that do not show an increased risk in subsequent pregnancies. More modern cervical preparation techniques through medication / slow mechanical dilation with osmotic dilators may have be associated with lower risks than older techniques using rigid dilation.

Regarding the risks of pre-term delivery correlated to respectively medical or surgical abortion, data are conflicting. It is commonly accepted that medical abortions are less frequently associated with pre-term delivery but there is some controversy on this topic.

> *Q: What kind of training is provided to be able to perform surgical abortion, especially at the second trimester? Is there a required number of abortion to perform annually? Or some kind of certification to obtain?*

PL: Training is competency based, rather than based on a prescribed number of cases, and begins with understanding the technique and safe use of instruments. Another important aspect is to be

comfortable and to have confidence in the practice. Yet, reaching a good level of confidence requires time and experience. Training in second trimester surgical abortion is similar to an apprenticeship.

The suction method can be used up to 15 weeks of pregnancy and even 16 weeks with the use of larger cannula and suction tubing, but after that point use of forceps are needed to remove the larger fetal parts and placenta. Skills are usually rapidly acquired to 17 or 18 weeks gestation, but after 19 weeks when the bones becoming more ossified and the fetus is larger skills acquisition takes longer.

There is no absolute number of abortions to perform yearly, but it is recommended to perform regularly at the gestational age you are providing: at least twice a month as a minimum, but ideally once a week (meaning a full day of practice, 6 to 8 patients may suffice – but can amount to 12-16 patients a day at larger abortion clinics). It is also recommended to be exposed to abortions at different gestational ages.

> Q: *Is there an upper limit for the number of abortions a provider could perform? Is it considered as a burden to perform a high number of abortions, or are there practitioners who are employed full time to perform abortions ?*

PL: The people working for BPAS are on board with the idea of abortion and everything it encompasses. There is a sympathy for the cause and a desire to provide high quality comprehensive care. Some doctors only work for BPAS as a fulltime employment, but many work 1 or 2 days a week at BPAS or another abortion clinic and have another practice elsewhere (in an NHShospital). In BPAS, individuals sometimes have their own gestational age limit. But BPAS tries to recruit what we need in terms of providers' competencies, willingness to train, and the matching profile of the applicant. We recruit those who are willing to offer up to certain limits. Hospitals would work similarly.

In abortion clinics, attention is paid to the training and sensitization of the whole chain of workers, from the person who answers the phone, to the nurse, to the doctors performing abortion. Team is important: everyone needs to be supported and committed. When there is a need to advance gestational age, it is helpful to carry out values clarification with the whole team so they understand the need for second trimester abortion, the procedure, risks and safety to see where everyone is at in terms of their views and barriers to advancing practice. You can make a plan to slowly move up in gestational age. Sometimes it can take many years but sometimes can move faster.

> *Q: What is the position of the BPAS organization within England and its medical landscape: is the structure state organized ?*

PL: BPAS is a non-profit medical organization that exists at the national level. There are clinics in England and Wales, as well as a consultation centre in Scotland, which supports women travelling from Scotland to England for second trimester abortion. This network of clinics treats about 100,000 patients every year and offers, among other medical services, abortion up to 24 weeks of gestation. There is indeed a restriction in the abortion regulations in the UK establishing that abortion for pregnancies over 24 weeks have to be performed in an NHS hospital. The service of abortion is publicly funded through the National Health Service (NHS). The vast majority of patients coming to an abortion clinic do not have to pay anything (with the very exceptional cases of patient residing in a foreign country or not complying with the medical criteria, such as GP consultation, which is rarely requried).

Marie Stopes International (MSI Reproductive Choices) offer similar services, whereas hospitals also provide abortion but less often and even less often in the second trimester. Apart from offering abortions, there is also a teaching/training component in BPAS (Patricia Lohr is interested in this aspect).

Q: Could you describe a typical BPAS clinic, in terms of team, equipment, infrastructures…?

PL: The BPAS clinics are usually free standing buildings, which are large Victorian homes converted in medical facilities. The ones dedicated to terminations of pregnancy at a later stage under general anaesthesia usually have-

- A waiting room
- One operating room
- Anaesthetic machines
- A 1st recovery area
- A 2nd recovery area
- A discharge area
- Lift (if several floors)

Abortions to 17 weeks and 6 days are provided in some smaller clinics under conscious sedation. This is carried out in a treatment room and only requires one recovery area.

Since it is not possible to provide blood in all locations, they have the necessary material to stabilize the patient for quick transfer to a hospital, or to intubate the patient if needed (usually it is stabilization and referral with ambulance).

Most are day-care centres. One clinic dedicated for 2nd trimester medical abortions offers the possibility to stay overnight (available beds, kitchen, bathroom).

Day case (outpatient) surgical centres which are integrated into hospitals also exist. In this case, the possibility to transfer patients to the main hospital in case of complication is facilitated.

Q: Is there a mandatory waiting period or is it possible to get an appointment and have the abortion procedure immediately afterwards?

The possibility for an immediate abortion procedure has always existed (after a medical consultation) and there has never been a waiting period in the UK law. The National Institute for Health and Care and Excellence (NICE) offers national guidance on abortion and it has recommended against any form of mandatory counselling or waiting period. One of the arguments is that a waiting period would lead patients to reach a more advanced stage of pregnancy and no longer be eligible for abortion.

Q: Are there numbers or data available regarding complications related with 2nd trimester abortions?

PL: Complication rates are low, but higher for 2nd trimester abortions than for 1st trimester abortions. Serious complications for 2nd trimester abortion occur in approximately 1/100 procedures. Haemorrhage is most common with either medical or surgical abortion , uterine perforation (for surgical abortion) or rupture (medical abortion) are less common. The complication rate is slightly higher with medical abortion but can be easily managed whereas complications following surgical abortions are more likely to require repair – and they are more likely to do so in the 2nd trimester than in the 1st trimester.

Q: For medical abortions, is a locoregional analgesia proposed ?

PL: It is not available in abortion clinics. The only options are anti-inflammatories (oral) or mild opioids (oral or injectable). It is not always sufficient and locoregional anesthesia would be a good option to have available, since a medical abortion in the second trimester can last for several hours.

Q: Is anesthesia offered for 1st trimester abortions ?

PL: Mostly women have local anaesthesia or low doses of midazolam and fentanyl to achieve a state of conscious sedation for 1st trimester abortions. Numbers from 2019 at BPAS allow to establish that 19,000 vacuum aspiration abortions have been processed for pregnancies up to 13 weeks and 6 days during that year. Among those, 60% were made under conscious sedation, which offers the possibility to talk to the patient and reassure them, which is seen as a positive for women and staff. Another 30% was done with local anaesthesia and 10% with general anaesthesia using propofol and fentanyl. D&E can be done with conscious sedation before 18 weeks, whereas later 2nd trimester abortions are always performed with general anaesthesia at BPAS.

Q: Is there an anaesthetist available at all time at the clinic?

PL: The Association of Medical Royal Colleges provides a guideline for the use of sedation, they notably specify the type of staff that should be available for all levels of sedation from minimal to deep (or general anaesthesia). It is mentioned that there is no need of an anaesthetist for conscious sedation notably but staff need the skills to manage oversedation including resuscitation should this occur.. They don't use anaesthesiologist for conscious sedation as routine at BPAS. For propofol they need an anaesthesiologist. BPAS has a Lead Anaesthetist available for advice to all clinics.

Q: The abortion clinics are funded through the NHS, but is it a closed envelope that the clinics have to manage or is it funded by act (i.e. based on the actual number of abortion and medical acts provided) ?

PL: It is a mix. Abortions are NHS funded for almost all women. The whole NHS budget is regulated at the national level, with a geographic repartition to Integrated Care Boards who commission services from abortion providers like BPAS but also local NHS hospitals that provide abortion care. Sometimes more than one provider is commissioned in a given area. Previous statistics on abortions performed in a certain territory will underpin the estimated budget to provide all or part of the service. Sometimes

funding is received in blocks but more often is paid after invoicing the local integrated care board (ICB) with the abortions performed. This way of funding is generally working, although the service is also adapted with what the budget allows. The regional abortion statistics tend to be quite stable, but the budget could be adapted if they were to change. The reporting is made on the basis of the patient's address.

Q: You insisted on a wide availability of the training in abortion techniques, but what kind of medical profession does it concern ? Ob/gyn, GP, midwives maybe ?

PL: Any doctor can be trained to provide any kind of abortion technique. Most often it is ob/gyns or sexual and reproductive health specialists because they have abortion as part of their core training. The law is more restricted for other professions. Midwives and nurses can perform medical abortion, although the medications have to be prescribed by a doctor. Midwives and nurses can also take an active part in surgical evacuations for miscarriage, but only doctors can do surgical abortions.

Q: In the talks surrounding the possibility of extending the legal gestational age for abortion, several fears are expressed under the form of trauma for the pregnant woman, risks in terms of fertility, pre-term deliveries for further pregnancies… Are those fears legitimate ?

PL: I consider that there is far more damage from denying abortion than providing abortion in the 2nd trimester. There are some risks associated with abortion techniques, but restricting access to abortion also leads to dangerous situations.

Q: In Belgium, the medical method is the most used for fetal malformations. How does it work in England, since there is a higher access to surgical abortion ? Is it based on the patient's preference?

PL: Abortions for fetal anomaly would mostly happen in hospitals, with most of those doctors not being trained for 2nd trimester surgical abortion techniques. In other countries (the US notably), there is a better training for surgical abortion for fetal anomaly.

One argument that is sometimes heard is that medical abortion would be preferable in order to have an intact fetus, in case a post mortem has to be done. To this, it can be answered that ultrasound is often enough for diagnoses or post mortem on basis of D&E specimens.

A recent survey in the UK showed that most people who have to go through an abortion for medical reasons are not offered the choice of method, and many would actually prefer surgical abortion in case of abortion for fetal anomaly. BPAS has a service that complements hospital provision for on abortion for fetal anomalies, using the existing expertise and a specific care pathway so that women in areas where only medical abortion is offered in the local hospital have more choices. .

There is a myth that people who have to go through an abortion for fetal anomaly would want to see the fetus in whole – although having a choice in the procedure would be a better help in coping with the situation. There is a type of D&E (intact D&E) where the fetus is not removed in parts that can be used.

Q: How would the financing work with undocumented and/or homeless women who don't have an address ?

PL: An address can usually be found for the purpose of invoices or reported. It can be someone living in the area, or alternative forms of residence : address of a shelter, of a GP… The bigger problem concerns the funding for people who have to travel to have an abortion because they have no near facility offering abortion at later stages: they need to gather money for the travel itself (and sometimes for the abortion, if they are not English residents). Those issues tend to delay their access to abortion and have more complicate procedures with a more advanced pregnancy.

Q: The question of the pain experienced by the fetus could be a reason why some doctors are reluctant to the d&e method (this concerns mostly surgical abortions, that seem more potentially painful for the fetus)

PL: This is an unanswerable question… The Royal College of Obstetricians and Gynaecologists (RCOG) is currently revising its paper on fetal pain and sentience and the new guidelines should go out soon. However, we don't know what the fetal pain experience is – we know where pain occurs and that the pathway is not complete before 26 to 28 weeks. What can be studied is the exposure to stimuli and the question would be the ability to recognize it.

One stance on the issue could be the swiftness of the potential pain. Feticidal injection induces a heart attack, which is likely to be painful on a fetus but for a short period of time : the heart beat stops very quickly. For a medical abortion, contractions could be painful and long-lasting. Surgical abortion: induces demise almost immediately. Heart rate does not go on, the foetus dies very quickly. Quick death via surgical procedure seems kinder.

Another stance would be to consider who we are doing the procedure for? The aim is to focus on the comfort of the woman. (Patricia emphasises that she is mainly on that side of the spectrum)

This is ultimately an unknowable discussion.

Q: In the case of a feticide, we actually inject pain killers to the fetus. It seems it doesn't feel the heart attack.

PL: Many pregnant women when seeking abortion demonstrate some care about the fetus and express a desire for feticide. However, it is not always the case. Some would not want an abortion with prior foeticide because they don't want to carry a dead foetus for 24h in their uterus.

What is not done is specifically giving anaesthesia to the foetus before the D&E.

The main method for feticidal injection we use is potassium chloride or digoxin. More common than using lidocaine.

Q: In the case of a conscientious sedation or general anesthesia, should we consider that the fetus is sedated as well ?

PL: We don't know for sure but it is a possibility. It is still possible to inject anaesthetics directly to the fetus.

b) Dr. Raïna Brethouwer (Medical coordinator Beahuis & Bloemenhovekliniek – Heemstede)

Steering committee of the interuniversity, multidisciplinary and independent committee in charge of the study and evaluation of the practice and legislation on voluntary termination of pregnancy

Expert Seminar Raïna Brethouwer – 7 July 2022 – Teams

PLEASE NOTE THAT IN THESE MINUTES, PREGNANCY AGE IS USUALLY PRESENTED COUNTING FROM THE LAST MENSTRUAL PERIOD INSTEAD OF CONCEPTION.

Minutes

1. **Legal framework**

- Abortion is in the Criminal Code
- In 1984: allowed under certain conditions
    - Licensed hospital or clinic
    - 5 days reflection period after 1st consultation with doctor
    - Up to and including 23 weeks (viability limit)
        - Officially, the law situates viability at 24 weeks, but in practice, they have taken a margin of error to offer ToPs only up to 22 weeks and 2 days > for late presentations, they can only estimate the pregnancy duration (error margin of 7-10 days)
        - Before 22 weeks and a few days, it is still manageable to do surgical ToP, later it becomes more technically challenging. This also explains the choice for top up to 22 weeks.
        - ToPs between 22 and 24 weeks can still happen at the hospital via the medical method. However, hospitals may be more strict than clinics/the law when it comes to judging the reason for a ToP, both between 22-24 weeks as before 22 weeks.
    - Contract with backup hospital
    - Report to Inspectorate

- Evaluation of the legal framework in 2020-20..
    - Detach the time limit for abortion from viability (just maintain the time limit, but do not refer to viability)
    - Remove the mandatory waiting period of 5 days (recently adopted in 2nd and 1st chambers)

2. **Financial regulation**

- <u>For Dutch residents</u>
    - Directly through ministry
    - For everything related to treatment
        - Abortion
        - Anesthesia/PSA or local anesthetic
        - Placement LARC

- because of this: no financial incentive to choose something based on money

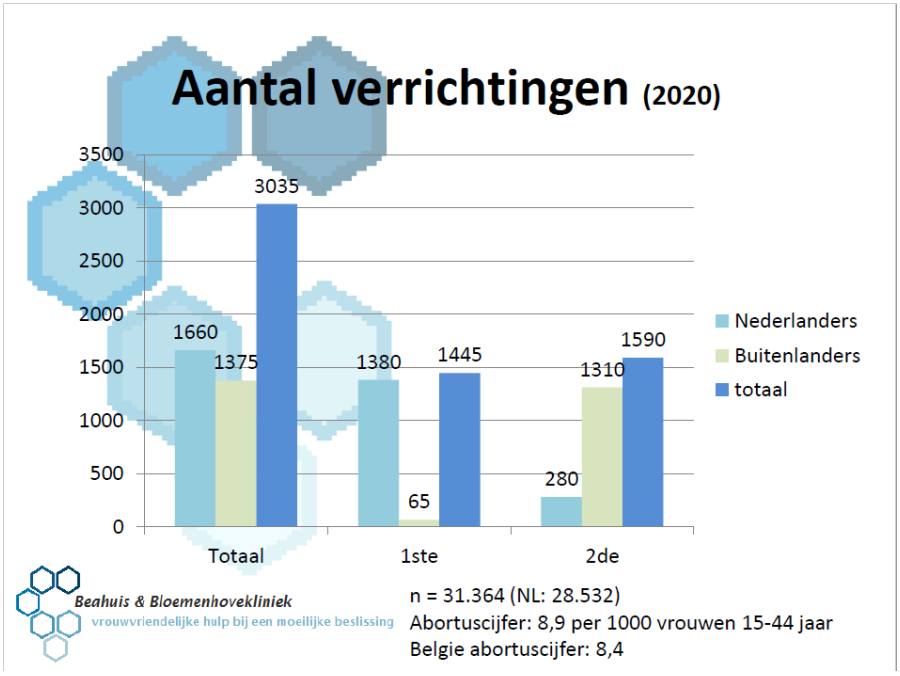
- Foreigners: to pay themselves
  - Tarif decided by ZorgAuthoriteit
  - Based on reports to Inspection
    - Reported:
      - Age (category block of 5 years)
      - Nuptial state
      - 2 digits of zip code (total 4 digits and 2 letters)
      - Previous pregnancies and abortions
      - Birth control

3. Role of the NGVA: Nederlands Genootschap van Abortusartsen

- Registration of abortion doctors
- Establish quality standards
- Perform quality inspections
- Give training recognitions
- Organise at least twice a year a training day
- Link between government and inspectorate
- Link between other specialists (gyn, general practitioners, etc.)

4. Beahuis and Bloemenhovekliniek

- Goal: performing abortions on social indication
  - Sometimes also: Fetal abnormalities
    But… severity of anomaly or reason for termination is not questioned <-> hospitals
- Target audience: women with an unwanted pregnancy until 22 weeks ammenorhea (BPD 56, FL 38)
- Number of abortions performed in 2020 at Beahuis/Bloemenhovekliniek (total number / number 1st trim / number 2nd trim). Foreigners especially come in the 2nd trimester.



- Complication rate at Beahuis/Bloemenhovekliniek

Complicaties (2020) landelijk: 2,7 %

	1ste trim	%	2e trim	%	totaal	%
Totaal aantal	1445		1590		3035	
Geen	1408	97,4%	1574	98,99 %	2982	98,25 %
Totaal complicaties	37 (14*)	2,6% (0,96%*)	16	1%	53 (30*)	1,75 % (0,988%*)
Bloedverlies > 500 mL	1		3		4	
Incomplete abortus	24 (5*)		2		26	
Letsel aan uterus	0		8		8	
Infectie	6 (2*)		0		6	
Bijwerking medicatie	6		3		6	

Beahuis & Bloemenhovekliniek
vrouwvriendelijke hulp bij een moeilijke beslissing

* Zonder medicamenteuse behandeling

Hospital care in case of severe complications! Clinic in Amsterdam who performs abortions up to 18 weeks amenorrhea hardly ever sends anyone to hospital, while at Bloemenhove this happens more often (3x a year) because they also perform later terminations.

- **! Belgian clients at Beahuis/Bloemenhovekliniek per gestational week**

Belgische Clienten

Amenorroe duur	Aantal
13	1
14	3
15	11
16	15
17	10
18	8
19	6
20	15
21	22
22	9
Totaal	100

Beahuis & Bloemenhovekliniek
vrouwvriendelijke hulp bij een moeilijke beslissing

Question: why do we have a lower number around 18-19 weeks and a higher number around 20-21 weeks?

- ⇨ The drop at 18/19 can be explained because the procedure is then more expensive, which causes a rush to have the ToP before the 18th week (higher number around 16/17w).
- ⇨ The higher number around 20/21 is explained because of the rush to have a pregnancy before 22weeks, because after 22 weeks it will become almost impossible.

- ⇨ The drop at 22 weeks is best explained by the fact that it only includes ToPs up to 22 weeks + 2 days, so that is the maximum term it is offered in practice. It is not the entire 22nd week.

5. Procedure (before ToP)

- By appointment
  - The 5 day waiting period can start running from the first contact with a doctor, it does not have to be the first contact with the abortion clinic. 5 day waiting period is now removed from the law.
- Sign up at reception
  - List of questions to fill in
- Doctor's role
  - Anamnesis and history
  - Decision: make sure there is nodoubt left
  - Birth control is discussed (up to 15 weeks they can place a spiral)
  - Echo: always do it themselves, even if they had an echo the day before
- Nurse's role
  - Establishing blood group and possibly Hb and INR
  - Registration of legally required data
- Reception's role
  - Handling of payment
    - Dutch women: through AWBZ (Algemene Wet Bijzondere Ziektekosten)
    - Foreign women: pay themselves

Procedure (ToP-day)

- Often the same day as the previous steps.
- Patients come in sober
- Raina is the responsible doctor (or one of my 4 colleagues), and a trained nurse assists.
- Treatment
  - Can go from early treatment to treatment up to 22 weeks
  - Can have deep sedation or local anesthesia
- Patients go home the same day. The clinic can always close for the night between 5 and 6 pm.
- After control: usually after 3 weeks. Can be at the clinic or own doctor.

6. Abortion methods

Behandelmethode 1ste trim

- Abortuspil
  - Tot 8 weken 6 dagen
  - Dag 1: 200 mg mifepriston (Mifegyne®)
  - Dag 3: 800 µg misoprostol (Cytotec®)
- Nacontrole telefonisch na 4 weken

Behandelmethode 1ste trim

- Zuigcurettage
  - Tot en met 12 weken
  - Lokale verdoving of diepe sedatie
  - Afhankelijk van termijn oprekken cervix met Hawkin-Ambler dilatoren tot max 10 mm
  - Vacuum aspiratie met starre gekromde zuigbuis
  - Echo controle bij afronden behandeling
  - Controle van curettement op compleetheid
- 1 uur blijven na de behandeling

Behandeling t/m 22 weken

- Dilatatie en Evacuatie (D&E)
- T/m BPD 56 mm
- Keuze tussen diepe sedatie en lokale verdoving
- 2 uur blijven na de behandeling

pictogram bb.png

Beahuis & Bloemenhovekliniek
vrouwvriendelijke hulp bij een moeilijke beslissing

Foetus is reduced with instruments, most of the placenta too

Suction curettage is somethimes used for the last remaining pieces.

Behandeling t/m 22 weken

- Oprekken cervix met Hawkin-Ambler dilatoren tot maximaal 17 mm
- Met instrumenten wordt vrucht verkleind en geaborteerd
- Ook (meerendeel van) placenta
- Eventueel zuigcurettage aansluitend
- Echo controle bij afronden behandeling

Cytotec voorbereiding

- Cervicale priming met misopostol
- Tot/met 8 weken niet
- 9-17 weken 1 uur 400 µg sublinguaal
- 18-20 weken 2 uur 400 µg sublinguaal
- 21-22 weken 2x 400 µg sublinguaal met 1,5 uur ertussen (totaal 3 uur wachten)

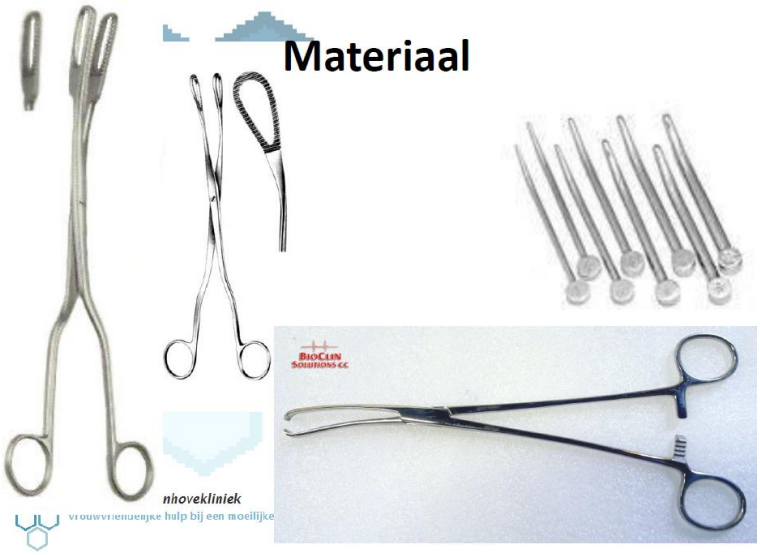
7. Difference between earlier and later abortions

- Instrumental vs Suction Curettage
    - Requires longer training
- Number of complications increases
    - Most at 21 and 22 weeks. Expanding to 18w is less of a problem. Up to 22 is a substantial extension. It's harder to do.
    - Foetus parts are larger and harder -> can cause damage to the uterus or cervix
    - Possible damage with (larger) instruments
    - Atony with larger uterus
- Care impact very high
    - Grief/processing heavier
    - Medication side effects
    - Pain
    - Diarrhea
    - Throwing up
    - Cold
- Stay longer
    - --> about 6 hours in department
- Treatment itself longer
    - --> up to 30 minutes instead of 5 minutes

8. Safety and quality guarantees

- Very good training and much experience required
- At least 2 doctors must always be present in the clinic
- Doctors have ALS schooling
- Open conversation needed with associated hospital

9. Materials



10. QUESTIONS

Is the number of women who cannot be treated in the clinic and who have to go to hospital significant?

- There are a number of them, but they are filtered out in advance by the reception. They often do not come to the clinic.
- Limited group who are rejected in the clinic: after new information about their health, because they have not communicated their weight correctly (too high BMI), etc.
- Recent example: cardiac anomaly that was thought to require instrumental ToP, but was not possible in a separate clinic; they then went to the hospital with their instruments to do it themselves. Was a danger if that person were to give birth in hospital via the medication method.

Will a woman who has a medical background which requires a termination in a hospital be helped by the hospitals, when the reason for ToP is social?

- Hospitals are not very willing to get involved if there is no medical reason for ToP, although willingness and acceptation is growing the last years.

What do patients think of the fact that the ToP is often on the same day as when they have their first consultation at the clinic?

- Not a problem for patients, rather a wish to have it a.s.a.p.
- Conversation with doctor is aimed at checking whether there is still doubt
- In any case, if there is doubt, they usually do not come to the clinic, and cancel the appointment

It is also possible to come in advance for a conversation or ultrasound, but that is really not often used or desired by the women.

Is there anything done to the foetus to cope with possible pain sensation/ethical concerns? They never perform foeticide (this would require more than a 1 day stay). First they break membranes, they ensure that amniotic fluid drains, and then you almost always have the umbilical cord in your forceps, you then "cut" it through. The moment the umbilical cord is cut, the blood pressure drops almost immediately. It is like fainting for persons, you feel nothing, notice nothing. Moreover, sedation offered to woman also arrives at the foetus, local anesthetic is also absorbed by the foetus because it is administered close to the placenta. In any case, whether the foetus 'feels' at this stage is another discussion, of which neonatologists seem to suggest that the pain reception stimulus have not yet been developed.

Is deep sedation also offered for 1st trim in NL? Not possible in Belgium. Yes, this is a possibility. Doctors and nurses are all trained in ALS (ERC training). Difficult training. In the clinic a lot of people choose sedation because it is always available, no new appointment needed

Is there data about long-term complications, particularly psychological and obstetrical complications?
Psychological impact: a lot of research. Their clinic participated in a study. What was found: abortion by itself does not cause psychological problems. What is true, is that people who had psychological

issues in the past, can have temporary complaints as well after abortion, usually they go back to normal state (no long term psychological effects).

Long-term effects future pregnancies: no clear research? Only studies that look back to a cohort of born children, then they checked in their files if the mother in birth had in the past had an abortion. What they found? More abortions in the past associated with preterm births. Too easy to say that it is because of instrumental /medical abortion, there was no distinction made in the research. No check whether the group who did not have a preterm birth lied about their abortion. Conclusion: No qualitative research on this.

Ditzhuijzen J van e.a. Abortus en psychische gezondheid. Een longitudinale cohortstudie naar de psychische gezondheid van vrouwen die een abortus meemaken. Utrecht, 2016.
See also https://www.tijdschriftvoorpsychiatrie.nl/nl/artikelen/article/50-11719_Abortus-en-het-risico-op-psychische-aandoeningen

Scholten e.a. : The influence of pregnancy termination on the outcome of subsequent pregnancies: a retrospective cohort study. See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3669713/

Intake by hospital in case of complications: Clinic in Amsterdam that performs abortions up to 18 LMP weeks almost never sends anyone to hospital, whereas this occurs +-3 times a year at Bloemenhovekliniek (as the clinic performs up to 22 weeks LMP).

Is psychological assistance offered after ToP at the clinic?

For foreign women, the clinic notices that they prefer psychological help in their own country. Nevertheless, everyone is trained in psychosocial help, yet there is relatively little demand for it. Patients are rather relieved.

How many staff members, and how much do they work? Are there recommendations for their stress levels?

Because it is the core business of the clinics (=2B clinic, distant 2nd trim clinic), you do not see staff who have emotional problems with it. It can happen when they're just starting out, because it's a bit different from what they are used to. Then there is psychological counselling. After a while you become more acquainted with it.

Because they are an abortion specific clincic the staff is very much behind it. There are several 2B treatments every day. Everyone works almost part time. Clinic is open for 4 days a week. There are 5 doctors, 2 are present every day. Doctors work +- 3 days a week. About the same for nurses.

What is the volume of the activity, and are there recommendations on minimum volume given expertise of personnel (avoiding complications) – maximum volume the staff can take?

Volume around 3000 per year for the clinic. Roughly speaking 1000 in 1st trim, 1000 beginning of 2nd trim , 1000 at the end 2nd trim. An average of 14 per day. Of these, about 6 are further 2nd trim, 6 beginning 1st trim. If everyone continues with the termination when they come for the appointment, it can be really busy, it can be 20 per day. Then you continue as a doctor until you are done.

Official guidelines require performing 75 abortions/year of a category to stay registered. (In practice at the Beahuis/bloemehovekliniek it is more)

The clinic has decided, if someone is on vacation, you should be able to fill the gap it with all the remaining staff. It is preferable that everyone works for 2 or 3 days, than there is flexibility if someone is sick or on holiday. Abortion clinic MUST have 2 doctors in house. If you don't have that, you don't meet the safety requirements.

What do you think of (abolishing) the 5 day waiting period[1]?

Raina is very happy with the abolition of the deliberation period, which remained an additional barrier, because they needed to speak to a doctor first. Paternalistic view. In the 1980s, the waiting period was included as a concession. Today, the idea behind abortion is also more of an autonomous decision by women, whereby the forced provision of additional information about adoption, contraception, etc. is seen as paternalistic. It is also recognised that a woman who wants to know more can really ask. Doctor adds little to this process, although doctor should be there for women who want it. Dutch law works well, because it also ensures quality safeguards. This should be ensured in the conditions of the clinic.

Is there a debate about involvement of the partner?
In our clinic the role of the partner is small, the client can be accompanied in the waiting room. Only minors have a parent with them when they are admitted to the ward.

What questions about medical background are asked in the list of questions?

List that asks questions about gynecological history, also matters that influence sedation, then general questions (medical). They also ask about psychological background.

What is the profile of Belgian women/women who come for abortion in the 2nd trimester?

Group that is a bit further, on average they are slightly younger. Largest group is 25-30, then 30-35, then 20-25. Those who come far before 25, have more often no children, have never been pregnant.

What is the main reason women present later for abortion?

Often they simply did not realise. Other common reason is a changing situation (relationship that ends), partner cheating, extreme situations that have changed the basis of the decision. The group that cannot make the decision and postpone it is relatively small.

Is any reason allowed to have a ToP, also when they are possibly ethically problematic (mild anomaly/sex)?

Officially no reason is too crazy to get an abortion. That can be personally difficult, e.g. if the reason is cleft lip, or a club foot, also sex. It was agreed among doctors that there will be no objection for these reasons. In the team they do talk about it, it can be difficult. On the other hand, it may be hard enough for that woman right now in her own situation + There is also little control on the real reason she is asking an abortion. Raina prefers that they are honest and that they are helped. In NL, sex

[1] Difference with Belgium: in Belgium it is the first appointment with the doctor at the abortion clinic which starts the 6 day period.

determination has been removed from NIPT. Not in favour of this approach. After all, on ultrasound you may see the sex a little later > then you may also be confronted with a later abortion request.

c) Bérangère Marques-Pereira (Emeritus professor of political sciences, Université Libre de Bruxelles)

ZWA | Stuurgroep van het interuniversitair, multidisciplinair en onafhankelijk comité belast met de studie en de evaluatie van de praktijk en de wetgeving inzake vrijwillige zwangerschapsafbreking
IVG | Groupe de pilotage du comité interuniversitaire multidisciplinaire indépendant en charge de l'étude et de l'évaluation de la pratique et de la législation sur l'Interruption Volontaire de Grossesse

Hearing Bérengère Marques-Pereira

08/07/2022

Présentation : « Evolution historique et socio-politique de la revendication féministe sur le droit à l'avortement depuis 1970 »

1. Les fondements féministes de la revendication du droit à l'avortement et les expressions nationales en Belgique et dans les pays voisins

1.1. Droit à l'avortement

Les droits des femmes à l'auto-détermination, à l'autonomie et à l'égalité avec les hommes, en matière de sexualité et de procréation, renvoient à une revendication majeure mise en avant par les mouvements féministes des années 1970 : la liberté reproductive. Le féminisme des années 1970 s'est avant tout développé sous la bannière du Mouvement de libération des femmes en France et dans les pays francophones et du Women's Liberation Movement au Royaume-Uni et aux États-Unis. A l'époque, l'aspect libertaire, issu de Mai 68, dominait le mouvement de libération des femmes. Le droit à la *privacy* renvoie à l'intégrité corporelle de la femme confrontée à l'avortement, et son auto-détermination implique qu'elle puisse décider seule d'une question aussi intime. Dans cette optique, l'autonomie de décision personnelle est vue comme une liberté positive et non pas seulement comme la liberté négative d'un choix libre de toute contrainte venant d'un tiers (le père, le mari, le conjoint), ou de la collectivité (l'État, une Église, l'opinion publique, le pouvoir judiciaire). Dans cette perspective, l'autonomie de décision n'est pas non plus un simple outil au service de la santé publique pour éradiquer l'avortement clandestin.

Durant cette décennie, la lutte en faveur de cette liberté s'est effectuée à travers une politisation de ce qui était vécu jusqu'alors comme intime, privé et tabou. Autrement dit, cette

lutte a interrogé le périmètre même du domaine politique et l'a enrichi. Dès la rupture du tabou de l'avortement, dans les années 1970, les féministes ont réclamé la libre disposition de soi et de son corps dans le débat public émergeant. Les slogans de l'époque (« Mon corps est à moi » ou « Our bodies, ourselves ») traduisent une volonté d'auto-détermination des femmes, de contrôle sur leur corps, de liberté à l'égard des hommes. L'argument philosophico-politique qui sous-tend ce choix n'est pas tant l'idée de propriété de soi (le corps n'est pas une chose) que le droit à la liberté de la personne sur l'usage de son corps, (le slogan *« Un enfant, quand je veux, si je veux* »), le droit à la *privacy* (ce qu'exprimaient les slogans « *Maître de mon ventre* » et « *Baas in eigen buik* » des manifestations des années 1970 pour la légalisation de l'avortement en Belgique, en France et aux Pays-Bas.

1.2. La désobéissance civile comme répertoire d'actions

Dans les années 1970, la lutte en faveur du droit à l'avortement a consisté à transgresser le tabou qui pesait sur la pratique de l'IVG. Transformer une pratique éminemment intime en un enjeu public – soit un processus de politisation par excellence – a requis de briser la loi du silence qui entourait cette pratique. Tel a été, par exemple, le sens des *manifestes* de femmes françaises (1971) puis belges (1973) proclamant publiquement avoir eu recours à un avortement, ce qui constituait une transgression ouverte de la loi pénale. Elle exprimait une résistance publique, non clandestine, non violente, de femmes qui avaient eu recours à un avortement, ainsi que de médecins et de membres du personnel de la santé qui avaient pratiqué des avortements sécurisés ou y avaient pris part.

En Belgique, les groupes féministes proches des milieux populaires tels que les Dolle Mina (1969) en Flandre et inspirées du mouvement anarchiste hollandais Provo, et les Marie Mineure (1970) en Wallonie, furent les premiers à entreprendre des actions de rue sur base des slogans auxquels je viens de faire mention. Les Dolle Mina organisaient des réseaux vers les Pays-Bas pour avorter en sécurité. Les Marie Mineur, elles aussi, décident de sortir l'avortement de la clandestinité : elles ouvrent le premier centre « SOS avortement » avec la complicité du docteur Peers, et d'autres gynécologues en Wallonie. Les Dolle Mina et les Marie Mineur sont confrontées aux grossesses non désirées et aux ravages des avortements clandestins. L'adoption, en 1967, d'une législation libérale en Grande-Bretagne (à l'exception de l'Irlande du nord) et la situation de tolérance aux Pays-Bas (depuis 1970 à l'égard des médecins progressistes qui ont mis sur pied des cliniques pratiquant des IVG) ont amené Willy Peers à faire sauter progressivement le verrou de la peur et de la honte qui entourait l'avortement. Au lendemain de l'Affaire Peers, en 1973, le groupe A est fondé à Bruxelles lors

de la journée des femmes du 11 novembre et organise des accueils pour les femmes désirant interrompre leur grossesse. Il y a lieu de remarquer que dès 1962, le premier centre de planning familial francophone laïque, La Famille Heureuse, avait été créé, s'inspirant des centres existant en Angleterre et aux Pays-Bas.

Cette résistance va perdurer lorsqu'il est manifeste que la politique d'accomodement entre élites politiques débouche sur la décision de ne pas décider en matière d'avortement. A l'issue de l'Affaire Peers, la dépénalisation de l'information en matière de contraception avait été obtenue. En outre, une trêve judiciaire de fait était installée pour permettre un processus de décision politique dans une atmosphère sereine. Face à la défaillance du législatif et de l'exécutif, pour des raisons que je ne détaillerai pas ici, des centres extrahospitaliers pratiquant l'avortement médical sont créés. Une pratique illégale, mais non clandestine de l'avortement médical s'installe au sein de la société civile. Pendant que se développe cette désobéissance civile, plusieurs organisations au sein de la société civile voient le jour. En effet, les Comités de dépénalisation de l'avortement (1976) lancent une plate-forme commune sur la base féministe : « avortement les femmes décident », et dès l'année suivante distribuent, lors de manifestations en faveur du droit à l'avortement, la liste des centres qui pratiquent des IVG. Parallèlement, des femmes et des médecins progressistes qui ont ouverts des centres extrahospitaliers forment le Groupe d'action des centres extrahospitaliers pratiquant l'avortement GACEPHA (1978), réclamant toujours l'avortement hors du code pénal, libre et gratuit. Par ailleurs, dans un registre légal, suite à la rupture de la trêve judiciaire de fait, le Comité de suspension des poursuites est mis sur pied. Ce Comité joue un rôle important de sensibilisation des responsables politiques. En effet, dès 1978, la trêve judiciaire de fait est rompue tout en évitant une répression généralisée, politiquement impraticable. A partir de 1981, les poursuites débouchent sur des procès, dans différents arrondissements judiciaires, contre des médecins et des femmes du personnel de la santé. Cette fois, c'est la loi qui est mise en procès au sein même de l'enceinte judiciaire. Les médecins et les membres du personnel de la santé en butte à la répression proclament devant leur juges une volonté de résistance ouverte, ne craignant pas d'encourir des peines de prison ferme.

2. Transnationalisation du féminisme et légitimation de la revendication en termes de droits humains dans les années 1980-1990

2.1. Construction des droits reproductifs et sexuels

Dans les années 1980, une série d'associations féministes internationales, notamment centrées sur la santé reproductive et sexuelle des femmes, entreprennent un travail intense de lobbying, de plaidoyer et d'expertise. En outre, la transnationalisation de la question des droits reproductifs s'appuie sur la mobilisation internationale en faveur de la reconnaissance des droits humains des femmes.

Ces associations ont ainsi participé à la construction sociale et politique de la notion de droits reproductifs et sexuels, notions qui furent institutionnalisées par l'OMS et l'IPPF, à la faveur des alliances nouées entre ces associations et organisations internationales lors de la préparation des grands conférences onusiennes des années 1990 axées sur les droits humains (1993 Vienne : reconnaissance que les droits de l'Homme s'appliquent de manière indivisible aux femmes et aux filles ; 1994 Le Caire sur la Population et le Développement : nouveau paradigme reconnaissant aux individus et non plus aux seuls couples le droit de choisir le nombre d'enfants et l'espacement des naissances ; 1995 Pékin sur les droits des femmes : constitue un tournant par la reconnaissance de la dissociation entre sexualité et procréation). Si ces conférences internationales n'ont pas expressément reconnu un droit à l'avortement, elles furent cependant importantes pour la légitimation des acteurs qui portaient la revendication d'un droit d'accès à l'avortement sûr (donc comme acte médical fondé sur la santé publique et l'accès aux soins pré et post avortement, notamment) et légal (dans les Etats ayant une législation à cet égard, les appelant à respecter leurs propres lois et à instaurer à l'époque a minima une légalisation de l'avortement en cas de danger pour la vie de la femme, en cas de malformation du fœtus, de viol ou d'inceste).

2.2. Montée des mouvements anti-IVG et anti-genre

A partir des années 1990, une nouvelle génération de mouvements anti-IVG se développe et est le fruit d'alliances entre différents courants conservateurs, réactionnaires, d'extrême droite et d'intégrismes religieux de diverses confessions. Cette nouvelle génération est en consonnance cognitive avec la sphère religieuse, et se construit en réaction aux conférences onusiennes du Caire, en 1994, et de Pékin, en 1995. En effet, le Saint-Siège a émis des réserves en matière de santé reproductive et sexuelle et de droits reproductifs et sexuels, aux plan et programme d'action de ces deux conférences.

Ces mouvements se rejoignent autour de l'idée que le but exclusif de la sexualité est la procréation. Ce rejet de la dissociation entre sexualité et procréation s'ancre dans le projet d'un

retour à l'ordre naturel. Celui-ci considère que la « Loi naturelle », transcendante et immuable, doit s'inscrire dans le droit positif et s'imposer aux croyants mais aussi aux non-croyants.

Cette perspective est promue par le réseau *Agenda Europe* qui structure la coordination européenne des principale organisations s'auto-désignant comme pro vie. L'une de leur cible principale est le féminisme et les droits des femmes, en particulier le droit à l'avortement, à la contraception, à l'éducation sexuelle. Plus largement, ces mouvements s'en prennent à ce qu'ils nomment, à la suite du Vatican, « l'idéologie du genre » ou la « théorie du genre ». Ces termes renvoient à une sorte de théorie du complot qui serait ourdi par les féministes, les militants LGBT ainsi que les recherches en études de genre. Cet ensemble s'inscrit dans ce que ces associations conçoivent comme une guerre culturelle contre la civilisation européenne et occidentale, contre l'ordre sexué et l'ordre des sexes.

Développée au moment des conférences onusiennes des années 1990, la dite idéologie du genre est une invention vaticane destinée à s'opposer à toute reconnaissance des droits reproductifs et sexuels et à leur inclusion dans le champ des droits humains. Elle fait office d'une sorte de sens commun pour les fondamentalismes religieux et les mouvements populistes identitaires qui leur permet de construire une redéfinition de la démocratie libérale glissant vers l'illibéralisme fondé sur une vision du monde clivé entre le « nous » et le « eux ».

3. Articulation entre droit à l'avortement comme libre disposition de soi et droit d'accès à un avortement sûr et légal dans le féminisme depuis les années 2000

3.1. Vigilance féministe et laïque en Belgique

C'est dans ce contexte de régression des droits des femmes que va se développer un nouvel activisme en faveur du droit à l'avortement. Il s'appuie sur une appropriation des résultats des conférences onusiennes des années 1990, par le niveau supranational. En effet, depuis les années 2000, un ensemble de résolutions du Parlement européen reconnaissent les acquis des conférences de Vienne, du Caire et de Pékin et s'inscrivent dans une vision dynamique des droits humains, considérant les droits reproductifs et sexuels comme de nouveaux droits devant être inclus dans le champ des droits humains. La santé reproductive et sexuelle est mise en avant pour légitimer un droit d'accès à un avortement sûr et légal.

Dans le même moment, le féminisme s'est non seulement transnationalisé, mais aussi professionnalisé et institutionnalisé. La participation à l'élaboration de nouvelles normes concernant la liberté reproductive et le droit d'accès à l'avortement sûr et légal s'est ainsi

déployée à travers des expertises, des plaidoyers de cause dans les forums internationaux et européens et devant des instances juridictionnelles internationales et européennes. L'accent est mis sur une politique du droit à l'avortement qui considère non seulement le sujet juridique et moral ayant droit à la vie privée et à la liberté de conscience mais aussi le sujet empirique et sociologique en butte aux inégalités et aux discriminations de genre, de classe et culturelles.

Dans ce contexte, le féminisme est devenu en Belgique un nouvel arc-boutant de la laïcité. Confrontés à la montée des mouvements anti-IVG et anti-genre, féminisme et laïcité s'organisent face aux *Marches pour la vie* mises sur pied à Bruxelles depuis 2010. Celles-ci cherchent à en finir avec la loi de 1990 sur la dépénalisation partielle de l'avortement. Au cours de ces marches, les activistes opposés au droit à l'IVG n'hésitent pas à recourir à une série de moyens de désinformation médicale sur l'IVG ou à des discours stigmatisant l'avortement et culpabilisant les femmes enceintes qui pensent en faire la demande.

Face à une telle mobilisation, la défense du droit à l'avortement connaît une nouvelle phase marquée par le développement de coordinations nationales et transnationales des pratiques de vigilance. En Belgique, les partisans de ce droit, rassemblant féministes, laïques et fédérations de centres de planning familial, recourent à des répertoires d'action éprouvés tels que les marches, les pétitions, le lobbying ou les plaidoyers de cause. Ces actions ne se limitent pas au cadre national, mais revendiquent le droit à l'avortement pour toutes les femmes vivant en Europe, ciblant particulièrement les pays qui maintiennent l'interdit pénal ou cherchent à y revenir (Espagne, Malte et Pologne notamment).

Devant l'augmentation de la fréquentation des rassemblements annuels hostiles à la loi de 1990, les partisans du droit à l'avortement ont maintenu les efforts de mobilisation et ont, en 2011, constitué une Plateforme pour le droit à l'avortement, dénommée *Abortion Right*. Cette plateforme pluraliste de vigilance et d'action réunit des associations représentatives de la laïcité organisée, des organisations féministes, les fédérations de centres de planning familial francophones, la Fédération générale du travail de Belgique (FGTB, syndicat socialiste), le GACEHPA, LUNA, le Mouvement ouvrier chrétien (MOC), les Mutualités socialistes. *Abortion Right* vise à garantir le droit à l'avortement et le libre choix des femmes, à l'échelle belge et européenne. Plusieurs marches ont ainsi eu lieu, lors de la journée internationale en faveur du droit à l'avortement, chaque année le 25 septembre, ou lors du 8 mars journée internationale des droits des femmes. Les activistes féministes et laïques exercent également leur vigilance à l'égard des discours du Saint-Siège et de ses relais politiques ou associatifs, notamment au Parlement européen, tandis qu'ils œuvrent au développement d'une stratégie de

coalition entre organisations se revendiquant de la liberté de choix et d'une stratégie de relais de leurs revendications par les partis politiques de gauche ou proches des milieux laïques.

3.2. Un éclairage socio-politique sur l'autonomie des femmes au prisme du droit à l'avortement et du droit à l'avortement sût et légal

Le droit à l'avortement fondé sur le droit à l'autonomie, à l'autodétermination et à la libre disposition de soi relève d'un droit-liberté. Mais ce droit-liberté est également réclamé au nom de droits-créances. Ainsi, les politiques sociales visant notamment l'éducation sexuelle, le remboursement de la contraception et de l'avortement, ainsi que l'accès aux services de santé sont-ils fondamentaux pour compenser les inégalités auxquelles les femmes sont confrontées. L'activisme féministe de masse qui s'est déployé depuis les années 2010 notamment en Europe en faveur du droit à l'avortement a mis l'accent sur les dimensions collectives et politiques de ces revendications, au-delà du seul choix individuel. À ce titre, le droit à l'avortement est conçu comme un droit-créance que l'individu – ici la femme – possède sur l'État. La problématique de la citoyenneté sociale des femmes entre ainsi en jeu avec le couple liberté/égalité qui dessine un terrain discursif incluant la réalité empirique et sociologique des rapports sociaux de sexe dans leur imbrication avec les rapports de classe et les rapports culturels.

Dans le même temps, la légitimation et du droit à l'avortement et du droit d'accès à un avortement sûr et légal s'effectue en termes de droits humains. Ce qui pose la question des tensions et des articulations entre droits de citoyenneté et droits humains au prisme de la revendication du droit à l'avortement et du droit d'accès à l'avortement sûr et légal.

Les droits humains sont d'ordre inclusif, visant l'être humain comme tel, la commune humanité des personnes. Les droits de citoyenneté sont d'ordre exclusif, définissant qui peut être citoyen et citoyenne sur un territoire donné et quels sont les droits et devoirs des citoyens et citoyennes. Le principe de subsidiarité dans l'UE en matière de santé et donc d'avortement renvoie à l'Etat la possibilité de légiférer en la matière. C'est dire que l'accès effectif à un avortement sûr et légal dépend de l'Etat, l'Etat comme garant des droits de citoyenneté et l'Etat social comme garant de la citoyenneté sociale. Or, dans les États, les politiques d'austérité budgétaire et les forces politiques conservatrices entravent généralement l'exercice des droits sociaux, compromettant ainsi les politiques de santé publique. Aussi, la portée émancipatrice de l'appel aux droits humains se heurte aux limites qu'imposent les crises économiques et financières à la citoyenneté sociale.

Cette tension entre droits humains et citoyenneté sociale est d'autant plus forte pour les femmes dépourvues du statut de citoyennes. En attestent les restrictions créées par les États à l'accès à l'avortement à l'encontre des femmes migrantes, des femmes sans papiers, des étrangères et des non-résidentes (que ce soit en Allemagne, en Croatie, en Espagne, en Irlande, en Lettonie, en Lituanie, en Pologne, au Portugal, en Slovénie ou encore en Roumanie) ou encore des filles mineures dans la majorité des pays de l'Union européenne (à l'exception de l'Autriche, de la Belgique, de l'Espagne tout récemment, de la Finlande, de la France, des Pays-Bas et de la Suède). En atteste également le fait que le recours aux instances judiciaires internationales et européennes suppose d'avoir épuiser toutes les voies de recours aux instances judiciaires nationales.

Le statut de citoyenne est conforté par les soutiens institutionnels garantissant les droits des femmes. On peut relever des instruments juridiques internationaux, européens et nationaux tels que les conventions et traités, l'obligation des États de reddition de comptes devant les instances onusiennes et parlementaires, les recommandations émises à l'intention des États par les comités de suivi des conventions, les recours possibles devant les instances judiciaires européennes, la reconnaissance institutionnelle des organisations de femmes qui mettent en œuvre la vigilance à l'égard des engagements internationaux pris par les États, ou encore la mise en place d'outils de l'action publique. Si ces instruments institutionnels n'assurent pas une reconnaissance du droit à l'avortement en tant que liberté reproductive, ils peuvent cependant garantir un accès à l'avortement plus ou moins large.

Ces articulations relèvent d'une logique d'émancipation des femmes des différentes tutelles masculines, qui fut rendue possible par les processus de subjectivation sociale et politique (le fait de devenir un sujet social et politique à part entière) à travers différentes dynamiques collectives de politisation dont le droit à l'avortement.

Séance de questions et réponses (FR)

[an english version of the questions and answers can found hereafter]

- *Question : On a constaté l'évolution récente aux Etats-Unis où le droit à l'avortement a été révoqué par la Cour Suprême. Quel impact cela peut-il avoir sur la situation belge (notamment avec la proposition de révision de la constitution pour y inscrire le droit à l'avortement) ?*

BMP : Aux Etas-Unis, l'avortement devient par ce fait un droit à géométrie variable. La décision de le rendre ou non légal est renvoyée aux Etats fédérés et on constate que, dans la foulée de la décision de la Cour Suprême, jusqu'à la moitié des Etats suppriment ou vont supprimer à court terme tout droit à l'avortement, en excluant parfois même jusqu'aux situations considérées comme extrêmes (grossesses résultant d'un viol, d'un inceste…).

Des formes de répression plus poussées se mettent également en place. Ainsi, il existe des propositions législatives de constituer des listes de femmes enceintes, de manière à vérifier que la grossesse se solde bien par un accouchement. En conséquence, des poursuites pour avortement deviennent envisageables si l'accouchement n'a pas lieu, y compris pour cause de fausse-couche. Indirectement, cela risque de pousser les femmes à consulter de moins en moins les médecins de crainte de ce type de délation.

Au Salvador, une telle législation est déjà mise en place, qui donne lieu à des peines de prison très lourdes même en cas de fausses-couches.

Ordo Iuris, une association catholique particulièrement influente en Pologne élabore actuellement un projet de loi dans le pays qui irait dans ce sens.

Les associations conservatrices anti-avortement ont une personnalité juridique qui leur permet notamment de se présenter comme plaignantes dans les instances judiciaires internationales et européennes

Concernant l'inscription du droit à l'avortement dans la Constitution, elle n'est pas une garantie absolue, puisqu'elle dépend de la majorité au pouvoir à un moment donné. Ainsi, la Hongrie a, quant à elle, inscrit le « droit à la vie » dans sa Constitution. Les législations dépendent de rapports de force politiques par définition instables : toute législation peut donc basculer.

- *Q : Comment articuler le concept citoyenneté sociale avec celui de justice reproductive, notamment au regard de ce qui se passe aux Etats-Unis ?*

BMP : Le terme fait référence aux textes de Jane Jenson sur le concept de « social citizenship » qui développent l'idée que l'exercice de la citoyenneté n'est efficace que si des efforts sont entrepris pour limiter les inégalités sociales.

Cette notion peut s'articuler avec le concept d'intersectionnalité, en cherchant à comprendre les types d'inégalités qui vont générer des accès différenciés aux droits reproductifs.

NB : ce concept d'intersectionnalité fait l'objet de réinterprétations diverses, politiques et militantes, mais il s'entend ici telle que sa créatrice, Kimberlé Crenshaw l'a défini, à savoir la prise

en considération de l'entrecroisement des discriminations dont une personne peut être victime du fait de sa position sociale et des ses identités.

- *Q : les notions liées aux droits du foetus et au statut du fœtus sont arrivées dans les années 1990 et sont à présent amplement reprises par les mouvements pro-vie. Est-ce que les mouvements féministes s'en saisissent et se positionnent à ce sujet ? Ou est-ce considéré comme irrelevant au regard du fait que c'est la maîtrise de son propre corps qui prime ?*

BMP : Les mouvements féministes considèrent en effet que c'est l'autonomie de la femme qui prime en matière de prise de décision. La question ne se formule donc aucunement en termes de droit du fœtus. Par ailleurs, aucune convention internationale ne confère au fœtus le statut de sujet titulaire de droits Des tentative de mouvements anti-IVG sont en cours pour introduire une telle notion par exemple dans la Convention européenne des droits humains.

- *Q. Historiquement, c'est la religion chrétienne qui est identifiée comme opposante au droit à l'avortement, avec des acteurs religieux locaux comme internationaux. Mais qu'en est-il des positionnements de responsables religieux musulmans ou juifs sur la question ?*

BMP : Lorsque l'ONU a émis des recommandations en termes de santé reproductive et sexuelle ciblant en particulier les femmes, le Saint-Siège a réussi a former une coalition avec les États islamiques de pays du Golfe ainsi que de pays de religion orthodoxe.

Les acteurs catholiques jouent aussi un rôle politique non négligeable, à l'exemple Commission des épiscopats de la communauté européenne qui représente l'épiscopat des Etats membres auprès de l'Union européenne. C'est pour la religion catholique que cette centralisation du pouvoir et des interlocuteurs est la plus forte.

En revanche, des coalitions d'autres acteurs sont possibles : des religions autres le monde chrétien sont moins des moteurs d'initiatives anti-IVG mais peuvent se positionner en tant qu'alliées et rejoindre le mouvement. Certaines alliances sont néanmoins plus difficiles à mettre en place que d'autres (exemple de l'échec de coalitions avec les imams en France lors des mobilisations de la Manif pour Tous).

- *Q : Réflexions sur les implications éthiques : la notion d'autonomie doit s'articuler à celle de la citoyenneté. Elle renvoie aussi à la question du travail politique qui se conçoit comme un horizon de lutte politique entre plusieurs groupes.*

  Quel est le positionnement actuel des revendications féministes à l'égard du cadre médical ? Comment formuler la revendication d'autonomisation dans ce contexte ? L'égalité semble peu acquise dans le monde médical qui est particulièrement hiérarchisé.

BMP : La lutte pour le droit à l'avortement est en effet représentative de certaines conceptions de la démocratie, comme en témoigne le fait que certains mouvements anti-genre considèrent qu'il ne peut exister de débat d'idée avec les pro-choix/~~pro-genre~~ et que la cause anti-genre peut légitimer des moyens anti-démocratiques.

Le mouvement féministe des années 1970, héritier de mai 68, a manifesté des inflexions libertaires importantes. Dans les pays occidentaux, la conjugaison de l'égalité entre femmes et hommes et la liberté individuelle des femmes au regard des hommes s'impose dans les questions d'émancipation sexuelle et reproductive. Dans les années 1980, un glissement des revendications les oriente vers la santé sexuelle et reproductive en hybridation avec les droits sexuels et reproductifs.

On peut considérer aujourd'hui que cette logique libertaire n'est plus d'actualité. Sur la question de l'avortement, les groupes féministes sont passés d'une logique de la subversion à une ~~la~~ logique de la subvention (avec pour objectif de pallier les manques de l'Etat social dans le cadre actuel du néo-libéralisme). Ceci s'inscrit dans féminisme qui s'est institutionnalisé dans des structures stables, parfois désigné comme un féminisme d'Etat.

Ce féminisme institutionnalisé étend donc sa capacité d'influence, notamment en occupant une position de concertation qui lui permet de peser dans l'élaboration de politiques publiques.

> Ex. : Loi du « gender mainstreaming » (peu appliquée cependant) qui a mis en lumière l'idée que les politiques publiques ne sont pas neutres et ont des incidences en termes de genre

En Belgique, les revendications liées à l'avortement se sont faites historiquement dans le cadre d'alliances ou plutôt de convergences avec le monde médical lorsqu'il est progressiste (au contraire par exemple de la France qui a connu un militantisme pro-avortement en rupture avec le monde médical – en mettant en place notamment des pratiques d'avortements volontairement démédicalisés).

Ainsi, la question de l'avortement est cadrée à la fois et inextricablement comme une question de santé publique et une question de genre.

La dimension sociale est aussi très présente historiquement, puisque ce sont des mouvements féministes ouvriers (Marie Mineur, Dolle Minas) qui s'en saisissent initialement. Le contexte belge de pilarisation structure aussi la forme prise par les débats.

Quant à la manière de considérer la problématique de l'autonomisation vis-à-vis du champ médical, elle n'est pas monolithique selon les groupes féministes.

L'avortement médicamenteux change la donne au regard de ces paramètres, dans la mesure où il permettrait potentiellement de s'autonomiser du monde médical.

> Ex. de Women on Waves / Women on Web : association qui proposait des avortements dans les eaux internationales, puis actuellement s'occupe de diffuser des pilules abortives dans un format de télémédecine (la fondatrice est médecin).
>
> Ex. de l'Argentine, qui a connu un mouvement féministe particulièrement massif, malgré et contre le poids de l'Eglise catholique très puissante (Eglise qui a collaboré localement avec le système dictatorial) : les féministes ont noué de véritables alliances avec des médecins progressistes pour proposer des avortements, aider les femmes ayant avorté et distribuer des pilules abortives.

En Belgique, la réflexion n'est pas structurée autour de cette articulation de l'autonomie des femmes par opposition au monde médical étant donné les ponts qui ont existé d'entrée de jeu.

Pour prolonger les développement concernant la conception de la démocratie, la Pologne ou la Hongrie sont en train de mettre en place des législations restrictives sous l'influence nette de mouvements anti-genre et anti-IVG. Une question politique se pose alors : il s'agit de groupes qui relèvent d'une logique réactionnaire selon laquelle ce serait une « loi naturelle » qui prime sur l'autonomie. La liberté religieuse est donc considérée comme ayant plus de poids que la liberté de conscience, qui se trouve rabattue sur la première.

Ces groupes formulent leur positionnement comme un clivage irréductible entre « nous » et « eux » et selon une rhétorique qui identifie les interlocuteurs comme amis ou ennemis, entraînant l'impossibilité du compromis politique (ou même du dialogue).

Or, à la base de la démocratie se trouve l'idée qu'il faut négocier, faire des compromis avec des adversaires qui ne partagent pas les mêmes idées, la même conception de la chose politique. La démocratie libérale part donc du principe du conflit, qui est identifié et reconnu, de manière à ensuite rechercher, à travers les négociations et les concessions réciproques, les moyens de la décision collective qui s'avère un compromis.

- *Q : Quel horizon dès lors pour le compromis si l'on ne peut s'entendre sur les fondements de la démocratie et les valeurs de base ?*

BMP : Les fondement de la démocratie libérale reposent sur les notions d'égalité et de liberté héritées des Lumières. Les remises en question de l'Etat de droit par des politiciens comme Viktor Orban peuvent tout à fait s'interpréter comme de l'illibéralisme mais non de la démocratie. Certaines valeurs philosophiques telles que l'égalité de principe ou la liberté en deviennent inconcevables.

> Ex. dans le Brésil de Jair Bolsonaro, l'égalité hommes-femmes n'est pas concevable, pas plus que la liberté : il ne peut exister que *des* libertés sous condition.

Ainsi, la question de l'IVG est une question sociale : elle est révélatrice, tout comme le sont en général les droits des femmes, d'un système de pensée politique et de l'état d'une société civile.

- *Q : Avez-vous une opinion à formuler sur l'état actuel de la loi encadrant l'IVG en Belgique ? Est-elle suffisante en termes d'autonomie ?*

BMP :

La révision de 2018 montre certains aspects positifs sous la forme d'acquis.

- La suppression de l'état de détresse en fait partie, en rompant avec l'idée de vulnérabilité des femmes et avec l'idée selon laquelle l'IVG était un geste de compassion nécessaire.
- La clause de conscience représente une situation plus mitigée : une objection de conscience peut être émise mais cela doit être annoncé à la patiente d'entrée de jeu. Il n'y a cependant pas de sanction si ce n'est pas appliqué.
- Le développement de l'avortement médicamenteux est une avancée importante.
- Concernant le délit d'entrave, le projet initial impliquait une sanction pénale en cas d'obstruction physique à l'avortement mais a finalement été renvoyé à une notion de faute et pas de délit. Cela dit, il existe déjà une interdiction qui concerne les soins de santé de manière générale : il est interdit d'empêcher l'accès à des structures de soin.

L'étendue potentielle de l'entrave n'a pas été creusé : le délit d'entrave ne semble pas s'étendre à l'information médicale.

Concernant une amélioration de l'autonomie des femmes, il demeure en revanche une série d'obstacles :

- Le délai légal de 12 semaines de grossesse

Dans les pays européens, on constate une très grande variabilité concernant ce délai, ce qui montre qu'il s'agit davantage d'une question politique que sanitaire.

L'allongement du délai jouerait un rôle favorable en termes d'autonomisation, mais aussi un rôle favorable pour les femmes qui manquent de cadres de référence (médical, social) pour découvrir leur grossesse à temps. Le fait qu'elles soient envoyées aux Pays-Bas pour un avortement du deuxième trimestre est coûteux, demande de l'organisation, de la flexibilité et du temps, qui sont des ressources inéquitablement réparties selon les profils socio-démographiques. On peut donc considérer que cette inégalité pour pouvoir avorter constitue une restriction d'accès la citoyenneté sociale.

- L'obligation d'un entretien avec équipe pluri disciplinaire

Le problème ne réside pas dans l'entretien lui-même, qui peut être similaire à tout entretien avec un médecin en vue d'un acte médical. Le problème peut en revanche se poser si l'entretien prend une tournure paternaliste.

- Délai de réflexion

Ici également, on constate une variabilité selon les pays : le délai est inexistant dans une série de pays ou, quand il existe, connaît des longueurs variables. Il faudrait partir du principe que les femmes réfléchissent par elles-mêmes plutôt que de partir du principe qu'il faut les y obliger, ce qui constitue une démarche d'infantilisation.

- L'avortement médicamenteux est une option positive pour autant que l'on favorise sa distribution.
- La dépénalisation n'est que partielle, puisqu'il demeure un risque de sanction

- *Q : L'Etat cible, dans la sanction pénale, les femmes qui avortent et les médecins mais pas les pères biologiques qui ont pourtant pu peser dans le choix de l'avortement. Peut-on considérer qu'il s'agit d'un parti pris ou d'une approche partiale de la part de l'Etat ? Cette symétrisation des sanctions pourrait être un argument en faveur d'une suppression des sanctions.*

BMP : Il faudrait plutôt envisager la liberté en matière de choix reproductifs au prisme de la coercition reproductive, envisagée comme une limitation du choix par les géniteurs masculins – plutôt qu'au prisme de leur rôle dans la décision d'avortement.

Égalité n'est pas similitude : seules les femmes peuvent accoucher (tout au moins celles qui ont un utérus). Seules celles-ci sont concernées par la libre disposition du corps en matière de gestation et d'accès à l'IVG.

Remarques additionnelles :

Si on attaque l'asymétrie hommes-femmes sur la question des sanctions, le risque est qu'elle soit attaquée aussi sur la liberté de choix et d'autonomie et, par là, de donner un droit de décision sur la grossesse à un partenaire masculin.

Concernant la coercition reproductive, il existe déjà des sanctions pénales.

La logique de la loi médicale est de protéger les patients et de faire peser la responsabilité sur le prestataire de soin : le·la patient·e peut demander les actes de son choix. C'est le rôle du·de la prestataire de soin de refuser ce qui sort des limites légales et déontologiques.

- *Q : Quel est le positionnement féministe sur les modalités de la loi décrites ci-avant ? Y a-t-il des mobilisations sur ces dernières évolutions ?*

BMP : Une organisation récemment constituée, Fem&L.A.W [2] a produit en 2020 un code commenté de Droits des femmes[3], édité par Diane Bernard et Chloé Harmel, qui rassemble toutes les législations qui concernent les droits des femmes

- *Q : Plusieurs dispositions visent à reconnaître le deuil périnatal, notamment en déclarant à l'état civil les fœtus nés sans vie suite à des fausses-couches ou interruptions médicales de grossesse[4]. Des dispositions de ce type, pourtant tout à fait légitimes dans leurs intentions, risquent-elles d'ouvrir des brèches ou d'être instrumentalisées à des fins de restriction du droit à l'avortement ?*

BMP : Concernant le statut du fœtus, l'ensemble des législations internationales ne reconnaissent un individu comme titulaire de droits qu'une fois qu'il est né.

Des tentatives de donner des droits citoyens aux fœtus existent cependant : le Centre européen pour le droit et la justice (ONG chrétienne conservatrice) a ainsi lancé une pétition pour reformuler la Convention européenne des droits humains en y incluant des droits du fœtus. Cette stratégie de mise en cause du droit à l'avortement consiste à tenter de modifier les conventions internationales pour ensuite investir les législations nationales.

Concernant le deuil périnatal, il s'agit de se demander s'il est nécessaire ou non d'institutionnaliser les mécanismes de deuil. Le processus et les rituels de deuil ne nécessitent pas forcément d'encadrement légal et peuvent être considérés comme relevant de l'intimité familiale.

- *Q : Un stéréotype tenace voudrait qu'il faut protéger les femmes des influences auxquelles elles seraient soumises, que ce soit dans leur volonté d'avorter ou de ne pas avorter. Est-ce que postuler l'aliénation d'une catégorie de personnes ne constitue pas un déni de citoyenneté et de capacité d'autonomie ?*

[2] International FEMinist Legal Association for Women's rights (https://femandlaw.be/)
[3] https://femandlaw.be/wp-content/uploads/2021/01/PLCOMFEM-auteur-OK.pdf
[4] Pour autant que la grossesse ait atteint 180 jours.

BMP : Dans l'état actuel de la loi, le dispositif semble surtout vouloir protéger les femmes d'une influence qui les pousserait à avorter (plutôt que l'inverse). Le délai de réflexion va dans ce sens, qui est de laisser de la place à la possibilité de ne pas avorter malgré une intention initiale.

Or, personne n'est exempt d'influences, culturelles ou idéologiques.

Il serait plutôt intéressant de s'assurer d'un cadre qui favorise l'expression d'un choix personnel.

Dans tout acte médical, le médecin doit s'assurer du consentement du·de la patient·e, mais pour l'avortement des barrières supplémentaires existent. La nécessité légale pour la patiente de formuler par écrit la décision d'avorter est une illustration du caractère particulier que revêt l'avortement comme pratique médicale. Le cadre juridique de l'avortement le situe hors de la législation générale des soins de santé.

Le délai de réflexion de 6 jours peut être vu comme un reliquat de la loi de 1990 sous la forme d'un compromis moral face à la suppression de l'état de détresse.

Quant à la possibilité de réduire ce délai à 48h en cas d'urgence médicale, c'est un compromis sur le compromis, qui rappelle aussi cet état de détresse, mais d'un point de vue médical, à valider par un médecin.

La possibilité d'autonomisation vis-à-vis du champ médical repose sur les intentions et volontés des médecins : quel niveau de pouvoir médical repose entre les mains du médecins ? Qu'est-ce qui en est fait pour le bien des patient·es ou à l'inverse quelles place potentielle est laissée à des potentielles rétention de soin ou d'info ?

L'autonomisation dépend des conditions sociales et de vie des patient·es : les conditions matérielles et symboliques permettant d'être autonome ne sont pas données d'emblée, elles dépendent des milieux sociaux auxquels on appartient.

La possibilité de mener des avortements autogérés est en soi intéressante mais elle favoriserait vraisemblablement des femmes davantage informées et privilégiées.

Ce qui est en jeu derrière ces questions, c'est le degré de progressisme ou de conservatisme du milieu médical, qui est détenteur d'un pouvoir décisif dans l'accès aux soins. Cet enjeu de la discrimination sociale est présent dans l'ensemble de la médecine.

Le rôle de l'Etat est donc d'aplanir ces rapports, en menant des actions de prévention, d'amélioration de l'accès pratique et financier ainsi que d'information. Assurer un accès aux centres de planning familial est crucial, pour l'accès à l'avortement, mais aussi parce que la pratique n'y est pas que médicale. Les enjeux d'autorité et de classe y sont moins forts. Or, il n'y a pas un renouvellement suffisant des médecins formés à l'avortement, ce qui est un frein manifeste à l'accessibilité pour les patientes.

Questions and answers (EN)

- *Question : We have seen the recent evolution in the United States where the right to abortion was revoked by the Supreme Court. What impact could this have on the Belgian situation (especially with the proposal to revise the constitution to include the right to abortion)?*

BMP: In the United States, abortion has now become a right with variable geometry. The decision on whether or not to make it legal is left to the federated states, and we can see that, in the wake of the Supreme Court decision, up to half of the states are eliminating or will eliminate in the short term any right to abortion, sometimes even excluding situations considered extreme (pregnancies resulting from rape, incest, etc.).

More advanced forms of repression are also being put in place. For example, there are legislative proposals to compile lists of pregnant women, in order to verify that the pregnancy actually ends in a birth. As a result, prosecution for abortion becomes possible if the delivery does not take place, including for miscarriage. Indirectly, this may lead women to consult doctors less and less for fear of this type of denunciation.

In El Salvador, such legislation is already in place, which gives rise to very heavy prison sentences even in cases of miscarriage.

Ordo Iuris, a particularly influential Catholic association in Poland, is currently drafting a bill in the country that would go in this direction.

Conservative anti-abortion associations have a legal personality which allows them to present themselves as plaintiffs in international and European courts.

As for the inclusion of the right to abortion in the constitution, it is not an absolute guarantee, since it depends on the majority in power at a given time. For example, Hungary has written the "right to life" into its constitution. Legislation depends on the political balance of power, which is by definition unstable: any legislation can therefore be overturned.

- *Q: How do you articulate the concept of social citizenship with that of reproductive justice, especially in light of what is happening in the United States?*

BMP: The term refers to Jane Jenson's texts on the concept of "social citizenship" which develop the idea that the exercise of citizenship is only effective if efforts are made to limit social inequalities.

This notion can be articulated with the concept of intersectionality, by seeking to understand the types of inequalities that will generate differential access to reproductive rights.

NB: this concept of intersectionality is subject to various reinterpretations, both political and militant, but it is understood here as its creator, Kimberlé Crenshaw, has defined it, namely the consideration of the interweaving of discriminations of which a person may be a victim because of his/her social position and identities.

- *Q: Notions related to fetal rights and legal status of the fetus arrived in the 1990s and are now widely embraced by pro-life movements. Are feminist movements seizing on this and taking a stand on it? Or is it seen as irrelevant in terms of the fact that it is the control of one's own body that is paramount?*

BMP: Feminist movements do indeed consider that it is the autonomy of the woman that takes precedence in terms of decision making. The question is not formulated in terms of the right of the fetus. Furthermore, no international convention confers on the fetus the status of a subject with rights. Attempts are being made by anti-abortion movements to introduce such a notion into the European Convention on Human Rights, for example.

- *Q. Historically, it is the Christian religion that is identified as being opposed to the right to abortion, with both local and international religious actors. But what about the positions of Muslim or Jewish religious leaders on the issue?*

BMP: When the UN issued recommendations in terms of reproductive and sexual health targeting women in particular, the Holy See managed to form a coalition with Islamic states from the Gulf countries as well as from countries of the Orthodox faith.

Catholic actors also play a significant political role, such as the Commission of the Bishops' Conferences of the European Community, which represents the episcopate of the member states at the European Union. This centralization of power and interlocutors is strongest for the Catholic religion.

On the other hand, coalitions of other actors are possible: religions other than the Christian world are less of a driving force behind anti-abortion initiatives but can position themselves as allies and join the movement. Some alliances are nevertheless more difficult to set up than others (example of the failure of coalitions with imams in France during the mobilizations of the Manif pour Tous).

- *Q: Reflections on the ethical implications: the notion of autonomy must be articulated with that of citizenship. It also refers to the question of political work which is conceived as a horizon of political struggle between several groups.*

  What is the current positioning of feminist claims with regard to the medical framework? How can the claim of empowerment be formulated in this context? There seems to be little equality in the medical world, which is particularly hierarchical.

BMP: The struggle for abortion rights is indeed representative of certain conceptions of democracy, as evidenced by the fact that some anti-gender movements consider that there can be no debate of ideas with pro-choice/pro-gender and that the anti-gender cause can legitimize anti-democratic means.

The feminist movement of the 1970s, heir to May 68, showed important libertarian inflections. In Western countries, the combination of equality between women and men and the individual freedom of women with regard to men has imposed in the questions of sexual and reproductive emancipation. In the 1980s, a shift in the demands directed them towards sexual and reproductive health in hybridity with sexual and reproductive rights.

Today, we can consider that this libertarian logic is no longer relevant. On the question of abortion, feminist groups have moved from a logic of subversion to a logic of subsidy (with the aim of making up for the shortcomings of the social state in the current framework of neo-liberalism). This is part of a feminism that has become institutionalized in stable structures, sometimes referred to as a state feminism.

This institutionalized feminism thus extends its capacity of influence, in particular by occupying a position of consultation which allows it to weigh in the elaboration of public policies.

> E.g.: the law on "gender mainstreaming" (not very much applied, however), which has highlighted the idea that public policies are not neutral and have an impact in terms of gender

In Belgium, the demands related to abortion have historically been made within the framework of alliances or rather convergences with the medical world when it is progressive (contrary to France, for example, which has experienced pro-abortion activism at odds with the medical world - in particular by setting up voluntarily demedicalized abortion practices).

Thus, the issue of abortion is framed both and inextricably as a public health issue and a gender issue.

The social dimension is also very present historically, since it is the feminist workers' movements (Marie Mineur, Dolle Minas) that initially have taken up the issue. The Belgian context of pillarization also structures the form taken by the debates.

As for the way of considering the problem of autonomy vis-à-vis the medical field, it is not monolithic according to the feminist groups.

Medical abortion changes the situation with regard to these parameters, insofar as it would potentially allow autonomy from the medical world.

> Example of Women on Waves / Women on Web: an association that used to offer abortions in international waters, and now distributes abortion pills in a telemedicine format (the founder is a doctor).
>
> Example of Argentina, which has seen a particularly massive feminist movement, despite and against the weight of the very powerful Catholic Church (a church that collaborated locally with the dictatorial system): feminists have formed real alliances with progressive doctors to offer abortions, help women who have had abortions and distribute abortion pills.

In Belgium, the reflection is not structured around this articulation of women's autonomy versus the medical world, given the bridges that existed from the start.

To extend the developments concerning the conception of democracy, Poland or Hungary are in the process of setting up restrictive legislations under the clear influence of anti-gender and anti-IVG movements. A political question then arises: these are groups that belong to a reactionary logic according to which a "natural law" takes precedence over autonomy. Religious freedom is thus considered to have more weight than freedom of conscience, which is reduced to the former.

These groups formulate their position as an irreducible divide between "us" and "them" and according to a rhetoric that identifies the interlocutors as friends or enemies, leading to the impossibility of political compromise (or even of dialogue).

Yet, at the basis of democracy is the idea that it is necessary to negotiate, to make compromises with adversaries who do not share the same ideas, the same conception of politics. Liberal democracy therefore starts from the principle of conflict, which is identified and recognized, so as to then seek, through negotiations and reciprocal concessions, the means of a collective decision which turns out to be a compromise.

- *Q: What is the horizon for compromise if we cannot agree on the foundations of democracy and the basic values?*

BMP: The foundations of liberal democracy are based on the notions of equality and freedom inherited from the Enlightenment. The questioning of the rule of law by politicians like Viktor Orban can be interpreted as illiberalism but not as democracy. Certain philosophical values such as equality in principle or freedom become inconceivable.

> For example, in Jair Bolsonaro's Brazil, equality between men and women is not conceivable, nor is freedom: there can only be conditional freedom.

Thus, the issue of abortion is a social issue: it is indicative, as are women's rights in general, of a system of political thought and of the state of a civil society.

- *Q: Do you have an opinion on the current state of the law governing abortion in Belgium? Is it sufficient in terms of autonomy?*

BMP:

The 2018 revision shows some positive aspects in the form of achievements.

- The abolition of the state of distress is one of them, breaking with the idea of women's vulnerability and with the idea that abortion was a necessary compassionate act.
- The conscience clause represents a more mixed situation: a conscientious objection can be made but this must be announced to the patient at the outset. However, there is no sanction if this is not applied.
- The development of medical abortion is an important advance.
- Concerning the offence of obstruction, the initial project implied a penal sanction in case of physical obstruction of the abortion but was finally referred to a notion of fault and not of offence. That said, there is already a prohibition on health care in general: it is prohibited to prevent access to health care facilities. The potential scope of obstruction has not been explored: the offence of obstruction does not seem to extend to medical information.

On the other hand, a series of obstacles to improving women's autonomy remain:

- The legal deadline of 12 weeks of pregnancy

In European countries, there is a great deal of variability concerning this period, which shows that it is more a political issue than a health issue.

The extension of the deadline would play a favorable role in terms of empowerment, but also a favorable role for women who lack reference frameworks (medical, social) to discover their pregnancy in time. Being sent to the Netherlands for a second trimester abortion is costly, requires organization, flexibility and time, which are resources that are inequitably distributed according to socio-demographic profiles. This inequality in access to abortion can therefore be seen as a restriction of access to social citizenship.

- The obligation of an interview with a multidisciplinary team

The problem does not lie in the interview itself, which can be similar to any interview with a doctor for a medical procedure. The problem may arise if the interview becomes paternalistic.

- Reflection period

Here again, there is variability from country to country: in a number of countries, the period is non-existent or, when it does exist, of varying length. It should be assumed that women think for themselves rather than being forced to do so, which is an infantilizing approach.

- Medical abortion is a positive option as long as its distribution is promoted.
- Decriminalization is only partial, since there remains a risk of punishment

- *Q: The State targets, in the penal sanction, women who have abortions and doctors but not biological fathers who may have weighed in the choice of abortion. Can we consider this as a bias or a partial approach on the part of the State? This symmetrization of sanctions could be an argument for removing sanctions.*

BMP: Freedom of reproductive choice should be viewed through the lens of reproductive coercion, seen as a limitation of choice by male progenitors - rather than through their role in the abortion decision.

Equality is not sameness: only women can give birth (at least those with a uterus). Only women are concerned with the free disposition of the body in matters of gestation and access to abortion.

Additional remarks:

If gender asymmetry is attacked on the issue of sanctions, there is a risk that it will also be attacked on the issue of freedom of choice and autonomy, and thereby give a male partner the right to decide on pregnancy.

Concerning reproductive coercion, there are already criminal sanctions.

The logic of medical law is to protect the patient and to place the responsibility on the health care provider: the patient can request the procedures of their choice. It is the role of the health care provider to refuse what is outside the legal and ethical limits.

- *Q: What is the feminist position on the modalities of the law described above? Are there any mobilizations on these latest developments?*

BMP: A recently constituted organization, Fem&L.A.W[5], produced in 2020 an annotated code of women's rights[6], edited by Diane Bernard and Chloé Harmel, which brings together all the legislation concerning women's rights

- *Q : Several provisions aim at recognizing perinatal loss, in particular by declaring a civil status for fetuses born without life following miscarriages or medical terminations of pregnancy[7]. Do provisions of this type, although entirely legitimate in their intentions, risk opening loopholes or being used to restrict the right to abortion?*

BMP: Concerning the status of the fetus, all international legislation only recognizes an individual as a holder of rights once they have been born.

However, there are attempts to give citizen rights to the fetus: the European Centre for Law and Justice (a conservative Christian NGO) has launched a petition to reformulate the European Convention on Human Rights by including fetal rights. This strategy of questioning the right to abortion consists of trying to modify international conventions and then investing national legislations.

With regard to perinatal loss, the question is whether or not it is necessary to institutionalize mourning mechanisms. The process and rituals of mourning do not necessarily require a legal framework and can be considered as part of family intimacy.

- *Q: There is a persistent stereotype that women should be protected from the influences to which they would be subjected, whether it be in their desire to have an abortion or not to have one. Doesn't postulating the alienation of a category of people constitute a denial of citizenship and capacity for autonomy?*

BMP: As the law currently stands, it seems that the main purpose of the provision is to protect women from being influenced to have an abortion (rather than the other way around). The reflection period goes in this direction, which is to leave room for the possibility of not having an abortion despite an initial intention.

However, no one is free from cultural or ideological influences.

It would be more interesting to ensure a framework that favours the expression of a personal choice.

In any medical procedure, the physician must ensure the patient's consent, but for abortion additional barriers exist. The legal requirement for the patient to put the decision to have an abortion in a written consent form is an illustration of the special nature of abortion as a medical practice. The legal framework for abortion places it outside the general health care legislation.

The 6-day reflection period can be seen as a remnant of the 1990 law in the form of a moral compromise in the face of the suppression of the state of distress.

[5] International FEMinist Legal Association for Women's rights (https://femandlaw.be/)
[6] https://femandlaw.be/wp-content/uploads/2021/01/PLCOMFEM-auteur-OK.pdf
[7] Provided the pregnancy has reached 180 days.

As for the possibility of reducing this period to 48 hours in the case of a medical emergency, it is a compromise on the compromise, which also recalls this state of distress, but from a medical point of view, to be validated by a doctor.

The possibility of empowerment vis-à-vis the medical field rests on the intentions and wills of physicians: what level of medical power rests in the hands of the physician? What is done with it for the good of the patients or conversely what potential room is left for potential withholding of care or information?

Empowerment depends on the social and life conditions of the patients: the material and symbolic conditions allowing to be autonomous are not given from the start, they depend on the social environment to which one belongs.

The possibility of conducting self-induced abortions is interesting in itself, but it would likely favor more informed and privileged women.

What is at stake behind these issues is the degree of progressivism or conservatism of the medical community, which holds decisive power in access to care. This issue of social discrimination is present throughout medicine.

The role of the State is therefore to smooth out these power relations by carrying out preventive actions, improving practical and financial access, and providing information. Ensuring access to family planning centers is crucial, not only for access to abortion, but also because their practice is not only medical. The stakes of authority and class are less strong there. However, there is not enough generational renewal of doctors trained in abortion, which is a clear obstacle to accessibility for patients.

---

d) Dutch-speaking abortion centers representatives

ZWA | Stuurgroep van het interuniversitair, multidisciplinair en onafhankelijk comité belast met de studie en de evaluatie van de praktijk en de wetgeving inzake vrijwillige zwangerschapsafbreking
IVG | Groupe de pilotage du comité interuniversitaire multidisciplinaire indépendant en charge de l'étude et de l'évaluation de la pratique et de la législation sur l'Interruption Volontaire de Grossesse

Hearing abortion clinics – Vlaanderen

12/09/2022

Presents :

Nausikaa Martens (VUB Dilemma)
Anne Verougstraete (VUB Dilemma + WG1)
Lut Daniëls (LUNA)
Yvon Englert
Kristien Roelens
Aurélie Aromatario

1. Presentation of the missions of the Scientific Committee

Composition :
4 working groups (Medical abortion ; elective abortion; Ethical and legal aspects ; abortion requests after 12 weeks). These groups are composed of experts from different fields.

In the context of WG1 and WG3, we wished to receive feedback from experts from the field of abortion, such as hospitals and abortion centers, who are directly confronted with the practice of abortion, its practical and legal aspects.

An optional discussion guide has been provided :

1. Hoe beoordeelt u de huidige praktijk van het centrum dat u vertegenwoordigt, en wat zijn de belangrijkste problemen waarmee het centrum wordt geconfronteerd?

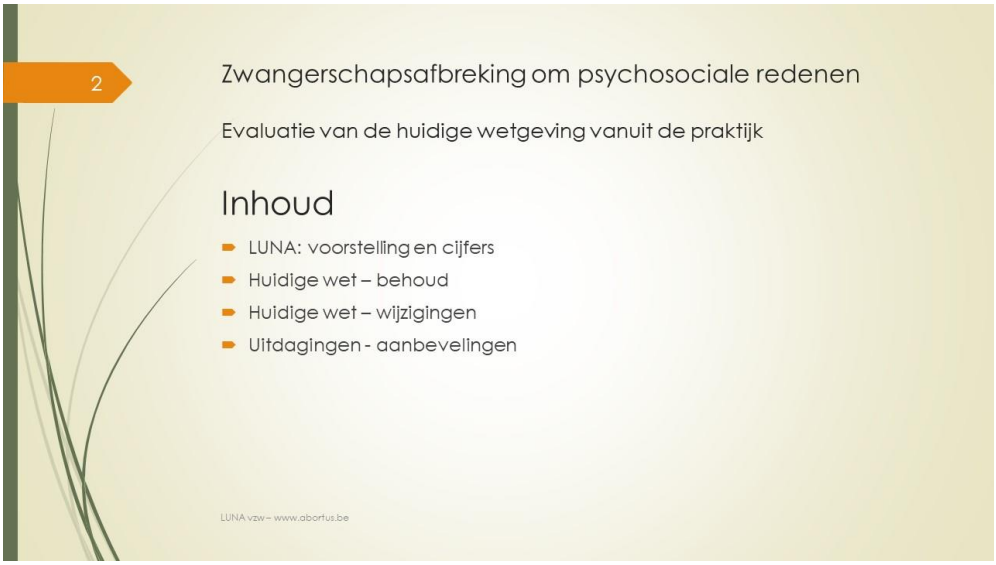
2. Welke bepalingen van de Wet vrijwillige zwangerschapsafbreking 2018 moeten volgens u absoluut behouden blijven en waarom?

3. Welke bepalingen van de Wet vrijwillige zwangerschapsafbreking 2018 moeten volgens u worden gewijzigd, geschrapt of toegevoegd en waarom?

4. Zijn er buiten het wettelijk kader specifieke uitdagingen of professionele aanbevelingen in de praktijk van abortusgerelateerde zorg die u zou willen doorgeven aan de stuurgroep die deze evaluatie uitvoert, met bijzondere aandacht voor kwetsbare groepen?

2. Presentation from Lut Daniëls, from LUNA

(psycholoog, uit LUNA)

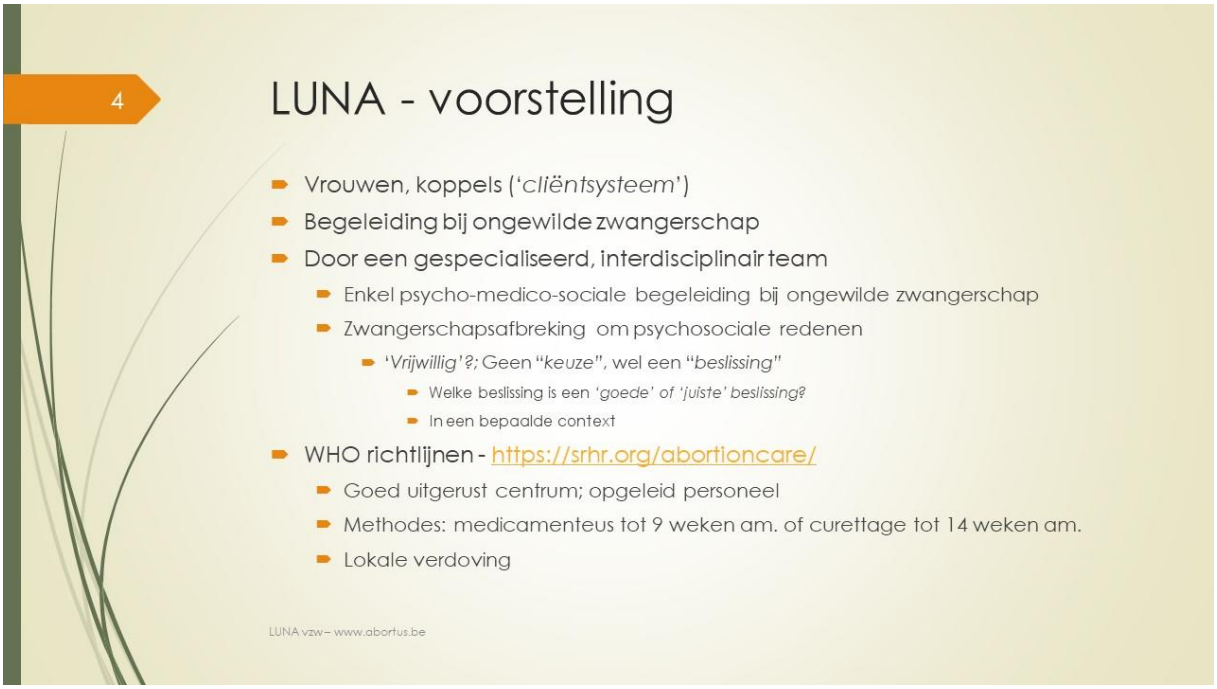


The LUNA concept was born in 2018

Clients of LUNA are abortion seekers or women too far in the pregnancy to obtain abortion in Belgium.

The network configuration of LUNA allows sharing good practice between the centers, but also providing better access for the clients : network and information diffusion.

There is a current renegociation of the RIZIV convention – to encompass the 2018 law but also for a better / more adapted funding, notably with regard to telemedicine and intake of Mifégyne and Cytotec at home. The convention is not really adequate with those matters since it was made even before Mifégyne was on the market. The royal decree on distribution of Mifégyne has been published in a context where the possibility of a traffic of those pills was highly feared. They are currently very carefully prescribed with pharmaceutical count of the stocks (Mifégyne alone can stop a pregnancy (and is created for that) – while Cytotec can also have this effect, it was not put on the market with this purpose. The combination of Mifégyne and Cytotec is still the more efficient solution. The client must sign a document : it engages her to take it herself and at the right time.



LUNA centers take in women with unwanted pregnancies. They do not offer neither emergency contraception nor emergency IUD (although it could be considered part of the work). Prescription of contraception is included in follow up care, but those aspects are not financed currently within the RIZIV convention, neither is the follow up of wanted pregnancies, nor insertion of IUD.

During the COVID crisis, telemedicine has been used : the 1st consultation was made on the phone with great care to cover the same topics with the same dedication as for an in-person consultation. Then the 2nd phase would be pursued with the abortion procedure if the woman decided so. The same invoicing forfeits were used for each phase. But the clients still had to be coming to the center to receive the pill : intake of Mifégyne was at the center and intake of Cytotec at home. During the early stages of the lockdown, abortion centers decided to remain opened. In order to have only 1

appointment in person, the visit was dedicated to abortion with the surgical method (which leads to less complication, bleeding etc) or to the distribution of Mifégyne and Cytotec.

LUNA has a collaboration with Fara (for the follow up of fertility, sex life, eventually abortion and psychological support). Good qualitative work and collaboration is permitted thanks to funds from the Flemish Community. Fara can send clients to LUNA and vice versa. Fara clients are usually the most in doubt with the pregnancy. Even if clients are sent by Fara, there still is a consultation at the abortion center (aimed at knowing the client, their need, giving them information about the procedure, contraception, etc). Abortion centers are highly specialized in abortion care and counselling. In other structures, however, the 1st psycho-social consultation is not always qualitative : there is a lack of knowledge abortion among GP or ob/gyn (in own practice or hospitals) that prevents them giving adequate information when referring patients. The assets of abortion clinics consist mainly in the psychosocial and interdisciplinary follow up.

Choice of abortion technique : the question of pain can be determinant in that choice (Tramadol / ibuprofen are routinely offered as painkillers for medication abortion).

LD recommends to increase access to medication abortion, notably for early terminations of pregnancy, by facilitating the intake of abortion pills at home (see further point about telemedicine).

Women without health insurance can ask for an intervention of the OCMW. For precarious women with later pregnancies who need to go to the Netherlands for the abortion procedure, LUNA offers to pay the invoice, and then re-invoice the amount to the client. By doing so with clients in financial difficulties, they know they cannot expect to be paid back, or not entirely. Another financial support they offer is free insertion of copper IUD for fragilized clients. These represent financial burdens for the centers, but also meets their care missions.

Background for these recommendations :

- Decision should belong to the women : the role of the clinic is to assess the absence of pressure or influence, even for minors of age, even if the client come in as a couple
- Interdisciplinary team for the 1st psychosocial consultation : it is a criteria for qualitative care. Abortion is not envisioned just as a medical act. There must also be an explanation about the procedure and technique for the client to know what to expect.
- No waiting period : To be decided with the client, depending on the level of emergency of the procedure, her wish and expectations etc.
- Mandatory information : Elements of this information are pertinent but it has to be adapted to the situation, adjusted to the individual : tailor made conversation

10

Huidige wet – wijziging

4. Weglaten: strafbepalingen

- Arts die ingreep uitvoert buiten de grenzen van de wet;
- Vrouw die ingreep laat uitvoeren buiten de grenzen van de wet

- In de praktijk
  - Zwangerschapsafbreking kadert in kwalitatieve gezondheidszorg; aansprakelijkheid is wettelijk geregeld

11

Uitdagingen – aanbevelingen

1. Behoud lage abortusratio

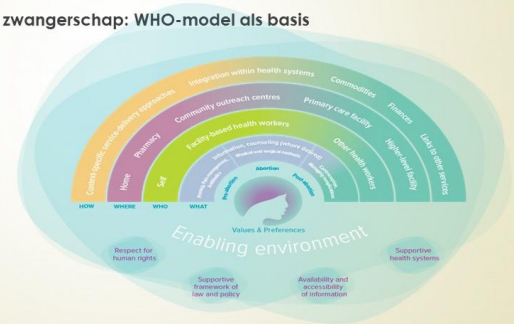
- Inzetten op preventie van ongewilde zwangerschap
  - Anticonceptie én seksuele relaties bespreekbaar (Sensoa);
  - Gratis AC voor iedereen
    - Met educatie: AC werkt niet 100%: *'ongewilde zwangerschap kan iedereen overkomen'*
    - Mogelijke consultatie in abortuscentrum voor plaatsing nood IUD?; aparte financiering
- NIET: preventie van zwangerschapsafbreking
  - Zwangerschapsafbreking: zo weinig mogelijk, zo veel als nodig

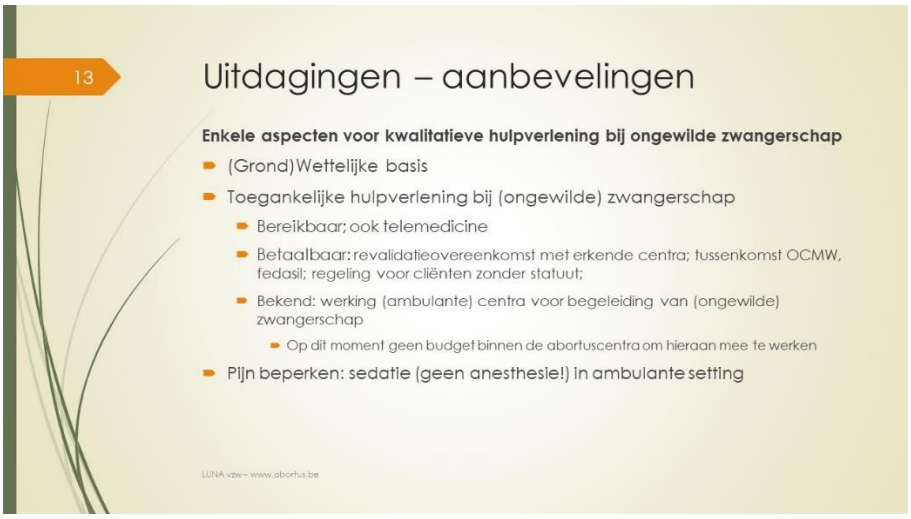
12

Uitdagingen – aanbevelingen

2. Toegankelijke, kwalitatieve, interdisciplinaire hulpverlening voor elke vrouw die zwanger is, gewild of ongewild

Voor ongewilde zwangerschap: WHO-model als basis





Any form of waiting time should be removed but with the possibility to adapt to the need of the client in case of doubt. LUNA workers never pressurize the client : they consider that it is sometimes better to have a second trimester in the Netherlands if the client still has some doubt about interrupting her pregnancy close to the legal limit.

Telemedicine would improve accessibility. Medication abortion should also be made easier.

Additional points discussed :

- Abortion for medical reasons

LD encourages to be careful with interdisciplinary teams/committees, notably for medical abortion – the decision should not be theirs but well in the hands of the patient

Medical abortions should kept being practiced in hospitals : the current dispositions seem adequate. Yet, some medical abortions are practiced in abortion clinics : if they are early (<14 w) or in case of suspicions of fetal anomalies that are not yet confirmed.

- Second trimester elective abortion :

Current problems : second trimester abortions are now decentralized abroad, which results in emotional costs, practical difficulties, and financial cost for the client (also for the abortion center in

Belgium : see upper point about financial support offered by the LUNA centers for precarious women in need of an abortion abroad).
If it were to happen in Belgium for elective abortion, it should be under the form of an annex to a hospital (rather than dedicated clinics as in the Netherlands). It could be an apart facility, or a portion of building of the attached hospital, with a separate and specialized team only dedicated to second trimester abortion. There could be a possibility to have 3 centers, one for each region, requiring training, infrastructure, human resources but should still be affordable. It would be necessary to have general anesthesia (short sedation) available at those centers.
One remaining question would be to organize the collaboration with the existing outpatient centers : how to connect the network and the current expertise.

- Forms of support

Financial support would be adequate for vulnerable clients (OCMW, people without status, fedasil beneficiaries, …)

Additional services could support an informed decision, such as “tolkdienst” (publicly funded services of interpretation)

3. Presentation from Nausikaa Mertens and Anne Verougstraete (VUB-Dilemma)

Nausikaa is coordinator of the center (she worked previously in a Luna center)

Anne is a doctor for the center

800 clients/year for VUB-Dilemma is similar to Oostende for LUNA : smaller than Gent or Antwerp- but still a significant number regarding the vast offer for abortion centers in Brussels (note : the problem

in Brussels is the number of abortion per week and per available doctors. Doctors usually have a 1 day permanence and work in another center the rest of the time)

The center wants to remain attached to the VUB, which is the reason for not to merging with LUNA although they are very close, with similar functioning and good collaboration. Being on an university campus is an asset for accessibility.

The center is funded only though the RIZIV convention and its reimbursements (other expenses include notably a preferential monthly fee for real estate rental from the VUB)

Doctors who do not perform abortions have to mandatorily reference a place for abortion but they always have a right to refuse.

NB : weeks are expressed in weeks since last menstrual period.

Lack of knowledge :

- From the women requesting an abortion procedure : they don't know where to get it, who to ask
- From healthcare professionals : there can be moments of panic when abortion is mentioned by a patient in consultation or misunderstanding of the law (which often causes multiplication of waiting time)

➔ Exploit/develop scientific research on abortion

➔ Facilitate solutions for financially vulnerable clients (for instance, undocumented refugees, without health insurance, women with financial difficulties…) .

Most abortion centers have an internal protocol for establishing a “social rate” of 250€ for vulnerable women. This rate is just an internal convention : it is not funded while the actual cost of the procedure is approximately 500€ (200€ + 300€). This financial gesture represents a loss of money for the centers.

Intervention from Anne Verougstraete:

<u>Problemen door de wettelijke wachttijd en eenheid van plaats</u>:

een paar voorbeelden

1/ Een vrouw gaat bij haar huisarts met een ongewenste zwangerschap, deze verwijst haar door naar een gynaecoloog die haar zegt dat hij/zij geen abortussen uitvoert; Zij komt uiteindelijk naar het abortuscentrum waar haar wettelijke wachttijd van 6 dagen pas begint te lopen. Op die manier is deze vrouw al weken op zoek naar hulp. Als men weet dat het risico op complicaties stijgt met de duur van de zwangerschap, kan men zich hierbij toch vragen stellen! Er is daarbij ook een grote kans dat zij niet meer in aanmerking komt voor een medicamenteuze behandeling wat haar keuzevrijheid en haar autonomie beperkt.

Ziekenhuizen zouden duidelijk moeten laten weten (bvb op hun website) of zij zwangerschapsafbrekingen uitvoeren omwille van psychosociale redenen en op diezelfde site laten weten waar de vrouw wel terecht kan.

2/ Een vrouw komt komt op vooronderzoek in het abortuscentrum; zij heeft een algemene narcose nodig. Een deel van de ziekenhuizen zal **opnieuw** een wachttijd van 6 dagen opleggen.

<u>Sedatie:</u>

In 2019 in Vlaanderen, worden bijna alle zwangerschapsafbrekingen in abortuscentra uitgevoerd (van 88,69% in Vlaams Brabant tot 99,57% in Limburg). In Brussel worden 75% van de ingrepen uitgevoerd in centra buiten het ziekenhuis. **De RIZIV-conventie laat geen sedatie toe in de abortuscentra**. Dit beperkt de keuzevrijheid van de vrouw. In de ons omringende landen worden een flink deel van de abortusingrepen uitgevoerd onder sedatie. In Beahuis&Bloemenhovekliniek werd in 2021 86% van de zuigcurettages uitgevoerd onder sedatie. (communicatie van Dr Raïna Brethouwer op het FIAPAC congres in RIGA september 2022: “Safe Sedation Without Anaesthesiologist”).

<u>Opleiding:</u>

Artsen, vroedvrouwen en verpleegkundigen krijgen in sommige universiteiten geen of amper opleiding over de abortuswet en over de problematiek van ongeplande en ongewenste zwangerschap. Tijdens hun stage in de ziekenhuizen zullen zij deze problematiek ook niet leren kennen gezien de abortussen in centra buiten het ziekenhuis plaatsvinden. Hierdoor constateren wij een grote onwetendheid bij sommigen. Men zou best het thema ongeplande, ongewenste zwangerschap en abortus verplicht opnemen in het curriculum zoals in de Frantalige gemeenschap.

<u>Telemedicine:</u>

Telemedicine moet het mogelijk maken om het aantal in situ afspraken in het abortuscentrum te beperken. Sommige vrouwen vrezen voor hun job; andere vrouwen vrezen een geweldadige, controlerende partner, die het moeilijk maakt om herhaaldelijk naar een centrum te komen. Een klein aantal vrouwen doet daarom beroep op Women On Web om aan abortuspillen te geraken.

Onderzoek in Engeland heeft bewezen dat online consultaties (zelfde tijdsduur als face to face) veilig is (na een rigoureuse screening).

4. Discussion

Representatives from the Dutch-speaking abortion centers estimate that it should be mandatory for health practitioners to mention whether they practice abortion or not (on the hospital website, for instance). The current issue is that it is impossible for the patient to know who performs or doesn't perform abortion procedures. Although conscientious objection is supposed to be only individual and not collective, it may happen that some hospitals or ob/gyn departments chose not to perform abortion (for various motives, including lack of means, of interest…). According to the representatives, hospitals should also clearly state if it is possible to get an abortion within their structure.

All representatives are in favor of a central website providing all needed information at the national level.

Telemedicine is an asset for women who cannot easily go out (some are even locked in at home). A phone call is then easier than appointment in person. Representatives have proof that some of those women currently use the services of the organization "Women on Web" to obtain abortion pills – although it is still quite exceptional. However, for abortions done illegally in such conditions, the service of psychosocial consultation is not provided (where it is maybe the most needed). Telemedicine could be helpful in those situations of vulnerability but could also help a wider number of women of all profiles, and thus should be broadly legalized and accessible. One option would be not to mention in the law the context of place and content of the initial consultation, to allow for virtual consultation.

Abortion should be removed from the penal code, as per unanimous request : the penal code is already sufficient to sanction illegal medical acts. However, abortion is not currently recognized as healthcare and thus not covered by the laws protecting the patients. Abortion centers representatives are in favor of suppressing entirely any form of sanction against women requesting and/or obtaining abortion procedures even illegally.

Question about access to abortion centers for women : LUNA has opted for a strategy of centralization in larger cities whereas family planning centers as they exist in Wallonia and Brussels form a more extended network. It represents different strategies in term of access, with different outcomes. Some women have no transport option (no personal or public transport available, presence of small children…) – but a more tight-knit network wouldn't necessarily help.

e) French-speaking abortion centers representatives

ZWA | Stuurgroep van het interuniversitair, multidisciplinair en onafhankelijk comité belast met de studie en de evaluatie van de praktijk en de wetgeving inzake vrijwillige zwangerschapsafbreking
IVG | Groupe de pilotage du comité interuniversitaire multidisciplinaire indépendant en charge de l'étude et de l'évaluation de la pratique et de la législation sur l'Interruption Volontaire de Grossesse

Hearing abortion clinics – Wallonia and Brussels

12/09/2022

Present :
Céline Tixier-Thomas (FLCPF)
Cécile Rousseau (FLCPF)
Carine Lemaître (FCPPF)
Lola Clavreul (FCPPF)
Eloïse Malcourant (FCPF FPS – Sofélia)
Frédéric Brichau (FCPF FPS – Sofélia)
Irina Amato (GACEHPA)
Isabelle Bomboir (GACEHPA)

Yvon Englert (Scientific committee)
Kristien Roelens (Scientific committee)
Anne Verougstraete (Scientific committee)
Aurélie Aromatario (Scientific committee)

Absent :
Anne-Catherine Slangen (FCPC)

Presentation of the missions of the Scientific Committee

Composition :
4 working groups (Medical abortion ; elective abortion; Ethical and legal aspects ; abortion requests after 12 weeks). These groups are composed of experts from different fields.

In the context of WG1 and WG3, we wished to receive feedback from experts from the field of abortion, such as hospitals and abortion centers, who are directly confronted with the practice of abortion, its practical and legal aspects.

The mission of the Committee is to provide an evaluation of the current situation as well as recommendations/proposals based on these observations.

Our intention is to supplement the perspectives from the WG with field experts, confronted to the practice of abortion (although members of the WG are from academia but also field actors in some

cases). To do so, we are in the process of meeting hospitals federations, Dutch-speaking abortion centers, the National Evaluation Commission, and the INAMI/RIZIV.

An optional discussion guide has been provided :

1. Comment évaluez-vous la pratique actuelle des centres que vous représentez, et quelles sont les difficultés principales qu'ils rencontrent?
2. Quelles dispositions de la loi de 2018 relative à l'Interruption volontaire de grossesse devraient, selon vous, être absolument maintenues, et pourquoi ?
3. Quelles dispositions de la loi de 2018 relative à l'Interruption volontaire de grossesse devraient, selon vous, ê tre modifiées, supprimées ou ajoutées, et pourquoi ?
4. Au-delà du cadre légal, y a-t-il des défis particuliers ou des recommandations professionnelles dans la pratique des soins liés à l'avortement que vous aimeriez transmettre au comité de pilotage qui mène cette évaluation avec une attention particulière aux groupes vulnérables ?

1. Fédération Laïque de Centres de Planning Familial (FLCPF)

La fédération travaille sur le thème des droits et de la santé sexuelle et reproductive qu'elle défend comme faisant partie des droits humains fondamentaux.
La fédération regroupe 42 centres dont 22 pratiquent l'IVG.

Problèmes posés par le cadre légal actuel :
Parmi les obstacles rencontrés sur le terrain, les principaux relevés sont les suivants :
Le **délai gestationnel** de 12 semaines post-conception pour l'avortement légal amène 500 femmes à avorter à l'étranger chaque année. Ce sont des soins qui pourraient plutôt être faits en Belgique dans de bonnes conditions. Le risque est que des femmes soient amenées à garder une grossesse par contrainte et par manque d'accès à l'avortement après 12 semaines.
En effet, aucune femme ne reporte sa décision d'interruption par distraction, manque de temps, encore moins par plaisir. Les professionnel.les des centres de planning familial confirment même que la tendance actuelle est pour les femmes de venir de plus en plus tôt demander une interruption volontaire de grossesse : elles sont à 5, voire parfois à 4 semaines d'aménorrhée, au moment de la demande.

La fédération a identifié plusieurs facteurs médicaux, sociologiques et sociaux qui amènent à dépasser l'âge gestationnel légal :

- Aucun moyen de contraception n'est efficace à 100% : d'après le dernier rapport de la Commission nationale d'évaluation, 50% des personnes qui ont demandé un avortement en 2019 utilisaient un moyen de contraception. Certains moyens de contraception mais aussi certaines affections hormonales ou de santé amènent des règles absentes ou irrégulières qui rendent difficile l'identification de la grossesse.
- La grossesse est une période à risques pour l'apparition des violences conjugales et du temps peut être nécessaire pour réaliser qu'on ne souhaite pas donner naissance dans un tel contexte familial violent.
- Un changement dans la vie des femmes (rupture, perte d'un emploi, décès d'un.e proche, maladie) peut rendre une grossesse, qui avait été désirée, inenvisageable.
- Les demandes d'interruption de grossesse de second trimestre peuvent aussi émaner de patientes qui ont été réorientées trop tardivement par un médecin ne souhaitant pas pratiquer d'avortement.
- Enfin, de nombreuses femmes sont trop occupées par une lutte quotidienne contre la pauvreté et par la survie de leurs familles pour se soucier de suivre leur cycle menstruel et détecter une grossesse à temps. Ce sont les femmes précarisées qui pâtissent le plus de cette loi injuste, n'ayant pas les moyens de voyager à l'étranger pour interrompre une grossesse qui ne fera que les enfoncer, elles et leurs familles, dans une situation de détresse sociale.

Le **délai dit de réflexion de 6 jours obligatoire** constitue aussi un obstacle ainsi qu'une forme de violence : toute attente supplémentaire est généralement mal vécue. Ce délai peut mettre encore plus en danger des femmes qui vivent dans un contexte de violences conjugales et intrafamiliales et doivent cacher leur grossesse à leur conjoint de peur de représailles ou d'une escalade des violences. Celles qui subissent des symptômes de grossesse vécus comme extrêmement gênants (fatigue, nausée, vomissements, douleurs abdominales, douleurs dans les seins, etc.) se voient imposer 6 jours de

souffrance supplémentaire. Pour toutes les femmes, il est tout simplement insupportable d'attendre en étant enceinte sachant qu'elles souhaitent mettre fin à leur grossesse.
La mission des centres de planning familial est d'écouter le choix des femmes et de les accompagner. Un temps de réflexion est parfois nécessaire, parfois pas. Dans tous les cas, le cheminement psychologique de la prise de décision de garder ou d'interrompre sa grossesse commence lors de la découverte de la grossesse - et non lors du premier rendez-vous avec un.e médecin.

La fédération est en faveur de la suppression des sanctions pénales à l'égard des femmes et des médecins, considérant qu'un maintien de la pénalisation constitue une stigmatisation de la pratique, alors que celle-ci devrait plutôt être abordée comme un soin, faisant partie de l'art de guérir. Il ne s'agit donc pas de banaliser la pratique mais de mieux l'entourer. Bien qu'environ 80% des avortements aient lieu dans des centres extra-hospitaliers, des référencements de patientes vers les hôpitaux sont parfois nécessaires (pour le confort et une prise en charge médicale adaptée de la patiente) : l'approche de l'avortement en hôpital est compliquée par la crainte de sanctions pénales et les centres se retrouvent parfois dans des situations où les référencements de patientes vers les hôpitaux sont difficiles.

Recommandations légales :

La FLCPF recommande de conserver les dispositions suivantes :

- La condition de "bonnes conditions médicales" et de pratique "dans un établissement de soins où existe un service d'information qui accueille la femme enceinte";
- La nécessité pour le médecin de "s'assurer de la détermination de la femme à faire pratiquer une interruption de grossesse". C'est en effet le but des entretiens pré-IVG : s'assurer que le choix d'avorter est posé librement, loin de toute coercition.
- Le maintien d'une possibilité de clause de conscience individuelle mais qui devrait être à mentionner lors du 1er contact (et pas seulement lors du 1er rendez-vous): "Aucun médecin, aucun infirmier ou infirmière, aucun auxiliaire médical n'est tenu de concourir à une interruption de grossesse": un.e soignant.e maltraité.e est potentiellement un.e soignant.e maltraitant.e

La FLCPF émet les recommandations suivantes concernant une modification de la loi:

- Une extension du délai légal pour avorter jusqu'à au moins 18 semaines post-conception.
- Une suppression du délai dit de réflexion obligatoire de 6 jours
- Une suppression de mentionner une liste d'informations obligatoires (par exemple concernant l'adoption et « les diverses possibilités d'accueil de l'enfant à naître »). Un accueil psycho-médico-social de qualité doit suffire à calibrer les échanges et informations pertinentes.
- L'établissement de sanctions pour tout délit de désinformation et d'entrave
- Une suppression des sanctions pénales associées à l'avortement : les lois et règlements en vigueur qui concernent les actes médicaux suffisent à encadrer la pratique et à émettre des sanctions au besoin.
- L'interdiction et la sanction de la clause de conscience institutionnelle

Autres défis :

- Recommandations en termes de formation/disponibilité des professionnels :

La fédération émet plusieurs inquiétudes aussi concernant la pénurie de médecins pratiquant l'IVG : dans le cadre d'une enquête réalisée en 2017 auprès des centres de planning familial bruxellois, 71,5% d'entre eux indiquaient être confrontés à cette pénurie. En août 2019, la FLCPF a actualisé l'état des

lieux au sujet des médecins qui pratiquent des IVG dans les 42 centres affiliés : sur 79 médecins formé.es à l'IVG, 25% avaient 55 ans ou plus et seraient donc retraités dans un avenir plus ou moins proche. Les CPF, particulièrement en milieu rural, rencontrent des difficultés à engager et certains sont restés jusqu'à deux ans sans médecin. Même dans les grandes villes, le recrutement est compliqué : toujours selon l'enquête bruxelloise, 88% des CPF interrogés expliquaient rencontrer des difficultés à recruter des médecins qui pratiquent l'avortement.
Cette pénurie menace le droit à l'IVG en lui-même. Or, l'aspect pénal attaché à la pratique n'aide pas les médecins à s'y engager. Un autre aspect réside dans le fait que l'avortement en centre est surtout pratiqué par des généralistes. Or ces derniers sont tout particulièrement en déficit numérique.
La FLCPF recommande par conséquent les mesures suivantes en termes de formation à l'IVG :

- Une meilleure sensibilisation au cours des divers cursus en santé pour plusieurs professions psycho-médico-sociale sur l'IVG, le cadre légal, l'organisation de sa pratique, les réalités des femmes et leur adéquate réorientation
- Établir une formation spécifique à l'IVG dans le cursus de médecine

- Problèmes liés à l'accès à l'IVG

Régulièrement, des femmes sans mutuelles ou en situation précaire se présentent dans les centres de planning familial. Un temps conséquent est alors le plus souvent consacré à des procédures de mise en ordre du statut administratif de la personne.
Pour les femmes n'ayant aucune couverture de santé, la procédure d'Aide Médicale Urgente (AMU) est actuellement trop lente (il faut d'abord identifier grossesse, ensuite arriver dans le centre de planning familial, que celui-ci fasse un signalement au CPAS, puis seulement entamer les démarches relatives à l'IVG). Les centres de planning familial affiliés au GACEHPA pratiquent alors un tarif solidaire de 200€ - qui reste une somme très importante pour ces femmes. Beaucoup de centres proposent un prêt solidaire, d'autres demandent aux femmes de payer ce qu'elles peuvent, d'autres enfin pratiquent la gratuité (mettant souvent à mal leurs propres finances).
Les démarches administratives globales et liées à l'AMU gagneraient donc à être simplifiées, pour un accès plus aisé et rapide à l'IVG. Les travailleur.euses de première ligne (notamment dans les CPAS) devraient être mieux sensibilisé.es aux questions de demandes d'AMU dans le cadre d'un avortement (l'IVG, le cadre légal, l'organisation de sa pratique, les réalités des femmes et leur adéquate réorientation).

- EVRAS, contraception & IVG

La FLCPF rappelle le lien entre la question de l'avortement et la contraception et de l'éducation à la vie relationnelle, affective et sexuelle (EVRAS), comme moyens distincts, mais complémentaires, qui permettent aux individus de poser des choix libres et éclairés, pour une (non-)parentalité responsable et choisie. La fédération recommande

- La gratuité de tous les moyens de contraception pour toutes les femmes;
- La poursuite des efforts visant la généralisation de l'EVRAS

- Une information officielle claire sur le recours à l'interruption volontaire de grossesse

La FLCPF demande que l'Etat prenne toutes les mesures nécessaires pour assurer, par tous les canaux, une information complète, exacte et neutre sur le droit et l'accès à l'IVG. Cela passe notamment par la prise en charge d'un référencement adéquat sur des sites internet officiels et la mise à disposition des coordonnées de toutes les structures agréées à la pratique de l'interruption volontaire de grossesse.

- Les législations qui risquent d'entraver le droit à l'avortement

La FLCPF attire l'attention sur le fait que, pour garantir, sur le plan juridique et légal, le droit d'accès à l'interruption volontaire (IVG) et médicale (IMG) de grossesse, il faut s'assurer qu'aucune autre initiative législative, directement ou indirectement, ne menace ce droit et ne représente une entrave à celui-ci.

En découle une recommandation :

- De revenir à la précédente législation, en vigueur avant décembre 2018, réglant l'octroi d'un statut à un embryon issu d'une fausse couche ou d'un enfant né sans vie.
- De mettre en place des protocoles d'accompagnement spécifiques dans les hôpitaux et les centres extra-hospitaliers pour les personnes confrontées à un deuil prénatal, comprenant entre autres des consultations psycho-médico-sociales de longue durée et un meilleur remboursement forfaitaire de cette prise en charge.
- De faire inscrire à l'article 329bis §2 du Code civil que la déclaration de reconnaissance paternelle prénatale auprès de l'officier de l'État civil ne peut en aucun cas constituer une entrave au droit de la femme à recourir à une IVG dans le cas où cette reconnaissance interviendrait en deçà du délai gestationnel légal de l'IVG.

2. Fédération des Centres Pluralistes de Planning Familial (FCPPF)

Le premier constat que souhaite souligner la fédération est le manque de médecins pratiquant l'avortement et correctement formés. Ceci amène les centres à refuser des patientes, et donc à mettre à mal le droit des femmes à obtenir une IVG.

Ainsi, la fédération regroupe 26 centres dont deux 2 pratiquent l'IVG (Uccle et centre du Terril à Jumet). Or, le centre d'Uccle ne dispose plus de médecin depuis plus d'1 an.

Dispositions légales actuelles :

Concernant les dispositions légales actuellement en vigueur, la fédération souligne les éléments suivants :

- La nécessité d'un cadre de qualité et adapté aux soins d'avortement est vue comme une condition positive
- Le délit d'entrave tel qu'il existe est aussi perçu positivement
- Le délai d'attente obligatoire en revanche est vu comme une prolongation inutile de l'âge gestationnel au moment de l'avortement. Cette période d'attente devrait être supprimée.
- Les informations obligatoires à fournir à la femme demandant l'avortement sont un problème et vues comme inadaptées à la variété de situations
- Lorsqu'il s'agit d'aborder la contraception, tout choix en la matière doit rester une option libre
- Si un praticien refuse de pratiquer l'IVG, cela devrait être mentionné dès le moment de la prise de rendez-vous, pas lors du rendez-vous lui-même, pour éviter toute perte de temps entre les deux.

Dispositions légales à modifier :

- Le délai légal pour avorter devrait être allongé jusqu'à au moins 18 semaines post-conception. Un argument motivant cette recommandation réside dans le fait que la majorité des demandes d'avortement se font au 1er trimestre de la grossesse. Les demandes plus tardives sont donc une minorité, mais celles-ci sont motivées par des situations diverses, souvent complexes.

  Un autre argument réside dans le fait qu'il est possible pour les femmes belges d'obtenir un avortement au-delà de 12 semaines, mais en se rendant à l'étranger. Or, le coût de ces déplacements crée des inégalités entre les femmes qui peuvent se le permettre et celles qui ne peuvent pas. Il faut en effet compter entre 400 et 1500€ pour la seule procédure aux Pays-Bas, alors même que ces interventions plus tardives concernent souvent des femmes déjà précaires.
- La fédération demande une suppression des sanctions pénales potentiellement attachées à la pratique de l'avortement. Elles sont vues comme injustifiées puisque les lois encadrant la pratique médicale protègent déjà des éventuels abus par les prestataires de soin. L'absence de poursuites ou de condamnations liées à l'avortement depuis 30 ans montre bien que le maintien de ces sanctions relève davantage d'une posture morale que d'un réel besoin de protection.

  Indirectement, la suppression des sanctions aurait d'autres conséquences positives : elle jouerait un rôle important sur les représentations associées à l'IVG, pour les médecins et les patientes – amenant à favoriser l'accès à l'IVG pour les patientes mais aussi à inciter davantage la formation des médecins.
- La fédération recommande la suppression du délai obligatoire avant l'avortement. De tels délais de réflexion sont déconseillés par l'OMS, considérés comme un protocole infantilisant. Les professionnels du secteur sont conscients que le cheminement de la patiente est déjà entamé en amont (dès la découverte de la grossesse). Un principe de bonne pratique est de choisir un délai en accord avec la patiente et l'équipe, qui soit adapté selon les besoins.
- La FCPPF est en faveur d'une suppression de la mention obligatoire d'informations telles que la mention de l'adoption comme alternative : cette clause apparaît comme un jugement pour la femme enceinte et sur la pratique de l'avortement, laissant entendre que mener une grossesse à terme serait préférable à un avortement.
- La FCPPF relève en outre que 45 mineures de moins de 14 ans ont avorté en 2019. D'après la loi, elles sont considérées comme légalement incapables de consentir à un rapport sexuel. Il devrait donc aller de soi qu'elles ne sont pas en mesure de décider de garder un enfant.

Défis particuliers

- Pénurie : La fédération constate une pénurie de médecins pratiquant l'avortement. Plusieurs aspects sont mis en cause : le manque de possibilités de formation, le manque d'attraction de la profession, le maintien de possibles sanctions pénales. À cela s'ajoute la problématique des zones de désert médical (en province du Luxembourg notamment).
- Formation : la nécessité se fait sentir d'une analyse portant sur les contenus de la formation concrète actuellement donnée en médecine (techniques d'avortement, vision de la pratique…)
- Information :
  - la fédération relève le besoin d'un site centralisé d'information, qui est actuellement absent et amène donc des risques de désinformation et d'orientation vers des sources d'information anti-choix en l'absence de source officielle.
  - Un besoin est aussi manifeste de campagnes de sensibilisation aux possibilités en matière d'avortement
  - L'EVRAS devrait être généralisée

Ces indications sont nourries par le constat d'une gêne et d'un sentiment de stigmatisation des femmes qui demandent une IVG, témoignant de la nécessité d'une approche moins culpabilisante. Ainsi, des récits dédramatisant l'avortement pourraient contribuer à lever le stigmate. La fédération donne l'exemple d'un travail de sensibilisation mené avec la plateforme Abortion Right !, reprenant des récits de femmes qui ont dû avorter au-delà de 12 semaines et qui en montre la diversité.

Toute décision à l'égard de l'avortement devrait être dirigée vers l'objectif de proposer une prise en charge de qualité en Belgique et reposer sur une considération des femmes comme capables de raison et de choix éclairés.

3. Fédération des Centres de Planning familial des Femmes Prévoyantes Socialistes (FCPF-FPS - Sofélia)

La fédération compte 17 centres de planning familial dont 9 pratiquent les IVG et tous sont situés en Wallonie. L'objectif principal de la fédération et de ses Centres est de garantir un accès à l'information, à la contraception, à l'IVG et à l'éducation relationnelle, affective et sexuelle (EVRAS), ainsi que de lutter contre toutes les formes de violences (sexuelles, conjugales) faites aux femmes.

En 2021, les 9 centres de planning familial des FPS pratiquant des IVG en ont réalisé 1.963. Cette même année, les centres de la fédération ont assuré environ 14.000 consultations IVG, ce qui constitue environ 25% du total des activités de tous les centres de planning familial affiliés à Sofélia.

Dispositions légales actuelles

La fédération apprécie la garantie légale de fournir des avortements dans de bonnes conditions médicales, avec l'intervention d'un médecin, et en fournissant des informations circonstanciées (mais sans imposer plus de précisions). Le maintien d'un accord écrit de la patiente signifiant son consentement le jour de l'intervention est vu comme positif.

Les points suivants sont jugés comme étant à améliorer :

- En vue de reconnaitre l'IVG comme une véritable question de santé publique, la FCPF-FPS (désormais Sofélia) et ses Centres affiliés plaide pour la suppression des sanctions pénales à l'égard des femmes et des médecins en cas de non-respect de conditions imposées par la loi, qui entraînent une culpabilisation autour de la pratique de l'avortement. Ceci pourrait se faire à l'exemple de pays voisins : au Grand-Duché du Luxembourg, l'avortement trouve sa place dans une loi relative à l'information sexuelle, à la prévention de l'avortement clandestin et à la règlementation de l'IVG. La FCPF-FPS (Sofélia) et ses Centres revendiquent donc l'abrogation de la loi du 15 octobre 2018 relative à l'IVG et l'adoption d'une nouvelle loi relevant du droit médical, rattachée à la loi du 10 mai 2015 relative aux soins de santé et à la loi du 22 août 2002 sur les droits de la·du patient·e pour lesquels des sanctions existent déjà en cas de mauvaises pratiques et de non-respect de la loi.

- Supprimer l'obligation de fournir des informations spécifiques sur l'adoption en tant qu'alternative notamment. Au vu des prises en charge qualitatives réalisées par nos CPF, il apparait plus pertinent d'écouter chaque situation et demande d'IVG dans leur singularité et d'informer de manière circonstanciée. Au vu des retours des professionnel·le·s de nos Centres, l'option de l'adoption de l'enfant à naitre est systématiquement rejetée par la femme et

perçue comme une solution plus traumatisante que le choix d'avorter. Seules des femmes en situation d'incapacité d'avorter légalement, y compris à l'étranger, ont envisagé dans nos Centres et toujours par défaut, le choix de l'adoption de l'enfant à naître. Elles représentent des exceptions parmi l'ensemble des femmes ne pouvant plus avorter. La proposition d'une adoption doit faire partie du panel des informations circonstanciées qu'il est possible de mettre à disposition de la femme. Autrement dit, quand cela est opportun et en fonction de la situation ou du vécu de la femme. La proposition systématique de cette option est culpabilisante et heurte la quasi entièreté des femmes que nos Centres de Planning familial prennent en charge.

- Supprimer l'obligation de fournir des informations sur la contraception : cette obligation apparaît elle aussi infantilisante, car un suivi de qualité sur la contraception est déjà assuré. Si la question de la contraception est pertinente dans le cas de la patiente, elle est de toute façon amenée. Pour les Centres extrahospitaliers ayant une convention avec l'INAMI, l'information et la mise en place d'une contraception sont déjà prévues dans le forfait alloué. Mais professionnellement, puisque les Centres sont confrontés à la pratique à l'avortement, ils ne peuvent que percevoir la nécessité d'informer sur la contraception. Il est donc inutile d'en faire une obligation dans la loi sur l'avortement. Qui plus est, le secteur du planning familial réclame depuis plusieurs années la gratuité des moyens de contraception pour toutes les femmes et pas uniquement pour les femmes âgées de moins de 25 ans comme c'est le cas actuellement. L'âge moyen des femmes ayant recours à un avortement se situe autour de 28 ans. Il y a donc davantage de femmes entre 25 et 35 ans qui sont concernées par l'avortement que des femmes de moins de 25 ans.

- Allonger le délai légal pour l'obtention d'un avortement jusqu'à un minimum de 18 semaines (équivalent au délai en vigueur en Suède). La fédération constate actuellement une précarisation de la situation des femmes qui sont au-delà de 12 semaines et se rendent aux Pays-Bas pour obtenir un avortement au-delà du délai belge.

- En conséquence de cet allongement, il serait nécessaire de développer des structures d'avortement adaptées à des interventions au second trimestre, puisque les structures extra-hospitalières proposant l'avortement actuellement ne sont pas adaptées à ces interventions plus tardives. Un plateau opératoire permettant une anesthésie générale serait notamment une nécessité. Précisons que d'après les Centres de Planning familial des FPS, les femmes se rendent au sein de leur structure pour avorter de plus en plus tôt dans la grossesse. Ainsi, l'âge moyen de l'IVG au sein des CPF-FPS se situe aux alentours de 7 semaines de grossesse.

La fédération insiste sur le fait qu'il n'existe pas de profil type des femmes qui avortent, qu'elles avortent d'une grossesse de moins de 12 semaines ou de plus de 12 semaines, en termes d'influence socio-démographique (situation de couple, niveau d'éducation, expérience de violences, état des finances, santé, situation familiale et enfants…). En revanche, il existe des **facteurs qui facilitent l'accès avortement** :

- Une formulation de loi qui facilite l'acceptation sociale de l'acte d'avortement en se dissociant du stigmate associé à l'avortement.
- Une communication sur les possibilités d'avortement via plusieurs canaux : web, animation, médias, brochures, et cela afin de fournir une orientation plus efficace et plus rapide des personnes qui cherchent des informations.
- Un entourage soutenant et non jugeant : découvrir une grossesse rapidement en étant bien accompagnée, permet de réagir plus vite. Une amélioration de l'autonomie facilite la décision et demande d'avortement.

Au vu de ces constats, une femme qui s'inquiète rapidement de la possibilité d'être enceinte réagira plus rapidement. Au contraire, une femme qui, pour diverses raisons n'envisage pas la possibilité d'être enceinte et dont les accès aux informations sont limités ou encore une femme qui est isolée, risque de réagir plus tardivement dans la grossesse pour demander une IVG.

Moins la femme aura d'autonomie, moins elle aura la possibilité de pouvoir formuler sa demande d'avortement rapidement. Ci-dessous, sont repris des exemples concrets de freins à son autonomie.

Interpréter des pertes de sang en début de grossesse comme étant des menstruations, ne pas avoir conscience d'avoir eu des rapports sexuels à risque, ne pas avoir de symptômes évidents de grossesse, méconnaitre les méthodes contraceptives, méconnaitre son corps… sont autant de facteurs qui peuvent influencer le temps de réaction d'une femme enceinte à s'adresser à un Centre pratiquant l'IVG si elle souhaite avorter.

Si une femme vit dans un contexte de contrôle (familial, parental, de son partenaire, etc.), de violences intrafamiliales ou conjugales, ou encore dans un contexte culpabilisant avec un risque de rejet en cas de grossesse et/ou d'avortement, elle risque de manquer de ressources et d'arriver plus tardivement à une demande d'avortement.

Certaines femmes ne savent pas qu'elles peuvent se rendre aux Pays-Bas si leur demande arrive tardivement ou ne souhaitent pas s'y rendre parce qu'elles pensent que la pratique est illégale étant donné que la loi belge a un délai légal fixé à 12 semaines. La loi belge devient ainsi culpabilisante pour ces femmes qui pourraient se rendre aux Pays-Bas.

Certaines femmes précarisées hésitent à faire les démarches de demander une IVG pour des raisons financières. Parmi ces femmes, certaines ne savent pas que la mutuelle couvrira la quasi-totalité des frais en Centres extra-hospitalier comme les Centres de Planning familial en Belgique. Ces femmes et celles qui n'ont pas de droit auprès d'une mutuelle repoussent leur démarche, attendant d'avoir un peu de marges financières.

Certaines femmes ont été confrontées à des professionnel·le·s qui ont cherché à les dissuader, à les culpabiliser voire à les mettre hors délai.

Certaines grossesses sont initialement souhaitées. Un incident vient changer le souhait de poursuivre la grossesse (décès du partenaire, annonce d'une maladie, séparation, perte d'un emploi….).

Plus exceptionnellement, certaines femmes font face à un déni de grossesse. Elles rejettent inconsciemment l'hypothèse d'être enceintes et ne sont pas en mesure d'envisager consciemment cette possibilité.

- Supprimer le délai de réflexion obligatoire, à remplacer par un délai flexible, à calibrer selon les besoins de la femme. Ce temps d'attente rigide génère des souffrances et montre une méfiance vis-à-vis de la capacité de réflexion des femmes. Ce temps supplémentaire, en augmentant l'âge de la grossesse au moment de l'intervention, restreint parfois le choix de la méthode d'avortement. Cette condition constitue donc un frein à plusieurs égards à l'accès à l'avortement, au détriment d'une souplesse d'organisation que permettent pourtant les centres de planning familial (il est toujours possible de revenir, de reprendre rendez-vous, etc.).

- Les médecins pratiquant la clause de conscience devraient être obligés de mentionner dès le 1er contact, et pas lors de la 1re visite , qui intervient trop tard (parfois des semaines plus tard). Si la loi mentionne que le praticien refusant de pratiquer l'IVG doit référer la patiente auprès d'un autre médecin, elle ne précise pas de s'assurer que le nouveau médecin pratique bien l'IVG – ce qui devrait être le cas (comme c'est déjà présent dans le décret de la Région wallonne relatif aux centres de planning familial). Lorsqu'il s'agit d'un refus d'intervention pour des

raisons de conscience, la·le médecin, son secrétariat et/ou la structure dans laquelle elle·il preste, devraient avoir l'obligation d'informer immédiatement la femme des raisons de ce refus. Et, par conséquent, dès le premier contact, la femme devrait être orientée aussitôt qu'elle évoque la possibilité d'avorter. Seules des raisons techniques, médicales ou de sécurité empêchant l'organisation de l'avortement auprès de la·du médecin contacté·e pourraient justifier la nécessité d'une consultation avant une orientation. En effet, ces raisons ne sont pas toujours connues lors de la prise du premier rendez-vous.

- Donner des informations de qualité :
    - La fédération recommande de qualifier en tant que délit l'entrave à l'avortement sur internet et les réseaux sociaux, tel que le fait la France. Internet est aujourd'hui le 1er moyen d'information des patientes alors qu'on y trouve aussi beaucoup de désinformation. Cette question renvoie cependant aussi à l'aspect sensible de la liberté d'expression.
    - Une information complète, exacte et neutre doit pouvoir être obtenue aisément sur les canaux officiels (un site au niveau fédéral par exemple), mentionnant notamment une liste de tous les lieux qui pratiquent l'IVG. Ce travail est actuellement assuré par la société civile mais le gouvernement quant à lui n'assure pas ce travail d'information. Il serait également judicieux à l'avenir de **mettre en place des larges campagnes d'information et de sensibilisation sur l'avortement émanant des institutions publiques** afin de renseigner le grand public sur le droit à l'avortement en Belgique et ses conditions d'accès.

- Veiller à une formation adéquate et d'un nombre de médecins suffisant, et lutter contre la pénurie de médecins pratiquant l'avortement. Ceci peut se faire en inscrivant la formation aux techniques d'IVG dans tous les cursus des facultés de médecine. Une attention continue doit être exercée quant aux attaques indirectes au droit à l'avortement, par exemple par le biais de la volonté de donner un statut civil à l'embryon/au fœtus. Il est évident que nous sommes favorables au fait d'humaniser le deuil des personnes concernées par une fausse couche, si ces personnes en manifestent le besoin. Mais, prévoir un acte de naissance pour un embryon ou un fœtus non viable, ne répond pas à un souci d'accompagnement des personnes confrontées à une fausse fauche. Accompagner ces personnes suppose avant tout de dégager des moyens afin de leur offrir un suivi professionnel et pluridisciplinaire de qualité. Donner un statut au fœtus entrave la liberté de la femme de décider de poursuivre sa grossesse sereinement, sans pression extérieure, ni culpabilité. Et ce, alors que la stigmatisation de l'IVG tant envers les femmes ayant ou souhaitant avorter qu'envers les praticien·ne·s pratiquant l'avortement est déjà bien réelle dans notre société.

4. Groupe d'Action des Centres Extra-Hospitaliers Pratiquant L'Avortement (GACEHPA)

Le GACEHPA existe depuis 1979 et s'est constitué autour de la lutte pour l'accès à l'avortement. Son souhait ultime serait de voir le droit à l'avortement inscrit dans la Constitution en tant que droit fondamental.

Dispositions légales actuelles :

La loi actuelle permet d'accompagner et suivre les femmes dans un contexte de qualité, mais elle n'en a pas moins une série d'aspects contraignants qui obligent à refuser des demandes d'avortement.

La révision de la loi en 2018 n'a pas permis de beaucoup faire évoluer les critères d'accès à l'avortement, ni de garantir une protection des prestataires contre des peines pénales. Le GACEHPA en conclut à une illusion de progrès.
Les avancées concrètes relevées comme positives sont les suivantes :

- Retrait partiel de l'avortement du Code pénal
- Suppression de la notion de détresse
- Maintien délai 6 jours mais qui est réductible sous conditions
- Apparition d'un délit d'entrave physique
- Autorisation de diffuser des informations relatives à l'avortement (mais cette autorisation vaut aussi pour les anti-choix)

Recommandations

- Le GACEHPA recommande de supprimer le délai d'attente obligatoire : celui de 6 jours actuellement en vigueur est parmi les délais d'attente obligatoires les plus longs au monde. Or, les praticiens sur le terrain constatent que pour les femmes demandant un avortement, le cheminement est déjà fait en amont : l'idée même d'une grossesse et de ses conséquences fait partie de la vie intime (et de famille/de couple), même avant de découvrir la grossesse. Le temps de la réflexion, lorsqu'il est nécessaire, peut être établi au besoin avec l'équipe en charge de l'avortement.
Les femmes qui avortent sont en outre confrontées à des réalités professionnelles et des contraintes de disponibilités professionnelles ou familiales déjà suffisamment complexes, qui doivent se gérer en parallèle de rendez-vous auprès des centres IVG. Tout temps supplémentaire fragilise la situation des femmes et rajoute des contraintes. La qualité d'accueil des professionnels de l'avortement est reconnue et les équipes sont formées à accompagner les femmes et respecter leurs doutes lorsqu'ils apparaissent – ce qui constitue des garanties suffisantes d'un accompagnement libre et éclairé du choix. Les études montrent que si des regrets apparaissent, ils concernent le fait d'avoir vécu une grossesse non voulue, mais pas le choix qui a été fait de ne pas la garder (99% des femmes confirment ainsi être convaincues d'avoir fait le bon choix[8]). Elles confient en revanche être humiliées de considérer que l'on pense à leur place : c'est l'indépendance du choix et la qualité de choix qui doivent être préservés.

- Le GACEHPA constate également la perte de temps qui est engendrée par les rendez-vous pris avec des médecins qui s'avèrent au bout du compte refuser de pratiquer des avortements. Les patientes devraient être notifiées en amont de leur refus.

- Le GACEHPA recommande de supprimer la mention obligatoire d'informations concernant des alternatives à l'avortement (tells que l'adoption, etc.), considérant qu'il s'agit d'une violence institutionnelle. Ceci sous-entendrait que leurs raisons d'avorter ne seraient pas suffisantes. Ces informations devraient uniquement être mentionnées quand l'avortement n'est plus un choix envisageable : par exemple, lorsque la grossesse est à un stade trop tardif pour un avortement, même à l'étranger.

[8] Rocca CH, Kimport K, Roberts SCM, Gould H, Neuhaus J, Foster DG. Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study. *PLOS ONE* 2015;10:e0128832. Public Library of Science.

- Le GACEHPA recommande une extension du délai légal auquel sont autorisés les avortements. En l'absence d'une proposition plus légitime qu'une autre pour chiffrer cette extension, le GACEHPA trouve envisageable de n'établir aucune limite légale d'âge gestationnel pour la pratique de l'avortement. Une extension significative serait de nature à protéger les femmes les plus précaires : femmes pauvres, migrantes, en détresse, très jeunes, sans papier, etc. qui sont les plus susceptibles de découvrir une grossesse après 12 semaines. Le GACEHPA souligne aussi la détresse du personnel des centres d'avortement qui se voient dans l'impossibilité de proposer l'avortement à certaines femmes alors que rien ne justifie médicalement cette interdiction. En outre, la nécessité pour certaines femmes de prendre du temps pour réfléchir s'oppose parfois au principe d'un délai légal et amène à précipiter une décision.
Le GACEHPA souligne que des modifications trop limitantes de la loi font courir le risque que celle-ci semble trop vite obsolète et qu'il faille y retravailler ensuite. Pour cette raison, il recommande de laisser dans la loi des options ouvertes en termes de délais et d'insister sur la mise en place de bonnes pratiques qui constitueront des garanties de soins de qualité. Ainsi, il est constaté que dans les pays qui autorisent l'avortement jusqu'à des stades avancés de la grossesse, l'énorme majorité des avortements se produit tout de même avant 12 semaines. Les femmes concernées émettent d'elles-mêmes dans leur grande majorité le souhait d'avorter le plus vite possible.

- La législation doit tenir compte du stigmate qui continue d'entourer l'avortement et s'efforcer de travailler à lever celui-ci. Or, plusieurs éléments de la situation actuelle continuent d'alimenter le stigmate. Ainsi, l'obligation de voyager hors des frontières pour obtenir un avortement au-delà de 12 semaines en fait partie. De même, la diffusion d'informations stigmatisantes ou anti-choix (qui ce soit sur le web ou par des médecins) continue à influencer négativement les femmes et leur faire craindre la procédure d'avortement – ce qui les amène à repousser la décision, et donc à obtenir un avortement plus tardif, mais sans finalement dissuader la décision d'avorter.

La décriminalisation de l'avortement est une manière d'aller dans le sens de cette déculpabilisation et de considérer que la loi IVG s'inscrit dans une logique de santé publique et de droits reproductifs, de manière à déstigmatiser les patientes et les praticiens.

La déstigmatisation passe aussi par la nécessité de parler librement d'avortement. Ceci passe autant par l'information au grand public que la formation donnée aux médecins. L'actuel maintien de sanctions pénales associées à l'avortement contribue au désintérêt des médecins pour la pratique et alimente le tabou lié à l'avortement, constituant ainsi un cercle vicieux. Le GACEHPA recommande de former mieux les médecins généralistes et gynécologues à l'avortement, mais aussi l'ensemble des professions médicales et paramédicales (assistants sociaux, infirmières, etc.) notamment par le prisme de l'éthique et de la déontologie.

Une meilleure diffusion de l'information relative à l'avortement s'avère aussi nécessaire, par le biais d'un site fédéral centralisant l'information, ainsi que de campagnes régulières destinées à la population. Ces informations doivent contribuer à normaliser la possibilité de faire le choix de l'avortement.

Une reconnaissance de la pratique au niveau professionnel s'impose également : pas seulement avec les conventions INAMI (qui dont déjà un point positif pour le secteur des centres d'avortement) – mais

aussi en reconnaissant les prestations médicales associées aux interruptions de grossesse et en les faisant rembourser par l'INAMI comme telles.

La nécessité de prendre en charge des patientes sans couverture sociale constitue une charge financière grandissante pour les centres de planning familial : c'est à travers cela un danger de précarisation croissante qui pèse sur les centres et qui devrait être pris en considération par des moyens de support aux femmes les plus vulnérables.

Conclusion

Les points essentiels que souhaite souligner le GACEHPA sont les suivants :

- La nécessité d'une loi non discriminante à plusieurs égards
- Accessibilité : dans la formulation de la loi, les critères d'accès ne doivent pas pouvoir être rediscutés d'une législature à l'autre
- Inscription du droit à l'IVG dans la constitution
- La nécessité de protéger et faciliter l'accès à l'avortement

5. Fédération des centres de planning et de consultations (FCPC)

(La position de la FCPC a été transmise par email, en raison d'un empêchement de sa représentante.)

Bien que la pratique de l'avortement ne se réalise pas dans les centres de la FCPC, la fédération est engagée sur le thème de la santé sexuelle des femmes au sens large et relaie toute communication, signe toute carte blanche ou participe à toute réflexion concernant ce thème.

La fédération émet les recommandations suivantes :

- Harmoniser les moyens accessibles concernant la contraception.
  En effet, la possibilité d'achats groupés concernant les pilules contraceptives et pilules du lendemain devrait pouvoir se faire en groupement interfédérations puisque l'objectif reste le même : la santé sexuelle des femmes. Or pour le moment, et d'autant plus dans la situation économique qui se profile pour 2022-2023, pour la population mais également pour les petites entreprises et ASBL, l'achat de contraceptifs et de matériel ne devrait pas constituer un frein pour les centres.
- Résoudre la problématique de plus en plus pressante de la prise en charge des personnes sans statut légal.
  La prise en charge de personnes non mutuellistes a doublé en un an, c'est-à-dire les personnes émargeant à l'AMU, qui ne sont plus en ordre de mutuelle ou pour des questions de nationalité et d'accès au territoire. L'AMU a été créée pour ce genre de situations mais nombre de CPAS refusent d'intervenir en disant qu'il ne s'agit pas d'une urgence[9] (tout comme certains cas de mutilations génitales féminines), ou mettent à mal les conséquences de cette IVG en refusant la prise en charge d'antibiotiques, par exemple. Les hôpitaux de la région réorientent parfois les patientes dans ces situations, sous prétexte (erroné) de gratuité en centre de planning familial ce qui représente une charge financière et mentale considérable pour les travailleurs et l'équipe en charge de chaque dossier.

[9] L'avortement n'est en effet pas reconnu comme un soin urgent dans la procédure AMU.

Synthèse des positions

Le nom de la/des fédération(s) ayant évoqué une prise de position ou recommandation est indiqué en dessous de celle-ci. La non-mention d'une fédération ne signifie pas pour autant son désaccord avec la proposition.

- Délai d'âge gestationnel maximal pour l'avortement
    - Extension jusqu'à au moins 18 semaines post-conception
      FLCPF/ FCPPF/ FCPF FPS
    - Extension sans précision de limite
      GACEHPA

- Temps d'attente obligatoire : suppression
  FLCPF/ FCPPF/ FCPF FPS/ GACEHPA

- Suppression de la mention d'informations obligatoires sur « les possibilités d'accueil de l'enfant à naître »
  FLCPF/ FCPPF/ FCPF FPS/ GACEHPA

- Suppression de l'obligation de fournir des informations sur la contraception
  FCPPF/ FCPF FPS

- Dépénalisation complète de l'avortement
  FLCPF/ FCPPF/ FCPF FPS/ GACEHPA

- Inscription du droit à l'avortement dans la constitution
  GACEHPA

- Instauration d'un délit d'entrave
    - Numérique
      FCPF FPS
    - Pour diffusion de fausses informations
      FLCPF

- Maintien de l'obligation de "bonnes conditions médicales" et de pratique "dans un établissement de soins où existe un service d'information qui accueille la femme enceinte";
  FLCPF / FCPPF

- Maintien du délit d'entrave physique
  FCPPF

- Maintien de la nécessité de s'assurer du consentement libre et éclairé de la femme qui demande une IVG
  FLCPF

- Maintien de la possibilité de clause de conscience pour les praticien·nes
  FLCPF/ FCPPF

-
- Mention de l'objection de conscience dès la prise de rendez-vous (c'est-à-dire au premier contact et pas lors du rendez-vous)
  FLCPF/ GACEHPA / FCPF FPS
  - En cas d'objection de conscience, renvoi obligatoire vers un·e prestataire qui pratique l'avortement
    FCPF FPS

- Amélioration de la formation relative à l'IVG (pratique et circonstances sociales)
  - Pour les médecins

  FLCPF/ FCPPF/ FCPF FPS/ GACEHPA
  - Pour toutes les professions médicales et paramédicales

  FLCPF/ GACEHPA

- Une meilleure reconnaissance et un meilleur financement de la pratique médicale de l'IVG
  FLCPF/ GACEHPA

- Faciliter l'accès à l'AMU pour les femmes les plus précaires recourant à l'IVG
  FLCPF/ FCPC

- Centraliser au niveau fédéral les informations objectives relatives à la pratique et l'obtention d'une IVG
  - Au moyen d'un site web centralisé
    FLCPF/ FCPPF/ FCPF FPS/ GACEHPA
  - Au moyen de campagnes d'information
    FCPPF/ FCPF FPS/ GACEHPA

- Gratuité de tous les moyens de contraception
  FLCPF

- Généralisation de l'EVRAS
  FLCPF/ FCPPF

- Maintenir une vigilance face aux évolutions de la législation relative au statut de l'embryon/ du fœtus, notamment dans le cadre de la déclaration à l'état civil d'un enfant né sans vie ou d'une fausse couche
  FLCPF

Questions et échanges

Question : Le chiffre de 18 semaines comme minimum de l'extension du délai gestationnel pour l'avortement est récurrent parmi les interventions : pourquoi ce chiffre et pas un autre ?

- Ce chiffre se base sur le principe de la clause de l'Européenne la plus favorisée, défendu par Gisèle Halimi, en prenant l'exemple de la Suède

Q : Mais alors, pourquoi ne pas prendre l'exemple des Pays-Bas, qui ont quant à eux établi la limite à 22 semaines post-conception ?

- Le chiffre de 18 semaines est le résultat d'un compromis entre de multiples parties, et aussi comme compromis issu des débats autour de la proposition de loi de 2018. Mais il reflète un minimum, pas l'objectif idéal des fédérations de planning familial qui sont en faveur d'une extension de plus de 18 semaines (20 ou 22 semaines sont des options envisageables). Il s'agit d'une position d'alignement stratégique, qui inclut aussi la plateforme Abortion Right !
  De nouvelles structures devraient être créées pour procéder à ces avortements de plus de 12 semaines, puisque les centres de planning familial ne sont pas équipés pour cela.
- Il est admis que des cas rares de grossesses associées à des circonstances difficiles devraient pouvoir être interrompues au-delà de 18 – 22 semaines : même si cela pose des questions éthiques et morales délicates.

Q : Comment se déroulent les interruptions médicamenteuses de grossesse, notamment au regard des possibilités de télémédecine et de l'intervention INAMI ?

- La convention INAMI précise qu'il faut une consultation en présentiel ainsi qu'une expulsion qui se déroulent toutes deux en centre d'avortement, ce qui ne correspond plus aux réalités actuelles, liées à la crise du COVID et l'augmentation d'usage de l'avortement médicamenteux. L'arrêté royal précise pour sa part que la Mifégyne doit être prescrite et son administration supervisée par un médecin mais ne mentionne pas que la prise doit se faire devant ce médecin. Il faut aussi mentionner que le délai d'attente obligatoire, en ajoutant 6 jours à la grossesse, peut freiner l'usage de l'interruption médicamenteuse, étant donné qu'elle est recommandée jusqu'à un stade peu avancé de la grossesse (pour la pratique en centre extra-hospitalier). Les recommandations internationales indiquent 9 à 10 semaines comme âge gestationnel maximal en centre extra-hospitalier, tandis que les centres belges ont pour principe de ne pas dépasser 7 à 8 semaines d'âge gestationnel.
  En réponse à cela, la plupart des centres on mis des protocoles en place : le centre prévoit des plages de disponibilité (avec une permanence téléphonique par exemple) pour la patiente qui procède à la 2^{e} phase d'une interruption médicamenteuse à domicile. Une supervision médicale est donc garantie au cas où ce serait nécessaire. D'autres formes de garantie sont prévues, en plus de la possibilité de contact, telles qu'une distance maximale entre le centre et le domicile, des appels de suivi, etc. Des filets de sécurité et de bonnes pratiques supplémentaires existent, par exemple des « red flags » qui alertent le centre sur quelles patientes / quelles situations nécessitent une intervention immédiate. La question de la capacité de la patiente à se déplacer est également en jeu et à peser : une IVG à domicile peut se justifier pour les personnes qui ont du mal à se déplacer jusqu'au centre de planning familial – mais ce sont des personnes qui risquent d'avoir du mal à se rendre aux urgences si un problème médical survient en cours de processus.

Q : Concernant la pénurie de médecins pratiquant l'avortement et les difficultés d'accès pratiques aux centres d'avortement, deux questions sont posées :

a. Bruxelles et la Wallonie ont, historiquement et stratégiquement, opté pour un maillage constitué par un grand nombre de centres de planning familial, alors

que la Flandre a opté pour des cliniques spécialisées uniquement dans l'avortement et davantage centralisées dans de grandes et moyennes villes. Le large réseau francophone n'est-il pas un obstacle au recrutement ?

b. Une potentielle solution à la pénurie de médecins ne serait-elle pas d'élargir la pratique de l'avortement aux sage-femmes ou aux infirmières ?

- La Flandre dispose de centres spécialisés uniquement sur la pratique de l'avortement, tandis que les centres de planning familial de la Fédération Wallonie-Bruxelles exercent des missions multiples. La répartition dispersée sur le territoire peut aussi se justifier par le maillage du réseau de transport et, dès lors, le choix de faire se déplacer les médecins plutôt que les patientes : les médecins spécialistes de l'IVG travaillent dans plusieurs centres, où ils assurent les consultations certains jours de la semaine.

- Concernant l'insistance sur les nécessités de formation, il faut indiquer que ce n'est pas l'IVG seulement sur le plan technique qui doit être abordée mais aussi ce que signifie la pratique sur le plan social. Il faut également mentionner que la pénurie de médecins ne s'arrête pas à l'IVG : la médecine sociale (en maison médicale comme en cpf) n'est pas assez attirante ou rémunératrice.

- Concernant la possibilité d'inclure les sage-femmes : elles sont elles aussi demandeuses et réclament de pouvoir pratiquer les IVG médicamenteuses. Le Conseil fédéral des sage-femmes s'est prononcé à cet égard (une note sera disponible sous peu). Néanmoins, la pratique d'IVG médicamenteuse par des sage-femmes requiert de s'assurer qu'une formation spécifique à cette pratique est acquise. Il serait aussi envisageable, si le contenu des études était amené à changer pour inclure cette compétence dans le diplôme, d'offrir des possibilités de formation par la suite à celles qui ont déjà terminé leur cursus.

- Certains centres de planning familial sont favorables à l'engagement de sage-femmes dans leurs structures et peuvent témoigner d'une bonne expérience en la matière, mais cela dépend des régions. Certaines sage-femmes ont des réticences à la pratique de l'avortement, vu l'orientation de leur formation initiale. En outre, les régions font face à des contraintes distinctes sur les profils de personnes qu'il est possible d'engager ou non en cpf.

Q : Les centres de planning familial ayant des missions variées et n'étant pas tous conventionnés pour la pratique de l'avortement, les patientes sont-elles au clair sur quel centre pratique l'IVG ou pas ? Comment s'assurer qu'elles ne perdent pas de temps en rendez-vous et contacts ?

- L'information des centres qui pratiquent ou non l'IVG est disponible sur le site web http://www.loveattitude.be/ qui regroupe les informations sur tous les centres de planning familial, toutes fédérations confondues. Ce site web, à l'initiative des fédérations de planning familial, est actuellement le seul endroit où est disponible une information centralisée. Un site web au niveau fédéral est donc réclamé, pour encore mieux centraliser ces informations et les rendre accessibles au plus grand public.

Q : Dans l'hypothèse d'une extension de l'âge gestationnel pour l'IVG, des structures dédiées aux spécificités des avortements du 2e trimestre devraient être mises en place. Comment les fédérations de planning envisagent-elles cette organisation ?

- Il serait nécessaire d'avoir des structures qui dépendent ou sont en contact direct avec un plateau hospitalier (cette discussion a été abordée avec la plateforme Abortion Right !), qui permettrait notamment de pratiquer des anesthésies, des IVG médicamenteuses tardives. L'expertise dans cette dernière pratique est d'ailleurs déjà existante dans certains hôpitaux, qui la pratiquent déjà dans le cadre des interruptions médicales de grossesse.
- L'option idéale considérée serait la création de centres extra-hospitaliers liés à des hôpitaux, avec des professionnels spécialisés dans la pratique de l'avortement et qui ont choisi d'y travailler (il faut à tout prix éviter dans ce genre d'endroits du personnel non sensibilisé à la question de l'avortement). Une répartition d'une structure par région serait vue comme optimale.

Q : Quelle est la position des fédérations de planning familial concernant la possibilité de proposer des sédations légères en centres extra hospitaliers pour les IVG du 1er trimestre ?

- Une sédation qui ne requiert pas une anesthésie peut se faire en centre extra-hospitalier sur le plan technique, mais ce n'est pas autorisé légalement. Dès lors, pour les femmes, le choix du type de sédation est contraint par la structure à laquelle elles s'adressent : une anesthésie générale n'est possible qu'en hôpital, tandis qu'une anesthésie locale pour une IVG par aspiration n'est possible qu'en centre extra-hospitalier.
  Il est à noter qu'aux Pays-Bas, c'est d'office une sédation qui est proposée mais par contre les centres n'offrent pas la possibilité d'une anesthésie locale après 12 semaines. En France, en centre de planning familial, c'est l'anesthésie générale qui est majoritaire (avec des infirmières anesthésistes). En Grande-Bretagne, les chiffres varient entre les deux options, montrant l'intérêt des deux méthodes.

Q : quels sont les rapports avec hôpitaux, par exemple lorsqu'il est nécessaire de référer une patiente qui aurait besoin d'une anesthésie générale ? Est-ce que, après un premier rendez-vous en centre extra-hospitalier, elles doivent répéter les 6 jours de délais d'attente ?

- Dans les hôpitaux avec lesquels les centres ont une bonne collaboration (par exemple Saint-Pierre à Bruxelles), ce n'est pas le cas et c'est le centre qui atteste que la consultation psycho-sociale a bien eu lieu. Un délai s'applique parfois, mais qui est surtout dû à l'obligation de reprendre un rendez-vous pour une consultation afin de planifier l'intervention, mais ce n'est pas par application du principe des 6 jours.

Q : Comment est pratiqué le tarif dit social, dans le cas où la patiente ne dispose pas d'une mutuelle ?

- Les centres ont pour principe de tenter de trouver un financement autre. Lorsque ce n'est pas possible, ils émettent une facture dite « sociale » à hauteur d'environ 200€ et le montant restant que l'intervention coûte au centre est abandonné (il n'y a pas de reconnaissance de dette). Certains centres choisissent de proposer la gratuité dans ce genre de cas, d'autres négocient un montant selon les possibilités de la patiente. Certains centres sont plus exposés aux patientes précaires que d'autres, qui représentent entre 5 et 20% des patientes – 5% étant la moyenne nationale de personnes qui ne sont pas en ordre de mutuelle. Les centres de St Josse, de l'hôpital Saint-Pierre, d'Aimer Jeunes sont des exemples où le taux monte à 20%.
  Un autre enjeu est la facilité à obtenir une validation plus ou moins facile de l'AMU. Or, celle-ci dépend de la qualité de la collaboration ou de l'attitude de certains CPAS.
  Pour répondre à ces enjeux financiers importants, certains réseaux de centre ont mis en place des caisses de solidarité.

Q : La suppression du délai d'attente obligatoire semble faire consensus, mais quel devrait être le délai après la première consultation psycho-sociale pour l'obtention de l'intervention d'avortement ? Est-il pertinent de conserver la distinction entre 1re et 2e consultation ?

- Tout délai obligatoire peut être considéré comme arbitraire, même s'il n'est que de 1 jour. C'est le moment du 1er contact qui permet d'établir la situation et de refléter des réalités très distinctes face à la grossesse, à la prise de décision. Les équipes des centres sont formées à traiter les situations au cas par cas. La position unanimement défendue est de n'avoir aucune contrainte d'attente, même pas en établissant un temps minimum. Les rendez-vous pourraient en principe se suivre, même s'il est aussi possible de déterminer avec la patiente le temps dont elle a besoin.

Q : Que pensent les fédérations de la possibilité d'étendre l'âge gestationnel maximal pour l'avortement en établissant des dispositions (ou garanties ou conditions…) spécifiques pour tout avortement qui aurait lieu après 12 semaines ?

- La position partagée est de ne pas établir de division de principe entre différents délais : il devrait s'agir simplement d'une prolongation du délai prévu dans la loi avec les assouplissements proposés dans les interventions ci-dessus.

Q : Quelle est la position des fédérations vis-à-vis de la télémédecine / de la possibilité de pratiquer des avortements médicamenteux à distance dans l'hypothèse où cela serait validé en accord avec l'INAMI ?

- La possibilité d'avortement à distance doit être une option parmi d'autres : elle n'est ni meilleure ni moins bonne, tout dépend de la situation, qu'il faut mesurer en accord avec la patiente. Il est en revanche nécessaire d'assouplir les protocoles actuels en se demandant quel est le rôle de chaque étape et en quoi c'est nécessaire/pertinent à des soins de qualité et sûrs. Le rôle des équipes à cet égard doit être clairement défini lui aussi, et garantir une disponibilité pour les femmes depuis leur domicile. Cela doit absolument constituer un choix de plus pour les femmes – mais en aucun cas une réduction du service pour raisons financières : l'IVG médicamenteuse doit toujours pouvoir aussi se faire dans le centre si c'est le choix privilégié. Dans l'idée d'une centralisation de l'information sur le web, il faudrait lister sur le site web quel CPF propose ou non la pratique d'une 2e étape de l'IVG médicamenteuse dans le centre/à domicile.

Q : Au sujet de la pénurie de médecins : si une extension de l'âge gestationnel maximal pour l'avortement devait intervenir, ne risque-t-on pas d'accroître la pénurie (que l'on voit se dessiner aux Pays-Bas) ?

- Catherine Blanpain, médecin généraliste travaillant en cpf, a réalisé un mémoire sur la charge professionnelle et mentale des médecins pratiquant l'IVG[10]. Elle y indique notamment que le rapport des médecins à une forme de militantisme et d'engagement pour les droits des femmes dans la pratique a changé au fur et à mesure de la professionnalisation de l'IVG. Pour les plus jeunes générations, si une sensibilisation à la question est réapparue ces dernières années, il faut en outre compter le temps de la formation et le temps de leur arrivée sur le marché de l'emploi. Un autre frein est constitué par le manque d'attractivité de la profession : la formation spécifique en matière d'IVG n'est pas valorisée (encore moins lorsqu'elle est

[10] https://docplayer.fr/54659257-Ces-medecins-funambules.html

pratiquée en hôpital, où aucun code INAMI n'existe pour facturer les actes). En outre, les places disponibles en dans les formations et les stages avec des médecins expérimentés sont rares. C'est donc tout le système de formation qui est à revoir.

---

f) Hospital associations representatives

ZWA | Stuurgroep van het interuniversitair, multidisciplinair en onafhankelijk comité belast met de studie en de evaluatie van de praktijk en de wetgeving inzake vrijwillige zwangerschapsafbreking
IVG | Groupe de pilotage du comité interuniversitaire multidisciplinaire indépendant en charge de l'étude et de l'évaluation de la pratique et de la législation sur l'Interruption Volontaire de Grossesse

Hospital associations hearing

06/09/2022

Present :

Hospital associations representatives
Emmanuelle Ceysens (Santhea)
Dr. Philippe Lejeune (Santhea)
Yannick Manigart (GIBBIS)
Pr. Siham Zaytouni (CHAB/RUZB)
Pr. Frédéric Debième (CHAB/RUZB)

Members of the scientific committee
Heidi Mertes (member WG1)
Yvon Englert
Kristien Roelens
Aurélie Aromatario
Fien De Meyer

1. Presentation of the project of evaluating practice and legal aspects surrounding termination of pregnancy

Members of the Scientific Committee estimate that hospitals play an important role in the provision of abortions, at three levels :

- Elective terminations of pregnancy can be performed in hospitals
- Hospitals are also in charge for terminations of pregnancy for medical motives, particularly after 12 weeks post-conception
- Hospitals play a role in referencing patients to extra-hospital abortion centers

Hospitals representatives are invited to express their evaluation of the current situation and propose recommendations. They express the point of view of their whole federation / hospital association.

Representatives were provided with a discussion guide in preparation of the hearing :

GUIDE DE DISCUSSION : ÉVALUATION DES PRATIQUES ET DE LA LÉGISLATION EN MATIÈRE D'AVORTEMENT

5. Comment évaluez-vous la pratique actuelle des hôpitaux que vous représentez, et quelles sont les difficultés principales qu'ils rencontrent ?
    a. Concernant les interruptions volontaires de grossesse
    b. Concernant les interruptions de grossesse pour raison médicale

6. Quelles dispositions de la loi de 2018 relative à l'Interruption volontaire de grossesse devraient, selon vous, être absolument maintenues, et pourquoi ?

7. Quelles dispositions de la loi de 2018 relative à l'Interruption volontaire de grossesse devraient, selon vous, être modifiées, supprimées ou ajoutées, et pourquoi ?

8. Au-delà du cadre légal, y a-t-il des défis particuliers ou des recommandations professionnelles dans la pratique des soins liés à l'avortement que vous aimeriez transmettre au comité de pilotage qui mène cette évaluation ?

---

2. Current situation : evaluation

2.1. Positive feedbacks on the 2018 legal changes :

- Suppression of the state of distress (mentioned by 1 hospitals representative)
- Suppression of the prohibition on advertising about abortion (mentioned by 1 hospitals representative)
- Apparition of the obstruction offence (mentioned by 1 hospitals representative)
- Obligation to refer the patient to another practitioner in case of conscientious objection
- (mentioned by 1 hospitals representative)

2.2. Negative impact of the law (1990 / 2018)

- Mandatory information (mentioned by 3 hospitals representatives))
  Notably the mandatory information regarding the possibilities of support for the child to be born (art.2 – 2b) is seen as inappropriate for 1st trimester abortion (mentioned by 2 hospitals representatives))

- Mandatory waiting period of 6 days (unless urgent medical motive) (mentioned by 3 hospitals representatives))
  Is seen as unnecessary since reflection starts well before the 1st appointment for the woman confronted with an unwanted pregnancy
  In addition, each time the pregnant woman has an appointment with another practitioner (for instance, if the 1st one she met doesn't perform ToP and she is then referred to an abortion center), she has to repeat the 6-days waiting period. This can result in up to 3 weeks lost in waiting time.

In addition, lost time can prevent access to medication abortion.

- Maximal gestational age of 12 weeks post-conception is too short. (mentioned by 2 hospitals representatives))
    - The consequence is that women travel to have an abortion in the Netherlands, which appears as a moral unload to another country. (mentioned by 1 hospitals representative)
    - It is financially (1000-2000€) and practically (passport, days off, language…) inaccessible for many women (mentioned by 2 hospitals representatives))

2.3. Access to abortion

- Lack of doctors duly trained and willing to practice ToP (mentioned by 3 hospitals representatives))
  Notably resulting in lack of availability of the abortion centers

- The practice of elective abortion represents an important investment for the hospital which must free up working time for multidisciplinary consultations on the issue without any funding for social workers and psychologists (mentioned by 1 hospitals representative)

- The practice of medical abortion also represents a financial burden in the absence of financial support for :
    - the time of psychological care necessary to accompany patients by psychologists, midwives, ...
    - multidisciplinary meetings necessary for optimal management of situations leading to an medical abortion decision. Depending on the situation, the presence of the gynecologist, pediatrician, pediatric surgeon, orthopedic surgeon, cardiopediatrician, geneticist, radiologist, anatomopathologist, midwife, psychologist, etc., and the person in charge of coordination must be coordinated
    - Specialized ultrasound examinations that are very time-consuming and only reimbused 11,21€ before 18 weeks PC (20 weeks LMP) in the context of medical abortion

- Abortion requests for pregnancies aged of more than 12 weeks are mostly due to
    - Dysfunction of contraceptive (ex. of progestative contraception suppressing menstruation)
    - Irregular menstrual cycles (PCOS for instance) and late discovery of the pregnancy
    - Pregnancy denial
    - Lack of knowledge about where to get an abortion (ex. of migrant women)
    - Complex situations and multifactorial vulnerability (migration, pregnancy from rape, domestic violence, HIV, impossibility to travel… all of those sometimes intertwine). (mentioned by 1 hospitals representative)

2.4. Varia

- Good existing collaboration with abortion centers (patients regularly referred) (mentioned by 3 hospitals representatives))
    - Assets of pluri-disciplinary teams
    - Good working method
    - Asset of collaborating with the GACEHPA
    - Improved protocols and improved safety

3. Proposals and recommendations

3.2. General proposals

- Recommendation to express the law in terms of amenorrhea weeks instead of weeks post-conception, so that it matches the medical terminology most used (mentioned by 1 hospitals representative)

- Harmonization of practices between hospital protocols and extra-hospital protocols for abortion procedures (mentioned by 1 hospitals representative)
    - Through a national website listing the protocols
    - Centralized information

- Insist on- and improve education about contraception (mentioned by 1 hospitals representative)

- Facilitate and simplify administrative reporting of ToP, notably through a digitalized system (mentioned by 1 hospitals representative)

- Offer financial incentives for practitioners involved in the intake of terminations of pregnancy, to improve abortion access for patients (mentioned by 1 hospitals representative)

- Recognition of the hospital departments that perform terminations of pregnancy in a similar way as the recognition (and convention) of the outpatient abortion centers : this would improve the identification of abortion practitioners for the patients, and prevent the patient to plan a consultation with a practitioner who doesn't perform abortion procedures (and thus prevent unnecessary delay and a potential judgmental attitude towards her request). (mentioned by 1 hospitals representative)

- Implication of the fathers, notably by referring to the couples in the law (whenever possible / pertinent) (mentioned by 1 hospitals representative)

- Need to develop information campaigns about abortion practice and abortion providers (notably, but not only through EVRAS programs) (mentioned by 1 hospitals representative)

- Need to develop a central website, at the national level (mentioned by 2 hospitals representatives)

- Involvement of midwives in abortion procedures to help with the lack of practitioners (mentioned by 1 hospitals representative)
    - They are already trained for delivery, they should be qualified as well for medication abortion procedures (as it is the case in France)
    - They could assist in surgical abortion, paired up with a doctor

- Improvement of the current educational cursus about the practice of abortion in medical school (currently, complete training with actual practice is only on a voluntary basis) (mentioned by 2 hospitals representatives)

- Recognition of abortion as a medical act (mentioned by 1 hospitals representative)

3.3. Elective abortion

- Recommendation to suppress the 6-days waiting period (mentioned by 3 hospitals representatives)
  Good practice to establish a period in agreement between the practitioner and the patient
    - a 24h or 48h waiting period as largely sufficient (1)
    - No waiting period (1)

- If the patient is confronted with a practitioner refusing to perform ToP and is close to the legal limit, she should obtain a prolongation of the delay (mentioned by 1 hospitals representative)

- Better training for medical assistants to ToP (mentioned by 1 hospitals representative)

- Elective abortion : systematic counselling with a multi-disciplinary team (mentioned by 1 hospitals representative)

- Facilitate the obtention and delivery of abortive medicine (mifepristone, misoprostol) inside the hospitals (EC), notably through the possibility of keeping stocks outside of the pharmacy (mentioned by 1 hospitals representative)

- Census for the abortion centers : have a list of practitioners (mentioned by 1 hospitals representative)

- No motivation should be provided for an elective abortion, just like many other medical interventions (mentioned by 1 hospitals representative)

3.4. Recommendation to extend the gestational age for elective abortion

- Recommendation to extend the gestational age limit beyond 12 weeks (mentioned by 3 hospitals representatives)
    - no agreement on the number of weeks (mentioned by 1 hospitals representative)
    - 20 weeks (mentioned by 2 hospitals representatives)

LEGAL CHANGES

- Proposal to assimilate elective abortions after 12 weeks post-conception to ToP for medical motives : such later ToP are likely to reflect broader medical or social issues. This would allow to solve the issue of available facilities for second trimester ToP : those ToP could be performed in hospitals already equipped for later ToP (mentioned by 1 hospitals representative)

TECHNICAL CHALLENGES

- Need to consider the technical challenges related to second trimester abortions : it requires specialized facilities whereas the existing abortion centers are not equipped to perform those procedures (mentioned by 2 hospitals representatives)
    - There should be at least one center for second trimester abortion in each region (mentioned by 1 hospitals representative)

- Practical issues to solve:
    - delivery aisles in the obstetrics departments are not the appropriate place for elective ToP (mentioned by 1 hospitals representative)
    - Obstetric departments in province hospital could be a solution for a good territorial coverage (mentioned by 1 hospitals representative)

TRAINING

- Training for surgical and medication abortion techniques should be adapted in case of extension of the legal delay (mentioned by 3 hospitals representatives)

3.5. Abortion for medical motives

- Need to clarify more accurately the legal framing for ToP for medical motives (mentioned by 2 hospitals representatives)
    - Some hospitals have their own commissions : this type of good practice could be generalized. (mentioned by 1 hospitals representative)
    - Definition of the type of examination that is required (mentioned by 1 hospitals representative)
    - Clarifications about the process and legal framing for neonatal euthanasia (mentioned by 1 hospitals representative)

- Recommendation to have a separate law for medical abortion, due to very different circumstances (mentioned by 2 hospitals representatives)

- Termination of pregnancy for medical motive : better counselling and coordination of the teams of practitioners (ob/gyn, psychologist…) (mentioned by 1 hospitals representative)

4. Informal discussion

Question : Quelqu'un peut-il expliquer le contenu et l'organisation de la formation médicale à l'IVG en faculté de médecine ?

- à l'ULB, il existe une possibilité de formation certifiante via le GACEHPA, qui est surtout demandée par les généralistes qui veulent travailler en planning. Elle consiste en une approche de l'histoire et de la pratique de l'avortement, suivie par une formation sur le terrain. Celle-ci prend la forme d'un stage dans un planning familial pratiquant l'avortement. Au terme de tout cela peut être obtenue la formation certifiante.

  A Erasme, une collaboration avec le planning familial local permet de former un gynécologue et 3 généralistes chaque année (il s'agit d'une première année pilote en cours).

  Pour les gynécologues qui ne font pas la démarche de suivre ces formations, l'expérience d'apprentissage de l'IVG se résume à opérer au bloc, sur des patientes inconnues, sans réaliser une anamnèse auparavant. Les indications techniques consistent en une évocation rapide de la sonde d'aspiration et de la curette. Si elle est suivie au sein de l'ULB (et pas avec le GACEHPA), cette formation n'est pas certifiante à l'ULB : ce n'est pas prévu dans l'administration académique. Cela concerne donc juste des médecins motivés.

- C'est Marco Schengen qui a coordonné cette formation lors de sa création. Il peut être un bon contact pour en savoir plus.

Question : Concernant le calcul du délai des 6 jours : interviennent-ils à partir du moment où le planning familial reçoit la patiente ? ou recommence-t-il dès qu'il y a nouvel intervenant qui reçoit la patiente ? Ou son calcul diffère-t-il selon les structures ?

- La loi précise que l'IVG peut être pratiquée 6 jours après la 1ere consultation prévue pour une interruption de grossesse. Ces termes ne sont donc pas assez clairs pour lever les ambiguïtés. Sur le terrain, si l'on a une trace écrite d'un 1er rendez-vous existant avec un médecin, alors c'est ce rendez-vous qui est pris en compte pour le calcul, même si un autre rendez-vous est pris, par exemple en planning familial.

- Il existe cependant une contrainte due à la convention INAMI pour les Centres de Planning Familial et les cliniques d'avortement. Sauf rares exceptions à justifier, il faut que les 2 rendez-

vous (psycho-social et procédure d'avortement) aient lieu dans leur structure pour obtenir le remboursement de la part de l'INAMI.

Question : Avez-vous des remarques à formuler concernant le financement des procédures d'avortement ?

- Le CHU ST Pierre n'est pas conventionné par l'INAMI ni financé par la Cocof, mais par Iriscare. Cela signifie qu'il n'existe pas de budget spécifique pour réaliser les consultations pré- et post-IVG (consultation elle-même et encadrement par d'autres prestataires). Il n'y a plus de possibilité de conventionner de nouveaux centres d'avortement extra-hospitaliers : l'INAMI estime que le nombre actuel est suffisant.

  Cela n'empêche pas les collaborations, voire des conventions spécifiques (par exemples, les patientes avec des mutilations génitales féminines sont envoyées par les centres vers les hôpitaux). L'IVG est cependant plus chère en hôpital qu'en centre de planning familial, ce qui amène certains hôpitaux à ne faire payer à la patiente que le tiers payant.

- Il semblerait que la situation favorise la pratique de l'avortement en centre extra-hospitalier, autant sur des aspects financiers que sur les référencements par les gynécologues.

- Il n'y a pas eu de retour sur cet aspect depuis la fédération d'hôpitaux Santhea.

  Concernant les améliorations des aspects informatifs, il serait possible d'aller plus loin que le seul projet de site web centralisé, en formulant l'idée de trajet de soin. Il faudrait ainsi informer que, selon le choix de structure, la patiente entre dans un trajet de soin ou un autre.

Question : Qu'en est-il de la pratique de l'interruption médicale de grossesse ? Comment est-elle financée dans les hôpitaux ?

- Une interruption médicale de grossesse est considérée administrativement comme un accouchement au-delà 22 semaines. En dessous de cet âge gestationnel, l'intervention est encodée comme une fausse couche. Ce sont donc les codes respectifs de ces actes qui sont repris.

- Le financement par ces codes ne reflète pas toute la réalité des actes médicaux : ni l'énergie investie, ni le personnel requis, ni l'impact de ces pratiques. Pour une IVG, le code de facturation est celui d'un curetage, ce qui ne correspond pas à la pratique réelle (qui n'est pas un curetage). Si appel est fait à un psychologue, les frais sont à la charge de la patiente. S'il s'avère que cette dernière est précaire, alors le suivi psychologique risque de ne pas être fait. Certains hôpitaux peuvent aussi choisir de facturer une prestation à prix rabaissé. Pouvoir refléter administrativement l'avortement comme une prestation globale serait nécessaire, de manière à la rendre aussi plus représentative des coûts réels. Actuellement, l'avortement en intra-hospitalier est une activité à perte. Il est donc hautement nécessaire de la financer correctement pour assurer la pérennité de la prise en charge des patientes IVG.

- Le constat est le même pour le trajet de soin des demandes d'interruption médicale de grossesse. Il est difficile de faire intervenir des psychologues ou des psychiatres pour les patients en processus d' IMG sans avoir au préalable une reconnaissance de ce qui entoure l'IMG comme spécificités au-delà de la fausse couche. Certains hôpitaux bienveillants ont créé des trajets de soin qui vont dans ce sens, mais c'est coûteux. La bonne collaboration entre plannings familiaux et hôpitaux (par exemple en se référant mutuellement des patientes selon le type anesthésie requis) permet notamment une complémentarité qui compense une petite partie de ces difficultés.

Question : Concernant la confidentialité, si un code INAMI devenait dédié à l'IVG en hôpital, comment faire pour que cela n'apparaisse pas dans le dossier si la patiente le refuse (pour sa propre sécurité, le plus souvent) ?

En complément à cette question de la confidentialité, qui se pose plus largement avec l'informatisation du dossier médical : c'est ainsi que, souvent, tous les actes et résultats obtenus en hôpital sont automatiquement transmis au généraliste.

- On peut confirmer que beaucoup de patientes requièrent de la confidentialité (+ 90% refusent que les informations liées à l'avortement soient transmises au généraliste). Ce problème a déjà été abordé auprès de l'INAMI avec la Commission Nationale d'Evaluation, mais sans qu'apparaisse de solution évidente.

- Les solutions informatiques ne sont jamais totalement sûres dans le temps long. Cependant, un aspect de solution peut être que le partage des données peut être limité à certaines données destinées à certains soignants. Il y a des pistes, mais pas de solution simple.

- Le problème est qu'alors on ampute aussi le dossier d'une partie de l'information médicale.

- Le domaine de la génétique est soumis au même problème quant à la transmission d'informations. Celles-ci ne peuvent pas passer les frontières de l'hôpital, ce qui génère alors des réticences de prise en charge par des médecins extérieurs.

Question : Existe-t-il des codes INAMI différents en hôpital pour les IVG médicamenteuses et chirurgicales ?

- Il n'y a pas de code du tout pour les IVG médicamenteuses, dès lors, ces soins ne sont pas du tout financés. On peut seulement facturer le tiers payant pour l'échographie et les consultations pré- et post-intervention. Certains codes ont même été supprimés pour certains postes, qui autrement revenaient trop cher à la patiente pour pratiquer une IVG en hôpital par rapport à la tarification d'un planning familial. La facturation d'une IVG est d'environ 30€ et cette somme ne rapporte rien à l'hôpital.

- Une possible solution mise en place dans certains hôpitaux est de faire faire la consultation péri-avortement par des sage-femmes, ce qui permet un autre système de tarification (en tant que consultation prénatale).

Question : Une proposition qui a été faite en amont de cette discussion est d'assimiler les demandes d'avortement au-delà de 12 semaines à des demandes d'interruption de grossesse pour raisons médicales. Or, vu les soucis mentionnés ci-avant quant au financement des avortements (à la demande ou médicaux) en hôpital, cela semble contradictoire, et peut déboucher sur un alourdissement des procédures.

- Les IVG de moins de 12 semaines sont actuellement mieux prises en charge dans les centres d'avortement extra-hospitaliers. Cependant, pour les IVG au-delà de 12 semaines (dans l'hypothèse d'une extension de la loi), il est dangereux de les pratiquer en centre extra-hospitalier. Mais il est vrai que la prise en charge par les hôpitaux pourrait poser des problèmes. On peut estimer le nombre nécessaire de ces IVG au-delà de 12 semaines à environ 500 par an. L'idéal serait donc d'avoir des centres habilités à prendre en charge ces IVG tardives – de manière distincte de l'IMG. Une autre solution est de reprendre ces IVG tardives comme étant issues d'une détresse psycho-sociale et ainsi à les intégrer à la régulation existante pour les IMG. Le problème est alors que des IVG seraient autorisées au-delà de la viabilité (puisque c'est autorisé pour les IMG). Les avortements motivés par des causes psycho-sociales devraient dès lors être limités en temps à un âge gestationnel en dessous du seuil de viabilité (contrairement à l'IMG actuelle – qui pourrait alors être réduite à la viabilité aussi). Ces réflexions montrent qu'il est aussi utile de développer et repréciser la loi sur IMG pour surtout améliorer la prise en charge.

- Le risque de cette approche qui associe les IVG de plus de 12 semaines à des IMG est de conditionner l'approbation au caractère subjectif de la demande de la patiente, ce qui pourrait amener des refus de soin d'avortement sans grand besoin de les justifier. Les avortements de plus de 12 semaines pour motif psychologique ou psychiatrique rentrent déjà dans le cadre des IMG puisqu'on établit l'existence d'une situation pathologique. Juger de la situation sociale en revanche est plus difficile et le risque majeur est de laisser le médecin interpréter et juger des conditions sociales de la patiente. Or, la pratique de l'avortement volontaire devrait être centrée sur la volonté de la patiente, sans qu'une intervention extérieure vienne évaluer la légitimité de cette demande.

- La nécessité d'une approbation équivaudrait à ramener la notion de situation de détresse comme l'évoquait la loi de 1990. Pour l'IMG, il est possible de faire appel à une Commission éthique, qui peut établir les cas spécifiques où la préservation de la santé est ce qui doit primer (il est possible pour cela de se baser sur la définition de la santé établie par l'OMS, qui est très large). Pour l'IVG, il est nécessaire en revanche de sécuriser la demande de la patiente sans faire intervenir l'arbitraire de la perspective philosophique d'un médecin ou d'un autre intervenant.

Question : Il a été évoqué dans les demandes d'exprimer dans la loi l'âge de grossesse en semaines d'aménorrhée, qui est l'usage médical le plus répandu, plutôt qu'en semaines post-conception et ainsi d'éviter tout risque de confusion. Mais, dans la réalité, il y a un risque que cela représente une diminution concrète du délai pour les femmes avec des cycles menstruels longs (par exemple les femmes souffrant d'ovaires polykystiques qui représentent 10% des femmes). Les semaines de différence (entre semaines PC et SA) leur seront préjudiciables puisque cela peut représenter chez ces femmes plus que les deux semaines de moyenne qui sont ajoutées entre aménorrhée et conception.

- It should be noted that the Belgian law lies on the concept of conception to define gestational age. Any change with this regards means that we would have to change a lot of other laws if we prefer calculation from last menstrual period) (for instance the law on the declaration of stillbirth; law on embryo selection; ...).

- Il y a un besoin de clarification, quel que soit le terme choisi au final.

- En effet, la nécessité de définir plus clairement les termes employés dans la loi est évidente.

Question : Quelle est la situation actuelle de l'objection de conscience actuellement dans la pratique de l'avortement en Belgique : quelle proportion de médecins cela représente-t-il ? Avec quelles éventuelles difficultés ?

- L'enjeu est compliqué, comme en témoigne le cas de l'Italie. Mais il semble difficile d'obliger les praticiens à pratique l'avortement, ne fût-ce que par considération pour ce que serait l'expérience de patientes entre leurs mains. Faire intervenir des sage-femmes dans l'avortement peut être une réponse : conscientes des enjeux, elles peuvent être plus motivées à pratiquer des IVG. La question se pose aussi avec les interventions des anesthésistes pour les avortements. La situation s'est améliorée, mais la collaboration reste difficile avec cette profession (malgré qu'il existe une clause à signer dans leur contrat). Une discussion en cours est que tout le personnel qui est amené à travailler au bloc IVG devrait être en faveur de la pratique de l'avortement.

- On ne constate pas de grandes difficultés avec l'objection de conscience en Belgique, mais il est nécessaire de respecter aussi le choix des soignants. L'une des difficultés rencontrées est la difficulté éthique d'anesthésier une mineure sans autorisation des parents. Il serait utile d'avoir un texte pour protéger les médecins anesthésistes à cet égard.

- Il y a bien une disposition de l'Ordre des médecins qui autorise à anesthésier / intervenir si le ou la mineure est capable de discernement. Donc les médecins sont déjà couverts légalement. Mais cela n'empêche pas les craintes sur le terrain…

- L'objection de conscience est parfois un problème, car certains plannings familiaux ont aussi en leur sein des objecteurs de conscience. Cela complique l'accès à l'avortement au sein de ces plannings (un en particulier est cité), qui renvoient vers un hôpital ou vers un autre

planning lorsque les praticiens objecteurs ne veulent pas intervenir. On peut postuler que le problème doit être similaire dans les hôpitaux.

Question : Quelles sont les possibilités d'anesthésies (locale, générale…) en hôpital pour l'IVG ?

- Au CHU Saint-Pierre, les IVG ne sont pas pratiquées sous anesthésies locales. Ce choix s'explique par le fait que le contexte est angoissant (salle d'op, lumières, blouses vertes d'opération, personnes inconnues…). En outre, le personnel n'est pas formé pour traiter une patiente consciente. Si c'est demandé par la patiente, elle est référée vers un planning. Régulièrement, une rencontre est organisée avec le responsable du service anesthésie pour dessiner le trajet de soin, tandis qu'un examen de la loi est fait avec un juriste. Ces rencontres ont notamment permis d'établir que pour les patientes mineuses, une consultation pré anesthésie est organisée et que c'est un médecin senior qui réalise l'IVG.

Question : Serait-il envisageable que des remboursements tels que ceux obtenus dans les centres d'avortement soient donnés aux hôpitaux pour les IVG réalisées sous anesthésie générale ? Ce serait ainsi le choix du type d'anesthésie qui présiderait au choix, et déterminerait le forfait (cela pourrait intervenir dans le cadre de la convention INAMI plutôt que dans celui de la loi). Les autres formes de facturation resteraient de l'ordre de la liberté de l'hôpital, avec un financement classique.

- C'est une excellente idée pour les interruptions du 1er trimestre. Actuellement ce sont des sédations assez superficielles qui sont employées.

- il peut cependant y avoir d'autres raisons que l'anesthésie pour faire une IVG en hôpital (comme l'existence d'une pathologie). Il faut aussi prendre en considération la possibilité de sédations légères autres que la bipartition anesthésie locale/générale (comme la « conscious sedation » largement utilisée pour les avortements aux Pays-Bas et Royaume-Uni).

---

g) National Evaluation Commission : Sylvie Lausberg and Mario Van Essche (co-presidents)

ZWA | Stuurgroep van het interuniversitair, multidisciplinair en onafhankelijk comité belast met de studie en de evaluatie van de praktijk en de wetgeving inzake vrijwillige zwangerschapsafbreking
IVG | Groupe de pilotage du comité interuniversitaire multidisciplinaire indépendant en charge de l'étude et de l'évaluation de la pratique et de la législation sur l'Interruption Volontaire de Grossesse

Hearing of the National Commission of Evaluation

15/09/2022

Present :

Sylvie Lausberg, co-president of the Commission
Mario Van Essche, co-president of the Commission
Anne Verougstraete (WG1)
Yvon Englert
Kristien Roelens
Aurélie Aromatario

1. Current situation : evaluation

The first statement is that the Commission has limited and determined missions : it doesn't include an evaluation of the situation of abortion practice in abortion centers but is rather about analyzing and commenting statistics and data gathered about abortion practice. Another aspect is the formulation of recommendations to reduce the number of abortion procedures and improve the care of women requesting abortion.

These missions should be connected to the context in which the 1990 abortion law appeared: it was feared that creating legal conditions to provide abortion procedures would create an influx of abortion requests. Yet, it has been observed that the abortion rate has remained quite stable and low in the last decades.

> Remark (YE) : Usual practice to provide the abortion rate is to calculate it by 1000 women in fertile age (15-44 yo). It is also possible to provide a rate per 100 000 live births, which takes into account the possible variations in terms of natality.

There has been a gap of 6 years without any meeting of the Commission, because of the impossibility to renew the board of members in 2011. Renewal of the members in 2017 was based on their interest for the practice of abortion and will to commit to the evaluation process rather than by political affiliation as it was the case before, with the purpose to represent all kinds of philosophical and political views. Law from the 16th of June 2016 has indeed changed the rules of composition of the Commission.

The Commission always offers a possibility to mention minority opinions, that are mentioned as such, in order to reflect all positions from all of its members.

Work has been resumed in 2017 with the purpose to summarize the situation in Belgium for the previous 6 years.

Then appeared the legal change on abortion in 2018 : it has had impacts on the data sent by the Commission to the Parliament, as well as on the form that the doctors must fill in for abortion procedures. The Commission has also been working on communicating the legal changes to the abortion practitioners :

- Change in terms of waiting period (possibility to shorten it)
- Suppression of article 383 prohibiting advertising abortion → the Commission has advised providing information campaigns that were impossible before that (as a prevention strategy, notably to avoid abortions after 12 weeks)

2. Abortion practice in hospital and abortion centers

It is difficult to obtain data and reporting from abortion procedures performed in hospitals. Several factors can explain this difficulty :

- Hospitals don't have inner reporting nor specific invoicing nomenclature mentioning abortion (they usually invoice curettage and ultrasound)
- They don't always fill in the reporting documents from the Commission

An INAMI/RIZIV code could solve this issue : data then could be obtained from INAMI/RIZIV

The Commission also recommends to officially recognize psycho-social counselling, finance it and organize it in hospitals. Currently, it is often done by roughly patching up different services and professionals.

Abortion centers, on the other hand, are very diligent in filling in the reports. Most of the abortion centers have an INAMI/RIZIV convention that allows them to obtain direct reimbursements. A few of them works without such convention and are funded for each medical act.

The gaps in the reporting are a major issue for the Commission: data and reporting are the core of its work. Having an overview of the actual abortion procedures that have been performed is also essential. Removing the obligation to provide a motive for abortion is a positive evolution.

3. Roles and missions of the Commission

Remark (YE) : motives for abortion procedures is a most subtle and difficult thing to assess. Maybe it would be more accurately reflected with ad hoc transversal periodic studies (for instance, for 6 months every 5 years).

It is currently not possible for the Commission to obtain such studies, because it is not organized nor funded for that work.

A possibility would be to reduce the workload in terms of manual data collection and make it more systematic among abortion practitioners (improve the system based on the current experience of what works/doesn't work, on the model of the national registration of births)

The Commission's missions should also be adapted to current realities: the Commission is still supposed to assess the profiles and situations of women requesting an abortion, although the notion of "state of distress" has been removed in 2018 (this is notably assessed through the form, trying to understand the causes of the unwanted pregnancy and the state of distress).

The Commission defends the idea that any woman should have access to abortion if she needs one.

> Remark (AV) : in the Netherlands, it was assessed that abortion rates were higher in specific communities or among people with determined socio-demographic characteristics : these observations allow working on information campaigns dedicated to certain profiles.

The central question is : what should be measured and assessed ? and when ? (all the time or on specific periodicity)

Prevention is also part of the Commission's missions : it is observed that contraceptive coverage is already very good and helps to prevent unwanted pregnancies.

For instance, the Commission has contributed in spreading information about the recommended use of hormonal IUD (Mirena) for nulliparous women – which has contributed in lowering the number of abortion procedures among women of 29 y o and less.

The Commission has at heart to reflect to the political world an accurate and non-prejudiced vision of abortion care. Yet, a context in which abortion is still criminalized is not serene enough : there is always a subjacent fear that, if the paperwork is not done properly, there could be legal pursuits.

(sanctions in case of incorrect/incomplete reporting should be avoided at all costs : it would reduce access to abortion by fear of sanctions from abortion practitioners.)

Should the Commission be a qualitative or consultative or representative organ ? Should it provide analysis or representation of civil society ?

4. Composition of the Commission

It would be useful to pursue this type of work through scientific studies (with epidemiologists, social scientists, demographers, etc.). Those persons should be hired full time for the studies, to provide thorough work – which is difficult with the current configuration.

People working with the commission are :

- 32 members (16 effective + 16 alternate – all can attend the meetings)
  They are volunteers with other full-time positions, who receive attendance fees
  (2 legal experts, 4 doctors, 2 workers from abortion centers = 8 for each linguistic community, making 16 persons in total).
- Administrative workers (they collect and gather the data)
- 2 co-presidents (they analyze the data gathered by the employees)

There is up to 12 meetings / year.

There is still a lack of applications to become member of the Commission.

The members of the Commission are appointed, by royal decree deliberated in the Council of Ministers, on a double list presented by the House of Representatives, in compliance with linguistic parity and pluralist representation.

There is a recurring question about whether or not the Commission should be representative of the philosophico-political orientations composing the society? Co-presidents of the Commission are of the opinion that this is a condition for the Parliament to be democratic but not the role of the Commission. On the other hand, the Commission is careful about representing the opinion of all its members, even when it's a minority opinion (then presented as such).

As an example, a study from the Federatie Vrijzinnige Centra indicates that a majority (60%) of the population is in favor of lawful abortion and its availability. In the Parliament, a lot of parties are in favor of restricting access to abortion, totalizing more than 60% of the political world : this demonstrates a form of discrepancy in representativeness.

Yet, this pretext of the Commission being not representative has been used notably through a law proposal to suppress it entirely.

> Question (YE) : would a number of 16 members (8 effective + 8 alternate) be enough ? With the possibility to delegate the analysis to university departments (of demography, for instance) or Sciensano, who has expertise as a state center for research and science.

A Commission composed of specialists would include more or less the same people who are already members : current members are those who are already actively involved in the field of abortion practice. It is because of that experience and the recurrent confrontation with women requesting abortion that they are in favor of improving access to abortion.

The missions of the Commission cover discussions about the state of the scientific debate (for instance : criteria of viability). However, they do not include decisions/recommendations about what should be decided in the political arena. Those political aspects include for instance the aspects of the waiting period or criminalization of abortion.

Missions have also evolved through time, together with the kind of data to collect and its purpose (notably through changes in the registration form for abortion procedures, the suppression of the notion of state of distress…)

> Question (YE) : Initially, the idea underlying in the creation of the Commission was that abortion is a problem and that recourse to it should be as minimal as possible. Data was collected with a purpose of prevention and reduction (or eradication) of the practice of abortion. On the other hand, there is also data collection about medical acts that are considered expensive in the global health care budget (medical imaging, dialysis, transplantation surgery, …) or when there are questions of contamination and public health at stake (AIDS, COVID…).

To answer this, the Commission notes that stigma towards abortion and making women guilty for requesting an abortion procedure only increases the abortion rates and worsen the situation. We need

laws that do not aim at lowering abortion rates (nor increasing it). Yet, several recourses to the State Council in the last years (about decriminalization, waiting period…) were requested by fear that those measures would impact the number of abortion requests.

The current situation should be taken into account : the abortion rate in Belgium is already very low and stable, it doesn't seem necessary to include the reduction of abortion requests in the missions of the Commission.

The focus should no longer be on moral aspects but rather on qualitative care : improvement of patient intake, of the trajectory of care, counselling, access to abortion care…

Law from 13/08 1990 (see p. 126; §3 of the report 2019-2020) that instates the Commission already indicates that the mission of reduction of abortion is a facultative mission.

The expertise and qualification of the members of the Commission need to be recognized and valorized (most of them are doctors) and dedicating budgets for scientific studies by university departments of SPF/FOD Health could constitute a mean of recognition.

> Remark (KR) : Insistence should be on the already low rates of abortion in Belgium and on the need to have a qualitative context to take in the actual abortion requests

The content of the reporting forms is a good reflection of the Commission's missions and their evolution. At first, the motives for the abortion request were needed in order to demonstrate the state of distress. But in the current context, a list of boxes to tick is maybe not the best way to do so. And doctors performing abortions lack the time and will to commit to analyze those abortion motives with the patient. Other sections are supposed to draw the attention of the doctor on sensitive points: for instance, there is a section asking if the patient agrees with sending the ToP file to her GP. The goal is to draw attention from the abortion practitioner to the potential confidentiality stakes for the patient and to the fact that transmission of a ToP file should not be automatic. A box indicating the age of the pregnancy at the moment of the abortion request is a recent addition. It has helped demonstrate that abortion requests are happening at earlier stages of the pregnancy, making recourse to VEMA[11] techniques necessary.

A way to acknowledge and improve the role of expertise of the Commission would be to give it a status similar to the Bioethics Committee. With this purpose in mind, the addition of expert profiles, in philosophy for instance, could be helpful.

The Commission is sometimes asked to answer parliamentary questions but they have to refuse : The jurisdiction of the Commission is determined by the law that establishes it. Answering parliamentary questions, both materially and formally, does not fall within its competence as defined by law.

Any legal revision should keep the perspective of not adding administrative or legal burdens to the doctors involved in abortion practice : it should aim for a better quality of care for the patient rather than for increased control over the doctors. The 2018 law goes in that direction, by focusing on a decision process based on the pregnant women, who is assisted and supported by the psycho-socio-

[11] Very Early Medical Abortion techniques

medical team. The sampling and data currently obtained via the Commission's forms are already quite satisfying.

The Commission also recommends splitting the law and distinguish on the one hand what is related to medical abortion and on the other hand what is related to elective abortion with regard to the roles of the Evaluation Commission.

> Remark (YE) : There may be a risk that, by splitting the law, access could be more restrictive for medical and/or elective abortion.

h) INAMI/RIZIV representatives

ZWA | Stuurgroep van het interuniversitair, multidisciplinair en onafhankelijk comité belast met de studie en de evaluatie van de praktijk en de wetgeving inzake vrijwillige zwangerschapsafbreking

IVG | Groupe de pilotage du comité interuniversitaire multidisciplinaire indépendant en charge de l'étude et de l'évaluation de la pratique et de la législation sur l'Interruption Volontaire de Grossesse

Meeting RIZIV-INAMI: Exchange about abortion practice, financing and regulations

Present: - INAMI/RIZIV representatives, including director Benoît Collin.

- Interuniversity Committee Evaluating Abortion Law and Practice: Yvon Englert (ULB, Co-Président) Kristien Roelens (UGent, Co-Président) Anne Verougstraete (VUB) Aurelie Aromatario (Scientific Collaborator)

- **Introduction :**
  Background to the 'Interuniversity Committee Evaluating Abortion Law and Practice'
  Goals of this exchange

General context : INAMI/RIZIV and the conventions with abortion centres

- How and when were the conventions drafted and by who (INAMI/RIZIV alone or was there an input from the political level? Who has a power of decision at the INAMI/RIZIV level ?)
- What is the status of the conventions emitted by the RIZIV-INAMI: what is the balance between an autonomous position and the government/federal laws?

No decision comes in from the ministry : the INAMI/RIZIV conventions can stem from specific laws or agreements or needs that appear from the field.

The board of director doctors can make proposals, and find agreement together with the insurance committee who proposes a budget.

When it comes to attributing a convention to an abortion center, the decisions are based on the conditions of the convention and the budget attributed to the sector (which doesn't have an upper limit – although it is quite stable).

An observation from the field underlines that there are important contrasts between the communities : in the Dutch-speaking community, the Luna centers have a centralized approach of the skills and competences with a focus on ToP, while in the French-speaking community, the Centres de Planning Familial have an integrated approach, offering abortion care among other health and prevention services.

Abortion conventions provide a reimbursement in two steps :

In 2021 :

17249 prestation for 2 first phases

14495 prestation for 2 last phases

With a 7 500 000 € budget

> NB : hospitals do not use the same nomenclature – medical acts related to abortion are not registered the same way.

In 2019 : 2885 abortion in hospitals (evaluation commission) – but there is a possibility that some have not been registered.

Among abortion centers, no new convention has been attributed for the 10 last years due to a decision from the INAMI/RIZIV stating that the necessity was not obvious. The existing coverage and geographical repartition are also taken into account (6 centers in Flanders, over 30 for Brussels and Wallonia).

> Remark : emitting a convention for a new center would not lead to an increased budget for abortion but more likely to a different repartition of a similar number of abortion procedures. The budget dedicated to abortion reimbursement is not defined nor closed.

The budget allocated to abortion centers and the reimbursement of abortion procedures would however increase if the gestational age limit were to be augmented, with the need to create new dedicated centers.

These potential new centers (hospitals or departments adjacent to hospitals) should be validated with a convention according to INAMI/RIZIV. Then a budget should be validated to support these new services. It would require to create a specific convention for abortion after 12 weeks.

- **Points to discuss**

1. **Content of the convention** 'Revalidatieovereenkomst Betreffende Medisch-Psycho-Sociale Begeleiding Bij Ongewenste Zwangerschap' / 'Convention De Rééducation Concernant L'accompagnement Médico Psycho-Social En Cas De Grossesse Non Désirée'

Background: Changes to the 2018 law + changes in practice following covid19 crisis + growing importance of medication abortion.

This context of change explains that there a various pending request from abortion clinics/centres to update convention notably on the following topics :

- Remote psycho-social consultation
- Distribution of abortion medicine
  - Overlapping rules from the 2018 law on voluntary termination of pregnancy, INAMI/RIZIV, the royal decree (KB 2000 myfegine) and medicine label indications
  - Convention for abortion centres with hospital pharmacy

- Remote intake of second phase of abortion pill procedure (misoprostol): position of INAMI/RIZIV
- Role for midwives/nurses in administering medication (currently only allowed for 'doctors' according to the KB/AR)

Based on the experience from the COVID crisis and from protocols in use in other countries : it is considered good practice to have the 2nd phase (Cytotec) at home for the patient if it is wished by the patient (otherwise it should always be possible at the abortion center).

> Nb : the protocols used during the COVID situation were not formally validated but were legitimated by a crisis context

This point has already been asked by the LUNA federation – and is still under investigation.

This principle is also supported by the need to facilitate very early abortions.

Currently, there must be 4 different appointments for a medical abortion – this doesn't facilitate the use of medical abortion.

The request is mainly to extend the use of remote consultations as well as the remote intake of Cytotec : this could be reviewed in the context of a global amendment of the convention.

Regarding the role of nurses and midwives : there is a possibility to extend the scope of their responsibilities and competences. However, this decision is under the responsibility of the ministry of health. This kind of negotiation would be to allow them to supervise medical abortions.

Currently, the prescription of contraception up to 6 months post-partum is allowed for labor and delivery nurses ("infirmières accoucheuses").

2. Sedation and anaesthesia

Background: refusal (?) of INAMI/RIZIV to practice and/or reimburse light sedatives used by abortion clinics + reluctance from the Professional associations of anaesthesiology (BeSARPP and BSAR/APSAR)

Possibility to use sedative substances without anaesthetist (midazolam / propofol / fentanyl) in extra-hospital centres: discuss procedure of discussion and position INAMI/RIZIV

The main issue is a problem of distribution :

Some medicines are only authorized for distribution in hospital pharmacy : this decision stems from the AFMPS or the more specifically the "commission des médicaments à usage humain" (which is part of the AFMPS).

Some restrictions can be emitted for the distribution or for the reimbursement of the medication, which is why mifegyne but also substances for sedation are not allowed outside of distribution from hospital pharmacy.

> NB : this should not be an issue for midazolam

There is a possibility to create a new legal framework, similar to the royal decree on Mifegyne distribution. However, it regulates the distribution, but not the reimbursement of the medicine.

It seems pertinent to implement the possibility to reimburse midazolam with a distribution from hospital pharmacy and with use of the product outside of hospital (as in the case of abortion centers).

AFMPS is a key actor defining those aspects : there should be a possibility to renegotiate with them the convention and add of the possibility for the use of sedation medication in outpatient abortion centers.

The distribution of Mifegyne is also considered as too strict (regulated by the royal decree from 2000): it could beneficiate from more flexibility and adaptation.

The same adaptation as mentioned above should be planned for the use of Mifegyne in case of miscarriage – although the medication is not planned for this use (but it is recommended by international guidelines).

3. Confidentiality

Background: issues ensuing from digitalization and centralization of the medical files: Reimbursement and codes appearing on statement: contraception, abortion, ultrasound, blood samples (hcg)…

The initial convention was using “pseudo codes” of reimbursement for health insurance : they would not appear in the reports of reimbursement by health insurance.

The digitalization made the codes reappear. In addition, with current means of communication and information, it is also easily possible to look up the meaning of the code online and understand that it was associated with an abortion procedure.

It raises a series of problems : the GP or other doctors would know about the abortion intervention. The same goes for the owner of the health insurance account (husband, father, other member of the family).

> NB : For underage patients, the responsibility of the doctor is to assess their ability for decision and autonomy – but also the need to inform a caretaker if the doctor finds it necessary. They can undergo an abortion procedure without the parents knowing about it under those conditions.

The INAMI/RIZIV is well aware of these issues. It also extends to visits with some specialists, or medication regime.

A possible solution exists : a totally free intervention in the current system could be untraceable. However, legal negotiations are currently happening that might change this system.

This is a complex issue that would require a case by case solution. There is no clear solution.

The ideal solution would be to create an administrative “black box” where information doesn’t appear for medical care such as

- Gynecological care (abortion, contraception, …)
- Psychiatry
- Fertility treatments
- Addiction treatments
- …

4. **Current absence of reimbursement** of multidisciplinary discussions in hospital about foetal diagnosis (cf. COM) and weakness in registrations (National Evaluation Commission) by hospitals

Background: multidisciplinary discussions are considered crucial, but require working hours and efforts from staff

Discuss: what is required by INAMI/RIZIV to consider a reimbursement similar to the COM[12] system ?

(For instance, in the conventions signed with abortion centres, the reimbursement can be linked to an official registration of the termination of pregnancy with the National Evaluation Commission regarding the termination of pregnancy, which helps achieve the goal of proper registration of terminations op pregnancy).

The context in which a wanted pregnancy has to be interrupted for medical indication is quite specific (whether it is for maternal or foetal reason). It would be an asset to create at the INAMI/RIZIV level a code of nomenclature for a multidisciplinary discussion of this type : it is a possibility to envision.

Terminations o pregnancy for medical indication are not sufficiently registered in hospital. There are probably two main reasons for that :

- it is not "IVG" (elective abortion) and, as a consequence, doctors don't see the need to register it.
- There is currently no nomenclature for the medical acts related to terminations of pregnancy in hospitals : only "curettage" or anaesthesia forfeits can be used, whereas in case of medical abortion after 22 weeks, it is invoiced as a delivery.

A system similar to the COM would solve the registration and financial issue. But it would add a confidentiality issue.

According to INAMI/RIZIV, it is possible to use pseudonyms for the patient's name. In addition, COM-type invoices are not sent to the patient : few people would see the report of the COM.

NB : a process similar to the COM exists for psychiatry

[12] Consultation Oncologique Multidisciplinaire.

5. Collaboration between hospitals and abortion centres

Background: abortions are performed both in hospitals and centres. Only centres have an abortion-specific convention for reimbursement.

Yet, there are multiples collaboration lines for medications, abortion under general anaesthesia, complications. It would be possible to make the convention simpler:

- If the mifegyne is no longer to be obtained from a hospital pharmacy
- If the collaboration rule with hospitals is simplified
- If centres can use sedation and then take in some abortions that were previously taken in hospitals

Annexe/bijlage IV : Reports from the working groups

a) Working group 1 : Current functioning and potential improvements in centers and hospitals regarding elective termination of pregnancy within the current gestational age limit, including prevention and follow-up issues.

1. Voluntary termination of pregnancy in Belgium : missions and processes

1.1. Brief history

- 1973: l'affaire Peers (gynécologue de Namur incarcéré pendant 34 jours en 1973 pour pratique illégale d'IVG). Il n'a jamais été condamné.
- 3 avril 1990: Loi dépénalisant partiellement l'avortement
- 2002-2003: les centres extra-hospitaliers signent une convention avec l'INAMI qui permet de rembourser l'IVG dans les centres
- 2018 : légères adaptations de la loi

17 ans après l'incarcération du gynécologue Willy Peers en 1973, une loi dépénalisant partiellement l'avortement a finalement vu le jour le 3 avril 1990 après des années de manifestations, de procès et de condamnations pour avortement illégal.

- Dans la majorité des pays, un avortement illégal est cher et souvent dangereux. En Belgique, ce n'était pas le cas : Porté par mai 68 et le mouvement féministe des années 70, soutenu par l'ULB et la VUB, un groupe de médecins et leurs sympathisants ont décidé d'enfreindre la loi et de faire des IVGs pour peu d'argent, dans de bonnes conditions médicales.
- **Hôpitaux** : Willy Peers, le Prof Hubinon (ULB) et le Prof JJ Amy (VUB) tous respectés pour leur intégrité morale en ont été les figures de proue dans les hôpitaux. Du côté francophone, plusieurs hôpitaux ont décidé de faire des IVG . Du coté néerlandophone l'AZ-VUB était seule à en faire à partir de 1977.
- **Centres extra-hospitaliers** : Du côté francophone, dès 1975 certains centres de planning décident de faire des IVG à Bruxelles. Ils se regroupent en 1979 et créent le GACEHPA (Groupe d'Action des Centres Extra-Hospitaliers Pratiquant l'Avortement). Du côté néerlandophone, création du CCNAC (Centrale Coordinatie van Nederlandstalige Abortus Centra) en 1980; le KAC (Kollectief Anti Conceptie) de Gand et CEVO Brussel font des IVG dans des « abortuscentra » avec l'appui de STIMEZO aux Pays Bas et sur le même modèle que cette organisation : un réseau de généralistes, de gynécologues et de centres de plannings flamands (CGSO) leur réfèrent les femmes qui veulent une IVG.

- **C'est ainsi qu'il y a actuellement 33 centres extrahospitaliers pratiquant l'IVG du côté francophone) (8358 IVG en 2019) (dont 1 lié à un hôpital) et 7 centres du côté néerlandophone (7732 IVG en2019).(dont 1 lié à un hôpital). En 2019, 8358 IVG ont été réalisées du côté francophone et 7732 du côté néerlandophone. La convention INAMI (uniquement possible pour les centres qui font les IVG en extra-hospitalier) concerne 32 centres francophones et 5 centres flamands.**

Que dit la loi de 1990 : Toute femme enceinte que son état place en situation de détresse, peut demander à un médecin d'interrompre sa grossesse. l'IVG doit avoir lieu avant la fin de la 12ème semaine de la conception (=14 sem. DR) dans un établissement de soin où existe un service d'information (accueil, soutien psychologique, information concernant ses droits aux aides si elle reste enceinte, envisager l'adoption), après un délai de réflexion de 6 jours. La femme doit bénéficier d'une information en matière de contraception. Les mineures (<18 ans) n'ont pas besoin de l'autorisation de leurs parents. Aucun médecin ne peut être obligé à pratiquer une IVG, mais il est tenu d'en informer la patiente dès la première visite. Tous les deux ans une commission d'évaluation, chargée de surveiller l'application de la loi, doit présenter un rapport au parlement.

Que dit la loi de 2018 : La loi de 2018 prévoit quelques assouplissements :

La notion de « **détresse** » disparait . Le médecin ne peut au plus tôt, pratiquer l'IVG que 6 jours après la première consultation, **sauf s'il existe une raison médicale urgente**. Si la première consultation a lieu moins de six jours avant l'échéance du délai, ce délai est prolongé au prorata du nombre de jours non écoulés du délai de six jours. Toutefois lorsque le dernier jour de cette prolongation est un samedi, un dimanche ou un jour férié légal, l'interruption de grossesse peut être pratiquée le jour ouvrable suivant. Le médecin sollicité est tenu d'informer, dès la première visite, de son refus d'intervention. Il indique dans ce cas les coordonnées d'un autre médecin, d'un centre d'interruption de grossesse ou d'un service hospitalier qu'elle peut solliciter pour une nouvelle demande d'interruption de grossesse. Le médecin qui refuse l'interruption volontaire transmet le dossier médical au nouveau médecin consulté par la femme. Il n'est plus illégal de donner des informations concernant l'IVG et où l'obtenir.

Disposition pénale : L'IVG reste dans le code pénal si les conditions de la loi ne sont pas respectées. Également punissable, le délit d'entrave : Celui qui tente d'empêcher une femme d'accéder librement à un établissement de soins pratiquant des interruptions volontaires de grossesse sera condamné à un emprisonnement de trois mois à un an et à une amende de cent euros à cinq cents euros.

1.2. Voluntary termination of pregnancy in Federation Wallonia-Brussels and the Flemish region

1.2.1. Steps of the process in abortion centers

First contact

The patient contacts the abortion center by phone, mail or in presence (depending on the centers). This first contact may be spontaneous or the patient may be referred by a health professional this allows to arrange a first appointment.

Psychosocial consultation

During this consultation, various topics can be discussed in details : an overview of the personal and social context, of the desire for children, couple status, the possible personal difficulties and potential help and welfare possibilities (…). The various options regarding the pregnancy (termination or not) and of the options in case of a continuation of the pregnancy are also discussed, as well as the topic of contraception (in inquiring what led to an unwanted pregnancy, current contraceptive use, future needs regarding the personal situation etc.). Abortion methods are presented in details, together with the afferent procedures, costs, conditions of realization.

Medical consultation

The first appointment includes a medical examination, encompassing medical anamnesis, gynecological examination, ultrasound as well as possible additional tests at the decision of the medical team (STI , blood type for instance).

Depending on the organization of the abortion center, the abortion and the follow up consultation will be done by the same team of professionals (psychosocial worker and doctor) to allow continuity of care or by persons available at the time of the next possible appointment, to avoid additional delay.

Abortion procedure

After the waiting period, the patient is welcomed for a second appointment during which the abortion procedure will be executed. Two methods are then available, depending on the gestational age.

- Medical abortion is currently a protocol usually proposed to the patient if the pregnancy is not older than 7 weeks post conception. It consists in a first phase with intake of Mifepristone and is followed, after a delay of 24 to 48 h, of a second phase with the intake of misoprostol (prostaglandin) at the abortion center or at home.

Surgical abortion by vacuum aspiration (VA) is performed in outpatient abortion centers under local anesthesia. After cervical preparation by misoprostol or by mifepristone, , vacuum aspiration is done using a suction device. The operation, with a duration of about 15 minutes, is followed by a resting time under medical supervision. For some centers, the surgical act is performed in the adjunct hospital (as in the case of Labyrinth with ZNA Antwerpen, or City planning with Hôpital St Pierre). These centers don’t have a convention as conventions are only for centers performing abortions in an outpatient setting. **Follow up**

The procedure can be followed by a final follow up visit. Psychosocial follow up is also offered for the patient who feel a need for it.

1.2.2. Similarities and differences between the regions

The French speaking “Centres de Planning familial” provide not only health care surrounding abortion but also of providing health care surrounding mental and physical health (such as the detection and treatment of STI). They are also in charge of providing information and educative material regarding health, sexuality, reproductive rights, family planning, legal advice, etc. This is done through counselling sessions, documentation and educational animations.

These centers are structured in several Federations following more or less the Belgian pillarized structure. Among those centers, 33 of them perform abortions:

- Fédération laïque de centres de planning familial (FLCPF)
    - 42 centers in total
    - 22 performing abortions
- Fédération des Centres de Planning familial des Femmes Prévoyantes Socialistes (FCPF FPS)
    - 19 centers in total
    - 9 performing abortions
- Fédération des Centres de Planning et de Consultations (FCPC)
    - 17 centers and one secundary office
    - None of them are performing abortions[13]
- Fédération des Centres Pluralistes de Planning Familial (FCPPF)
    - 26 centers in total
    - 2 performing abortions
- Groupe d'Action des Centres Extra hospitaliers Pratiquant l'Avortement (GACEHPA). This group is formed by the abortion centers of the FLCPF and of the FCPPF performing abortions.

In the Flemish region, the abortion clinics are specialized in abortion care and the psychosocial support surrounding the unplanned/unwanted pregnancy and post abortion contraception while the educative missions regarding sexual health are under the scope of Sensoa.

- Several clinics have merged in order to form the LUNA network with Antwerp, Gent, Hasselt and Oostende.
- VUB-Dilemma is connected to the VUB in Brussels and works together with LUNA.
- The Labyrint centrum in Borgerhout is part of the ZNA Sint-Erasmus hospital (abortions are performed in the hospital under general anesthesia ~~,~~ the center doesn't have a convention with RIZIV-INAMI)
- The Abortuscentrum Durmelaan is located in Lokeren (the center doesn't have a convention with RIZIV-INAMI)

The last evaluation commission's report (*Part 2: Annual reports of health care institutions - page 58*) shows that the French-speaking and Dutch-speaking ambulatory abortion centers performed 8358 (75.5% of abortions in French speaking health facilities) and 7732 (98% of abortions in Dutch speaking health facilities) abortions respectively in 2019. The following table indicate the percentage of abortions procedures depending on the type of facility who provided the procedure, with a national province repartition and over the last two registered years.

Province of residence	**Hospital**	**Abortion center**
	2019	
West Flanders	1,81%	98,19%
East Flanders	6,55%	93,45%
Antwerp	1,36%	98,64%
Limburg	0,43%	99,57%
Flemish Brabant	11,31%	88,69%
Brussels	24,78%	75,22%

[13] Some of those centers have requested and INAMI/RIZIV convention in order to perform abortions, but it has been declined due to the existing number of centers in the French speaking region.

Walloon Brabant	19,97%	80,03%
Hainaut	45,26%	54,74%
Namur	23,06%	76,94%
Liège	31,90%	68,10%
Luxemburg	4,12%	95,88%
Abroad	14,53%	85,47%

(Source : Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018)

This repartition indicates another type of contrast between the regions, with the vast majority of abortions in Flanders being provided in abortion clinics, whereas the Brussels and Walloon regions are more subjected to local variations and a significant part of abortions are performed in hospitals. Before abortion was legally regulated, the only abortion providers in Flanders were abortion centers). This situation did not change after abortion was legalized. The Luna network in Flanders is known by patients as the main abortion provider. In Walloon provinces, mainly in Hainaut or Liège, a significant proportion of women contact their regular practitioner and/or local hospital for abortion, in the continuity of their usual gynecological care. The network of family planning centers providing abortion procedures is of a unequal density depending on the province. This is also true regarding hospital and practitioners willing to perform abortions : in the province of Luxemburg, it is a notable fact that very few practitioners provide abortion procedure, which explains that the majority of abortions take place in abortion centers (and, more exactly, in the only abortion center of the province).

1.2.3. Steps of the process in hospitals

The group has chosen not to go through the process in hospitals, due to the fact that there is no standardized protocol similar to the trajectory of care that is found in abortion centers. Abortion practitioners in hospitals are complying with the same legal requirements (informed consent, waiting period, information, quality of care…) as abortion centers. However, due to different agreements with INAMI/RIZIV in terms of invoicing and to internal organization, the trajectories may vary : some hospitals organize a consultation with a psychologist and/or a social worker, whereas in other, the gynecologist is the practitioner in charge of all the consultations. Options in terms of abortion techniques (medical or surgical) and sedation or anesthesia may also vary from one practitioner to another.

The group wishes to underline that, as a consequence, patients cannot know in advance what to expect in terms of trajectory of care and protocols (not to mention the possibility for conscientious objection regarding abortion). Not all hospitals perform abortions. Some hospitals perform abortions since the time of illegality for abortion and continue to help patients who come to them with their unwanted pregnancy. In some structures, patients take an appointment with a gynaecologist, who will refer her to a psychosocial worker in a later appointment. Other hospitals have organized a more integrated care trajectory, similar to Family Planning Centers or abortion centers (in one appointment). Some hospitals work together with a FPC because of their expertise in dealing with unplanned/unwanted pregnancies.

Since the fusion of hospitals, there has been quite some changes in abortion matters. Some hospitals did not perform abortions before, and perform abortions since the fusion; while in other hospitals, abortion care was stopped since the fusion.

Although pregnancy termination should be considered part of standard medical care, many hospitals still do not perform abortions for psychosocial reasons and will only accept abortions for serious medical reasons. While there can be historical reasons for this and while there is adequate expertise available in specialized abortion centres, the segregation of this care from other care can be perceived as stigmatizing.

There is a clear lack of knowledge among some gynaecologists concerning the abortion law: some think abortion is allowed only up to 12 weeks since LMP; others don't know the 6 days can be shortened for medical reasons; still others don't know the law obliges them to help patients in finding a place where they can get an abortion: "zoek het zelf maar uit; ik ga u daar niet bij helpen"!

Most abortions in hospital are done under general anaesthesia (some patients and some general practitioners know this so that patients who want a general anaesthesia will rather directly take an appointment in a hospital in Brussels and the Walloon region). It would be a great help for women if they knew in which hospitals they can be helped!

2. The process of abortion

The first step consists in meeting with the patient requesting abortion and have an individualized discussion through which the patient's will and needs are assessed according to their personal and medical history. The psychosocial interview is followed by a medical examination that will assess the age of the pregnancy, eventual medical conditions and the abortion method(s) to envision and sometimes perform some tests (detection of STI, blood type).

In agreement with the woman, the intervention is planned, after at least the 6 days waiting period. Depending on the local team's organization, it is either with the same team who has made the first consultation (pair of doctor and psycho-social worker) either with the team available at the moment of the appointment – in order not to add unnecessary delay.

The choice of medical or surgical abortion is determined by medical aspects, such as the gestational age but also by the preference of the patient as well as by other determinants (psychological aspects, socio-economic considerations such as necessary leave from work …). Almost all family planning centers performing abortions and abortion clinics have an INAMI/RIZIV convention. This convention is only possible for centers performing their abortions in outpatient facilities (that is why centers that perform the abortions in hospital, don't have a convention). This INAMI/RIZIV convention stipulates the need to have a convention with at least 1 hospital.

Art. 9. Het Centrum heeft ten allen tijde met de dienst gynaecologie van minstens één ziekenhuis naar keuze een samenwerkingsovereenkomst, met een uitgewerkt schriftelijk protocol waarin de inhoud en vorm van de samenwerking concreet organisatorisch uitgewerkt worden.

De samenwerking in haar geheel heeft ten minste betrekking op:

1. de modaliteiten voor dringende opvang door het ziekenhuis van elke rechthebbende bij wie er complicaties optreden tijdens of onmiddellijk na de zwangerschapsafbreking in het Centrum die daar niet ter plaatse kunnen behandeld worden;
2. de modaliteiten voor opvang door het ziekenhuis van elke rechthebbende van wie het Centrum vermoedt dat het voltooien van de zwangerschap een ernstig gevaar inhoudt voor de gezondheid of dat het kind dat geboren zal worden, zal lijden aan een uiterst zware kwaal die als ongeneeslijk wordt erkend op het ogenblik van de eventuele diagnose;
3. de modaliteiten voor opvang door het ziekenhuis van elke rechthebbende die een zwangerschapsafbreking wenst onder volledige verdoving of bij wie een zwangerschapsafbreking slechts kan gebeuren onder het toezicht van een arts-specialist in de anesthesiologie;
4. de modaliteiten voor opvang door het Centrum van elke rechthebbende die door het ziekenhuis gestuurd is daar dit oordeelt dat deze meer psychosociale opvang en begeleiding nodig heeft dan het ziekenhuis kan geven.

It is also through this convention that centers performing abortions get Mifegyne from the hospital pharmacy, and can send patients in case of medical complications. In case general anesthesia is needed, or in case patients have serious health problems and need an abortion in hospital, some centers need to have a convention with a second hospital that agrees to do these abortions (because the first hospital with which they have a convention does not accept to perform abortions).

A follow up appointment can be planned after the abortion procedure. This follow up is offered at the wish of the patient, in order to discuss and check her medical state, her psychological state if needed and discuss the contraception initiated at the time of the abortion. It should be noted that a majority of patient doesn't show up for the follow up appointment. Additional appointments can also be arranged if the patient feels the need to do so. Since the COVID crisis, follow up consultations are also offered under the form of a video or telephonic consultation. This possibility should be maintained.

Two main aspects should lead the process of abortion and the relationship with the patient : individualized care and trust. Professionals and experts among WG1 consider those aspects to be at the center of the mission of first line abortion providers – although in the current situation, this sometimes means that parts of the legal requirements are in direct conflict with good medical care, making it impossible to implement them in all cases. The current standardized mandatory information is an example of requirement in conflict with good practice : pushing pieces of information inadequate in the individual situation of the pregnant woman leads to more stigma and confusion than tailoring the content of the interview, as it will be developed further.

Dealing with intimate aspects of the medical history, sentimental and/or sexual life of the patient and a potential state of vulnerability requests that the patient feels she can have trust in the care providers and tell personal and medical information in all honesty.

2.1. Pre-abortion legal requirements

2.1.1. (Mandatory) information

The conditions in building such a climate of trust and honesty rely on an individualized approach of the needs and the situation of the patient. If needed, causes that led to the pregnancy (whether it was initially planned or not) are explored as well as potential personal or medical issues that the patient is willing to share.

Such an individualized approach contributes in avoiding a prejudiced and stereotypical image of the women requesting abortions. It also contributes in adapting to the actual personal situation and contributes to an autonomous decision regarding abortion and the process of abortion. Members of WG1 estimate that an individualized approach is not compatible with a list of mandatory information. They advocate for a good practice approach, that includes having available a list of topics that may need to be addressed but adapting which ones are discussed, their content and how it is dispensed to the specific situation of this patient.

Contraception

As per the legal requirements, contraception is always discussed, both in terms of prior contraception use and in terms of contraception choice for the period following the abortion procedure. If the pregnancy is caused by a failure of contraception or if the patient is not satisfied with the current mode of contraception, this is an occasion to find a more suitable option with specialists.

Financial help for parenthood

According to the current legal dispositions, the existence of financial help in support of parenthood (family allowances for instance) has to be systematically mentioned during the psychosocial interview. Field workers specify that those aspects are however only discussed when financial issues appear to be a factor weighing in the decision to have an abortion or to keep the pregnancy, which doesn't happen in all cases. It is then discussed both in terms of how financial issues can affect the decision in the immediate circumstances and whether financial help could change the perspective of a potential child in the future. However, members of the working group insist on the fact that the reasons for requesting an abortion are usually multifactorial, and financial problems are seldom the only reason. Financial problems are usually just one element signaling an overall precarious situation, which the person seeking the abortion does not find compatible with raising a child. Therefore, although financial help for parenthood is welcomed, we are also very much aware that this is not a sufficient solution for many "financially related" abortions

Adoption

Professionals and experts from WG1 all agree that, in the current situation, the possibility for adoption is almost never mentioned to the patient. They consider that it is particularly harmful to even mention the option of carrying an unwanted pregnancy to term to someone who explicitly seeks to end this pregnancy – or to someone who is in doubt about discontinuing the pregnancy or raise the child. Given the taboo surrounding abortion, patients already face difficulties finding environments where their request for an abortion is understood and respected in a non-judgmental way. Adoption is only mentioned in specific cases that very seldom happen : if the patient spontaneously mentions adoption or if the gestational age is past the legal delay for an abortion (in Belgium or in other countries) and the patient doesn't want or doesn't have the capacity to have and raise a child.

Ariane Van den Berghe, "adoptie ambtenaar" for Flanders, explicitly stated to the Chamber of Representatives during the 2018 hearing (Brotcorne & Calomne, 2017), that there is only a very weak relation between the choice for abortion and the choice to entrust a child to adoption services[14]. The only connection between both options is that they offer a potential solution for an unwanted pregnancy. There is no typical journey for an adoption decision, neither in terms of socio-demographic profiles of the women, nor in terms of gestational age at which the decision is taken (it can be decided very early in the pregnancy or at a later stage, be a very quick and firm decision or a progressive one, that requires long-term counselling from specialized adoption services). Such a decision is considered as a very difficult one and, among pregnant women who expressed an interest in entrusting the child to be born to adoption services, only a third will ultimately actually make that choice. Adoption should be considered a specific decision process, that requires counselling and follow up from specialized teams, and should in no circumstances be presented as simply an alternative to abortion. The past history of women in the 1960's, 70's or 80's who had to resort to adoption for lack of options or because of external (social or moral) pressures is a violent history according to the expert.

Adoption being a specific decisional path, away from abortion, is confirmed by a longitudinal study in the US that compares the long-term outcomes of a cohort having obtained an abortion and another cohort having being denied an abortion[15]. Among the women who were denied the option of abortion, only a small portion (9%) opted for adoption (Sisson et al., 2017). According to the authors, this highlights that adoption is only envisioned as a last resort, when the two other preferred options – that are abortion and then parenting – are no longer accessible for legal or practical reasons. Thus, for women experiencing an unplanned or unwanted pregnancy, entrusting the child to adoption is not just one option among others, but what remains when other possibilities have been removed.

Field experts from WG1 rejoin Ariane Van den Berghe's opinion and experience as well as the Turnaway study chapter on adoption : even at this time and date, it is a traumatic experience for women to be forced or pressured into carrying an unwanted pregnancy and entrusting the child. In the same way, systematically presenting adoption as an alternative to abortion is not just simplistic, it is also disregarding the variety of experiences of an unwanted pregnancy and the emotional or even traumatic state it may induce. For these reasons, and in order to ensure a qualitative and respectful counselling, the vast majority of psychosocial workers and abortion practitioners make the ethical

[14] https://www.lachambre.be/FLWB/PDF/54/3216/54K3216003.pdf
[15] ansirh.org/turnaway

choice not to mention adoption, unless in specific cases, when it is pertinent or mentioned by the pregnant woman herself.

2.1.2. (Mandatory) waiting period

Currently, a mandatory six days waiting period has to be observed between the first appointment and the abortion procedure. Since the 2018 legal change, however, there is a possibility to shorten this delay for urgent medical reasons. Some patients need or request additional time to make a decision, during which additional appointments and interviews can be planned.

Several issues are noted with regard to the waiting period. First of all, most legal and political analyses consider that a mandatory time to reflect on the decision is a patronizing disposition, that seems contradictory with the objective of granting women autonomy on the process (Minkenberg, 2003; Victorian Law Reform Commission, 2008). From a medical point of view, several prestigious health institutions also strongly advise against mandatory waiting periods (Royal College of Obstetricians and Gynecologists, 2022; World Health Organization, 2022). The members of WG1 want to underline that the mandatory waiting period is only one part of the total waiting period and most of the time does not overlap with the period in which patients actively deliberate about whether or not to abort. Most patients start the reflective process before contacting and coming to an abortion center. For those patients who have made their final decision before entering the abortion clinic, the additional mandatory waiting period only adds burdens and no benefits.

A large amount of studies and evaluations underline that mandatory waiting periods do not improve the quality of counselling nor help the decision process of elective abortion (Goenee et al., 2014; Joyce et al., 2009; Vandamme, 2017; Visser et al., 2005). Several studies also support the affirmation from field experts about the anticipated reflection from the patients, by demonstrating that for a vast majority of women requesting an abortion, the decision is already very firm before the first consultation and becomes for many of them even more certain after the counselling (Goenee et al., 2014; Joyce et al., 2009; Vandamme, 2017). Since the goal of the first psychosocial appointment as it is organized in Belgium is to provide counselling, information and assist the pregnant woman in her decision process, the acquired certainty during the process seems to indicate that this goal is reached. Reassurance and confidence in the procedure and certainty in the decision reduce the stress experienced by women with an unwanted pregnancy (Vandamme, 2017). The longitudinal Turnaway study in the US indicates that this certainty about the abortion decision is maintained in the long-term, with 99% of women confirming that they made the right choice even five years after the abortion decision and procedure (Rocca et al., 2015, 2020).

Not all patients however are immediately certain about their decision and the psychosocial team is available for as many consultations as necessary, with as much delay as needed. Those patients who have not made their final decision would opt for a waiting period regardless of whether it is mandatory, thus also for them, its mandatory nature does not add any benefits. For patients expressing a high level of certainty, on the other hand, the mandatory waiting period is not only redundant, it is also considered as potentially harmful (Joyce et al., 2009; Visser et al., 2005). It indeed maintains the patient in a state of dependance towards the medical authority, obligated to withhold the required medical service which goes against the patient's autonomy. In addition, this waiting period forces the pregnant

woman to experience and feel the symptoms of a pregnancy that is explicitly unwanted and maintain her in a state of emotional insecurity (Vandamme, 2017).

Grey (Jooken & Sermeus, 2002) and scientific literature (Joyce et al., 2009; Victorian Law Reform Commission, 2008; Visser et al., 2005), as well as enquiries among women and field experts (Brotcorne & Calomne, 2017)[16] converge in arguing for the suppression of a mandatory waiting period. Suppressing the mandatory waiting period would thus only suppress the mandatory aspect, and allow for a tailor-made waiting period, in agreement between the psychosocial and medical team and the patient in order to match her actual need and decision process.

It can also be argued that the waiting period unnecessarily increases the gestational age, and thus the difficulty and risks associated with the abortion procedure. For more advanced pregnancy (from +/- 10 weeks), although it is still under the scope of the legal term for an elective abortion, the abortion protocol will be more difficult with every additional day.

The mandatory waiting period of 6 days also denies a considerable number of patients the choice of having a medical abortion (in Belgium, it is offered up to 7 weeks since conception).

There are also practical issues in how the waiting period is calculated and its application by the different actors of the sector. First, the calculation method can also be slightly different from one center to another (6 days period can start the day of the 1st appointment or the day after). There are also different perspectives in considering the moment at which the waiting period starts : some consider it starts from the first appointment with a doctor (GP or gynecologist) referring the patient or the first echography from the hospital whereas others consider the need for a unity of place and calculate the period from the first appointment in the same abortion center (patients referred by a doctor to an abortion center may have a much longer waiting period than 6 days since they first requested an abortion).

These differences in calculating the start of the 6 days waiting period is also different from one health insurance to another. In addition, it should be noted that, although it is a legal disposition, there are restrictions unduly applied by some health insurance organizations. Some health insurances seem to be unaware of the new law of 2018 regarding the mandatory waiting period. The majority of abortion clinics and centers have for instance encountered refusal of reimbursement by some health insurance companies when the waiting period is shortened for urgent medical reasons (which is allowed by new dispositions since the 2018 law). This situation results in more time and money spent by abortion centers in administrative work and negotiations. The INAMI/RIZIV convention also needs to be adapted to the new law of 2018 (discussions are ongoing). The members of the group wish to underline that the administrative management of health insurance, INAMI/RIZIV conventions and reimbursement do not always align quickly enough with legal changes. In the event of a new legal adaptation of the dispositions surrounding abortion, it would be crucial to ensure that administrative processes are updated accordingly and in the shortest possible delay.

It should be noted that hospitals performing abortion do not encounter similar issues, as, for them, there is no special INAMI/RIZIV code for abortion (they use the code “curettage” also used for miscarriage).

[16] https://www.lachambre.be/FLWB/PDF/54/3216/54K3216003.pdf

Considering these arguments and experiences, all members of WG1 recommend a suppression of the six day mandatory waiting period from legal texts. This, however, doesn't imply that any form of waiting period should be removed: a waiting period should be left to the appreciation of the professionals together with the patient, depending on good practice guidelines. Good practices are defined as follows, in the scope of the waiting period :

- The first psychosocial consultation and the abortion should not take place on the same day in order to ensure that women have the time to digest the information that is provided in the first consultation. The first consultation can be a remote consultation (see 2.2.4), but needs to address the elements outlined below.
- A first psychosocial and medical appointment should take place at the request of the patient. It should be mandatory for structures who offer abortion procedures to also offer counselling from psychological and social professionals specially trained in the field of abortion. This service is a quality criteria for the abortion process.
- At the occasion of this consultation, the professionals together with the patient decide on the waiting period before the abortion procedure. Additional psycho-social consultations can be planned if needed and the period can be extended.
- They also recommend that what is considered as the first consultation should be the very first consultation with a healthcare provider where the patient requests an abortion, wherever that took place: in a hospital, in an abortion center or during a medical consultation (general practitioner, gynecologist, psychiatrist....).

The members of the group unanimously agree that two consultations separated in time should be maintained, to ensure the best possible quality of care. They also unanimously agree on the suppression of the existing mandatory waiting period of six days.

They propose two options that could advantageously replace the existing waiting period :

- **Option 1) is to conserve a legal delay of one day** between the first consultation where abortion is requested and the abortion procedure.
  Argument : The goal of this disposition is to prevent potential abuses and a commercial approach of abortion that would push for a quicker abortion procedure without proper psychosocial counselling.

- **Option 2) is to remove the legal delay from the legislation entirely** and rely on good practice recommendations instead.
  This option goes together with the insistence that good practice would require to have a period of at least one day between the first consultation where abortion was requested and the abortion procedure.
  Argument : This option aligns with international recommendation on abortion care.
  Another reason for not enshrining any legal delay in the law would be to accommodate exceptional circumstances in which women in precarious and/or urgent situations with a very clear, well-informed and well-considered request for an abortion could be helped more efficiently.

2.1.3. Abortion motives

The patients requesting abortion are usually facing an unwanted pregnancy. Some distinction should nonetheless be established between unintended and unwanted pregnancy (David, 2011; Vandamme, 2017). Unintended pregnancies are generally caused by sexual intercourse associated with the absence of contraception (whether by omission, pressure in not using it or lack of knowledge about it), the misuse of contraception or the malfunction of the contraceptive method employed. It should be noted that 60% of the persons requesting an abortion were using contraceptive (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018). An unintended pregnancy can result in the choice of pursuing the pregnancy, thus turning into a desired pregnancy or be conflated with an unwanted pregnancy and potentially leading to an abortion. On the other hand, a pregnancy that was initially planned and intended can change in nature (due to a change in the couple's situation, in the relationship, in the practical circumstances etc.) and become unwanted. In extreme cases of reproductive coercion, the pregnancy can be planned but not wanted. Those different trajectories between intention and will can also be blended with ambivalence and ambiguity in the decision process, making the counselling all the more important in order to guarantee an autonomous decision.

Parenthood in occidental, modern society is no longer seen as a default destiny but rather as a conscious choice. It is with respect to good parenthood and the quality of life of the child to be born that most parents prefer to decide when and in which conditions to pursue a pregnancy – hence leading to resorting to abortion if those good conditions are not met (Vandamme, 2017). Nonetheless, some socio-demographic groups – mostly of low educative level – are more at risk with regard to unplanned pregnancies, whereas some groups tend to keep those unplanned and sometimes unwanted pregnancies for cultural or religious reasons (Vandamme, 2017). Those specific risk groups should alert about the need for a continuous awareness-raising and information work regarding the availability and options for contraception, pregnancy and abortion.

The report of the Evaluation Commission provides an interesting insight of the reasons leading women into requesting an abortion procedure (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018). Even though the distress condition has been suppressed since the 2018 abortion law, abortion practitioners still can fill in reports of abortion motives from their patients. It should be noted that a certain bias from the patients cannot be excluded : the moral and social expectations surrounding abortion may weigh in the motives provided by the patients, although mentioning the motive is optional. The mention of a single reason tends to simplify a decision process that more often than not relies on a range of reasons rather than on a single aspect.

Since the suppression of the state of distress condition, the majority of woman requesting an abortion motivated the request by the absence of intention to have a child. Among the 6934 listed abortions, 6319 didn't wish to mention the reason for abortion : there are only 615 cases in which a motive is provided, since it is no longer mandatory. A total of 478 out of these answers mentioned the absence of intention to have a child as a motive (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018, p. 51). This main motive is followed by cultural or familial reasons (33 persons), relational reasons (33 persons), reasons related to reproductive health (31 persons), family composition or situation[17] (14 persons), personal situation (12 persons), patient health (10 persons),

[17] In spite of some fears that NIPT and earlier sex identification of the fetus can lead to abortion decisions motivated by sex-selection, field experts from working group 1 express that it is a situation that is extremely rarely encountered in daily practice.

fetal health (2 persons) and addiction issues (2 persons). Personal, socio-economic, relational and cultural motives are thus likely to be intertwined when unwinding the many subjacent explanations. The decision is also made on a two-dimensional time perspective : it is anchored in the moment at which the pregnancy is identified but also taking into account a projection for the future of the potential child (Vandamme, 2017).

2.2. Patient agency through the process

The need to respect a woman's autonomy when making decisions about a potential pregnancy termination is a recurring theme in the questions that were submitted to the working group. However, there appears to be different perspectives on how to optimally respect this principle and the principle is oftentimes invoked to argue both for and against certain measures.

Regarding mandatory information : the requirement to inform women about alternatives, most notably carrying the pregnancy to term and putting the child up for adoption, is commonly justified based on the assumption that this would increase reproductive autonomy as a woman is less likely to overlook potential options. However, this requirement has also been characterized as an impediment to reproductive autonomy, as women may perceive it as an implicit message that abortion is a more problematic option than these alternatives, which puts pressure on them to opt for the latter (besides also making them feel judged).

Regarding the mandatory waiting period : this requirement is justified with the argument that the decision to terminate a pregnancy might be taken at a very emotional moment, which may undermine well-informed, autonomous decision-making. The waiting period is then framed as supporting reproductive autonomy. However, the waiting period is also seen as a disregard for a woman's decision, and the imposition of carrying an unwanted pregnancy longer than necessary, thus being an infraction against reproductive autonomy.

Regarding pressure in general : some questions are framed in the assumption that (vulnerable) women are oftentimes pressured to abort – which would justify additional checks and barriers on the road to abortion. Others are framed in the assumption that (vulnerable) women are oftentimes pressured not to abort – which would justify removing checks and barriers.

It is clear that implementing strict rules will harm some women and help others. In our recommendations, we maximally seek to strike a balance that maximally helps and supports women, without harming them. When we use the concept (respect for) autonomy, we use it in the general sense of the word, without any pre-commitment to how the concept is used by different actors in the debate.

2.2.1. Patient-centered care : informed decisions and autonomy

As mentioned above, the psychosocial and medical teams working in abortion centers and clinics consider that individualized follow up of the patient and support of her personal decision process is their core mission. Placing the patient at the center of the care trajectory requires to individualize and tailor the consultation depending on her needs in terms of time, availability, information and emotional well-being. Attention should be devoted to the aspect of providing holistic care with specific

focus on the physical, psychological, social religious or spiritual wellbeing of the individual. The recommendations above regarding the information and the waiting period are headed in this direction.

In her PhD work, Joke Vandamme (2017) has extensively analyzed the decision process of a large amount of women having solicited the LUNA network (Hasselt, Gent, Antwerpen, Oostende and Brussels (VUB) with regard to their pregnancy (a sample of 971 women was analyzed). This work sheds light on the decision process but also on the qualitative criteria of counselling, allowing for informed decision and the patient's short and long term well-being.

One of the first parameter to acknowledge is that an unwanted or unplanned pregnancy causes a transitive stress. Yet, that stress is only lifted when a solution is found and an autonomous decision is made thanks to adequate and independent information. The role of counselling – which practically happens during the psychosocial consultation(s) – is threefold. Firstly, it is a time and space for the pregnant woman to receive various information regarding the abortion procedure and its practical aspects. Secondly, thanks to the information received and the discussion, the session serves as a confirmation for the choice that was already taking form. Thirdly, and thanks to these two other steps, the counselling session contributes in relieving the stress caused by the unwanted pregnancy.

The study underlines the correlation between a state of stress (or even of distress) and potential ambivalence, making the decision process more difficult. In such cases, counselling sessions can be duplicated and spaced according to the needs of the pregnant woman. However, in the study, only a very reduced fraction of the sample displayed such ambivalence[18], with a vast majority of patients showing high levels of certainty regarding their decision to terminate the pregnancy. The permanence of the decision is consistent with the findings of a previous study, underlining the certainty of the patients through the counselling process, even with a mandatory waiting period (Goenee et al., 2014). The patients with high levels of doubts were also displaying higher levels of stress, demonstrating that the intermediate state before a decision is made is what causes potential distress. Therefore, the decision to whether terminate or pursue the pregnancy appears as a solution that lifts the situation of stress.

A focus on the patient well-being should consequently consider on the one hand the needs of patients in a situation of ambivalence with adapted sessions of counselling – which are already available and proposed. On the other hand, it should also consider the needs of patient with high levels of certainty, by not forcing them to delay the abortion which unnecessarily prolongates a state of stress.

Another point underlined by the study is the need for an autonomous decision. Although any individual in any society is subjected to various cultural or social influences, in the current context of unwanted pregnancy, some external close influences may negatively weigh on the woman's ability for an autonomous decision.

One factor is the role of the partner: although a supporting partner can be an asset in the process, the role of the partner in the decision should remain secondary. If the patient has a feeling that the decision is not her own, she will remain dissatisfied with the outcome of the decision. With this regard, the members of the working group note that psychosocial teams in abortion clinics and family planning

[18] Expressed by more than two occurrences of dialectical thoughts about continuing the pregnancy.

centers are well aware of these stakes and often require to propose at least one consultation moment with the woman alone. Similar findings are mentioned in the study about family influence over the process.

Another factor regarding the patient autonomy concerns the moral considerations about abortion and the stigma that may surround the procedure. Vandamme (2017) and other authors demonstrate, respectively through thorough exploration of the scientific literature (Hanschmidt et al., 2016) and a longitudinal study (Biggs et al., 2020; Rocca et al., 2015) that the prejudices and stigma related to abortion reinforce the stress experienced by women with unwanted pregnancies, although they have no effect on the abortion rate at national levels. Women exposed to considerations about the potential moral weight of abortion are more likely to have their mental health endangered by an unwanted pregnancy. Authors note that penalization of abortion should be included as the kind of stigma that has a negative impact on the well-being of women facing an unwanted pregnancy (Hanschmidt et al., 2016).

It also seems important to point that cultural background and religious beliefs should not be considered as factors for vulnerability in the decision making. Any individual disposes of an assemblage of social and cultural conceptions that form a worldview, likely to influence their choices and decisions. Decisions related to the termination of a pregnancy may rely more specifically to ethical conceptions regarding autonomy and responsibility, that are likely to be informed by philosophical, religious beliefs and/or religious precepts[19]. Although abortion centers have no vocation in offering religious advice, taking into consideration the role of these parameters in the patient's decision making process supports an informed and autonomous decision.

> Example : Several members of the working group have mentioned recurring cases of patients experiencing moral conflicts between their intention regarding the outcome a pregnancy and religious precepts. It has been observed that occasional collaborations with religious representative able to provide pastoral guidance can offer good results in supporting the decision making process and sometimes alleviate potential moral conflicts.

2.2.2. Abortion methods, pain management and sedation : choice and determinants

The law on patient rights states that the patient has to be informed about different options for an intervention and can, where applicable, make an informed choice among the options. In the case of abortion procedures, this should translate in the possibility to have a choice in terms of procedures and sedation opportunities, but it is not always the case in practice. In addition, the patient can be influenced by partial information given by the institution and professionals.

Indeed, the choice of anesthetic and abortion technique often doesn't depend on the patients choice but on the kind of institution she goes to. In a hospital, surgical abortions are mostly performed under general anesthesia or sedation. However, the local protocol of the hospital often conditions the

[19] As an example, Islam has a stance of allowing terminations of pregnancy up to 120 days of gestation, while Catholicism considers that human life starts at the conception and should not be interrupted.

abortion technique, and even when both techniques could be envisioned, the patient cannot always choose between medical or surgical abortion.

Abortion centers, on the other hand, can only proceed with local anesthesia. Some women complain about the surgical abortion (under just local anesthesia) being a painful experience. In countries such as the Netherlands or England, however, abortion centers are allowed to offer certain forms of sedation (but not anesthesia), provided that there are trained professionals available. When it comes to medical or surgical abortion, abortion centers have as principle to offer the choice to the patient (as long as the age of pregnancy allows for a medical abortion).

The first appointment in one specific structure (whether it is an hospital or an abortion center) should neither determine the type of abortion technique nor the type of sedation. The members of the group have observed some good practice currently put in place in several institutions that should be generalized :

- The patient should be informed of the existing possibilities in terms of abortion techniques adapted to the gestational age and her health situation, regardless of the availability of said techniques at the health institution.
- The patient should be informed of the existing possibilities in terms of anesthesia, sedation and pain management adapted to the abortion technique, regardless of the availability of said techniques at the health institution.
- If the patient's preferred choice is not available at the institution, she should be referred to an abortion provider (abortion center, doctor or hospital) able to provide her with the abortion and sedation method of choice.
- In case of patient referral, the medical and administrative data from the first consultation should be transferred to the new abortion provider (when available) so that the first consultation can be considered as the first request for abortion.
- The patient should also have a choice to have a medical abortion in a medicalized abortion center or at home.

In order to improve the range of choice available to women and the quality of abortion care , the group recommends that sedation should be allowed in abortion centers – under the condition that structural criteria are fulfilled. Conditions of certification could involve a certain number of abortion procedures per year in the center, presence of specific medical material etc.

2.2.3. Collaboration between hospitals and abortion centers

The good collaboration between centers and hospitals is crucial to make an informed choice possible for patients.

Outpatient abortion centers who have a RIZIV-INAMI convention must have a signed convention with at least one hospital where they can send patients who would present complications, patients with a medically risk-profile who need specialized supervision, and to perform abortion under sedation/general anesthesia.

In some regions, an important lack of availability of hospitals performing abortions is observed. The reluctance in performing abortion has as consequence that some abortion centers must refer

patients with complications to hospitals that chose not to perform abortion for philosophical reasons. This results in poor understanding and follow up of the patient. Patients from those regions with a medically risk-profile or patients who want an abortion under sedation/general anesthesia will sometimes need to travel to another part of the country in order to have their abortion in a hospital.

After consulting every abortion center, we noted that, in some cases, there is one and only partnering hospital with a good collaboration, offering both the pharmaceutical access to mifepristone (Mifegyne), the complication follow up and abortion under general anesthesia/sedation; whereas in others, the lack of hospitals performing abortions at the local level requires the abortion centers have a multiple contact list. In some cases, there is one hospital for the pharmaceutical access to mifepristone (Mifegyne) (that can be sometimes dozens of kilometers away), and local reference hospitals that will only deal with gynecological emergencies.

According to the *Royal Decree determining the conditions for the delivery of the pharmaceutical speciality Mifegyne*, the outpatient abortion centers have to buy the Mifegyne for medical abortion procedure in a hospital pharmacy. Indeed, the delivery of Mifegyne may only be carried out by the hospital pharmacist upon presentation of a prescription. As some hospital pharmacies interpret the text of the royal decree very strictly, the purchase of Mifegyne can present unnecessary administrative barriers, that reduce its availability. Abortion centers should have available a certain stock of Mifegyne (as most already have) whereas access to Mifegyne for practitioners in hospitals should be simplified.

A minor amendment to the text of the royal decree could solve this administrative problem. If the royal decree stated that a hospital pharmacy could sell a number of boxes of Mifegyne to the outpatient abortion centers (e.g. outpatient abortion centers with a RIZIV-convention) with the possibility to hand in the prescriptions later, this would be a workable solution.

2.2.4. Remote abortion management

In March 2020, the entire country faced an unprecedented pandemic, resulting in a lockdown and further restrictive measures that compromised mainstream care as a whole. The healthcare system was forced to adjust the delivery of care to the circumstances of the moment. This also challenged the abortion centers to organize their care provision in such a way that continuity of care could be guaranteed.

The mean question was: which parts of the care provision could be done via remote care without compromising the quality and safety of care?

Two aspects of care provision qualify for remote management: the psychosocial consultation and the second phase of a medical termination of pregnancy.

Option to have a remote psychosocial consultation (“tele-counselling”)

When clients called to make an appointment, the possibility of doing a remote consultation was discussed. A careful assessment was made whether a remote consultation would ensure the same quality of care as a face-to-face consultation. Some circumstances clearly require a face to face consultation, for example, in cases of doubts about the length of the pregnancy, relational circumstances that made it difficult to make a decision or if there is a language / communication problem. The experience learned that remote consultations can have a high standard of quality, it can meet clients' needs and provide care 'tailored to the client'.

Second phase of a medical termination of pregnancy

For the changes to the protocol of the second phase of a medical ToP, we were able to call on the now regular protocol for medical ToP of the World Health Organization (WHO). Indeed, until march 2020 Belgium was the only country in the world where the second phase of a medical ToP needed to take place (due to the INAMI/RIZIV convention regulation) in the abortion center and not in the client's home.

The option of carrying out the second phase of the medical ToP at home, with telephone support from the abortion center team, was discussed with those eligible for and opting for a medical ToP. If the client wished to do this phase at the abortion center, this was of course an option. A striking finding was that the latter option was extremely little used. Clients reported feeling more comfortable in their own home environment.

Abortion services abroad faced similar challenges. An interesting study appeared in *BJOG, International Journal of Obstetrics and Gynaecology, in 2021* (Aiken et al., 2021). In Britain, the kind of protocol used in Belgium during the COVID-pandemic is the standard protocol (the second phase in the client's home environment)[20]. In the study published in BJOG, this protocol is the control cohort. The study compares this standard procedure with a protocol where all steps are done through telemedicine.

As per the COVID experience, the group states that some aspects of remote abortion management could be offered as an option, in order to improve and facilitate access to medical abortion and remove barriers for women with little flexibility in terms of time and movement. Such a procedures requires a few precautions :

- Assessing that the profile of the patient is suitable for a remote psychosocial consultation.
    - NB : sampling and ultrasound are still to be done in a medical center
    - Taking into account possible barriers and conflicts (language barrier, misunderstandings, couple conflicts, wrong estimate of the age of pregnancy, discussing private matters through phone can be easier or can be more difficult, some persons are more reassured by a in-person meeting…)
- The possibility for a good quality interview should be a necessary condition: ensuring that the first psycho-social consultation done remotely is as long and covers as many topics as it would have face to face.

[20] In most of the Planning Familial performing abortions (GACEHPA), the following choice was made during the pandemic (also inspired by what happened in the UK and in other countries): the pre-abortion psychosocial and medical consultation was maintained face to face and patients were offered the possibility to have the whole of the medical ToP at home (mifepristone as well as the expulsion phase) with shortening of the waiting period in order to have a maximum of patients who could opt for medical abortion. The day of the expulsion phase was chosen so that there was telephone support from the team, and that the patient could come to the center if needed. This has shown to be a satisfactory solution in most case and has significantly risen the proportion of medical abortion.

- Assessing that the patient is eligible for having the second phase of a medical procedure for the termination of pregnancy – notably with easy phone access and easy access to a hospital or to the center in case of complication.

2.2.4. Contraception and prevention

Contraception

Members of WG1 recommend to conserve the approach of a contraception discussion as it currently happens. Contraceptive prevalence rate among women in age of procreation (15 to 49 years old) in Belgium is estimated at 59%[21], which ranks in the mean of Western Europe. In terms of general access to contraception and reproductive rights Belgium has a distinctively better score ranks first in Europe[22], according to the European Parliamentary Forum for Reproductive rights. This situation is mostly attributed to the reimbursement of contraception up to age 25 and the work in sex education, prevention and access to abortion and contraception, notably provided by the wide network family planning centers, abortion centers and prevention organization.

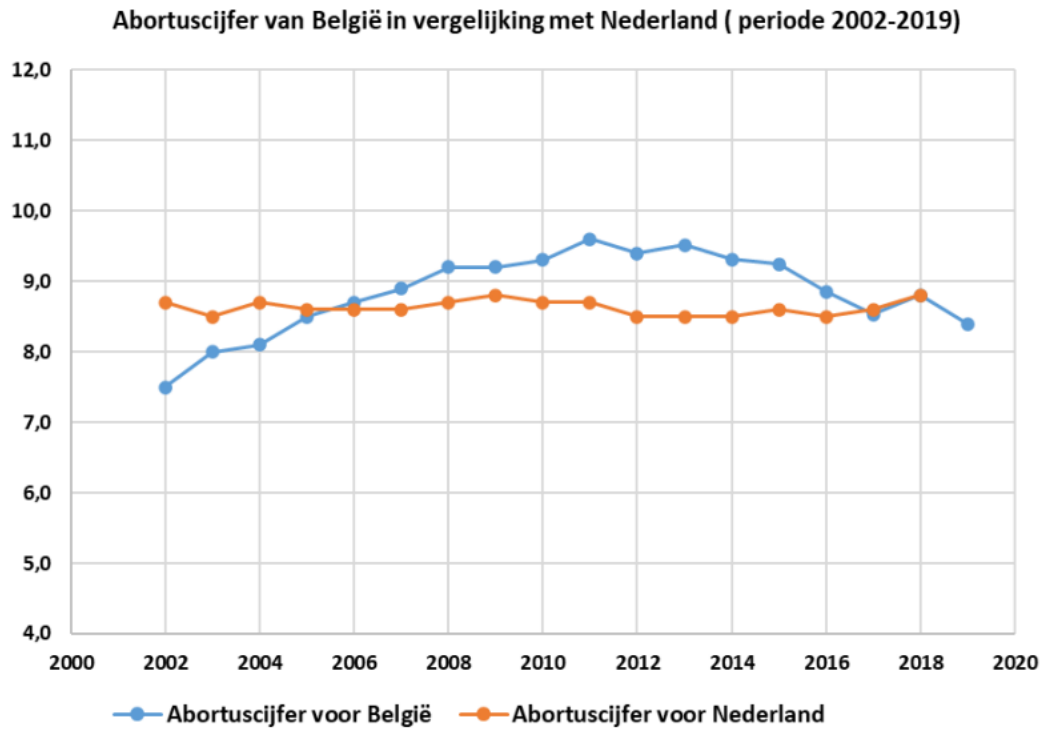
Members of the working group align with the recommendations of the European Parliamentary Forum for Reproductive rights regarding an extension of the reimbursement of contraception after 25 years old. They recommend to bind this strategy with an augmented access to LARC[23] through an extended reimbursement for patients also over 25 years old. LARC such as hormonal IUD or an implant are not expensive per se, regarding the time of use, but the entry costs (around 150€) can represent an access barrier for many patients over 25 years old and those who cannot benefit from the special regulation for people with a "verhoogde tegemoetkoming" status or BIM/VIPO status.

We expect this problem to remain prominent given the rising number of people living in poverty in Belgium. The medical literature clearly advises to insert the IUD immediately after a ToP as it is proven to prevent future unwanted pregnancies. It is a pity that the cost of a hormonal IUD will prevent some patients to have this opportunity. The generalization of offering to insert an IUD right after a ToP rather than having a second appointment only with this objective would save time and costs (both for the patient and the medical professionals) but also ensure contraceptive use in the immediate wake of the ToP.

Abortion rate

The Belgian abortion rate also ranks quite well among Western Europe, with a national abortion rate of 8,8 for 1000 women aged 15 to 44 for the year 2018 (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018, p. 87), whereas the Western Europe rate is estimated at 18‰ (Sedgh et al., 2016). A comparison of the Belgian abortion rate with the Netherlands displays a continuous similarity in the respective rates :

[21] Source : European Parliamentary Forum for Reproductive rights https://www.epfweb.org/node/704
[22] *Ibidem.*
[23] Long acting reversible contraception, such as DIU.

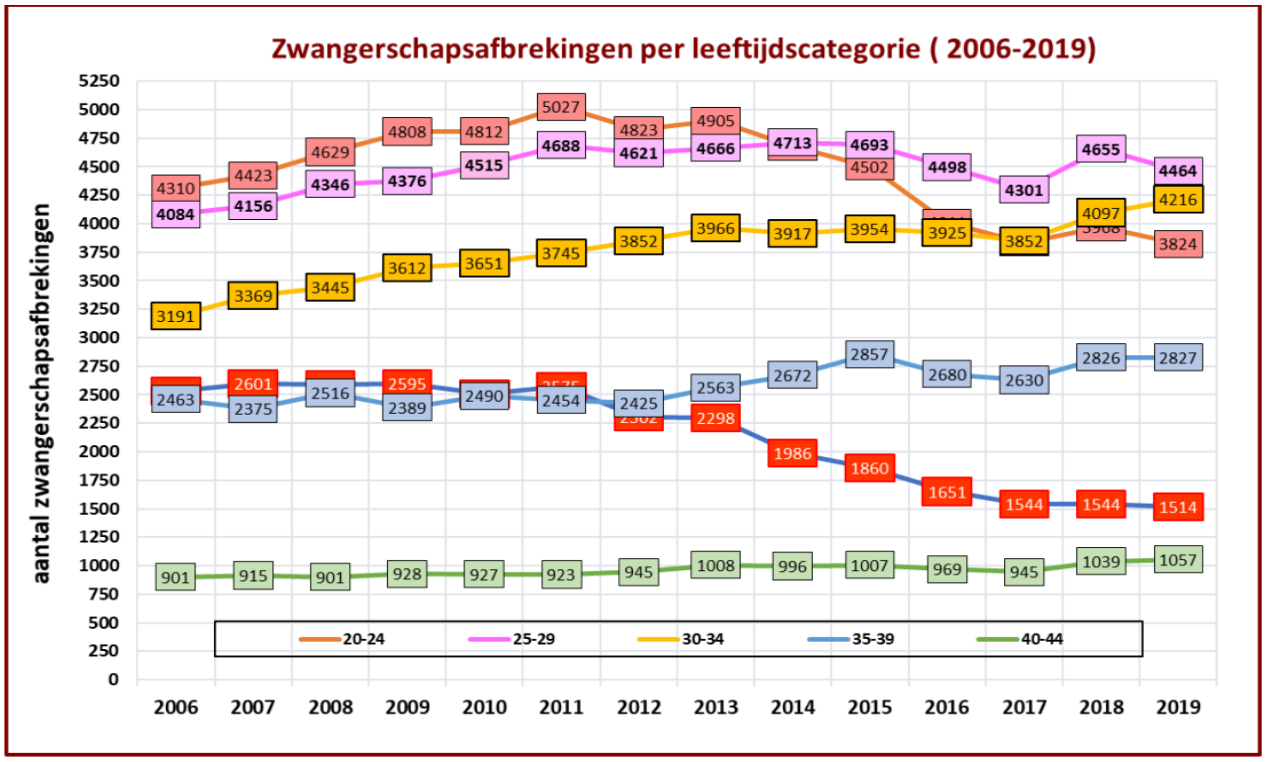


Source : (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018, p. 88)

Age of women having an abortion

Data gathered by the National Evaluation Commission on the respective ages of women having a termination of pregnancy indicates a lowering number of young women requesting an abortion. With a clear decrease of abortions among women of less than 25 years old after 2014, these data support demonstrates the preventive effects of the full reimbursement of contraception for women of less than 25 years old that took effect in 2014.

Zwangerschapsafbrekingen per leeftijdscategorie (2006-2019)														
leeftijdsgroep	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
15-19	2531	2601	2588	2595	2506	2575	2302	2298	1986	1860	1651	1544	1544	1514
20-24	4310	4423	4629	4808	4812	5027	4823	4905	4675	4502	4011	3836	3968	3824
25-29	4084	4156	4346	4376	4515	4688	4621	4666	4713	4693	4498	4301	4655	4464
30-34	3191	3369	3445	3612	3651	3745	3852	3966	3917	3954	3925	3852	4097	4216
35-39	2463	2375	2516	2389	2490	2454	2425	2563	2672	2857	2680	2630	2826	2827
40-44	901	915	901	928	927	923	945	1008	996	1007	969	945	1039	1057
	17480	17839	18425	18708	18901	19412	18968	19406	18959	18873	17734	17108	18129	17902



Source : (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018, p. 101-102)

The same source indicates that the mean age of women having an abortion remains stable, at 28 years old, while the majority of women is in the age group of 25-35 yo. For the two last registered years (2018 and 2019), this age group, represents over 69% of the women having had an abortion, whereas the age group of 15-19 yo represents less than 9% of the women having had an abortion. (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018, p. 91).

Gestational age at the moment of abortion

Most of the professional actors notice that, through time, women requesting an abortion present at significantly earlier stages of the pregnancy. This trend can be explained by the increased efficiency of pregnancy tests, able to detect pregnancy a couple of days after the sexual intercourse that led to fecundation. Prevention policies and accessibility of abortion centers probably also play a role in earlier request for professional support regarding unwanted pregnancies.

Numbered data gathered by the LUNA network provides an overview of the gestational age at which women have had an abortion in the Flemish network of abortion clinics. Based on the field experience, we consider that the conclusion of these data can be extrapolated to French speaking abortion centers.

Age of pregnancy (expressed in weeks post-conception) at moment of the abortion procedure

(LUNA network and VUB Dilemma)

2010

WEEK OF PREGNANCY (PC)	ABORTION PROCEDURES	PURCENTAGE OF THE TOTAL	
2	4	0,07%	42,69%
3	165	2,70%	
4	865	14,15%	
5	1575	25,77%	
6	1387	22,70%	49,30%
7	833	13,63%	
8	481	7,87%	
9	312	5,11%	
10	223	3,65%	8,00%
11	153	2,50%	
12	113	1,85%	
TOTAL	6111	100,00%	

2019			
WEEK OF PREGNANCY (PC)	ABORTION PROCEDURES	PURCENTAGE OF THE TOTAL	
2	28	0,39%	49,40%
3	411	5,78%	
4	1423	20,00%	
5	1653	23,23%	
6	1523	21,41%	44,15%
7	825	11,60%	
8	513	7,21%	
9	280	3,94%	
10	185	2,60%	6,45%
11	149	2,09%	
12	125	1,76%	
TOTAL	7115	100,00%	

2021			
WEEK OF PREGNANCY (PC)	ABORTION PROCEDURES	PURCENTAGE OF THE TOTAL	
2	39	0,59%	53,61%
3	451	6,78%	
4	1394	20,96%	
5	1681	25,28%	
6	1306	19,64%	40,69%
7	795	11,95%	
8	396	5,95%	
9	209	3,14%	
10	184	2,77%	5,70%
11	142	2,14%	
12	53	0,80%	

TOTAL	6650	100,00%	

The evolution towards earlier terminations of pregnancy with regards to the gestational age is palpable thanks to those tables. Between 2010 and 2019, there is notably a shift towards 2.3% less abortions during weeks 10 to 12 of the pregnancy (post-conception) and almost 11% more abortions during weeks 2 to 5 of the pregnancy (post-conception). However, with a focus on the age of the pregnancy at the moment of the abortion, these data do not allow to reflect on another aspect, which is that the age of the pregnancy at the moment of the first appointment is significantly earlier. Not only is the 6-days waiting period to be taken into account, but also the fact that abortions at the earlier stages of the pregnancy were not considered possible. Yet, to address this increasing need, abortion centers have developed in the recent years protocols for terminations of pregnancy at very early stages (VEMA: very early medical abortions).

2.3. Psychosocial consultation not followed by an abortion

Most women requesting a consultation concerning abortion have already decided to have one. A minority of women, however, come to this consultation because they need help in making a decision (ambivalence, moral issues).

Although the majority of patients requesting abortion remain consistent with their initial decision to have an abortion (Goenee et al., 2014; Vandamme, 2017), a small portion appear not to proceed with the abortion. According to the numbers provided by LUNA during 2018 hearing the at the Chamber of Representatives (Brotcorne & Calomne, 2017), among 100 women who presented to the first consultation, 83 pursued with the termination of pregnancy; 5 kept the pregnancy ; 3 had a miscarriage during the waiting period; 3 were referred to an abortion clinic abroad and 2 were actually not pregnant[24]. Those numbers, according to LUNA, are stable throughout the years. They are also consistent with data from other countries such as the Netherlands (Goenee et al., 2014). In Belgium, there is no follow up of the women who underwent that kind of decisional process.

There are, however, established negative outcomes if the pregnancy is pursued in spite of being unwanted. This may happen notably if the gestational age is over the legal limit for a termination of pregnancy on the Belgian ground.

The most common option is then to opt for an abortion in a foreign country, allowing abortion at further gestational ages, such as the Netherlands (up to 22 weeks of conception).

In some cases (inability to travel or to afford an abortion abroad, or too advanced gestational age), the unwanted pregnancy is in spite of all brought to term. Scientific literature alerts on the mental health and social outcomes of those unwanted pregnancies, for the mothers, the families and the born children (Biggs et al., 2017; David, 2011). Pursuing an unwanted pregnancy although an abortion was requested is correlated with higher levels of anxiety, low self esteem and low satisfaction and, after

[24] There is a remaining 4% of the sample about which there is no follow up information.

birth, with high risks of depression (Biggs et al., 2017; Foster et al., 2015; Harris et al., 2014; Miller et al., 2020). The Turnaway study has indeed extensively examined the effects of being refused an abortion on women with an unwanted pregnancy. Being denied a requested abortion is associated with higher anxiety and stress levels (Foster et al., 2015; Harris et al., 2014). It seems that women already having a past history of anxiety and depression are more likely to request abortion close to the legal limit in terms of gestational age (Foster et al., 2015). Women with those profiles are at risk for increased mental health issues if they are denied an abortion request (Biggs et al., 2017; Foster et al., 2015). According to the same wide scale study, women who were denied an abortion chose in their vast majority to give birth and parent. It is then observed that, in general, they are more confronted to high poverty rates and worse health in the next five years (Miller et al., 2020).

A longitudinal study of children born from unwanted pregnancies indicates that they are more at risk for negative psychosocial development and mental well-being. Although forms of resiliency are also observed in the person born in such contexts, there are also significant risks of being in need of psychiatric treatment (David, 2011).

3. Access to abortion

Vandamme's study (Vandamme, 2017) highlights main factors for dissatisfaction regarding the process of abortion. Those factors should also alert on the current situation of abortion provision in Belgium, the quality of the service and how to improve the conditions of abortion for the women facing an unwanted pregnancy. Dissatisfaction factors are listed as follows :

Access barriers : the mandatory waiting period but also the delay in obtaining an appointment, and being referred from one health practitioner to another are forms of barriers complicating the access to abortion and delaying the procedure. The need to travel several times, sometimes several hours (bus, train,metro…), each time having to take leave from work, complicates the access to abortion especially when you live in some remote parts of Belgium. The current legal dispositions regulating abortions are thus considered as indirect barriers to abortion.

- Inappropriate or incomplete information or inappropriate counselling is a second factor for dissatisfaction. The study also underlines that the current levels of satisfaction are very high regarding the quality of counselling at abortion centers and the information received. However, this is allowed by the training and professionalism of the teams more than by the legal dispositions.
- Interactions with the staff in charge of the abortion procedure : dissatisfaction is expressed when members of the staff express cold or judgmental attitudes towards the patient. Such attitudes are unlikely in abortion centers, with specially trained team members who have chosen to work in a facility providing abortion. It can however happen in hospitals, where the whole medical team – or even support team – may not be favorable to the practice of abortion and feel the need to express their views. These situation should point to the need for sensitivity training for medical paramedical and psychosocial professionals involved in abortion care.
- Medical complications, although they are globally rare, are an obvious factor for dissatisfaction. Abortion protocols are there to prevent complications. Availability of hospitals and practitioners in hospitals' gynecological emergencies are another important factor in dealing with abortion complications.

Women On Web is an organization that promotes women's reproductive health by providing educational information and enabling access to abortion medication. It plays a particularly important role in accessing safe abortion in countries where abortion is illegal or legal, but difficult to access. In Belgium, in 2021, during the COVID pandemic, 160 patients requested online consultations with WOW. Among the reasons for their demands (specific to WOW) were: to keep the abortion private, would be more comfortable at home, the need to keep abortion a secret from partner/family, having an abusive partner, would rather take care of their own abortion, it is hard to access abortion because of childcare, because of work/school commitments; because of the cost (no medical insurance), travel distance. Some were not aware abortion was legal and that abortion pills were available in Belgium. This shows access to information and abortion is not always easy for vulnerable people.

3.1. Information

The law of 2018 regulating abortion removes any sanctions regarding advertising on abortion. However, professionals of the field and members of the working group point that a lack of centralized, exhaustive information still constitutes a barrier. Ariane Van den Berghe's intervention (Brotcorne & Calomne, 2017), as well as other testimonies (Lausberg et al., 2022) indicate that, although persons from vulnerable socio-economic background are more likely to be in difficulty to find adequate information regarding sexual and reproductive health, contraception and abortion care, such difficulties are also present among more privileged women. This observation demonstrate a general lack of knowledge regarding sexual education and more specifically regarding how to obtain contraceptive and abortive care in good conditions. Partial and scattered information as it currently exists – but also retention of information from some practitioners – result in later abortion requests and more advanced pregnancies when the procedure is done (Commission Nationale d'Évaluation & Nationale commissie voor de evaluatie, 2018; Lausberg et al., 2022).

On the basis of these consideration, the working group advises for organizing information regarding abortion as follows:

- Online

Currently, there is useful information to be found online, notably on the federal portal Belgium.be but the architecture of the website can be misleading. Information regarding abortion and contraception is to be found under the heading "family" and then "children" whereas matters of reproductive health should not be correlated to family and could be registered under the existing "health" heading.

  - The group recommends to create a specific Government website centralizing all information about abortion and the available structures performing abortions (notably outpatient family planning centers and abortion centers, performing abortion with a INAMI/RIZIV convention).
  - This website should be referenced on research engine in such ways that it appears on top of the research results.
  - Official websites from the Government, Ministry of Health, INAMI/RIZIV, hospitals and health insurance companies should refer to this main website, so that the women looking for information relative to abortion are directly oriented to certified abortion

providers, in order to avoid losing time of information seeking and misorientation.

-

- In abortion centers : (see point 2.1.1)
    - Good practice would consist in having a whole series of detailed information at disposition (financial support, adoption, domestic violence…) and only dispense the one needed by the patient

- In hospitals : One current issue is that the gynecologist performing abortion or not performing abortions are not known. Members of WG1 observe on a regular basis that some patient wait several weeks to get an appointment with their usual gynecologist in order to have an abortion, only to find out that that practitioner doesn't perform abortion. This results in time lost and abortion performed at an unnecessary late pregnancy stage.
    - This could be avoided if hospitals websites had the obligation to refer to the aforementioned government website centralizing information about abortion and abortion providers.

- Spreading information about abortion also among more vulnerable groups.

3.2. Precarious and vulnerable persons

Being in a vulnerable situation, such as experiencing poverty, domestic violence, or prior mental health issues not only increase the likelihood of an unwanted pregnancy, but also an increased distress when facing such a pregnancy (Vandamme, 2017). Administrative, social or financial barriers must be faced in addition to the average stress generated by an unwanted pregnancy.

Although unwanted pregnancy and abortion requests are represented among every social categories of women, some factors are likely to increase the barriers to abortion. Members of the group have identified several factors for social and financial vulnerability that should be taken into account to facilitate the access to abortion for specific groups :

- Patients in illegal situation (undocumented)
- Domestic violence
- Homelessness
- Absence financial incomes
- Absence of health insurance (due to financial precariousness or inability to do administrative steps)
- Patients in need of a translator
- Underage patients

Those factors can interfere with getting an abortion for an unwanted pregnancy in several ways :

- Defiance with social and medical service (mostly : fear that an illegal situation could be reported to the authorities)

Undocumented patients are defiant towards health services such as abortion centers : there are cases in which they have been reported to the CPAS/OCMW or to the Police. They are also defiant regarding the condition for accessing abortion services : being undocumented and/or homeless prevents them to receive help from the CPAS/OCMW. For patients with multifactorial distress situation, abortion is the most urgent request. However, in family planning centers, the teams also try and refer the patient to other social services and provide help and solution (divorce procedure, help for domestic violence, financial support, administrative support for asylum or papers, …)

- More vulnerable patients (undocumented women, homeless women…) are also more exposed to sexual violence, that can lead to unwanted pregnancies

- Additional costs for translating services dedicated to patient who do not speak the local language. Situation that is also geographically dependent.

3.3. Financial access

Financial access is a two side coin that concerns the patients as well as the abortion centers. On the patients' side, it must be noted that the universal health insurance system allows abortion centers to perform abortion in a good quality and medicalized environment with a reduced cost for the patient (less than 5€). For abortion protocols in hospitals, the patient is billed directly by the hospital and reimbursed at the fixed rate of the health insurance organism. Costs may vary from one hospital to another. It should also be noted that socio-economic vulnerability is likely to be associated with an irregular administrative status and the absence of health insurance, which makes contraception unaffordable, as well as abortion. For homeless, and/or undocumented patients, however, the situation is much more complex. Those who are in the process of asylum request can address the structure where they are registered (Fedasil or Red Cross). If they are not registered in such a process, they can address a CPAS/OCMW structure or request an AMU/DMH – with the risk of being reported to the authorities and, eventually, expelled from the territory. During the hearings in preparation of this report, stories were shared about refugees not finding the way to help in accessing abortion during their first trimester. This brings them in an even more precarious situation when they have to travel abroad (which they legally are not allowed to do) to get an abortion at a cost they cannot afford (1000+ EUR). When it comes to the process of requesting AMU/DMH, the process is too slow and with too many conditions. This system is no longer efficient for the urgent cases it is supposed to support.

A report established in 2022 by the NGO Médecins du Monde / Dokters van de Wereld (Fligitter et al., 2022) describes how the administrative steps and conditioned access to the AMU/DMH can represent in practice an important barrier or even obstacle for abortion. This status allows for CPAS/OCMW to take over the cost for medical care for people who are not in legal stay or excluded from social help. If a doctor establishes that the patient needs urgent care, a request for an AMU/DMH status can be sent to the local CPAS/OCMW. The latter can then start a social inquiry which may result in a AMU/DMH status if a series of conditions are fulfilled. The report underlines several aspects that make the current dispositive of AMU/DMH inefficient for abortion requests.

1) *many CPAS/OCMW require to fulfill conditions that are more restrictive that the legal dispositions. (i.e. by providing an address of residence, by demanding a certain delay of residence on Belgian ground, by enquiring exhaustively the migration journey to ensure there is no other health insurance provider already active – which are all superfluous with regard to the current conditions).*
   The NGO recommends a simplification of the process, according to the current legal dispositions.
2) *The delays in obtaining an answer and the potential AMU/DMH status are too long : the law allows for an answer 38 days maximum following the initial request. In addition, since abortion care is not considered as urgent care, after obtaining the status, the patient still must have a consultation with a GP designated by the CPAS/OCMW who will give authorization for the abortion. There is an additional waiting time for the confirmation, which may last between 1 to 30 days. The abortion must then take place only in an abortion center that has a convention with the CPAS/OCMW.*
   This means that a pregnant woman is likely to wait from a couple of weeks to 11 more weeks before she can get an abortion with AMU/DMH status. There are extremely high chances for the gestational age to be then beyond the 12 weeks of legal delay.
   The NGO recommends to change the classification of abortion into urgent care, so that the second step can be removed (consultation with a GP after obtention of the status). In addition, the abortion procedure could then be obtained before the AMU/DMH status is confirmed, financed by the CPAS/OCMW, which can further be reimbursed by the AMU/DMH fund when the status is granted.
3) *Some workers at CPAS/OCMW, when confronted to women requesting an AMU/DMH status for an abortion, make derogatory comments about the abortion decision. This has led several demanders to quit the process of getting their AMU/DMH status.*
   The NGO recommends to offer an procedural and sensitivity training to first line social workers.

Abortion centers are consequently used in dealing with patients in such precarious situations with difficulties in paying for the abortion, notably for patients without health insurance or underage patients still with the insurance from the parents. One of the options for the family planning centers help them regularize the situation, which causes an additional delay and additional work for the social team. Another options, in the more difficult cases, is for the centers to pay part or all of the abortion costs instead of the patient, with a dedicated fund. This obviously causes a high financial burden on the structures who often have come up with a dedicated fund, often created thanks to donations or savings. It should also be added that centers located in geographical zones more exposed to precariousness have a more important ratio of financially vulnerable patients and, thus, more financial difficulties. Abortion centers are consequently not equals in terms of funding depending on the location and the socio-demographic profiles of their patients. The proportion of vulnerable patients and AMU/DMH patients is much higher in some localities or almost inexistent in others.

Expanding the perspective, we can observe that European countries offer several scenarios in funding abortion care (Grossman et al., 2016).

- Full funding : in this option, abortion procedures and surrounding care is integrally funded by the government. This can happen through two systems:
    - Abortion care is free of cost, at the condition that it is done in government facilities (or government approved facilities). The national health system then funds directly the facilities and their employees. This system is currently in application in England or in Portugal (Patricia Lohr Hearing, Oliveira da Silva, 2009). It should be noted that such a public funding system can coexist with private facilities who are free to charge the amount of their choice to the patients.
    - A second system consists in covering the costs of abortion care through national health insurance programs. Depending on the countries, there can be two main options:
        - universal health care systems (i.e. France or Iceland), where health care coverage is integrally funded by taxation.
        - compulsory national health insurance, usually with low premiums and participative systems, as in the case of Belgium or the Netherlands. The patient is reimbursed (almost) integrally for the costs of abortion through the insurance operator. In addition to this, a public coverage for low income persons is often observed – such as the AMU/DMH status described above or the BIM/VIPO/“verhoogde tegemoetkoming status.
- Partial funding : This options translates whether in partial funding of public facilities providing abortion care in order to decrease the final costs for the patient or in partial funding through health insurance. (This, again, is not exclusive of the existence of private facilities with higher costs for the patient).
    - The latter is observed in countries where the compulsory national health insurance only covers part of the costs of an abortion procedure (i.e. Finland, Montenegro, Sweden…)
    - Some countries have opted for compulsory private health insurance, with costly premiums, getting closer to a privatized system (Switzerland is the main example). There is, however, a small State intervention, that grows higher for low income people.
- Elective funding: in the case of elective funding, abortion is covered only in specific circumstances : medical abortion (Czech Republic, Latvia, Macedonia), or certain socio-demographic profiles of patients (Albania, Austria, Bulgaria, Germany), or criminal

circumstances of the conception such as rape (Germany). Elective funding can also be combined with partial funding for the remaining cases of abortions.

- Absence of funding usually expresses a strong moral stance against abortion. In the only two European countries providing no funding for abortion (Bosnia and Herzegovina, and Serbia), it is observed that on the other hand, maternity care and services are fully covered, which seems to indicate a natalist strategy.

Scientific literature observes that integrally funding abortion, just like legalizing it, is a decision working towards a public health management of abortion, considering that making abortion safe, available and affordable is of common interest for the general well-being (Hoedemaekers & Oortwijn, 2003; Kaposy, 2009).

We recommend :

- a financial help making ToP affordable whatever the status of the patient
- Simplified AMU/DMH access, in order to reduce the delay between the request and the answer.

One member of the group recommends the funding of abortion centers not per medical act but with a fixed budget, to stabilize the funding of the structures and allow procedures for vulnerable patients. This is explained by the fact that some abortion centers are confronted with many patients without health insurance and without AMU/DMH : this means these centers face financial problems since those patients are confronted to medical bills not covered by health insurance and that they are unable to pay. Special need budget could be created – but such realities are not equally shared among the institutions. A fixed budget would be dangerous for most centers/clinics who find the current INAMI/RIZIV system to be globally efficient.

3.4. Confidentiality

Several pieces of medical information related to the abortion are shared through the digital medical file of the patient, consequently making it difficult to maintain abortion confidential.

> As an example, field experts from the working group report being confronted on a regular basis to young women under 18 years old who chose to pay in full the costs of the abortion procedure, without being reimburse by the health insurance. As they depend on their parents' health insurance, the reimbursement would appear on the family report from the health insurance, thus breaching the confidentiality that certain young women want to keep about their termination of pregnancy. A similar issue is found with women experiencing domestic violence from their partner : some women could be in danger if the reimbursement of abortion were to appear on the health insurance statement. Their only option so far is to pay for the abortion cost without health insurance intervention.

The digitalized medical files regroup some of this confidential information (medication prescription, such as Mifégyne, can be found in the file, as well as the eventual LARC - IUD for instance - that has been placed at the moment of abortion, pregnancy blood sample). This information is likely to be disclosed to the GP or other practitioners unrelated to the abortion. A lot of hospitals automatically transfer any information regarding consultations and treatment received in their structure to the GP, without the explicit consent of the patient concerning this matter. Tania Moerenhoudt and her colleagues have investigated some of the consequences of the digitalization and centralization of medical data (Moerenhout et al., 2020). Although the research highlights the positive impact in the general quality of care, she underlines the risks of weakening the relation of trust between patient and healthcare provider and the potential breaches of confidentiality, especially in the cases of patients with family members or relatives belonging to the medical profession and thud able to easily access their file. Patient autonomy is also at stake, notably when they lose control over what kind of information is shared. The authors also mention that the file and the way information is shared is an additional risk for confirmation bias that could harm the quality of care.

The potential confidentiality breaches have been identified in the working group as follows :

- Digitalized medical file :
    - Information such as : blood analyses results for pregnancy, result of an ultrasound
    - Accessible to the GP or another doctor (who can be a relative)
    - NB : Abortion centers in Flanders print a report after the abortion, give it to patient who chooses who to share it with
- Shared pharmaceutical file
    - Information such as : prescription of Mifegyne
    - File is available for pharmacists and GP

- Monthly report of the reimbursement (from some health insurances), sent to the account holder
    - Information such as the reimbursement code for abortion can be mentioned
    - This report can be read by a partner or a relative (e.g. parent)
    - NB : a previous disposition prevented the INAMI/RIZIV code for abortion to appear anywhere
- Hospitals can send a report of the visits to the GP, including for abortions. It is often done automatically, without checking the consent of the patient in this matter.

However, other potential options have been identified, whether in other medical fields or with previous states of the information exchange protocol. In previous times, confidentiality by health insurance organisms was insured by a « pseudo-code » for INAMI/RIZIV that couldn't be traced. Currently, a similar disposition exists for assisted reproduction : the details of the protocol that has been followed is not mentioned in the file. The same questions and issues are also at stake for HIV medication or psychiatric follow up and prescriptions.

With this regard, we recommend that some points are taken in consideration with regards to abortion and all the medical exams, test results and data related to abortion. This discussion could also encompass other medical fields and protocols as well :

- We recommend that the patient has a say in validating case by case what appears in their file, whether it is the health insurance file, the general digitalized medical file, the hospital file and info sent to the GP. Those who prefer not to include information about their pregnancy termination in their electronic medical files, should be given access to a printed report of their abortion that they can share with health care providers on a needs-base.
- We recommend that some medication prescription or sample analyzes should only be viewed and accessible by the practitioner at the origin of the analysis request (ex. HCG blood test results)

4. Professional training and availability of abortion practitioners

A patient-centered approach requires that the professionals (social workers, psychologists, doctors) are well trained, in sufficient number and can adapt the care and the content of the discussion to the patient. However, we currently observe a lack of personal (nurses and doctors) in abortion centers and hospitals. This situation can be attributed to several factors. Abortion centers also note a difficulty in renewing qualified abortion practitioners in case of personal turn over, with what appears to be a generational gap in the training of doctors.

More generally, there are ob/gyn practitioners, or sometimes entire ob/gyn departments or even hospitals who have decided not to perform abortion, whether it is for philosophical reasons (consciousness objection) or for practical reasons. In some regions, it results in creating “abortion deserts”, having the patient travelling far away from their home for simple abortion procedures.

This situation causes not only geographical barriers to access abortion care – leading patients to travel further to obtain the procedure – but also significant delays. Indeed, delays in obtaining an appointment in an abortion center can vary between a couple of days up to several weeks, due to the lack of practitioner (this situation is particularly noticeable on holiday periods).

4.1. Training and sensitivity

In addition to this lack of personal, in hospital where abortions are performed, even when ob/gyn practitioners are trained and sensible to the question of reproductive rights attached to abortion, it is regularly reported that the rest of the team (nurses, anesthetists, administrative or support teams) may not share this approach and openly address their negative views on abortion to the patient.

4.2. Public health responsibility

Belated abortions due to a lack of available practitioners are at the source of a moral and public health issue. The legislation on abortion is notably based on a gradualist approach, according to which the moral value attributed to fetal life increases as time passes – which led to establishing a maximal gestational age for termination of pregnancy (see chapter dedicated to ethics). On a medical point of view, abortion at earlier stages of the pregnancy are also preferable, for the main reason that they are associated with lesser complication risks. In addition, the earlier the pregnancy, the more abortion techniques are available (medical and surgical) and in a wider range of facilities.

Delays inappropriate to the abortion procedure – whether it is a mandatory delay or a delay caused by a lack of practitioners – can have a negative impact on the patient's health and freedom of choice. Ensuring a qualitative training in a sufficient number of practitioner can thus be considered as a political responsibility oriented towards a public health policy.

Considering this general situation, we recommend that **a common base of knowledge for abortion should be mandatory for every doctor in medical school** (and not just gynecologists). This recommendation aligns with the 2019 declaration of government policy of the Wallonia-Brussels Federation and its intention to "include abortion techniques, awareness-raising and training for work in family planning centers in the teaching curriculum of the Faculty of Medicine"[25]. These basic knowledge should involve the history and social implications of abortion, legal and public health considerations and general data about abortion in Belgium. An overview of the abortion techniques

Specific training for abortion practice and the different methods is available notably the Federation Laïque de Planning Familial and the GACEHPA or in certain universities' medical department.

An assessment of the needs in terms of training and generational renewal of the qualified personal should be associated with the issues regarding social and geographical access to abortion and the regions in Belgium with a very low concentration of hospitals where abortions are performed. Examples from other countries in terms of solution for the lack of abortion practitioners could be further investigated. As an example, midwives in France are trained to perform abortion techniques.

5. How is abortion financed in Belgium?

5.1. Outpatient abortion structures:

5.1.1. Family Planning Centers and abortion centers who have a RIZIV/INAMI convention:

For the first appointment (F1) with the psychosocial provider and with the doctor, the mutuality pays 213 € (in 2022).

For performing the abortion and for the follow-up appointment, the mutuality pays 316,20€ (in 2022). Those costs cover the technical acts but also medical supplies, real estate rental costs, wages etc.

The patient will pay less than 5€ (If the patient has no medical insurance, she will have to pay the abortion herself; the amount she will have to pay depends on the structure and of her personal situation).

5.1.2. Outpatient structures without a RIZIV/INAMI convention

[25] https://pro.guidesocial.be/articles/actualites/ivg-en-belgique-un-an-apres-la-nouvelle-loi-toujours-le-meme-combat

The following costs will be reimbursed: a medical consultation, the curettage, and an ultrasound (if the doctor is a gynaecologist). The rest will have to be paid by the patient.

5.2. Hospitals:

Hospitals are not specifically financed for the psychosocial part of abortion care. Hospitals usually organize this care with the general psychosocial team working in the hospital. For surgical abortion, a curettage, an ultrasound and a one-day hospitalization will be reimbursed as well as the anesthesiologist in case of general anaesthesia. For medical abortion, only a medical consultation and an ultrasound will be reimbursed. For society and for the patient, abortion in hospital will be more costly.

It is difficult to provide an average cost of abortion care in hospital, due to the variety of factors influencing the invoicing : whether the doctor has a health insurance convention or not, which medical act is reported on the invoice etc.

List of recommendations abortion practice (upon request) WG1

1. Contraception and prevention

Members of WG1 recommend conserving the approach of a contraception discussion as it currently happens as a good practice recommendation.
Members of the working group recommend as a preventive measure the extension of the reimbursement of contraception after 25 years old. They recommend to bind this strategy with an augmented access to LARC[2] through an extended reimbursement for patients also over 25 years old. The generalization of offering to insert an IUD right after a ToP can be part of this preventive strategy.

2. Mandatory waiting period

All members of WG1 recommend a suppression of the six day mandatory waiting period from legal texts. This, however, doesn't imply that any form of waiting period should be removed: a waiting period should be left to the appreciation of the professionals together with the patient, depending on good practice guidelines. The members of the group unanimously agree that two consultations separated in time should be maintained, to ensure the best possible quality of care.
They propose two options that could advantageously replace the existing waiting period :

- **Option a) is to conserve a legal delay of one day** between the first consultation where abortion is requested and the abortion procedure.

In this scenario, the possibility for a remote psycho-social consultation, online or by phone, is particularly important (see point 5) to reduce practical barriers.

- **Option b) is to remove the legal delay from the legislation entirely** and rely on good practice recommendations instead.

This option goes together with the insistence that good practice would require to have a period of at least one day between the first consultation where abortion was requested and the abortion procedure.

3. Mandatory information

Members of WG1 estimate that an individualized approach is not compatible with a list of mandatory information. They recommend the information to be tailored to the individual needs of each patient, to be determined during the psycho-social consultation.
The recognition of abortion as health care would support this recommendation, by making the law on patients' rights (22 August 2002) applicable to information to dispense during pre-abortion consultations. In the field of abortion, this law would imply to provide Information about the nature, urgency, duration, contraindications, side effects and risks inherent to the procedure, follow-up care, possible alternatives and the financial implications. The law on patients' rights also indicates that the type of information must be selected to be relevant to the patient, which would solve the current issue of inadequacy.
They advocate for a good practice approach, that includes having available a list of topics that may need to be addressed but adapting which ones are discussed, their content and how it is dispensed to the specific situation of this patient.

4. Pain management for the patient

In order to improve the range of choice available to women and the quality of abortion care, the group recommends that sedation should be allowed in abortion centers – under the condition that structural criteria are fulfilled. Conditions of certification could involve a certain number of abortion procedures per year in the center, training of the team members presence of specific medical material etc.

5. Remote abortion management

The members of WG1 consider that extending the access to abortion includes the possibility to offer remote abortion management for the patients who would prefer this option (consultations and abortion procedures should also always be available in hospital or extra-hospital facilities).

a. Option to have a remote psychosocial consultation ("tele-counselling")

A remote consultation should be available when there are guarantees to have the same quality of care as a face-to-face consultation. However, there remains some circumstances clearly requiring a face to face consultation (for example, in cases of doubts about the length of the pregnancy, relational circumstances that made it difficult to make a decision or if there is a language / communication problem).

b. Second phase of a medical termination of pregnancy

The option of carrying out the second phase of the medical ToP at home, with telephone support from the abortion center team, should be possible for the patients preferring it.
was discussed with those eligible for and opting for a medical ToP. If the client wished to do this phase at the abortion center, this was of course an option. A striking finding was that the latter option was extremely little used. Clients reported feeling more comfortable in their own home environment.

6. Information about abortion

The group recommends to create a specific website at the level of the Federal State centralizing all information about abortion and the available structures performing abortions.
This website should be referenced on research engine in such ways that it appears on top of the research results.
Official websites from the Government, Ministry of Health, INAMI/RIZIV, hospitals and health insurance companies should refer to this main website, so that the women looking for information relative to abortion are directly oriented to certified abortion providers, in order to avoid losing time of information seeking and misorientation.

The group recommends information campaigns at the national level about abortion mentioning the legal situation and the type of facilities providing abortion procedures. In addition to this, special attention should be paid about spreading information about abortion also among more vulnerable groups.

7. Access to abortion : financial access

We recommend a financial help making ToP affordable whatever the status of the patient, and whatever the type of facility the procedure takes place in.
We also recommend simplified AMU/DMH access, with the recognition of abortion as urgent care in order to reduce the delay between the request and the answer.

8. Access to abortion : training and availability of practitioners

Considering the current scarcity of abortion practitioners for elective abortion, we recommend that **a common base of knowledge for abortion should be mandatory for every doctor in medical school** (and not just gynaecologists). This basic knowledge should involve the history and social implications of abortion, legal and public health considerations and general data about abortion in Belgium.

Financial incentives for abortion practitioners with a certification should be envisioned. The creation of INAMI/RIZIV codes of reimbursement for medical acts related to abortion is a useful mean that the INAMI/RIZIV is willing to implement.

An assessment of the needs in terms of training and generational renewal of the qualified personnel should be associated with the issues regarding social and geographical access to abortion and the regions in Belgium with a very low concentration of hospitals where abortions are performed. Examples from other countries in terms of solution for the lack of abortion practitioners, notably by involving other health professionals (midwives or nurses specially trained) could be further investigated.

9. Confidentiality

We recommend that some points are taken in consideration to the confidentiality of abortion, as well as medical acts related to the performance of abortion: medical examinations, test results and data related to abortion. This discussion could also encompass other medical fields and protocols but also administrative treatment in the hands of the INAMI/RIZIV and health insurance companies. INAMI/RIZIV has already initiated a process of reflexion with this regard. Considering the extent of the issue, we recommend acting as quickly as possible on this topic.

- We recommend that the patient has a say in validating case by case which practitioner has access to their file, whether it is the health insurance file, the general digitalized medical file, the hospital file and info sent to the GP. Those who prefer not to include information about their pregnancy termination in their electronic medical files, should be given access to a printed report of their abortion that they can share with health care providers on a needs-base.
- We recommend that some medication prescription or sample analyzes should only be viewed and accessible by the practitioner at the origin of the analysis request (ex. HCG blood test results)

b) Working group 2 : Termination of pregnancy for medical indication

The practice of abortion for medical conditions in Belgium

1. Number of terminations of pregnancy performed for medical conditions

Data from the National Evaluation Commission on Termination of Pregnancy

The National Evaluation Commission on Termination of Pregnancy collects data on all performed terminations of pregnancy. Of all reported pregnancy terminations, an average of around 4% were for medical reasons (during the period 2010-2019). Prior to 2018, these medical reasons were registered as 'situations of distress' through the National Evaluation Commission's registration form and reported under category A: 'physical and mental health of the pregnant woman and of the child to be born'. Regardless of the repeal of the 'situation of distress' in 2018, the reasons for termination of pregnancy are still collected by the National Evaluation Commission and reported under category A, through which it remains possible to identify terminations for medical reasons.[26] The categorisation relies on the reasons mentioned by the pregnant woman to the abortion provider. The medical reasons collected under category A may include a broad range of issues of physical and mental health issues for the pregnant woman and/or foetus, all connecting to different levels of severity.[27]

Year	Number of terminations of pregnancy for medical reasons	Percentage on total number of terminations of pregnancy
2010	1158	3,99%
2011	1182	4,01%
2012	1137	4,02%
2013	1213	4,22%
2014	1183	4,42%
2015	1158	4,21%
2016	1034	4,05%
2017	1062	4,47%
2018	962	3,91%
2019	813	3,60%

The above numbers represent abortions for medical reasons regardless of the duration of pregnancy. Terminations of pregnancy after 12 weeks post-conception represent only a portion of the numbers mapped under category A by the National Evaluation Commission. By law, abortion requests after 12 weeks have to abide by stricter rules: there has to be a severe and incurable condition affecting the child to be born, or continuing the pregnancy has to pose a severe threat to the health of the pregnant woman. For the period 2010-2019, the yearly average of reported pregnancy terminations on medical grounds after 12 weeks was 93. According to the data of the National Evaluation Commission, the

[26] Since the repeal of the situation of distress, a number of registration forms allow not to report the reason under category G. 99: 'other': 'no registration duty'. In 2019, around 1/3rd of all termination registrations were situated under this category.

[27] In addition to category A, category G. 'Other' is also used to register some terminations of which the reasons potentially have a medical component. For instance, in 2018-2019, the following situations were mentioned under category 'Other': Postpartum depression/ Serious and/or genetic disease / Recent surgery / Psychological problems / Depression / Burnout / Twin or multiple pregnancy / Cytomegalovirus / Non-Evolutionary Pregnancy / Drug addiction.

abortions performed after 12 weeks only represent around 8% of all terminations where a mental or physical medical reason in the woman/foetus was the main driver behind the abortion request.

Year	Reported number of terminations +12w
2010	125
2011	109
2012	84
2013	108
2014	97
2015	45
2016	95
2017	121
2018	69
2019	77

On the total average of abortions yearly performed (regardless of reason), terminations after 12 weeks for severe medical conditions only represent 0,3%. However, under-reporting of terminations of pregnancy performed after 12 weeks is an issue that most likely dilutes the percentages. It should be reminded that the data represented by the National Evaluation Commission depend on correct reporting by the providers of the termination of pregnancy. No correction is applied for suspected unreported terminations.

Missing data and potential causes of under-reporting

For over several years, the National Evaluation Commission has highlighted a gap in data which concerns terminations of pregnancy performed after 12 weeks. Using the EUROCAT register, which collects the number of anomalies detected in the foetal stage, at birth, and up to the age of 1, the Commission makes an estimation of the real number of terminations for foetal anomaly.[28] The EUROCAT register maps the terminations of pregnancy for foetal anomalies per 10.000 births. When incorporating Belgian birth statistics, an estimation can be made of the yearly number of terminations performed because of foetal anomaly.[29] This estimation excludes terminations performed for health conditions affecting the pregnant person, where under-reporting may also be present.

[28] Table by the National Evaluation Commission: see two-yearly report 2018-2019, p. 118 Dutch version; EUROCAT data available at: https://eu-rd-platform.jrc.ec.europa.eu/eurocat/eurocat-data/prevalence_en.

[29] Belgian birth statistics available at: https://statbel.fgov.be/nl/themas/bevolking/geboorten-en-vruchtbaarheid#figures.

Year	Number of births	Terminations for foetal anomalies +12w (National Evaluation Commission)	Terminations for foetal anomalies (prevalence per 10.000 births) EUROCAT	Estimated number of terminations for foetal anomaly
2012	126.993	79	36,53	464
2013	124.862	103	36,1	450
2014	124.415	94	37,75	469
2015	121.713	35	42,25	514
2016	121.161	93	40,74	493
2017	119.109	107	54,89	654

Based on the EUROCAT data, the National Evaluation Commission estimates that the number of terminations of pregnancy after 12 weeks in its reports represents only 7-23% of the estimated accurate number of terminations. Although this projection is considered largely accurate, it must be mentioned that EUROCAT registers all terminations for foetal anomaly regardless of the gestational age at which termination occurred. Hence, a portion of these terminations listed by EUROCAT may have occurred before 12 weeks post-conception. Moreover, the EUROCAT register does not report on terminations for maternal health reasons. Although these two categories represent only a small number of terminations on the total number of terminations of pregnancy for medical reasons, the different registration scopes of EUROCAT and the National Evaluation Commission complicate comparison.

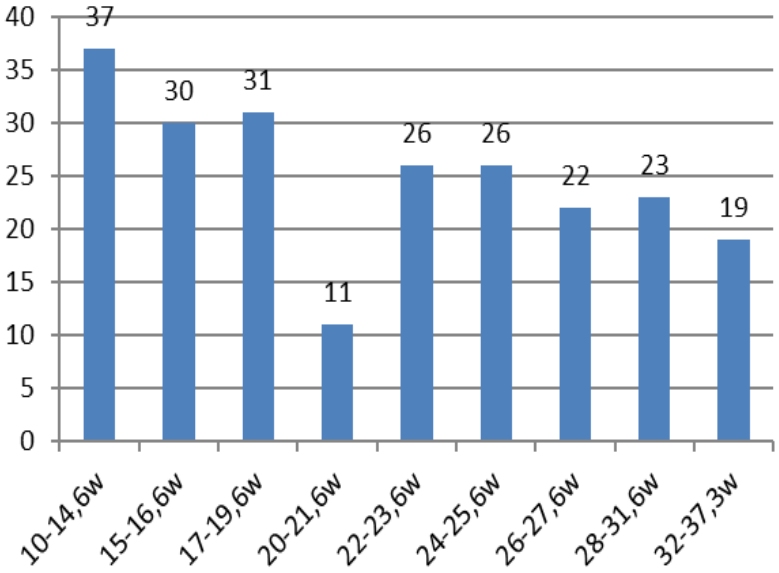
According to the National Evaluation Commission, explanations for under-reporting are the work load in hospitals, which means there is no time for reporting, doctors' different interpretations of the law regarding voluntary and medical termination of pregnancy, or finally, the wish to keep the practice confidential. These concur with the possible causes mentioned by Belgian hospital gynaecologists involved in termination of pregnancy after 12 weeks when asked why they think (some) hospitals do not report terminations.[30] Potential causes mentioned by the gynaecologists include:

- Administrative work load - no internal role division worked out
- Confusion with multiple other registration duties (e.g. EUROCAT / SPE/CEPIP / Livebirth and stillbirth legal declarations / …)
- Perception that internal registration in hospital suffices
- Fear of external control + lack of reaction when not reported
- Low confidence in the National Evaluation Commission's work/role
- Under-reporting of terminations after 12 weeks that can still happen with curettage

[30] Unpublished data gathered by F. De Meyer et. al. in study interviewing 23 Flemish hospital gynaecologists involved in decision-making on termination of pregnancy after 12 weeks.

- Unaware of the obligation to report to the National Evaluation Commission

Apart from under-reporting, the National Evaluation Commission does not report the number of terminations for medical reasons per specific gestational age. This is because the registration form filled in by the abortion providers only distinguishes between terminations before and after 12 weeks. For scientific purposes, an overview of terminations per gestational age week and per medical condition is recommended. According to health professionals involved in prenatal diagnosis, termination may be performed at different gestations due to the progressive nature of settling diagnosis and prognosis for foetal anomaly. Sometimes, a level of certainty is only attained in the latest stages of pregnancy, after foetal viability. As an example, the following table shows data from one Belgian reference hospital (over 5 years, 2014-2018), which shows that terminations of pregnancy on severe medical grounds occur at different gestational stages.



Lacking in the registration by the National Evaluation Commission as well is a division by nationality of the pregnant women requesting termination of pregnancy for medical reasons. Due to a variety of reasons, including stricter legislation in other countries, some foreign nationals may seek a termination of pregnancy in Belgium after deviant prenatal diagnosis. A situation where intake of foreign women may be reasonable concerns the situation of Dutch women seeking termination of pregnancy after 24 weeks on medical grounds in Belgium, as such access is more restricted in the Netherlands.[31] The Dutch Evaluation of the Regulation on Late Termination of Pregnancy confirms this dynamic.[32] According to this evaluation, the UZA, UZGent and UZLeuven together offer termination services to approximately 10 Dutch women a year after 24 weeks pregnancy. We do not currently possess accurate data to confirm this number, nor do we have data from other hospitals than the three mentioned. According

[31] 'Regeling Beoordelingscommissie Late Zwangerschapsafbreking en Levensbeëindiging bij Pasgeborenen' [Regulation Assessment Committee Late Termination of Pregnancy and End-of-life in Neonates] (in Dutch), 11 December 2015, available at https://wetten.overheid.nl/BWBR0037570/2018-08-01.

[32] ZonMw, 'Evaluatie Regeling beoordelingscommissie late zwangerschapsafbreking en levensbeëindiging bij pasgeborenen' [Evaluation Regulation Assessment Committee Late Termination of Pregnancy and End-of-life in Neonates] (in Dutch), February 2022], available at https://www.rijksoverheid.nl/documenten/rapporten/2022/02/28/regeling-beoordelingscommissie-late-zwangerschapsafbreking-en-levensbeeindiging-bij-pasgeborenen, p. 68.

to an expert involved in the Dutch evaluation, these patients have no specific profile, although it often involves women/couples who are outspoken and proactive in finding information.[33]

2. Medical conditions for which termination of pregnancy is performed

As mentioned, pregnancies are terminated for a variety of medical conditions. For what concerns termination of pregnancy before 12 weeks, there is no specific duty to articulate the exact medical condition in the registration form of the National Evaluation Commission. However, for terminations of pregnancy after 12 weeks, the registration form requires stipulating the medical condition affecting the foetus or pregnant individual. The following sections discuss the data from the National Evaluation Commission regarding the medical conditions that have led to termination of pregnancy after 12 weeks.

Between 2010-2019, on average 92% of terminations after 12 weeks reported to the National Evaluation Commission corresponded to terminations for conditions related to the foetus. Termination of pregnancy after 12 weeks for conditions affecting the health of the pregnant woman are exceptional and represent only 8%. These percentages need nuancing given the above estimations of under-reporting of terminations for foetal anomaly, and given the lack of data about the level of reporting of terminations for maternal health conditions.

2.1 Medical conditions related to the pregnant woman

Although rare, some pregnancies are terminated because of a serious risk to the health of the pregnant woman. These pregnancy terminations are predominantly performed for threats to the physical health of the pregnant person. Those can relate to the pregnancy itself or to pre-existing or recently emerged health conditions. Reported physical health conditions that have resulted in termination of pregnancy after 12 weeks can be found in the reports of the Evaluation Commission, and include HELLP (haemolysis elevated liver enzymes and low platelets) syndrome, pregnancy hypertension, (pre)eclampsia, caesarean scar with life threatening maternal haemorrhage, heavy uterine bleeding, anaemia, heart disease, breast cancer, cervical cancer, Hodgkin syndrome, herniated disc, severe neurological disease, thyroid carcinoma, and nephrotic syndrome. Moreover, the Evaluation Commission has reported mental health conditions in the past such as psychological pressure, a delicate psychological balance or mental instability, heroin abuse, risk of suicide, and a manic-depressive psychosis, as reasons for termination of pregnancy beyond 12 weeks. According to involved health professionals, these requests seem to be increasing, although they still represent a minority in the requests for termination of pregnancy on medical grounds. In practice, these requests are the subject of profound multidisciplinary evaluation.

2.2 Medical conditions related to the foetus

The reports of the National Evaluation Commission also list the foetal anomalies for which termination of pregnancy was performed after 12 weeks. They divide the foetal conditions into three main

[33] Oral conversation with Erwin Krol, Pro Facto.

categories: chromosomal conditions, anomalies and deformities, and teratogenic diseases. Conditions include both lethal conditions and non-lethal conditions that are considered substantially severe.[34]

Overview of foetal conditions for which termination was performed in 2018-2019, reported by the National Evaluation Commission		
Chromosomal conditions	Anomalies and deformities	Teratogenic diseases[35]
• Deletion on chromosome 22 / deletion 16p11.2 / deletion 22q11 • Hygroma colli (cystic) • Chromosomal disease / karyotype abnormality • Microdeletion chromosome 18 • Microduplication • Mutation of chromosome • Turner's syndrome • Wolf-Hirschhorn syndrome • Triploidy (69 xxy) • Trisomy 13 (Patau syndrome) • Trisomy 18 (Edward's syndrome) • Trisomy 21 (Down's syndrome) • Trisomy 22	2.2.1. Heart • Dextrocardia • Hypoplasia • Deadly heart malformation/anomaly • Tetralogy of Fallot 2.2.2. Lungs • Pulmonary atresia • Lung hypoplasia • Lung perforation 2.2.3. Skeleton • Thanatophoric skeletal dysplasia • Pseudoachondroplasia • Caudal regression syndrome • Phocomelia 2.2.4. Kidneys and adrenal glands • Bilateral renal agenesis • Congenital adrenal hyperplasia • Bilateral multicystic kidney 2.2.5. Liver • Hyperplasia 2.2.6. Central nervous system • Anencephaly • Spinal anomaly • Spina bifida 2.2.7. skull and brain • Acranie • Agenesis of the corpus callosum • Holoprosencephaly • Hydrocephalus • Severe brain malformation • Arnold Chiari syndrome • Ventriculomegaly 2.2.8. Various ailments • Absence of bladder • Disorder / defect of the abdominal wall / mass in the abdominal wall	•Conditions caused by taking isotretinoin (formerly Roaccutane®) • Cytomegalovirus • Toxoplasmosis

[34] Different interpretations exist over when a condition should be considered lethal / non-lethal. See, for instance, Wilkinson D, de Crespigny L, Xafis V. Ethical language and decision-making for prenatally diagnosed lethal malformations. *Seminars in Foetal & Neonatal Medicine* 19 (2014) 306-311.

[35] Involved health professionals in this committee have stated that they do not see a scientific and logical justification to treat teratogenic causes as a separate category as distinguished from the other categories.

	• Anamnios due to the breaking of the membranes • Sickle Cell Anemia • Abdominal wall defect • Anhydramnios • Ascites • Spontaneous miscarriage / spill in utero • Diaphragmatic hernia • Hydrops • PPROM (Preterm Premature Rupture of Membranes) • Intrauterine Growth Retardation (IUGR) • Polymalformative syndrome	

The reports of the National Evaluation Commission do not mention the prevalence of anomalies, nor the number of terminations per anomaly. According to internally gathered data, the majority of terminations of pregnancy are performed for chromosomal conditions, heart conditions, and conditions of the central nervous system and spine. This pattern concurs with data from other European jurisdictions where terminations of pregnancy can be performed for severe medical reasons. For instance, in England and Wales, the following data demonstrate for which category of conditions terminations of pregnancy were performed in 2020[36]:

- Congenital malformations nervous system: 21% (most common: other malformations of the brain, anencephaly, spina bifida)
- Other congenital malformations: 34% (most common: malformations of the cardiovascular system, malformations of the musculoskeletal system)
- Chromosomal abnormalities: 27% (most common: Down's Syndrome, Edwards' Syndrome, other syndromes)
- Other conditions: 18% (most common: foetus affected by maternal factors, Cystic Hygroma (Lymphangioma), hydrops foetalis not due to haemolytic disease)

The EUROCAT register offers more insight into both the prevalence of and termination rates for foetal anomaly in the Belgian regions of Hainaut and Antwerp, as well as other European regions. No large discrepancies in the termination pattern of Belgian regions and other European regions were detected, although minor regional deviations exist. According to a recent analysis of EUROCAT data by the province of Antwerp, the Antwerp termination rate for foetal anomalies (1989-2016) per 10.000 births

[36] Termination of pregnancy under ground E, which requires that there is a "substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously disabled". Abortion Statistics 2020, data tables, tab 9a: abortions performed under ground E, residents of England and Wales, 2020, available at https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020.

is 27, the Hainaut rate is 41, and the European average 42.[37] It is unknown whether the lower Antwerp rate is due to under-reporting or whether it represents an actual difference.

Interpretation of the EUROCAT data should happen carefully and with attention to the way data were collected and presented. First, termination rates reported by EUROCAT do not specify gestational age, which means that it includes terminations performed both before and after the Belgian legal limit of 12 weeks post-conception. Moreover, both prenatal and postnatal[38] diagnoses of anomalies are included in the prevalence rates, which means that termination rates need to be nuanced when compared to prevalence rates. Lastly, all anomalies are reported, whether they appear isolated or in conjunction with other anomalies. This means that there will be more foetal anomalies than pregnancies. In the period from 2010 to 2019, 256 foetal anomalies per 10.000 births were diagnosed based on the data from the regions of Antwerp and Hainaut. The termination rate for foetal anomalies was 39 per 10.000 births.[39] Diagnosed genetic disorders are associated with a 43% termination of pregnancy rate. Around 50% of trisomy 21 diagnoses resulted in a decision to terminate the pregnancy. For trisomy 18 and Turner syndrome diagnoses, the termination rate is around 80 percent. Nervous system anomalies are associated with a termination rate of 35% in the EUROCAT data. Congenital heart defects have a termination rate of 8,4 % compared to total prevalence rates. As mentioned, the termination rates per foetal anomaly prevalence rate need a correction as diagnoses up to 1 year after birth are included in the prevalence rate (which inherently exclude a termination decision).

3. Medical diagnosis and counselling

Prenatal diagnosis can take place at different stages of pregnancy and makes use of different diagnostic techniques. Prenatal testing can involve blood tests, imaging studies, chromosome analysis and other genetic testing to assess the health of the pregnant woman as well as the foetus' health. The non-invasive prenatal test is usually offered at 12 weeks pregnancy (amenorrhea), and results can be available within 5 to 10 days later. In a relatively early stage of pregnancy, this genetic screening test can offer reliable information on the DNA composition of the foetus, and predict increased risk of large chromosomal deviations such as trisomy 21, trisomy 18, trisomy 13. A deviating test result is always followed by an invasive procedure to confirm the diagnosis (amniocentesis or chorionic villus sampling). Other procedures such as repetitive ultrasound imaging and foetal MRI are regularly used to attain a (clearer) diagnosis and prognosis of a foetal anomaly.

The medical profession has formulated recommendations on good practice that can strengthen careful and diligent care from health professionals prior to termination of pregnancy at a later pregnancy stage (VVOG, 2020). Although local differences may be possible and workable, these recommendations form a solid basis for taking care of women/couples affected by a troubled pregnancy. Among others, the recommendation highlights respect for the request to terminate the pregnancy, referral to another

[37] Table 2 of report by Provincie Antwerpen, 'Registratie van aangeboren afwijkingen, EUROCAT PROVINCIE ANTWERPEN, Rapport 1989-2016', 2020, available at https://www.provincieantwerpen.be/content/dam/provant/dlm/pih/Eurocat%20rapport%202020_finaal_tg.pdf.

[38] Diagnoses up to 1 year after birth.

[39] When considering the yearly average birth rate between 2010-2019 for Belgium based on the STATBEL data, we reach a number of 483 terminations of pregnancy for foetal anomaly per year.

centre when the request is not in line with the multidisciplinary decision-making of the team, promotion of informed decision-making and non-directive counselling, discussion of the alternative treatment options (including different termination methods, and postnatal comfort care), and aligning the aftercare with the wishes of the patient. Moreover, it recommends multidisciplinary staff discussion and additional, objective information provision by a health professional(s) specialised in the specific condition(s) regarding follow-up, therapeutic possibilities and limitations, and prognosis. In the presence of a serious medical condition, the woman/couple is offered the option of termination of pregnancy, in addition to other potential options such as neonatal evaluation and possibly palliative support (VVOG, 2020).

Another corner stone of high quality care in these situations concerns psychological and administrative assistance, especially if the woman/couple wishes to receive such support (VVOG, 2020). Case managers, social assistants and/or psychologists usually provide this type of support. In some hospitals, midwives also take up this role. Referral to external professionals is sometimes necessary. Administrative support is relevant to inform the patient, if applicable, about potential governmental benefits after pregnancy/birth (e.g. maternity leave), mandatory and optional civil registration duties, options to organise a burial or cremation, etc.

4. Decision-making process regarding termination of pregnancy

Decision-making process and coping of the patient - couple

If a patient is confronted with adverse ultrasound findings or NIPT/PND results or a maternal health issue, this induces a complex decision-making process and different coping mechanisms. The emotional difficulties relate to the fact that these pregnancies were usually planned and/or welcomed, and examinations have confirmed the existence of the foetus.

Different studies have explored the decision-making of women/couples confronted with a troubled pregnancy. Studies show that, above all, the severity of the condition and quality of life play a crucial role in parental decisions to terminate (Dreux et al., 2008; Evans et al., 1996; Pryde et al. 1993; Shaffer et al., 2006). A distinction between motives is often made in research between the foetal anomaly's impact on the child, the woman, the partner, and other children (Korenromp, 2006). An important parental motive to terminate is to avoid suffering, stigma, and a sense of not belonging of the child (Mc Coyd, 2007; Järvholm, 2016). Moreover, the expected emotional, physical and financial burden of care for the parents/family is an additional factor (Mc Coyd, 2007; Järvholm, 2016). The well-being of other (future) siblings is also frequently regarded in parental decisions on termination of pregnancy (Mc Coyd, 2007; Järvholm et al., 2014). Other factors that do not directly relate to the (impact of the) anomaly can be at stake. One influencing factor is the religious, ethnic, and cultural background of the woman which can impact decisions to take up prenatal diagnostic testing and to terminate or continue pregnancies (Haidar e.a., 2018; Ahmed e.a. 2017; Fransen e.a., 2015; Gitsels-van der Wal e.a. 2014). Moreover, the pregnancy duration, the age of the pregnant woman, the position of the partner, the presence of other children in the family, etc. can all play a role in the woman/couple's final decision. A strong desire to have a child, and general ambivalence towards termination of pregnancy, have been associated with a tendency to continue the pregnancy (Decruyenaere, 2007).

The VVOG has noted that it is a growing trend for couples to request a palliative trajectory instead of an active intervention terminating the pregnancy (VVOG, 2020) (see also chapter 3.2 and 5.). Especially when post-natal survival duration is expected to be limited, the option not to actively cause foetal demise but to anticipate spontaneous death after birth can be considered. These complex decisions are often made case-by-case, taking into account the specific characteristics of the foetus, the woman, and parental preferences.

Later termination decisions can evoke significant distress and conflicting emotions (Andersson, 2014; Hodgson 2018). For instance, grief after termination of pregnancy may go hand in hand with relief over avoiding long-term suffering of a severely disabled child on the other hand. Research and involved health professionals stress the importance of a conscious and informed decision-making process to improve coping during and after the decision-making process regarding termination of pregnancy. In this process, empowerment of the patient's emotional security and agency is key. Moreover, facilitating time and space for the patient/couple to gather information, to adjust, and to seek support from trusted people and professionals is considered beneficial (Roegiers, 2019). Coping resources, particularly prior mental health and social support, contribute to reducing the risk of chronic grief reactions (Lasker, 1991).

In supporting women's autonomous decision-making, health professionals may also need to establish whether there is external pressure of any sort on the patient to keep or terminate the pregnancy. Securing the patient's informed consent ought to be highly context-sensitive and responsive to the needs of each individual, requiring trusting relationships with patients (Woodcock, 2011). A climate of trust and cooperation in the medical team is encouraged, as to guide the information to the patient/couple in a complementary rather than contradictory way. Moreover, health professionals involved in the working group emphasise that the majority of pregnancies affected with a foetal or maternal health problem is the result of a couple's project / intent to have a child. This explains why these termination decisions are often discussed between and with both partners. Involved health professionals support the idea that it is good practice to involve the partner to the extent feasible in the counselling process, although the final and overriding decision to terminate or continue the pregnancy should rest with the pregnant individual (as currently safeguarded by the abortion legislation) due to the impact of these decisions on her bodily integrity and autonomy.

The process of offering this sensitive type of supportive and informative counselling may require professionals to adopt a rigorous interdisciplinary approach (Dekkers, 2019). This may include specific training for perinatal teams, the modules of which are already organized in certain places in Belgium (CIU, 2020; Hodgson 2018).

Decision-making and coping of health professionals

Acceptance of termination of pregnancy for medical reasons, including when performed at later stages, is considered high among involved health professionals in Belgium (Roets, 2020; Dombrecht, 2020). Non-directive counselling and respect for autonomous, informed decision-making of patients is recommended for this type of medical care (VVOG, 2020). As mentioned, diligent medical practice recommends collective evaluation and decision-making among two or more staff members, preferably in a multidisciplinary setting. Although not a legal obligation, some Belgian hospitals have the policy to request a (non-binding) advice from the hospital's Ethics Committee on the acceptability of late termination of pregnancy requests. Ethics' Committees are sometimes also asked ad hoc to give an

advice when conflicting opinions are expressed in the multidisciplinary team meeting. Involved health professionals emphasise that transparent communication about these institutional decision-making processes to the patient/couple is an important aspect of good medical practice. They also stress that the patient should be given the opportunity to be heard by a specialist doctor and (other members of) the multidisciplinary team.

Health professionals may experience challenges in assessing the ethical, medical, personal and legal acceptability of termination in some cases. These challenges are particularly expressed by health professionals for situations when a clear-cut diagnosis and/or prognosis is difficult to attain. Moreover, it is reported that advanced gestational age may complicate health professionals' personal acceptance of or involvement in termination of pregnancy for severe medical conditions.[40]

Research in France, where similar legislation as in Belgium applies to termination of pregnancy in the 2nd and 3rd trimester, estimates that around 94% of all terminations occurs in reaction to anomalies which are clearly lethal or would lead to substantial physical and/or mental disabilities (Dommergues, 2010). The other 6% of cases are considered "unsettled", meaning that although termination was eventually authorised following multidisciplinary discussion, at least one of three criteria (probability, severity, incurability) could be disputed (Dommergues, 2010). Among others, this unsettled group may include (1) diseases for which the individual's probability of severe handicap is not known precisely (e.g. agenesis of corpus callosum), (2) disease of late onset (e.g. Huntington's disease), (3) potentially curable diseases occurring in families with a history of treatment failure (e.g. sickle cell disease) and (4) conditions with no professional consensus on the severity of the handicap (e.g. achondroplasia, single limb defect) (Dommergues, 2010).

Multifactorial assessment and consultation of relevant disciplines are encouraged to navigate these uncertain areas in medicine, especially since the law leaves a margin of appreciation for the medical profession.

5. Termination of pregnancy techniques

Before 12 weeks pregnancy post-conception, a pregnancy affected by a foetal condition or maternal health problem can be terminated both surgically or medically (cf. pregnancies without underlying medical condition). In the first trimester, medical abortion, which induces a miscarriage, is generally advised for a pregnancy duration of less than 7 weeks calculated from conception (9 weeks LMP).[41] Medical abortion regimens include sequential use of mifepristone (an anti-hormone that that weakens the cervix and blocks the effects of progesterone – a hormone needed for the pregnancy to continue) followed by misoprostol (which causes contractions). The medications are taken orally and/or vaginally. Surgical abortion through vacuum aspiration is generally advised up to 12 weeks (14 weeks LMP) (WHO, 2022, 63).[42] In Belgium, vacuum aspiration before 12 weeks can be performed in specialised abortion clinics (under local anaesthesia), or in hospital (also possible under general

[40] Unpublished data gathered by F. De Meyer et. al. in study interviewing 23 Flemish hospital gynaecologists involved in decision-making on termination of pregnancy after 12 weeks.

[41] https://abortus.be/hoe-verloopt-een-abortus/de-medicamenteuze-behandeling/. Minor varieties in protocols of hospitals exist as to the medication regimes used and corresponding gestational ages.

[42] The WHO points out that appropriateness of methods at different gestational ages co-depend on training an access to instruments: "For example, most trained providers can safely undertake vacuum aspiration up to 12 weeks of pregnancy, while others with sufficient experience and access to appropriately sized cannulae can use this procedure safely for terminating pregnancies of less than 15 weeks' duration (WHO, Safe Abortion 2nd Edition, 2012, 37.

anaesthesia). Pregnancies over 12 weeks affected with a severe health condition are terminated in hospitals, using the two-step medication regime of mifepristone and misoprostol. At advanced gestational age, actively causing foetal demise (also known as 'foeticide') is recommended prior to the medication procedure to prevent neonatal survival after expulsion. After all, combination regimens of mifepristone and misoprostol or misoprostol alone, do not in itself cause demise of a viable foetus (WHO, 2012, 40). Foeticide is a short invasive ultrasound guided procedure under local anaesthetics in which an agent causing foetal cardiac arrest is administered via the umbilical vein and/or foetal heart. The VVOG advises to offer foeticide from 22 weeks (LMP), although some hospitals have the policy to perform it a little bit earlier/later (hospitals' protocols ranging from 18-22 weeks LMP). The WHO suggests that causing pre-procedure foetal demise is advised from 20 weeks pregnancy (LMP) (WHO, 2012, 40). Surgical dilation and evacuation is currently not commonly used in Belgium to terminate a later pregnancy affected with a maternal or foetal health condition. Potential explanations include: the possible need for a post-mortem autopsy or post-mortem imaging (MR, CT, …) which requires an intact foetus; the possible wish of the woman/couple to see an intact foetus after expulsion; the lack of professional skill to perform dilation and evacuation; a potential risk of complications which may compromise future fertility (Scholten e.a., 2013)[43]; a general preference of involved health professionals of medical abortion due to less active involvement in the procedure as opposed to with D&E.[44]

6. Follow-up care and administrative support after termination of pregnancy

In the absence of medical, obstetrical and psychological problems, most patients leave the hospital the day after termination of pregnancy, having received information on possible lactation inhibition, contraception, and possible social benefits. However, interaction with the patients usually does not end with the hospital discharge. An autopsy of the foetal remains is recommended after expulsion, unless the diagnosis is clear-cut. A postpartum check-up is foreseen with the referring gynaecologist. The patient/couple is invited for a discussion of the results when the definitive results of additional examinations are in, around 5 to 6 weeks after expulsion. Where applicable, this includes discussion of recurrence risk, genetic advice, and examinations or interventions needed for a subsequent pregnancy (VVOG, 2020).

Where the patient/couple could benefit from psychological support or bereavement counselling after termination of pregnancy, support (either internal or through referral) should be offered. Research estimates that around 45% of these patients experiences PTSD within/ 4 months after termination, and up to 20% experiences negative psychological consequences up to one year after termination of a wanted pregnancy, despite the fact that few of them regret their decision (Korenromp et al., 2009). Coping with termination for foetal anomaly is widely acknowledged as a long-term process, in which the lack of aftercare may pose important implications for women's long-term adjustment to the situation (Lafarge, 2017). Belgian health professionals involved in working group 2 indicate the need

[43] The study compares women who had a previous abortion with those who did not have a previous abortion. Overall risks from surgical abortion were considered low in the study. Moreover, the study did not collect exact data about the used technique, which makes it difficult to assess whether the found risks are similar or distinct for surgical vs. medical abortion methods. See also chapter X on abortion techniques.

[44] Reasons mentioned in to be published study by F. De Meyer et. al. interviewing 23 Flemish hospital gynaecologists involved in decision-making on termination of pregnancy after 12 weeks. See also Harries & Constant, 2020.

for financial resources and staff to improve long-term psychological support to this particular group of patients and their partners.

The law on abortion for severe medical conditions after 12 weeks: insights from practice

The following sections describe medical insights from involved health professionals heard by this Committee/involved in working group 2 with regards to the law.

1. The position of termination of pregnancy for severe medical conditions in the law

Members of working group 2 have the impression that abortion for severe medical conditions is treated as a sub-section of 'elective' abortion in the AVTOP, although they perceive it as a contextually distinct matter. Overall, members of working group 2 preferred a more distinct regulation of abortion for severe medical conditions. The working group recommends a separate article in the AVTOP dealing with the conditions applicable to abortion for severe medical reasons, regardless of gestational age. In addition, some members of the working group mention that the term 'voluntary' in the title of the law can be insensitive to women who terminate a pregnancy in case of severe maternal or foetal conditions. While these interruptions are in essence consensual, they are often not experienced as expressions of volition or free will.

2. Medical grounds after 12 weeks

Abortion after 12 weeks is only legal under the law in case of a serious medical condition (art. 2, 5° AVTOP) (see also chapter 3.2). Two grounds were formulated in 1990 and retained by the 2018 AVTOP: *1) continuing* the pregnancy poses a severe threat to the health of the woman, or 2) it is certain that the child to be born will suffer from a particularly severe condition that is recognised as incurable at the moment of the diagnosis.

Members of the working group have voiced concern over the 'certainty' requirement given the uncertainties that frequently affect clinical diagnosis and prognosis. Research mapping Belgian healthcare professionals' attitudes' towards late[45] termination of pregnancy show that even in the situation of polymalformation with an unclear diagnosis and unpredictable prognosis, 85.6% of professionals would still consider late termination of pregnancy (Roets e.a., 2020). Similar professional attitudes can be expected for earlier terminations of pregnancy. The working group members are in favour of requesting a high level of assurance regarding diagnosis/prognosis, but argue that certainty is not always attainable. It suggests phrasing the legal provision in terms of 'very high' or 'substantial risk' of the particularly severe and incurable foetal condition.

[45] After viability.

With regards to abortion for maternal health conditions, parliamentary commentary suggests that a severe threat to the maternal health includes both physical and mental health problems, but not social situations of distress (DOC 247/2, 152; Nys, 2016, 231). Despite these clarifications in Parliament, researchers and members of this working group suggest that Belgian health professionals remain in disagreement over whether severe maternal health problems can be considered under the law to allow a termination of pregnancy after 12 weeks.[46] Some involved health professionals only regard somatic health conditions, whereas others include severe mental health conditions as grounds for termination of pregnancy after 12 weeks. Involved health professionals suggest that the gestational age of the foetus also seems to play a role in the acceptance of these requests in practice. Although rare, uncertainty also surrounds termination requests after 12 weeks within the context of psychosocial or socio-economic issues that could fall under the concept of 'social health' (e.g. severe poverty, incest, homelessness, severe substance abuse, rape, migrant status, etc.). Although parliamentary interpretation suggests that termination of pregnancy can also take place after 12 weeks when continuing the pregnancy poses a severe threat to the mental health of the woman, involved health professionals preferred that the legislator confirm this position. Some suggested to also include psycho-social health issues as a medical indication for abortion after 12 weeks. At the same time, health professionals recognised that such an explicit inclusion may be superfluous if the time limit for abortion upon request is extended, as such a policy would also enable access of a substantial number of these patients to termination of pregnancy.

Although some legal uncertainty remains, the working group does not deem it possible, nor desirable, to produce an exhaustive list of what should (not) fall under the maternal and foetal health grounds. These matters require case-by-case assessment and complex decision-making in light of the most recent state of the art scientific knowledge, as well as multidisciplinary professional dialogue between health professionals. Some members of the working group express a desire for initiatives within the medical profession that enable exchange of approaches, cases, and protocols between different providers of termination of pregnancy. As these initiatives are time-consuming, remuneration should be foreseen.

3. Second opinion

As described under chapter 1.4, team consultation or broader multidisciplinary debate often precedes termination of pregnancy for medical reasons. For more complex foetal diagnoses/prognoses or termination of pregnancy at advanced gestational age, a non-binding advice from a multidisciplinary Ethics Committee is part of some hospitals' policies.

Members of the working group recommend having multidisciplinary debate prior to performing termination of pregnancy on medical grounds.[47] They view multidisciplinary debate as advisory rather

[46] Unpublished data gathered by F. De Meyer et. al. in study interviewing 23 Flemish hospital gynaecologists involved in decision-making on termination of pregnancy after 12 weeks.

[47] This recommendation may require an exception for urgent medical cases (e.g. life-threatening condition in the pregnant woman).

than decisive for the responsible doctor(s). The advice of the multidisciplinary team should be well documented. Moreover, they preferred that the law would specify that the multidisciplinary team includes at least another doctor who is a specialist in the field of the main medical condition involved.

Finally, members of this working group observed that article 2, 5° AVTOP suggests a shared decision-making process between two doctors, but does not recognise the patient's role and agency in this process. The law seems to limit that role to 'requesting' the termination of pregnancy. Some working group members have challenged this phrasing, as it could express a paternalistic form of healthcare that is no longer the reality today. As an alternative, they suggest recognising in the law that the woman should be heard and given the opportunity to express concerns and wishes regarding the continuation or termination of the pregnancy. An example of such patient recognition can be found in the French law: «*Dans les cas prévus aux I et II, préalablement à la réunion de l'équipe pluridisciplinaire compétente, la femme concernée ou le couple peut, à sa demande, être entendu par tout ou partie des membres de ladite équipe*.».[48] However, other formulations are also thinkable.

4. No end limit

Late termination of a pregnancy is an accepted and common clinical practice in Belgium (Roets e.a., 2020). Foeticide is to be performed by particularly experienced health professionals in a hospital setting and is necessary to prevent live birth and consequent suffering of a severely impaired foetus (VVOG, 2020) (see also chapter 3 and 4). Clinical-technical skill and experience in conducting foeticide is considered crucial by members of this working group in order to prevent potential health risks for the patient (Coke e.a., 2004). Due to the medical reality and availability of foeticide and the existence of late discovery of severe anomalies in the foetus, health professionals involved in this working group support an understanding of termination of pregnancy that is not limited to viability or to a specific gestational age in these cases. For purposes of legal clarity, it recommends to state that abortion for severe medical conditions can be terminated "regardless of gestational age" (compare with French law: article L. 2213-1 of the Code de la Santé Publique).

5. Six-day waiting period

A Belgian interview study questioned 23 Flemish hospital obstetricians about the mandatory 6-day waiting period in the context of termination of pregnancy for medical conditions.[49] The obstetricians favoured a period of reflection in this context, but disagreed over whether it should be a strict six-day criterion. A common perception among the obstetricians was that a waiting period offers patients room for emotional, logistical and administrative preparation prior to actual expulsion. Submissions to this working group also suggest that, in the case of medical conditions affecting the foetus, having time is considered beneficial in the process of decision-making, preparation, and seeking support (Roegiers, 2019). In addition, obstetricians believed a break prevented patients from making decisions they would later come to regret. Additional benefits were perceived for the obstetricians/medical team to better organise and prepare themselves, and protect them from having to act 'immediately', which could disrupt the workflow. Despite overall positive attitudes towards a waiting period, some obstetricians also recognised adverse effects of a strict application of the legal requirement. They mentioned

[48] Article L. 2213-1 du code de la santé publique.

[49] Unpublished data gathered by F. De Meyer et. al. in study interviewing 23 Flemish hospital obstetricians involved in decision-making on termination of pregnancy after 12 weeks.

emotional hardships that the temporal obligation could pose to patients when the medical diagnosis and associated termination request are considered clear-cut. Moreover, obstetricians admit that the waiting period is often flexibly applied in practice or simply redundant. This is linked to disagreement over when the 6 days start to run, given that the law merely states that it runs from 'the first consultation'. Obstetricians mentioned different possible starting points for the waiting period, including: the first (uncertain) indication of an anomaly, the final confirmation of a diagnosis, the patient's suggestion that termination would be an option, the patient's explicit request to terminate the pregnancy, the obstetrician discussion of the fact that ToP is an option, the first consultation with a health professional, the first consultation with a specialist health professional, etc. Some doubt existed as well over whether the administration of medication or the day of admission to the hospital for expulsion ends the waiting period. Finally, many obstetricians recognised that the process of prenatal diagnosis, follow-up appointments and counselling usually takes up more than six days, making the mandatory waiting period often redundant in practice. A Swedish study found that the mean time interval from suspicion of foetal anomaly to the woman's decision is 5 days before gestational week 18, 7 days after gestational week 18, and 13 days after gestational week 21 (Edling *et al.*, 2021). More days are added when counting up to the day of the actual termination of the pregnancy.

The study investigating professional attitudes in Flanders did not directly study patients' appreciation of the mandatory waiting period in the context of medical conditions. As few countries have a mandatory waiting period in the context of abortion for medical conditions, qualitative research on patient attitudes in that specific context is, to our knowledge, lacking. The Committee recognises this gap in the report. For similar advantages as listed above, however, health professionals hypothesise that most patients do not mind or even appreciate having 6 days between the first consultation and the actual termination of pregnancy. On the other hand, an appreciation of time to reflect and process does not, in itself, imply that it should be mandatory. Some health professionals also described situations when being confronted with patients who feel distressed by additional waiting and who do not like to stay pregnant any longer after deviant prenatal diagnosis.

Although the mandatory waiting period is not viewed as a major obstacle in the context of abortion for medical reasons and is associated with potential advantages, members of WG2 emphasise that there is no "standard" duration of maturation for decision-making. Informed consent and emotional stabilisation was considered of high value. WG2 is of the opinion that a fixed, mandatory waiting period is not indispensable to safeguard these principles, and focus should instead lie on the quality of prenatal diagnosis and the stabilisation of the patient by the doctor/medical team.

6. Mandatory information

Health professionals involved in offering termination of pregnancy have raised the point that some information duties are not recommended in the context of termination of pregnancy for medical reasons (e.g. information about adoption or 'opvangmogelijkheden'/'possibilités d'accueil' after diagnosis of particularly severe or lethal anomalies). Moreover, involved health professionals are not always aware of the legal information duties of the AVTOP, but instead, offer case-by-case, patient-

and context specific information.[50] This approach flows from both their legal and deontological duty to extensively inform patients and retrieve informed consent before any medical intervention, including termination pregnancy. Some members of WG2 stress that information about adoption or post-natal assistance is not, per definition, inappropriate to give in the context of abortion for medical conditions. For instance, for severe mental health issues in the pregnant woman, or for certain viable foetuses affected with a medical condition, adoption can be discussed with the patient. The option to discuss adoption or assistance with the woman/couple if continuation of the pregnancy is considered can be valuable. However, working group members emphasise that it should never be mandatory to discuss this with every patient who requests a termination of pregnancy, as this could be insensitive and inappropriate in many cases. According to WG2, this section in the law could be more in line with actual medical practice.

Involved health professionals mention that they consider the following information the minimum standard in practice: information on the severity of the diagnosis/prognosis according to the state of the art scientific and medical knowledge, and information on available alternative therapies (e.g. foetal therapy and surgery options, postnatal care trajectory, postnatal palliative trajectory, …). Information about immediate and future medical risks associated with termination of pregnancy was considered important information by health professionals (mandated by article 2, 2°, a AVTOP), but so was information about the immediate and future medical risks of a [continuation] of pregnancy, if these medical risks would be present. They also stress the importance of qualitative assessment and careful document of the condition by autopsy, imaging, genetics, etc., preferably through interdisciplinary cooperation between specialists. Patients must also be given the opportunity to ask for a second advice elsewhere. The WG highlights that most of these are currently embedded as mandatory information on behalf of the doctor in the Patient's Rights Law. Among others, article 8, § 2 determines: "*De inlichtingen die aan de patiënt verstrekt worden, met het oog op het verlenen van diens toestemming bedoeld in § 1, hebben betrekking op het doel, de aard, de graad van urgentie, de duur, de frequentie, de voor de patiënt relevante tegenaanwijzingen, nevenwerkingen en risico's verbonden aan de tussenkomst, de nazorg, de mogelijke alternatieven en de financiële gevolgen. Ze betreffen bovendien de mogelijke gevolgen ingeval van weigering of intrekking van de toestemming, en andere door de patiënt of de beroepsbeoefenaar relevant geachte verduidelijkingen, desgevallend met inbegrip van de wettelijke bepalingen die met betrekking tot een tussenkomst dienen te worden nageleefd.*" / "*Les informations fournies au patient, en vue de la manifestation de son consentement visé au § 1er, concernent l'objectif, la nature, le degré d'urgence, la durée, la fréquence, les contre-indications, effets secondaires et risques inhérents à l'intervention et pertinents pour le patient, les soins de suivi, les alternatives possibles et les répercussions financières. Elles concernent en outre les conséquences possibles en cas de refus ou de retrait du consentement, et les autres précisions jugées souhaitables par le patient ou le praticien professionnel, le cas échéant en ce compris les dispositions légales devant être respectées en ce qui concerne une intervention.*» This law offers safeguards to the patient requesting termination of pregnancy, at least should this law be considered applicable to the provision of termination of pregnancy.

[50] Unpublished data gathered by F. De Meyer et. al. in study interviewing 23 Flemish hospital gynaecologists involved in decision-making on termination of pregnancy after 12 weeks.

7. Location of provision and type of provider

According to the AVTOP, abortion must be performed under medically responsible circumstances by a doctor in a healthcare institution to which an information service is connected (article 2, 1°, b) AVTOP). Several members of the working group express the importance of high quality standards and clarified that some terminations of pregnancy are best followed-up and/or performed in hospitals with a broad expertise in prenatal diagnosis and (late) termination of pregnancy. The need for specific expertise and high-quality care was particularly articulated with regards to the following aspects:

- Prenatal diagnosis and prognosis (including genetic analysis when appropriate), especially for more complex anomalies + potential post-mortem investigation
- Performance of foeticide in case of a late termination of pregnancy
- Psycho-social assistance and counselling of the woman/couple

Although some members of working group 2 find the law's reference to 'medically responsible circumstances' sufficient, others express the need to specify quality requirements for termination of pregnancy on medical grounds, especially when performed at a later gestational age such as post-viability.

With regards to the legal requirement which mandates that it should be a doctor who performs the termination of pregnancy, the medical profession highlights that the actual procedure of medication abortion may also be "performed" by other professions under guidance of a doctor. Some other aspects of abortion care may also be performed by different people and at different locations. In this regard, the Committee draws the attention to the WHO's Abortion Care Guideline, which lists different options and models that exist in regard to abortion service delivery, including after 12 weeks gestation.[51]

8. Right to refuse and duty to refer

Given the ethical dimensions and medical uncertainties that often affect terminations of pregnancy on medical grounds / at advanced gestational age, health professionals heard by the Committee have expressed their support of the right to refuse. They also are supportive of the duty to refer after refusal, in light of the patient's wellbeing.

9. Declaration and registration

The civil code mandates the registration by the civil servant of a lifeless child from 180 days post-conception (see art. 58 Civil Code). Since a legal amendment to the civil code in 2018, this can also happen at parental request after 140 to 179 days of pregnancy (art. 58, §2 Civil Code). The acte/akte of the stillborn child has no automatic legal consequences, unless explicitly foreseen in the law (art. 58, §3 Civil Code). In addition to the regulation of the Civil Code, some laws guarantee rights for the parents after stillbirth.

Involved health professionals have mentioned some practical issues and interpretational differences in hospitals with regards to these laws.

First, different policies and preferences were expressed regarding declaration of children that were born alive but that lack the capacity of long-term survival, both in the context of induced termination

[51] WHO Abortion Care Guideline available at: https://srhr.org/abortioncare/.

of pregnancy and spontaneous birth. Some would register the birth as a stillbirth (model IIID), whereas others register it first as a livebirth (model I) and later as a stillbirth (model IIID). Officially, declaration of a live born child in Belgian civil law can only happen when the child is considered born viable.[52] Hence, a legal gap was perceived for those children that are not born lifeless but that are not considered viable either. Among others, a specific tab in E-birth in which it can be specified whether the registration happens in the context of an intentional termination of pregnancy was recommended by involved health professionals.

Second, regardless of the possibility of voluntary declaration of a stillborn child from 140 days pregnancy, a number of laws attach legal consequences to the birth of the lifeless child after 180 days of pregnancy post-conception only (e.g. maternity rest[53] and maternal leave[54]). Some involved health professionals have expressed the wish to see these legal consequences automatically be awarded from 140 days pregnancy, a limit which would be in line with current medical understanding of viability (see also: Royal Decree of 17/06/1999 about statistics of death causes and the definition of stillbirth contained there: "Stillbirth is understood to mean any foetal death if the weight at birth is equal to or greater than 500 g (or if the weight at birth is unknown, which exceeds the corresponding gestational age (22 full weeks) or the corresponding body length (25 cm from crown to heel) has reached"). However, other health professionals did not find this appropriate, as some women/couples do not wish to automatically have that level of recognition after a stillbirth.

Third, the co-existence of multiple registration/declaration duties for health professionals in the context of termination of pregnancy seemed to cause confusion and inconsistencies. These involve: - the declaration to the civil authorities based on the rules in the Civil Code (via model III), - the registration of livebirths/stillbirths for statistical purposes of Statbel based on the threshold of the Royal Decree of 17/06/1999 (via model IIID), the data collection by EUROCAT (European network of population-based registries for the epidemiological surveillance of congenital anomalies), the registration of terminations of pregnancy for the National Evaluation Commission on Termination of Pregnancy (via registration forms of the National Evaluation Commission[55]).

The potential relevance of foetal viability and foetal pain in the context of termination of pregnancy for severe medical conditions

1. Foetal viability

On average around 22-24 weeks of gestation, the developing foetus is considered viable. In chapter X we discussed options for abortion law reform, one of which includes extending the gestational age limit of 12 weeks. The potential relevance of the criterion in the context of abortion for non-medical reasons is thoroughly discussed there.

---

[52] See also articles 3.13, 4.4 en 4.137 Civil Code, and article 331bis old Civil Code.

[53] Artikel 114, vierde lid, van de wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen.

[54] Artikel 39, tweede lid, van de arbeidswet van 16 maart 1971.

[55] Document for termination of pregnancy case registration: https://overlegorganen.gezondheid.belgie.be/sites/default/files/documents/laatste_reg_formulier_-_2022.pdf; Document for the yearly report of the institution: https://overlegorganen.gezondheid.belgie.be/nl/documenten/ivg-jaarlijks-verslag ; Document for the yearly report of the information service: https://overlegorganen.gezondheid.belgie.be/nl/documenten/ivg-jaarlijks-verslag-0.

It should be noted that there are many, sometimes conflicting, conceptions of 'viability'. In the context of foetal anomaly detection, it is important to mention a difference between viability in abstracto and viability in concreto (Huygens, 2011). Abstract viability refers to the age at which the average foetus gains the capacity to survive outside of the uterus with some level of medical-technical support. This is the notion of viability as a temporal benchmark that often enters the abortion debate. In concreto viability refers to the individual capacity of a particular foetus to survive outside of the uterus with some level of medical-technical support, taking into account the specific characteristics and (impact of) anomalies of the foetus. As summarised well in a report by the Victorian Law Reform Commission, "the medical profession considers 22–26 weeks gestation as a 'grey zone', where some fetuses have survived, most with ongoing disability, through major medical intervention. These survival rates do not apply to fetuses with existing disability, where survival depends on the nature and extent of the disability." (Victorian Law Reform Commission, 2008, 3.60). In the Belgian abortion law, neither abstract nor concrete viability thresholds limit access to abortion for severe medical conditions.

In the submissions in WG2, the abstract viability limit was considered of little importance when it comes to the acceptability of abortion for severe foetal anomalies. The Committee observed high levels of support from the medical profession and other WG2 members to retain the option to perform a termination of pregnancy after the viability limit for severe medical conditions. In one Belgian study, acceptance of late termination of pregnancy among involved health professionals was particularly high in both lethal foetal conditions (100%) and serious (but not lethal) foetal conditions (95,6%) (Roets e.a., 2020). Lower support levels exist for post-viability termination of pregnancy when the foetus is healthy but the pregnant woman faces psychological problems (19,8%) or socio-economic problems (13,2%) (Roets e.a., 2020).

Without challenging the acceptance of late abortion for severe medical conditions, some health professionals suggested that the different treatment of fetuses of the same gestational age (those in neonatal intensive care receiving significant pediatric intervention vs. those subject to termination of pregnancy) sometimes posed a psychological challenge. Others believed both contexts to be entirely detached from one another due to the distinct health status of those fetuses.

Rather than having moral significance for abortion for medical reasons, emerging viability was mentioned by WG2 members as necessitating a technically different procedure. These submissions refer to the earlier described procedure of foeticide prior to medical induction in order to prevent live birth and potential survival.

Moreover, *in concreto* viability was considered to play a role in medical practice when it comes to choice of procedure. If a fetus is not considered viable due to the lethal anomalies that affect it, patients/couples have the option either to terminate the pregnancy prematurely, or to anticipate birth and consequent spontaneous death. The latter option is not available if the fetus can be considered

capable of survival (although affected with a particularly severe and incurable anomaly). After all, active end-of-life interventions for a severely impaired child are not legally available in Belgium (for an example of an opposite policy, see end-of-life decisions of newborns policy in the Netherlands).

Finally, the viability of a foetus plays a significant role in termination of pregnancy decisions when considering severe threats to the health of the pregnant woman. If ex-utero survival chances of the foetus are significant and the impact of premature birth on the health of the foetus limited, patients may request an induction of pregnancy without prior foeticide, followed by a neonatal care trajectory to support the premature neonate. The anticipated level of prematurity and associated health risks for the child will influence these complex clinical decisions.

2. Foetal pain and consciousness

In the submissions in WG2, the emergence of foetal pain/consciousness in a fetus did not seem to hinder acceptance of termination of pregnancy for severe medical conditions. In fact, many submitters to this Committee suggest that late termination of pregnancy after diagnosis of a severe and incurable foetal anomaly is precisely considered to prevent the birth of a child that is expected to endure substantial pain and suffering.

A concern for foetal pain and foetal consciousness was, however, expressed by some professionals represented in the WGs with regards to the technical procedure. Due to scientific, moral, and personal grey zones and perceptions surrounding foetal pain and consciousness, different clinical policies were submitted vis-à-vis the need for foetal anesthesia that reach the fetus prior to medical abortion/foeticide. While information on foetal pain is conflicting, the Committee encourages ongoing review of authoritative medical bodies' guidelines, as well as of scientific studies on the topic within the medical profession (see more about scientific evidence on foetal pain and technical concerns in chapter X).

List of recommendations WG2

These recommendations relate to the current law. Some of these may become superfluous if other legal amendments would be introduced. The following recommendations should be read with that understanding in mind.

1. Regulate termination of pregnancy for severe medical conditions in a separate section in the AVTOP to enhance legal clarity. This allows drafting the conditions regarding the procedure in a manner that is tailor-made to this distinct context.

2. To avoid legal uncertainty, specify that termination of pregnancy for severe medical conditions can take place “regardless of gestational age”.

3. **Severe medical conditions**

- Replace ‘certainty’ of the particularly severe and incurable condition of the child to be born by a high risk standard (several options were mentioned: e.g. ‘very high risk’/’substantial risk’/’strong probability’).

- Avoid drafting a limitative list of severe maternal or foetal conditions that could qualify for lawful termination of pregnancy regardless of gestational age.

- Maternal health ground

In the text of the law, clarify that “health” of the pregnant woman includes mental/psychiatric health.

Example of phrasing*: “*

A pregnancy can be terminated … when it is necessary to prevent a severe threat to the <u>physical or mental</u> health of the pregnant woman.”

4. **Second opinion and decision-making process**

Recommend involving a specialist second doctor in the counselling and decision-making process prior to termination of pregnancy for severe medical conditions. Install multidisciplinary discussion prior to

terminating the pregnancy on medical indication. Recognise the agency of the pregnant woman in this process, who should be able to voice concerns and wishes and should share decision-making with doctors.

Example of phrasing:

"A pregnancy can be terminated, regardless of gestational age, when the responsible doctor, after having heard the pregnant woman and having obtained the advice of a multidisciplinary team which includes a second doctor who is specialised in the main condition, taking into account the state of the art medicine, professional standards and deontology, comes to the conclusion that [*continuing the pregnancy poses a severe threat to the health of the pregnant woman or it is certain that the child, if born, will suffer from a particularly severe condition that is considered incurable at the moment of diagnosis.*][56].

5. Mandatory information

Remove the mandatory duty to inform each patient who requests a termination of pregnancy for severe medical reasons about **adoption**, and about different '**opvangmogelijkheden'/'possibilités d'accueil**' for the child that will be born. Instead, prioritise case-by-case information according to the specific context of the termination request.

No fundamental objections were raised to the condition which state that "at the request of the doctor or of the woman, it must give her help and advice as to the means she can rely upon to solve the psychological and social problems that have arisen by her condition", nor to the condition that mandates information "about the woman's "rights, support and advantages guaranteed by law and decree to families, to married and unmarried mothers, and to their children". However, a more general and less paternalistic rephrasing was preferred. Example: "at the request of the doctor or of the woman, it must give her help and advice about the means she can rely upon for psychological, social, legal, financial, and administrative support". Involved health professionals recommend financial support in order to improve this type of support to patients/couples in and outside the hospital.

Information about "immediate and future medical risks to which [the woman] exposes herself by terminating the pregnancy" was considered of importance. However, the legislator should consider that, if the Law on Patient's Rights applies, this information on behalf of the doctor is already mandatory by law (see article 8, §2 of the Law on Patient's Rights). If this law would not be considered applicable, or if a specific preposition in the AVTOP is considered justified by the legislator, the Committee recommends to amend the phrase in the Act on Voluntary Termination of Pregnancy as follows: inform the woman about the "immediate and future medical risks to which she is exposed by terminating '*or continuing'* the pregnancy*, if such medical risks would be present"*.

Remove the mandatory information on contraceptives. In practice, such information is discussed after termination of pregnancy with the health and future pregnancy perspectives of the woman in mind. Discussing this with patients to whom it is of relevance is considered a standard measure of good quality of healthcare in practice.

Alternative treatment therapies:

[56] Current phrasing of the medical grounds in the AVTOP, which may require amendments based on the other recommendations.

Information about alternative treatment therapies is currently not specifically mandated by the AVTOP, although it was deemed of importance in practice by involved health professionals. Article 8 of the Patient's Rights Law mandates information on the possible alternatives. If that law applies to termination of pregnancy, this information may be covered by a legal obligation for the healthcare provider. If not, it may be inserted in the AVTOP.

6. Mandatory waiting period

Remove the six-day mandatory waiting period in the context of severe medical conditions as a rigid obligation in the law.

Professionals are encouraged to recommend a period for decision and preparation as an aspect of qualitative medical care. As already safeguarded by the AVTOP, by general health laws (if applicable) and deontological principles, professionals remain obliged to duly inform patients, obtain consent, ascertain their "steady will", and reach the required confirmation about the diagnosis/prognosis, before carrying out the termination of pregnancy. The advice from the multidisciplinary team which includes a doctor specialised in the main condition (see recommendation 4) is considered to safeguard proper and unpressured decision-making.

7. Registration and data collection

Improve scientific data collection about termination of pregnancy on medical grounds. Raise awareness among health professionals about the scientific importance of accurate registration. Evaluate, synchronise and simplify the different registration duties that exist for health professionals in the context of termination of pregnancy to the extent possible.

8. Civil declaration of stillborn child and associated rights/duties

Increase clarity for both parents and health professionals on the different legal duties and rights that exist in the context of a termination of pregnancy after a certain pregnancy age, and those connected to voluntary/mandatory civil declaration of a stillborn child.

To avoid confusion on calculation of pregnancy age, consider mentioning both post-conception pregnancy and ultrasound gestational age in the laws dealing with these rights and duties.

9. **Support initiatives among health professionals/institutions to organise multidisciplinary debate and exchange of approaches/protocols**

Consider financial reimbursement for the organisation, documentation, and reporting of multidisciplinary team deliberation.

Consider support for initiatives in which health professionals from different institutions can share case insights, protocols and approaches regarding termination of pregnancy for medical conditions.

c) Working group 3 : The issue of elective abortion requests beyond 12 weeks, including the analysis of international comparison.

Admission of abortion requests after current 12-week limit / extension of the 12-week time limit

1. Typology of arguments regulating abortion laws

When confronted with the willingness to regulate abortion, legislators usually have to deal with different conceptions and framing of abortion but also different types of argument and rationales to ground the decision. Resting on moral or even religious conceptions as well as medical guidelines, conceptions of social justice and of public health, those arguments not only shape the debates and the legal framework ensuing, but usually rely on deeper – and often unspoken – conceptions of the role of the State, as well as conceptions of sexuality, gender roles, family, natality, and motherhood.

The ethical dilemma between the moral and ethical status of the fetus (regardless of its legal one) and the autonomy of the women on their own body are at the center of the ethical dilemma : the ethical positioning on abortion is a balance between these two central values. These questions have been extensively discussed in opinion 18 of the Belgian advisory committee of bioethics (Belgian Advisory Committee on Bioethics, 2002) where an extensive discussion on the ethical positions regarding the status of the embryo and the fetus can be found. Nevertheless, in the practice, the public health dimension remains an important parameter to be taken into account in the discussion due to the impact of clandestine (unsafe) abortion in women mortality and morbidity.

Such arguments are not only determinants in the regulation of abortion but also in the legal limitation of gestational age for an abortion. When compared, the legal frameworks of a vast array of countries usually distinguish between three distinctive motives for the termination of pregnancy :

Abortion upon request (which can be motivated by a psychosocial situation, but relies on the decision of the pregnant woman)

pregnancy resulting from circumstances that are considered as extreme (proceeding from rape, incest or, in some countries, illness or death of the male genitor preventing him from exerting parenthood)

pregnancy presenting either a medical risk for the pregnant woman or for the fetus, or is affecting the life, the sufferings or the quality of life of the future child to be born.

The present text focuses on elective abortion, defined as abortion requested by the pregnant woman based on psychosocial motives (that are not necessarily to be mentioned). In several countries, the legal framework can interweave those three situations, whereas in others, they are objects to very distinct dispositions. Since the Belgian framework – from and toward which the present reflection is based – is displaying a clear distinction between abortion for social or medical motives, the arguments presented here are those presiding to abortion for psychosocial motives.

1.1. Argument of the absolute value of life

Rooted in a philosophical or moral conception that values embryonic/fetal life in early stages of the conception, this argument can either be integral, leading to a prohibition of abortion, or be put in balance with other considerations (see point 1.2.). Similar findings are expressed by the Belgian Advisory Committee on Bioethics, describing a "fixist" position consisting in considering that the conception is the radical criterion defining the embryo as a person (Belgian Advisory Committee on Bioethics, 2002). Although it can be balanced, this position puts a symbolic value on embryonic or fetal life. From there, several laws consider abortion as a "lesser evil" that can be authorized and regulated but should somehow be avoided as much as possible.

According to Minkenberg, legislation displaying an emphasis on the fetal life over other social or medical considerations are often found in countries with a weak or absent separation of Church and State (Minkenberg, 2003).

1.1.1. Absolute position : fetal life should never be intentionally ended

In this most radical position, the embryo or the fetus is considered as a person from the moment of conception. It can be interpreted as a radical position in that the moral value attributed to fetal life surpasses the moral value attributed to the life of the pregnant woman. It is from this position that some activists advocate for the "rights of the fetus".

> Example : In Nicaragua and El Salvador, abortion is prohibited in any case, even if the pregnancy endangers the pregnant woman (Boland, 2010).

1.1.2. Value of life Vs circumstances of conception

Most of the national laws presenting with a radical conception regarding the value of fetal life consider, however, that fetal life can be ended in the case of dramatic circumstances tarnishing the conception, such as cases of rape and incest.

Countries applying this kind of reasoning in their legal framework generally require a formal complaint, a judicial authorization or a medical statement in order for the abortion to be legal. Regarding the many difficulties and barriers in obtaining those documents and proofs (Guillaume and Rossier, 2018), it can be argued that position 1 a) and 1 b) are in practice similar.

1.2. Argument of the value of both lives (fetus and pregnant woman)

According to this position, the fetal life has an important value but it should be put in balance with the pregnant woman's life or quality of life from several aspects. Laws formed on the grounds of this range of arguments are classified as the "indication model", according to which abortion is still considered as illegal or to be avoided but permitted under specific circumstances (Minkenberg, 2003).

Abortion authorized in case of life-threatening condition for the pregnant woman

This is the most common disposition in abortion regulation : almost all countries, even those with very restrictive access to abortion, allow abortion on the ground of danger to the maternal life (Boland, 2010). Some national laws allow abortion in case of lethal risk only up until a specific gestational age (e.g. 12 weeks), whereas in most national laws, there is no upper limit of gestational age.

> Example : In Ireland, the 8th amendment to the Irish constitution voted in 1983 (and abolished in 2018 (De Meyer, 2020) established equal rights for the unborn fetus as

for the pregnant woman, resulting in prohibiting abortion in any cases, unless the pregnant woman's life was endangered by the pregnancy (Carnegie and Roth, 2019).

1.2.1. Abortion authorized in case of health-threatening condition for the pregnant woman

The rationale is similar, but extended to the health of the pregnant woman, sometimes including her mental health. Such legislation is often ambiguous as to what should be considered as health impairment (Boland, 2010).

Example : In Poland, a bill passed in 2020 makes abortion only legal if the pregnancy ensues criminal acts, or presents life- or health-threatening risks for the pregnant woman but does no longer include fetal malformations or impairment[57].

1.2.2. Abortion authorized if the pregnancy is harmful to the pregnant woman based on social grounds

This rationale usually derives from the previous health approach : in many cases, considerations towards the pregnant woman's physical and mental health led to also consider the social harm induced by an unwanted pregnancy. This approach puts in balance not only life itself but the quality of life of both the pregnant woman and the child to be born (Minkenberg, 2003). According to this rationale, not only general health but also the living conditions are a responsibility of the State. Such a development in the regulation of abortion is more common in countries defending a welfare State approach (Linders, 1998).

Such trajectories are called the "distress model" (Minkenberg, 2003) : abortion is granted on the basis of an exceptional state, and are considered as a lesser evil, in what is qualified as a "moderately liberal" stance. The State regulates abortion on the grounds of its role in terms of health protection and social welfare, out of commiseration to the situation of women confronted with unwanted pregnancies and the related social, financial and health consequences. Consequently, abortion is conditioned not only to the state of distress, but also to the assessment of said state by medico-psycho-social professionals. This translates into mandatory pre-abortion counselling, waiting periods and approbation by health practitioners.

Example : in Belgium, the mention of the state of distress in the 1990 law can be considered as a middle ground to satisfy both sides, one considering abortion as a public health issue and another willing to maintain it as an exceptional situation (Expert hearing: Berengère Marques-Pereira).

Example : a similar situation can be found in the Victoria State in Australia, with a ruling from 1969 establishing that abortion was still a criminal offence but could be lawfully performed in specific circumstances. Those circumstances corresponded to cases in which the pregnancy was harmful to the pregnant woman on various grounds (Victorian Law Reform Commission, 2008).

1.3. Logic of the gradual value of the fetal life

The arguments putting fetal and maternal lives in balance often include a dimension of the embryonic or fetal life acquiring a gradual value as time passes by (which is not the case in the most radical positions such as 1a, asserting the absolute value of life from conception). The Belgian Advisory

[57] https://dziennikustaw.gov.pl/DU/2021/175

Committee on Bioethics referred to this type of reasoning as the "gradualist approach" – according to which the ethical status of the embryo or of the fetus varies through time (Belgian Advisory Committee on Bioethics, 2002). As a consequence, the vast majority of legislations regulating abortions under more or less restrictive conditions also include considerations and limitations regarding the gestational age at which abortion should occur, in what is called the "period model" (Minkenberg, 2003).
The perspective of a gradual value of the fetal life goes together with medical considerations towards fetal development and the related abortion techniques. Legislations with a regulation of gestational age thus frequently encompass philosophical considerations about fetal life together with considerations about medical technical constraints and knowledge. It should also be pointed that, whereas some legislators offer a rationale for their decision in terms of gestational age limit (whether it is expressed in the law or in the previous debates motivating the decision), such a limit seems to have become an tacit convention in many national laws and is thus not further motivated.

1.3.1. First trimester benchmark

An important number of countries who have regulated a right for abortion have defined a gestational age limit of 12 weeks for abortion for psycho-social motives. Although the legal texts often mention motives for regulating abortion, the gestational age limit itself is usually not explained. Twelve weeks of pregnancy equates with the first trimester and can be considered as a benchmark in the timeline of the pregnancy. However, this benchmark should be discussed beyond the arbitrary aspects of fractioning the length of the pregnancy.

In the well-known Roe v. Wade decision formulated by the US Supreme Court in 1973, it was established that abortion should be admissible on the basis of a trimester framework : during the first trimester of gestation, the abortion decision was left to the medical judgement of the doctor attending the pregnant woman; in the second trimester, the State could adopt restrictions to abortion at the condition to be reasonably related to maternal health; the third trimester, being associated with viability, was the point at which abortion was prohibited (at the exception of cases of maternal health risks)[58]. The main argument supporting this decision was that abortion up to the twelfth week had, with the techniques available then, a lower mortality rate than childbirth (Rhoden, 1986). The 1992 Planned Parenthood v. Casey ruling removed the first trimester benchmark to only conserve the viability benchmark as gestational age limitation (Beck, 2011). Yet, for decades, the 12-week time limit has remained an important benchmark in lawmaking regarding abortion, in an array of reasons that seem to mix medical notions and international jurisprudence.

When abortion became progressively legal and regulated, several countries have opted for a model based on a trimester framework, which mentions the 12 week time limit as one of two relevant benchmarks in the regulation of abortion (the other being viability), that some authors attribute to the influence of the Roe v. Wade decision (Erdman, 2017). The notion of abortion up to the first 12 weeks of pregnancy is so influential that it sometimes used in much more recent legislation, in spite of the medical and technical advances in the field of abortion, but also in ambiguous terms, as it is the case in Ireland.

> Example : The 2018 Irish law states that abortion is now legal (under conditions) up to 12 weeks of pregnancy. However, in this case, 12 weeks do not refer to the first trimester but to a shorter period. Indeed, as the text further explains "12 weeks of pregnancy shall be construed in accordance with the medical principle that pregnancy

[58] https://supreme.justia.com/cases/federal/us/410/113/#163%E2%80%9366

is generally dated from the first day of a woman's last menstrual period." – meaning that abortion is actually allowed up to a gestational age of 10 weeks. (Carnegie and Roth, 2019)

The Irish example demonstrates that the benchmark is more a symbolic one based on a number, rather than just a medical marker based on the development of the pregnancy.

Gestational age benchmarks and their uses in the regulation of abortion thus combine legal, technical, medical, and social perceptions of pregnancy age. If the medical field distinguishes between the first and the second trimester of pregnancy, it is not only for practical reasons, neither only regarding fetal development but also in consideration of the rates of spontaneous miscarriages at those different stages of the pregnancy. An estimate of 15% of the identified pregnancies end in spontaneous miscarriage during the first trimester (Cohain *et al.*, 2017), whereas approximately 80% of miscarriages happen during the first trimester (Dugas and Slane, 2022). It should also be noted that an important number of pregnancies end spontaneously even before the pregnancy can be identified – with numbers estimated between 40 to 75 % of embryonic death occurring before and during implantation (Jarvis, 2017). The risk of spontaneous miscarriage significantly decreases after the first 12 weeks of pregnancy. In phase with those medical data, the end of the first trimester is consequently the moment the (planned) pregnancy becomes socially acknowledged and announced, ending a time of uncertainty (Purcell *et al.*, 2017). The 12-week benchmark is thus strongly associated with the moment the pregnancy changes from an intimate state to a state that can be socially recognized. Although this motive is not mentioned in the legal texts nor debates, it should be considered as a potential influence weighing on the 12 weeks benchmark[59].

1.3.2. Rationale of the extra-uterine fetal viability

In the context of time-limit models for abortion regulation, another possible benchmark is the viability of the fetus. Defined as the moment from which the fetus is potentially able to live an independent life outside of the uterus, the stage of viability can be seen as a "grey zone" comprised somewhere between 22 and 26 weeks (Keogh *et al.*, 2007). In 1977, with the aim of establishing a threshold for the registration of premature birth, the WHO established fetal viability at 20 weeks of gestation post-conception or 500 gr of fetal weight (WHO, 1977) whereas there is a medical consensus to establish fetal viability at 22 weeks of gestation post-conception, although the topic may remain reviewed (Great Britain: Parliament: House of Commons: Science and Technology Committee, 2007; Robertson, 2011; Ploem *et al.*, 2020).

Among the arguments supporting the fetal viability as a time-limit benchmark for abortion, there is the idea that, since the fetus could potentially be delivered and survive, it could consequently acquire a civil status and the afferent rights (Victorian Law Reform Commission, 2008; Guillaume and Rossier, 2018).

Several authors underline that the extra-uterine fetal viability benchmark, although based on scientific consensus, is still an arbitrary notion when applied to abortion. In scientific terms, indeed, fetal viability is more about probability than actual certainty : there is no standard as to the probability of survival determining fetal viability (Erdman, 2017), and the probability of survival at 24 weeks is not ascertained but estimated at 42-57% (Ecker *et al.*, 2017) and is carrying a significant risk of severe

[59] It can additionally be noted that some authors still refer to the 12th week of the pregnancy as the moment from which the embryo becomes a fetus (Requejo, 2011; Marta, 2020). Although this notion is no longer correct (the embryo phase is admitted to end with the 8th week of pregnancy), it is likely that this outdated notion could still have an influence in lawmaking decisions.

handicap. Instead, actual viability is based on an array of parameters that vary from one pregnancy to another. In addition, there is a probability that, in the future, fetal viability could be reached at earlier pregnancy ages. This would imply to review the maximal gestational age for abortion along with the scientific evolution, thus risking reducing the width of abortion rights for women as science progresses (Rhoden, 1986; Victorian Law Reform Commission, 2008; Askola, 2018).

For instance, ongoing scientific efforts to make ectogestation (pregnancy outside of a human's body) possible through the development of artificial "wombs" could lower the extra-uterine viability limit (Di Stefano *et al.*, 2020). Some fear that directly referring to viability as the relevant benchmark in abortion law could imply continuous needs to lower the gestational age up to which abortion can be performed, thus risking to reduce the width of abortion rights for women as science progresses (Askola, 2018; Rhoden, 1986; Victorian Law Reform Commission, 2008). Others believe that the medical technology to keep premature foetuses alive will or should not necessarily impact upon abortion policy. Potential impact relies also on our understanding of 'viability' and the extent to which it (does not) exclude(s) the use of far-reaching medical-technological support systems. After all, external support systems do not increase the inherent survival capacity of the embryo/foetus involved, but simply assist in ongoing fetal development. Nevertheless, it seems that at least a level of medical-technological support is already considered today as influencing/lowering 'foetal viability' (e.g. incubator).

The arbitrary aspect also stands in correlating a potentiality (of survival ex-utero) with the actual situation of persons experiencing an unwanted pregnancy (Erdman, 2017). In the words of Erdman (2017, p. 33) : "Viability is a measurement only sensible as applied to a neonate post-birth, but it is used to define the status of a fetus in utero. Moral arguments from viability thus treat pre- and post-birth as though they were equivalent states, when the very argument is that they are not."
The fetal viability can nonetheless be adequately employed as per what it is : a technical benchmark providing an ethical support to balance notions such as women's bodily autonomy and the value gradually placed on fetal life.

> Example : In the Netherlands, whereas the law on abortion allows the procedure of abortion on demand, the article 82a of the penal code prohibits to cause the death of a fetus that can reasonably be expected to remain alive outside the pregnant woman's body. The law understands viability as a fictional hypothesis that is never to happen but contributes in establishing a limit. According to a national evaluation of the Dutch law (Ploem *et al.*, 2020), the distinction is well acknowledged both by the general public and the health practitioners. Also in the field of extreme neonatal care, it is recognized that the situations are actually different and expectations placed on the pregnancy in the case of extreme premature birth and second trimester abortion have very little in common. The conclusion of the report mentions that "Thus, the "abortion limit" and the "treatment limit" meet, but do not overlap. Because of the latter, there is no reason to operationalize the viability limit differently from the current 24 weeks[60]. (…) In short, these are different groups about which different decisions are made." (Ploem *et al.*, 2020). The authors recommend keeping the 24-week time limit (22 weeks post-conception) but also to loosen the logical relation between neonatal care and abortion care. The shared benchmark is not more than an indication but does not

[60] It must be noted that those numbers refer to amenorrhea weeks and not gestational age – which is the notion used in the rest of this document and in the Belgian law.

equate the ethical stakes. The authors also recommend moving the 24-week time limit from the penal code to the abortion law itself, as a guideline for the practice rather than as a criminal limit. It should also be noted that in spite of the law allowing abortion up to 24 weeks of pregnancy (22 weeks post-conception), the abortion clinics usually perform abortion only up to 22 weeks and 2 days (or 20 weeks and 2 days post-conception), in order to maintain a margin of error in the estimated age of the pregnancy. Technical criteria are also taken into account : second trimester abortion clinics can manage surgical abortions up to 22 weeks, when abortions between 22 and 24 weeks have to be performed in hospitals (Expert hearing Raïna Brethouwer). Despite the use of viability in Dutch abortion legislation, it should be reminded that viability is not used as a limiting principle when considering abortion after diagnosis of lethal and particularly severe foetal anomalies[61].

Example : In Great Britain, the abortion act of 1967 (see page **Erreur ! Signet non défini.** for more details) allowed abortion on some conditions up to 26 weeks of gestation (post-conception). In 1990, however, the Human Fertilisation and Embryology Act amended the main law in reducing the gestational age limit from 26 weeks to 22 weeks post-conception. The rationale motivating this amendment was the more recent scientific understandings of fetal viability (Great Britain: Parliament: House of Commons: Science and Technology Committee, 2007).

1.3.3. Rationale of the sensory development of the fetus

One of the reasons fetal life is considered to grow in importance as it develops is related to the progressive development of bodily features, organs and sensory activity that lead the fetus to become progressively more sentient and potentially autonomous, and, consequently, be more considered as close to a person. Those considerations are ethically and logically close to the arguments related to fetal viability, both relying on scientific data regarding fetal development and both establishing the benchmark at 22 weeks of gestational age post-conception. The technical focus of viability is the potential survival chance outside of the womb and its ethical focus is the ability to be born and acquire a civil status. The ethical focus of sensory development is very similar, being about what makes a human fetus similar to a person. One important distinction remains, however, in the technical focus of sensory development, which is oriented towards what the fetus could actually feel in case of induced abortion.

Philosophical criteria usually held to define personhood can difficultly apply to fetuses : consciousness (and ability to feel pain), reasoning, self-motivating activity, communication and self-awareness (Warren, 1973). In the domain of abortion and fetal development, the criteria of consciousness seems, however, to be kept as an important ethical and practical marker, mainly due to its relation with the ability to feel pain. More broadly, it raises questions about the moral value attributed to biological facts, sur as pain perception : although biological facts can be established with increasing degrees of accuracy, the moral arguments to draw from those elements are not obvious.

[61] Regeling van de Minister van Veiligheid en Justitie en de Minister van Volksgezondheid, Welzijn en Sport van 11 december 2015, kenmerk 885614-145412-PG, houdende instelling van een commissie voor de beoordeling van gemelde gevallen van late zwangerschapsafbreking en levensbeëindiging bij pasgeborenen.d

The so-called consciousness is then connected to the development of the sensory system, and, more accurately to the development of neurological structures (the cortex and the thalamus and the nerve system connecting one to the other) (Robertson, 2011). Scientific data recollected by the Great Britain Parliament in its report on the abortion law tend to the conclusion that the main elements of the sensory system in the fetus do not mature until 22 to 26 weeks gestation : nerve endings, spinal cord, and thalamic connections able to penetrate the cortex (Great Britain: Parliament: House of Commons: Science and Technology Committee, 2007). Fetal stress, however, can be detected before those ages, notably under the form of endocrine signals. The report concludes that such stimuli are not indicators that pain is consciously felt, certainly not before 22 to 26 weeks gestation. With this argument, a gestational age limit for abortion of 22 weeks is estimated reasonable by the report of the Great Britain Parliement in consideration of the development of the fetus. The 22-week benchmark consequently offers a legal answer to the ethical concern regarding the consciousness criteria as a potential limit for the possibility to terminate the pregnancy.
This topic remains disputed, as evidence of the development of the sensory system in fetuses becomes more accurate.: nerve terminals appear from 11 weeks post-conception, neuromediators from 8 to 12 weeks, the amygdala is present towards the middle of the gestation whereas the cortical thalamus fibers begin to take possession of the cortex between 22 and 30 weeks of gestation (Bellieni, 2021). This study shows that the spinothalamic tract for the conduction of touch and pain stimuli and the thalamus, gateway to the cerebral cortex are present since the 15th week and sufficiently developed at 17 weeks to relay the affective side of our sensation, especially pain.

How those developments can determine the perception of pain is not entirely certain, notably as per doubts regarding the role of the cortex. More accurate fetal response to stimuli toward mid-pregnancy however seem to provide converging indications on fetal sensory developments.

With similar reasoning, Nebraska has banned in 2010 abortions after 20 weeks of gestation, considering some scientific evidence about the ability of fetuses over 20 weeks to feel pain (Robertson, 2011). It indicates that there is no unanimity on this topic, neither from a legal perspective, nor from a medical one. It also shows that, just like for the argument of fetal viability, legislation based on a specific state of the fetal development is susceptible to be based on various interpretations, but also evolve and thus reduce or increase abortion access.

As mentioned earlier part of the technical focus of the sensory development argument is the possibility for the fetus to feel pain during the abortion procedure. However, contemporary abortion techniques allow the administration of anaesthetic or myo-relaxing substances that reach the fetus or are conveyed through the pregnant woman (Great Britain: Parliament: House of Commons: Science and Technology Committee, 2007; Robertson, 2011, Expert hearing : Raïna Brethouwer). Bellieni, supported by more recent research, insists on the need to administer anesthetics directly to the fetus, since maternal administration doesn't necessarily prove effective on the fetus (Bellieni, 2021). Although directed to fetal surgery procedures, those recommendation may apply also in the case of termination of pregnancy. Such practices seem to solve the technical preoccupations regarding the actual pain felt by the fetus during a second trimester abortion.

1.4. Rights issue

Advocating for abortion as a right in the name of the humanity, citizenship or reproductive autonomy of the pregnant person requires to provide an understanding on how reproduction, abortion or fetal

life are at stake in this perspective. Based on these rhetorical framings, legal institutions or tools can be mobilized in order to advocate for a specific position.

1.4.1. Human rights framing

Framing abortion as a human rights issue is a matter of debate. Several health risks associated with pregnancy can weigh on the pregnant woman's health or even life. Access to safe abortion in such circumstances is consequently easily framed in terms of human rights (Zampas and Gher, 2008). Abortion on request and/or on socio-economic ground is, however, not considered as a fundamental human right by supranational and international legal authorities (e.g. European Court of Human Rights), but the health consequences of unsafe illegal abortions could fall under that scope (Cook and Dickens, 2003).

It is also on the ground of human rights that some pro-life activists are advocating for the rights to life of the fetus, although no international legal instance has yet acknowledged such requests (Cook and Dickens, 2003; Zampas and Gher, 2008; Marques-Pereira, 2021).

The discourse of human rights is thus likely to be bent in contradictory ways, bringing back the idea that a balance should be found between the entity of the unborn fetus and the pregnant woman. A classical essay by Judith Jarvis Thomson in 1971 attempted to discuss this tension on the respective right to life of the fetus and of the pregnant woman (Thomson, 1971). Through a series of ethical arguments, she concludes in the prevalence of the pregnant in terms of choice, over the potential rights of the fetus. This conclusion is mainly based on the premises that the woman is the one owning the rights over what happens in her body – more exactly over anything relying on her bodily functions[62].

1.4.2. Women's rights framing

If reproductive rights are a part of human rights and should be considered as universal (under the form of sexual and reproductive education, freedom of sexual preferences, access to reproductive health services and support to parenthood for instance), pregnancy is an ability only related to the female reproductive system and, as such, would be framed as a gendered issue rather than a universal one. In those terms, there should be specific reproductive rights addressed to women - not as a privilege at the expense of men, but as a counterpart to the fact that their reproductive autonomy is a condition for individuation and citizenship, allowing for their full access to human rights (Marques-Pereira and Raes, 2002).

Positioning individuation as a central question comes from a long history of instrumentation or exploitation of women's reproductive ability. Feminist authors, notably through materialist analyzes (Héritier, 1996; Rubin, 2010) have widely explored the means through which this feminine reproductive ability has been appropriated and exploited in order to maintain a patrilinear lineage, allowing for the conservation of private propriety through male descendants. This system lies on a strict control of the origin of paternity, encompassing a dominion over female sexuality.

Unsurprisingly, a women's rights perspective comes together with attention towards bodily, sexual and reproductive autonomy, as a reaction towards assigned roles of motherhood and restricted sexuality.

[62] As a consequence, her argument logically considers this ability to decide over the fetal life developing in utero to cease after viability : if the pregnancy was to be interrupted after the fetus becomes viable, the living, healthy fetus would have a right to live.

Access to autonomy and individuation is then opposed to being considered only through the prism of motherhood (Mishtal, 2014; Erdman, 2017; Gijbels and Vanderpelen-Diagre, 2020). Some cultural or religious views sacralizing motherhood are indeed opposing the right to bodily autonomy for women (Marques-Pereira and Raes, 2002; Minkenberg, 2003). History shows examples of natalist policies strongly burdening women's bodily autonomy by interfering with their right to choose if or when to get pregnant (David and Wright, 1971; Linders, 1998).

> Example : In Romania, in spite of a traditional permissive regulation of abortion issued from the Russian Bolshevik revolution and inherited by the communist administration, the Ceaușescu era was marked by a severe restriction on abortion (between 1967 and 1990) with the objective to raise the natality rate of the country (David and Wright, 1971).

Mentioning reproductive rights in a gendered perspective compels to mention also sexual rights : if restricting of access to abortion is viewed as a limitation of women's bodily autonomy, it is also viewed as a way of sanctioning women for their sexual activity.

By focusing on bodily and reproductive autonomy, this approach values the possibility of choice for the woman over other constraints. Although moral arguments and considerations can weigh in the personal choice of abortion, they pertain to a different sphere subordinated to the exercise of individual rights. In this perspective, the moral or philosophical value attributed to fetal life should not legally or politically counterbalance the possibility of choice. This doesn't mean, however, that there shouldn't exist legal and practical regulations of that choice, such as establishing a gestational age limit (for practical or technical reasons for instance).

In this perspective, regulation should then be based on actual practices and situations, leaving aside moral considerations. One criteria would be to establish a gestational age limit that encompasses the majority of abortions that would actually take place (which requires to have available an estimation of the terminations of pregnancy at different ages). Other criteria would be to take into account not only a gestational age limit but also acknowledging circumstances in which continuing the pregnancy would be harmful for the pregnant woman, for any reasons, whether it is medical, social, economical, etc.

1.5. Public health approach

Although, in European countries, abortion is no longer seen as a matter of life and death, thanks to an almost generalized access to "safe abortion practices" as defined by the WHO. Instead, the focus has mostly switched to the complex ethical aspects of the question. The role of the State then resides in supervising the conditions in which the procedure is performed and eventually regulating access or conditions – along with educative and preventive missions. This role consequently encompasses questioning the potential stigma attached to legal dispositions – likely to weigh on the freedom and autonomy of the citizens – or the unexpected uses and loopholes misorienting the dispositions from their initial goals (Fathalla, 2020).

1.5.1. Abortion as a contraception method/population regulation method

This very radical approach is historically and geographically situated in the context of the USSR policies regulating health and sexuality. In the early years of the communist regime, not only abortion was normalized in the wake of the sexual freedom politics, but the USSR had also been a pioneer of abortion techniques (Claro, 2016). On the contrary, hormonal or mechanical contraception methods

were hardly available (Melani, 2005) and abortion has durably been used as a valid (and very safe) birth regulation method, up to the late years of the regime. This historical context sheds light as to why several former communist countries, although not very liberal oriented, still have quite liberal laws regarding abortion and gestational age limits (Rahman and Katzive, 1999; Guillaume and Rossier, 2018).

In a more extreme case, (forced) abortion has also been used in China as a population regulation method to achieve reproductive planning objectives seen as needed for economic development, also in the context of the communist regime and also in the context of very restrictive birth control campaigns (Attané and Barbieri, 2009)

1.5.2. Pragmatic approach : avoiding clandestine abortions

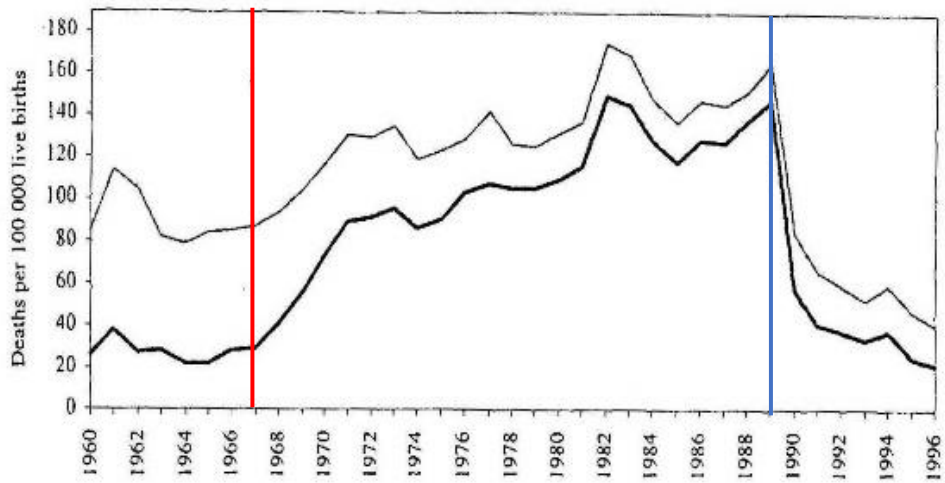
A contemporary public health approach goes together with the idea that it is the role of the State to provide for the general health of the citizen, as it is the case in conceptions of the welfare State. When it comes to abortion, the public health approach focuses mostly on the outcomes of unwanted pregnancies : child abandonment, poverty, and clandestine abortions. It is also coupled with a prevention strategy, including sex education and the diffusion of contraception methods.

This type of global public health strategy explains the stable and low rates of abortion, notably in Western Europe (18 abortions for 1000 women aged 15 to 44 yo on a yearly basis between 2010 and 2014), Northern Europe (18 ‰), and North America (17 ‰) (Sedgh *et al.*, 2016; Guillaume and Rossier, 2018). Global data indicate that a public health approach focusing on prevention, associated with liberalized and safe abortion, results in lowering abortion rates – whereas access restriction to abortion does not reduce abortion rates.

Clandestine abortions and sanitary conditions

The main goal of public health preoccupations is to avoid clandestine abortions in poor sanitary conditions that happen mostly when abortion is prohibited or its access strongly restricted (Shah and Åhman, 2012). The Romanian story reported above has had as consequences, not a rise in birth rate but in women mortality, showing the rapid use of clandestine abortions by women brutally discarded from the health care system (as illustrated by the table below).

Effects of the introduction in Romania in November 1966 of an anti-abortion law, and of legalisation of abortion in December 1989



Source: *World Health Statistics Annual*, various years

The WHO estimates that, around the globe, about 47.000 pregnant women die every year from clandestine abortions[63]. International organisms such as WHO or the UN thus encourage States to legalize abortion at least up to 12 weeks of gestation[64].

Example : In Great Britain, concerns for unsanitary clandestine abortion and the afferent rates of maternal deaths rose as early as the 1930's. A 1929 law indeed authorized therapeutic abortion in the case of vital risk for the pregnant woman – but on quite vague grounds. This led some practitioners to perform abortions of wider psycho-social grounds, such as Dr Aleck Bourne, acquitted in 1938 for performing an illegal abortion (Costa, 2009). It is mainly with those precedents and with the public health purpose in mind that the abortion act of 1967 legalized abortion in England, Wales and Scotland. From then on, abortion was no longer considered as a criminal offence, providing a series of conditions were fulfilled and specific grounds were covered (Sheldon *et al.*, 2019). Conditions of realization imply that abortions must be performed in authorized medical facilities and under medical control by registered practitioners (Pinter *et al.*, 2005). Abortion is legal based on seven grounds, and two doctors must agree in good faith that one or more of the following grounds are met :

a) the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated

b) the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman

c) the pregnancy has not exceeded its twenty-fourth week

and the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman

d) the pregnancy has not exceeded its twenty-fourth week

and the continuance of the pregnancy would involve risk of injury to the physical or mental health of any existing children of the family of the pregnant woman

e) there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped

[63] https://www.ohchr.org/fr/2016/09/unsafe-abortion-still-killing-tens-thousands-women-around-world-un-rights-experts-warn?LangID=F&NewsID=20600

[64] *Ibidem*

Two addition grounds allow for immediate emergency termination of the pregnancy by one operating practitioner
f) to save the life of the pregnant woman
g) to prevent grave permanent injury to the physical or mental health of the pregnant woman
(Great Britain: Parliament: House of Commons: Science and Technology Committee, 2007)

Illegal abortions outside of the State authority

Illegal abortions are not necessarily done in poor sanitary conditions. In France or Belgium, in the years before abortion was legalized, abortions were performed by activists with adequate medical training and in good conditions – some of them being general practitioners or even gynecologists (Denis and Rokeghem, 1992; Donnay *et al.*, 1993; Ruault, 2021). The goal was, in addition to help women with unwanted pregnancies and to decrease the mortality observed by clandestine abortions, to publicize how frequent abortions were and normalize the practice. By doing so, they intended to demonstrate that the State, being unable to prevent abortion, should rather legalize it.

Abortions abroad, outside of the State authority

In a lot of countries, restrictions and conditions of access to abortion within the country lead a number of women to have an abortion abroad, whether because they are past the gestational age allowed for an abortion in the country or because they do not satisfy the conditions (notably when abortion is only permitted on medical or specific moral grounds).

International organizations, such as the activists of Women on Waves[65], have also tackled the issue of abortion access and found ways to provide safe abortion methods where abortions are not legal or not available. The organization, created in 1999, provides evasive strategies, such as performing abortions on board of a ship sailing in international waters and equipped with abortion facilities. More recently, in 2005, it has created another branch, Women on Web[66], dedicated in providing medical abortion by sending abortion pills worldwide, together with supervision and information about safe abortion.

It could be argued that such a situation is a failure of the role and responsibility of the State in terms of public health. The State then fails to meet the needs of people so determined to have an abortion that they are ready to travel abroad for the procedure, in spite of the time and costs that it represents (De Zordo *et al.*, 2021). According to a legal rationale, no State is responsible for foreign laws and what they allow or prohibit, neither should it be influenced by those laws. The argument formulated in terms of public health cannot possibly deny this aspect, but it focuses pragmatically on the outcomes of the actions (legal or illegal) of the citizens and aspects of equality among them (and, in this case, about the inequal situation allowing for some women to have an abortion abroad and some not to be able to afford or organize it).

From an authoritarian perspective, it can also be considered that it is not acceptable for citizens to escape the legal framework established by their country. Some countries have even passed laws criminalizing the act of crossing borders in order to get an abortion, although this type of laws have been condemned by the European Parliament as of 1991 (Pennings, 2002). A relativist perspective, on the other hand, would oppose that such a situation is acceptable as long as the State's legislation is respected, no matter what happens outside its borders.

[65] https://www.womenonwaves.org/
[66] https://www.womenonweb.org/

1.6. Technical approach : available procedures, techniques and related risks

Considering that abortion is a matter of public health and should be regulated from the perspective of the general well-being can be coupled with a logic of risk reduction. In several countries, the regulation of the practice of abortion expresses such a central concern for risk reduction. The widespread obligation to perform abortion in a medical environment reflects this concern (Berer, 2009), but it can also be reflected in the limitation of the gestational age.

The aforementioned Roe v. Wade decision with a first trimester benchmark for unconditional abortion was based on the respective mortality rates (at the time of the decision) of delivery and of abortion up to 12 weeks of gestation. The much more recent French revision of the gestational age limit in 2020 was based on similar considerations, based this time on complications occurring during abortion at different gestational ages[67].

> Example : The French government examined in 2020 a proposition of law extending the gestational age limit for an abortion from 12 to 14 weeks post-conception. The proposition has been submitted to the National Advisory Committee of Ethics (CCNE)[68] who expressed its opinion mainly in terms of complication probability between 12 to 14 weeks of gestation (Comité Consultatif National d'Ethique, 2020). The Committee established (based on the available scientific literature) that there were little differences between the two terms of 12 and 14 weeks. They also took in consideration that, in spite of the high number of abortions being performed at less than 6 weeks of gestation (about 50%), there still was a number of women discovering their pregnancy after 10 weeks (5,3% of the ToP). They also pointed that several practical barriers had as consequence that the average delay for obtaining an abortion on the French territory was 7,4 days (varying between 3 to 11 days) between the first contact and the actual performance of abortion. This delay increases from 3 to 5 weeks for the women discovering their pregnancy after the 10th week and seeking an abortion solution abroad. Based on those delays and risk considerations, the CCNE advised for an extension to 14 weeks gestational age – which was adopted in the law in February 2022.

It is interesting to note, in this opinion, the preoccupation for practical aspects relative to abortion outside of the borders of the country. It implies that – in this view – the public health responsibility does not end at the border : having an abortion abroad significantly increases the gestational age at which the abortion occurs, exposing women to higher risks of complications for which the national legislation has a responsibility. It should be underlined that, in spite of specific risks associated with abortion methods and pregnancy age, abortions performed in a safe and medicalized environment are still safer than childbirth (Janiak *et al.*, 2014; Purcell *et al.*, 2017).

1.7. Current framing in Belgium

[67] Mortality rates being currently extremely low thanks to modern and medicalized abortion techniques, it is no longer a relevant criteria.

[68] https://www.ccne-ethique.fr/sites/default/files/2021-07/CCNE-%20saisine%20IVG.pdf

1.7.1. 1990 law

This section does not ambition to extensively comment on the previous Belgian legal dispositions nor on the historical context but to situate the Belgian approach in the frame of the arguments and rationales as presented above.

As soon as 1973, the popular support for the actions of Dr Peers becomes manifest whereas the feminist mobilizations towards a normalization and legalization of abortion increase. In the 1980's, the publications of GACEHPA collecting the data of the centers practicing openly voluntary abortions as well as numerous public declarations of women having had an abortion or declaration from practitioners offering the procedure contribute to this strategy of normalization. These elements pushed the government into assuming public health responsibilities and gaining a form of statal control over abortion as well as birth regulation methods. The resumption of the prosecutions by the judicial corps exasperated as much by the openly transgression of the law than by the political immobilism paved the way for the 1990 law that expressed these concerns in legally and medically regulating abortion.

The choice of a 12 weeks gestational age limit can be explained in this historical context, as expressing not only the prominence of the first trimester benchmark but also the influence of a majority of other national legislations voted in the previous decades.

Three other dispositions indeed (the mention of the state of distress, the mandatory waiting period and the counselling providing mandatory information) counterbalance the public health approach with moral considerations, illustrating the Belgian culture of compromises between philosophical and political traditions. The criminalization of abortion unless satisfying to a series of conditions also clearly expresses a strong moral stance against the act of abortion.

The mention of a state of distress from the pregnant woman highlighted the fact that a moral justification appeared to be necessary at that moment to legitimate abortion. The pregnancy has to be considered as harmful enough for the pregnant woman to justify the termination, indicating that fetal life and the woman' "state of distress" are both morally valued.

The mandatory waiting period, mainly inspired by the idea to offer women enough time to make a conscious decision, can be considered as a form of protection for the fetus from a premature decision, giving more chances for the pregnancy to continue (Minkenberg, 2003). It has also received a lot of criticism as it could signal lack of confidence for women's ability to take a thoughtful decision. This adds to the hypothesis that the fetal life was put in balance with the pregnant women's choice, through the notion that not having an abortion is generally preferable to having an abortion. It also displays a certain disregard for women's autonomy and their ability to make their own choice without being expressly told by a figure of authority to take some time to reflect – which is assimilated in some legal commentary to a paternalist attitude (Victorian Law Reform Commission, 2008).

In conclusion, the Belgian model based on the 1990 law expresses a variety of concerns, balancing between a public health approach and a logic of the gradual value of the fetal life. The 1990 model showed numerous similarities to the German model, which the scientific literature qualifies as an "indication" and "distress model" (Minkenberg, 2003). Abortion was indeed only allowed under certain specific criteria – and only if a state of distress is identified by health practitioners – and was otherwise

criminalized, meaning that "*This model emphasises the priority of the unborn life but leaves the final decision up to the woman*" (Minkenberg, 2003).

1.7.2. 2018 law

In spite of upstream parliamentary discussions and hearings heading towards a reduction of the mandatory waiting period and the extension of the gestational age limit, these aspects have remained similar to the previous law when it was revised in 2018. These moral – and even paternalist – aspects attributing an important weight on the fetal life seemed difficult to change in the political climate.

The suppression of the state of distress, nonetheless, can be considered as an important step in shifting the considerations towards a fuller public health approach. Facing an unwanted pregnancy is no longer pathologized but tackled in its social consequences and abortion is primarily determined by the will and choice of the pregnant woman. This is a shift towards a model of abortion upon request, meaning abortion is no longer conditioned to a psychosocial motive as long as it remains within a certain gestational age limit.

A pathological aspect still remains in the form of a new disposition allowing for the reduction or suppression of the waiting period for medical reasons, justified by the doctor performing the abortion (among which mental distress is considered as a valid reason).

Another new peripheral disposition consists in bypassing the actual gestational age limit for pregnant women who have reached 12 weeks of gestation post-conception at the time of the abortion request, for whom the waiting period is maintained but is not counted in the pregnancy age). It was presented by the legislator as a progress through preventing the waiting period to penalize women presenting at a more advanced gestational age, who can consequently abort up to 12 weeks and 6 days of gestation. On the other hand, it seems to indicate that the notion of the waiting period is a notion more important than the actual gestational limit – which may seem contradictory in the hierarchization of arguments displayed by the law. It could also be argued that it has set an interesting precedent in increasing – even though moderately – the gestational limit without much debate.

Belgium is also confronted with the Netherlands as neighboring country with a much more extended abortion law with respect to the gestational age limit, with the effect of almost automatically being the destination for Belgian women facing a pregnancy beyond the legal delay[69]. This confronts Belgium with the ethical question of allowing on foreign grounds what is not legal within the country but also what are the practical consequences in the line of its legal guidelines.

A frequent argument with this regard is the argument of discrimination : although the law affects every citizen equally, obtaining an abortion in a foreign country is only possible for people with sufficient financial and material means, due to increased medical costs, the organizational necessity of time off, accommodation and transport.

Whether the gestational age limit is motivated by a concern for the fetal life or for the risks induced by a second trimester abortion, the time lost by pregnant women over 12 weeks of gestational

[69] It is interesting to note that, in the case of abortions for medical reasons, the opposite happens : Belgium having no gestational age limit on medical abortion, a number of Dutch patients travel to our country in order to obtain medical abortion after 24 weeks of gestation.

age in preparing and obtaining an abortion in the Netherlands adds as many days to the fetal development. The abortion of an unnecessarily older fetus does not meet the ends of public health and risk reduction nor the perspective of gradually protecting the fetus as it develops. It can nonetheless be argued that the State is not supposed to endorse responsibility for events that are happening beyond its borders.

2. State of affairs of abortion requests after 12 weeks of gestational age

2.1. Current situation in Belgium

Abortion is allowed on request up to 12 weeks of pregnancy post-conception. Beyond this stage, abortion is only permitted for medical reasons, whether the pregnancy presents with a risk for the woman and/or for the fetus.

Regarding the mandatory 6 days delay between the first appointment and the abortion, there are several nuances that should be developed here. Several professionals have mentioned being uncertain about whether the delay starts with the first appointment with a general practitioner or whether it has to be an appointment with a specialist or in a specialized abortion center.

By obvious mechanical effect, the 6 days waiting period leads to an additional week of pregnancy that has to be considered in the process and technique of abortion. However, since the abortion law revision on 2018, there are two situations in which this delay is reconsidered with regards to the best interest of the patient. First, the waiting period is likely to be shortened for medical reasons, justified by the doctor performing the abortion, among which mental distress is considered as a valid reason. Secondly, in case the patient has reached the 12 weeks of pregnancy age when requesting the abortion, the 6 days period suspends the age count of the pregnancy, leading to actually performing legal abortions for pregnancies of 13 weeks[70].

The Evaluation Commission's[71] report mentions that 69 terminations of pregnancy over 12 weeks have been operated for medical reasons in 2018 and 77 in 2019. In most cases, the risk of continuing the pregnancy was directed towards the fetus (65 in 2018 and 73 in 2019), whereas in 4 cases (both in 2018 and 2019) the risk was directed at the pregnant woman.

As per voluntary terminations, a small portion of women requesting an abortion present with a pregnancy beyond the 12 weeks limit. Reports from the abortion centers Luna, established between

[70] "de bedenktermijn blijft op zes dagen, maar nieuw is dat deze bedenktermijn de maximumtermijn van twaalf weken waarbinnen een abortus wordt toegestaan, opschort; in feite wordt de maximumtermijn waarbinnen een abortus wordt toegestaan, zo verlengd tot dertien weken; (…)"
" le délai de réflexion reste fixé à six jours, mais la nouveauté est que ce délai suspend la période maximale de douze semaines durant laquelle l'avortement est autorisé; dans les faits, le délai maximum dans lequel l'avortement est autorisé est ainsi porté à treize semaines; (…) »
https://www.lachambre.be/FLWB/PDF/54/3216/54K3216003.pdf

[71] Rapport à l'attention du parlement 1 janvier 2018 – 31 décembre 2019, p. 111 / Verslag ten behoeve van het Parlement 1 januari 2018 – 31 december 2019, p. 69; p.86)

2013 and 2016 and recollected by Van de Velde et al. (2019), estimate that such late requests represent a stable number of approximately 3% of the abortion requests. Among those requests, 29% are about pregnancies aged 11 weeks and 2 to 6 days[72] – meaning that, in the law before 2018, they were considered late due to the mandatory 6 days waiting period[73]. Van de Velde et al. estimates that, during the studied period (2013-2016) a total of 293 women were in a situation in which the mandatory 6 days period made them falling beyond the legal limit only and thus unable to receive the requested abortion.

Among the women who are denied the right to abortion in Belgium due to a late request, most are referred to abortion clinics abroad, mostly to the Netherlands, where the procedure is permitted up to 22 weeks. According to the Evaluation Commission report, an estimate of 500 to 800 women each year are redirected towards abortion clinics abroad in such context.

In the sample studied by Van de Velde et al. (2019), 60% of women who presented beyond the 12 weeks limit were referred for abortion in another country (Netherlands mostly). An estimate of 17% renounced abortion and resorted to lead the pregnancy to term and become parent, whereas 3% were referred to adoption services. The authors mention that for 20% of the women presenting beyond 12 weeks, the information is missing.

It appears that, in addition to the time and financial cost of referring women requesting abortion to clinics abroad, it is mostly a displacement of the issue, outsourced to a neighboring country. The majority of abortions will however occur, but with a greater delay and a higher cost both for the patient and the health system (Pennings, 2002; Van de Velde *et al.*, 2019). The additional costs and barriers to access abortion abroad after 12 weeks of pregnancy seems in contradiction with the WHO recommendation of non-discrimination among the patients regarding sexual and reproductive health services[74].

2.2. Possible causes for abortion requests after 12 weeks of gestation

2.2.1. Profiles of women requesting abortion after 12 weeks of gestation

Based on the Luna centers data between 2013 and 2016, Van de Velde et al.'s study provides an interesting overview of the socio-demographic factors increasing the odds to present for an abortion beyond the legal limit (Van de Velde *et al.*, 2019). The main factors are

- Upper secondary education or less rather than higher
- Unemployement situation
- Belgian nationality
- Age under 18 or between 18 and 19

Based on those factors, the authors discuss the importance of taking into account the socioeconomic vulnerability of abortion patients, mostly at more advanced pregnancy stages.

[72] Van de Velde et al. mention a pregnancy age of 13 weeks and 2 to 6 days, but there seems to be a confusion between pregnancy age and weeks of amenorrhea.

[73] This waiting period is likely to be shortened for medical reasons, justified by the doctor performing the abortion. Medical reasons can also include mental distress.

[74] https://srhr.org/abortioncare/chapter-2/recommendations-relating-to-regulation-of-abortion-2-2/law-policy-recommendation-3-gestational-age-limits-2-2-3/

These factors weight even more regarding the pregnancies older than 12 weeks where the socioeconomic vulnerability is even more patent. These considerations are in line with the reports of the WHO, establishing that vulnerable women are the ones most likely to be negatively impacted by gestational age limits (i.e. women with cognitive impairment, younger and underage women, women with more difficulty accessing medical and abortion facilities, women with financially precarious or women with lower educational level)[75].

Van de Velde et al. highlight a few differences between abortion requested for pregnancies just past the legal limit (11 weeks + 2 to 6 days at the time of the study) and for pregnancies over 12 weeks. For the latter, the risk factors are indeed slightly different, with a overrepresentation of women of young age that are nulliparous and non-Belgian. Although Belgian patients are more represented in the sample, non-Belgian migrant women are indeed more at risk of not being able to access healthcare and abortion care due to their restricted access to information regarding the health system, but also due to barriers such as language, fear of racism from healthcare providers and the fear of putting at risk their legal status.

These findings are consistent with analysis of the profiles of women requesting an abortion during the second trimester in other countries. In the Netherlands, the young age of the patient is also a risk factor, with 26% of the second trimester abortions performed for patients of age 15 to 19, and 19% of age 20 to 24 (Loeber and Wijsen, 2008). Young age is indeed a recurrent factor of late pregnancy interruption request as per several studies in Europe (Lee and Ingham, 2010; Mentula *et al.*, 2010; Cameron *et al.*, 2016; Purcell *et al.*, 2017) or the United States (Finer *et al.*, 2006; Kiley *et al.*, 2010a).

It should also be noted that there an overrepresentation of foreigners not residing in the Netherlands among the patients requesting a second trimester abortions (72%) (Loeber and Wijsen, 2008). This must be attributed to the people travelling to the country for an abortion because they have fallen beyond the legal delay in their countries.

In the context of the United States, financial vulnerability of the patient and the lack of access (practical and financial) to abortion facilities are causing later abortion requests. Not having the necessary funds to finance abortion causes patients to delay the procedure, whereas the abortion procedure's costs increase with the gestational age (Kiley *et al.*, 2010a).

In Europe, however, in countries where abortion facilities are available and financially affordable, the number of second trimester abortion requests remains stable, as it is the case in the Netherlands (Loeber and Wijsen, 2008) and Finland (Mentula *et al.*, 2010). A potential explanation for the continuous need of second trimester abortion services resides in the vulnerable profiles of the patients, in terms of contraceptive, health or conjugal status, leading to a later recognition of the pregnancy.

2.2.2. Reasons for later abortion requests

[75] https://srhr.org/abortioncare/chapter-2/recommendations-relating-to-regulation-of-abortion-2-2/law-policy-recommendation-3-gestational-age-limits-2-2-3/

Delay in recognizing pregnancy symptoms

Before the patient can assess whether the pregnancy will be continued or terminated, they need to realize that they are pregnant. This first step can be challenging, especially if the pregnancy is not expected and if the patient has trouble recognizing the pregnancy symptoms. Such delays for pregnancy recognition are one important cause for late abortion requests, as several studies indicate.

Young age and absence of previous pregnancy experience

In some studies, the late pregnancy recognition is correlated to the young age of the patients and the absence of a previous pregnancy experience (Van de Velde *et al.*, 2019), thus preventing to identity typical pregnancy symptoms.

Irregularity in the menstrual cycle : hormonal causes, amenorrhea induced by contraceptive, drug abuse or eating disorders

Irregular menstrual cycle is another factor : patients familiar with irregular cycles tend not to be alerted by the absence of menstruation (Ingham *et al.*, 2008; Lee and Ingham, 2010; Purcell *et al.*, 2017; Van de Velde *et al.*, 2019).

Irregular cycles or absent menstruation can be caused by the patient's hormonal profile but also by the use of certain types of contraceptive (injectable or oral) suppressing menstruation. Even though these factors are likely to mask pregnancy symptoms and thus causing late recognition, these results regarding the use of contraceptive should be nuanced, since it is also a factor obviously reducing unwanted pregnancies.

Other causes of amenorrhea, such as drug abuse or eating disorders, can not only cause a later pregnancy discovery but also an increased vulnerability in seeking and obtaining healthcare. Drug abuse is also correlated to a lower resort to healthcare and low quality living conditions, among which eating disorders are frequent, specifically under the form of dietary deficiency (Simmat-Durand, 2002). Hormonal disorders and amenorrhea are frequent under such conditions, thus possibly causing a later pregnancy discovery. Delays in recognizing the pregnancy among drug users is a known cause for late abortion requests, consequently denied to the patient (Simmat-Durand, 2002; Rutman *et al.*, 2022). Such pregnancies are at risk for the women and the fetus, not only because of the substance consumption, but also because of a sporadic medical follow up due to the unstable living conditions of the patient. Some testimonies also indicate that, if abortion is denied, increased consumption and lack of self-care are sometimes used hoping this would lead to a 'spontaneous' termination of the pregnancy. Drug abuse is often a multi-substance practice, increasing the difficulty to identify specific risks (Simmat-Durand, 2002).

Experiencing eating disorders, especially in the case of anorexia nervosa, is another possible cause for late pregnancy detection. Although patients with anorexia are frequently confronted with amenorrhea, fecundation and pregnancy can still occur and, in the absence of the signs of a menstrual cycle, remain undetected (Bonne *et al.*, 1996; Bulik *et al.*, 2010). Some patients can also be under the (erroneous) impression that amenorrhea offers protection from unwanted pregnancy (Bulik *et al.*, 2010). Some case studies also underline that other symptoms of pregnancy (nausea, vomiting, weakness, lassitude) are very similar to the physical sensations caused by anorexia and consequently not considered alarming (Bonne *et al.*, 1996).

Pregnancy denial

Denial of pregnancy is a specific situation of late pregnancy discovery – however, in this case, the late or absent identification of the pregnancy is attributed to psychological causes. Pregnancy denial is defined as the inability for the patient to identify and recognize the pregnancy and its symptoms[76] (Brezinka *et al.*, 1994; Chaulet *et al.*, 2013; Delong *et al.*, 2022). Consequent to this psychological state, several somatic expressions can characterize the pregnancy : no significant weight variation, continuous menstruation, less fetal movement (and no perception of it), absence of nausea (Brezinka *et al.*, 1994; Chaulet *et al.*, 2013). Similar to other causes for late stage identification of pregnancy, familiarity with irregular menstruation and use of hormonal contraceptive inducing monthly bleedings is mentioned as a factor for prolongated pregnancy denial (Brezinka *et al.*, 1994). The absence of visible distension of the abdominal wall, usually perceptible after the first trimester of a regular pregnancy, is attributed to a permanent contraction of the rectus abdominis muscle and a modified position of the uterus in case of pregnancy denial (Grobet *et al.*, 2020).

Scientific literature distinguishes between partial and total denial of pregnancy. Total denial is encountered when the pregnancy is only acknowledged while in labor or giving birth, whereas partial denial characterizes a pregnancy acknowledged before labor (Chaulet *et al.*, 2013; Grobet *et al.*, 2020). There is no consensus in literature, however, about the pregnancy age from which a unidentified pregnancy should be considered denied.

Several studies indicate a prevalence of approximately 2 to 3 cases of pregnancy denial for 1000 births (Wessel *et al.*, 2007; Chaulet *et al.*, 2013). Far from being a rare affection, pregnancy denial and the care of affected patients should beneficiate from the better understanding that is progressively being developed in contemporary research.

Cases of neonaticides attributed to total pregnancy denial have shed some mediatic light on this issue, but this doesn't reflect the variety of outcomes of denied pregnancies. A study from Chaulet et al. in Angers (France) among 75 patient confronted with pregnancy denial indicates that, although most of those pregnancies happened without prior intent of conception, only 16 (23%) of the patients requested an abortion[77] (Chaulet *et al.*, 2013). The main risk weighing on denied pregnancies towards the fetus is the absence of adapted lifestyle from the pregnant woman (leisure or occupational hazards, alcohol or drug consumption) (Brezinka *et al.*, 1994). Prematurity (several stages) and fetal growth retardation are the main risks for the fetus, according to two studies (Brezinka *et al.*, 1994; Chaulet *et al.*, 2013). In the same two studies, a fetal death rate of respectively 8 and 14% is found but without being able to draw a causality with the denial of pregnancy (*Ibidem*).

Regarding the pregnant woman, the risks are more oriented towards their psychological well-being, requiring professional help in order to acknowledge and process their state of being pregnant and the existence of the fetus or infant. Although the profiles of the patients experiencing pregnancy denial are very diverse, far from the stereotypes of low intelligence or education and social isolation (Wessel *et al.*, 2007), several risk factors have been identified. Wessel et al. (2007) indicate that very young age or relatively late reproductive ages are risk factors, as well as an unstable relationship and

[76] Denial of pregnancy should be distinguished from pregnancy dissimulation, which designates a pregnancy consciously identified by the patient, but dissimulated to the relatives due to a conflicting relation with the pregnant state and the fetus (Chaulet *et al.*, 2013; Delong *et al.*, 2022).

[77] Abortion could not always be performed, depending on the age of pregnancy. The option of entrusting the infant to adoption services is then proposed.

a critical social situation. The authors however insist on the fact that those risk factors are not sufficient to identify all the patients. They also point that the women who committed neonaticides had no specific profiles either, except for shared patterns of powerlessness, or poverty or alienation, but caused by a variety socio-demographic backgrounds (*Ibidem*). Other studies underline that a preexisting history of late pregnancy identification and/or of pregnancy denial predisposes patients to further denial of pregnancy (Chaulet *et al.*, 2013; Delong *et al.*, 2022). In the absence of medical classification (no entry in DSM nor ICD), such antecedents should be indicators for caregivers to further explore symptoms of pregnancy with such at-risk patients (*Ibidem*).

Delay in decision making

When the pregnancy is identified or suspected through its symptoms, delays can also occur first in the gesture of taking a pregnancy test and then in making a choice regarding its continuation or termination, consequently causing delays than can lead to a second trimester abortion (Foster, 2003, 2003; Ingham *et al.*, 2008; Lee and Ingham, 2010; Cameron *et al.*, 2016; Gerdts *et al.*, 2016; Purcell *et al.*, 2017).

Several authors mention a position of ambivalence regarding the pregnancy, between a personal desire (or its absence) to have a child and external factors, such as the living conditions, financial stability and the nature of the relationship with the partner (Ingham *et al.*, 2008; Lee and Ingham, 2010). This last point, usually categorized as a main factor in the literature, actually encompasses various situations, from unstable relationship, disagreement about the pregnancy and its outcome, broken relationship but also experience of domestic violence.

The fear of the abortion procedure is another factor influencing a delayed decision (Kiley *et al.*, 2010b; Van de Velde *et al.*, 2019). This fear can be increased by the consequences of a second trimester abortion procedure, consequently causing even more delay in an already advanced pregnancy (Kiley *et al.*, 2010b). On the other hand, having previously had an abortion has been associated with less fear of the procedure, which may reduce delay in seeking abortion care (Van de Velde *et al.*, 2019).

Delay caused by a reduced access to medical professionals and/or abortion facilities

Healthcare costs and the financial barriers to health insurance in several countries such as the United States have already been mentioned as factors delaying the access to abortion but also delaying the decision making (Foster, 2003).

However, even in countries providing public and affordable healthcare systems, the lack of facilities in rural areas can cause delays and additional costs that influence the decision making of the pregnant women (Ingham *et al.*, 2008; Cameron *et al.*, 2016; Gerdts *et al.*, 2016; Shaw and Norman, 2020).

Difficulties to access health care professionals are also mentioned as potential barriers for several reasons :

- Lack of abortion facilities (or of 2nd trimester abortion facilities) in certain areas (Ingham *et al.*, 2008, 2008; Loeber and Wijsen, 2008; Van de Velde *et al.*, 2019; Shaw and Norman, 2020)
- Lack of trained abortion providers (Foster, 2003; Gerdts *et al.*, 2016)

- Difficulty to access health care professionals (i.e. : women not wanting to address their regular doctor by fear of judgement or confidentiality issues) (Ingham *et al.*, 2008; Lee and Ingham, 2010; Gerdts *et al.*, 2016)

2.3. Abortion motives at the second trimester

When enquiring the reasons motivating women with pregnancies over 12 weeks to have an abortion, those reasons seem convergent with those motivating earlier abortions. It seems that the difference resides mostly in the conditions surrounding the discovery of the pregnancy, the access to abortion and the process of decision making but not the kind of motives for the abortion itself.

The sample studied by Loeber and Wijsen (2008) for the Netherlands in 2006 was enumerating the following motives :

- relationship with the partner : 40% of local patients – 23 % of foreign patients
- too early to have children 35% local – 42 % foreign
- family is complete 11% local – 10 % foreign

In comparison with the motives mentioned in the Evaluation Commission report[78], the main motives were as follows :

- absence of desire for a child at the moment : 17.91%
- relationship : 14,21 %
- family is complete : 9.51%
- precarious situation : 8.73%
  (…)

As stated earlier, it should be noted that abortion motives related to the relationship with the partner are likely to encompass distinct situations. The Evaluation Commission's[79] report distinguishes between recently broken relationship, a partner not willing to become a parent, a new or unstable relationship, an extramarital relationship, legal problems related to a divorce, but also couple issues and relational issues with the family and close relatives.

These two last situations can possibly (but not necessarily) be related to psychological and/or physical violence experienced in the domestic of wider family context. The correlation between domestic violence and ambivalence towards the pregnancy and/or late abortion requests will be here developed, drawing a continuous line between the factual explanation leading to late abortion requests and the personal motives determined by the relationship status.

Existing patterns of violence and abuse from the partner have several effects on a pregnancy. First of all, a climate of violence and coercion is known to prevent the victim from managing their fertility, consequently leading to unwanted pregnancies (Pallitto *et al.*, 2013). Pregnancy in itself is identified as a trigger in such violent patterns: a preexisting context of domestic violence is a major risk factor for intimate partner violence during the pregnancy, whereas pregnancy can also be a cause for the

[78] Rapport a l'attention du parlement 1 janvier 2018 – 31 décembre 2019, p. 111 / Verslag ten behoeve van het Parlement 1 januari 2018 – 31 december 2019, p. 23)
[79] Rapport à l'attention du parlement 1 janvier 2018 – 31 décembre 2019, p. 111 / Verslag ten behoeve van het Parlement 1 januari 2018 – 31 december 2019, p. 69; p.86)

apparition of a violent pattern from the partner (Glander *et al.*, 1998; James *et al.*, 2013; Pallitto *et al.*, 2013). Although pregnancy is considered as a vulnerable state, this correlation between increased or (re)appearing partner violence and pregnancy is explained on a psycho-social level as a loss of control against the pregnant partner's bodily autonomy (Bacchus *et al.*, 2006). We should also note that, even though certain studies indicate an increase of domestic violence during pregnancy, others underline a decrease of the preexisting domestic violence in this same condition (Burch and Gallup, 2004; Jasinski, 2004), thus indicating that the discovery of pregnancy can cause a shift in the patterns of domination and behaviors between the partners.

Such data has a strong impact on the abortion possibilities for the pregnant partner. First, the absence of contraceptive choice, sexual coercion or the lack of autonomy in terms of healthcare and follow up should be considered for patients victims of domestic abuse. Not only do such situations lead to more unplanned and unwanted pregnancies but also to a lesser possibility to resort to healthcare and prenatal care (Jasinski, 2004), including the possibility to resort to abortion in case of an unwanted pregnancy. Late identification of the pregnancy and late abortion request are consequently to be expected in this context. The shift of behavior from the abusive partner at the discovery of the pregnancy (whether it is expressed in an increase or a decrease of the violent acts), leading to a unusual couple dynamic, can also make it more difficult for the pregnant woman to envision her choice regarding the outcome of the pregnancy. An apparent "personal motive" related to the relationship status can thus hide a complex situation causing legitimate delays in the decision making.

2.4. The experience of a second trimester abortion

In countries where the delay for terminations of pregnancy is over 12 weeks, the rates of second trimester abortions remains quite low but also stable. It varies between 5 and 10 % between Finland, Sweden, the UK, Canada and the USA (Ingham *et al.*, 2008; Mentula *et al.*, 2010; Shaw and Norman, 2020).

In Europe, most countries authorize abortion up to 12 weeks pregnancy. The main reason for women to travel and have an abortion abroad is the restricted number of countries allowing abortion procedures after 12 weeks of gestation (Berer, 2008). In the UK in 2014, 5521 abortions were requested by non-residents for such reasons, mostly by Irish, Italian and French women (Gerdts *et al.*, 2016). In the Netherlands in 2006, 2940 abortions were requested by non-residents.

Anthropological perspectives as presented in the article of Purcell et al. offers useful insight about some of the determinants leading to a delayed recognition of pregnancy and a delayed request for abortion (Purcell *et al.*, 2017).

The article questions the narrative of pregnancy discovery, supposedly starting with a missed period, followed by a pregnancy test and continued with a medical appointment (whether to keep the pregnancy or not). Such narratives are not representative of the experience lived by many women, for who the signs of pregnancy and their status remain vastly ambiguous. Not fitting into the narrative appears as a form of failure of managing one's fertility even though many reasons can justify a delay in the pregnancy discovery and the delayed decision making.

Most women in the study experiencing a late discovery of their pregnancy focus indeed on the signs that were absent : no amenorrhea, no "belly bump" even after 12 weeks. Those "common sense" signs of pregnancy being absent, the women express a deep astonishment and confusion when

discovering their situation. The confusion and dismay is not only related to the unwanted aspect of the pregnancy but also to their unawareness the pregnancy for so long. This state of confusion is also frequently followed by a fear of judgement for their failure to identify pregnancy, possibly leading to keeping the pregnancy secret.

The authors mention the concept of pregnancy liminality, represented by the period during which the pregnancy is not yet fully acknowledged : before establishing pregnancy with certainty or before making a firm decision, women are seeing themselves as neither pregnant nor not pregnant.

The first visible signs of pregnancy and the social consequence of acknowledging it are factors in prompting decision and action. However, the first feelings of fetal movement create a sense of responsibility toward the fetus : even those who have a made a firm decision on abortion are worried that they did not engage in the self-regulating practices surrounding pregnancy (in terms of alimentation, alcohol consumption etc.). This feeling of responsibility and the absence of pregnancy precautions can weight on the decision to terminate the pregnancy, since it has not started with the due care.

Regarding the experience of a second trimester abortion procedure, “A lack of readily available narratives specifically of the second trimester medical abortion procedure, including how the fetus is actually expelled from the woman’s body, means that women undergo a largely unknown, unexpected and challenging process” (Purcell *et al.*, 2017).

Several women express surprise when realizing how close late abortion can be to actual labour, with the same terminology (i.e. : “having to push”)[80]. Women who undergo such abortions under general anesthetic seem more satisfied with their experience, and less under the impression of having given birth. Some consider a medical environment as reassuring and framing the abortion procedure as a normal, medical issue to be fixed by health professionals.

3. Options for legal dispositions in the context of an extension of the gestational age limit for abortion

In the general context of scientific and technical advances, second trimester abortion are becoming progressively safer (Comité Consultatif National d’Ethique, 2020), thus questioning a range of safeguards that had been placed in terms of gestational age limit for abortion. In addition, Belgium finds itself in a situation where some women with an unwanted pregnancy of more than 12 weeks post-conception have the option to obtain an abortion in the Netherlands. However, this possibility is costly in terms of financial, administrative and time resources, and it represents a psychological burden, not even mentioning the administrative difficulties in leaving the country for some people (undocumented women notably).

[80] Some women even experiences hormonal variations similar to those of giving birth and some are lactating. Nulliparous women describe it as a shock whereas women with children are disturbed the similarity with their previous nursing experience.

According to data collected by Luna abortion clinics in 2018, 3% of the patients in contact with their clinics present with a gestational age over 11 weeks and 1 day[81] and are redirected to the Netherlands for an abortion of the second trimester in specialized clinics. Among them, the gestational age repartition is as follows :

Patients redirected	
Year 2018	
12 weeks	21%
13 weeks	10%
14 weeks	10%
15 weeks	7%
16 weeks	13%
17 weeks	5%
18 weeks	4%
19 weeks	4%
20 or > 20 weeks	20%

This seems consistent with data from the Dutch yearly report on abortion from 2018[82], which spreads out gestational ages at the time of pregnancy as follows :

Number of abortion per gestational age in the Netherlands		
	Year 2018	
	Total	***%***
4 weeks	996	3,21%
5 weeks	4.936	15,92%
6 weeks	6.532	21,07%
7 weeks	4.532	14,62%
8 weeks	3.599	11,61%
9 weeks	2.195	7,08%
10 weeks	1.164	3,75%
11 weeks	919	2,96%
12 weeks	673	2,17%
13 weeks	529	1,71%
14 weeks	604	1,95%
15 weeks	602	1,94%
16 weeks	634	2,05%
17 weeks	567	1,83%
18 weeks	548	1,77%
19 weeks	510	1,65%
20 weeks	486	1,57%
21 weeks	482	1,55%

[81] in the law before 2018, they were considered late due to the mandatory 6 days waiting period.

[82] https://zoek.officielebekendmakingen.nl/blg-922827.pdf

22 weeks	314	1,01%
23 weeks	166	0,54%
N/A	14	0,05%
	31002	100,00%

As indicated by Dr Raïna Bretthouwer during the expert hearing, an increase of abortion procedures before the 18th week can be explained by a higher financial cost of the procedure at that term, leading to a rush of patients at weeks 16 and 17.

The Belgian National Evaluation Committee has established that between 500 and 800 women each year are redirected to abortion clinics in the Netherlands (Commission Nationale d'Évaluation, 2021) because they have exceeded the gestational age allowed in Belgium. The numbers reported for the last four registered years (2015 to 2018) show an average of 493 women in this situation. Combining those two sets of data allows to estimate how many additional women could beneficiate from an abortion in Belgium if the gestational age limit were to be extended. As for Great Britain, the yearly abortion statistics indicate a small but stable number of Belgian women having obtained abortion in the country in the three four registered years : 4 in 2019, 4 in 2020 and 5 in 2021[83].

However, since the 2018 law, if the legal gestational age of 12 weeks has been reached when requesting the abortion, the 6-day period suspends the age count of the pregnancy. It must by consequence be considered that the first line of the table, representing 21% of the former abortions abroad, is currently covered by the national legislation. The 2018 legal change is likely to have allowed 103 women to obtain abortion in Belgium rather than having to travel abroad. This is, however, purely speculative, as we lack the necessary data to know with certainty how those abortions have been treated.

Second trimester abortion is thus possible but unequally accessible among women residing in Belgium. With those main concerns in mind, WG3 is envisioning several options for the legal and practical framing of the practice of abortion for pregnancies aged of more than 12 weeks post-conception.

3.1. Extension of the current legal framing

In this scenario, the existing legal framing for elective abortion is conserved – and potentially adapted according to the recommendations (see WG1).

Abortion after 12 weeks post-conception and up to the newly defined gestational age limit would be available upon request, without conditions of situation or motives.

Dispositions

[83] https://www.gov.uk/government/collections/abortion-statistics-for-england-and-wales

Current dispositions would be conserved, notably regarding a first appointment for counselling and medical assessment and then a second appointment for the abortion procedure, as well as conditions of safe medical environment and conditions of informed consent.

It should be noted that compliance to the condition of safe medical environment for a second trimester abortion would require different facilities than those currently available for first trimester abortion procedures. This will be more exhaustively developed under section C.

Compliance to the law on patients rights (22 August 2002) and to the law on abortion (10 October 2018) already requires to provide specific information regarding the procedure :

- Information about the nature, urgency, duration, contraindications, side effects and risks inherent in the procedure and relevant to the patient, follow-up care, possible alternatives and the financial implications of the termination of pregnancy.
- Information about the present or future medical risks faced as a result of the termination of the pregnancy

Similarly to the information currently provided in a first trimester abortion preliminary consultation in order to obtain informed consent, information for a second trimester abortion would thus require explanations about the specific techniques and the potential risks of the procedure, notably with regard to further pregnancies.

Arguments

- This scenario appears as an update of the existing law.
- The philosophical focus is on providing an extended possibility for abortion care for women in Belgium, thus insisting on women's right to opt for abortion in a wider extent.

3.2. Specific dispositions :

In this scenario, the context of elective abortions after a certain delay post-conception is considered as distinct from elective abortions before that delay and thus requiring specific dispositions.

Regarding the gestational age representing the threshold for specific dispositions, two options are to be considered :

a) The threshold for specific dispositions is established at 12 weeks of gestation post-conception - which matches the gestational age currently defined as the legal limit for abortion.
b) The threshold for specific dispositions is established at 14 or 15 weeks of gestation post-conception. This proposal is motivated by the fact that the abortion procedure up to 14 or 15 weeks of gestation is similar to the first trimester procedure, with no significant additional social risks (Fetal growth between week 12 and weeks 14-15 is, however, not neglectable and to be considered in the procedure).

   It should be noted that, although specific dispositions would only start at 14 or 15 weeks of gestation, extra-hospital abortion centers dedicated to abortions of the first trimester would

continue to perform abortion procedures up to 12 weeks of gestation, and not extend the gestational age at which they are allowed to operate.

Dispositions

Such dispositions might include :

- Counselling from a pluri-disciplinary psycho-social team (similar to what is currently offered in abortion centers but not always available in hospitals).
    - Composition : doctor + psychologist + social worker
    - PB: Il faut enlever les () du travailleur social. Vu la fréquence importante de la vulnérabilité sociale parmi les demandeuses d'IVG tardive et l'importante de la prévention de récidive, le travailleur social ne doit pas être "optionnel"
    - Role :
        - Offer counselling
        - Ensure the ability for informed consent
        - Receive consent (through signed form)

- An insistence on the specificities of second trimester abortion methods and their respective risks (in concordance to the law on patients rights regarding information provision).
  Informative and consent aspects are, as mentioned earlier, already covered by the law on patients rights (22 August 2002) and to the law on abortion (10 October 2018) which require to :
        - Provide Information about the nature, urgency, duration, contraindications, side effects and risks inherent in the procedure and relevant to the patient, follow-up care, possible alternatives and the financial implications of the termination of pregnancy.
        - Inform about the present or future medical risks faced as a result of the termination of the pregnancy

- Other dispositions deriving from the medical necessities :
        - Description of the type of facility where 2nd trimester ToP can take place
        - Description of the required training and type of staff habilitated for these abortions
        - (…)
          These aspects will be developed on section C.

Arguments

- This scenario emphasizes the distinction between first trimester and second trimester abortions, both in practical and symbolic terms.
- The philosophical focus is then on public health concerns in securing the best conditions for second trimester terminations of pregnancy and offering a clear trajectory of care. Among these aspects, ensuring qualitative counselling and high level of medical expertise are the main concerns.

3.3. Extension of the current legal framing for medical abortions

In this scenario, abortions after 12 weeks post-conception would fall under the scope of abortions for medical motives. This would imply an extension of the definition of the current medical abortions to “abortions for socio-medical motives”. In this perspective, abortions of pregnancies aged of more than 12 weeks post-conception are considered as exceptional circumstances and associated with higher risks of mental, social or material precariousness of the patient.

Dispositions

The current dispositions and protocols for terminations of pregnancy for medical motive could apply, but having different meanings and outcome depending on the status of the abortion request.

Arguments

- Techniques, teams and infrastructures are already available and could be extended to these specific cases.
- The legal changes would reduced although having an important practical impact.

Counter arguments

- Nothing prevents from making abortions with no gestational age limit virtually possible.
    - Common practice currently implies that feticides are not performed on medical abortions for maternal reasons after the viability limit, leading to “elective prematurities”. This can be rationalized by the relation of the pregnant woman to a pregnancy that is likely to be planned and wanted. Application of this protocol to elective abortion requests on healthy fetuses would imply that, after the viability limit, the termination of pregnancy could result in the birth of a viable baby. De facto, elective abortion requests would be very unlikely at gestational ages close to the viability. The protocol of not performing a feticide for terminations of pregnancy with medical motive is however not mandatory, which virtually opens a possibility for psycho-social abortions without time limitation.
    - Specific restrictions in terms of gestational age (close to viability) could apply for terminations of pregnancy for psycho-social motives. However the goal of legal simplification is not fulfilled if a distinction of the motives reappears further.
- Risk of confusion between maternal psychiatric indications for termination of pregnancy and termination of pregnancy for psycho-social reasons.
- Risk of pathologizing abortion requests for psycho-social reasons after 12 weeks of gestation (similar to the notion of “state of distress” that was removed in 2018).
- The current law on abortions for medical motives requires signed approval by two doctors, which couldn’t apply for abortions motivated by psycho-social reasons.
- Reluctance expressed by the obstetricians currently performing terminations of pregnancy for medical indication to take care of the requests of abortion for psycho-medical motives.
    - One could fear the same reluctance with the other legal scenarios (scenario A1 of extension of the legal frame and scenario A2 of adding specific dispositions for second trimester abortions for psycho-social motives).
    - However, keeping a clear legal distinction between abortion for medical motives and psycho-social motive could be helpful in drawing a line between both medical acts so that practitioners can position themselves and perform one or the other according to the possibility for consciousness objection.

3.4. Legal dispositions : intermediary conclusions

There is a consensus among the group that options 1 and 2 are preferable. Due to major counter-arguments and complications, the group advises not to follow option n°3.

4. Options for gestational age limit

It should be noted that, although in some national laws, the legal texts offer a rationale explaining the choice for a specific gestational age limit, many do not provide such motives. However, recurrences in terms of numbers seem to indicate not only potential mutual influences in lawmaking decisions but also typified thresholds that become symbolic (see text on arguments and rationales for gestational age limit).

4.1. No gestational age limit

A position in favor of the absence of limit has been expressed by some field actors during hearings with abortion practitioners and representatives.

The only few international examples of the absence of gestational age limits (Canada being the most notable case) seem to indicate that, in the absence of a general legal framing, local governments, medical institutions and practitioners tend to set their own ethical or practical limits (Shaw and Norman, 2020).

Arguments

- Determining a specific limit is necessarily a choice and an arbitration between different lines of arguments, priorities and moral positions. The option of the absence of limit is a consequence of the impossibility to define a position as superior to others.
- Limits related to fetal development thresholds such as viability are seen as artificial and likely to be evolving. The absence of limit is more consistent with the possibility for fluid adjustments.
- The absence of gestational age limit can contribute in removing the stigma attached to abortion. The Canadian example indicates that the lift of the moral stigma together with a strategy of prevention helps in obtaining earlier abortions requests even without gestational age limit.

Counter-arguments

- Such a fundamental change of legal orientation could stress more resistance than support.
- The absence of legal limitation opens the risk for practitioners to substitute for the law and make their own limitation, leading to stricter limits in practice.
- It could result in a lack of clarity in the practical dispositions (type of training, of available qualified personal for specific gestational ages…)
- Weakening of the exceptional status of terminations of pregnancy for severe medical reasons that is view as very important to be preserved as such.

- This significant change would create a contrast with other neighboring countries such as France (current gestational age limit for abortion : 14 weeks PC) or Germany (current gestational age limit for abortion : 12 weeks PC). In case of a legal change in Belgium with this regard, this might generate an afflux of foreign patients.

4.2. 22 weeks post-conception

This is the current legal limit in the Netherlands and Great Britain. These laws and the gestational age limit that they mention originate in the notion of viability (Ingham *et al.*, 2008; Eades, 2019). However, several scientific sources converge in the opinion that viability as a criterium is a shifting and unstable threshold (Robertson, 2011; Han *et al.*, 2018).

An extension of the gestational age limit over 20 weeks would encompass the total number of women currently requesting an abortion outside Belgium to obtain the procedure within the country, representing an average 493 women per year .

The Dutch law evaluation report (Ploem *et al.*, 2020) advises to conserve the 22 weeks post-conception delay[84], but to distinguish the notion of viability in the context of abortion care, where it is established as a time limitation – from viability in the context of neonatal care, where it is an actual potentiality for treatment and survival.

Evaluations from a legal and medical perspective from these two countries (Netherlands and Great Britain) offer encouraging perspectives supporting this gestational age limit (Great Britain: Parliament: House of Commons: Science and Technology Committee, 2007; Ploem *et al.*, 2020). Although there is a large body of scientific literature documenting abortions techniques of the second trimester, as well as testimonies from experimented practitioners, underlining the respective assets of surgical and medical methods for abortion, there were discussions in the working group about the diversification of techniques involved. One member emitted strong objections against the use of surgical abortion after 14 weeks post-conception, doubting that Belgian practitioners would be inclined to use it, and rather prefer the medical method for abortion. It was concluded that the choice of method should be left to the practitioner and to the patient after being duly informed.

Arguments

- This scenario can be presented as an alignment with the Netherlands for pragmatic purposes:
    - We already have a good overview of the current demands and their distribution in terms of gestational ages. It helps in anticipating the needs and numbers.
    - Dutch feedbacks are globally positive, regarding patient care, patient satisfaction, techniques efficiency and complications.

- It also helps fulfilling ethical and public health purposes :

[84] In practice, however, abortion clinics do not perform abortion for pregnancies over 20 weeks and 2 days post-conception. Patients then have the possibility to request an abortion in hospitals, although it is quite unlikely to find practitioners for such later stages of abortion.

- It is a way to avoid the current discriminatory situation : second trimester abortions are actually available for Belgian women but only if they have sufficient means. This extension would provide the possibility for abortion for that total number of women who would otherwise have to travel to obtain it.
- It aligns not only with a neighboring country, but also with the most favorable abortion laws in Europe for women and access to abortion in terms of gestational age.

Counter-arguments

- The argument of providing abortion in Belgium for a wider number of women is an endless one : there is always a proportion of women who will fall behind the legal limit, wherever it is established.
- Such a change of legal orientation could stress more resistance than support.
- The 22 weeks threshold aligns with the most accepted current notion of viability : there is a risk that it shifts through time and thus fragilizes the law.
- Aligning with the Dutch law which is more liberal in terms of gestational age would create a contrast with other neighboring countries such as France (current gestational age limit for abortion : 14 weeks PC) or Germany (current gestational age limit for abortion : 12 weeks PC). In case of a legal change in Belgium with this regard, this might generate an afflux of foreign patients.

4.3. 20 weeks post-conception

Outside of Europe, Nebraska reduced in 2010 the gestational age limit at 20 weeks for elective abortions, considering (disputed) scientific evidence about the ability of fetuses over 20 weeks to feel pain (Robertson, 2011). Although it provides a form of motivated basis for lawmaking, scientific notions about fetal perceptive abilities present the same contraindication as the notion of viability : there are (although highly unlikely in the current situation) possibilities that it will shift through time and thus destabilize the basis on which the law is formed.

Arguments and counter-arguments

- Arguments and counter-arguments for this option are similar to those expressed for the 22 weeks post-conception option.
- Yet, it is a more moderate and cautionary approach in terms of fetal development

4.4. 18 weeks post-conception

Two countries, Sweden and Norway, have opted for an 18 weeks gestational age limit (Boland, 2010). Sweden has a particularly long history with the liberalization of abortion, for broad social reasons, but also on medical and eugenic grounds, with a first step of legalization in 1938, later (in 1974) reshaped in consideration of the women's rights framing (Askola, 2018). In Sweden, abortion is now available on request up to 18 week post-conception. After this term, the abortion request must be addressed to the National Board of Health and Welfare and motivated by the vague determinant

of “special reasons” – in which case abortion can be authorized up to viability (set at 22 weeks) (Askola, 2018).

An extension of the gestational age limit to 18 weeks of pregnancy would allow 49% of the women currently requesting an abortion outside Belgium to obtain the procedure within the country, representing a total of 242 women.

Preliminary versions of the 2018 Belgian law on abortion were mentioning a gestational age limit of 18 weeks post-conception. At the time, several field actors such as abortion centers were aligning with this option, expressing satisfaction with a substantial increase of the limit that was seen as an acceptable compromise between different options. Disappointment towards the final decision has since been repeatedly voiced. It was also expressed during the hearings, where abortion centers were all in favor of an extension of the gestational age limit up to at least 18 weeks (or more).

Arguments

- Argument of a “reasonable” recommendation that is less likely to meet strong opposition. In Parliament and in civil society, there was already some support for the 18 weeks gestational limit in 2018.
- In terms of fetal development, it allows to establish a security time zone to avoid overlapping with the period of viability and neurological maturation of the pain perception system. At those more advanced medical stages, two weeks of fetal development lead to significant increase of weight and size, hence impacting the abortion process itself. This option appears is defended by some members as more cautionary in terms of fetal development and in balance with the inclusion of a significant number of abortion requests.
- This more liberal option in terms of gestational age would create a contrast with other neighboring countries such as France (current gestational age limit for abortion : 14 weeks PC) or Germany (current gestational age limit for abortion : 12 weeks PC). In case of a legal change in Belgium with this regard, this might generate an afflux of foreign patients.

4.5. Gestational age limit : intermediary conclusions

There is a consensus among the group that gestational age limit should be extended to a minimum of 18 weeks post-conception. Most of the members of the group are in favor of an extension of the maximal gestational age for abortion up to 22 weeks post-conception. Some members support the option of 20 weeks or 18 weeks post-conception.

The group underlines its strong position in favor of an extension, supported mostly by arguments of social equity.

5. Practical organization

5.1. Facilities

5.1.1. Type of facility

- In hospitals
    - Extension of the missions of existing departments of obstetrics/gynecology in hospitals.
        - Pro : easier implementation
        - Con : departments with a current experience in second trimester abortion are dedicated to terminations of pregnancy for medical motives. Not all of them might be willing to extend the care to elective abortion. The respective approaches of elective abortions and pre- or post-natal obstetrical care seem too different to be taken in by the same medical teams and the same theater.

    - Creation of new, dedicated departments in hospitals
        - Pro : possibility to adapt to the best qualitative conditions of abortion care for the second trimester.
        - Easy access to urgent specialized care in hospital in case of complication
        - Cons : Slower and more costly implementation. Potential need to call on members of the general hospital staff not sensibilized to abortion care.

      In both cases, it would require to have specific theater for abortions, since delivery theaters would not be suitable.

- Facility adjacent to hospitals
    - Pros :
        - Possibility to create new multi-disciplinary teams to provide qualitative counselling and second trimester abortion care.
        - Dedicated centers are more welcoming for patients, in terms of confidentiality and sensibilization of the staff.
        - Based on the existing model of centers for the management of sexual abuse (CPVS / ZSG)
        - Easy access to urgent specialized care in hospital in case of complication
    - Cons : costs and time of implementation

- Extra-hospital : this option is not supported for obvious reasons of safety and medical requirements that would imply higher costs.

5.1.2. Number

Depending on the numbers available from the Evaluation Commission over the last four registered years, we estimated that an average of 493 Belgian women per year could beneficiate from second trimester abortion in Belgium.

In the scenario of an extension of the gestational age limit for abortion in Belgium, it is likely that the country would absorb a fraction of patients from neighboring countries with a stricter delay, who currently opt for having an abortion in the Netherlands (and, in a lesser proportion, in Spain or Great Britain).

The Dutch Ministry of Health provides numbers of foreign patients having had an abortion in the Dutch health system[85]. The table below recollects numbers for the four last registered years and for the countries sharing a border with Belgium.

	2017	2018	2019	2020
Belgium/ Luxemburg	472	444	428	330
Germany	1.219	1.237	1.247	1.125
France	967	810	744	590

There is a high likelihood that the majority of the French[86] patients currently requesting an abortion procedure in the Netherlands might rather report to practitioners in Belgium. In the case of Germany[87], it is more difficult to establish if the main preference will remain for patients to go to the Netherlands (or other countries) or if a significant amount of German patients will come to Belgium.

5.1.3. Repartition

How many facilities and how to dispatch them around the territory ?

- Option 1) Regional repartition : 1 center in Flanders, 1 in Brussels and 1 in Wallonia
    - Concentration of competences and costs
    - Linguistic and regional repartition
    - More realistic in terms of needs and patient affluence

- Option 2) Repartition under the model of the CPVS/ZSG[88] :
    - good territorial coverage
    - already existing structures (to be extended with a new department), adjacent to academic hospitals
    - corresponds more or less to the largest cities
    - The number is probably to high regarding the needs at the national level.

Feasibility in terms of practicalities, financing and willingness has not been further explored for neither options.

5.1.4. Medical services

Regarding the techniques to be used, both medical and chirurgical abortions (see sections describing the techniques) are promoted in the international literature which stress their safety and the

[85] https://www.igj.nl/over-ons/publicaties/rapporten/2021/12/09/definities-en-cijfers-bij-jaarrapportage-2020-wafz

[86] In France, abortion is currently available up to 14 weeks of gestation.

[87] In Germany, gestational age limit is currently set at 12 weeks post-conception.

[88] The CPVS/ZSG centers are currently dispatched in the following cities (which doesn't imply that 2nd trimester abortion center could or would follow the same structure) : Brussels (Hospital St Pierre Brussels) ; Charleroi (CHU Charleroi) ; Liège (CHU Liège) ; Antwerpen (UZ Antwerpen) ; Leuven (UZ Leuven) ; Gent (UZ Gent) ; Roeselare (AZ Delta).

importance to give the women a choice. Nevertheless an individual opinion in the working group supports strongly that only medical abortion should be performed as well for prevention of complications as for ethical, symbolic and societal acceptance reasons.

What kind of services should be provided according to the specific needs of second trimester abortions?

- Night stay
- General anesthesia, loco-regional anesthesia, sedation)
- Management of complications
- …

Available services will also depend on the relation and possibility of collaboration with hospitals. Although the model of the CPVS/ZSG is not comparable in terms of medical requirements, their procedures in terms of confidentiality, holistic approach and interdisciplinarity could contribute in elaborating the organization of abortion centers related to hospitals.

5.2. Facilities : conclusions

The group advises against implementing units for elective second trimester abortions in the existing ob/gyn departments. They are unanimously in favor of creating new departments, dedicated only to elective second trimester abortion, whether in center adjacent to a hospital or as new hospital departments. Close collaboration and possibility for quick transfers are key elements.

Most of the members of the group are in favor of having three centers, following a regional repartition, as a starting point for second trimester abortion provision. A small number of centers, proving regional, geographical and linguistic coverage would be an asset also in concentrating competences and knowledge.

6. Professionals and training

6.1. Training

Belgian ob/gyn are currently not specifically trained for the more demanding techniques of second trimester surgical abortions but have however acquired the experience of dilatation and evacuation during the second trimester . The group discussed the possibility for GP to perform second trimester abortions : although some members expressed a reluctance, other members underlined that this possibility exists in other countries (Great Britain notably).

- How should training be provided ? Different options can be envisioned
    - Academic training in medical school
    - Specialization training for practitioners in Belgium : this would require to create a dedicated program. Ob/gyns having had a certification and/or an experience of second trimester abortion techniques in other countries could be hired with this purpose.
    - Specialization training abroad (for a quicker obtention of the certification)
    - Hiring of foreign practitioners already trained for second trimester abortion or practitioners with an experience acquired in other countries allowing it.

- Should there be forms of certification ?
    - Simple training certification
    - Conditions of experience and quantitative practice (similar to the Netherlands)

6.2. Team composition

In the option of specific facilities, what kind of personal should be available and compose the team ?

This question is related to the type of support and medical service that should be offered for second trimester abortion (in terms legal dispositions but also sedation and anesthesia possibilities)

- Doctor (ob/gyn or other specific training to be defined)
- Anesthesiologist
- Nurse
- Midwife
- Psychologist
- Social worker
- Support team (administration etc.)
- (…)
-

7. Delay of provision

How much time should be considered for implementing the legal and practical changes ? Should a deadline or a planning be established at the intention of the government in the legal recommendations ?

8. Financing

How to establish the costs and financing this extension of provision of abortion care ?

The group wishes to underline the need to remove any financial barriers to the access of second trimester abortion, which should affordable in a similar way as first trimester abortion. Equity of access to abortion care is at the center of our recommendation for an extension of the gestational age limit, it should then be also supported by an attention to make second trimester abortion financially accessible, without discriminating between the patients.

Currently, abortion care is publicly funded and reimbursed to the patient by the INAMI/RIZIV with the intermediary of health insurance programs.

List of recommendations for abortion time limit extensions WG3

Introduction and definition :

This part of the text covers the scope of elective abortion, motivated by psycho-social indications. "Elective abortion" should be understood as a request for abortion stemming from the pregnant woman, who choses on her own free will to terminate an unwanted pregnancy. The mention of "psycho-social motives" or "indications" should not be understood as a criteria in itself, but as a mean of distinction with an abortion request relying on medical motives, whether it concerns the health of the fetus or the health of the pregnant woman.

We consider elective abortion with psycho-social motives as a form of health care that should be available upon request of the pregnant woman, with no other condition than her own informed decision about terminating the pregnancy.

1. Legal dispositions

The group unanimously advises to extend the maximal gestational age for an elective termination of pregnancy.

Three legal options have been discussed and there are presented here in order of preference :

A. <u>Extension of the maximal gestational age with specific dispositions :</u>

The context of elective psycho-social abortions after a certain delay is considered as distinct from elective abortions before that delay and thus requiring specific dispositions. The threshold for specific dispositions can be established whether at 12 weeks of gestation post-conception or at 14 weeks of gestation post-conception.

Specific dispositions should be understood as qualitative conditions for the medical and psycho-social consultations required.

The group recommends the following dispositions :

- Facilities : elective psycho-social termination of pregnancies aged of more than 12 weeks post-conception (independently of the threshold for specific dispositions) should only be performed in dedicated facilities.
- The trajectory of care should involve interdisciplinary accompaniment, in two steps, involving a psycho-social consultation as well as the medical care. As a first step, the psycho-social consultation with a psychologist and social worker should provide the pregnant woman with the range of information needed for her to give informed consent. There should be no mandatory list of information but rather a discussion tailored to the needs of the pregnant woman and with a focus on the specificities of second trimester abortion methods and their respective risks.

B. <u>Extension of the current legal framing</u>

In this scenario, the existing legal framing for elective abortion for psycho-social motive is conserved – and adapted. The main modification is the maximal gestational age for elective abortion.

Current dispositions would be conserved, notably regarding a first appointment for psycho-social counselling and medical assessment and then a second appointment for the abortion procedure, as well as conditions of safe medical environment and conditions of informed consent.

It should be noted that compliance to the condition of safe medical environment for a second trimester abortion would require different facilities than those currently available for first trimester abortion procedures.

C. <u>Extension of the current legal framing for medical abortions</u>

In this scenario, abortions after 12 weeks post-conception would fall under the scope of abortions for medical motives. This would allow to conserve the existing legal structure, with, on the one hand, abortion on request allowed up to 12 weeks and, on the other hand, abortion with a specific indication after that threshold. It induces an extension of the definition of the current medical abortions to "abortions for socio-medical motives". Some of the current dispositions for abortions for medical motives however do not seem easily applicable to this scenario, such as the absence of a gestational age limit or the requirement to have two different doctors' signature for the procedure.
Due to major counter-arguments and complications, the group advises not to follow this option.

2. Gestational age limit for elective abortions for psycho-social motives

An extension of the gestational age limit for elective abortion is unanimously supported. Options not supporting an extension of the gestational age limit or supporting an extension of less than 18 weeks post-conception were not followed. Another option of having no gestational age limit in the law was not followed either.
Members of the group wish to underline the two following principles :
1/ Abortion should be safe and affordable in Belgium, and in no way conditioned to individual means (whether they are financial or other).
2/ The state of development of the foetus should be taken into account in abortion law, for medical as well as for moral reasons.
The group emphasizes its strong position in favour of an extension, supported mostly by arguments of social equity. There is a consensus among the group that gestational age limit should be extended to a minimum of 18 weeks post-conception. Most members of the group are in favour of an extension of the maximal gestational age for abortion up to 22 weeks post-conception, while a gestational age of 20 weeks post-conception is envisioned as well. Some members support the option of 18 weeks post-conception.

3. Facilities

The group is unanimously in favour of creating new departments, dedicated only to elective second trimester abortion, whether in centre adjacent to a hospital or as new hospital departments. This option is motivated by the possibility in specialized department to offer heavier equipment, full anaesthesia, and the possibility for night stay.
Interdisciplinarity, expertise in abortion care at the psycho-social and medical levels and confidentiality are also criteria for second trimester abortion facilities. Other key elements are close collaboration with hospitals and the possibility for quick transfers.
The group advises against implementing units for elective second trimester abortions in the existing ob/gyn departments. They are
The members of the group are in majority in favour of having three dedicated centres, following a balanced territorial repartition.

4. Training and hiring

A quick implementation of the new facilities dedicated to second trimester elective abortions could be obtained by hiring practitioners with a pre-existing expertise and experience in second trimester abortions.

5. Financial access

The group wishes to underline the need to remove any financial barriers to the access of second trimester abortion, which should affordable in a similar way as first trimester abortion. Equity of access to abortion care is at the centre of our recommendation for an extension of the gestational age limit, it should then be also supported by an attention to make second trimester abortion financially accessible, without discriminating between the patients

d) Working group 4 : Abortion law – ethical and legal aspects

History and structure of the Act on (Voluntary) Termination of Pregnancy 1990/2018

1. Abortion ('vruchtafdrijving'/'avortement') was already criminalised by the Napoleonic Criminal Code of 1810, and remained prohibited in the Belgian Criminal Code of 1867 (Colette-Basecqz and Blaise, 26). The 1867 Criminal Code criminalised abortion under all circumstances in its former articles 348–353. This remained the case until 1990, when Belgium partially decriminalised abortion. It retained voluntary[89] abortion as an offence in the Criminal Code, but specified exceptions to criminalisation if the abortion met a number of procedural and substantive conditions.

2. The 1990 legal reform remains the basis of the current abortion law in Belgium, with the exception of some legal amendments introduced in 2018. Among others, 2018 law reform removed the regulation of voluntary abortion from the Criminal Code and embedded it in a separate 'Act on Voluntary Termination of Pregnancy' (hereafter: AVTOP). It also changed the principle in the law from 'abortion is a crime, unless it meets conditions…' to 'the pregnant woman can request a termination of pregnancy under conditions...' (Vansweevelt e.a., 2018, 225). The idea behind the amendment was that voluntary abortion should no longer be considered a crime as the base line (*Parl*. Chamber 2018, doc. no. 54 3216/001, 4). Second, it introduced some smaller amendments to the content of the law, but retained most of the conditions installed by the 1990 law. Retained conditions include a 12-week time limit, medical grounds that justify access to abortion after 12 weeks, procedural conditions such as a mandatory waiting period and obligatory information duties, and criminal sanctions for provider and woman when abortion happens outside of the legal conditions. The scope of these legal conditions will be discussed in greater detail in the following sections.

Main terminology: 'avortement'/'vruchtafdrijving' – 'voluntary' – 'termination of pregnancy'

[89] Abortion without the woman's consent, including abortion as a consequence of intentional violence, remained criminalised without exception. Prohibited are situations where: 1) the abortion is *intentionally* caused without consent of the pregnant woman (art. 348 CC); and 2) the abortion is caused after *intentional* violence but without the aim to cause abortion (art. 349 CC). Heavier sanctions exist when the non-consensual abortion results in the death of the woman (art. 352 CC). Involuntary abortion will not be further discussed in detail as it was not requested by the commissioner of this report.

3. Neither the 1990 nor the 2018 Law on (Voluntary) Termination of Pregnancy contain any definitions (Nys, 1991, 1189). This leaves some room for interpretation regarding the terminology used in the law. This section discusses the legal meaning of the terms 'avortement/vruchtafdrijving', 'voluntary', and 'termination of pregnancy', as these figure prominently in the AVTOP.

4. Historically, the Criminal Code used the terms **avortement/vruchtafdrijving** to prohibit all abortions, regardless of whether they happened with or without the woman's consent. When abortion was partially decriminalised in 1990, the term '**termination of pregnancy**' was introduced for endings of pregnancy that meet the legal conditions. This is also the case in the 2018 Law on Voluntary Termination of Pregnancy. The terms avortement/vruchtafdrijving are still used in article 3 of the AVTOP, which deals with the criminal offences and sanctions for abortions performed in violation of the legal conditions. In addition, the Criminal Code still refers to **avortement/vruchtafdrijving** in its offences regarding endings of pregnancy without the woman's consent (arts. 348-349, 352 Criminal Code). This particular use of the terms 'avortement'/'vruchtafdrijving' suggests that they refer to unlawful behaviour, whereas the term 'termination of pregnancy' refers to lawful behaviour. Some members of WG4 have questioned this use of distinctive terms, especially in the AVTOP.[90] First, the material acts in both lawful and unlawful abortions are essentially the same: intentional endings of pregnancy (Vansweevelt, 2022, 143; Nys, 2005, 248). Second, at least the term 'avortement' is often used in the French-speaking abortion practice to describe lawful or accepted endings of pregnancy.[91] Mentioning the term 'avortement' only in relation to unlawful behaviour could have a stigmatising effect on (the use of) that term. Members of WG4 recognise that both 'abortus'/'avortement' and 'zwangerschapsafbreking'/'interruption de grossesse' are used in practice, which is why this report uses these terms interchangeably and as synonyms.

5. The 2018 Act on Voluntary Termination of Pregnancy introduced the term **'voluntary'** termination of pregnancy in its title and some of its articles, distinguishing it explicitly from abortion without the woman's consent which remained situated in the Criminal Code. This suggests that 'voluntary' abortion refers to abortion 'at the request' and/or 'with consent'[92] of the pregnant woman.

[90] WG4 members considered a distinctive use of terms more justified when considering abortions at the request of the woman vs. abortion without such request, although these also involve similar material behaviours (intentional endings of pregnancy).
[91] The term 'vruchtafdrijving' has no such connotation or is not commonly used in abortion practice to designate accepted endings of pregnancy.
[92] Despite their distinct connotations, both terms seem to overlap largely.

Some members of WG4 submitted that the term 'voluntary' could be insensitive to women who terminate a pregnancy, particularly in case of severe maternal or foetal medical conditions. While these interruptions are in essence consensual, they are not always experienced by patients as expressions of volition or free will. Despite this perception, WG4 recognises that the use of 'voluntary' is not entirely uncommon in abortion legislation (e.g. interruption volontaire de grossesse (IVG) in France; interrupción voluntaria del embarazo in Spain). Members of WG4 discussed the option to replace the term 'voluntary' by 'consensual', but that term was considered potentially problematic as well.[93] They expressed more support to replace 'voluntary' by 'at the request' of the pregnant individual, as such a request is considered the basic element underpinning the different types of abortions considered by the abortion law.[94]

6. '**Termination of pregnancy'** is the main term used by the AVTOP. In the absence of a legal definition in the AVTOP, WG4 discussed the possible meaning of the term with regards to the start of a pregnancy, the means and methods that can be considered to terminate a pregnancy, and the term's relation to timing and viability.

When is there a pregnancy in the context of 'termination of pregnancy'?

7. Medically, biologically and ethically speaking, different answers to this question exist. As to legal definition, the AVTOP does not explicitly state when pregnancy begins. However, it does refer to the moment of conception to calculate the 12-week pregnancy period in which abortion upon request is allowed. The moment of conception is a common reference point in other Belgian laws to calculate pregnancy duration (e.g.: art. 2, 4° Wet menselijk lichaamsmateriaal/Loi matériel corporel humain; art. 326 former Civil Code). In practice, however, medical professionals present pregnancies in weeks calculated from the last menstrual period, which approximately takes place two weeks prior to conception. This crucial distinction has been a source of misunderstandings in medical practice and in the drafting of this report, and thus needs to be taken into account by anyone reviewing the Belgian abortion law.

[93] According to some members of WG4, using the term 'consensual' could diminish agency and autonomy of the pregnant person when the abortion happens at own request, and wrongfully suggest that a woman can only receive an abortion after someone else proposed the procedure to her.

[94] Exceptions to this principle exist in medical practice (e.g. abortion performed for the purpose of saving the life of an unconscious patient).

8. Disagreement exists on the understanding of 'conception' as the starting point of pregnancy (Chung *et al.*, 2012). Conception is understood by some as the moment of fertilization, which occurs when a single sperm gradually penetrates the layers of an egg to form a new cell ("zygote").[95] Yet, another position holds that conception refers to implantation, which is the moment when the fertilized egg descends into the uterus and attaches itself to the uterine lining.[96] Complete implantation usually takes place around six days after fertilisation. These different understandings complicate establishing the beginning of pregnancy according to the law. The understanding of when a pregnancy begins has implications beyond the mere theoretical level. Especially in the United States, particular definitions have been used to scrutinise **post-coïtal emergency contraceptives** (Benson Gold, 2005)**.** The claim is that these means could affect an already conceived pregnancy and thus be considered 'abortive'. However, scientific evidence shows that hormonal emergency contraceptives uniquely act through inhibition of ovulation or prevention of fertilization instead of implantation (Gemzell-Danielsson *et al.*, 2013; Endler *et al.*, 2022). Cu-IUD inserted as emergency contraception can inhibit the implantation of a fertilized egg, whereas common use of Cu-IUD acts mainly through prevention of fertilization by affecting sperm function. In any case, emergency contraceptives have no effects on a pregnancy after implantation. Members of WG4 unanimously oppose a potential legal qualification of the use of **post-coïtal emergency contraceptives** as 'terminations of pregnancy' which would be subject to the conditions of the AVTOP.[97]

What can be considered in terms of means and methods to terminate a pregnancy?

9. The old articles 348 and 350 Criminal Code prohibited 'vruchtafdrijving'/'avortement' through foods, drinks, medicines, or "any other means" (spijzen, dranken, artsenijen of door enig ander middel/ aliments, breuvages, médicaments ou par tout autre moyen). "Any other means" implied that the method to end the pregnancy was irrelevant to be considered abortion (Vansweevelt, 2022, 157-158). The 2018 law removed the reference to "foods, drinks, medicines, or any other means" as methods to perform abortion from article 349 in the Criminal Code. The abortion law does not specify means or methods to perform an abortion, although it does stipulate that the abortion must take place "onder medisch verantwoorde omstandigheden/dans de bonnes conditions médicales" (article 2, 1°, b AVTOP)

[95] See, for instance, list of medical terms of the Royal College of Obstetricians and Gynaecologists: https://www.rcog.org.uk/for-the-public/a-z-of-medical-terms/.

[96] This is the position of the American College of Obstetricians and Gynecologists.

[97] In the Netherlands, these post-coïtal contraceptives have been explicitly excluded from the scope of application of the abortion legislation, see Dutch 'Wet Afbreking Zwangerschap, Article 1.2 Waz states: "Voor de toepassing van het bij of krachtens deze wet bepaalde wordt onder het afbreken van zwangerschap niet verstaan het toepassen van een middel ter voorkoming van de innesteling van een bevruchte eicel in de baarmoeder."

10. In different sections of this report, the most common abortion means and methods are described in detail. This sections reflects upon the term 'termination of pregnancy' in connection to these means and techniques.

First, although the AVTOP regulates 'termination of pregnancy', **not all medical procedures causing foetal demise also technically 'terminate pregnancies'**. In the case of selective foetal reduction in a multiple pregnancy, a clinical intervention causes the death of one or more foetuses *in utero* while the pregnancy continues for one or more other foetuses to enable improved chances of development for the latter foetus(es). Although technically the pregnancy is not "terminated", different legal scholars consider selective foetal reduction to fall under the scope of the AVTOP as the procedure involves an intentional action causing foetal destruction during pregnancy (Guldix, 1995, 163-174; Nys, 2016, 219-220). If this position is accepted, a clarification in the law to include selective foetal reduction under the scope of the AVTOP may be considered (for examples of such a clarification, see the Icelandic Termination of Pregnancy Act[98]; see also 'interruption volontaire partielle d'une grossesse' in French law, Code de la Santé Publique, Art. L. 2213-1.-II).

Second, **not all terminations of pregnancy cause direct foetal demise**. Some pregnancies are medically terminated at an advanced stage of pregnancy due to health concerns for the pregnant individual, but with the expectance of the foetus' survival. In this context, some medical professionals have declared uncertainty about how to qualify a medical induction of labour for maternal health reasons with the intention to save the neonate, after which it still dies from its prematurity. These medical interventions 'terminate the pregnancy' but are not carried out with the intention of causing the eventual death of the foetus/neonate. Both members of WG4 and the legal doctrine suggest that the intention to cause such demise is presumed under the meaning of 'termination of pregnancy' in the abortion law (e.g. Vansweevelt, 146, 2022: "Abortus veronderstelt een menselijke handeling met het oog op de vernietiging of de doding van het embryo of de foetus."). Similarly, in the context of termination of pregnancy on medical grounds, medical induction of a pregnancy alone does not, per definition, result in direct foetal demise if the foetus is considered viable.[99] Actively causing foetal demise *in utero* before

[98] Article 1-2, Termination of Pregnancy Act, No. 43/2019, available at: https://www.government.is/lisalib/getfile.aspx?itemid=60ae8fd2-0b91-11ea-9453-005056bc4d74.

[99] This is dependent on the gestational age of the foetus and the severity of the foetal anomaly, in relation to the impact of the procedure of medical induction on the foetus.

inducing labour is recommended to prevent potential postnatal survival in this particular case (see also chapter X about foeticide[100]).

Does the term 'termination of pregnancy' include endings of pregnancy regardless of timing or viability?

11. The 1990/2018 abortion law itself does not contain an end limit on abortion for severe medical conditions. However, some suggest that the definitions of 'abortion'/'termination of pregnancy' contains an inherent limit. Before the 1990 legal reform, several academics defined abortion as "an artificial and voluntary destruction of a product of conception before the end of the pregnancy, regardless of gestational age or viability" (Rigaux & Trousse, 1968, 139; see also Piret, 1964, 355; Van Look, 429, 433). During the parliamentary debates preceding the 1990 abortion law, abortion was defined by one drafter of the bill as "an intervention or administration of medication, after which a foetus that cannot live an independent life yet, is expulsed" (*Parl*. Senate 1988, doc. no. 247/2, 148). This caused some confusion over the legal status of abortion of foetuses that can live an independent life given their stage of development. The parliament finally adopted the abortion law without end-limit in 1990, and an amendment to include a restricting limit around the point of viability was explicitly rejected. After the law was adopted, some discussion arose in academia on whether the parliamentary opinion that limited the definition of abortion to non-viable foetuses should be followed or not (e.g. De Keyser and De Meuter, 1993; Nys, 1995; Leleu and Langenaken, 2002; Delannay 2010; De Nauw, 2010; Genicot, 2010; Colette-Baseqcz & Blaise, 2011; Vansweevelt, 2022; Van Assche, 2017; De Meyer, 2020). If the viability-limited definition of abortion as suggested by the 1990 parliamentarians would be accepted, post-viability abortions would not fall under the scope of application of the abortion law, nor under criminal law offences such as infanticide or murder. Post-viability abortion would, in fact, reside in a legal void (Nys, 1995, 34-42). Belgian lower courts have also received the question of whether abortion after viability for severe medical reasons is lawful, but have issued opposing judgements (case law discussed by Vansweevelt, 2022, 209-210; Van Assche, 2017). The question of the legal and ethical permissibility of 'late termination of pregnancy' and the practice of foeticide was put to the Belgian Advisory Committee on Bioethics (Advisory Committee on Bioethics, Advice no. 71). The Committee reiterated that the law allows termination of pregnancy after 12 weeks in case of a particularly severe and incurable foetal anomaly, and that no legal regulation exists on the methods through which a termination of pregnancy should occur. Moreover, the Committee reiterated that the foetus does not have the

[100] More generally, this term refers to the act of causing the death of a foetus. In a medical context and in this report, it is used to describe the administration of a lethal drug to the foetus to stop its vital functions.

status of a person in Belgian law. Only when the child is in the process of birth, criminal law recognises it as a person (Court of Cassation, 11 February 1987). The discussion was not revisited in the 2018 parliamentary debates on the reform of the 1990 Act on Termination of Pregnancy, nor did anyone suggest a viability-restricted interpretation of the terms 'abortion'/'termination of pregnancy'.

Today, performing foeticide as part of a late termination of a pregnancy is an accepted and common clinical practice in Belgium and in countries where post-viability abortions are permitted on medical grounds (see chapter X). To remove any remaining legal doubt and to avoid inconsistency with medical practice, WG4 recommends to confirm an understanding of termination of pregnancy that is not limited to viability or to a specific gestational age in these cases. Such a definition does not exclude the possibility to regulate abortion as the pregnancy advances, as is currently the case. A possible approach is present in the French abortion law, which specifies that termination of pregnancy on medical grounds can take place "regardless of gestational age" (article L. 2213-1 of the Code de la Santé Publique). A similar legal amendment or statement during parliamentary debates/in the explanatory memorandum may suffice to increase legal certainty.

Conditions for lawful voluntary termination of pregnancy

12. Article 2 of the AVTOP deals with the conditions and procedure on voluntary abortion. It stipulates that a woman can request a doctor to terminate her pregnancy under stipulated conditions. WG4 notes that it would be more accurate to state that a termination of pregnancy, at the request of the pregnant woman, can be performed under stipulated conditions. After all, article 3 AVTOP criminalises performing abortion or letting someone perform abortion outside of the legal conditions in article 2.

1. The 12-week time limit

13. The Belgian abortion law contains a time limit of 12 weeks post-conception for abortion upon request, introduced by the 1990 law and retained when the law was amended in 2018 (article 2, 1°, a) AVTOP). Since 2018, the mandatory six-day waiting period may surpass the 12-week time limit, which means in practice that a pregnancy can be terminated up to 12 weeks and six days (see point X).

14. The drafters of the 1990 law stated that the 12-week time limit was the result of different viewpoints expressed by the proponents of legal reform.[101] They acknowledged that the 12-week time limit was prone to criticism due to the variety of medical, moral and affective factors influencing opinions on termination of pregnancy (*Parl.* Senate 1988, doc. no. 247-1, 11). Despite these difficulties, the drafters believed it was opportune to draw a line between two stadia of pregnancy, taking into account the "altered perceptions and reactions [to abortion], and the aggravation of the affective or medical consequences that can occur depending on whether the pregnancy is terminated at a moment closer to or further from conception" (*Parl.* Senate 1988, doc. no. 247-1, 12).

15. In the parliamentary debates, some arguments for and perceptions of the 12-week limit were presented. Among others, drafters of the bill justified the 12-week limit by arguing that 97-98% of abortions occur in the first three months (*Parl.* Senate 1988, doc. no. 247-1, 26). Although it is true that the majority of abortions are performed in the first trimester, this reasoning has the weakness that it remains unclear which percentage of access is needed to justify a precise limit. In fact, the reasoning could also apply to earlier or later gestational age limits.[102] According to a member of parliament, the 12-week limit would concur with the transition between the embryonic period and the foetal period.[103] However, WG4 members note that this does not reflect the common medical and legal understanding of the terms 'embryo' and 'foetus' (De Meyer & De Mulder, 2021). Transition between both is usually situated at 8 weeks pregnancy post-conception (see also art. 2, 4° and 5° Wet menselijk lichaamsmateriaal/Loi matériel corporel humain; (Advisory Committee on Bioethics, Advice no. 18). The moral relevance of a biological transition from embryo to foetus for determining a time limit on abortion can also be criticised (De Meyer & De Mulder, 2021). A member of WG4 emphasises that the mere presence or emergence of a biological characteristic cannot be confused with the moral value we attach to the characteristic.

16. In parliamentary debates in 2019-2020 on possible abortion law reform, some members of parliament referred to technical needs and increasing health risks in defence of retaining the 12-week limit and against a later time limit on abortion. Chapter X and X analyse more in depth these technical arguments in the abortion time limit debate.

[101] Note that in an earlier version of the legal proposal discussed in 1989, a 15-week limit was proposed. An amendment was later accepted reducing the limit to 12 weeks.
[102] In fact, in 2022, US Supreme Court judge Roberts in his concurring opinion on the Dobbs v. Jackson judgement repealing Roe v. Wade, used the argument to justify a 15-week ban on abortion in Mississippi.
[103] Verslag *Parl.St.* Senaat BZ 1988, nr. 247-2, p. 29.

17. Several members of WG4 and involved professionals expressed concerns over the impact of the 12-week time limit on individuals who need a later abortion, and the disproportionate impact of the temporal restriction and consequent abortion travel on women in precarious situations. These elements have led to considering pathways to help these patients beyond 12 weeks, which will be thoroughly discussed in chapter X.

2. Request of the pregnant woman without 'state of distress' before 12 weeks

18. Before 12 weeks, a pregnancy termination can be requested by the woman and performed without further motivation (article 2, 1°, a) AVTOP). Before 2018, the abortion law required the woman to find herself in a 'state of distress'. According to the proponents of the bill, this requirement consisted of a subjective assessment by the woman herself (*Parl.* Senate 1988-89, doc. no 247-2, 24, 81-82, 89). The appreciation of the doctor of the state of distress could no longer be challenged if the conditions of former article 350, 2° Criminal Code were fulfilled. Nevertheless, the extent of the doctor's role to ascertain or assess the 'state of distress' was unclear. The Council of State had previously voiced criticism to the 'state of distress' lack of legal meaning and the presumed overlap with the woman's 'firm will' (see below point X), and recommended to remove it (Advice from the Council of State 27 October 1989, *Parl*. Senate 1989, doc. no. 247-8). In 2018, the Belgian Federal Parliament removed the criterion from the law. Main arguments mentioned were the vagueness of the concept, a better alignment with the facts and needs, and increased recognition of individual freedom of choice (*Parl.* Chamber 2018, doc. no. 54 3216/003, 5-6, 26).

19. According to abortion providers heard by this Committee and academic scholars (Vansweevelt e.a., 2018), the impact of the legal amendment is limited in practice, although it has important symbolic significance and a destigmatising effect. In its latest reports, the National Evaluation Commission on Termination of Pregnancy did observe an impact of the removal of the 'state of distress' on the level of registration (Report National Evaluation Commission 2018-2019, 47-51). Since women no longer have to justify their abortion request based on a situation of distress, an increasing number of abortion registrations mention as justification for abortion "no notification duty".[104] In 2019, a little bit more than 1/3rd of all registrations mentioned "no notification duty" in the section where to specify the reason for the termination of pregnancy. WG4 considers the perceived or mentioned reasons for termination of pregnancy as relevant data for scientific and preventive purposes. It recommends to continue collection of these and other relevant data in order

[104] Reasons for abortion reside under different codes established by the National Evaluation Commission. "No notification duty" is increasingly mentioned as a specification under code 99: "Other" in abortion registrations.

to gain better understanding of the social and societal context in which abortions are requested, and to improve assistance to women (see also chapter X).

3. Medical conditions after 12 weeks

20. Abortion after 12 weeks is currently lawful in case of a serious medical condition affecting the foetus/woman (art. 2, 5° AVTOP) (see also chapter X). Two grounds were formulated in 1990 and retained by the 2018 AVTOP: 1) continuing[105] the pregnancy poses a severe threat to the health of the woman, or 2) it is certain that the child to be born will suffer from a particularly severe condition that is recognised as incurable at the moment of the diagnosis. The scope of interpretation of the medical grounds is not specified. With regards of the threat to the health of the woman, one of the drafters of the 1990 law clarified that a severe threat to the maternal health includes physical and mental health problems, but not social situations of distress (DOC 247/2, 152; Nys, 2016, 231). However, some uncertainty about the acceptability of termination of pregnancy after 12 weeks when necessary to prevent severe mental health issues remains in practice (see also chapter X). With regards to the foetal condition, the AVTOP requires certainty that the child to be born will suffer from a particularly severe and incurable condition (compare, for instance, with the French or UK law which define this section in terms of risks/probability). Several members of WG4 preferred a formulation in terms of (high/substantial) risk over certainty.[106] In practice, the assessment of certainty, severity and incurability of the medical condition falls under the margin of appreciation and clinical responsibility of the health professionals involved (De Meyer, 2020) (see also chapter X).

21. Article 2, 5° adds: "In that case, the doctor to whom the woman has presented herself needs to ask for the cooperation of a second doctor, whose advice will be attached to the file" (article 2, 5° AVTOP). The law leaves unclear what the cooperation from the second doctor entails, and whether it implies agreement with the first doctor. In parliamentary discussions preceding the 1990 law, it was suggested that the advice of the consulted doctor should be concurring (*Parl*. Chamber 1988-1989, doc. no. 950/9, 133). Moreover, the AVTOP does not require a specific expertise from the first and/or second doctor. In fact, it does not explicitly state who makes the decision whether the medical grounds are present, but merely suggests that the pregnancy 'can be terminated' if stipulated conditions are fulfilled. Abortion laws and regulations in neighbouring countries more explicitly refer

[105] The Dutch version mentions "de voltooiing van de zwangerschap" whereas the French version mentions "la poursuite de la grossesse" with regards to the maternal health ground (Nys, 2016, 231). This inconsistency needs to be addressed.

[106] See, for instance, this legal proposal: Wetsvoorstel tot wijziging van diverse wetsbepalingen teneinde de voorwaarden om tot een vrijwillige zwangerschapsafbreking over te gaan te versoepelen/Proposition de loi modifiant diverses dispositions législatives en vue d'assouplir les conditions pour recourir à l'interruption volontaire de grossesse, 30 December 2019, approved after second reading by Commission of Justice, DOC 55 0158/009.

to medical decision-making when describing access to later abortion on medical grounds. In the UK, abortion (after 24 weeks) can happen if two registered medical practitioners are of the opinion, formed in good faith, that stipulated medical conditions are present. The Dutch regulation on late termination of pregnancy mentions that the doctor must have the conviction that the medical conditions are fulfilled. The French legislation states a voluntary termination of pregnancy can, at any time, be performed if two health members of a multidisciplinary team attest that stipulated medical conditions are present. WG4 recommends to acknowledge professional decision-making and specify the health professionals' function in the section dealing with medical conditions that justify access to later abortion (see chapter X). At the same time, it emphasises the importance of legal phrasing which acknowledges the agency of and shared decision-making process with the pregnant individual, who should be heard and able to express concerns/wishes. This section in the law may be revised based on these observations.

22. Overall, WG4 finds the distinction between abortion before and after the 12-week time limit not clearly present in the law. Some members of WG4 have the impression that abortion for severe medical conditions is treated as a sub-section of "regular"[107] abortion in the AVTOP, although they perceive it as a contextually distinct matter. A separate article in the law dealing with the conditions applicable to abortion for severe medical reasons regardless of gestational age is recommended (see more in chapter X).

4. Six-day waiting period

23. Abortion law reform in 1990 introduced a mandatory waiting period prior to abortion provision. A doctor cannot perform a lawful termination of pregnancy earlier than six days after the first consultation. The waiting period is considered to give the pregnant woman suffient time to make a knowledgeable decision (*Parl*. Senate 1988, doc. no. 247-1, 11). The law and the parliamentary proceedings seem to suggest that the six days start running from the first consultation with the performing doctor (Court of first instance Bruges, 7 February 2006; Parl. Senate 1988, doc. no. 247/5, 5; Nys, 2016, 228), although different approaches exist in practice (see chapter X).

24. WG4 finds the law unclear as to when the six-day period starts to run precisely, how the six days are calculated, and when the period ends (for a discussion of the waiting period experiences of providers in practice: see chapter X and X). It does not specify whether or not the consultation must be in person, and whether the day of consultation is counted as one of the six days. According to

[107] Abortion typically for non-medical reasons.

legal calculation principles, consultation on Wednesday means that the 6 days start to run on Thursday, so that the abortion can be performed the next Wednesday (see also similar application in Court of first instance Bruges, 7 February 2006; Vansweevelt 2022, 196-197). In the procedure of medication abortion, it should be reminded that the procedure happens in different steps, with two types of medications that need to be taken on separate days, and actual expulsion can also take place on another day. In practice, most health professionals count 6 days up to when the first pill is administered (mifepristone, which does not cause immediate expulsion when taken alone).

25. In 2018, the Federal Parliament recognised a need to relax the waiting period, mitigating the condition in two ways. First, the AVTOP introduced an exception to the waiting period when there is an urgent medical reason. According to some parliamentary members, the urgent medical reason can be both physical and psychological and respond to patients' individual needs (*Parl*. Chamber 2017-2018, doc. no. 54-3216/006, 9-10; *Parl*. Chamber 2017-2018, doc. no. CRIV 54 PLEN 246, 54, 71). Second, if a woman presents herself less than 6 days before the end of the 12-week period, the mandatory six-day waiting period can now surpass the 12-week time limit.[108] If the final day of this extension is a holiday or weekend day, the abortion can take place the first following working day.

26. WG4 members and involved health professionals (see chapter X) have questioned the justification of a mandatory waiting period. From a legal point of view, WG4 members observe that the legal obligation for the doctor to 'ascertain the firm will' of the woman (article 2, 2° AVTOP) and to obtain her (written) informed consent (article 2, 4° AVTOP) prior to performing an abortion serve a similar goal as the mandatory waiting period, although in a less rigid way. After all, "(i)nformed consent requires that patients possess the capacity to make decisions about their medical treatment, that their decision is voluntary, and that they are given adequate and appropriate information on which to base their decision" (Myers, 2021). These principle of informed consent is additionally safeguarded by general health laws and deontological principles.

27. WG4 has reviewed a number of studies which look into the effects of mandatory waiting periods. These (overall US-based) studies mainly focus on two aspects: 1) burdens on patients associated with mandatory waiting and counselling, and 2) causal effects of mandatory waiting periods on abortion rates and timing. A 2009 literature review of mandatory counselling and waiting

[108] In case law, a similar exception to the 6-day waiting period had already been accepted in some scenarios based on a noodtoestand/état de necessité (which is an objective justification ground in criminal law, not to be confused with 'situation of distress') (See Court of first instance Bruges, 7 February 2006). In this case, no sanction was imposed on health professionals for not respecting the 6-day waiting period when they performed an abortion on a 14-year old girl on the last day of the 12-week period.

period statutes in the United States suggests multiple burdens for patients and providers (Joyce e.a., 2009, referring to Althaus e.a., 1994; Lupfer e.a. 1981). Patients reported increased physical discomfort and mental distress, struggles from multiple visits, including increased personal and financial cost for the patient. Reviewed studies also suggested a decline in abortions and a delay of timing of abortion as a direct effect, increasing second trimester abortion rates (Althaus e.a. 1994; Joyce e.a., 1997 and 2000). It also appears that laws that allow counselling over the internet or by mail/telephone reduced the associated burdens on patients and providers, although mandatory waiting periods, by definition, still cause some delay (Jocye e.a. 2009). The academic literature reviewed by the latter study has its limitations, such as incomplete data and inadequate controls for factors other than the imposition of the law.[109]

More recent studies align with the findings that waiting periods "burden" rather than "cool-off" patients (Myers, 2021). It is also found that one-trip waiting periods do not have significant effects on abortions or births, whereas two-trip waiting periods "reduce abortions and delay those that still occur, increasing second trimester abortions by 19,1%, reducing resident abortion rates by 8,9%, and increasing births by 1.5%"[110]. Two in-person visits would be required in a law which mandates in-person counselling (after which the mandatory waiting period starts to run) in addition to the in-person visit that is needed for the procedure itself. Lindo and Pineda-Torres investigated a two-trip 48-hour mandatory waiting period introduced in Tennessee in 2015, and found that it resulted in a 53-69 percent increase in the share of abortions occurring in the second trimester (Lindo e.a., 2021). It also found increased monetary cost associated with the two-trip 48-hour mandatory waiting period (Lindo e.a., 2021; see also Medoff, 2015). A study reviewing the introduction of a two-visit 24 hour mandatory waiting period in Arizona investigated anticipations of patients seeking abortion, before introduction of the legal change. It found that "(o)nly a small minority of women seeking abortion care view a two-visit waiting period law as benefiting them; the overwhelming majority expect a waiting period to have adverse consequences." (Karasek e.a., 2016). 90% of women in the study expected the waiting period to lead to hardships. Finally, authors of a 2022 synthesis conclude that "evidence from the reviewed studies and international human rights law points clearly towards the inappropriateness of MWPs [mandatory waiting periods][111] in abortion law and policy" (De Londras e.a., 2022).

[109] Guttmacher Institute, 'The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review', New York 2009, available at: https://www.guttmacher.org/sites/default/files/report_pdf/mandatorycounseling.pdf.

[110] It is observed that, from a pro-life viewpoint, the reduction of abortion rates as the result of a two-trip waiting period could be considered a positive rather than a negative side effect. From a pro-choice viewpoint, however, it could be viewed as a legal hurdle obstructing women in making an important choice they would have pursued in absence of that measure.

[111] Inserted.

28. On the one hand, WG4 notes that the literature discussed above investigates effects from US statutes, which entail much shorter waiting periods than the Belgian six-day waiting period (mostly 24 hours). It estimates an increase of burdens with increased length of waiting period. On the other hand, study results from the US are obtained in contexts where far-distance travelling to abortion clinics is more likely than in Belgium.[112] These distinctive contexts must be considered when reviewing the waiting period impact in Belgium.

29. Some studies investigate decision certainty in relation to the waiting period. Roberts e.a. find that most women are not doubting their decision when they seek care, which renders the 72-hour waiting period in Utah unnecessary. They also find that individualized care for the conflicted minority would have been more appropriate (Roberts e.a. 2016). Similar conclusions were made by Rowlands e.a. based on psychological literature on decision-making and regret (Rowlands e.a., 2020). The study also discussed literature on regret, highlighting that 'when thinking about pregnancy options, the choice that maximises a woman's wellbeing, however, is not inevitably the choice that leaves her with no regrets." (quote from Greasley, 2012). Foster e.a. argue that interactions with trained staff who can assess and respond to women's individual needs may meet women's complex needs more than regulations requiring mandatory waiting periods and state-approved information (Foster e.a., 2012). They found that 87% of women had high confidence in their decision before receiving counselling. Finally, Ralph e.a. find that the level of decision uncertainty in abortion is comparable to or lower than other health decisions (Ralph e.a., 2017).

30. Finally, some members of this WG4 draw attention to the fact that the World Health Organisation recommends against barriers which diminish access to safe and timely abortion.[113] Similarly, the Committee on Economic, Social and Cultural Rights suggests that "[s]tates should repeal and refrain from introducing measures that create barriers to [sexual and reproductive health] goods and services" (CESCR, General comment no. 22 on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (2016) (UN Doc. E/C.12/GC/22)). Some others in WG4 raise the point that a six-day waiting period is particularly long and exceptional in international legal comparison (Rowlands e.a., 2020, table 1). In Europe, the majority of countries does not have a mandatory waiting period (United Kingdom, France, the

[112] Myers states that the impact of waiting periods on abortion and birth rates are larger "in counties that are far from abortion providers". WG4 members estimate that a similar conclusion is likely with regards to the psychological and financial impact of mandatory waiting periods. This is not to suggest that a smaller negative impact of a mandatory waiting period should not be taken into account.

[113] WHO, 'Safe abortion: technical and policy guidance for health systems', Genève 2012, p. 96. See also p. 9: 'Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed.'

Netherlands (recently repealed its 5-day waiting period), Serbia, Austria, Denmark, Finland, Norway, Iceland, Sweden, Switzerland, etc.). Countries that have a statutory waiting period maintain a three-day period on average (Germany, Ireland, Latvia, Luxembourg, Hungary, Portugal, Spain, Montenegro, etc.). To WG4's knowledge, only two European countries, Italy and Albania, have a longer waiting period than Belgium (7 days).

31. Above findings were supported by abortion providers heard by and involved in this Committee (see chapter X). According to WG4 members, the gained benefits for a small number of women do no outweigh the burdens imposed on a majority of women, especially since it estimates that women in the first group can, in practice, be supported through a professional and individual care path. WG4 therefore recommends to remove the mandatory waiting period of six days, and suggests an alternative phrasing discussed in chapter X.

5. Mandatory information

32. The abortion legislation contains several information duties for professionals involved in abortion services. It first stipulates that the involved healthcare institution must be connected to an '**information service**' (voorlichtingsdienst/service d'information) who receives and informs the woman in detail about her rights, support and advantages guaranteed by law and decree to families, to married and unmarried mothers, and to their children. In addition, the information service must inform the woman about the possibilities to have the child that will be born adopted. Finally, at the request of the doctor or of the woman, it must give her help and advice as to the means she can rely upon to solve the psychological and social problems that have arisen by her condition (article 2, 1°, b AVTOP).

33. Moreover, some specific information duties rest upon the **doctor** who the woman has come to with the request to terminate the pregnancy. The doctor is obliged to inform the woman of the immediate and future medical risks to which she exposes herself by terminating the pregnancy. The doctor must also remind the woman of the different 'opvangmogelijkheden'/'possibilités d'accueil' for the child that will be born, and can rely on the staff of the information service to provide help and counsel (article 2, 2°, b AVTOP). Article 2, 6° stipulates, as a condition for lawful termination of pregnancy, that the doctor or another qualified person of the healthcare institution where the abortion was performed must give the (needed)[114] information on contraceptives.

[114] Note that the French version does not mention the term 'needed', but simply mandates to give information on contraceptives.

34. According to WG4, this section in the law could be improved. First, it notes that some abortion facilities, hospitals in particular, do not have a structural 'voorlichtingsdienst'/'service d'information' regarding termination of pregnancy but rely on a number of staff (psychologists, nurses, midwifes, genetic counsellors, etc.) to assist in the administrative and informative support of the woman. In addition, it questions the need to give the different strands of information to every woman seeking abortion. WG4 members note that an application of a strict obligation to inform could have an inappropriate effect in some scenarios and is not adhered to in practice (e.g. information about adoption in the case of termination for a lethal foetal malformation). Moreover, practitioners involved in abortion services have voiced concern over the content of and mandatory nature of some of the specific information duties (see also chapter X and X). In this regard, it is noted that a number of studies on mandatory waiting period effects discussed above also identify burdens associated with mandatory counselling and information. Finally, WG4 members have emphasised that appropriate information duties exist in good medical practice, medical deontology and health laws. Crucially, they have referred to article 8, §2 of the Law concerning the Rights of the Patient of 2002 (hereafter: Patient's Rights Law) which mandates information about "het doel, de aard, de graad van urgentie, de duur, de frequentie, de voor de patiënt relevante tegenaanwijzingen, nevenwerkingen en risico's verbonden aan de tussenkomst, de nazorg, de mogelijke alternatieven en de financiële gevolgen."Although legal discussion exists on the applicability of the Patient's Rights Law to voluntary termination of pregnancy (see chapter X), it was perceived as relevant to several involved health professionals (see also chapter X and X). These elements should be taken into account when reviewing the mandatory information duties.

35. Furthermore, it should be mentioned that the AVTOP removed an aspect of the previous abortion regulation in terms of information. Up to 2018, the criminal code sanctioned "advertising" abortion means and giving information about how to buy or use these means, or about the people who apply these means (former art. 383, part 5). In addition, it criminalised the person trading in abortion means (former art. 383, part 6). These offences were considered problematic and archaic, especially after abortion became legalised under conditions in 1990 (Vansweevelt, 2014, 219-220).

In the 2018 legal reform, these offences were removed. For the reasons mentioned, WG4 positively evaluates the legal amendment. In addition, WG4 emphasises the importance of (access) to objective, scientific and neutral information on abortion to help women make an informed choice. An official website containing pertinent and objective information on abortion (provision) is recommended by the National Evaluation Commission, and supported by WG4 (National Evaluation Commission

Termination of Pregnancy, Memorandum to the Parliament 2020, 10).

6. Firm will and consent of the pregnant woman

36. The AVTOP states that the doctor must ascertain the firm will (vaste wil/détermination) of the woman to have a termination of pregnancy. The appreciation of the determination of the pregnant woman, upon which the doctor accepts to perform the abortion, can no longer be challenged if the conditions in article 2 are fulfilled (Article 2, 2°, c AVTOP). In addition, the woman needs to confirm her determination to terminate the pregnancy in written on the day of the abortion.[115] The declaration needs to be added to the medical file (article 2, 4° AVTOP).

The question of consent and representation of minors and incapacitated adults

37. WG4 members observe that the situation of consent/representation of minors or incapacitated adults is not clearly regulated. The AVTOP only states that a lawful termination of pregnancy requires the woman's request and written consent. Dit doet de vraag rijzen of vertegenwoordiging van de zwangere persoon hierdoor in alle gevallen wordt uitgesloten. Volgens de Commissie is een verduidelijking hier op zijn plaats. Die kan enerzijds gebracht worden door een abortus-specifieke regeling m.b.t. vertegenwoordiging uit te werken en op te nemen in de Wet Vrijwillige Zwangerschapsafbreking. Anderzijds kunnen de vertegenwoordigingsprincipes om patiëntenrechten te kunnen uitoefenen, zoals uitgewerkt in de Wet Patiëntenrechten, ook worden toegepast op abortus (zie over deze regeling hoofdstuk X). Dit kan door er expliciet naar te verwijzen in de Wet Vrijwillige Zwangerschapsafbreking, of door abortus als gezondheidszorg te beschouwen. Een kwalificatie als gezondheidszorg sluit niet uit dat afwijkende regels met betrekking tot toestemming/vertegenwoordiging in de Wet Vrijwillige Zwangerschap als *lex specialis* kunnen worden opgenomen.

38. WG4 acht het van belang dat de autonomie, menselijke waardigheid en fysieke integriteit van deze individuen zo veel als mogelijk worden gewaarborgd in desbetreffende regeling. Wat betreft **minderjarigen** wordt in de praktijk en door deze Commissie aanvaard dat zij zelfstandig een abortus kunnen verzoeken zonder betrekking van de ouder(s). Het gebrek aan enige regeling in de Wet Vrijwillige Zwangerschapsregeling impliceert tevens dat dergelijke raadpleging of toestemming van ouders in principe niet vereist is. Het Arbitragehof (nu: Grondwettelijk Hof) bevestigde eveneens dat ouders niet gediscrimineerd worden bij toepassing van het 'recht op gezinsleven' door een

[115] See also Court of first instance Bruges, 7 February 2006, where consent to an abortion was considered invalid.

gebrek aan middelen om zich te verzetten tegen de beslissing van hun dochter om de zwangerschap af te breken (Arbitragehof nr. 39/91, 19 december 1991, 6.B.17).

Een zelfstandig toestemmingsrecht van de minderjarige houdt echter wel in dat de minderjarige wilsbekwaam is om toe te stemmen. Indien de minderjarige wilsonbekwaam wordt geacht, rijst de vraag of een vertegenwoordiger kan beslissen over (stopzetting van) de zwangerschap. In de Wet Patiëntenrechten is een vertegenwoordigingsregeling uitgewerkt voor het uitoefenen van de geïnformeerde toestemming tot een medische handeling voor de minderjarige patiënt die niet tot een redelijk oordeel van zijn belangen in staat wordt geacht (zie hoofdstuk X). De wetgever dient zich uit te spreken of het deze regeling van toepassing op en geschikt acht voor het verzoek tot zwangerschapsafbreking, of of het een afwijkende regeling meer gepast acht.

39. Wat betreft **meerderjarige, wilsonbekwame personen** dient eerst een onderscheid gemaakt te worden tussen wilsonbekwaamheid en handelingsonbekwaamheid. Wilsonbekwaamheid heeft betrekking op de *feitelijke* onmogelijkheid van een persoon om zijn wil te vormen of te uiten en dient *in concreto* en ad hoc te worden beoordeeld. Dit onderscheidt zich van handelingsonbekwaamheid, wat de *juridische* toestand is die een zelfstandige uitoefening van rechten verbiedt.

40. Ten eerste is de situatie van zwangerschapsafbreking bij **wilsonbekwame meerderjarigen** die niet onder rechterlijke bescherming zijn gebracht niet expliciet geregeld. Academici zijn het oneens over welke regels en principes van toepassing zijn op dergelijke situaties (voor een overzicht van verschillende posities, zie T. Vansweevelt, 2022, 177-180). Ten tweede wordt de regeling met betrekking tot **meerderjarigen die handelingsonbekwaam** zijn verklaard onduidelijk en ontoereikend geacht. Ten gevolge van de Wet van 17 maart 2013 tot hervorming van de regelingen inzake onbekwaamheid en tot instelling van een nieuwe beschermingsstatus die strookt met de menselijke waardigheid, kunnen meerderjarige personen door de vrederechter voor één of meerdere handelingen onbekwaam worden verklaard en vervolgens ook bijgestaan of vertegenwoordigd worden. Echter is op grond van artikel 497/2, 19° oud BW het verzoek tot vrijwillige zwangerschapsafbreking niet vatbaar voor bijstand of vertegenwoordiging door de bewindvoerder in zoverre de beschermde persoon daarvoor **handelingsonbekwaam** werd verklaard. Dit suggereert dat noch de handelingsonbekwame persoon, noch een vertegenwoordiger een verzoek tot vrijwillige zwangerschapsafbreking kan stellen. De Commissie acht deze regeling onbillijk. Bovendien bestaat in de rechtsleer onenigheid over de vraag of de rechter personen voor een dergelijke strikte persoonlijke handeling wel handelingsonbekwaam *kan* verklaren (Opgenhaffen, 2020 p. 129). Een deel van de rechtsleer neemt immers aan dat het voor het verzoek tot vrijwillige

zwangerschapsafbreking enkel mogelijk is om *ad hoc* wilsonbekwaam te worden verklaard, eerder dan handelingsonbekwaam (Swennen, 2013-14 p. 574).

41. Bij het uitwerken van een regeling met betrekking tot meerderjarige personen met een beperking verdient het volgens leden van deze Commissie aanbeveling dat de wetgever aanknoopt bij het criterium van wilsbekwaamheid voor het zelfstandig verzoeken van een abortus. Een genuanceerde vertegenwoordigingsregeling gelijk(aardig) aan de regeling in de Wet Patiëntenrechten voor personen die niet in staat zijn hun rechten uit te oefenen werd gepast geacht. De regeling in de Wet Patiëntenrechten wordt in hoofdstuk X verder toegelicht.

7. Location of abortion and type of provider

42. Abortion must be performed under medically responsible circumstances by a doctor in a healthcare institution to which an information service is connected (article 2, 1°, b) AVTOP). The law does not specify the expertise or training of the doctor. General practitioners can also perform abortion, as long as it happens under medically responsible circumstances in a healthcare institution. Other professions, like midwives, are not permitted to perform abortions (article 6, §2, 7 of Koninklijk besluit betreffende de uitoefening van het beroep van vroedvrouw, which prohibits induction of a termination of pregnancy by midwives). With healthcare institution, lawmakers meant to include not only hospitals but also (private) abortion centres (*Parl*. Senate 1988, doc. no. 247/1, 10). The information service is not defined. In practice, it seems that hospitals and clinics do not always have a structural information service, but instead, have a number of staff members that are responsible for reception, counselling and information tasks.

43. The AVTOP does not explicitly mention whether the doctor performing the abortion must be the same as the doctor who fulfils the other conditions (e.g. give certain information and assess the firm will) (Nys, 2016, 228). In medical practice, it is often the case that different doctors and health professions are involved in the entire care pathway. WG4 also notes that different safety and quality needs may exist depending on the abortion method and gestational age of the embryo/foetus (see also chapter 3). For instance, a pregnancy can be terminated using medication: only a doctor can administer the medication in a healthcare institution under the conditions of the AVTOP (see also Royal Decree 7 May 2000 establishing the conditions for the prescription and the distribution of the medications that contain mifepristone, misoprostol or gemeprost). This was viewed as too strict by many abortion providers and members of the working groups. As explained in chapter X, the COVID19 pandemic has highlighted issues with institutional provision of abortion, encouraging different countries, including Belgium, to enable forms of early telemedicine / self-managed abortion

at home (Moreau e.a., 2021; RTBF, 2021). WG4 recommends lawmakers to reflect on these developments and review the legal conditions it sets with regards to type of provider and location of provision, taking into account the views from practitioners described in chapter X. Legal amendments are needed if decided to broaden service provision to other qualified professionals than doctors.

8. Refusal to cooperate and mandatory referral

44. Article 2, 7° AVTOP states that no doctor, no nurse, no member of the paramedical personnel can be forced to lend its cooperation to a termination of pregnancy. The involved doctor must inform the woman at her first visit about his refusal. In 2018, a subsequent duty was added to article 2, 7° stating that he[116] who refuses must mention the contact details of another doctor, of a centre for termination of pregnancy or a hospital department where the woman can go with a new request to terminate the pregnancy. The doctor who refuses to perform the voluntary termination must send the medical file to the new doctor who is consulted by the woman. Violation of the duty to refer in article 2, 7° AVTOP is currently not criminally sanctioned.[117] Similarly, forcing health professionals to cooperate in a termination of pregnancy is not penalised.[118]

45. The Constitutional Court considered the duty to refer in line with the Constitution, and stated that it fulfils a legitimate public health objective by respecting the woman's right to request a termination of pregnancy in a safe medical environment (Constitutional Court no. 122/2020, 24 September 2020, B.14.2.). The court finds the referral obligation legitimate, necessary and proportionate to the objectives of the law. In doing so, the doctor's freedom of conscience and his choice not to perform the termination of pregnancy are respected, while at the same time respecting the rights of women (Constitutional Court no. 122/2020, 24 September 2020, B.14.3.).

46. Article 2, 7° AVTOP is understood as an individual right to refuse, but does not extend to institutions. An institution cannot use the legal provision to justify an institutional refusal policy (see also Tack & Balthazar, 2011, 61-91 in the context of end-of-life decisions). Still, the extent to which institutions can have a rejection policy vis-à-vis abortion or can uphold stricter rules than the law in practice remains the topic of debate (see also in the context of euthanasia: Advisory Committee on Bioethics, Advice no. 59). WG4 welcomes any clarifications with regards to the permissibility of restrictive institutional policies vis-à-vis lawful abortion.

[116] WG4 recommends against the use of the pronoun 'he', as women and other genders can also be (refusing) doctors.
[117] Article 3 AVTOP only sanctions performing or letting an abortion be performed outside of the legal conditions outlined in article 2. In the case of refusal to cooperate, no abortion was performed by the health professional involved.
[118] In contrast to what the minister of Justice stated in 1990 Parliament (Nys, 2016, 228).

47. Article 2, 7° does not deal with a "condition" under which the woman can request a termination of pregnancy, but rather, with a right of the involved health professionals. In this sense, article 2, 7° differs from article 2, 1°-6°. WG4 recommends to separate the right to refuse from the previous points for legal clarity, as it does not deal with a condition under which abortion can be performed.

9. Criminal sanctions for unlawful voluntary termination of pregnancy

48. Although voluntary abortion is no longer a crime in principle since 2018[119], the conditions on lawful abortion in the AVTOP remain backed by specific criminal offences and sanctions, i.e., imprisonment and fines.[120] These sanctions exist for both the abortion provider and the pregnant individual when the provision of abortion occurred in breach of the legal conditions. Fulfilment of all conditions is needed for a lawful termination of pregnancy. Analogously, violation of one of the conditions above suffices for qualification as criminal offence. The same penalties apply irrespective of whether the violation was of a substantive or procedural nature, although the judge has some discretion in imposing the sanction. More specifically, article 3, part 1[121] AVTOP criminalises he who causes an abortion on a woman who consented to it outside of the legal conditions, with imprisonment of three months to one year and a fine of 100 to 500 euro. Heavier sanction (5 to 10 years imprisonment) applies to the person causing an unlawful abortion with the consent of the woman when it results in the woman's death (article 3, part 4 AVTOP). Finally, article 3, part 3 sanctions the woman who intentionally lets[122] someone perform an abortion outside of the conditions in article 2, with imprisonment of one month to one year and a fine of 50 to 200 euro.

49. Some members of WG4 expressed concern over the fact that breach of a procedural condition (e.g. waiting period) could give rise to the same criminal punishment as breach of a substantive condition. In this regard, a WG4 member suggests considering possible implications of a recent Constitutional Court judgement on euthanasia, where a lack of distinctive sanctions for procedural/substantive violations of the law was considered unconstitutional (Constitutional Court,

[119] Prior to 2018, the Belgian Criminal Code regulated abortion as a crime in principle, although broad exceptions to this rule were included for consensual abortions. Old Articles 348, 350, 351 and 352 of the Belgian Criminal Code, introduced by the Act on Termination of Pregnancy 1990, available at: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/wet_03_04_1990_zwangerschapsafbreking.pdf (in Dutch and French). For an elaborate discussion (in Dutch) of the Belgian abortion legislation prior to reform in 2018, see T. VANSWEEVELT, "Abortus" in T. VANSWEEVELT and F. DEWALLENS (eds.), *Handboek Gezondheidsrecht*, II, Antwerp, Intersentia, 2014, 189-289.

[120] Article 3, Act on Voluntary Termination of Pregnancy 2018.

[121] Article 3 could use the structural benefit of numbering the different offences.

[122] This seems to exclude self-managed abortion outside of the legal conditions.

no. 134/2000, 20 October 2022). Moreover, WG4 members draw attention to the fact that the AVTOP is mainly based on a philosophy which taps into the responsibility of the health professionals involved to respect the rules. In the same vein, WG4 members did not consider it justified to punish women who seek an abortion, even if intentionally sought outside of the legal conditions (see also chapter X: decriminalisation)

50. Finally, WG4 recommends formal improvements, such as an improved structure of article 3 (e.g. the positioning of the offence discussed in X below does not serve coherency), and the replacement of reference to "he" who commits the offences by more gender-neutral formulations such as 'the person'.

10. The offence of hindering access to a healthcare institution offering termination of pregnancy services

51. 2018 law reform introduced a new offence in the AVTOP. Article 3, part 2 criminalises he who tries to hinder a woman from having free access to a healthcare institution that performs voluntary terminations of pregnancy. Sanctions can go from three months to one year in prison and a fine of 100 to 500 euro. While the offence still leaves room for interpretation, the explanatory memorandum to the proposed amendment specified that only physical hindrance would be considered (*Parl*. Chamber 2017-2018, doc. no. 54-3216/001, 4). The Constitutional Court confirmed that the parliamentary proceedings are clear in stating that only physical hindrance is considered, and that the fear that other types of non-physical hindrance could be criminalised is ill-founded (Constitutional Court no. 122/2020, 24 September 2020, B.2.1.). Only hindrance of the woman, not of health professionals, is considered.

The offence gave rise to controversy when a legal amendment was suggested in 2019 to prohibit both physical hindrance and "hindrance in any way" (Garré, 2020, 17; De Meyer & De Mulder, 2021, 32-34). This addition was considered too broad by some members of Parliament, and also required clarification from the Council of State (Advice Council of State, 24 February 2020, doc. no. 66.881/AV). Main concerns for the Council of State related to freedom of speech, mainly of the partner and with regards to false information and personal opinions. Moreover, the Council of State requested a justification of the offence now that the Law on Healthcare Professions also prohibits prevention or hindrance, by acts or violence, of the regular and normal practice of medicine or pharmacy exercises by a person who fulfils the required conditions (article 30, Coordinated Law of 10 May 2015 on the Exercise of Healthcare Professions). The latter comment seems relevant for the current phrasing of the

offence if abortion were to be qualified as healthcare and should, in that case, be considered by the legislator.

11. National Commission for the Evaluation of the Act on Termination of Pregnancy

52. The role and composition of the National Evaluation Commission for the Evaluation of the Act on Termination of Pregnancy is regulated by the Law of 13 August 1990. The commission is an evaluation commission and has no control function on individual abortion cases (cf. Control- and Evaluation Commission Euthanasia). Some issues with regards to the National Evaluation Commission have been identified in academic literature, including the lack of voluntary membership, the limited role and scope of data gathering, the political composition of the commission, etc. (Vansweevelt, 2022, 223-225).

From our own findings and from a hearing with the presidents of the National Evaluation Commission (NEC), the Scientific Committee identifies the following issues.

(to be further developed by steering committee:)

- Data collection by the NEC has its constraints and weaknesses
- The NEC struggles to find members
- The NEC members prefer overviewing and commanding studies from external research bodies in the future

The qualification of voluntary abortion as healthcare

53. The question was put to this Committee to what extent women and unborn life would be protected (by criminal law) if the Law on Voluntary Termination of Pregnancy would be included in the Law on Patient's Rights. WG4 analyses this question from a broader perspective, namely, the impact of a legal qualification of voluntary termination of pregnancy as 'healthcare'. In Belgium, healthcare services and professions are subject to general health laws, among which the Law on Patient's Rights[123], but also other laws such as the Coordinated Law on the Exercising of Healthcare Professions[124] and the Law on Qualitative Practice in Healthcare[125].[126] These laws define healthcare as "services provided by a healthcare professional for the purpose of promoting, establishing, maintaining, restoring or improving a patient's health, altering a patient's appearance for primarily aesthetic reasons, or assisting the patient in dying."

When considering the qualification of voluntary abortion as healthcare, WG4 emphasises that a distinction should be made between two questions. The first concerns the **underlying normative question of whether voluntary abortion should be considered a healthcare intervention** based on its characteristics. WG4 observed many opposing views regarding this matter, both in academic literature and in the positions of some of its members. A part of the controversy is explained by the lack of a common understanding of what healthcare is or should be, and disagreement about whether the concept requires a strict/stable or broad/evolving interpretation. Voluntary termination of pregnancy is often considered to reside in a grey-zone: it requires a surgical or medication intervention and can have, but not *per definition*, a therapeutic effect on the woman. WG4 points out that, in the past, the legislator has broadened the definition of healthcare for two other so-called "grey-zone" interventions: esthetical interventions changing the appearance of patients, and assistance in dying. Those interventions were added to the definition of healthcare without regarding them, per definition, as services aimed at "bevorderen, vaststellen, behouden, herstellen of verbeteren" of the health status. Moreover, there seems to exist different understandings of what qualifying abortion as healthcare entails. In one approach, it means removing all abortion-specific regulations and treating abortion as a regular medical procedure to which only general health laws apply. In another approach, it means applying general health laws and principles, while keeping additional abortion-specific rules and sanctions. It seems that at least some other healthcare interventions are regulated by a *lex specialis*

[123] Wet betreffende de rechten van de patiënt / Loi relative aux droits du patient, 22 August 2022.
[124] Gecoördineerde wet betreffende de uitoefening van de gezondheidszorgberoepen/ Loi coordonnée relative à l'exercice des professions des soins de santé, 10 May 2015.
[125] Wet inzake de kwaliteitsvolle praktijkvoering in de gezondheidszorg / Loi relative à la qualité de la pratique des soins de santé, 22 April 2019.
[126] Non-limitative list, other general health laws exist as well.

on top of general health laws (e.g. esthetical surgery or assisted reproduction, see more *infra*). Hence, both approaches are possible according to WG4, although a justification for maintaining an abortion-specific regulation and deviation of general health laws is recommended.

A second, distinct question concerns the **effects and implications** of a legal approach which recognises voluntary abortion as healthcare, which will be discussed in the following sections.

1. Current legal status of voluntary abortion: is it healthcare?

54. De wetgever heeft er in 1990 en 2018 voor gekozen om vrijwillige zwangerschapsafbreking te regelen via specifieke wetgeving. Hiermee is in eerste instantie gekozen om vrijwillige zwangerschapsafbreking niet te behandelen als een reguliere medische handeling, maar om specifieke voorwaarden en restricties te formuleren. De wetgever koos voor een gelijkaardige aanpak bij de regeling van onder meer de medisch begeleide voortplanting en de esthetische geneeskunde. De vraag is gerezen of, naast de regels in abortuswetgeving, de algemene gezondheidsrechtelijke wetten en de kwaliteitswaarborgen eveneens van toepassing zijn op vrijwillige zwangerschapsafbreking. De wetgever leek er voor wat de Wet Patiëntenrechten betreft aanvankelijk van uit te gaan dat vrijwillige zwangerschapsafbreking niet onder de definitie van gezondheidszorg viel (*Parl*. Chamber 2001-02, no. 50-1642/012, p. 5328). Vrijwillige zwangerschapsafbreking wordt althans niet expliciet vermeld in de definitie van gezondheidszorg zoals vervat in de algemene gezondheidsrechtelijke wetten. In de rechtsleer bestaat echter onenigheid over de vraag of de vrijwillige zwangerschapsafbreking vandaag kan of moet worden beschouwd als gezondheidszorg (bv. Nys, 2016, 107-108; Vansweevelt, 2022, 171-172).

2. Legal impact of qualifying voluntary abortion as healthcare

55. De kwalificatie van vrijwillige zwangerschapsafbreking als gezondheidszorg zou in eerste instantie een einde stellen aan deze onenigheid en zorgen voor de juridische bevestiging dat algemene gezondheidsrechtelijke wetten van toepassing zijn op de context van vrijwillige zwangerschapsafbreking. De Wet Vrijwillige Zwangerschapsafbreking blijft onverkort en met voorrang gelden, maar wordt aangevuld met en geïnterpreteerd in het licht van die algemene gezondheidswetten. Van belang is onder meer de toepassing van de Wet Patiëntenrechten, waarop een patiënt die een abortus verzoekt zich zal kunnen beroepen. Deze wet beschermt onder meer het recht van de patiënt op informatie, op diens geïnformeerde toestemming, op een zorgvuldig bewaard patiëntendossier, op bescherming van diens persoonlijke levenssfeer, … Ook bevat de Wet Patiëntenrechten een regeling met betrekking tot vertegenwoordiging van minderjarigen en wilsonbekwame meerderjarigen (*infra* X). Daarnaast garandeert de Wet Patiëntenrechten en de

verdere uitwerking hiervan in de Kwaliteitswet tevens de kwaliteit van de zorg. De Gezondheidszorgberoepenwet waarborgt tevens de bekwaamheid van de gezondheidszorgbeoefenaar, door onder meer voorwaarden te stellen inzake diploma's en beroepstitels. Ten slotte bevatten deze gezondheidsrechtelijke wetten een aantal niet-strafrechtelijke toezicht-, klacht- en sanctiemechanismen ter handhaving van de bepalingen.

56. Zoals hierboven gesteld, werd aan de Commissie gevraagd in hoeverre vrouwen en de foetus strafrechtelijk beschermd worden indien vrijwillige abortus onder de Wet Patiëntenrechten zou worden behandeld. De kwalificatie als gezondheidszorg zorgt er voor dat een aantal niet-strafrechtelijke toezicht-, klacht- en sanctiemechanismen die vervat zitten in de betrokken gezondheidsrechtelijke wetten aanvullend van toepassing worden op vrijwillige zwangerschapsafbreking. Daarnaast is de kwalificatie van vrijwillige zwangerschapsafbreking als 'gezondheidszorg' niet onverenigbaar met de aanwezigheid van specifieke strafsancties in de Wet Vrijwillige Zwangerschapsafbreking, en heeft het dus op zichzelf geen impact op de strafrechtelijke bescherming. Zo bevat ook de wet betreffende de esthetische geneeskunde specifieke strafsancties. De Wet van 23 mei 2013 tot regeling van de esthetische geneeskunde stelt onder meer strafbaar "het gewoonlijk uitvoeren van de betrokken handelingen zonder daarvoor bevoegd te zijn" (artikel 21), het niet respecteren van een wachtperiode van 15 dagen (artikel 20 en 22), schending van de vereiste van een schriftelijk akkoord van een wettelijke vertegenwoordiger of vertegenwoordigers voor een ingreep bij een minderjarige (artikel 17), en schending van het verplicht verstrekken van bepaalde informatie (artikel 18). Het is volgens de Commissie mogelijk om, mits een rechtvaardiging, afwijkende regels met bijhorende strafsancties in een bijzondere wet te plaatsen ondanks een kwalificatie als gezondheidszorg, al zou de wetgever tevens een andere beleidskeuze kunnen maken door vrijwillige zwangerschapsafbreking verregaander te dereguleren en decriminaliseren. De mate waarin dit gebeurt bepaalt de overblijvende strafrechtelijke bescherming van vrouwen en ongeboren leven. De Commissie merkt op dat the qualification of **abortion as a form of healthcare** often goes hand in hand with initiatives to remove the criminal status of abortion to a great extent (Berer, 2017). This will be further discussed in title X about 'decriminalisation of abortion'.

57. While the call to treat abortion as healthcare often plays in women's rights and feminist debates, some WG4 members have noted that a trend for de-medicalisation of abortion provision is emerging in feminist literature and abortion practices worldwide as well. The underlying idea is to enable safe, self-managed medical abortion (see also chapter X), with no or limited medico-legal regulation, control or interference (Assis and Erdman, 2021). A member of WG4 emphasises that both approaches are combinable and are not contradictory *per se*, as they both can safeguard autonomy, wellbeing and safety of pregnant individuals. However, as the provision of healthcare in

Belgium is currently limited to health professionals, legal exceptions to this principle would be required if the legislator decides that forms of self-managed abortion or management could be appropriate (see also chapter X and X).

The regulation of consent/representation of minors and incapacitated adults in health law

58. Indien de wetgever vrijwillige zwangerschapsafbreking kwalificeert als gezondheidszorg, kan de wetgever *óf* een afwijkende regeling opnemen in de Wet Vrijwillige Zwangerschapsafbreking, *óf* terugvallen op de bestaande regeling voorzien in de Wet Patiëntenrechten met betrekking tot vertegenwoordiging van minderjarige en meerderjarige (wilsonbekwame) patiënten.

59. De Wet Patiëntenrechten bepaalt dat de patiëntenrechten van een **minderjarige** worden uitgeoefend door de ouders die het gezag over de minderjarige uitoefenen of door hun voogd (art. 12, § 1 Wet Patiëntenrechten). De minderjarige moet evenwel worden betrokken bij de uitoefening van zijn rechten, rekening houdend met zijn leeftijd en maturiteit. Indien de minderjarige tot een redelijke beoordeling van zijn belangen in staat kan worden geacht, kan deze de rechten onder de Wet Patiëntenrechten zelfstandig uitoefenen. Dit zou volgens sommige auteurs voor het merendeel van de zwangere minderjarigen een zelfstandig verzoekrecht tot abortus inhouden zonder betrekking van de ouders (Veys, 2006-07 p. 159; Vansweevelt, 2022, p. 184-185). Deze opvatting lijkt in overeenstemming te zijn met hoe abortusartsen in de praktijk handelen.

60. Daarnaast bevat de Wet Patiëntenrechten een regeling voor de vertegenwoordiging van **wilsonbekwame meerderjarige patiënten** (artikel 14 Wet Patiëntenrechten). De Wet Patiëntenrechten vertrekt vanuit het principe van wils(on)bekwaamheid: wilsbekwame meerderjarigen kunnen de rechten gewaarborgd door de wet zelfstandig uitoefenen. Voor wilsonbekwame meerderjarigen is een cascaderegeling van vertegenwoordiging van toepassing. De toepassing van de vertegenwoordigingsregels uit de Wet Patiëntenrechten op zwangerschapsafbreking bij wilsonbekwame personen is echter niet volledig afgestemd op de wetgeving inzake **meerderjarige beschermde personen**. Zoals uiteengezet in hoofdstuk X, suggereert artikel 497/2, 19° oud BW dat een persoon handelingsonbekwaam kan worden verklaard voor het verzoek tot zwangerschapsafbreking, en in zoverre dit gebeurd is, is de handeling niet vatbaar voor bijstand of vertegenwoordiging.Het is, zoals vermeld, niettemin betwist in rechtsleer of een persoon voor dergelijke hoogstpersoonlijke handelingen onbekwaam kan worden verklaard en of hier niet beter wordt aanknoopt bij het criterium van wilsbekwaamheid, zoals het geval is voor de uitoefeningen van de rechten onder de Wet Patiëntenrechten. Onder deze wet is het immers de arts

die oordeelt of een persoon wilsbekwaam is om de rechten onder deze wet uit te oefenen *(Parl.St.* nr. 50-1642/1). Hierdoor zou het de vrederechter niet toe komen te oordelen over de handelingsbekwaamheid van de te beschermen persoon (*Parl.St.* nr. 54-3303/1) (Opgenhaffen, 2020 p. 122); (Wuyts, 2019 p. 13); (Scheers en Scheers, 2018-19 p. 1525). Indien vrijwillige zwangerschapsafbreking uitdrukkelijk gekwalificeerd wordt als gezondheidszorg, iseen aanpassing van artikel 497/2, 19° oud BW o.i. aangewezen.

61. Verder dient met betrekking tot deze problematiek aandacht te worden gevestigd op het **recht op eerbiediging van het privéleven** (art. 8 EVRM) en het **VN-Verdrag inzake de Rechten van Personen met een Handicap (VRPH).** Vooral in het licht van dit laatste Verdrag lijkt het verbod op gedwongen abortus[127] te worden uitgebreid naar een verbod op abortus door plaatsvervangende toestemming tegen de wil in van de betrokkene (Opgenhaffen, 2020, p. 150). Vertegenwoordiging bij abortus wordt niet in alle gevallen uitgesloten, maar van gedwongen abortus kan alvast sprake zijn wanneer de zwangerschapsafbreking plaatsvindt na een beslissing genomen door de vertegenwoordiger tegen de wil in van de zwangere persoon met een beperking.[128] Aan staten wordt aanbevolen om te voorzien in effectieve waarborgen ter bescherming van de rechten van personen met een beperking via een model van ondersteuning bij ieder beslissingsproces dat verband houdt met seksuele of reproductieve gezondheid.[129] Van belang hierbij is dat de wilsonbekwame zwangere persoon voor zover mogelijk de beslissing zelf kan nemen en hierbij de nodige ondersteuning en voorlichting krijgt.[130]

Dit laatste komt tot uiting in de Wet Patiëntenrechten. Op grond van artikel 14, § 4 moet de patiënt zo veel mogelijk en in verhouding tot zijn begripsvermogen worden betrokken bij de uitoefening van zijn rechten. Verzet door een wilsonbekwame zwangere persoon specifiek gericht tegen de zwangerschapsafbreking zal in het licht van voormelde verdragen in beginsel moeten worden

[127] Recommendation CM/Rec (2012)6 of the Committee of Ministers to member States on the protection and promotion of the rights of women and girls with disabilities, 13 juni 2012, CM/Rec (2012)6, p. 8; Report of the Office of the United Nations High Commissioner for Human Rights on the Issue of Violence against Women and Girls and Disability, 30 maart 2012, *Un Doc.* A/HRC/20/5, § 29.

[128] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment on the promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development, 15 januari 2008*, UN.Doc*. A/HRC/7/3, § 38; Concluding observations of the Committee on the Rights of persons with Disabilities on the initial report of Argentina as approved by the Committee at its eighth session (17–28 September 2012), 8 oktober 2012, *UN.Doc.* CRPD/C/ARG/CO/1, §§ 31-32; Concluding observations of the Committee on the Rights of Persons with Disabilities on the initial report of Germany, 13 mei 2015, CRPD/C/DEU/CO/1, § 37.

[129] Concluding observations of the Committee on Economic, Social and Cultural Rights on the sixth periodic report of Finland, E/c.12/FIN/CO/6, § 26.

[130] Concluding observations of the Committee on the Rights of persons with Disabilities on the initial report of Argentina as approved by the Committee at its eighth session (17–28 September 2012), 8 oktober 2012, *UN.Doc.* CRPD/C/ARG/CO/1, §§ 31-32; General comment No. 3 (2016) of the Committee on the Rights of Persons with Disabilities, 25 november 2016, UN.Doc. CRPD/C/GC/3, § 32; §§40; 44.

gerespecteerd. Het verrichten van een abortus zonder de zwangere persoon in verhouding tot diens begripsvermogen bij de beslissing te betrekken en dus zonder rekening te houden met diens wens om de zwangerschap uit te dragen, zou wegens gebrek aan geldige toestemming overigens ook strafbaar kunnen zijn onder artikel 348 Sw. dat betrekking heeft op vruchtafdrijving zonder de toestemming van de zwangere persoon.

62. Zelfs indien de wetgever vrijwillige zwangerschapsafbreking kwalificeert als gezondheidszorg zou die er volgens de Commissie bij gebaat zijn om de verhouding tussen de Wet Vrijwillige Zwangerschapsafbreking en de regeling in de Wet Patiëntenrechten inzake vertegenwoordiging toe te lichten. Enige onduidelijkheid blijft immers bestaan doordat de Wet Vrijwillige Zwangerschapsafbreking louter spreekt over het verzoek en de schriftelijke toestemming van de zwangere vrouw (wat door sommigen zou kunnen worden geïnterpreteerd als een regeling die afwijkt van de Wet Patiëntenrechten).

Position of WG4 on qualification of voluntary abortion as healthcare

The position of WG4 is to recommend qualifying voluntary termination of pregnancy as healthcare. This recommendation is predominantly based on the fact that WG4 considers that 1) a legal qualification of healthcare can put an end to uncertainty about the legal status of voluntary termination of pregnancy; 2) it is beneficial to apply general principles in health law to voluntary termination of pregnancy, such as patient's rights (including informed consent guarantees and a nuanced regulation of consent/representation of minors/incapacitated adults), and quality measures on healthcare (Kwaliteitswet); a 2) a legal qualification of voluntary termination of pregnancy healthcare does not trivialise the matter, as specific regulations and criminal sanctions can be maintained in a *lex specialis*. A member of WG4 does not confidently support the recommendation because the member considers the legal and social impact too unclear. In particular, the member questions the impact on the conscientious objection clause if termination of pregnancy is considered healthcare. Other WG4 members maintain that the recommendations of the group do not touch upon the conscientious objection clause currently maintained in the AVTOP.

Decriminalisation of voluntary abortion

The question was put to this Scientific Committee of whether medical personnel, women, and third persons involved in unlawful abortion could still be criminally or disciplinary sanctioned if all the specific criminal sanctions in the AVTOP would be removed. This question can be situated in the debate on 'decriminalisation' of abortion. The next sections discuss the meaning, aims, and impact of decriminalising abortion.

1. Defining decriminalisation

63. Decriminalisation can be defined as the removal or reduction of the criminal classification or status of something, and more specifically as repealing a strict ban on something while retaining some form of regulation (Fearn, 2014). Decriminalisation of abortion can both be comprehensive or partial, and can be aimed at different actors involved in the abortion process.

Comprehensive or full decriminalisation of abortion has been described as the withdrawal of the regulation of abortion from criminal codes and statutes and the removal of all abortion-specific criminal sanctions (De Meyer, 2021). Regulation can be upheld, but should take place outside of the criminal law and without resorting to abortion-specific criminal penalties (Sheldon and Wellings, 2020). Remaining regulations are, for example, embedded in general or abortion-specific (health) statutes, professional guidelines and/or institutional policies. As a result, professional failure to comply with the regulations would constitute an issue for professional and deontological sanctioning and civil liability rather than for the criminal law (BMA, 2017). However, it needs mentioning that the removal of abortion-specific sanctions and offences in Belgium will not necessarily rule out any criminal law response to abortion if legal conditions for lawful abortion are kept. As will be described later, criminal offences in the Criminal Code that were not necessarily adopted with abortion in mind could apply to the situation of provision of unlawful abortion (see also in this sense: Advice no. 66.881/AV, Council of State, 24 February 2020).

A few jurisdictions have decriminalised abortion comprehensively, such as Canada, New Zealand, and some Australian jurisdictions (e.g. Victoria, Tasmania, Queensland, New South Wales). In Canada, there is no abortion-specific legislation regulating abortion. This renders the practice legal at all stages of pregnancy, although in practice, hospitals and clinics set their own time limits. Abortion is publicly funded as a medical procedure under the federal Canada Health Act and provincial health-care regulations. New Zealand and several Australian states have also completely decriminalised voluntary abortion, but have retained an abortion-specific law, usually including a gestational age limit around 18-22 weeks gestation for abortion upon request (De Meyer, 2021).

Partial decriminalisation removes only some abortion offences or criminal sanctions, or creates exceptions to the criminality of abortion when certain legal conditions are met. In this situation, providing or having an abortion will sometimes be a criminal offence, and sometimes not. Most jurisdictions in Europe, including Belgium, have partially decriminalised abortion.

64. Although voluntary abortion is no longer a crime in principle since the reform of the abortion legislation in 2018, specific criminal sanctions for provider and pregnant woman apply when an abortion is performed unlawfully, meaning, outside of the legal conditions (article 3 AVTOP). A legislative proposal was discussed in the Belgian Parliament in 2019-2020 to remove all abortion-specific criminal sanctions currently still embedded in the Act on Voluntary Termination of Pregnancy. In the next sections, **common arguments implications** of this approach are discussed.

65.

2. Arguments in the debate on comprehensive decriminalisation of abortion

WG4 observed that, both in academic literature and in political debate, different notions of 'decriminalisation'/'depenalisation' are used and argued. The lack of a common understanding of the term complicates the debate on comprehensive decriminalisation of abortion. It is recommended that those involved in the legislative debate establish what is meant when discussing 'decriminalisation'. Moreover, the reasoning behind decriminalisation may differ depending on whether the focus is on women, providers or other involved persons. The following arguments for and against removing all abortion-specific criminal sanctions were identified in literature and by WG4 members.

Proponents of comprehensive decriminalisation submit that **decriminalising the pregnant woman** would align with a more women-supportive and health-oriented approach, in which the patient is not criminally responsible for wanting to seek an abortion, even when unlawful. The idea is that these women, who frequently find themselves in difficult situations, should not receive criminal punishment for seeking unlawful abortion. Especially – but not exclusively – with regards to women, human rights consensus is moving towards decriminalization of abortion (Erdman and Cook, 2020). Decriminalising the woman who seeks an abortion could help destigmatise the matter of abortion, and contribute to more serene decision-making without fear. (See also argumentation in a legislative proposal to fully decriminalise abortion in Parl.*St.* Kamer, 2019-20, nr. 55-0158/003, 10).

Decriminalising the abortion provider would reduce the chilling effect of criminal sanctions, which can deter providers even from performing lawful abortions. According to those in favour, the policy would render applicable more appropriate accountability mechanisms in medical law, clinical and ethical

guidelines, and disciplinary rules. Arguments in favour of such a policy also estimate improved quality and transparency of care. It should be reminded that those goals are not fully realised if charges based on general criminal offences (see *infra*) can still be brought against the health professionals when violating a legal condition on abortion. (See also argumentation in a legislative proposal to fully decriminalise abortion in Parl.*St.* Kamer, 2019-20, nr. 55-0158/003, 9).

On the other hand, opponents of removing abortion-specific criminal offences/sanctions submit that they are needed to prevent and deter women/providers from having/performing unlawful abortions. Criminal sanctions are also considered necessary to express a jurisdiction's moral disapproval of some abortions, even if prevention would be limited because women would still get abortions abroad/via illegal pathways. A fear also exists among opponents that removing all abortion-specific criminal sanctions disregards the moral value of the embryo/foetus. Finally, opponents argue that criminal sanctions and offences are needed to have an effective punishment for those who violate the law. After all, it is submitted that medical law and deontological sanctioning mechanisms do not have the same expressive value (in terms of protection of the embryo/foetus) as criminal law mechanisms. Moreover, medical-professional sanctioning and control mechanisms are by some considered relatively weak and impractical in Belgium. Finally, opponents question whether it is possible at all that a legal condition installed by the legislator is checked/controlled/sanctioned by the medical profession in the absence of authority of a criminal prosecutor.

66. Only a limited number of academic studies have mapped the impact of legal (de)criminalisation of abortion in certain jurisdictions on the practice of abortion. Research from Canada suggests that the abortion rate since decriminalisation has not substantially increased, and that the average gestational age at the time of abortion continues to decrease (Johnson et al., 2020; Shaw and Norman, 2020). Similarly, since the 2008 decriminalisation of abortion in the Australian state of Victoria, the total number of abortions, as well as the number of abortions performed after 20 weeks' gestation for psychosocial reasons, have dropped. Abortions performed after 20 weeks due to foetal abnormality have risen slightly, although this rise has been linked to the increased importance of prenatal diagnosis (Johnson *et al.*, 2020). Some reservation is needed in interpreting these results, as different variables explain if and when women seek an abortion. Nevertheless, the studies seem to carefully suggest that concern about increase in abortions and unbridled access to abortion on potentially problematic grounds after comprehensive decriminalisation is unwarranted. WG4 estimates that this can potentially be explained by the presence of other regulations in place. After all, non-criminal legislation and professional/institutional guidelines and policies may succeed in restricting (some) abortions, even when these lack criminal sanctions. In fact, factors outside of

the law will also influence access to abortion. According to health professionals in Victoria (Australia), decriminalisation in 2008 "had repositioned abortion as a health rather than legal issue, had shifted the power in decision making from doctors to women, and had increased clarity and safety for doctors" (Keogh *et al.*, 2017). However, the study also describes remaining concerns, such as limited public provision of surgical abortion; reduced access to abortion after 20 weeks; ongoing stigma; lack of a state-wide strategy for equitable abortion provision; and an unsustainable workforce (Keogh *et al.*, 2017). While formal decriminalisation produces a legitimation of abortion services, it will not instantly remove the stigma that attaches to those who seek access to, or work within, them (Sheldon, 2017; Hughes, 2017). If the legislator would consider comprehensive decriminalisation of abortion with the aim to destigmatise and improve abortion access, contextual aspects such as the healthcare infrastructure, funding, quality and logistical organisation of provision, geographical barriers, education and training of providers, institutional restrictions, social stigma, etc. should also be regarded.

67. Members of WG4 find it important to underline that Belgium has its own features, partially nuancing the relevance of studies in common law countries for Belgium. Accordingly, the question of comprehensive decriminalisation of abortion is further investigated with the Belgian law in mind.

3. Legal impact of comprehensive decriminalisation of abortion in Belgium

68. Zoals eerder gesteld, is de vraag gerezen wat de invloed zou zijn van het schrappen van de specifieke strafsancties uit de Wet betreffende de vrijwillige zwangerschapsafbreking op de strafrechtelijke en tuchtrechtelijke aansprakelijkheid van personen die een abortus uitvoeren of ondergaan buiten de wettelijke voorwaarden. De Commissie benadrukt dat enkel de verregaande decriminalisering van vrijwillige zwangerschapsafbreking wordt onderzocht. Abortion without consent of the woman is distinguished from voluntary abortion and treated as an offence in the Belgian Criminal Code. The withdrawal of criminal sanctions from the Act on Voluntary Termination of Pregnancy would not impact the criminal law protection of pregnant women against coercion or violence.

69. The next sections discuss the legal impact of comprehensive decriminalisation of voluntary abortion in more detail. Hierbij moet een onderscheid worden gemaakt tussen sancties met betrekking tot medisch personeel, derden, en de zwangere persoon.

Arts

70. Het schrappen van de specifieke strafsancties uit de Wet vrijwillige zwangerschapsafbreking sluit **sanctionering van de arts** niet uit. In de eerste plaats moet worden gedacht aan tuchtrechtelijke sanctioneringsmechanismen. Zo zal het opleggen van tuchtsancties mogelijk zijn op grond van artikel 16 van het Koninklijk besluit 79 van 10 november 1967 betreffende de Orde der artsen. Mogelijke tuchtsancties voor artsen betreffen een waarschuwing, censuur, berisping, schorsing in het recht de geneeskunde uit te oefenen gedurende een termijn die twee jaar niet mag te boven gaan en schrapping van de lijst der Orde (artikel 16, eerste lid, KB 79). Het is van belang om te duiden dat tucht- en strafrecht beide sanctioneringsmechanismen omvatten, maar doorgaans een andere aard en finaliteit kennen. De strafvordering beoogt bij wet vastgelegde inbreuken op de maatschappelijke orde te doen bestraffen en wordt uitgeoefend in het belang van de maatschappij. De mate waarin een handeling als maatschappelijk onverdedigbaar wordt beschouwd, bepaalt of een preventieve en repressieve strafregel aan de orde is. Het tuchtrecht of disciplinair recht is groepsgebonden en beoogt loyaal en maatschappelijk verantwoord professioneel gedrag te vrijwaren (Hoet, 2015). De tuchtvordering beoogt in eerste instantie inbreuk op de disciplinaire en deontologische regels van de beroepsgroep te sanctioneren en wordt uitgeoefend in het ruimer belang van de beroepsgroep, de patiënt, en de samenleving. Zij is van toepassing op handelingen die niet noodzakelijk het voorwerp uitmaken van een precieze definitie of rechtsgrond. De werking en implementatie van tuchtrecht is afhankelijk van de wil en organisatie van de beroepsgroep.

71. Naast tuchtrecht blijft ook het gemeen strafrecht van toepassing op grond waarvan de arts in beginsel zou kunnen worden vervolgd voor het opzettelijk (art. 398 Sw.) of onopzettelijk (art. 420 Sw.) toebrengen van **slagen of verwondingen** aan de zwangere persoon in geval van gebrek aan voorzichtigheid of voorzorg[131] (Bosly en De Valkeneer, 2020, 609-696) of wanneer de wettelijke voorwaarden niet werden nageleefd. Ook de Raad van State leek deze mening toegedaan wanneer het gevraagd werd te oordelen over een amendement dat alle specifieke strafsancties uit de Wet Vrijwillige Zwangerschapsafbreking zou verwijderen (Advies Raad van State, nr. 66.881/AV, 24 februari 2020, 8.2). In het kader van de beoefening van de geneeskunde wordt aangenomen dat het toebrengen van slagen en verwondingen niet wederrechtelijk is wanneer de gedragingen door de wet worden geduld. (De Nauw, 2010, p. 204; Dewandeleer, 2001, o160/145-146; I. Casier e.a., 2014). Wanneer de gedragingen niet geduld worden door de wet, kunnen toegebrachte slagen en verwondingen aan een persoon wel worden gekwalificeerd als misdrijf. De toestemming van het slachtoffer inzake het toebrengen van opzettelijke slagen en verwondingen neemt noch het

[131] Eventueel is ook vervolging mogelijk wegens onopzettelijk toebrengen van slagen en verwondingen (art. 418 Sw.); zie algemeen over slagen en verwondingen in het kader van de geneeskunde: F. Swennen, 'Juridische grondslagen van de strafrechtelijke immuniteit van de geneesheer i.h.b. de vereiste van het therapeutisch oogmerk', T. Gez. 1997-98, p. 3-21.

wederrechtelijk karakter van de feiten, noch de schuld van de dader weg en vormt geen rechtvaardigingsgrond (Cass. 6 december 2005, nr. AR P.05.0576.N, Arr.Cass. 2005, 2429, nr. 3.1; Swennen 1997-98, p. 8; Dierickx, 2006, p. 119).

72. Bij een vrijwillige zwangerschapsafbreking zal wellicht geen sprake zijn van een slag, maar mogelijk wel van een verwonding, waaraan een zeer ruimte omschrijving wordt gegeven (zie onder meer Delannay, 2020, 333-340). Alternatief kan de handeling ook worden gekwalificeerd als feitelijkheid of lichte gewelddaad in de zin van artikel 563, 3° Sw. Hiervan is sprake bij ieder feit, anders dan een slag, dat door contact de fysieke integriteit van een persoon aantast zonder deze te verwonden (Meganck, 2013 O160/29).[132] Het lijkt waarschijnlijk dat de arts – minstens in theorie – strafrechtelijk kan worden vervolgd voor (één of meerdere) van bovenstaande misdrijven van zodra die de Wet Vrijwillige Zwangerschapsafbreking niet respecteert. Een aantal uitspraken in de parlementaire, voorbereidende werken[133] en ook de Raad van State bevestigen deze opvatting (Advies RvS van 24 februari 2020 nr. 66.881/AV, *Parl.St.* Kamer 2019-20, nr. 55-0158/10, p. 14.) Dit betekent dat een werkelijke decriminalisering van de arts in de praktijk niet mogelijk blijkt wanneer die overblijvende wettelijke voorwaarden overtreedt. Het verwijderen van specifieke strafsancties uit de Wet Vrijwillige Zwangerschap leidt dus niet automatisch tot strafrechtelijke immuniteit voor de arts.

Het misdrijf opzettelijke slagen en verwondingen met voorbedachten rade kent een gelijkaardige strafmaat als die van onwettige zwangerschapsafbreking in de huidige Wet Vrijwillige Zwangerschapsafbreking.[134] Indien louter sprake zou zijn van een feitelijkheid of lichte gewelddaad, is de strafmaat beduidend lager.

73. Hoewel theoretisch mogelijk, verdient het terugvallen op deze gemeenrechtelijke misdrijven ter bestraffing van een uitvoerder van een vrijwillige abortus volgens deze Commissie geen aanbeveling. Immers moet aandacht besteed worden aan de ratio legis van deze misdrijven, die in

[132] In het geval van medicamenteuze zwangerschapsafbreking is een mogelijke toepassing van het misdrijf van het toedienen van gevaarlijke stoffen (artikel 402 Sw.) eveneens denkbaar. Strafbaar is de persoon die bij een ander een ziekte of ongeschiktheid tot het verrichten van persoonlijke arbeid veroorzaakt door het toedienen van stoffen die de dood teweeg kunnen brengen of de gezondheid zwaar kunnen schaden, zonder het oogmerk om te doden. Medicamenteuze zwangerschap gaat doorgaans gepaard met een aantal nevenwerkingen, waarvan de feitenrechter steeds *in concreto* zal beoordelen of er sprake is van een ziekte of arbeidsongeschiktheid ten gevolge van het toedienen van de medicatie.

[133] Parl.*St.* 2019-20, nr. 55-0158/4, p. 53 waarin wordt vermeld dat het gemeen strafrecht van toepassing is "indien een arts bij een medische ingreep als zwangerschapsafbreking de bij wet bepaalde voorschriften niet naleeft"; zie ook p. 62 van dit verslag. Zie echter de tussenkomst van de heer Verherstraeten (CD&V) op p. 63-64.

[134] Vergelijk de sancties in huidig art. 3, eerste lid Wet Vrijwillige Zwangerschapsafbreking met de sancties voorzien in art. 398 Sw. In geval van voorbedachte rade (art. 398, tweede lid Sw.) geldt dezelfde maximum gevangenisstraf als in huidig artikel 3, eerste lid Wet Vrijwillige Zwangerschapsafbreking.

eerste instantie de bescherming van het slachtoffer en diens lichamelijke integriteit nastreven. Indien de wetgever het noodzakelijk en gerechtvaardigd acht om tevens een maatschappelijke bescherming van de foetus na te streven (bv. bij abortus na een bepaalde termijn), is het behouden van een abortus-specifieke strafsanctie in de Wet op Vrijwillige Zwangerschapsafbreking aan te bevelen. Volgens de Commissie dragen specifieke strafsancties bij tot de rechtszekerheid en hebben zij het voordeel dat ze op maat kunnen worden ontwikkeld in tegenstelling tot de situatie waarbij moet worden teruggevallen op een algemeen misdrijf dat in zijn aard minder aansluit bij de materie die men wenst te bestraffen. De Commissie herinnert hier ook aan het eerder aangehaalde arrest van het Grondwettelijk Hof in het kader van euthanasie, waarbij het een niet-gediversifieerde sanctieregeling met betrekking tot gediversifieerde inbreuken op de euthanasiewetgeving ongrondwettelijk achtte (Constitutional Court, no. 134/2000, 20 October 2022). De Commissie beveelt aan om de mogelijke relevantie van deze uitspraak in acht te nemen wanneer het de strafsancties met betrekking tot vrijwillige zwangerschapsafbreking evalueert. Waar de wetgever een versoepeling van de huidige normen of sancties voor artsen betrokken bij abortus nodig acht, verdient het aanbeveling om de wettelijke voorwaarden te herzien of te verwijderen.

74. De Commissie stelt vast dat bepaalde voorwaarden nauwer aansluiten bij een maatschappelijk belang in de bescherming van de foetus en dus bij een strafrechtelijk kader, zoals een termijn en inhoudelijke voorwaarden voor late zwangerschapsafbreking. Sommige wettelijke voorwaarden zijn eerder gericht op de arts-patiënt relatie, kwaliteit van zorg, en besluitvorming, zoals verplichte informatie of uitvoering in medisch verantwoorde omstandigheden. De Commissie is van oordeel dat een aantal van deze patiënt-beschermende principes gebaat kan zijn met een gezondheidsrechtelijke aanpak. Sommige ervan worden nu al gewaarborgd in de Wet Patiëntenrechten en worden expliciet van toepassing op vrijwillige zwangerschapsafbreking indien de praktijk zou worden gekwalificeerd als gezondheidzorg. De Wet Patiëntenrechten bevat evenmin specifieke strafsancties, maar gaat uit van professionele handhaving en controle. Schending van deze wet kan in sommige gevallen echter ook aanleiding geven tot een gemeenrechtelijk misdrijf zoals slagen en verwondingen, waardoor ook bij het terugvallen op die wet de optie tot strafrechtelijke sanctionering overeind blijft.

Derden, andere dan de arts

75. Enkel de arts mag de vrijwillige zwangerschapsafbreking verrichten[135] volgens art. 2 van de Wet Vrijwillige Zwangerschapsafbreking, en dit onder medisch verantwoorde omstandigheden in een instelling voor gezondheidszorg. Bij gebrek aan specifieke strafsancties in de Wet Vrijwillige Zwangerschapsafbreking rijst de vraag of een **niet-arts** nog strafrechtelijk vervolgd kan worden na het verrichten van een zwangerschapsafbreking.

76. De niet-arts die een vrijwillige zwangerschapsafbreking verricht kan in principe worden vervolgd voor dezelfde **gemeenrechtelijke misdrijven** waarvoor de arts kan worden vervolgd na decriminalisering (*supra*). De redenering met betrekking tot slagen en verwondingen, de feitelijkheid of lichte gewelddaad kunnen hier naar analogie worden toegepast. De ingreep gebeurt immers niet in het kader van de geneeskunde en met miskenning van minstens één van de wettelijke voorwaarden, met name de vereiste van uitvoering door een arts (onder medisch verantwoorde omstandigheden in een instelling voor gezondheidszorg). Niettemin wordt door verschillende leden van de commissie een voorkeur gegeven aan het behoud van een specifieke strafsanctie voor de uitvoering van abortus door een niet-gekwalificeerde persoon, ter voorkoming van misbruiken en ter bescherming van de zwangere persoon.

77. De Commissie wijst ten slotte nog op strafsancties voor de "onwettige uitoefening van de geneeskunde" in de Gezondheidszorgberoepenwet. Die wet bestraft personen voor het gewoonlijk uitvoeren van geneeskundige handelingen zonder daarvoor het wettelijk diploma van doctor in de genees-, heel- en verloskunde te bezitten (artikel 3, §1, eerste en tweede lid Gezondheidszorgberoepenwet; artikel 122 Gezondheidszorgberoepenwet), doch lijkt voornamelijk betrekking te hebben op handelingen met betrekking tot een pathologische toestand (zie ook de aanvulling met betrekking tot esthetische ingrepen in artikel 3, §1, vierde lid Gezondheidszorgberoepenwet). De Commissie beveelt aan om het toepassingsgebied van deze bepaling en de mogelijke relatie tot zwangerschapsafbreking te evalueren wanneer het de sanctionering van niet-gekwalificeerde uitvoerders van abortus overweegt.

78. De Commissie verwijst ten slotte terug naar wat reeds gesteld werd onder titel X., waar aandacht wordt gevestigd op de verschillende actoren die vandaag betrokken kunnen zijn bij de uitvoering van een abortus, zowel binnen als buiten de traditionele gezondheidszorg (zie bv. Women on Waves). Het is aan de wetgever om de diverse actoren en rollen te identificeren en een gewenste juridische regeling te determineren die aansluit bij de hedendaagse realiteit.

[135] De wetgever heeft niet verduidelijkt wat bedoeld wordt met het 'verrichten van de zwangerschapsafbreking'. Dit leidt vooral met betrekking tot de medicamenteuze zwangerschapsafbreking tot rechtsonzekerheid.

De zwangere persoon

De Wet Vrijwillige Zwangerschapsafbreking bevat een strafsanctie voor de vrouw die opzettelijk een vruchtafdrijving laat verrichten buiten de wettelijke voorwaarden. Bij schrapping van deze specifieke strafsanctie wordt strafbaarstelling van de zwangere persoon in beginsel uitgesloten, ook bij het uitvoeren van een vrijwillige zwangerschapsafbreking buiten de voorwaarden van de wet. Niettemin rijst ook hier de vraag naar de toepassing van het gemeen strafrecht op de zwangere persoon. De rechtspraak van het Europees Hof voor de Rechten van de Mens lijkt uit te sluiten dat het slachtoffer van slagen en verwondingen door middel van diens toestemming kan worden beschouwd als deelnemer aan het misdrijf (K.A. en A.D. v. België)**.** Indien de wetgever de zwangere persoon die een zwangerschap laat verrichten in alle zekerheid en volledigheid wenst te decriminaliseren, ook onder het gemeen strafrecht, bestaat een mogelijkheid om strafbaarstelling en vervolging expliciet uit te sluiten in de Wet op Vrijwillige Zwangerschapsafbreking. Naar analogie zou deze expliciete uitsluiting ook kunnen worden uitgebreid naar de vrouw die zelfstanding haar zwangerschap afbreekt.[136]

Een expliciete decriminalisering van de zwangere persoon krijgt de voorkeur van deze commissie. WG4 is of the opinion that imposing criminal sanctions disproportionately harms women who are in need of an abortion outside of the law. It considers that abortion providers are in charge of securing respect of the legal conditions. De Commissie verwijst eveneens terug naar wat reeds gesteld werd onder titel X, alsook naar het feit dat in mensenrechtendiscours en Europese-nationale wetgeving een groeiende consensus bestaat om de persoon die een onrechtmatige abortus ondergaat vrij te stellen van enige strafrechtelijke vervolging.

[136] Vergelijk ook met de Franse abortuswetgeving, waar artikel L2222-4 Code de la Santé Publique in verband met de bestraffing van het verschaffen van middelen aan een zwangere persoon om op zichzelf een zwangerschapsafbreking uit te voeren, uitdrukkelijk bepaalt dat de zwangere persoon zelf niet als medeplichtig mag worden beschouwd; J. Pradel, M. Danti-Juan, Droit pénal spécial, Parijs: Editions Cujas 2007, p. 55.

List of recommendations

1. WG4 recommends to consider qualifying voluntary termination of pregnancy as a (regulated form of) healthcare for the purposes of legal clarity and the increased protection of the pregnant person who seeks an abortion. This does not exclude the possibility to regulate abortion as a special form of healthcare, nor to sanction some violations of the regulation, if the legislator deems such regulation appropriate and necessary.
2. WG4 recommends to address the situation of consent/representation of minors and incapacitated adults with respect to their autonomy and bodily integrity. A regulation in line with the principles embedded in the Patients' Rights Law or a direct application of that law to abortion was preferred. WG4 recommends to authorise professionals not to inform nor require consent of the minor's caregiver(s) when the minor is capable of reasonable judgment, and to keep confidentiality.
3. WG4 recommends to remove the mandatory six-day waiting period which requires two in-person visits. It recommends to retain one mandatory consultation with the patient (which can also occur online/via telephone).
4. WG4 recommends consider which (stages/types of) abortions can occur out-of-clinic and without a doctor, bearing in mind the evolutions regarding telehealth and the abortion pill.
5. WG4 recommends to improve the general structure of the abortion law, and to review terminology used, including language inconsistencies, outdated and gender-insensitive phrasing.
6. WG4 recommends to regulate abortion on severe medical grounds (regardless of gestational age) in a separate legal article in the AVTOP to benefit legal clarity.
7. WG4 recommends referring to a risk standard instead of certainty in the legal sections dealing with abortion on severe medical grounds. (e.g. substantial risk, (very) high risk, …).
8. WG4 recommends to explicitly decriminalise the pregnant person undergoing or self-performing voluntary abortion in violation of remaining legal conditions.
9. WG4 recommends to prioritise abortion-specific sanctions in the abortion law over the application of general criminal offences for abortions providers who violate legal conditions maintained in the abortion law. A diversification of sanctions and a regulatory/sanctioning role for the medical profession should be considered in light of the nature and gravity of the condition/violation.
10. WG4 recommends to discourage unsafe abortion provision and retain a specific criminal sanction for abortion provision by unqualified providers.

11. WG4 recommends improved collection of data for scientific and preventive purposes, to allow better understanding of the social and societal context in which abortions are requested, and to improve assistance to women. WG4 recommends to rethink the role and functioning of the National Evaluation Commission on Termination of Pregnancy in order to enable more scientific and qualitative data analysis.

Annexe/bijlage V : « Les valeurs d'autonomie, d'égalité et de justice reproductive » by Guy Lebeer and Florence Caeymaex

Section éthique
Les valeurs d'autonomie, d'égalité et de justice reproductive

Guy Lebeer
Florence Caeymaex

La question de l'interruption volontaire de grossesse sera déployée ici selon l'angle de trois principes : l'autonomie, l'égalité et la justice reproductive. Ces principes constituent, le plus souvent combinés, les balises éthiques de l'histoire des luttes en faveur du droit à l'avortement[1]. Ils se retrouvent en effet au fondement de ces luttes, luttes qui leur donnent des tonalités et des consistances variées. Il semble éclairant, de ce point de vue, et c'est le choix adopté ici, de poser le questionnement éthique suscité par la pratique de l'avortement, non à partir d'un lieu désincarné, mais à partir de cette histoire.

Autonomie et égalité

Les mouvements féministes des années 70 ont élevé la liberté reproductive et le droit à l'avortement au premier rang de leurs revendications. L'autonomie et l'égalité en sont les pierres angulaires. C'est aux femmes de décider pour elles-mêmes de l'usage qui peut être fait de leur corps (« Mon corps est à moi », « Un enfant quand je veux, si je veux »). Pour ce qui est de l'égalité, la citation suivante, toute marquée par cet héritage historique et s'inscrivant dans la perspective des droits humains, paraît particulièrement parlante : « *Pourtant nous* (les femmes) *sommes plutôt magnanimes. Les hommes, nous ne les avorterons pas, nous ne les priverons pas d'éducation, nous ne les brûlerons pas sur un bûcher, nous ne les tuerons pas dans les rues, nous ne les tuerons pas lorsqu'ils font leur jogging, … nous ne leur ferons pas honte d'être nés de leur sexe, … nous ne les violerons pas, nous ne les toucherons pas sous les tables, nous ne les dénigrerons pas parce qu'ils désirent du sexe, nous ne leur interdirons pas l'espace public, … nous ne les mutilerons pas,* ***… nous ne les forcerons pas à enfanter,*** *…****nous ne confisquerons pas leur sexualité****….Quand nous disons égalité, nous ne parlons pas de cette égalité-là… »*[2].

A cette revendication d'autonomie personnelle et d'égalité s'est ajoutée, l'idée que cette autonomie doive s'exercer libre de toute intervention de l'État. C'est l'un des éléments du raisonnement de la Cour Suprême des USA dans l'arrêt Roe *vs.* Wade en 1972 qui, au nom du droit au respect de la vie privée, établissait le caractère anticonstitutionnel des législations anti-avortement. Cette perspective se développe alors hors de la sphère de la santé publique.

Santé publique

Cependant, en Belgique, contrairement à d'autres pays (la France par exemple), les liens des associations féministes avec la médecine ont été très étroits dès les années soixante. Dans le premier centre francophone de planning familial, « la Famille heureuse », créé en 1962, œuvrait le docteur Pierre Hubinont, qui travaillait aussi à l'hôpital Saint-Pierre de Bruxelles où

il faisait à l'époque le douloureux constat des conséquences des avortements clandestins. Après l'Affaire du docteur Willy Peers (1973), l'information sur la contraception fut dépénalisée –soutenant la dissociation entre sexualité et procréation - et des centres extra-hospitaliers pratiquant illégalement des avortements furent mis sur pied.

Dans les années 80, les revendications, portées par des associations féministes internationales, s'orientent vers la reconnaissance d'un droit d'accès à un avortement *sûr et légal*, entérinant le glissement du cadre éthique vers la santé publique. Ce n'est plus tant l'autonomie corporelle des femmes qui est au cœur du travail politique en faveur du droit à l'avortement que la prévention des risques pour la santé de la mère et du fœtus, notamment en raison des avortements clandestins. C'est aussi dans les années 90 que l'on assiste à un renouveau des mouvements anti-IVG se disant pro-vie par opposition aux pro-choix (contre les féministes, contre les personnes LGBT, contre celles qualifiées par ces mouvements comme partisanes de « l'idéologie du genre »).

La loi de dépénalisation partielle de 1990 s'inscrit dans un mouvement de médicalisation de l'avortement, généralisé dans le monde occidental. Pour certaines chercheuses, cette médicalisation est apparue alors comme le nouvel instrument d'un contrôle social sur le corps des femmes, « les médecins devenant l'agent privilégié de l'encadrement du pouvoir gagné par les femmes de décider ou non de donner la vie. Ce contrôle perpétuant le stéréotype de la femme-mère, la maternité étant la normalité des femmes »[3]. Avec le temps, la santé publique a pu également constituer le levier d'une libéralisation accrue. En témoignent les nouvelles lignes directrices de l'OMS sur l'avortement, publiées en mars 2022. Celles-ci conjuguent santé et droits reproductifs, prévention des avortements insécurisés et réduction de la mortalité et morbidité maternelles. Au nom de ces impératifs, l'OMS recommande d'ailleurs de supprimer des corpus juridiques nationaux toute disposition relative d'une part aux « limites de la période gestationnelle » et d'autre part au « délai de réflexion ».

Á l'appui de la première recommandation, l'OMS fait état d'études selon lesquelles : *The evidence from these studies showed that women with cognitive impairments, adolescents, younger women, women living further from clinics, women who need to travel for abortion, women with lower educational attainment, women facing financial hardship and unemployed women were disproportionately impacted by gestational age limits. This points to the disproportionate impact of gestational age limits on certain groups of women, with implications for States' obligation to ensure non-discrimination and equality …*[4]

Et plus loin: *The evidence did not establish any benefits of mandatory waiting periods for women*[5]

Justice reproductive

On ne peut manquer de voir dans cette référence cardinale aux principes de non-discrimination et d'égalité, mise en avant par une organisation comme l'OMS, une influence, au moins partielle, au moins indirecte, de mouvements comme celui de la « justice reproductive ». Ce mouvement de la « justice reproductive » a émané d'un groupe de femmes africaines américaines, réunies en 1994 et qui se sont appelées *Women of African Descent for*

Reproductive Justice. Il s'agit d'un mouvement se distinguant des mouvements des droits reproductifs des années 1970, parce que les femmes à faible revenu, les femmes de couleur, les femmes en situation de handicap et les personnes LGBTQ+ s'y sentaient marginalisées. Il apparaissait clairement à leurs yeux que, malgré l'accès légal à l'avortement, ces femmes n'étaient pas en mesure d'y accéder et d'exercer leurs choix en matière de procréation aussi facilement que leurs consœurs plus privilégiées. Pour ces militantes, la maîtrise sur son corps et son destin reproductif n'est pas tant une question de choix que de justice. D'où les distances prises avec l'éthique du « choix individuel » qui ignore les facteurs structurels qui le conditionnent tels que la condition économique, la racialisation, le statut d'immigration, …

Ce mouvement a contribué avec d'autres au développement des études sur l'intersectionnalité, la conjugaison de multiples formes d'oppression sur les vies sexuelles, reproductives et maternelles des femmes de diverses communautés. Il envisage ces oppressions comme des effets de la domination, c'est-à-dire de la répartition inéquitable du pouvoir entre catégories sociales (distinguées selon les critères de « race », classe, âge, genre, orientation sexuelle, (in)capacité, etc.), qui se traduit, pour les moins favorisées, par une privation du pouvoir d'agir individuel et collectif. Placé sous l'horizon de la justice, le projet fondamental de ce mouvement est celui d'une récupération de ce pouvoir d'agir sur sa propre vie, sur ses conditions d'existence, et dans la société – une capacité d'agir sans laquelle « choisir » ou « décider » est tout bonnement impossible.

Combinant droits reproductifs, accès aux soins et justice sociale, le mouvement de la « justice reproductive » n'en délaisse cependant pas le principe d'autonomie défendant pour chaque femme le droit fondamental de décider si et quand elle aura un enfant, de décider de ne pas avoir d'enfant et d'avoir le choix de prévenir ou d'interrompre une grossesse[6]. Et ce droit exige de supprimer toute forme de contrôle sur le corps des femmes et dans le même temps, dans une perspective de féminisme radical, de transformer les mécanismes politiques, économiques et sociaux responsables de leur aliénation.

Le mouvement de la justice reproductive, diversement relayé en Europe – en particulier dans des associations non gouvernementales - articule ainsi, sur un mode radical, deux types de droits dont Bérengère Marquès-Pereira a bien montré la mise en tension. D'un côté le droit à l'avortement comme droit-liberté – droit à l'autonomie, à la libre disposition de soi – et de l'autre un droit-créance que la femme réclamerait de l'État pour assurer un accès effectif et égalitaire au droit à l'avortement – droit de citoyenneté que l'État a pour pouvoir (a le devoir ?) d'établir et de garantir.

« *La problématique de la citoyenneté sociale des femmes entre ainsi en jeu avec le couple liberté/égalité qui dessine un terrain discursif incluant la réalité empirique et sociologique des rapports sociaux de sexe dans leur imbrication avec les rapports de classe et les rapports culturels ».*[7]

<u>Une question éthique, une question politique</u>

Autonomie, égalité, justice reproductive et répartition équitable du pouvoir sont donc inextricablement liés dans ce qui compte aujourd'hui pour les femmes qui luttent en faveur du droit à l'avortement. L'ancrage de cette lutte dans le principe d'autonomie reste

fondamental, l'idée centrale est bien d'assurer les conditions de la liberté de disposer de son corps. Les entraves à cette liberté appellent à la revendication de droits pour les femmes : d'abord comme droits humains, fondés sur l'appartenance à une commune humanité, composée d'égaux, ensuite sous la forme de droits sociaux et reproductifs soutenant la réalisation effective des droits fondamentaux. Mais la concrétisation progressive de cette aspiration ne s'est pas faite sans concessions aux volontés de l'État de maintenir son contrôle sur le corps des femmes. Le glissement des revendications vers la santé sexuelle et reproductive a sans doute permis de prendre en compte la question cruciale de l'accès inégalitaire aux droits reproductifs mais dans le même temps a instauré une dépendance à l'État avec la nécessité de se confronter à des forces politiques quelquefois peu favorables à ces droits. D'où l'émergence de ce que l'on a pu appeler un féminisme institutionnalisé - d'État - et le maintien d'un contrôle social assuré par l'entremise de la médecine. Ce contrôle peut par ailleurs prendre des formes assez variables, assez libérales même comme celle de la politique prônée et promue par l'OMS depuis 2022.

Dans le mouvement de « justice reproductive », venu tout droit de la tradition africaine-américaine des droits civiques, l'État est très directement interpellé. Il n'y est plus question de concessions mais de revendications frontales. Ici les discriminations dans l'accès aux soins, à l'information sexuelle, à la contraception, à l'avortement, à des accouchements sûrs sont ouvertement dénoncées. Que ces discriminations soient plus profondes aux Etats-Unis ne fait aucun doute mais elles ne peuvent pas être dites inexistantes en Belgique. Le mouvement de « justice reproductive » interroge radicalement les systèmes de pouvoir et en appelle à une transformation en profondeur des structures sociales, économiques et politiques qui génèrent ces discriminations « intersectionnelles », entremêlant la « race », le genre, la classe sociale, le statut économique, etc.

Le recours à ce sommaire historique des luttes féministes a permis de rendre perceptible que plusieurs principes éthiques sont à tout moment mobilisés ensemble dans des configurations variables. Il a permis aussi de les incarner en certaines situations historiques concrètes. Enfin il indique les relations évidentes entre contenu et positionnement éthiques d'une part et enjeu politique d'autre part. Si permettre l'expression d'un choix personnel, assurer l'accès à des services publics de qualité en matière de santé sexuelle et reproductive et en même temps veiller à faire pièce à tous les mécanismes de discrimination qui ont cours dans ce domaine relève bien du champ de l'éthique, ces aspirations sont inséparables d'un travail politique en mouvement, dans leur contenu comme dans leurs modalités expressives. Et leur réalisation relève elle-même « d'un système de pensée politique et de l'état d'une société civile »[8].

La question éthique a été déployée ici à partir et tout au long des mobilisations des femmes – les premières concernées - en faveur du droit à l'avortement. Comme on le voit, elle ne s'est pas formulée en termes d'un éventuel droit du fœtus. …

La féministe Maider Moreno Garcia pose dans les termes suivants la question de la pertinence d'un tel cadre de débat :

« La plupart de nos gouvernements ne reconnaissent pas aux femmes le droit au premier mot, ni au dernier d'ailleurs, lorsqu'il s'agit de quelque chose d'aussi fondamental que le « destin de leurs vies ». En définitive, ce que nous essayons de souligner, c'est la véritable nature de la

question qui se pose ; parler de la dépénalisation de l'avortement ce n'est pas demander de prendre parti pour la vie de la mère ou du zygote/fœtus, mais bien de s'interroger sur le degré de responsabilité nécessaire pour décider d'interrompre une grossesse qui n'est pas souhaitée »[9].

Conclusion

La ligne argumentaire déployée par le mouvement de la justice reproductive construit une position éthique forte qui s'articule précisément autour d'une conception complexe de la responsabilité.

Cette perspective, sensible comme toutes les perspectives féministes à l'autonomie corporelle des femmes, considère cependant que celle-ci ne saurait être contenue dans une définition étroite de la « propriété de soi ». Cette autonomie ne saurait être atteinte sans mettre en place ses conditions socio-politiques de possibilité, qui supposent des mécanismes de solidarité sociale et d'égalisation des conditions de vie. L'autonomie que l'on reconnaît formellement à toutes est, en pratique, un privilège réservé à quelques-unes : celles qui, par les supports sociaux dont elles bénéficient (éducation, moyens financiers, soutien familial ou des proches dans l'exercice de sa liberté, accès aux soins, etc.), sont en mesure de faire des choix libres et éclairés, et de décider pour elles-mêmes. Séparer le principe d'autonomie de ses conditions de réalisation jette dans l'ombre les mécanismes de discrimination et de subordination sociale, générateurs d'abus, qui affectent de nombreuses femmes encore aujourd'hui : femmes discriminées en raison de la race, du handicap, du statut socio-économique, ou encore en raison de leur orientation sexuelle. Dans cette perspective, il est de la responsabilité collective d'organiser et de mettre en place les conditions de possibilité d'une autonomie véritable. Ces conditions sont à trouver tant du côté des droits et de la législation que du côté des services, socialement organisés, destinés à corriger concrètement ces discriminations – protections sociales, services de santé et d'éducation. Il s'agit donc d'une responsabilité sociale, qui engage l'ensemble d'une société.

Ainsi, cette perspective décline-t-elle la notion de responsabilité de façon bilatérale. D'une part il s'agit de soutenir que la responsabilité des femmes doit faire l'objet d'une *reconnaissance*, à rebours de la « responsabilisation » paternaliste qui, comme ce fut toujours le cas historiquement, moralise les femmes tout en leur retirant le droit, la capacité et la possibilité matérielle de réellement exercer leurs responsabilités. D'autre part l'actualisation de cette responsabilité/autonomie est inséparable de l'exercice d'une responsabilité collective, d'un engagement collectif dont se démarque une conception néo-libérale de la responsabilité qui a, au contraire, pour caractéristique d'en exonérer nos institutions. Responsabiliser n'est ici ni geste paternaliste ni injonction faite aux individus qui dispenserait les Autorités de leur devoir de justice. Il s'agit, en conséquence, d'affirmer que la responsabilité pleine et entière des femmes doit être reconnue de manière principielle et qu'elle exige une responsabilité institutionnelle sous la figure impérative d'une solidarité sociale.

Suivant cette logique, il est parfaitement possible de soutenir une législation qui ne mettrait aucune limite temporelle dans l'accès à l'IVG (comme c'est le cas dans certains pays déjà, Canada, Etat-Capitale d'Australie). Celle-ci constituerait la reconnaissance pleine et entière de

la liberté ou de l'autonomie de toutes les femmes, et de la responsabilité inhérente à celle-ci. Mais cette reconnaissance ne peut s'affranchir, nous l'avons expliqué, d'un engagement de la société à faire bénéficier également toutes les femmes de politiques sociales et de santé publique fortes, passant par la facilitation de l'accès aux structures de santé, à l'information sur la vie sexuelle et reproductive et aux services de promotion des droits reproductifs. Cette disposition – ou absence de disposition – rencontrerait par ailleurs les dernières recommandations de l'OMS qui, au nom de la santé publique, la considère comme la mesure la plus pertinente pour lutter contre l'avortement clandestin.