UNIVERSAL PERIODIC REVIEW – 4th CYCLE

CONTRIBUTION TO ARGENTINA'S REVIEW

Access to abortion in Argentina

Civil society report produced jointly by the Center for Legal and Social Studies (CELS), Equipo Latinoamericano de Justicia y Género (ELA), Amnesty International Argentina (AIAR), Fundación para el Desarrollo de Políticas Sustentables (Fundeps) and Fundación Mujeres x Mujeres (MxM).

I. Abortion in Argentina: legal framework

1. At policy level, we achieved enactment of Law 27,610 on Access to Voluntary Interruption of Pregnancy (VIP), in force since January 15, 2021, Decree 510/2021 (regulating Law 27,610) and the modification of the National Criminal Code.

2. In addition, Congress approved the "*Protocol for comprehensive care of persons with the right to legal, voluntary interruption of pregnancy*" (Edition 2021, created under National Ministry of Health Res. 1531/2021). This protocol, unlike the laws mentioned previously, is non-binding for rest of the country's jurisdictions due to Argentina's federal makeup. Nevertheless, many provinces apply it within their jurisdictions (such as Neuquén and La Rioja). Others have issued their own local regulations, such as the "Implementation guide for voluntary interruption of pregnancy in the Province of Buenos Aires."

3. Law 27,610 recognizes abortion as a right, framing it within "*the commitments undertaken by the Argentine State on matters of public health and the human rights of women and persons with other gender identities with the capacity for gestation, for the purposes of reducing morbidity and preventable mortality*," in keeping with numerous international recommendations.[1] It furthermore stipulates that the rights to decent treatment, privacy, confidentiality, free will, access to information and quality care must be guaranteed.

[1] See A/HRC/37/5 recommendations 107.102, "Enact pending legislation that would allow legal access to women to complete reproductive health services including comprehensive sex education, family planning, prevention and response to sexual and gender-motivated violence, legal, safe abortion and post-abortion care", and 107.110, "Decriminalize abortion in all circumstances and ensure that women and girls have access to safe, legal abortion," among others.

4. The law adopts a blended system consisting of the right to choose and have access to an abortion through week fourteen of pregnancy. Beyond this timeframe, the law states that access to an abortion shall be available if the pregnancy was the result of rape or if the life or health of the birthing person is at risk.[2]

5. On the rights of girls and adolescents, the law also establishes that persons over the age of 16 have full capacity to give their consent and exercise the rights granted under the law. In the case of persons between the ages of 13 and 16, they may give their own consent as long as the process does not pose a serious risk to their health or life. In this case, they must also have consent from their parents, legal representatives, formal or informal caregivers, relatives or loved-ones.

6. In the case of minors below the age of 13, they may give their consent but must also have consent from their parents, legal representatives, formal or informal caregivers, relatives or loved-ones.

7. In the case of persons with restricted capacity, the law stipulates that they may give informed consent without impediment and be provided a support system if they so desire, ensuring respect for their autonomy. In cases where the person is under a court order of restricted capacity that prevents the person from giving their own consent, they must have access to assistance by their legal representative to provide their informed consent or, in absence thereof, a relative.

8. With regard to conscientious objection, the law establishes that it can only be exercised by professionals involved directly in the abortion procedure. Furthermore, said professional must uphold their decision in all areas of healthcare, refer the birthing person in good faith and fulfill the rest of their professional duties and legal obligations. The law also stipulates that conscientious objection cannot be exercised during post-abortion care or if the life or health of the birthing person is at risk. In addition, it indicates that health establishments in the private healthcare or social security sub-sectors that do not have practitioners who are not conscientious objectors must refer the birthing person to another establishment, always ensuring the abortion may be carried out. These requirements are consistent with the recommendations to the Argentine State by the Committee for the Elimination of Discrimination against Women in 2016. [3]

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[2] See A/HRC/37/5 recommendation 107.112, "Guarantee safe access to a legal abortion, also to women who are victims of rape, in the framework of the public health system and in all regions. Initiate a public debate around the decriminalization of abortion."

[3] See CEDAW/C/ARG/CO/7/Add.1 recommendation 31. c) Advocate for women to have access to risk-free legal abortion and post-abortion care, and define and apply strict requirements of justification to prevent the general use of conscientious objection by doctors who refuse to perform abortions, especially in cases of early pregnancy resulting from rape or incest that could be considered equivalent to torture.

9. At the same time, the law modifies articles of the National Criminal Code, penalizing abortion carried out without the birthing person's consent and performed after week 14 of gestation without due cause, whether this was caused by the birthing person or someone else. It also creates Art. 85 bis, penalizing unjustified delays, hindrance or denial of abortion in cases where it is legally authorized.

10. The law expressly establishes that abortion must be fully covered, free of charge, by all health care subsystems, including the Obligatory Medical Plan (PMO) and the National Healthcare Guarantee Program.

II. Barriers hindering access to abortion

11. Despite the progress made during the first year of implementation of the abortion law, there continue to be obstacles causing delays or blocking access to abortion.

12. The first obstacle is the lack of clear information with federal reach on this new right for birthing persons. **The Argentine State is not running federal communications campaigns** despite international recommendations in this regard.[4] Neither are the provinces and, with few exceptions, they are not actively publishing (even though formally required to do so) information on where and how to access an abortion. This causes serious problems such as delays in consultation, people continuing to resort to unsafe methods due to ignorance of their rights, in addition to the ongoing clandestine nature of this service in practice due to stigma.

13. In August 2021 a woman died as a consequence of an unsafe abortion.[5] The communication issued reads: "This death could have been prevented by a healthcare agent delivering brochures and providing information about how to access an abortion in Marcos Paz." The information that is available is largely the result of efforts by civil society.

[4] See A/HRC/37/5 recommendation 107.109 "Guarantee access to legal abortion in all jurisdictions throughout the country with support by publicity campaigns on the right to legally terminate a pregnancy pursuant to the provisions set forth in the law, as well as provide training to health professionals."

[5] "No militamos la ley para seguir lamentando muertes por abortos inseguros", *La vaca*, 27/08/2021. Available at: https://bit.ly/3n6Mlbk.

14. The phone line at the National Office on Sexual and Reproductive Health (DNSSR) records complaints about non-compliance with the provisions of the abortion law or infringements of the right. The line provides assistance for facilitating access to sexual and reproductive health services, but occasionally identifies complex situations requiring a different kind of intervention. In such cases, a set of procedures is generated and sent to the DNSSR. That office initiates a circuit of intervention by notifying the respective jurisdictional programs. These programs process requests in their territories and report on the status of the procedures. In some cases, the DNSSR intervenes with technical advice or coordination with other inter-provincial offices, for instance when the consultation cannot be resolved in the jurisdiction of origin.[6]

15. In these cases, the DNSSR reported[7] that it resolved access for abortion requests through transfers. The age range of the birthing persons involved is 10-23. in all cases, **the reason for the transfers was lack of immediate availability of healthcare equipment to ensure comprehensive care in the provinces where it was required**. With regard to the ways requests for hospitalization were submitted, in cases on record it was generated through a sequence on the 0800 Sexual Health hotline or through an external note. The transfer requests were all for VIP and in gestational week 20 or more.

16. In many of the cases resolved via transfers, the birthing person is moved from a rural area to an urban center. **The lack of uniformity in the provision of health services highlights inequality within provincial territories, between sectors that are closer or farther away from urban centers** and shows the continued relevance of recommendations made in 2017. [8] In some jurisdictions surveyed,[9] people must travel between 200-300 kilometers by their own means to access an abortion. In these cases, the distance and cost of transportation are compounded by other barriers like the impossibility of being absent from precarious work or delegating domestic or caregiving tasks. This situation of obstacles related to lack of services nearby goes beyond abortion services, affecting sexual health and contraceptive methods.

[6] Ministry of Health. Access to Contraceptive Methods and Voluntary, Legal Interruption of Pregnancy. Bimonthly report based on procedures called into 0800 – November-December 2021. Ministry of Health: 2021. [Available online at: https://bit.ly/3mS4cCY]. Access: 05/06/2022.

[7] Response to request for access to public information from the National Office of Sexual and Reproductive Health by CELS (EX-2021-105165668- -APN-DD#MS).

[8] See A/HRC/37/5 recommendation 107.104 "Ensure that access to legal abortion is equally available in all regions of the country."

[9] Such as the cases of Catamarca, Tierra del Fuego, La Rioja and Santiago del Estero.

[10] Response to request for access to public information from the National Office of Sexual and Reproductive Health by the Latin American Team for Justice and Gender and Amnesty International (EX-2021-124925214- -APN-DNAIP#AAIP).

17. As for the calls to the hotline with that were met with a negative response, we obtained data[10] for the province of Buenos Aires. Of the 4,022 abortion requests in the province between January 15 and October 31, 2021, 359 reported obstacles in access to the procedure. Of those, 153 made a single call, 157 two calls, and 49 three or more calls. In that period, the province reported 28 calls with a negative response out of a total 4,022 generated. Although that number represents less than 1% of all calls, the State did not provide information on the reasons for the negative response, nor on the resolution of those situations.

18. In the report created by the phone hotline for November-December 2021, the calls requesting abortions are distinguished based on gestational age. Of the 2,775 requests submitted for that period, 90.4% were submitted in the first trimester of gestation (2,509 cases of under 12 weeks), 5.5% submitted during the early second trimester (153 cases between 12 and 15 weeks) and 4.1 % in the late second trimester (133 cases of 16 weeks or more).

19. Another item is the distribution of requests by gestational age and age range. In birthing persons between ages 10-14, the cases reported in late second trimester reach 11% and for ages 11-19, 7%. In other words, **girls and adolescents up to age 19 are more likely to request abortions in advanced stages of pregnancy and to that access being denied**.

20. In the cases of late second trimester, there were negative responses that were not present in cases of first trimester or early second trimester, as well as more situations in which there is no available information. **The lack of professionals who were not conscientious objectors, in addition to specialized training in late second-trimester abortion procedures is a major unresolved problem in the public health arena**. More still if we consider that the majority of those arriving in advanced stages of gestation are cis women from low-income sectors, girls and adolescents.

21. There is state effort to provide training to healthcare personnel, but **these training opportunities are not mandatory**. At the same time, in the jurisdictions surveyed **the number of non-objector health professionals did not increase despite the foreseeable increase in demand in health centers**. We find ourselves faced with **healthcare teams who cannot meet the timeframes provided by law – which at the same time stipulates a maximum timeframe for voluntary abortions – and that exposes persons requesting the procedure to situations of vulnerability**.

[10] Response to request for access to public information from the National Office of Sexual and Reproductive Health by the Latin American Team for Justice and Gender and Amnesty International (EX-2021-124925214- -APN-DNAIP#AAIP).

22. We furthermore identified practices of "covert conscientious objection" and ignorance about the legal scope of conscientious objections. The former in regard to interventions or micro actions intended to dissuade or hinder access to abortion by healthcare personnel who, without declaring objection, restrict access to the procedure and wear down the birthing person's confidence. The latter in regard to denial or strong resistance and ill treatment of colleagues and patients who must carry out necessary medical procedures, prior to or after the abortion, in the name of a mistakenly broad interpretation of the limits of conscientious objection. All of this ultimately has repercussions on the bodies of women, girls, adolescents and gestating persons.

23. Access to the procedure is uneven in the private[11] and in the social security subsectors, where obstacles to coverage have been detected.[12] Although VIP is included in the Obligatory Medical Plan, **delays and reticence persist in public and private healthcare companies when it comes to incorporating the procedure into their Medical Care Plans**. Nor do they inform their affiliates through the official channels. These omissions generate disinformation, undue delays in access, overload the public health system and involve high fees to guarantee the procedure is available in the private sector. **Situations of abuse and violation of duty to provide information and decent treatment have been detected, in addition to imposing illegal barriers such as requiring a mental health assessment to validate the patient's decision before going ahead with the procedure**.

[11] In Argentina the health sector – set of resources and activities that cover health necessities and medical needs – is comprised of three subsectors: public health, social security and the private sector.
[12] According to information provided by the Superintendency of National Health Services, in 2021 there were 270 claims for defects in abortion coverage. The Deputy Secretary of Actions for Consumer Defense informed that it received 261 claims in 2021.

24. Furthermore, we have documented irregularities and ill treatment in care with regard to clinical standards, violation of patients' rights in the form of physical and psychological abuse toward users and/or their families, violations of the duty to preserve confidentiality and the impact on patient privacy. Many of these situations occur in the post-abortion period, when birthing persons resort to a health center after unsuccessfully attempting a self-induced abortion at home. Furthermore, in the case of advanced pregnancies we have identified delays in care, often resulting from being unable to carry out the procedure due to the complexity of the case (and consequently, having to refer the cases to another, more specialized health clinic). However, these types of delays are often perceived by patients and their companions as an arbitrary practice intended to let the pregnancy advance to the point of extrauterine viability for the fetus. We have on record a case in which the referral to a health clinic that handles more complex cases (in addition to being located far from the patient's home) occurred when a vacancy came available in the neonatal unit. In other words, the referral that should have been made for an abortion was delayed to the point when the person who had requested the abortion ended up giving a live birth.

25. We are also aware of services often involving unnecessary and invasive practices, such as questioning or reiterated personal interrogations of birthing persons: showing them the fetus, mentioning the fetal genitals and forcing them to listen to the fetal heartbeat. On one occasion, a patient said a nurse had taken a photo right after expulsion of the fetus, without her consent or explanation. Finally, some patients say they have been subjected to unrecommendable procedures such as D and C.[13] One patient said she was subjected to a D and C without anesthesia and in a shared room. In this particular case, the justification for this service was to act quickly, since taking her into the operating room for anesthesia and doing the procedure there would prolong the shift of those on duty for too long.

26. Access to abortion for trans men and non-binary persons with gestational capacity involves a more complex route. They go in search of support from organizations before seeking help at healthcare spaces. The most recurring obstacle they face is the characterization of abortion as something only affecting cis, i.e. heterosexual, women. This mindset hinders access to information about sexual health, gynecological exams, contraception as well as informed, supported, non-violent pregnancy interruption. For these reasons, seeking VIP services from the health system involves overexposure or denial of self-perceived gender identity for these patients. The obstacles in the way of access to abortion and lack of policies aimed at the trans and non-binary population causes disinformation even among some healthcare personnel, for example, in terms of the use of hormones and reproductive capacity.[14]

[13] Procedure carried out to scrape and collect endometrial tissue from inside the uterus.

[14] CELS, Monitoring of life conditions of the trans, transvestite and non-binary population during the Covid-19 pandemic and mandatory quarantine, 2022.

III. Situations of criminalization

27. In the province of Salta, a young doctor was prosecuted in September 2021 for guaranteeing access to an abortion.[15] Healthcare professionals are a fundamental part of ensuring the right to a healthy life with dignity and free from violence. The prosecutor in charge of the investigation, with the support of the local justice system, insisted on pursuing the case despite the extensive body of evidence proving the absence of crime and in disregard of the principles of objectivity and legality that should guide criminal investigations. Opponents of the law violated the patient's right to confidentiality and tried to block her access to the health service.

28. In February 2019, two doctors in the province of Tucumán were prosecuted for performing an abortion on an 11-year-old girl.[16] The pregnancy was the result of rape and her mother requested the procedure in the sixteenth month, a legal practice since 1921. Due to court intervention and other doctors' refusal to provide the procedure, the pregnancy advanced to week 23. The two doctors who performed the abortion were indicted on criminal charges by the public prosecutor's office. They were acquitted in December 2021. Similarly, and in the same province, in January 2022 two girls, aged 10[17] and 11, became mothers as a consequence of the late detection of sexual abuse and the State's refusal to allow asystole – a legal medical procedure in these cases – in order to interrupt a pregnancy in the second trimester, despite international recommendations in this regard.[18]

[15] More information at: https://www.cels.org.ar/web/2021/09/salta-la-medica-garantizo-los-derechos-de-la-joven-a-una-interrupcion-legal-del-embarazo/

[16] "Una niña de 10 años, violada y llevada al parto en Tucumán", available at: https://bit.ly/3xINScJ.

[17] "Quedó libre la pareja acusada de matar a su nieta en Lomas de Tafí", available at: https://bit.ly/3Nf9i71.

[18] See A/HRC/37/5 recommendation 107.106 "Adopt new measures to eliminate obstacles that may arise in access to health products and reproductive services, with special attention to women who have been victims of rape."

29. In 2019 the district attorney for Tucumán brought charges against a 14-year-old girl who had a home abortion; when it was impossible to legally prosecute her, the investigation continued against her parents. The same thing happened in 2021 against another girl of the same age. The common denominator in both cases, aside from **the criminalization of the girls and their close relatives**, was the abuse of "criminal" category, in which they were accused of "aggravated homicide by complicity," even though this was not the reality revealed in the forensic exams and other evidence collected in both investigations. These **punitive assaults on obstetric events**, in addition to constituting a strong gender bias in state prosecution and disregard for international recommendations,[19] dissuade in the short and long term the decision to seek health care in the event of adverse obstetric events. In the first case, the parents spent 29 days in pre-trial custody and, even though they were acquitted, the stigma on their lives continues due to the media publicity generated by the district attorney's office.[20]

30. It is important to highlight that **in the Argentine criminal system, both girls are unimputable**. For this reason, the criminal prosecution of the girls – even if they had been at the center of provoked obstetric events – is an even graver violation of rights.

31. We understand that **the criminalization of abortion constitutes forms of torture, inhuman and degrading treatment**, at any link in the chain. It is necessary that doctors be able to work and fulfill their social role without running the risk of being criminally prosecuted. These judicial processes have disciplinary effects and must call upon authorities to guarantee access. Furthermore, they reinforce the stigma attached to a health service.

32. As for criminal cases against those who had abortions prior to the abortion law being passed, the Executive Power (despite its commitment to monitor, promote the closure, filing, dismissal or modification of the sentence based on the most benign application of the criminal law) has not intervened or actively participated in a solution. Nor has it disseminated or compiled data on the period after legalization. The lack of data makes it difficult to assess the law's evolution and demand the dismissal of these cases. It is essential that the State follow up on these open cases, because the criminal policy had a selective bias against the poorest women, with other rights violated and few material and symbolic tools at their disposal.

[19] See A/HRC/37/5 recommendation 107.111 "Adopt measures to ensure that no woman or girl is subject to criminal sanctions for having an abortion; apply all methods necessary, including legal ones, so that in no circumstances a woman or girl can be prosecuted for having requested or obtained an abortion."

[20] File N° 64581/19

33. Despite the lack of data, we were able to ascertain from civil society organizations that in the national courts – which handle abortion crimes in the Autonomous City of Buenos Aires – one case was brought after Law 27,610 was enacted, but the person was ultimately acquitted. As for the cases brought before the law was passed, of the 145 characterized as self-induced abortions, abortion with the woman's consent, we learned that 56 were acquitted, five lacked merit and 25 had been dropped. In the province of Corrientes, of 60 abortion cases reported, nine remain "in process", the remaining ones were dropped, ended in acquittal or were dismissed on grounds of exceeding the statute of limitations for prosecution.

34. Nevertheless, other scenarios of criminalization persist with regard to obstetric events not linked to abortion, but are within reach of the stigmatization and the criminal system. These are situations in which the death of a newborn soon after birth – premature, spontaneous, to term – is attributed to conduct by the birthing person. The effect of so many years of criminalized abortion has extended its punitive shadow over any unpredictable situations in the reproductive life of birthing persons. We exposed cases of this type being prosecuted in Buenos Aires, Corrientes, the City of Buenos Aires, Salta, and San Juan. the criminal prosecution of Rosalía Reyes[21] (since absolved) is an example. These cases show severe infringement of the rights of birthing persons in judicial decisions based on prejudice and gender and class stereotypes.

35. Unequal access to an abortion at the federal level, as mentioned, mainly affects women, girls and adolescents of little means. They also bear the burden of punitive consequences in violation of their rights and guarantees. Moreover, the diverse institutions in charge of criminal prosecution and sentencing with their distinct capacities (security forces, district attorney, judicial power, ministries of justice) do not usually coordinate their records or databases.

IV. Forced maternity in girls and adolescents

36. According to the latest available vital statistics for 2020,[22] 1,293 girls under the age of 15 were admitted to a delivery room; 51,967 adolescents ages 15-19 had babies. We still do not have data available for 2021 after the abortion law passed. In light of the new law, it is important that state statistics account for how many births during 2021 were preceded by the request for VIP.[23]

[21] Sousa Dias, Gisele, Parió en el baño, se desmayó y terminó presa: "Dijeron que una mamá tendría que haber sabido cómo cortar el cordón", *Infobae*, 21/12/2020. Available at: https://bit.ly/39ya8xW.
[22] Country vital statistices. National Ministry of Health. Available at: https://www.argentina.gob.ar/sites/default/files/serie5numero64_web.pdf
[23] Mujeres x mujeres, ¿Cuáles son los datos sobre abortos legales después de la ley 27,610?, available at: https://bit.ly/3MVQGJ8.

37. The National Plan for the Prevention of Unintended Pregnancy in Adolescence (Plan ENIA in Spanish) is under the purview of the National Ministry of Health and is being implemented in twelve provinces: Buenos Aires, Catamarca, Chaco, Corrientes, Entre Ríos, Formosa, Jujuy, La Rioja, Misiones, Salta, Santiago del Estero and Tucumán. This plan focuses on reducing teen pregnancy through a school initiative. It concerns us that this initiative is only being implemented in half of the provinces of Argentina and that Comprehensive Sex Education (CSE) is not a priority. Nor is there any clarity on actions to guarantee abortions in advanced pregnancies, which is usually the case when Child Sexual Abuse is detected.

38. The number of reports received from minors on the hotline for the Sexual Health Program doubled from 2020 to 2021. While there were 2,062 calls from girls in 2020, in 2021 – when the abortion law was passed – there were 4,114. The symbolic effect of the law is particularly notable in the strengthening of youth sexual citizenship in Argentina. Regrettably, there are no national or provincial campaigns around these issues.

V. Distribution of misoprostol and other medical supplies

39. The WHO has for years included misoprostol and mifepristone on its lists of essential medicines for their effectiveness when it comes to safe abortions. As essential supplies, they must meet the minimum requirements of availability as well as accessibility and acceptability.

40. Based on data from some provinces and the National Office of Sexual and Reproductive Health (DNSSR in Spanish) on the distribution of misoprostol, we have found that some provinces receive misoprostol treatments from the DNSSR, but many others buy it from their respective ministries of health through a bidding system or direct purchase. In the province of Buenos Aires, distribution is done centrally based on information on consumption of the drug, population criteria, number of providers and number of abortions registered in each health region.

41. At the national level, the DNSSR acquires misoprostol centrally and distributes it to the 24 jurisdictions through the Remediar Program. In 2021, according to official data, the DNSSR made three purchases of misoprostol: one in the framework of an agreement with the United Nations Population Fund (UNFPA) and two through an agreement with the Laboratorio Industrial Farmacéutico (LIF) of Santa Fe. It thus acquired a total of 110,500 treatments (12 pills of 200 mcg) of misoprostol. It likewise brokered a donation of 25,000 treatments with the Fos Feminista alliance (formerly IPPF/RHO) to be distributed in 2022. In November 2021, the agency also initiated a process to acquire 50,000 Combipack treatments of (Mifepristona 200 mg + Misoprostol 200 mcg) through UNFPA to be imported into the country in the second semester of 2022.

42. In June 2022, the DNSSR announced the introduction of a basket of Medabon© combipack supplies, currently sold in countries like the UK, Netherlands and Sweden. Along with the announcement, it published a technical article to systematize clinical recommendations and a memo identifying priority groups to receive the medication and the methodology used to assign treatment quantities for each province. The DNSSR also informed that it had processed a donation of 250 manual vacuum aspiration (MVA) systems through IPAS[24] organization directly to 18 provinces.[25] The Autonomous City of Buenos Aires and the Province of Buenos Aires received direct donations from IPAS.

43. The data indicate that there is a broad, complete supply of misoprostol to cover the demand and that mechanisms are being put in place to guarantee this supply and increase provision. Futhermore, there is notable acquisition of treatments combined with mifepristone and MVA equipment that will improve the quality of these abortion procedures provided by the public health system.

44. Nevertheless, obstacles continue to exist when it comes to the availability, accessibility and acceptability of these essential medicines. Mifepristone has not been authorized in Argentina by resolution of the National Food, Drug and Medical Technology Administration (ANMAT) (the importation of the combipacks was done through a special permit) and misoprostol in pharmacies is expensive and sale conditions very restrictive. All of this in addition to the fact that the main form of access to abortion in the first weeks is through medication.

VI. Access to and production of information

45. As we have highlighted in the report, there continues to be a lack of data production. In Argentina, the federal and provincial governments participate in the production of official information on the health system through different registration systems for compiling and systematizing health data. Also, at the federal level they have produced the ImplementAR report, but recordkeeping errors exist, such as under-registration and lack of disaggregated data. Our meetings with the different provincial programs on sexual and reproductive health revealed that healthcare personnel often do not register abortion procedures in order to avoid harassment from objector staff members; due to the lack of care when it comes to the privacy of clinical histories; to protect users from future stigma from healthcare providers; due to lack of recordkeeping instruments. And in terms of the aggregated data on abortions performed per jurisdiction, without disaggregation we cannot have basic information to establish a baseline to precisely identify the main barriers to access in each jurisdiction and monitor the effective progress in the implementation of the abortion law.

[24] https://www.ipas.org/our-work/partnership/asociacion/

[25] Catamarca, Chaco, Chubut, Córdoba, Formosa, Jujuy, La Pampa, Mendoza, Misiones, Neuquén, Río Negro, Salta, San Juan, San Luis, Santa Fe, Santiago del Estero, Tierra del Fuego and Tucumán.

46. In addition, at the jurisdictional level there continue to be denials of information and restrictive criteria with regard to the duty to produce and publish information on the implementation of Law 27,610. In particular, with few exceptions in which proactive policies for disseminating information have been adopted, the jurisdictions are reticent to actively (or by requirement) publish basic statistical information for monitoring compliance with the abortion law in order to guarantee citizens' access to information andythe right to abortion.

47. There is no uniform was to get data at the federal level. Data is needed on the quantity and evolution of abortions guaranteed in each jurisdiction.

48. There is little available information on the type of procedure used to access abortion. Of the seven provinces that have data, the majority of interventions were with medications like misoprostol, but there is no cross-data for the number of weeks or for level of provider. And there is a lack of data on type of surgical procedure.

There is no public data produced by the State on the actual status of open cases for the crime of abortion prior to the entry into force of Law 27,610. Nor is there any data available on how many births were the result of being denied access to an abortion.

VII. Questions for the State

1. What measures are planned to guarantee abortion care throughout the country?
2. What measures will be adopted to ensure that access to abortion and the health professionals who provide it will not be unduly criminalized?
3. What measures will be taken to ensure the presence of non-objector professionals in public health services at the federal level?
4. What measures will be taken to strengthen healthcare services at all levels to meet the increased demand now that Law 27,610 has been approved?
5. How does the State plan to ensure federal and intercultural access to information on the right to legal and voluntary interruption of pregnancy?
6. How will you ensure the production and publication of complete, accurate, updated, disaggregated and uniform information throughout Argentina on the implementation of Law 27,610, including the network of providers in each jurisdiction to guarantee access to the procedure?
7. What measures have been or will be taken to effectively decriminalize abortion and other obstetric events?

VIII. Recommendations to the State

1. Disseminate throughout federal territory the content of Law 27,610 in a clear and accessible way to health centers, hospitals, strategic public places, websites and official social media outlets, mass media, and coordinate with local health authorities for them to replicate and disseminate the materials in the campaign.

2. In its capacity as guarantor of the right to health and in exercise of its stewardship on the subject, to reinforce the correct application of Law 27,610 by the different jurisdictions in an egalitarian and non-discriminatory way throughout national territory.

3. Promote the provision of training for justice operators and general instructions for the Attorney General's Office that ensure that justice operators abstain from undue criminalization of legal abortions and other obstetric events, as well as health professionals acting in compliance with their obligations under Law 27,610.

4. Recommend to local district attorney offices the production of quality, reliable evidence with scientific rigor in order to avoid the stigmatization of criminal proceedings without solutions.

5. Coordinate with local health authorities to develop mandatory training for administrative staff and health providers (objectors and non-objectors) on the scope of the right to voluntary interruption of pregnancy, conscientious objection, informed consent and duty to preserve confidentiality. Also to healthcare providers, in particular all gynecologists, general and family physicians and residents specialized in techniques for carrying out VIP.

6. To promote the authorization and provision of mifepristone in the suggested dosage throughout national territory.

7. Strengthen the powers of supervision, oversight and enactment of the National Superintendency of Health Services and the Deputy Secretariat of Actions for Consumer Defense with regard to public health plans, private health insurance and private health centers, respectively.

8. Promote hiring health professionals qualified to carry out abortions at the secondary level of care in conditions of safety and respect for the rights of the birthing person.

9. Promote the creation of trans-inclusive, intercultural sexual and reproductive health councils, with healthcare teams trained to provide support for the medical abortion technique or MVA at the primary level of care.

10. Promote the production and publication of complete, accurate, updated, disaggregated and uniform information on the implementation of Law 27,610 throughout Argentina, including the network of healthcare providers in each jurisdiction that guarantee access to the procedure.