

# A Review of Abortion Tourism Conditions in Some Countries with Liberal Abortion Laws and Islamic Countries: A Systematic Review

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#### Abstract

**Background:** Abortion bans, restrictive laws, financial and procedural barriers, criminalization, and punishment-oriented approaches limit access to information about abortion services and increase out-of-state travel to obtain these services. The purpose of this study is to investigate abortion tourism conditions in some countries with liberal abortion laws and in Islamic countries, using a systematic review approach.

**Methods:** This systematic review searched for articles published between 1970 and 2022 in available Iranian and international databases, such as: SID, Magiran, Irandoc, PubMed, Google Scholar, and ScienceDirect, using the following keywords: “induced abortion”, “tourism”, “European”, “Islamic”, and “laws”. The literature search was performed according to PRISMA guidelines. Following the PICO framework, we included studies on women of reproductive age who had traveled for abortion procedures.

**Results:** Of 68 articles identified from European and Muslim countries, 24 met the inclusion criteria and were reviewed. Due to the diversity of conditions and contexts, it was not possible to categorize travel approaches uniformly. Studies showed that young age and first pregnancy, delays in seeking care, concerns about negative attitudes, moral and religious stigma, fear of being judged and mistreated by health care providers, as well as legal restrictions and lack of service availability are key conditions that encourage women to travel for abortion.

**Conclusion:** Abortion laws worldwide, shaped by different political, cultural, social, and religious backgrounds, range from complete prohibition to complete liberalization. To address the rise in abortion tourism, policymakers and planners must develop strategies to respond to these conditions.

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## Introduction

Many Innocent and defenseless babies are aborted, and the numbers continue to rise alarmingly every year. In a world with a rapidly aging population and declining birth rates, current policies may appear to favor this

phenomenon. A society composed solely of the elderly and devoid of children is comparable to a barren desert. Although contemporary movements continue to advocate for women’s rights, the increasing rate of abortions poses concerns about the future generation of women—and men—yet to be born. Humanity threatens

its own existence through abortion, which some view as stubborn and irregular behavior.<sup>1</sup>

One of the important dimensions of abortion involves the big ideological differences among thinkers and policymakers, reflected in a spectrum ranging from “absolute permission” to “absolute prohibition.” Currently, abortion is prohibited in an estimated 25% of countries. However, even in these nations, abortion is permitted when the pregnant woman’s life is at risk. In countries with liberal laws, access to termination of pregnancy may still be limited due to gestational age restrictions, restrictions on the types of facilities authorized to perform induced abortions, and the medical community’s attitudes toward abortion.<sup>2</sup>

According to the World Health Organization (2024), six out of every ten unintended pregnancies globally end in induced abortion.<sup>3</sup> Additionally, the results of Bearak et al. show that, based on World Bank income groups, regional classifications, and the legal status of abortion, there were 121 million unintended pregnancies annually during 2015–19, corresponding to a global rate of 64 unintended pregnancies per 1000 women aged 15–49 years. Of these, 61% ended in abortion, totaling approximately 73.3 million abortions per year.<sup>4</sup>

In Iran, Rashidpouraie et al. (2017), in a survey of 751 individuals in the suburbs of Tehran between 2009 and 2017, reported that about 95 people (4.2%) had undergone illegal abortions.<sup>5</sup> In another study, Alipanahpour et al. examined 5848 births over four months in 2016 and reported 437 legal abortions in Shiraz hospitals, with an overall prevalence of 7.46%.<sup>6</sup> Due to existing legal restrictions in Iran, many induced abortions are performed under unsafe conditions, and women often present to hospitals only after experiencing serious complications. As a result, many cases of induced abortion are never registered or reported.<sup>7</sup>

Although debates regarding the ethical, religious, and legal aspects of abortion persist, many women who undergo abortions report difficulties balancing school, work, and family responsibilities. Western societies increasingly move toward a more secular structure, reducing the authority of political and religious institutions over individuals’ lives and placing greater emphasis on personal autonomy.<sup>8</sup> Fundamentally, differences in abortion laws and attitudes stem from differing perceptions of human life, fetal life, fetal dignity, human rights, and women’s rights.<sup>9</sup>

Opponents of abortion regard the fetus as a potential human being and consider abortion a criminal act. Once the egg is fertilized and implanted in the uterus, the fetus is believed to possess the right

to life, which neither the mother nor others have the right to violate or terminate.<sup>10</sup> However, this right to life is not absolute. In some societies, human autonomy is prioritized, and the fetus’s existence is viewed as dependent on the will of the parents, particularly the mother’s will.<sup>11</sup>

According to Shia jurists, intentional abortion is haram (forbidden), with no distinction made between different stages of fetal development.<sup>12</sup> All major religions of the world regard life as sacred, beginning at conception and ending at death. Abortion is considered an act that interferes with God’s role as the creator and determiner of life and death.<sup>13</sup> Similarly, the Catholic Church prohibits abortion under all circumstances except when necessary to save the life of the mother, a case that is not regarded as morally reprehensible.<sup>14</sup>

Islam is no exception to this principle. The capacity for reproduction in humans and other creatures is viewed as a manifestation of divine power. The life and death of all beings are determined by God’s will and through His ordained means. Therefore, women do not possess the right to terminate their pregnancy or the life of their fetus.<sup>14</sup> Permission for abortion in Islam is limited to specific cases—such as when the mother’s life is threatened, when pregnancy occurs before ensoulment (traditionally believed to occur on the 120th day of gestation), or when the fetus presents with severe abnormalities incompatible with life (Figure 1).<sup>7, 12, 15-19</sup>

#### Abortion Tourism

Today, medical tourism is a complex phenomenon that includes a wide range of patients and medical treatments.<sup>20</sup> Abortion tourism falls within a broader category called “reproductive tourism.” Some authors

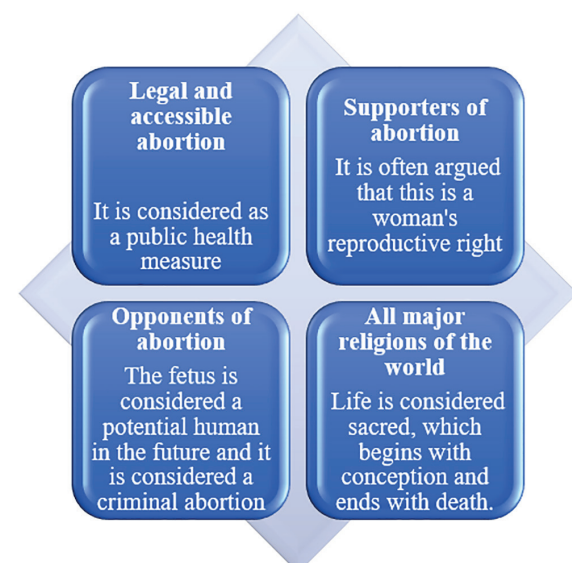


Figure 1: The basis of the difference lies in the perception of human life

argue that this term refers primarily to services such as sperm and egg donation and surrogate parenthood, although it can also encompass abortion, contraception, and vasectomy. Thus, fertility tourism may relate both to achieving pregnancy and, conversely, to preventing or terminating pregnancy.<sup>21</sup>

Abortion tourism refers to travel abroad or to a different state within a country to obtain an abortion when some or all abortion services are not available in the woman's place of residence. Individuals with higher incomes are generally more able to travel. In addition, some authors claim that destination choices are strongly influenced by cost. For example, less affluent Polish abortion tourists tend to travel to Ukraine or Belarus. In contrast, Polish women with higher incomes are more likely to travel to EU member states such as the Slovak Republic, Germany, Belgium, Austria, and the United Kingdom. In 2007, nearly 31,000 Polish women reportedly had abortions abroad.<sup>22</sup>

Such travel may result in physical, emotional, and spiritual trauma that can potentially last a lifetime. Traveling for abortion is a phenomenon driven by differences in abortion laws between neighboring countries. Not only the complete illegality of abortion, but even relatively small differences in legislation can contribute to the development of this phenomenon. For instance, in France, women are permitted to have an abortion up to 10 weeks of gestation, while in Spain, abortion laws allow termination up to 22 weeks. Consequently, French women have become regular clients of abortion clinics in Spain, to the extent that some Spanish clinics have produced informational booklets in French to guide these patients.<sup>23</sup>

Given the diversity of countries to which women travel for abortion, the present study aims to investigate abortion tourism conditions in selected countries with liberal abortion laws and in Islamic countries, using a systematic review approach.

## Methods

### *Study Design*

This study was conducted as a systematic review in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses, Therefore the study was reported in accordance with PRISMA 2009 guidelines.

### *Search Strategy*

Eligible studies were identified through comprehensive searches of the following online databases:

English Databases: PubMed, Web of Science, Scopus, ProQuest, Embase, and Cochrane Library, and Persian Databases: SID, Magiran, and IranMedex.

available Iranian and international databases, including SID, Magiran, Irandoc, PubMed, Google Scholar, and ScienceDirect

Searches were conducted using English keywords such as “induced abortion” [MeSH], “tourism” OR “travel” [MeSH], “European”, [MeSH] “Islamic”, [MeSH] “laws” [MeSH], in combination with non-MeSH terms. Boolean operators (AND, OR) were employed to combine keywords. The search was limited to articles published between 1970 and 2022.

### *Inclusion and Exclusion Criteria*

The search encompassed clinical trials, experimental, quasi-experimental, quantitative, qualitative, descriptive, and review articles published between 1997 and 2022. Studies were included if they addressed induced abortion, tourism related to abortion, or women's experiences with travel for abortion.

Initially, the review focused on five countries known for liberal abortion laws and ease of access for tourism: the United States, England, the Netherlands, France, and Spain. The rationale for selecting these specific countries, despite the wide global dispersion of abortion destinations, was their suitability for tourism, considering cost and logistical factors for women seeking abortions. Additionally, abortion conditions in some Muslim countries, including Iran, Egypt, Kuwait, Tunisia, Iraq, Indonesia, Afghanistan, Bangladesh, and Yemen, were investigated.

Given the limited number of retrieved articles, both full-text articles and abstracts were reviewed. Exclusion criteria included articles presented only at conferences and seminars, as well as letters to the editor.

A total of 68 articles were initially identified, from which 24 were selected for analysis. Notably, no written articles specifically addressing abortion tourism in the selected Islamic countries were found (Figure 2).

### *Search Outcomes*

Initial searches across the specified databases yielded 68 articles. Following the application of inclusion and exclusion criteria and a full-text review, 24 studies were retained for final analysis. A total of 44 studies were excluded during the screening and selection process. The article selection process, adhering to the four-stage PRISMA flow diagram (Figure 1), ensured a rigorous approach to identifying relevant literature. All retained studies met the minimum quality score on the STROBE checklist and were included in the analysis. A comprehensive list of the reviewed studies is provided in Table 1.

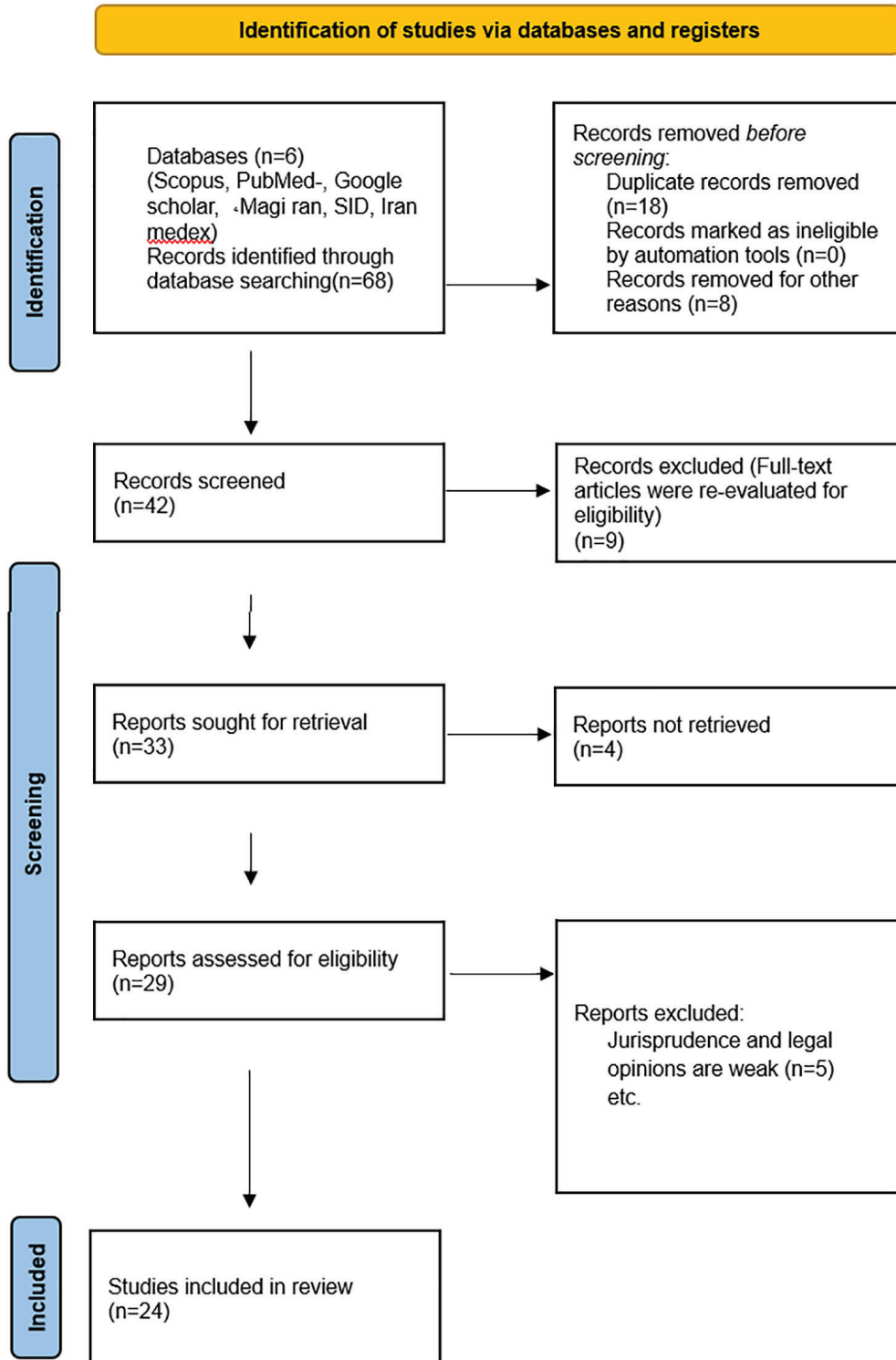


Figure 2: PRISMA Flow Diagram illustrating the study selection and inclusion process

*Quality Appraisal*

The quality of the included studies was independently assessed by two authors using design-specific appraisal tools. Cross-sectional and quantitative population-based studies were evaluated using the STROBE checklist. Qualitative studies were assessed using the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist. Mixed-methods studies were evaluated

using the MMAT (Mixed Methods Appraisal Tool). Descriptive studies were assessed using the JBI checklist for descriptive studies. Systematic reviews were evaluated using AMSTAR-2. Review articles that did not present original data were excluded from the primary analysis and used only for contextual background. All studies meeting the respective minimum quality thresholds were included in the final analysis.”

**Table 1:** Summary of the research background of other countries' articles on abortion tourism

The author year/reference	Country	Main Method	The result/key message of the research
Amandine Jubert. et al (2023) <sup>35</sup>	France	Descriptive, monocentric study	In France, abortion is restricted after 12 weeks, and they usually tend to travel to the Netherlands, where the maximum legal limit is 22 weeks of pregnancy. Besides, young age, first gravidas, and incomplete training of contraceptive methods are among the factors that lead to late abortion.
Camille Garnsey et al. (2021) <sup>33</sup>	England and Wales	Quantitative surveys in Multi clinic	The results show that pregnant women and people from across Europe experienced difficult travel to England and Wales for abortion care, which included different social contexts, describing logistical and financial difficulties.
Fiona Bloomer et al. (2014) <sup>32</sup>	Ireland and Northern Ireland	Review-article	In liberal countries, women have access to abortion pills online. But in Ireland, due to legal reforms and moral conservatism, access to abortion is limited, and it has turned Irish women into abortion tourists to England and Wales.
Abigail RA. Aiken, et al (2017) <sup>55</sup>	Ireland and Northern Ireland	Population-based study	The results of the internet study have shown that remote termination of pregnancy has been a positive and hassle-free experience for mothers and has resulted in the mental health and well-being of women in Ireland.
Rahman A et al.(1998) <sup>2</sup>		Review-article	The comfort and well-being of women in accessing abortion care and services depend on two factors. One of these factors is the laws approved in that country, and the other important factor is the attitude of the medical team.
Kimport K, Rasidjan MP (2023) <sup>56</sup>	United States	Qualitative research (in-depth interviews)	Being forced to travel due to legal restrictions and the unavailability of services will have a significant impact on the emotional aspects and stigma of abortion.
McNamara B. et al (2022) <sup>57</sup>	Western United States, California	Qualitative study and interview	Women travel due to gestational age restrictions at local clinics, medical needs, and cost reduction. Also, the applicant woman had an unwanted pregnancy, they were uncomfortable and regretted having to disclose all their private circumstances.
Harries J. et al. (2021) <sup>58</sup>	Cape Town, South Africa	Qualitative study	Women were aware of the legality of abortion in public clinics, but were concerned about negative attitudes, moral and religious stigma, being judged, and mistreatment by health care providers. The choice of private and non-governmental clinics, even though it caused medical complications after abortion, was made due to the protection of women's privacy and dignity; they felt more humiliated.
Favier M (2018) <sup>59</sup>	South Africa	Review-article	The results showed that a large number of conscientious opponents of abortion from the moral and religious aspect have made it difficult to access legal abortion, which is why they provide the opportunity for women to travel. They will use it if they are active outside the health system.
Lianne Holten et al. (2021) <sup>37</sup>	Netherlands	Mixed methods (Interviews with mother and health provider)	Four problems provide grounds for women to travel outside the residence, being under extreme taboo pressure, negative evaluation by medical personnel, feeling undressed, being under psychological pressure, and physical and mental damage.
Frances Doran (2015) <sup>60</sup>	Developed world	Systematic review -article	lack of access to services (including distance and lack of access to care services), negative attitudes of staff, and costs related to abortion, the context of using telehealth, and methods of referral to alternative providers when staff are morally opposed to abortion
Jenna Jerman et al. (2017) <sup>61</sup>	Michigan and New Mexico	Qualitative approach	While traveling to receive services, women described 5 barriers and 3 major outcomes. Barriers include logistical issues related to travel, Transportation problems, restrictive conditions at the treatment center, financial restrictions, and legal restrictions in the destination state. The consequences of that longer wait, which causes a delay in care, have been the negative impact of the situation on mental peace, and turning to the self-induction method for abortion.
Payal Chakraborty (2022) <sup>62</sup>	Ohio	Descriptive Essay	Ohio's abortion ban has increased travel distances for abortion care, with millions of people traveling to three nearby cities in the US.
Megan L Kavanaugh, et al. (2019) <sup>63</sup>	Michigan and New Mexico	Qualitative approach	We identified two barriers related to logistical information—a general lack of fertility-related knowledge and unhelpful health care community members—and a broader barrier of perceived stigma in respondents' narratives.
Kirsten M. J. Thompson. et al (2021) <sup>64</sup>	27 states, the American Community	Cross-sectional study	Is there an association between median travel distance to an abortion facility and abortion rate? The results of this cross-sectional study showed that there was an inverse relationship between the distance to the abortion service center and the prevalence of abortion. The general policy has been to increase various forms of medical care.

The quality of the included studies was independently assessed by two authors using *using design-specific appraisal tools* the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) checklist. This checklist comprises six main sections: title and abstract, introduction, methods, results, discussion, and other information,

with a total of 22 items. Studies achieving a minimum score of 16 out of 22 were considered acceptable for inclusion in the analysis. Following the STROBE checklist's categorization, which divides the studies into three levels: weak, medium, and strong<sup>1</sup>, studies scoring 70% or higher were classified as meeting the quality threshold for this review.<sup>24</sup>

### Data Extraction

Two authors independently reviewed titles and abstracts of the retrieved articles to identify and exclude irrelevant studies. Subsequently, data were extracted using a standardized data summary form developed by the researchers. This form captured key information, including author(s), study type/methodology, data collection tools, and primary study results. The researchers independently completed the data summary forms, and any discrepancies were resolved through consultation to ensure accuracy and agreement (Table 1).

### Ethical Aspect of Research

Ethical approval was not required, as this systematic review synthesized data from published literature and did not involve human participants or primary data collection.

## Results

Abortion laws exhibit considerable variation across countries, reflecting diverse political, cultural, social, and religious contexts, ranging from complete prohibition to full liberalization. The reviewed literature on European and Muslim countries presented a wide array of conditions influencing abortion-related travel, making a unified categorization of travel approaches unfeasible.

However, several key factors consistently emerged as drivers for women seeking abortions abroad:

- **Demographic and Situational Factors:** Young age (15-25 years), first pregnancy, delayed healthcare-seeking, and the presence of negative attitudes, moral and religious stigma, fear of judgment, and mistreatment by healthcare providers.

- **Access and Legal Barriers:** Legal restrictions and the unavailability of abortion services in the country of residence.

Due to this heterogeneity, the conditions within each country were examined separately. Various factors prevented a unified classification of the results. For instance, dimensions under investigation included:

- **Demographic Characteristics:** Young age, first gravidity (primiparity) or multiparity, age over 35, employment status, and educational level.

- **Access to Contraception and Services:** Availability and use of contraceptive methods, logistical and financial challenges, access to online abortion pills (not universally available even in liberal countries), and mental health and well-being post-abortion.

- **Socio-cultural and Legal Barriers:** Legal restrictions, moral and religious stigma, fear of

judgment, and mistreatment by healthcare providers.

### United States

In 2017, an estimated 65,000 abortions, representing nearly 8% of all abortions performed in the United States, were obtained by individuals who traveled out of state to access care.<sup>24</sup> Historically, abortion was largely illegal worldwide until the late 19th and early 20th centuries. A shift towards liberalization began in many European countries in the early 1950s. In the United States, a landmark decision by the Supreme Court in 1973, *Roe v. Wade*, legalized abortion during the first trimester of pregnancy.<sup>25</sup> This ruling established that a fetus, despite common perception, was not legally recognized as a person.<sup>26</sup>

New York was the second state to permit abortion access and, notably, the first state to allow non-residents to undergo the procedure within its borders. Subsequent studies have explored factors such as the distance women must travel and the geographical areas from which they originate.<sup>27, 28</sup> In 2019, New York further solidified abortion access by approving the Reproductive Health Act. This legislation decriminalized abortion and authorized licensed physicians, nurses, and midwives to provide abortion care up to 24 weeks of gestation.<sup>29</sup>

Hawaii was the first state to legalize abortion in 1970, with 3,643 procedures performed in its inaugural year. Among those seeking abortions, an estimated 20% were teenagers, and 54% were unmarried. The majority of clients seeking abortion services were identified as Caucasian (47%).<sup>30</sup> New York also saw a significant influx of individuals seeking abortions; by 1972, over 100,000 women had traveled to the state for the procedure. More recently, in 2021, approximately 1,400 individuals from Texas traveled monthly to neighboring states such as Mississippi and New Mexico, among others, to obtain abortion care.<sup>31</sup>

### England, Scotland, and Wales

In addition to England, abortion is permitted under specific legal conditions in Scotland and Wales. However, legal restrictions and prevailing moral conservatism in Ireland have historically led women to travel to England and Wales for abortion care, effectively making them "abortion tourists." While detailed information on the specific conditions for abortion care in these regions is limited, abortions for social or economic reasons are permissible up to 24 weeks of pregnancy.<sup>32, 33</sup> In 2018, an estimated 95% of foreign women seeking abortion care within the UK originated from the Republic of Ireland. The remaining 5% traveled from countries including Malta, Poland, Italy, France, Germany, and Denmark.<sup>34</sup> A significant number of women from 14 European countries have traveled to England or Wales for abortion care.<sup>33</sup>

### France

France maintains some of the most liberal abortion laws in Europe, allowing for abortions up to 12 weeks of pregnancy without requiring specific grounds, though this can facilitate seeking care abroad if needed. Travel to Paris to access abortion services has been reported among individuals who can overcome logistical and financial barriers. In 2019, 232,000 abortions were recorded in France.<sup>35</sup>

Despite the general ease of access to abortion and governmental efforts to facilitate it over recent decades, a 5-year study conducted in three Paris hospitals indicated that some women still faced challenging circumstances. These women were compelled to travel within the country to access the necessary care.<sup>36</sup>

### Netherlands

The Netherlands mandates a waiting period for the termination of pregnancy, and abortion seekers often encounter several obstacles. These primary obstacles include societal attitudes framing abortion as taboo, shameful, or sinful; the requirement for correct documentation, such as a Dutch health insurance certificate; proof of a mandatory five-day waiting period (though not statutorily defined); an ultrasound confirming an intrauterine pregnancy and its gestational age; and the necessity of speaking Dutch or English.<sup>37</sup> For women seeking a late-term abortion, the Netherlands offers a suitable option with a legal limit of 22 weeks of gestation.<sup>38</sup> Joubert's review highlights the social and demographic profile of women who experienced delays in France and consequently traveled to the Netherlands. Potential risk factors associated with abortion tourism identified in this context include being between 15 and 25 years old, being single and never having been pregnant, and possessing insufficient knowledge about contraceptive methods.<sup>38</sup>

### Spain

The issue of abortion is multifaceted, eliciting diverse feedback and attitudes shaped by the distinct cultural, religious, and legal frameworks of societies worldwide.<sup>39</sup> Historically, before Spain's progressive legislation, temporary alliances among medical professionals, travel agencies, and fertility/family planning clinics facilitated access to abortion services abroad. Notably, 160,000 abortions among Spanish women were registered in the United Kingdom, and a dedicated air travel route between the two countries was established between 1975 and 1985, underscoring the demand for services at a time when residency was not a prerequisite.<sup>40</sup>

In 2010, Spain enacted a new abortion law, permitting abortions on request up to 14 weeks of

gestation. This law also allowed for abortions up to 22 weeks in cases where the mother's physical health was at risk. Furthermore, it enabled minors aged 16 and 17 to undergo abortions without parental consent, requiring only notification of one parent unless it posed a significant conflict. A subsequent amendment in 2022 removed the requirement for parental or guardian notification altogether.

The 2022 legislation also explicitly prohibits any form of harassment outside health centers targeting women seeking abortions. Before this law, anti-abortion advocates frequently demonstrated near health centers, intimidating women seeking these services. Spain also facilitates international access by permitting individuals residing in countries where abortion is illegal to travel to Spain for the procedure.<sup>41</sup> As of 2023, abortion is legal in Spain, allowing individuals, for the first time, to decide on termination up to the 14th week of pregnancy upon request. In recent years, abortion rates have seen a decline, attributed in part to improved access to emergency contraception.<sup>42</sup>

### Abortion Tourism in Muslim Countries

Approximately one-quarter of the global population comprises Muslims, residing predominantly in Africa and Asia, with a growing presence in Europe and the Americas.<sup>43</sup> Within this demographic, countries like Turkey and Tunisia offer legal abortion services on request. Tunisia, notably, permits abortion up to 12 weeks of pregnancy at the mother's request, a policy that starkly contrasts with many other Muslim-majority nations.<sup>44</sup> While the laws in Egypt, Kuwait, and Tunisia have seen some liberalization, 18 out of 47 Muslim-majority countries, including Iraq, Egypt, Indonesia, Afghanistan, Bangladesh, and Yemen, permit abortion only when the mother's life is endangered by the pregnancy.<sup>45, 46</sup>

In Indonesia, the world's most populous Muslim country, efforts by non-governmental organizations and prominent Muslim groups have contributed to the normalization of the termination of pregnancy in cases posing a threat to the mother's life, a significant step given the country's previously high rates of unsafe abortions. In Pakistan, where an abortion is estimated to occur in the lifetime of nearly every Pakistani woman, the Pakistan Population Council facilitates early uterine evacuation for unwanted pregnancies.<sup>47</sup> Bangladesh permits abortion under the guise of "menstrual regulation," though abortion itself remains illegal.<sup>48</sup>

In 2010, it was estimated that Muslims constituted 23.4% of the world's population. Islamic jurisprudence generally prohibits abortion, and in many Muslim-majority countries, punitive legal views are

incorporated into their criminal laws.<sup>49</sup> Research by Razzak et al. indicates that maternal mortality rates are higher in Muslim-majority countries, often linked to unsafe abortions.<sup>50</sup> Broadly, Muslim jurists perceive abortion as an infringement upon divine authority over life and death. Consequently, restrictions on legal abortion often correlate with an increase in unsafe procedures.<sup>51, 52</sup> Abortion remains prohibited, illegal, clandestine, and unsafe in large segments of the Islamic world. In Iran, as in many developing nations, complications arising from illegal abortions are highly prevalent.<sup>53, 54</sup> A 2014 study by Erfani in Iran revealed that abortion rates were higher among more educated, affluent, employed, urban immigrant, or non-religious women, particularly those without more than one child.<sup>55</sup> While Iranian law and the laws of many Islamic countries include regulations concerning the entry and exit of foreign nationals, specific legislation addressing the objectives of travel for medical procedures like abortion is often absent. This lack of specific regulation allows individuals to travel to utilize legal privileges, becoming a common issue in countries with stringent abortion laws. However, official statistics on abortion in Iran and data on abortion tourism originating from Iran and other Islamic countries were not found (Table 1).

## Discussion

This study aimed to investigate the conditions surrounding abortion tourism, focusing on countries with both liberal abortion laws and significant Muslim populations. The American Convention on Human Rights, established in 1969 and adopted on November 20, 1989, is noted as a unique document that supports the human right to life from the moment of conception.<sup>65</sup> However, like other human rights instruments, this convention also underscores the principles of equal human rights, freedom, justice, global peace, and the protection of children during their formative years.

A central tenet discussed is the prohibition of abortion, rooted in the belief that life, even in its fetal stage, is divinely purposed and deserves protection due to its inherent helplessness. Consequently, preserving fetal life is considered a societal duty and a matter of social law. This principle holds that abortion is generally prohibited unless medically necessary to preserve the life of the mother or to address severe congenital disabilities in the fetus, a stance recognized across various legal systems.<sup>66</sup>

The study highlights that the use of services outside official government systems and legal frameworks is often driven by factors such as social stigma and conscientious objection among some medical professionals. Research by Gerdt et al. indicates that women may opt for the informal sector for abortions

due to experiences of stigma and mistreatment within governmental health centers. This preference for informal services raises concerns about the potential use of ineffective and unsafe methods, which can lead to complications.<sup>67</sup>

In a related study by Izugbara et al., the motivations for women seeking abortions in informal centers or traveling abroad were identified. Key drivers included the desire to maintain their social identity as “good women,” manage social stigma, protect their reputation, uphold respect within their social circles, and safeguard their livelihoods. These findings underscore the critical importance of addressing public health, social dimensions, and the overall safety of abortion procedures. Izugbara further analyzed additional factors influencing women’s decisions to terminate pregnancies outside legal channels. These include recommendations from trusted individuals, perceptions of risk associated with legal procedures, delays in accessing timely care, and economic considerations. An example cited is Zambia, where, despite legal abortion, a lack of awareness leads to significant risks for girls and women facing unwanted pregnancies and abortions.<sup>68</sup>

Studies indicate that mothers seeking abortions often experience high emotional costs, which can be more profound than the financial implications or other aspects of travel. The necessity of traveling for abortion care can induce considerable emotional distress, including stress, anxiety, and shame. This distress is exacerbated by the need to disclose their condition and the experience of being alone in an unfamiliar environment. Legal restrictions and the unavailability of services compel women to travel, significantly impacting their emotional well-being and intensifying the stigma associated with abortion.<sup>56</sup> The concept of “unwanted disclosure” is recognized as a significant emotional burden that often hinders individuals from seeking necessary medical support and services in their destination countries.<sup>57</sup>

Beyond the emotional toll, logistical challenges also complicate abortion travel. Factors such as adverse weather conditions and difficulties in securing reliable transportation can prolong travel times, even for short distances, thereby increasing discomfort and stress. For instance, one account details an 85-mile journey from Indiana to Michigan as both uncomfortable and stigmatizing. While a minority of individuals reported positive experiences, such as the opportunity to explore a new location and maintain privacy, the overall consensus suggests that long-distance travel for abortion is a negative experience. As one participant stated, “The trip made me endure stress, spending money, and other things for no reason, but despite this, it did not stop me from doing the trip”.<sup>61</sup>

A review by Kavanaugh et al. also noted a general deficit in fertility-related knowledge, unsupportive interactions with healthcare providers, and perceived stigma in the narratives of women undertaking such journeys.<sup>63</sup>

Social networks play a crucial role in encouraging women to access abortion care outside official health sectors.<sup>69</sup> In instances where financial obstacles and an unwillingness to use official clinics are present, particularly among young women, there is a preference for self-induced abortions, despite the inherent risks of such methods being unsafe and ineffective. Grossman et al.'s research found that only three out of 23 pregnancies resulted in successful self-abortions.<sup>70</sup>

Overall, women report both negative and positive aspects of abortion travel. A majority of women find the cost of travel and the abortion procedure itself to be substantial. While approximately 53% described the overall travel experience as difficult, another segment, despite acknowledging drawbacks, evaluated it favorably, viewing it as novel and pleasant.<sup>71-74</sup>

Given the wide range of legal, moral, and religious stances on abortion across countries—from complete permissibility to absolute prohibition—safe and quality abortion care remains a critical need in reproductive and women's health. Key considerations for improving care include:

- **Medical Team Awareness:** Healthcare professionals require sufficient knowledge of abortion laws, moral-religious tenets, and penalties for illegal abortions to provide adequate guidance to mothers.<sup>75</sup>

- **Healthcare System Training:** Health systems must be structured to offer safe, non-judgmental, private, and person-centered services.

- **Psychological Support:** Counseling and psychological guidance are essential for mothers, particularly given that stress levels in spontaneous abortions are generally lower than in induced abortions, whether permitted by forensic medicine or not.<sup>76</sup>

- **Addressing Service Limitations:** Restrictions on reproductive healthcare services, especially safe abortion, contribute to stress and anxiety, potentially driving individuals to seek care abroad.

- **Information Dissemination:** Women should be informed about the availability and conditions of abortion services within women's health departments.

- **Education on Unwanted Pregnancies:** Girls and women need comprehensive education regarding

unwanted pregnancies and the dangers of unsafe abortion methods, encompassing medical, moral, and religious perspectives.

For future research, it is recommended to investigate the multifaceted factors influencing abortion tourism. This includes exploring physical, mental, and logistical challenges, such as financial and economic constraints, restrictive legal frameworks, religious beliefs, and the varying levels of tolerance for abortion stigma in destination countries.

## Conclusion

Globally, very few countries permit abortion without restrictions; most allow it with certain limitations. This legal disparity drives individuals to travel to jurisdictions with more permissive laws, a phenomenon particularly prevalent in countries with stringent abortion regulations. For instance, tens of thousands of Irish women annually travel to England for abortions. While no specific data on abortion tourism in Islamic countries, where abortion is generally forbidden without justification, was presented, the text notes that some women opt for informal abortion services even when free formal services are available. This preference for informal care is often attributed to fears of mistreatment and judgmental attitudes from healthcare workers. Seeking abortion services in informal settings or through travel abroad is frequently motivated by a desire for privacy and confidentiality, which are perceived to be more readily available in such contexts.

## Authors' Contribution

FG and AE prepared the first draft of the manuscript. FG made critical revisions to the paper and responded to reviewers.

## Conflict of Interest

The authors declare no conflict of interest.

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