

Access to Safe Abortion: An Essential Strategy for Achieving the Millennium Development Goals to Improve Maternal Health, Promote Gender Equality, and Reduce Poverty*

* Revised title

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Background paper to the report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*

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Ipas is an international nongovernmental organization that works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. Ipas is an NGO in Special Consultative Status with the United Nations Economic and Social Council. For more information, see www.ipas.org.

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I. Introduction

Unplanned and unwanted pregnancies and unsafe abortions are serious public health problems in the developing world for which many governments and international organizations have not yet taken responsibility. Based on WHO estimates of annual deaths due to unsafe abortion, more than three-quarters of a million women have died since 1994, when this issue was first placed on the world's agenda at the International Conference on Population and Development (ICPD). These problems require increased attention and new actions by policymakers responsible for progress toward the Millennium Development Goals (MDGs) of reducing maternal mortality, promoting gender equality and empowering women, and eradicating poverty. Women's ability to regulate their own fertility is critical to the achievement of these internationally agreed goals. Conversely, the persistence of unsafe abortion³ in many countries is a key obstacle to meeting the MDGs.

National laws and policies directly affect women's access to safe abortion. An estimated 61 percent of the world's population lives in countries where laws permit abortion with no restriction as to reason or on broad socioeconomic grounds, with an additional 3 percent in countries whose laws permit abortion on broad physical and mental health grounds. In contrast, 36% of the world's population lives in countries where laws permit abortion only to save the woman's life or to protect her physical health (CRR, 2005b).

Restrictive national laws, particularly in developing countries, result in inequitable access to safe abortion, large numbers of maternal deaths and injuries, and violations of women's sexual and reproductive rights. The women most harmed by restrictive laws and policies are usually those without financial means or social connections: women who are poor, adolescents, survivors of sexual violence, victims of racial or ethnic discrimination, or others in vulnerable circumstances. In some countries, women who undergo abortions and their health care providers are imprisoned, or penalized in other ways. Among those countries where abortion is allowed by law only to save the woman's life or in the case of rape, safe public sector services are commonly not available even for eligible women. Restrictive abortion laws usually also preclude legal recourse for women who are victims of medical malpractice. Some countries with liberal laws also fail to ensure that safe services are available and accessible, leading to millions of unsafe abortions. In sum, the persistence and prevalence of unsafe abortion is a public health, human rights, social justice, and legal issue. Further, just as women have been forced to bear unwanted pregnancies, women in a few countries have been forced or pressured to have abortions, which is also an egregious violation of their rights.

A clear and preferred alternative exists to either of these extremes: many countries have laws in place that respect a woman's right to decide voluntarily whether to continue or terminate a pregnancy, according to her own moral principles, with minimal restrictions. Such laws are

³ Unsafe abortion is defined by the World Health Organization as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both.

implemented and enforced in countries with widely varying religious and cultural traditions with respect to the practice of abortion.⁴ As this paper will maintain, not only are such laws preferable from a pragmatic and health standpoint, but, in accordance with principles of women's human rights, governments have a duty to put such laws in place and take steps to ensure that the laws are fully implemented.

At the international level, governments agreed at the International Conference on Population and Development (ICPD) in 1994 that “any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process.” They settled on an uneasy compromise that “*in circumstances where abortion is not against the law*, health systems should...ensure that such abortion is safe and accessible” (United Nations, 1999).

This paper argues that while making abortion safe where “not against the law” is a very significant positive step, many women still have no access to abortion and are even subject to criminal prosecution and punishment. In this context, **it is not ethically justifiable for leaders in the international community to continue to maintain such a neutral position on abortion laws and policies.** For international leaders to express their views and in other ways advocate for reforms of national laws is consistent with the ICPD understanding. Such advocacy can be done in a way that is respectful of the principle that countries ultimately establish their own laws and policies on abortion, as on other economic, social, and human rights issues.

The purpose of this paper is:

- to analyze the need to reform abortion laws and policies in order to achieve the MDGs,
- to review existing international agreements concerning abortion and to demonstrate the extent of international support for abortion policy reform,
- to review progress toward policy reforms at the national level,
- to identify the key elements of rights-based abortion laws and policies, and
- to define the role of leaders in the international community in promoting informed dialogue on abortion and the legal and policy changes essential to achievement of the MDGs.

II. Abortion and the Millennium Development Goals

Abortion and maternal mortality and morbidity.

Abortion is a very common experience in every culture and society, with an estimated 46 million taking place each year. An estimated 19 million women experience unsafe abortions annually (see chart 1) (WHO, 2004a). WHO researchers calculate that on average, nearly one unsafe abortion will take place for every woman in the developing world (Shah and Åhman, 2004).

⁴ Leaders and practitioners representing the major religions of the world, including Christianity, Judaism, Islam, Hinduism, and Buddhism, evince widely varying – and evolving -- values and beliefs regarding abortion in different circumstances. (Maguire, 2001)

Cumulative number of unsafe abortions per woman by age 44

Worldwide average for women in developing countries: nearly one
Latin America and Caribbean: 0.8
Africa: 0.7
Asia: 0.6

Source: Shah and Åhman, 2004

Based on these WHO figures, it is safe to estimate that well over 100 million women alive today will experience the risk and trauma of an unsafe abortion during their lifetimes if safe services are not made available, and, of these, millions will suffer permanent injury or chronic illness. (In the absence of better data, including the number of repeat abortions, it is not possible to provide more exact information on the number or percentage of women who will have an unsafe abortion in their lifetimes.)

Young women are most seriously affected. Two of every three unsafe abortions globally occur among women 15-30, and 14% are among women not yet 20 years old. The figures are dramatically higher in some regions: 60% of all unsafe abortions in Africa occur among women under the age of 25 (WHO, 2004a).

Chart 1. Global and regional estimates of annual incidence of and mortality due to unsafe abortion, by United Nations region, around the year 2000

	Number of unsafe abortions (thousands)	Number of maternal deaths due to unsafe abortion	% of all maternal deaths
World	19,000	67,900	13
Developed countries*	500	300	14
Developing countries	18,400	67,500	13
Africa	4,200	29,800	12
Asia*	10,500	34,000	13
Europe	500	300	20
Latin America and the Caribbean	3,700	3,700	17
Northern America	--	--	--
Oceania*	30	<100	7

* Japan, Australia and New Zealand have been excluded from the regional estimates, but are included.

-- No estimates are shown for regions where the incidence is negligible.

Source: World Health Organization, 2004a

The target under the fifth MDG calls for reducing maternal mortality by 75% by 2015, which implies the need to reduce unsafe abortion. Although data are limited due to restrictive laws and

poor monitoring systems in much of the developing world, the World Health Organization (WHO) estimates that 13% of all maternal deaths globally are caused by unsafe abortion, or nearly 68,000 annually (WHO, 2004a). For some countries, the percentage of maternal deaths due to unsafe abortion is much higher than this average. Over half a million women will die due to unsafe abortion by 2015 if new actions are not taken. All but a fraction of these deaths could be prevented if unwanted pregnancies were decreased through widespread comprehensive sexuality education and use of modern contraception and if abortion and life-saving postabortion care were provided safely and legally, using known, low-cost technologies.

Most of the countries with restrictive abortion laws are in the developing world, and as a result of such laws, poor health and economic conditions, and other factors, women in these countries are the most likely to suffer or die from the complications of unsafe abortions—97% of unsafe abortions take place in the developing world (WHO, 2004a). Although legal abortion does not guarantee safety in places where providers are not trained or barriers prohibit broad access to services, evidence points to a strong correlation between liberal abortion laws and policies, safer abortion, and lower maternal mortality (Berer, 2004). Maternal deaths in Romania dropped immediately and dramatically after abortion was legalized in that country in late 1989 (WHO, 2004a; Hord, et al, 1991). More recently, evidence from South Africa shows that liberalizing the abortion law resulted in a decrease in abortion mortality of more than 90% between 1996 and 2000 (Jewkes, et al, 2005).

Morbidity from unsafe abortion is an even greater problem, including sepsis, hemorrhage, cervical trauma, uterine perforations, as well as chronic or permanent conditions. Between 10 and 50 percent of women experiencing unsafe abortion will need medical attention, although not all women seek or can find such care when the need arises (AbouZahr and Ahman, 1988). Between 20 and 30 percent of unsafe abortions cause reproductive tract infections, and of these, between 20 and 40 percent develop into pelvic inflammatory disease or bilateral tubal occlusion and infertility (AbouZahr and Ahman, 1998).

Proponents of restrictive abortion laws may assume that the alternative to unsafe abortion is a safe pregnancy and birth of a healthy child. Given extremely high maternal mortality and morbidity in the developing world, however, a woman who carries a pregnancy to term may suffer serious complications, resulting in death or chronic illness, precluding her from having a healthy, satisfying life. She may also incur risks because of denial of the pregnancy or because she cannot or does not use prenatal or delivery care (Cook and Dickens, 2003). Women in the developing world face a risk of death during pregnancy that is many times higher than their sisters in industrialized countries: one woman in every 2,800 will die from pregnancy-related complications in industrialized countries, while one in every 61 women in developing countries face this risk. The risk is even greater at a regional level — one in every 16 sub-Saharan African women will die from maternal causes (UNICEF, UNFPA, WHO, 2004).

Abortion, gender equality, and women's human rights. The ability to decide on a personal matter as important as whether or not to bear a child is essential to women's human rights and has direct implications for the achievement of MDG 3 on gender equality. In the words of Mahmoud Fathalla, former President of the International Federation of Gynecology and Obstetrics, "motherhood should be a dignified, informed, responsible choice...Women are

coerced into motherhood when governments fail to provide them with the information and means to regulate and control their fertility.” (Fathalla, 1995)

Laws that criminalize a procedure sought by tens of millions of women each year reflect continued lack of respect on the part of the State for women’s health, autonomy and self-determination. (Cook and Dickens, 2003) From a human rights perspective, compelling a woman to serve others by bearing an unwanted child is a clear denial of her human dignity and autonomy and an abuse of her reproductive capacities. Further, by taking away a woman’s ability to weigh the moral considerations relevant to the decision to continue or terminate her pregnancy, restrictive abortion laws effectively deny her full citizenship. Only when women have the right of reproductive choice and the ability to control their own fertility can they participate equally in their nation’s social, political, and economic life (Borgmann and Weiss, 2003).

Abortion and poverty eradication. Clearly, the determinants of a woman’s socioeconomic status are varied and complex, and achievement of MDG 1, eradication of extreme poverty and hunger, entails change on a vast scale. In general, however, women who can regulate their fertility, including access to safe abortion, can take advantage of opportunities for education, employment, and political empowerment, and have a greater ability to achieve and maintain overall health and well-being as well as to maintain their productivity and contributions to society. For example, when girls with unwanted pregnancies are allowed to stay in school rather than being forced to drop out, their chances of later gaining an income above poverty level are greatly increased.

Evidence also shows that poor women without access to safe abortion are more likely to turn to unsafe providers and be hospitalized for complications than higher-income women. In Bolivia, a study in 2003 of 201 women who presented with incomplete abortions at 7 public hospitals found that 65 percent were in the lowest income quintile and another 15 percent in the next lowest quintile. (Ipas, 2003b)

By providing safe abortion services, public health systems will save the high costs of treating complications of unsafe abortion in already over-burdened hospital facilities, freeing up resources to address other critical health needs of the low-income populations they serve. One illustrative study from Tanzania estimated that the cost per day of providing postabortion care was more than seven times the annual amount allocated by the Ministry of Health for per capita health expenses (Mpangile et al, 1993). A recent study shows that costs to provide treatment for unsafe or incomplete abortion can run on the order of ten times as high as providing women with early elective abortion services at a primary care level in their community (Johnston, 2004). Shifting the resources that could be saved by legalizing abortion to other essential preventive measures and obstetric care for poor women could go a long way toward improving their reproductive health status and well-being.

Finally, in countries where fertility was historically at high levels, access to abortion has been demonstrated by demographers to be a significant contributor to declining fertility and slower population growth (Bongaarts, 1997). These demographic changes in turn have been shown to facilitate economic growth, poverty reduction, and sustainable development. In the context of

national policies to stabilize population, promoting use of effective means of contraception – as a substitute for abortion – is generally regarded as a desired policy goal. At the same time, while supporting contraception, governments should also ensure access to legal, voluntary and safe abortion.

Access to safe abortion – a social necessity. Increasing use of contraception plays a key role in preventing unintended pregnancy and, over time, in reducing the number of abortions (Rahman et al, 2001). Nevertheless, lack of use or access to contraceptives persists as a major cause of unwanted pregnancy: More than half of all women in the developing world are at risk of unintended or unwanted pregnancy because they are using a method with high failure rates, their method is not regularly available, or they are using no method at all (AGI, 2003). Lack of prioritization of contraceptive supplies in budgets of donor agencies and national governments often results in shortages. Access to emergency contraception, which can prevent unwanted pregnancies, is still widely restricted. And since no contraceptive works perfectly every time, even widespread modern contraceptive use will not completely eliminate the need for abortion. With over 600 million users, small “failure rates” – the number of pregnancies resulting from one year of perfect use of a contraceptive method, such as one-tenth of a percent for male sterilization and 3 percent for periodic abstinence -- translate into nearly six million accidental pregnancies each year (WHO, 2003).

In addition, as the desired family size has grown smaller over the past 30 years, individuals’ desires to limit childbearing have risen faster than the availability or use of contraceptives. In many countries of Africa and South Asia, modern contraceptive use as a percentage of women of reproductive age is only in the range of 10 to 40 percent. In contrast, in the United States, Canada, and most of Northern Europe, more than 70 percent of women use modern methods. (United Nations, 2004). Yet millions of women in these countries also rely on abortion to manage their fertility. Abortion is regarded as a necessary reproductive health service even in countries such as the Netherlands, with widespread sexuality information, good access to contraceptive services, a small desired family size, and abortion rates that are among the lowest in the world. (Berer, 2000).

In sum, women will continue to need access to safe voluntary abortion. Other factors contribute to this need as well: earlier age of menarche and later age of marriage in many developing countries, which often leaves women at greater risk of unwanted pregnancy; increased use of condoms for prevention of HIV and other sexually transmitted infections, which have a higher failure rate than other modern contraceptives; widespread lack of comprehensive sexuality information and education, particularly for young and rural women, or active promotion of abstinence-only education; persistence of coercive sex, including incest, rape and sexual assault as a weapon of war; and women’s continued inability to make decisions about sex and contraceptive use in some places where gender inequality persists (based on Berer, 2000). Some women choose to terminate pregnancies for medical reasons including fetal malformations; pregnancies that can worsen a woman’s health prognosis (e.g., cancer); or pregnancies that are contraindicated due to drugs she is taking to treat medical conditions such as heart disease or HIV/AIDS. As previously discussed, other women find themselves in difficult personal or socioeconomic circumstances that shape their choice not to carry a pregnancy to term and to raise (another) child.

III. International Support for Access to Safe and Legal Abortion

Support is growing among UN, other international bodies, donor governments, and nongovernmental organizations for women's access to safe abortion, including for reform of applicable laws and policies. Selected examples are included here.

Abortion in global agreements. Abortion has been explicitly addressed in a number of intergovernmental agreements concerning health, population, and women's rights:

- 1994 - The ICPD Programme of Action established abortion as a major public health issue.⁵ Governments agreed that abortion should be safe where legal, but that it is up to nations to determine their own laws. Governments also agreed that abortion should not “be promoted as a method of family planning.” While there is no agreed definition of “as a method of family planning,” abortions in cases of rape, incest, and threat to the life or health of the woman should not be considered as belonging in this category. Many reproductive health providers also consider that in making abortion readily available to women, they are not “promoting” abortion as a choice. The ICPD Programme of Action also endorses each individual's right to determine the number and spacing of her children and to have the means to do so (United Nations, 1995a). Exercising this right fully is impossible without access to abortion.
- 1995 - The Fourth World Conference on Women reiterated ICPD paragraph 8.25 and called on governments to consider reviewing abortion laws containing punitive measures against women⁶ (United Nations, 1995b).
- 1999 - ICPD+5, in paragraph 63iii, called for health systems, “in circumstances where abortion is not against the law,” to “...train and equip health service providers and take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health.” (United Nations General Assembly, 1999).

⁵ICPD Paragraph 8.25 reads: “In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly which will also help to avoid repeat abortions.”

⁶Paragraph 106: “Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions [should]:

j. Recognize and deal with the health impact of unsafe abortion as a major public health concern, as agreed in paragraph 8.25 of the Programme of Action of the International Conference on Population and Development;

k. In the light of paragraph 8.25 of the Programme of Action of the International Conference on Population and Development . . . consider reviewing laws containing punitive measures against women who have undergone illegal abortions.”

- 2004 – ICPD was reaffirmed by virtually all governments.

Provisions and recommendations from international human rights documents. Support is growing among UN and other international and regional bodies for women’s access to safe abortion, including for reform of applicable laws and policies. A particularly significant step was the adoption by the African Union in July 2003 of the Optional Protocol on Women’s Rights to the African Charter on Human and People’s Rights. The Protocol entered into force in November 2005, following ratification by fifteen countries in the region, and is the first among human rights treaties to include wording that explicitly recognizes a right to abortion:

“States Parties shall take all appropriate measures to: c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.” (African Union, 2003) (*emphasis added*).

Abortion-related issues are now addressed in a number of General Recommendations and General Comments issued by Treaty Monitoring Committees to interpret human rights conventions:

1) Committee on the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). General Recommendation No. 24: Elaboration of Article 12 (1999)

“Paragraph 11. Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.”

“Paragraph 14: The obligation to *respect rights* requires States parties to refrain from obstructing action taken by women in pursuit of their health goals...Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.”

“Paragraph 31: State parties should also, in particular: (b) Ensure the removal of all barriers to women’s access to health services, education and information, including in the area of sexual and reproductive health ...; (c) Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion; (e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.” (*emphasis added*)

2) International Covenant on Civil and Political Rights, General Comment 28 on the Equality of Rights Between Men and Women; issued by the Human Rights Committee (2000)

Paragraph 10. When reporting on the right to life protected by article 6, States parties should provide data on birth rates and on pregnancy- and childbirth-related deaths of women. Gender-disaggregated data should be provided on infant mortality rates. States parties should give

information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions.

Paragraph 20: States parties must provide information to enable the Committee to assess the effect of any laws and practices that may interfere with women's right to enjoy privacy and other rights protected by article 17 on the basis of equality with men... Another area where States may fail to respect women's privacy relates to their reproductive functions, for example, where... States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion... In these instances, other rights in the Covenant, such as those of articles 6 and 7 might also be at stake... States parties should report on any laws and public or private actions that interfere with the equal enjoyment by women of the rights under article 17, and on the measures taken to eliminate such interference and to afford women protection from any such interference.”⁷ (*emphasis added*)

3) *Committee on the Rights of the Child, General Comment 4 (2003)*

Paragraph 31: “States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents... The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.” (*emphasis added*)

Though not legally binding, concluding comments presented to governments reporting to treaty monitoring bodies increasingly take note of restrictive abortion laws and high maternal mortality from unsafe abortion and call on governments to address these issues (see box).

Selected concluding comments from UN human rights treaty monitoring bodies

Zimbabwe, 1998. CEDAW, para 159. “Noting that illegal abortion is cited by the Government as a major cause of death for women in Zimbabwe, the Committee recommends that the Government reappraise the law on abortion with a view to its liberalization and decriminalization”.

Brazil, 2003: CEDAW, para 126. “The Committee is also concerned at the health condition of women from disadvantaged groups and at the high rate of clandestine abortion and its causes, linked to, among others, poverty, exclusion and a lack of access to information.

Chad, 1999: CRC, paragraph 30: “The Committee ... is also concerned at the impact that punitive legislation regarding abortion can have on maternal mortality rates for adolescent girls... The Committee encourages the State party to review its practices under the existing legislation authorising abortions for therapeutic reasons with a view to preventing illegal abortion and to improving protection of the mental and physical health of girls.”

Chile, 2004: Committee Against Torture, paragraph 6: “The Committee expresses concern about ... reports that life-saving medical care for women suffering complications after illegal abortions is administered only on condition that they provide information on those performing such abortions.” Paragraph 7: “The Committee recommends that the State party should... (m) Eliminate the practice of extracting confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion...”

⁷ Article 6 deals with the right to life; Article 7 addresses the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment, including being subjected without free consent to medical or scientific experimentation; Article 17 of the covenant addresses the right to privacy.

Poland, 2004: Human Rights Committee, paragraph 8: “ The Committee reiterates its deep concern about restrictive abortion laws in Poland, which may incite women to seek unsafe, illegal abortions, with attendant risks to their life and health. It is also concerned at the unavailability of abortion in practice even when the law permits it, for example in cases of pregnancy resulting from rape, and by the lack of information on the use of the conscientious objection clause by medical practitioners who refuse to carry out legal abortions... The State party should liberalize its legislation and practice on abortion.”

Sri Lanka, 2003: Human Rights Committee, paragraph 12: “The Committee is concerned that abortion remains a criminal offence under Sri Lankan law, except where it is performed to save the life of the mother. The Committee is also concerned by the high number of abortions in unsafe conditions, imperilling [sic] the life and health of the women concerned, in violation of articles 6 and 7 of the Covenant. The State party should ensure that women are not compelled to continue with pregnancies, where this would be incompatible with obligations arising under the Covenant (art. 7 and General Comment 28), and repeal the provisions criminalizing abortion.”

Kuwait, 2004: CESCR, paragraph 23: “The Committee takes note with concern of the statement made by the delegation of the State party that abortion is allowed only when the life of the mother is endangered....Paragraph 43: “The Committee recommends that the State party's legislation on abortion include other motives for performing legal abortion with a view to preventing illegal abortion.”

Most recently, the United Nations Human Rights Committee made a significant ruling in 2005 in the case of a formal complaint from a Peruvian woman with an anencephalic fetus who had been denied an abortion by Peruvian authorities and forced to carry the pregnancy to term. The Committee’s ruling stated that the Peruvian government “is required to furnish the author with an effective remedy, including compensation. The State party has an obligation to take steps to ensure that similar violations do not occur in the future.” (United Nations Human Rights Committee, 2005)

Support from international organizations. Explicit expressions of support for access to safe abortion in varying circumstances are increasingly contained in recent health and development strategy documents from various international organizations, although many adhere to the limitations of the ICPD+5 paragraph 63iii (United Nations, 1999). For example:

- In 2003, the World Health Organization issued technical and policy guidance for national health systems to offer induced abortion as allowed by law (WHO, 2003).
- The World Health Assembly endorsed a reproductive health strategy for WHO in May 2004 that states that eliminating unsafe abortion is one of the five core aspects of sexual and reproductive health. The strategy further states: “...unsafe abortion must be dealt with as part of the Millennium Development Goal on improving maternal health and other international development goals and targets. Several urgent actions are needed, including strengthening family planning services...and, to the extent allowed by law, providing abortion services at primary health care level.” (WHO, 2004b).
- UNAIDS and the Office of the UN High Commissioner for Human Rights issued guidelines on HIV/AIDS and human rights that called for access to safe, legal abortion for women living with HIV (United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, 1998).
- The Safe Motherhood Inter-Agency Group, (IAG) composed of a number of international and national agencies focused on improving maternal health, identified as one of the key services to be included: “Abortion-related care, including compassionate counselling and reliable information for women who have unwanted pregnancies, humane counselling and treatment for women who have had recourse to abortion, and safe abortion where not against the law.” (Safe Motherhood Inter-Agency Group, 2002) In September 2003, the Asia regional meeting on unsafe abortion organized by the IAG in Kuala Lumpur addressed the steps required to

- implement the WHO guidance on safe abortion in the region. (Safe Motherhood Inter-Agency Group, 2005)
- The World Bank states that “For women who resort to abortion to end an unwanted pregnancy, it is important that abortion services are safe and also that post-abortion services are provided, including guidance on contraceptive methods to avoid further unwanted pregnancies.” (World Bank, 2002) More recently, the World Bank issued a report on the Millennium Development Goals estimating that safe abortion could reduce maternal mortality by 16 percent. (World Bank, 2004)
 - The Task Force on Child Health and Maternal Health of the UN Millennium Project stated in regard to abortion that “...governments and other relevant actors should review and revise laws, regulations, and practices that jeopardize women’s health.” (United Nations Millennium Project, 2005)

Support from representatives of donor and developing country governments.

- The United Kingdom Department for International Development issued in 2004 a maternal health strategy that includes safe management of unwanted pregnancy as one of the three key interventions: “Where legal, safe abortion services should be provided.” (DFID, 2004) More recently, in 2006, DFID announced its support of an initiative of the International Planned Parenthood Federation, a new Global Safe Abortion Programme. In the words of International Development Minister Gareth Thomas, “We know from experience that the absence of sexual and reproductive health services results in an increase in unintended pregnancies and, inevitably, a greater number of unsafe abortions.” (DFID, 2006)
- The Swedish International Development Cooperation Agency (Sida) issued in 2004 an evaluation of Sida’s role in sexual and reproductive health and rights, stating that “Sweden is perhaps the strongest voice advocating for medically safe abortions, quality care for abortion-related complications, the liberalisation of abortion laws and the decriminalisation of women who have undergone illegal abortions.” (Sida, 2004, p. 59)
- The Minister for Development Cooperation of the Netherlands Ministry of Foreign Affairs, Agnes van Ardenne, called attention in a 2003 speech to the importance of reproductive choices, including a wide range of affordable contraceptives, and further stated that “access to safe abortion, as a last resort, has to be part of the full package of services.” (van Ardenne, 2003)
- The Ministry for Foreign Affairs of Finland, in a statement on sexual and reproductive health and rights issued in 2001, maintained that reproductive health care includes “the opportunity for safe abortion in line with the legislation of individual countries,” adding that “the last-mentioned formulation refers to the fact that it is not regarded as possible to force countries to permit abortions within the context of their own legal systems.” (Finland Ministry for Foreign Affairs, 2001).
- Parliamentarians from 90 countries at the 2004 International Parliamentarians Conference on the Implementation of the ICPD Programme of Action called for “high priority to efforts to reduce maternal mortality and morbidity and unsafe abortion in line with WHO’s *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003), both as a public health issue and a sexual and reproductive rights concern.” (Inter-European Parliamentary Forum on Population and Development, 2004)
- In January 2006, parliamentarians from Finland and Baltic countries attending the Finnish-Baltic Round Table on Development and Sexual and Reproductive Health and Rights issued the Riga Parliamentary Statement of Commitment, stating in part, “We, Parliamentarians commit ourselves to the following actions: Mobilize support for legislation, regulation and funding for comprehensive reproductive health services, including acceptable and affordable family planning, and for women to have services that enable them to go safely through

- pregnancy, have a safe delivery and post partum period, or a safe abortion.” (Riga Parliamentary Statement of Commitment, 2006)
- The West African Health Organisation (WAHO), a specialized agency of the 16-member Economic Community of West African States (ECOWAS), decided in 2004 to include attention to safe abortion in its strategy to reduce maternal mortality. (West African Health Organisation, 2004).

Support from nongovernmental organizations. Numerous NGO conferences and professional associations have addressed the issue of unsafe abortion and issued declarations or policy statements endorsing changes in abortion laws and policies and/or the importance of women’s access to safe and legal abortion. Selected examples follow:

- Recommendations for Sexual and Reproductive Rights issued by the Latin American Federation of Obstetrical and Gynecological Societies (FLASOG) at its XVII congress include a call for the development of guidelines for ensuring that women who meet legal requirements have easy access to abortion, for the development of guidelines to facilitate quick authorization where legal requirements are met, and for reliance on the woman herself to determine when a pregnancy presents a risk to her life or health when the law does not penalize abortion in those circumstances. (FLASOG, 2002).
- The Addis Ababa declaration, emanating from a regional conference on abortion held in March 2003, calls for advocacy to reduce the impact of unsafe abortion, increased funding to address unsafe abortion, review of restrictive abortion laws, expanded access to safe legal abortion, and specific attention to unsafe abortion as a strategy for achieving MDG5 (Action to reduce maternal mortality in Africa, 2003).
- The statement on Induced Abortion for Non-Medical Reasons issued by the Committee for the Ethical Aspects of Human Reproduction and Women's Health of the International Federation of Obstetrics and Gynecology (FIGO), recommends access to legal, safe, effective, acceptable and affordable methods of contraception; that after appropriate counseling, a woman has the right to have access to medical or surgical induced abortion and the health care service has an obligation to provide such services as safely as possible; and states that a woman's right to autonomy, combined with the need to prevent unsafe abortion, justifies the provision of safe abortion (FIGO, 2003).
- A global petition signed by over 160 NGOs from more than 36 countries as part of the ICPD at Ten process calls on all members of the international community to recognize unsafe abortion as a human rights and social justice issue and to remedy this injustice by ensuring access to safe abortion services to the fullest extent allowable by law, as well as to safe and effective contraceptive choices (Ipas, 2004).
- Forty religious leaders representing Christian (Protestant and Catholic), Jewish, Muslim, Hindu, and Buddhist faiths issued the Chiang Mai Declaration, which stated that: “Given the moral concern about abortion and the range of stances toward it, the view of any particular religious tradition should not be imposed on the consciences of others. Decriminalization of abortion is a minimal response to this reality and a reasonable means of protecting the life and health of women at risk.” (Peace Council, 2004)
- The final declaration of the London Countdown 2015 Roundtable, attended by 600 individuals from 109 countries, says in part, “We cannot end poverty without equitable access to sexual and reproductive health and rights...We want a world where women and girls do not die in childbirth and pregnancy; where they have access to safe and legal abortion; and where women and men can decide freely and responsibly whether and when to have children.” (International Planned Parenthood Federation, 2004).

IV. National Abortion Policies: An Overview of Progress toward Legalization

Abortion laws and policies at the national level. Abortion laws in developing countries were derived almost wholly from the laws of their European colonizers, and generally did not reflect local customs or practices at the time they were imposed. Most of these European nations have long since liberalized their own abortion laws. Globally, 11 countries have liberalized their abortion laws in fairly significant ways since 1995: Albania, Benin, Burkina Faso, Cambodia, Chad, Ethiopia, Guinea, Mali, Nepal, South Africa, and Switzerland (Center for Reproductive Rights, 2005a). The context for these changes varies: in Ethiopia, the change in the abortion law was undertaken as part of a revision of the Penal Code to conform to the 1994 Constitution; with unsafe abortion known to be a leading cause of maternal deaths, public health considerations were foremost. In Nepal, the abortion law was liberalized in 2002 as part of a sweeping women's rights bill. In South Africa, the post-apartheid drive for equality and human rights laid the groundwork for the 1996 Choice on Termination of Pregnancy Act.

In addition to these examples of legal reform, advocacy for more liberal abortion laws is increasing in numerous countries, including Argentina, Brazil, Colombia, Indonesia, Jamaica, Kenya, Mexico, Mozambique, Nigeria, Trinidad/Tobago, Uganda, and Uruguay. Advocacy efforts are often led by broad-based coalitions that may include health care professionals who treat women suffering the consequences of unsafe abortion, women's groups fighting for recognition and implementation of reproductive rights, and governmental actors who are interested in updating laws to reflect best practices in human rights and public health (Hessini, 2005).

Safe abortion is clearly an issue of social and economic justice. Even in countries with restrictive laws, women with means are able to obtain safe abortions; poor women are at much greater risk of recourse to unsafe abortion. (WHO, 2003). Moreover, the legality of abortion runs parallel with the economic power of nations, with the relatively restrictive laws in the poorest countries and the relatively liberal laws in more industrialized nations. Major exceptions include China, where abortion is legal and widely available; India, where the abortion law is relatively liberal but inadequate practice and lack of knowledge of the law result in more unsafe than safe abortions; and poor countries that have recently liberalized their laws such as Nepal and Ethiopia.

Where abortion laws are restrictive, explicit regulations or guidelines seldom exist for determining exactly which abortions are permissible under those laws. For example, laws that allow abortions only in cases of "risk of serious harm to health" seldom define what constitutes such a risk, who decides, and what are the procedures for authorizing an abortion in the particular case. The lack of clarifying guidance exacerbates the tendency for health professionals to consider all abortions illegal, keeps abortion clandestine and expensive, discourages training of providers in how to do safe abortion procedures, discourages discussion about when and in what circumstances abortion is available to women, leads inevitably to little or no provision of legal services, and results in preventable deaths and injuries when women seek unsafe abortions outside the formal health system. (Cook, Dickens and Fathalla, 2003)

An even more difficult situation for providers exists where laws prohibit abortion under all circumstances, even to save the life of the woman. Generally, criminal law permits the “defense of necessity” in cases where the commission of a crime avoids a greater evil. (Rahman, Katzive, and Henshaw, 1998). Lawyers specializing in reproductive rights believe that the defense of necessity means that abortion should be considered legal everywhere at least to save the pregnant woman’s life, and a provider should not be convicted of a crime if he or she performed the abortion under such circumstances. Neither provider nor women are well-informed, however, about the defense of necessity.

In recent years a number of governments have issued or begun developing clear guidelines for legal abortion services, often based on the 2003 WHO guidance on safe abortion (WHO, 2003). Brazil, Ethiopia, India, Moldova, Mongolia, Nepal, Romania, Thailand, and Vietnam are among these. Ghana is also taking steps to familiarize providers with the health indications for which abortion is legal under Ghanaian law. Brazil and Mexico are among the countries that have developed guidelines for provision of safe abortion specifically to survivors of sexual violence.

Opposition to abortion law reform. Opponents of abortion are increasingly organized at a global level. They are active in seeking to influence national debates, as evidenced recently in Uruguay, Kenya, Ethiopia, and Nicaragua. Some countries have adopted more restrictive laws in recent years, such as El Salvador, Hungary, Poland and Russia (CRR, 2005a; Ipas, 2003a). Opposition to abortion comes from different sources, including certain faith-based institutions as well as other political and social movements. Abortion opponents often object to other reproductive rights as well, including access to modern contraception. They seek to have their views enacted in public policy with little tolerance for the beliefs and principles of people of diverse faiths concerning abortion.

IV. Rights-based Abortion Laws and Policies: The Key Elements

A ‘rights-based framework’ is one that bases laws and policies on the principles and norms defined by the international human rights system in order to promote and protect human rights. Governments that embrace abortion laws and policies grounded in human rights principles would:

Support a woman’s autonomy in deciding whether to continue or terminate a pregnancy. Many restrictive abortion laws allow exceptions only for rape, incest, fetal abnormality, or risk to the woman’s physical health or life. Such laws reflect a lack of respect by the State for women’s rights to autonomy and bodily integrity and their rights to decide whether and when to have children. Additionally, such restrictive laws do not respect the range of important reasons women decide to terminate pregnancies. Studies show that women seek abortions primarily to limit childbearing, to resolve personal/relationship problems, or for socio-economic reasons (see box) (AGI, 1999; Rogo et al, 1999).

Minimize procedural and administrative barriers. Even laws that permit abortion in broad circumstances often place additional procedural or administrative barriers on access. Such

barriers may delay or prevent a woman from receiving care, thus increasing risks to her health. Common barriers include mandatory waiting times and biased counseling requirements; third-party notification or authorization requirements; limitations on the abortion methods available; excessive limitations on pregnancy terminations later in gestation; and regulations that are not evidence-based regarding who can provide abortion services and where they can be offered (WHO, 2003; CRR, 2004; Hord, 2001). WHO recommends against regulatory and administrative barriers to abortion access and states that the gains to public health by the removal of such barriers are likely to be considerable (WHO, 2003).

Requirements for spousal or parental consent can be particularly troublesome. Most can agree on the value of a woman being supported in her decisionmaking by her partner and her family (or parents in the case of a minor). However, imposing a law or regulation mandating spousal or parental consent to abortion, particularly when no judicial alternative is allowed, can preclude women from seeking or receiving safe abortion care. In the area of parental consent, the Convention on the Rights of the Child and subsequent UN agreements recognize a balance between the rights, duties and responsibilities of the parents and recognition of the evolving capacities of the child (United Nations, 1995a; United Nations General Assembly, 1989; WHO, 2000). This recognition is generally interpreted to mean that if an adolescent is capable of seeking reproductive health care on her own, she should be judged mature enough to make informed decisions without parental consent.

Why women choose abortion

To stop childbearing

I have already had as many children as I want.
I do not want any children.
My contraceptive method failed.

To postpone childbearing

My most recent child is still very young.
I want to delay having another child.

Socioeconomic conditions

I cannot afford a baby now.
I want to finish my education.
I need to work full-time to support [myself or] my children.

Relationship problems

I am having problems with my husband [or partner].
I do not want to raise a child alone.
I want my child to grow up with a father.
I should be married before I have a child.

Age

I think I am too young to be a good mother.
My parents do not want me to have a child.
I do not want my parents to know I am pregnant.
I am too old to have another child.

Health

The pregnancy will affect my health.
I have a chronic illness.
The fetus may be deformed.
I am infected with HIV.

Coercion

I have been raped.
My father [or other male relative] made me pregnant.
My husband [partner/parent] insists that I have an abortion.
Source: AGI, 1999.

Ensure that “conscience” clauses, if enacted, do not impede women’s access to care.

“Conscience” clauses, sometimes also called “refusal clauses,” allow healthcare providers to refuse to provide abortion—and sometimes other reproductive health care—based on their personal moral or religious convictions against involvement in such care. Refusal clauses have been enacted in a number of countries, most notably in South Africa, the United States, and parts of Europe (Bonavoglia, 1999; Guttmacher, et al., 1998; Sonfeld, 2004; Naylor and O’Sullivan, 2005). A human rights approach to protection of conscience balances the rights of the healthcare provider to object with his/her duties to the patient and the patient’s right to non-discriminatory access to care. Conscience clauses normally do not apply in emergency situations, such as when

the woman's life or permanent health is at risk. Providers must also be close to the procedure in order to refuse participation: While the person responsible for preparing the woman or performing the abortion may refuse to provide care due to religious beliefs, those providing general care or booking the procedure, for example, may not. Providers who object to a procedure have a duty to refer to other appropriate providers. At the institutional level, hospitals that serve the public have a duty to employ adequate staff to provide legal health services or have standing referral arrangements. (Cook, Dickens and Fathalla, 2003).

Consider rescinding all criminal laws specific to abortion. A question that deserves more consideration is whether countries even need to have special laws on abortion. Canada had a restrictive abortion law that was struck down in 1988 after it was found to be unconstitutional because of restrictions causing inequitable access to abortion services and the resulting threats to women's right to timely health services and their security of person (Cook and Dickens, 2003). Rather than treating abortion as a matter of criminal law, the most rights-based approach is to treat it as a matter between a woman and her health care provider and leave it to regulation by health authorities along with other medical procedures.

VI. The Role of the International Community

The citizens of each country must determine with their own governments the laws and policies that will apply in their countries, taking into account the relevant principles of public health, human rights, gender equality, and social justice as discussed above. The preceding analysis argues, moreover, that members of the UN system, nongovernmental organizations, professional leadership groups, and other institutions operating at the international level also have critical responsibilities to take a stand on this issue. Such leaders should:

- Promote informed dialogue on abortion as an ethical, human rights and public health issue and on the public policy implications of restrictive abortion laws.
- Advocate for serious and evidence-based reviews of the national situation regarding abortion in every country.
- Advocate for new language to reinforce the ICPD and Beijing agreements and to encourage legal and policy change in this area at the national level, as has occurred in other aspects of sexual and reproductive health: contraception, reproductive health services for adolescents, female genital mutilation, etc.
- Ensure that international donor agencies are implementing existing agreements and guidelines, including the WHO safe abortion guidance; providing financial and technical assistance to countries that request it; and engaging in policy dialogue with governments around the need to address abortion in order to achieve the MDGs.

VII. Conclusion

Much is at stake in the continuing failure of the international community to promote abortion policy reform – the lives and health of millions of women, their families, communities, and nations. The tragic consequences of unsafe abortion are well known, and the evidence and information to inform enlightened policymaking is readily available – from public health, medical, and legal experts; from religious leaders and ethicists; and most important, from women themselves.

Often, the question of abortion is not even openly discussed or raised by policymakers who fear repercussions from those who oppose abortion. A powerful collective response from respected and influential leaders in the international community can prevent vocal anti-abortion minorities from trampling on the lives and rights of women around the world. Strong efforts to develop new political will to advance women's access to safe abortion care should be pursued as part of the global commitment to achieve the Millennium Development Goals.

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