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REAFFIRMING THE RIGHT TO SAFE ABORTION

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Sexual and reproductive rights comprise of rights and fundamental freedoms about our bodies—the most personal realm each one of us possesses. Amongst these rights, a woman's right to safe abortion remains the most heavily contested and the most frequently limited across nations, cultures, and religions.

The right to safe abortion is simultaneously an issue of gender equality, bodily integrity, and personal liberty, and cannot be perceived as a separate right on its own but as one which helps define and clarify all other rights, and contributes to the overall framework on the sexual and reproductive autonomy of individuals.[1] Safe abortion services are required only by girls, women, and those who are biologically born as females, and as such, the denial of such services inflicts death, disability, and psychological trauma only on them. Forced pregnancy by the state denies them the right to decide on the number and timing of children to have, if at all. The state deciding which pregnancies should be carried to term and which need not be, as well as which groups of women and girls may procure safe abortion services for particular reasons and which groups may not, violates personal decision-making on individual reproduction.

Sexual and reproductive health and rights (SRHR) advocates and activists consider the International Conference on Population and Development Programme of Action (ICPD PoA), as a comprehensive, cohesive document on sexual and reproductive health. Yet, it also presents compromises on abortion as seen in the following paragraphs:

- **7.24**, which does not recognise the role of abortion in limiting births;
- **7.6**, which limits service provision to the prevention and management of abortion complications;
- **8.19**, which talks of abortion prevention but not of provision of safe abortion services; and
- **8.22**, which again talks only of service provision to treat abortion complications.[2]

The state deciding which pregnancies should be carried to term and which need not be, as well as which groups of women and girls may procure safe abortion services for particular reasons and which groups may not, violates personal decision-making on individual reproduction.

The compromises of 1994 led to safe abortion being placed with caveats at different policy levels, and the limiting of women's access to services. These compromises continue to haunt us throughout inter-governmental negotiations till today, including for the 2030 Agenda for Sustainable Development.

The work of the Human Rights Committees has helped push the envelope on one of the key shortcomings of the ICPD PoA: "access to safe, legal abortion [is] not recognised as part of reproductive health and rights; [in] deference to national laws; where illegal, [requiring] treatment of complications only."[3] The Committee on Economic, Social, and Cultural Rights has recognised the right to safe abortion as critical to realising gender equality and its denial as gender discrimination in its General Comment 22,[4] while the CEDAW Committee has affirmed that the denial or delay to access safe abortion services is a form of gender-based violence tantamount to torture in its General Recommendation 35.[5] Further, the Committee on the Rights of the Child has recognised access to safe abortion services as essential, especially marginalised groups of women such as adolescent girls, in its General Comment 20 on Adolescents.[6] The UN Committee Against Torture in its reviews on Nicaragua (2009), Paraguay (2011), and Peru (2006 and 2012) found the denial of safe abortion services—especially with regards sexual violence, incest, and foetal abnormalities—and the consequent forced carrying to term of these pregnancies, as a form of torture.

Across the Asia-Pacific region, some progressive changes in laws have occurred since 1994. In 1997, Cambodia decriminalised abortion in order to reduce unsafe abortions and reduce maternal mortality.[7] In 1989, Vietnam legalised abortion and menstrual regulation.[8] In 2002, Nepal legalised abortion without restrictions as to reason during the first 12 weeks of pregnancy.[9] In 2005, Thailand amended and expanded a medical regulation governing abortion, which permitted access to abortion services for reasons of mental health and foetal impairment.[10] In Indonesia, it was only in September 2009 that the law was amended, and stipulating narrowly (within four weeks of pregnancy) that only women

whose lives are in danger or those that have been raped can have an abortion.[11] In 2009, in Fiji, abortion was permitted on socioeconomic grounds or in cases of rape, incest, or foetal impairment.[12]

While we advocates celebrate progress in enabling women to realise their right to safe abortion, we also need to be wary as there are very real, continuous, and insidious attempts to restrict access to safe abortion.

In Asia and the Pacific, countries who championed ICPD in 1994 now have more conservative governments in place who have reversed governmental positions and commitments to ICPD ideals of reproductive rights. These include Bangladesh, Indonesia, Iran, Malaysia, and Pakistan—Islamic countries who are influenced by the Middle Eastern nations, such as Qatar and Saudi Arabia, to join their groups. The caveats in ICPD against abortion have been firmly and consistently held onto, without recognition of the advances in the human rights mechanisms. Additionally, some governments have introduced further restrictions.

Moreover, these new challenges have also been divisive to the feminist movement because they utilise the rights language and pit a number of different rights against women's right to safe abortion. In Asia and the Pacific, the pitting of other rights against the right to safe abortion occurs in four specific areas. All are aimed to whittle down women's rights to and access to safe abortion services. These attempts to restrict safe abortion introduce a discourse within society which powerfully drives and perpetuates abortion stigma.

The first is the rights of the unborn. The belief that life begins at conception is specific to Catholicism, which has been heavily borrowed by other religious fundamentalists. In 2014, in the Philippines, the sole Catholic country in Asia, the Supreme Court sided with anti-choice groups in affirming that life begins at fertilisation.[13] In 2017, Buddhist, Muslim, and Christian religious leaders united to oppose legalising abortion in Sri Lanka[14, 15] when the Cabinet approved the presentation of a bill to parliament to legalise abortion when a pregnancy is due to rape or if a foetus is diagnosed with a lethal congenital malformation. Leaders from these three religions told the government that they all believe that life begins at conception. China, which has had a liberal abortion law, has also seen a burgeoning of "pro-life" Christian groups and Buddhists,[16] who are introducing discourses on forced abortion, and on treating abortion as a sin since life begins at conception.

When the right to safe abortion is presented as contested and reduced by another right, it is imperative that we view access to abortion in a humane and just way.

The second is the rights of the unborn girl child. A number of Asian countries with more liberal abortion laws—such as China, India, and Vietnam—are known for a culture of son preference, and have strong population policies. Sex selection occurs because of the inherent devaluation of girls and women. Both pre-conception and pre-natal sex determination techniques are utilised by couples in these countries in order to have only male offspring, especially in the light of hard-line government policies on smaller family sizes.[17]

However, the issue of eradicating sex selection has been more narrowly focused on sex-selective abortion. India has a national Pre-Conception and Pre-Natal Diagnostics Techniques (PNDT) Act of 1994, and groups call for the stronger implementation of the law especially against abortion service providers. There have been calls in Vietnam for similar laws. In India, this has resulted in abortion service providers becoming more reluctant to provide abortion services, especially within the public sector due to hassles with the law. Low-income women are the ones who are most affected by this development since they are dependent on public health services.[18] This issue has then created deep fissures within the feminist movement on the right to safe abortion. Anti-abortion groups have also joined the sex-selective abortion bandwagon, amplifying the messages of restricting access to safe abortions,[19] but without presenting the nuances of gender discrimination presented by those in the feminist movement. In reality, to reverse sex selection, there need be laws and policies that encourage parents and families to have girl children and overall legal reform recognising equal rights for women and girls within families to help overturn son preference in societies.

The third is the anti-promiscuity rights view. The region is traditionally conservative and pre-marital sex is frowned upon. Usage of contraception and abortion are traditionally associated with promiscuous women, especially if unmarried, and service provision is regarded as encouraging promiscuity in society. In this regard, teenage pregnancies are analysed as the outcome of the low social morals of young women who engage in premarital sex. These young women are presented as then seeking and availing of safe abortion services. The gender inequality is evident as sexually active boys are not labelled as promiscuous and are not usually punished.

This is a discourse reiterated in a number of countries where abortion is accessible. This has been noted in Thailand, where availability of legally safe and inexpensive

abortions is seen as aggravating the problem of teen pregnancy and abortion and encouraging promiscuity amongst students.[20] In Nepal, where abortion laws have been liberalised since 2006, data showing an increase of 42% in abortions and that 70% of these were for young women under the age of 24 have been used as evidence that only promiscuous women and girls need abortion services. There have been demands that access to safe abortion services should, therefore, be restricted, and to amend the law accordingly.[21] In Vietnam, there have been reports in 2016 that pregnant teenagers account for 70% of secret abortions in the country, including repeat abortions.[22]

The last is disability rights. As recently as in 2017, the UN Committee on the Rights of Persons with Disabilities has objected to "fatal foetal impairments" being used as a specific ground for abortion. The Committee said such an approach was risky given there was no guarantee as to whether or not a foetal abnormality was fatal. The recommendation to its sister human rights bodies was to exercise caution when advocating for the right to abortion in these cases.[23] This has also picked up momentum in India,[24] where counselling is suggested as a key intervention for women seeking abortions on the basis of foetal abnormalities.

When the right to safe abortion is presented as contested and reduced by another right, it is imperative that we view access to abortion in a humane and just way. As Marge Berer said, "Women have abortions for only one reason—because they cannot cope with a particular pregnancy at a particular time. This can never be said enough. They may regret the reasons, but this does not alter the fact that abortion is the correct decision for them and necessary in the circumstances of their lives."[25] There can be no compromise on women's right to safe abortion.

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ADVANCING POSITIVE SEXUALITY AND ABORTION RIGHTS BY TACKLING STIGMA

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Research and practice show that challenging stigma is necessary in order for all people to access comprehensive sexual and reproductive health and rights, including access to safe, non-judgmental, quality abortion care.[1] Stigma occurs when individuals are labelled, dehumanised, and discriminated against due to their need for, or association with, abortion. A central part of the stigmatisation process is to label people who need abortions, health-care professionals who provide abortion services, and pharmacists who disperse misoprostol[2] as different and undesirable. These labels can lead to status loss, discrimination, and violence. While abortions are one of the most common medical procedures and can be managed safely by women and a range of healthcare providers,[3] abortion stigma contributes to its social, medical, and legal marginalisation.[4]

How Is Abortion Stigma Produced and Reproduced? Abortion stigma is difficult to isolate as it is produced and reproduced across different levels (including the individual, community, organisational, legal, and structural levels) and is advanced through media and public discourse. Even the language we use for abortion and the images that are associated with abortion reveal stigma. Abortion images often depict the foetus delinked from the womb from which it depends, rather than acknowledging the woman who is pregnant. Entire communities have developed ways of separating, stereotyping, and discriminating against women who need abortions by forcing them to hide their pregnancies and seek care from providers outside of their communities. Legal frameworks create categories of "acceptable" and "unacceptable" abortions. Structurally, abortions have been separated from comprehensive reproductive healthcare services; for example, being excluded from insurance programmes and totally dissociated from contraception.

Stigma manifests itself in different ways and over time. It intersects with personal attributes, geographic location, access to services, the timing of abortion, and other factors. Stigmas can be intersecting for women who come from socio-economic classes and identities that are undervalued by dominant social norms and practices.

Stigma manifests itself in different ways and over time. It intersects with personal attributes, geographic location, access to services, the timing of abortion, and other factors. Stigmas can be intersecting for women who come from socio-economic classes and identities that are undervalued by dominant social norms and practices. Stigma furthermore can be anticipated, perceived, and/or experienced. Some women may anticipate that if they disclose their abortion experience they will be stigmatised, or they may perceive that others judge them. Experienced stigma is what occurs when women are actually discriminated against or harmed due to their need for an abortion or their having had one.

It is important to understand that abortion stigma is never just about abortion, but plays out and attaches to different social issues and debates in our respective societies. In countries that are strongly influenced by Catholic institutions and in the U.S., abortion has become a lynchpin in political debates and culture wars, while in countries where contraception is readily available, abortion stigma may be a form of punishment for women who choose not to or are unable to access contraceptives. In pro-natalist countries, abortions might be stigmatised due to the desire by state powers for women to have large family sizes. Ultimately, abortion stigma is directly related to social and cultural norms related to women's authority, place, and status in society and is a direct way of controlling and subjugating women and limiting their life opportunities.

What Are the Consequences of Abortion Stigma? The consequences of abortion stigma are wide and deep. In countries such as Nigeria, where maternal death from unsafe abortion is exorbitantly high, the public health consequences of women not having access to safe abortions truly is a matter of life or death. Latin America has some of the world's most restrictive abortion

laws—and high rates of maternal death and injury as a result.[5]

Even in countries where abortion is legally available, stigma related to abortion means that most women still have abortions outside the formal healthcare system. In an interview with the Global Fund for Women for an online campaign in 2017 about sexual health and rights, we spoke with grantees about the range of ways their sexual health and rights are limited, including access to abortion. For example, while abortion is legal in Nepal, stigma remains a powerful barrier. Women who seek out abortions are often ostracised "at the family level, the community level, and at any religious functions," says Shanta Laxmi Shrestha, Chairperson of Beyond Beijing Committee. "Unless we address abortion stigma, even though the services are very much available, women who need them will not get them because of the stigma."[6]

What Are Some Strategies Women's Groups Can Use to Address Abortion Stigma? In response to the ongoing assault on abortion access, women's rights organisations are addressing stigma and affecting change at multiple levels. This ecosystem approach is exemplified in the Global Fund for Women's theory of change, which is the framework for our grantmaking and shows the change needed at institutional, structural, social, and individual levels.[7]

At the individual level, our perceptions of abortion are shaped by the words we hear and use. Women's rights organisations have shifted the language to be more about reproductive justice, rights, health, and pro-woman movements. Young people across Europe have reclaimed the narrative of their own abortion experiences in new and innovative ways.[8] The Women's Action Group in Zimbabwe frames abortion in terms of women's access to holistic, quality, and non-judgmental care, including for women with disabilities or marginalised women in hard to reach areas. The Nigerian organisation, Education as a Vaccine, frames its sexual and reproductive rights work within the context of the ability of young people to pursue their life goals and advance their own and their countries' educational and economic well-being. The Asian Safe-Abortion Partnership organises an annual youth advocacy institute that promotes learning, sharing, and strategising across activists who are reframing abortion rights as an issue that is key to their futures and rights.

Stigma is produced and reproduced at various levels of the ecosystem and only a comprehensive approach—reframing harmful language, changing discriminatory policies and practices, and ensuring implementation of quality services—will result in the right to self-determination and abortion access for all.

Discriminatory and punitive abortion laws are major causes of institutional abortion stigma. Laws perpetuate stigma in numerous ways—they create categories of "good abortions" versus "bad abortions" and who can and cannot obtain an abortion. This is non-existent for any other medical procedure. Women's movements have worked to liberalise abortion laws across the globe; Ireland recently liberalised its abortion laws and Chile expanded the legal indicators for abortion.

Working to ensure that abortion care is offered in women-centred ways is also critical to reducing stigma. Semillas, a women's fund in Mexico, works to address aspects of healthcare service delivery that stigmatise certain groups of women, especially those who are young and from disadvantaged social groups. Mexico's Fondo de Aborto para la Justicia Social MARIA seeks to destigmatise abortion by normalising its existence and providing women with easy to access information and care through hotline and in-person consultations. They also provide support for women from states where abortion is legally restricted to travel to Mexico City where abortion is legal.

Decentralising care through informal networks of activists is a strategy used by groups such as Centro Las Libres de Información en Salud Sexual Región Centro AC (Las Libres) in Mexico. Las Libres supplies women with abortion kits to conduct safe, self-induced medical abortions. Self-managed abortions are an innovative strategy led by women-led organisations that allow women to access abortions safely in their homes, reducing stigma, as well as reducing the risk of being criminalised by a medical practitioner who may hand them over to the authorities. The Line Aborto Libre, a collective of feminists in Chile, operates a 24-hour hotline to ensure that women have access to safe abortion information, care, medicine, and counselling. These interventions are centred on the needs of the women and are made to ensure women can safely access abortion services when and where they need them. The Indonesia-based feminist and rights-based organisation, Samsara, promotes the access to education and information on SRHR and safe abortion in multiple languages through apps accessible via mobile phones and tablets.

How to Tackle Abortion Stigma. Stigma is produced and reproduced at various levels of the ecosystem and only a comprehensive approach—reframing harmful language, changing

discriminatory policies and practices, and ensuring implementation of quality services—will result in the right to self-determination and abortion access for all. Linking organisations that work on abortion stigma and other forms of stigma—in the fields of HIV and AIDS, sex worker rights, and LBTQI organising—is also key. Global networks, like the International Network for the Reduction of Abortion Stigma and Discrimination,[9] are also critical for sharing knowledge and strategies, building resistance and resilience, and creating a future where abortion stigma is part of our past.

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MARGINALISED WOMEN AND REPRODUCTIVE RIGHTS: Who Should Mediate Access to Safe Abortion?

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Irrespective of their husbands' desires, Indian women of varying age, education, caste, and class status desire to have small families with two children.[1, 2]

Yet, rural women from lower socio-economic backgrounds, young women, and those from backward and scheduled castes continue to experience unwanted pregnancies, miscarriages, and abortions. Unable to exercise agency over their bodies and denied mobility in public spaces, they are much more dependent on government health facilities due to factors such as financial dependence, poverty, and their husbands' apathy to pregnancy and the reproductive health experiences of women.

Kalaimathi, a 25-year-old scheduled caste woman and a homemaker, is one of these women. She experienced five pregnancies, lost one child immediately after delivery, had a miscarriage at the 7th to 8th month of her pregnancy, and now has two living children. She recollects her experience of abortion:

> *When I was pregnant for the sixth time, I requested my husband to get me [medical abortion] tablets from the medical shop…I just had three days of menstruation after that and did not get my periods again for another two months. The lady doctor scolded me, saying I had lost my senses for conceiving again despite the multiple pregnancies. She scolded me for getting the pills and asked me why I did not get sterilised in the last delivery itself. I told her we were planning but still unsure. She asked me to come again [for the abortion procedure] after two days with Rs.5,000 (USD69.30). We went back to the hospital to ask if they could reduce the cost and as the doctor was not around, a nurse said she could do it for Rs.2,000 (USD27.70). The same evening, my husband managed to pawn my jewellery and got some money. The nurse did it in the hospital itself. It was so painful; much worse than a childbirth. I still have not been sterilised; I am afraid of it.*

In these circumstances, women's autonomy, sexuality, and identity are questioned when seeking abortion services. The state and private providers neglect and deny women's right to have safe and dignified abortion services. Respondents felt that the doctors are

desensitised to their plight. These health providers not only fail to recognise women's subjective experiences, but also tend to objectify them as seekers of sexual pleasure and judge them for their inability to restrict from conceiving. They also thrust the accountability of pregnancy solely on women. According to most respondents, "Doctors cannot possibly understand the circumstances in which these women have become pregnant, mainly by their inability to deny their husband's sexual demands."

Moreover, the doctors were unconcerned about the fears and physical discomfort/pain that women experienced when getting forced contraception, such as IUD (as a prerequisite to providing abortion). Some women referred to the practice of enforcing the IUD by service providers invasive. These contraceptive strategies by the providers make these women—who lack sexual autonomy—more vulnerable as they are forced to face their sullen husbands.

Rural women from lower socio-economic backgrounds, young women, and those from backward and scheduled castes continue to experience unwanted pregnancies, miscarriages, and abortions. Unable to exercise agency over their bodies and denied mobility in public spaces, they are much more dependent on government health facilities due to factors such as financial dependence, poverty, and their husbands' apathy to pregnancy and the reproductive health experiences of women.

Radha, a 35-year-old homemaker who belongs to a backward caste and who agreed to wear a copper-T following an abortion, shared:

> *Most nights, he will scream and curse at me, saying that it is hurting him like a blade when we are having sex. The nurse at the clinic who inserted it after the abortion refused to remove it. After almost bearing three to four months of ongoing abdominal and back pain, prolonged menstrual bleeding, fatigue, and my husband's constant assault, I had to travel to my hometown to get it removed... Eventually, I got pregnant again and had to deliver another girl.*

The doctors who deny abortion also disrespect the women for their decision, hurling abusive language and displaying hostile behaviour. There is also increased apathy and judgement, especially if the woman is from a lower socio-economic background, based on her caste, skin colour/appearance, occupation, language slang, and place/location of residence.

Ponnulatchmi, a 24-year-old labourer from a scheduled caste who is working in the construction sector and is a sexual violence survivor, shares her experience of seeking an abortion at a government hospital:

> *I told the doctor that my husband was cheating on me and was getting married to another woman. He was actually my second husband and I have a daughter from my first husband. I conceived thinking he wanted a child from me, but now he has left me and his mother has fixed another bride for him. It has been 45 days since I got my period. Please do something. The doctor scolded me, saying exactly these words, "You will go and sleep with all men and it is my responsibility to clean your stomach. You people have no other business than getting pregnant."*[3] *Those words hurt me very much. Then after begging her so much, she said, "If you get sterilised, I will do the abortion. I agreed simply for the reason of me being accused as a whore. They got signatures from me and then did the operation. But now...I struggle to raise my daughter all alone as no man will consider marrying me now that I am sterile...*

The shaming and blaming that women undergo in health institutions is a human rights violation. A woman's right to live with dignity is neither recognised by these state actors nor by her family members. The whole continuum of unwanted pregnancy and denial of abortion subjugates the woman to further marginalisation and exclusion.

The Medical Termination of Pregnancy (MTP) Act (1971) gives the authority to medical practitioners to provide induced abortion in good faith based on the woman's actual or foreseeable environment. Yet health providers often give the impression that it is only legal to carry out abortion when there are foetal abnormalities. The provider's general use of the word "healthy foetus," while denying abortion to a woman is a value-laden normative conceptualisation of disability and elimination of "unfit" (unhealthy) people. Such experiences have forced many respondents to believe that abortion is illegal in India for reasons other than foetal anomalies. This is irrespective of the fact that the MTP Act had created some avenues for women to access induced abortion services. These terminologies in the law, which were conceptualised by health service providers, ensure their authority in the decision-making process is maintained, thus systematically removing women's choices and denying them autonomy.

It is true that sex-selective abortion is prohibited in the country. Nevertheless, it is also an experiential understanding from my fieldwork that sex-based foetus personification is also a predominant strategy that doctors use to convince women to continue their unwanted pregnancy. The issue becomes even more complex when healthcare providers attach their personal values and faith-based belief to deny an abortion to women facing unwanted pregnancies.

An instance of this is the story of Kanaka, a 34-year-old rural homemaker with five living children and eight pregnancy experiences:

> *The government hospital does not provide any abortion services! The doctor from the government hospital runs a private clinic where abortion services are provided....Often, if it is in the initial weeks of pregnancy, I request my husband to get the pill from the neighbourhood pharmacy. These pills prove to be effective sometimes and many times the risk prevails! [Meaning the pregnancy is not effectively terminated with the use of self-induced medical abortion pills.] On the other hand, if we go to the government hospital at the district level, they will force us to do an operation [tubectomy] following the MTP!*

These experiences often force many women to seek out the help of unqualified and unsafe providers to induce abortion. When unwanted pregnancy and abortion become part of their day-to-day lived reality, women rely on information from key social networks (neighbours or distant relatives) on access to cheaper and, often times, harmful abortion providers. Many women prefer to go to unqualified providers simply because they do not have to justify themselves, as well as to avoid stigma and judgement.

It is true that sex-selective abortion is prohibited in the country.[4] Nevertheless, it is also an experiential understanding from my fieldwork that sex-based foetus personification[5] is also a predominant strategy that doctors use to convince women to continue their unwanted pregnancy. The issue becomes even more complex when healthcare providers attach their personal values and faith-based belief to deny an abortion to women facing unwanted pregnancies. A retired gynaecologist justified her decision to deny abortion by saying, *"Now I have a grandson, I no longer perform any abortions. Moreover, when we deny abortion, they may decide to continue their pregnancy; I convince and send them back."* Yet another doctor belonging to a higher caste hierarchy reflected on her decision to deny abortion services saying, *"I had vowed to my Guru that I will not perform any such acts as that of abortion...It is a sin!"* Corroborating the story of one of my respondents, the continuous denial and delay in providing abortion by one of the provider resorted to her performing a self-induced medical abortion.[6]

Women who are denied access to safe abortion services are denied crucial aspects of their human rights, most especially their sexual and reproductive rights. The law and policy on abortion should acknowledge historical gender discrimination and active gender discrimination by health providers. Legal abortion provision should be provided to women without any interference of moral judgements, social, religious, and cultural norms. The culpability of the state apparatus in failing to provide easy, informed, safe, and dignified access to abortion pushes women to the margins. It is time that we review the MTP Act and specifically address the issues of denial of women's rights and active discrimination exercised by health providers.

Legal abortion provision should be provided to women without any interference of moral judgements, social, religious, and cultural norms. The culpability of the state apparatus in failing to provide easy, informed, safe, and dignified access to abortion pushes women to the margins.

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1. The experiences of women that are shared in this article are based on the author's doctoral work conducted in a small town called Kumbakonam in Tamil Nadu, South India. The interviews were collected from April 2015 to October 2016.
2. Culturally, families often desire to have one girl and one boy.
3. The men and women working in the construction industry as masons and contractors belong to lower castes; being black-skinned, they are stereotyped to be "sexually loose." Most of the doctors in this locale belong in the higher hierarchy of caste status.
4. In India, the Pre-conception and Pre-Natal Diagnostics Techniques Act makes the act of sex determination of the foetus illegal. This law prohibits active sex determination and abortion of female foetuses, given the cultural preference for boys.
5. When women visit a provider seeking abortion, the provider following a scan convinces a woman not to undergo abortion, whereby she personifies a foetus as a boy and also as healthy.
6. Medical abortion (MA) pill in India cannot be legally obtained as an over-the-counter pill like many other medicines. It has to be sold by a pharmacist through prescription. However, pharmacists sell MA pills mostly (to men) who are local residents located within a particular geographic area around the pharmacy without prescriptions.

THE IMPACT OF THE GLOBAL GAG RULE ON SAFE ABORTION SERVICES:
Sparking a Movement for Safe Abortion

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On January 23, 2017, United States President Donald Trump reinstated the Mexico City Policy or the Global Gag Rule. The policy disqualifies non-governmental organisations (NGOs) from receiving funds if they continue to perform or promote abortions, including offering legal advice or counselling related to abortion. Trump's version of the Global Gag Rule dramatically and dangerously expanded the scope to be applied to all US global health aid, encompassing an estimated US$9.5 billion,[1] to the detriment of millions of women around the world, with only narrow exceptions being possible for cases of rape or incest.[2]

As a response, the then Dutch Minister for Foreign Trade and Dutch Cooperation, Lillianne Ploumen, swiftly announced that women and girls should have the right to choose, and that the Dutch government would step up funding for safe abortion services. This move was rapidly supported by the respective ministries of aid and trade of the Dutch, the Danish, the Belgian, and the Swedish governments, leading to the establishment of the SheDecides initiative. This initiative, launched on March 2, 2017 at the SheDecides conference, was strongly subscribed—attended by 50 progressive governments and by 450 participants from UN agencies, NGOs, and foundations from both sides of the Atlantic.

SheDecides pitched that governments and donors should, in essence, recognise, respect, and enable women and girls to decide and make choices for themselves. This was a pivotal moment as there was a global, inter-governmental response to President Trump's foreign policy. This moment was also based on the premise that women's rights, especially their sexual and reproductive rights, should not be bargained away in political horse-trading. SheDecides helped unify different movements working nationally and regionally, on a range of sexual and reproductive rights and gender equality, and put abortion access at the forefront of these issues. Without compromise.

Women's rights, especially their sexual and reproductive rights, should not be bargained away in political horse-trading.

Every year, 275,288 women die of pregnancy-related complications.[3] In 2014, at least 6% of all maternal deaths (or 5,400 deaths) in Asia were from unsafe abortion.[4] In the Asia-Pacific region, it is estimated that about 35.5 million abortions occur[5] out of the global estimate of 55.9 million abortions, largely due to the sheer size of the population of the region. As a regional average, most abortions in Asia are classified as safe, however, this number is weighted favourably by the numbers in China and Vietnam, where almost all abortions are safe due to expansive laws which enable access. In South Asia, the numbers are reversed, where two-thirds of all abortions are either less safe or least safe.

Already 9.8 million adolescent girls in Asia-Pacific have an unmet need for contraception;[6] one-third of all adolescent pregnancies are unintended,[7] more than half of these end in abortion, and 60% of these abortions take place in countries where abortions are less safe.

Trump's policy hits the poorest nations, which are donor-dependent and have a weak legal system in place. The policy hits hardest the poorest women and the youngest women in every country affected and goes against hard-fought global consensus agreements on women's reproductive rights. Moreover, the policy has shown itself as a failed strategy: curtailing the funding and the activities of organisations that provide modern contraception and safe abortion, which the Global Gag Rule does, may in actual fact lead to an increase in the unsafe abortion rate.[8]

Despite the launch of SheDecides, large funding gaps loom at the global level. For example, Marie Stopes International, which provides contraception and abortion services in 33 developing countries, faces a US$80 million funding gap. They estimate that 2 million women will no longer have access to sexual and reproductive health services. This will result in an extra 2.5 million unintended pregnancies, 870,000 unsafe abortions, 6,900 avoidable maternal deaths, and US$138 million increase in direct healthcare cost.[9]

The full impact of the policy is also difficult to distinguish and predict because it applies to NGOs who receive any US health assistance, not just family planning.[10] As such, the Global Gag Rule

leaves a chilling effect. At the country level, health providers have indicated confusion on implementation, lack of clear guidance on application, over-interpretation of the policy due to fear, and de-prioritisation on integrated health services, which affects the lives of women and girls across many developing countries.[11]

The need for strong platforms and alliances on the ground to push for sexual and reproductive health and rights has never been more essential. The growing threats around women and girls' right to decide over their bodies need a strong pushback. Earlier this year, ARROW and her partners across five countries—Bangladesh, Cambodia, India, Nepal, and the Philippines—initiated the Solidarity Alliance for the Right to Safe Abortion with the aim of working towards liberating abortion laws, while effectively implementing existing laws to increase safe abortion services.

With demand from women and girls on the ground and stronger accountability measures within countries around sexual and reproductive services, developing countries may not have to rely entirely and heavily on inconsistent foreign aid which shifts and dwindles at the snap of a finger. Until all governments realise that they have state obligations to protect women's rights to their bodies, and women's bodies are not theirs to control or to wage war on, we will not be able to realise the full potential of women and girls.

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EVERY WOMAN'S LIFE IS WORTH SAVING:
The Right to Safe Abortion in Asia

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Abortion, safe or unsafe, takes place as a response to unintended pregnancies and is an undeniable part of many women's lived realities. Between 2010 to 2014, globally 44% of the 227 million pregnancies per year were unintended and 56% of unintended pregnancies end in an abortion.[1] There are many well-known reasons and drivers to abortion, including socio-economic reasons, non-readiness, partnership situation, low age, threat to the mother's life, failed or lack of contraception, choices, birth-spacing, the desire to stop having children, changing circumstances, rape, and incest. Making abortions safe and accessible must be prioritised in any reproductive health and rights strategy.[2, 3]

This article shares global and regional estimates on access to safe abortion. It presents a framework for how safe abortion has to be addressed as a rights issue and shares the work of the Solidarity Alliance for the Right to Safe Abortion, a global South alliance for action.

Key Trends. Between 2010–2014, 55.9 million abortions occurred each year, most of which took place in developing regions (49.3 million). Globally, 35 abortions were done annually per 1,000 women aged 15–44, with 36 per 1,000 women having abortions in the developing world.[4] The annual abortion rate in Asia during 2010-2014 was around 36 per 1,000 (married women) and 24 per 1,000 (unmarried women) with 27% of pregnancies ending in abortion.[5] Between 1995-2000, unsafe abortions varied substantially by age across regions, which requires further attention in addressing the effects of unsafe abortion. Within this, adolescents (15–19

years) account for less than 25% of all unsafe abortions in Asia.[6]

Complications from unsafe abortions can lead to maternal mortality and morbidity over the short and long term. Globally, between 2010-2014, 14% of all abortions were least safe. 49% of those in the developing world are considered unsafe.[7] Around 4.6 million women of reproductive age in Asia were treated for complications from unsafe abortion in 2012 and around 6% of all maternal deaths in 2014 were from unsafe abortion.[8]

The consequences of unsafe abortion continue to affect women's mortality and morbidity.[9] Women seek treatment after an abortion depending on legal restrictions and accessibility, often when symptoms have become life-threatening. Some women, particularly poor and from rural areas, may forgo treatment altogether. Annually, 8.2 per 1,000 women of reproductive age were treated in facilities for post-abortion complications in Asia as of 2012. From 2010-2014, in Asia, 62 of 100,000 induced abortions led to death.[10]

The cost of treating these complications adds to the burden of health service budgets, as well as to families and women affected by unsafe abortions. Annually, costs are estimated at US$232 million; costs that would drop to US$20 million if abortions were provided safely. Related costs, such as child care, transportation and others would increase estimates of post-abortion care costs.[11]

The figures for abortion rates and its impact on maternal health and post-abortion care have to be considered together with fertility rates and access to contraception. Available data shows that wanted fertility rates are declining and reflect a wide unmet need for contraception amongst women in unions[12] globally and in the least developed countries.[13]

A Framework for Ensuring the Right to Safe Abortion. Recognising abortion as a human right presents avenues to address barriers and ensure the provision of holistic services. As a result, every woman's needs and circumstances are considered, acknowledging the need to address socioeconomic injustices that contribute to unintended pregnancy and unsafe abortion. Women are supported to make and act on reproductive health decisions freely and safely. Furthermore, drivers of marginalisation, discrimination, and inequalities are identified to be addressed as part of a holistic rights-based solution.[14]

Table 1 presents the interlinked issues, potential barriers and considerations for ensuring abortion as a human right. It includes not only the more clear-cut aspects of ensuring access to safe service, but also shows how barriers can form and change at various junctures. Further, it presents the broad-range of actions that need to be undertaken in the path to ensuring the right to safe abortion.

Global South Alliance. The Solidarity Alliance for the Right to Safe Abortion, launched in 2018, currently comprises six civil society organisations committed to realising the right to safe abortion for all women through strategic interventions that recognise abortion as a rights issue. Bringing the experience and expertise of six organisations from the Global South—Bangladesh (Naripokkho), Cambodia (Reproductive Health Association of Cambodia or RHAC), India (CommonHealth), Nepal (Beyond Beijing Committee or BBC), and the Philippines (Women's Global Network on Reproductive Rights or WGNRR)—the alliance aims to improve evidence on the drivers of unsafe abortion to inform regional and local advocacy and advocate for safer access to abortion.

The Alliance will implement interventions in varied contexts of legality, striving to ensure accountability towards the reproductive rights of women, including young women. Firstly, this will be done by improving awareness on the legality of abortion and availability of services in order to address the barriers that prevent access to some women over others. Secondly, the Alliance will ensure the right to abortion by addressing factors that cause stigma and prevent access to safe services and ensuring autonomy to claim these rights. Thirdly, the Alliance will focus on addressing barriers to access caused by the conscientious objection by service providers that denies services, including referrals. Lastly, it will work towards improving the quality of abortion services, including post-abortion care to help address the impact on maternal mortality and morbidity.

The diversity of Asia and legal restrictions around abortion means that targeted interventions to ensure access to safe services cannot be deprioritised. Efforts such as this come at a critical time, when conservatives in the region are threatening past gains, particularly for those who are most vulnerable, including younger women and those unable to access health services. Access to safe abortion is severely curtailed as a result and tends to be the most marginalised in efforts to ensure sexual and reproductive rights. It is time to change that as part of ensuring human rights for all and in the fight to leave no one behind.

TABLE 1: ISSUES ENCOMPASSED WITHIN THE RIGHT TO SAFE ABORTION

BROADER FACTORS TO CONSIDER:

- Every woman is a rights holder, capable of making informed decisions about her body and life choices.
- How barriers manifest depends on the context and multiple levels of marginalisation of women.
- Women are a heterogeneous group and intersectionality has to be considered.
- Lived realities and experiences of women guide decisions to end pregnancy.

Legislation, Policy, and Programming	Perceptions and Attitudes	Addressing Stigma	Access to Services	Access to Information
• Amending laws including penal codes • Broader legality continuum allowing abortion, including outside the context of marriage • Decriminalisation or conditional access to abortion—gestational period, medical approval, waiting periods, mandatory counselling, and others • Ensuring laws do not leave room for interpretation when implemented • No conflict with other laws on reproductive health • Guidelines for implementation documents of laws to ensure rights-based quality services, including post-abortion care • No third-party authorisation • Removal of third-party punitive actions • Decision rests solely with the woman • Non-use of conscientious objection	• Not influenced and bound by conscientious objection • Addressing social cultural barriers that position women as inferior and within a reproductive role • Enabling progressive narratives of abortion, right to choice, pro-choice, and others • Addressing perception across spheres, including informal (family) • Abortion outside the context of the institution of marriage	• Stigma has many dimensions • Women themselves perpetuate stigma • Women, providers, and advocates face stigma • Fear mongering through stigma • Stigma is dynamic—it changes over time and in relation to the space • Ensuring rights-based interventions to address stigma and its effects	• Follows WHO Technical Guidelines to provide comprehensive care • Abortion services are an integral part of healthcare • Availability and access to quality services, including pre- and post-counseling and contraception • Service provision by a broader range of skilled practitioners • Abortion services are integrated into youth-friendly services • Free of stigma, judgment, discrimination, and violence • Maintaining privacy and confidentiality • Political will and resources to ensure safe service provision • Cost and affordability • Privacy and confidentiality • Post-abortion care	• Availability and access to quality information on bodies, rights, social networks, RH, and abortion • Integration in healthcare services curriculum • Sources of information that are reliable • Accurate information

Sources: Created using Evelina Börjesson, Karah Pedersen, and Laura Villa Torres, Youth Act for Safe Abortion: A Training Guide for Future Health Professionals *(Chapel Hill, NC: Ipas, 2014) and Susheela Singh et al.,* Abortion Worldwide 2017: Uneven Progress and Unequal Access *(New York: Guttmacher Institute, 2018).*

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TELEMEDICINE ABORTION IN RESTRICTIVE SETTINGS:
An Abortion Revolution and a New Velvet Triangle[1]

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Abortion has long been a feverish topic of discussion in different socio-political realms. Amid the ongoing controversy, it has been proven that restricting abortion does not end abortion, but rather leads to unsafe abortion practices. Today, it is estimated that among the 55.7 million abortions that took place between 2010 and 2017, around 25.1 million (45%) were unsafe and potentially dangerous.[2] In effect, each year, unsafe abortion leads to 47,000 deaths and 5 million disabilities worldwide.[3]

As Grimes et al. put it, unsafe abortions appear to be a grave yet "preventable pandemic" since these deaths can be prevented through adequate and efficient provision of safe abortion services.[4] It is in this framework that this article will investigate the advent of medical abortion service provision through telemedicine (online counselling) in restrictive settings. By revealing a ground for safe abortion provision beyond laws, it will demonstrate how telemedicine is promising to change the terms and conditions of safe abortion access in countries with restrictive laws. As such, it will illustrate how women's quest for safe abortion and ensuring anonymity and security has effused online and how they are answered through telemedicine services and transnational feminist activism around it. Finally, the article will discuss how telemedicine can provide an alternative to unsafe abortion and how a new velvet triangle of women, telemedicine, and transnational feminist activism challenges restrictive abortion laws both in short term and long term.

The advancement of medical abortion and telemedicine did not only provide women with an alternative method but also paved the way to redefine the ways in which women access safe abortion.

A lot has changed since the initial demands to control fertility and ensure reproductive justice. Research and scientific development have contributed significantly to engender new terms and conditions for women's bodily autonomy. Medical abortion—abortion with pills—appears to be one of the most remarkable changes. The advancement of medical abortion and telemedicine did not only provide women with an alternative method but also paved the way to redefine the ways in which women access safe abortion. Moreover, this has specific consequences and implications for women living in restrictive settings, who now have a safe refuge in the face of dangerous underground abortions and legal containments. Self-administration of medical abortion and telemedicine has offered women the chance to do abortions on their own in early pregnancies regardless of legal status. As such, it also paved the way to lessen intimidation and stigma around the experience of abortion.

According to Gomperts, medical abortion with mifepristone and misoprostol is "one of the safest procedures in contemporary medical practice, with minimal morbidity and a negligible risk of death."[5] Research has shown that the procedure has few serious complications, which vary from heavy bleeding to incomplete abortion and infection. Medical abortion, with mifepristone and misoprostol, has proven to be 98.3% successful for women with gestational ages below 60 days.[6] Given the low risk of complications and high success rate, the World Health Organization (WHO) affirms that a medical abortion does not need to take place in a hospital or medical clinic; women can carry out the treatment safely and deal with the process themselves at home. The possibility of self-administration of medical abortion carries its potential further, as it empowers women while decentralising the abortion practice from medical circles towards women themselves.

Building on the principle of self-administration, and following previous models of helplines and the advent of the world wide web, internet-based telemedicine services provide help and information in "cost-effective and supportive ways."[7] Today, there are several telemedicine services as such, including Women on Web, Women Help Women, Safe2choose, TelAbortion, and Tabbot Foundation. Some of these telemedicine services work globally across borders, whereas some like Tabbot Foundation (in Australia) works nationally.[8]

Telemedicine services do not only provide safe abortion, but they also transform the abortion rhetoric around what constitutes a "safe abortion." Today, when we talk

about underground or clandestine abortions, it is not the same phenomenon predominant years ago. Scientific evidence shows that women can have medical abortions by themselves at home and this can be counted as a safe procedure when proper instructions are followed. For example, Gomperts et al. concluded that outcomes of care following telemedicine abortion is in the same range as the termination of pregnancy provided in outpatient settings.[9] Moreover, WHO classifies medical abortion obtained through reliable telemedicine services as "safe abortion."[10]

Although restrictive laws drive abortions underground, with the advent of medical abortion and telemedicine services, safe abortion alternatives. It is noteworthy that the website of Women on Web, which went online in 2006, currently has around 2 million unique visitors per year. Women on Web announced during its 10th anniversary that over 200,000 women from over 140 countries did online consultation through its service, approximately 50,000 women received medical abortion at home, and the helpdesk answered more than 600,000 emails.[11] As can be seen through this example, in places where women's only resort are dangerous procedures, unreliable sources, and the black market, reliable telemedicine services provide women with a safe alternative.

Surely, there are limitations to telemedicine services. As technology brings along new opportunities, it also brings risks. The internet is not available everywhere and many women are not internet literate. Moreover, such telemedicine services can easily be censured and/or blocked so that women have no access to them. Even when these services are allowed to operate online, the delivery of the pills might be blocked by the customs and women might face harassment and prosecution. In addition, although these services promise to keep women's information confidential, it is difficult to ensure data security and privacy. Moreover, many of the telemedicine services are pricey, and their sustainability is at risk if they are under-funded and not supported. The black market for telemedicine services make it difficult for women to find reliable and affordable services. Lastly, we need to acknowledge that knowledge gaps could mean that women may need more guidance and reassurance throughout the process, and follow-up may be needed.

By providing safe abortion alternatives in restrictive settings, telemedicine services, on the one hand, respond to women's persistence, and on the other hand, reduce abortion restrictions to absurdity and futility.

Despite these limitations, one can still argue that telemedicine abortion revolutionised access to safe abortion by rendering a significant number of self-managed abortions safe. As such, today it looms large as a key player in the new abortion debates.

However, telemedicine abortion cannot be a solution apart. Indeed, it is part of a larger struggle, which constitutes a new velvet triangle, for increasing access to safe abortion. As long as legal restrictions persist, telemedicine abortion is doomed to remain more of a cause or a strategy than a solution. In fact, telemedicine services can only be effective to foster a real change through a velvet triangle of defiant women who persist on their bodily autonomy and transnational feminist activism who ensure the viability and continuity of such services. Jelinska and Yanow note that services run predominantly by feminist collectives constitute a successful strategy to "disseminate information about using abortion pills for safe abortion and as a vehicle for social change." The study of Aiken et al. on self-reported outcomes after medical abortion through online telemedicine in Ireland[12] suggests the success of telemedicine services in restrictive settings. Aiken denotes that, among 1,000 women who were pregnant less than nine weeks and who received help from Women on Web between January 2010 and December 2012, 94.7% reported successfully ending their pregnancy and only 4.5% reported that they needed further surgical intervention following self-administration of medical abortion. This success rate is noted to be similar to the rates of medical abortions carried out in a clinical inpatient setting and reveals the effectivity of telemedicine and of self-administration of medical abortion. The results are especially significant for restrictive settings and enhance the validity of "strengthening services outside the formal healthcare as a vital component of strategies to reduce maternal mortality from unsafe abortion."[13]

As Petchesky notes, abortion has been among the means which women have resorted with the greatest persistence over time. Indeed, more than the suppression of abortion, it is the persistence of it which grounds "women's specific relation to fertility and the terms and conditions of fertility control and reproductive freedom for them."[14] By providing safe abortion alternatives in restrictive settings, telemedicine services, on the one hand, respond to women's persistence, and on the other hand, reduce abortion restrictions to absurdity and futility. In a press release dated June 21, 2016, Women on Web manifested: "Abortion pills are everywhere!"[15] As the access to safe abortion increases, if not through public health services, but through

reliable telemedicine services, women are less likely to be mere victims of restrictive abortion laws. Women's use of telemedicine services and access to safe abortion in restrictive settings are promising to change the terms and conditions of abortion access both in long term and short term.

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PROVIDER ATTITUDES, PERCEPTIONS, AND CONSCIENTIOUS OBJECTIONS: The Battle between "Right" and Responsibility

in our own words

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Pregnancy is a physiological event that may happen during a woman's reproductive age. Often, this is a happy occasion with positive connotations when the pregnancy is desired. However, some pregnancies are met with medical complications or the pregnancy itself may be undesired. Then negative and emotive perspectives may pervade this event. These perceptions do not only affect the pregnant woman but also the man responsible for the pregnancy (if present), as well as the healthcare provider (HCP) on whose shoulders fall the responsibility of caring for and making decisions about the care of the pregnancy. Needless to say, what happens subsequently will depend on the prevalent health systems, the views of the patient, the partner, the HCP, and the laws of the particular country.

Although abortions can be self-induced, abortion is safer when advice and care are provided by trained personnel in a suitable environment.[1] WHO defines unsafe abortion as a procedure for terminating an unwanted pregnancy "either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both."[2] An analogy can be drawn to maternal mortality where maternal mortality has been reduced when there is skilled attendance at delivery.

Women across the age span experience abortions. Most women who seek abortion are married women, trying to limit their family size or space births because of economic difficulties or other reasons. What defines the perception

of women towards abortion? Their educational level, social status, marital status, the status of women in their community, access to healthcare and contraception, and HCP attitudes towards abortion seekers would all be important determinants of a woman's perception of abortion.

Healthcare providers form an important element of the equation determining women's access to services, as well as the quality of care provided for abortion seekers. Their perception of abortion would be shaped by their own attitudes towards abortion, determined by their upbringing and family values, societal values in which they grew up in, religious and socio-cultural determinants, training provided in medical or nursing schools, their views on contraception, including its provision to unwed mothers, as well as their perception of the laws of the country with regards to abortion. One would also be reminded that aside from national laws, each country's commitment to international policies and covenants on human and healthcare rights relating to non-discrimination and reproductive self-determination would also shape the HCP's perception.

Healthcare providers in any country would be subject to the guidelines and regulations of their own national professional regulatory bodies, such as the medical or nursing councils. Ethical principles that govern the actions of HCPs in any dilemma regarding medical care would include autonomy (the patient who is above the age of majority and who is able to understand what is being informed to her should decide what is to be done), non-maleficence (the HCP's duty never to harm), beneficence (duty to always do good), and justice (always act in the patient's best interest). The principle of deontology (one must always do what is right irrespective of what happens to oneself) is a widely held ethical principle in medical practice reflecting the sanctity of the doctor-patient relationship. The principle of utilitarianism (the breaking of patient confidentiality for the greater good of the community) often does not come into play in the context of abortions as pregnancy and the care of it closely concerns only the woman and her partner.

Ethical principles that govern the actions of HCPs in any dilemma regarding medical care would include autonomy (the patient who is above the age of majority and who is able to understand what is being informed to her should decide what is to be done), non-maleficence (the HCP's duty never to harm), beneficence (duty to always do good), and justice (always act in the patient's best interest).

Conscientious objection has been defined as "the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs."[3] It is compatible with the concept that all healthcare providers have their own set of religious, cultural, and professional beliefs which in the light of the ethical principle of autonomy has to be respected. However, it is also known that communities and nations are governed along the principles of rules, regulations, and laws that are set according to each nation's philosophies and would evolve with the views of the majority or ruling parties. Professional practices in relation to abortion are dictated by the views of the medical councils as well as the laws of the country. In other words, professional behaviour is guided by the views of the peers and community. At the national level, laws and policies are an important tool for assuring the provision of quality services, whether for safe abortion, post-abortion care, or contraceptive provision. Laws may range from total prohibition of abortion to limiting the legal rights to abortion to save the woman's life, to preserve physical health, and preserve mental health, or more liberally to allowing the provision of abortions on socio-economic grounds or without restriction as to the reason. Myths that hinder women's ability to access abortion, such as that the incidence of abortion will be lower if abortion is illegal or that abortion will no longer occur if women have access to family planning, should be addressed and post-abortion care should always be offered.

There has been a debate whether there is a place for conscientious objection in medicine.[4] If there is, then one could deny care that is required and dictated by clinical guidelines to a patient because of a moral objection by the caregiver. Critics of conscientious objection cite the supremacy of patient autonomy and the professional duty of a physician as reasons to oppose.[5] On the other hand, those in favour stress that the morality of the physician is an integral part in the doctor-patient relationship and should not be ignored.[6]

Some have argued that the personal beliefs and morality of the doctor should not enter into medical decision making.[7] Doctors, after all, are human beings with their own set of values and judgements. Conscientious objection takes cognisance of individual variations but one has to ensure that the health service is big enough and has adequate safeguards to ensure access to the patients for procedures such as abortion.[8] Doctors should ultimately agree that they should do what is best for the patient as dictated

by the evidence for any treatment or procedure within the ambit of the laws of the country. The health service should expand more to protect conscientious objection as a concept, while ensuring universal access to healthcare.

Formulation of rules is one thing, observance of them in the rough and tumble of professional practice is quite another. A measure of the integrity of the medical profession can be found in the degree to which each practitioner recognises his personal responsibility for the preservation, through his own example, of the honour and dignity of the profession, and the fact that serious breaches of its ethical code are relatively rare.

Any change of legal status will not bring changes without a political commitment and clear directives to include abortions as an essential component of reproductive health services. This will help to destigmatise the issue to enable universal access to safe abortions for all women a reality.

Physicians may experience conflict between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of patients, proxy decision makers, other health professionals, employers, or other involved parties. Ultimately, the physician has to make his own decision and be able to defend it, if required, in the court of public/professional opinion or a court of law.

The International Federation of Gynaecology and Obstetrics (FIGO) in their statement on Ethical Issues in Obstetrics and Gynaecology put in succinctly their stance in relation to professional standards of care regarding conscientious objection to abortion. While providers have a right to conscientious objection and to not suffer discrimination on the basis of their beliefs, conscientious objection must be secondary to the duty of healthcare providers to treat (i.e., provide benefit and prevent harm to) patients.[9]

Patients have the right to be referred to practitioners who do not object to procedures medically indicated for their care. In emergency situations, providers must provide the medically indicated care, regardless of their own personal beliefs.[10]

Any change of legal status will not bring changes without a political commitment and clear directives to include abortions as an essential component of reproductive health services. This will help to destigmatise the issue to enable universal access to safe abortions for all women a reality.

In conclusion, conscientious objection is an ethical option in the arena of abortion management. However, regulatory bodies should ensure access to management options is not curtailed if the rights of women and men affected by an unwanted pregnancy are not to be infringed by the inclusion of conscientious objection in the regulatory area.

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FROM ANTI-CHOICE TO ABORTION PROVIDER
Reflections of an Abortion Provider

By Anna Maria*

**Name changed to protect the identity and institutional affiliation of the author*

I am personally responsible for hundreds of abortions in a country where abortion is legally restricted. I provide counselling and assist women to have a successful medical abortion. Before I became an abortion provider, however, I hated, even condemned, women who had an abortion, or even those who were considering having one. For me, they were irresponsible, promiscuous women who did not have a conscience and sense of humanity.

What changed my mind from being anti-choice to an abortion advocate and provider?

Well, as much as I want to say that there was one heartbreaking encounter that made me change my mind, the truth is, there was not. It was a process—a long process—of not only getting new ideas but also of unlearning and reshaping the beliefs and values I have.

My first encounter with abortion was with a regional network in Asia that conducts safe abortion discussions. At that time, even though I was against abortion, I listened. I was totally confused after the discussion ended, but I pretended that I understood everything, because it seems everybody was on the same page, except me.

Then, I conducted a research about abortion realities in my country, where I met Sheena (not her real name). At first, I considered her just a case study, but along the way, I felt her pain. She shared with me how she struggled for her life when she suffered from complications of unsafe abortion. She was 17 years old when she got pregnant; too young and not yet ready to raise a child, she had an abortion. Given how restricted safe abortion is in our country, her procedure was performed by untrained providers, in a non-sterile way. She was in pain for days and after the bleeding did not stop, she was rushed to the hospital. The doctors knew she induced an abortion and she was made to wait for hours before she was attended to. The hospital staff scolded her, even threatened her of being reported to the police. Worse, even in the delivery room, she was still verbally abused while the procedure was being performed.

Sheena could not stop her tears while she was reminiscing about this traumatic experience. I could see in her eyes the agony she had to bear. I felt guilty because I was also like those hospital staff that mistreated her. I hated and condemned women who had abortions, without considering what they were going through. I was too blinded by my beliefs to recognise that women like Sheena have suffered because of my prejudices.

With this, I tried to slowly open, not only my mind but also my heart for women who had an abortion. I tried to understand abortion, not based on a judgmental position, but rather as a person and a woman. It was not an easy process, because it was about challenging my personal beliefs and values, which for years have not been questioned.

It was difficult to admit that my perception that “women who had an abortion are irresponsible and immoral” is wrong. However, with the persistence of the advocates who kept on explaining to me the realities of unsafe abortion and how it kills and makes women suffer, my biases and misconceptions were replaced by compassion for women.

It was a long journey before I was finally convinced that abortion is a human right. It took a few years to finally decide to advocate for safe abortion and to provide medical abortion.

As a safe abortion advocate and provider in a country where abortion is heavily stigmatised and penalised, it has never been easy. As a provider, I fear to be caught and condemned, while at the same time, I know this should not stop me from providing the service. So I need to be very careful, especially as what I am doing is just an individual initiative. There is no organisation that would bail me out if I get caught. Aside from the legal penalties, what I fear the most is the stigma from the community. If women who had abortions are viewed as promiscuous, irresponsible, and immoral, abortion providers are perceived worse than these. They are represented in the media as terribly wicked and considered as “killers” of innocent babies. They are the main villain in the whole story of abortion. It is as if providing abortion, even if it is safe, is the most evil thing to do.

But there is always hope. I believe we can change this perception. Because abortion is happening, people are talking about it. It is just a matter of changing the conversation to be more compassionate and respectful of women’s decision over their bodies.

THE IMPACT OF STIGMA:
A Nepali Woman's Experience of Abortion

A 29-year-old, married, educated woman from urban Nepal shares her abortion experience.

Kamala (name changed to protect her identity) was doing her post-graduate degree when she found out she was pregnant for the second time. Although she had access to a range of contraceptives, she was allergic to most of them, thus limiting her contraceptive options. Kamala felt her allergy resulted in contraceptive failure and subsequently led to an unintended pregnancy. She felt she would not be able to take good care of herself and continue her studies if she carried the pregnancy to term and decided to terminate it at six weeks.

Kamala was aware that safe abortion services are available in Nepal, and she knows of the service providers in her area. Being an educated and independent woman, she feels that she was in a position to decide whether or not to continue her pregnancy. However, the process of making this decision was very difficult for her as she feared to face abortion-related complications.

Kamala chose a private abortion service provider in her area with the hope that it would offer a better quality of service and maintain her confidentiality. Although the behaviour of service provider towards her was positive, she was not satisfied with the offered pre- and post-abortion counselling. She was not provided adequate information on what would happen to her body after taking the abortion pills, what complications could arise, and the family planning methods she could use after abortion.

The lack of a separate waiting area in the service centre made her long waiting period even more uncomfortable. She was fearful of being recognised by family or community members while she waited. She felt that her privacy was not maintained, which resulted in her decision to not go for post-abortion care.

Kamala strongly believes that there is a need to make women aware of safe abortion services available to them. She also feels that the quality of abortion services have to be strengthened by providing appropriate pre- and post-abortion counselling. Women's privacy and confidentiality have to be maintained throughout the process so their right to safe abortion services is secured. Equally important is the need to deconstruct abortion stigma prevailing in Nepalese society so that women do not need to keep abortion a secret.

Kamala still keeps her abortion a secret from most people, except for her husband and a friend who helped her during the process. She believes her post-abortion experience would have been less stressful (both mentally and physically) if she had the support and understanding of her family and friends. However, she thinks that they would not have supported her decision because they think that abortion is morally wrong and a deviant behaviour. Despite experiencing heavy bleeding after the abortion and having difficulty doing household chores, she did not share the news with her family for fear of their reaction and judgement. So she lied, saying she was having her period.

Kamala strongly believes that there is a need to make women aware of safe abortion services available to them. She also feels that the quality of abortion services have to be strengthened by providing appropriate pre- and post-abortion counselling. Women's privacy and confidentiality have to be maintained throughout the process so their right to safe abortion services is secured. Equally important is the need to deconstruct abortion stigma prevailing in Nepalese society so that women do not need to keep abortion a secret.

The Editorial Team is grateful to Kamala for bravely sharing her story and to Aliza Singh from Beyond Beijing Committee, Nepal for her assistance in documenting this story.

ENHANCING WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS:
A Brief Review of the Menstrual Regulation Programme in Bangladesh

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In Bangladesh, abortion is prohibited under the Penal Code of 1860[1] and permissible only for saving the life of the woman. In all other cases, abortion, self-induced or otherwise, is a criminal offence punishable by imprisonment or fines.[2] In 1972, this law was waived for a very short period for rape survivors of the War on Liberation.[3] Using this as a premise, the government cautiously began its Menstrual Regulation (MR) programme in 1974 in selected urban clinics. The clear objective was "birth control," with MR used as a back-up to a contraceptive failure.[4] In 1976, legalisation of first-trimester abortion on broad medical and social grounds was proposed, but legislative action was not taken due to fear of opposition from religious quarters and thus the 1860 law still stands.[5]

In 1979, the Bangladesh government included MR in the national family planning (FP) programme and encouraged doctors and paramedics to provide MR services in all government hospitals and Family Planning complexes. This was done through a government circular citing the Bangladesh Institute of Law and International Affairs, which declared menstrual regulation as an "interim method of establishing non-pregnancy" for a woman at risk of being pregnant, whether or not she is actually pregnant and can be legally performed up to 10 weeks following a missed period.[6] MR is, therefore, not regulated by the Penal Code restricting abortion. The government has updated the definition of MR in 2013 as the "procedure of regulating the menstrual cycle when menstruation is absent for a short duration."[7] As per a government circular of February 2015, MR can be performed by an MR-trained registered medical practitioner up to 12 weeks and by trained Family Welfare Visitors, Sub-Assistant Community Medical Officers, paramedics, and nurses up to 10 weeks from the last menstrual period under the supervision of a physician.[8] The earlier approved duration was 10 and 8 weeks respectively.

SRHR policies should be geared to respecting, protecting, and fulfilling the human rights of women, including their dignity and freedom of choice, and must address the needs of women belonging to vulnerable and disadvantaged groups.

The introduction of menstrual regulation in the FP programme in Bangladesh was marked as a significant event, particularly because this had happened despite the restrictive legal status of pregnancy termination, and also because proper programmatic utilisation of this method can profoundly influence the country's ability to achieve the desired demographic goal. Since its introduction, MR has been playing a crucial backup for contraceptive failure, available free-of-charge in government facilities, and has gained enormous success over the past decades with the effort of the government and the other stakeholders.

Until 2010, the only approved methods for MR were manual vacuum aspiration (MVA)[9] and dilation and curettage (D&C).[10] In 2014, the Ministry of Health and Family Welfare formally approved the provision of MR using a dual regimen of mifepristone and misoprostol up to nine weeks after a woman's last menstrual period (LMP) after several successful pilots in selected facilities. Doctors are now authorised to provide MR using the two-drug regimen, which is commonly referred to within Bangladesh as MRM (MR with medication).[11] The approval of this method, which is less invasive and typically less expensive, has the potential to increase access to MR and improve quality of care. However, users' lack of proper knowledge and information, inadequate information provided by the drug sellers, and indiscriminate use of MRM are affecting the effectiveness of use and increasing health risks.[12]

A study by Guttmacher-BAPSA[13, 14] in 2014 estimated 430,000 MR procedures performed at facilities nationwide which

is a sharp decline (40%) in the number of MR (surgical) services from 2010 when 653,000 MR were performed. This is a decline from 17 to 10 per 1,000 women aged 15-49 age group. Several reasons have been identified for this decline in surgical MR: lack of awareness of women on MR (more than half of ever-married women had never heard of MR); lack of MR equipment and trained staff in the facilities (30% of lacked basic MR equipment, trained staff, or both); and refusal due to exceeding the approved time limit (27% reported turned away). However, the most valid reason may be the wide use of MRM drugs, an easy and affordable method.

Two studies by Guttmacher-BAPSA[15, 16] have provided evidence that the MR programme has contributed to the sharp decline in maternal mortality in Bangladesh over the past two decades. However, the proportion of complication has also risen significantly. According to the Guttmacher-BAPSA study, the proportion of complication with haemorrhage increased from 27% in 2010 to 48% in 2014.[17] It is possible that this rise is related to an increased incorrect, clandestine use of misoprostol. With the government approval of MRM drugs, it is being widely administered by the drug sellers without any formal training. This may be the main reason for the increase in post-abortion complications.

Proper training of services providers and drug sellers may reduce the risk of complications resulting from the indiscriminate use of MRM. Dissemination of information and education on how women can protect themselves from unintended pregnancies and what to do if they have one, support from husbands, counselling, and trustworthy and ethical providers are much-needed to ensure women are able to exercise their reproductive rights. SRHR policies should be geared to respecting, protecting, and fulfilling the human rights of women, including their dignity and freedom of choice, and must address the needs of women belonging to vulnerable and disadvantaged groups.

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10. D&C: Dilatation (of the uterus and cervix) and curettage (of the endometrium), also called instrumental Uterine Curettage or Sharp Curettage, is a technique that uses metal surgical instruments to empty the uterus, usually under general and local anaesthesia or heavy sedation. It also requires operation theatre facilities and skilled staff. It is used for the treatment of incomplete abortion in the middle to late second trimester and should be used by a very skilled and experienced clinician in a well-equipped facility. Nowadays its use is declining sharply because of the invention of newer techniques in treating post-abortion complications (MVA+).
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ABORTION IN VIETNAM: Actions in a Legal Context

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A Snapshot of Abortion in Vietnam. Abortion is legal upon request until 22 weeks of pregnancy in Vietnam. Services should be accessible, affordable, stigma-free, and non-judgmental. However, abortion remains a taboo issue, while inaccurate information about the health consequences of having an abortion proliferates on mainstream media and the internet.

Stigma around abortion is under-researched, but a rapid assessment from the Center for Creative Initiatives in Health and Population (CCIHP) in 2012 on perspectives about sexual and reproductive health in the mainstream media demonstrated that none of 56 published articles had a rights-based view on abortion, whereas 69.6% of the content presented negative attitudes toward abortion. Instead of recognising the barriers faced by young people in accessing sexuality education, and sexual and reproductive health services and information, most of the articles described young people who had pre-marital sex and abortion as irresponsible, easygoing people who indulged their sensual desires but lacked self-esteem and understanding about sex. A study by Tine Gammeltoft also showed a strong influence of ethics and morality in young adults' perceptions regarding abortion.[1]

Actions in a Legal Context and the Voices of CSOs and Young People. Public discourse on abortion was rarely opened until the new draft of the Population Law was issued in 2015 by the government. The draft law stated, "Women are entitled to: a) end a pregnancy by abortion as request before 12 weeks, unless the purpose of abortion is gender-related or might cause serious health consequences to the mother."

This crucial event sparked a new movement of professionals and young people getting involved in abortion discussion and advocacy. The Law Development Team did not seem to favour second-trimester abortion because they believed that it would help reduce adolescent abortion, as well as limit sex-selective abortion.

The most recent version of the law, submitted in June 2018 retains the former legal status for abortion services in Vietnam. This shows the transformative power of civil society and young people in Vietnam to come together to advocate for change in the country.

When this draft law was presented during the Reproductive Health Affinitive Group Meeting (RHAG), Dr. Phan Bich Thuy[2] raised her concerns over the law being potentially restrictive. She believed that this will likely result in the increase of the maternal mortality ratio (MMR), as women who require abortion during the second trimester might resort to unsafe abortion. Fifty-three percent of abortions that happen during this period is by unmarried women.[3] Moreover, Dr. Thuy reasoned that the majority of women who require this service are from vulnerable groups, such as young unmarried women, premenopausal women, and women who have difficulties in accessing abortion service.

Following this RHAG meeting, UNFPA took the lead to write a feedback letter to the Ministry of Health (MoH) analysing the root causes of the imbalanced sex ratio at birth (SRB) and adolescent pregnancies. The letter also highlighted the possible reasons why women find out about their pregnancies only during the second trimester, including inadequate information and counselling, as well as lack of comprehensive sexuality education.

The Asia Safe Abortion Partnership (ASAP), along with Dr. Thuy and the youth group Vietnam Youth Action for Choice (VYAC), collaborated in organising a policy dialogue with the law-making committee of the General Office for Population and Family Planning (GOPFP) in the MoH. During the first stage, the youth co-founders recruited youth allies and trained their peers on sexual and reproductive health and rights (SRHR) and advocacy to establish a working group. Each week, they wrote an essay sharing their views on why they support safe abortion.

The policy dialogue was held in September 2015 with 70 participants, including 20 young people, GOPFP representatives, non-government organisation partners, and other experts working in the population field. At the dialogue, VYAC emphasised the challenges that young people face in term of SRHR and stressed that legal restrictions on second-trimester abortion would push young women into having unsafe abortions, which

put their health and lives at risk. VYAC recommended policymakers to open the discussion and listen to youth voices before implementing the restriction on second-trimester abortion. This presentation received support from other civil society organisations and the law drafting committee stated they will reconsider the changes in the draft population law.

At the end of 2015, the Vietnam National Assembly delayed the approval of the new Population Law although public perception towards abortion was negative and the policymakers were still concerned about the high number of abortions and the imbalance in sex ratio at birth. During Vietnam's Women Day in 2016, Safer Abortion Partners, led by ASAP with the support of 24 individuals and organisations, wrote an advocacy letter explaining the need for second-trimester abortion and the negative consequences of restricting this health service. The letter also provided suggestions for policies supporting safe abortion. At the same time, Le Hoang Minh Son[4] and his colleague wrote another letter emphasising the importance of Comprehensive Sexuality Education for young people to reduce abortion cases, rather than restricting second-trimester abortion.

Since then, the population law has been edited many times and is still pending as it could not get the majority of agreements during the 2018 National Assembly meeting. However, the most recent version of the law, submitted in June 2018, retains the former legal status for abortion services in Vietnam. This shows the transformative power of civil society and young people in Vietnam to come together to advocate for change in the country.

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THE DILEMMA OF ACCESSING MEDICAL ABORTION PILLS OVER THE COUNTER IN NEPAL

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Selling of medical abortion pills is restricted in Nepal and is only sold with a prescription in a few pharmacies near Safe Abortion Service Sites. Only four medical abortion pills—Mariprist, Medabon, MTP Kit, and Pregno Kit—are registered in the Nepal Department of Drugs Administration (DDA).

Despite these policy restrictions, both registered and unregistered brands of medical abortion pills can easily be obtained at pharmacies. Many women visit pharmacies for abortion information, and ensuring that they receive effective care from pharmacy workers remains an important challenge. Pharmacies are usually many Nepalis' first point of healthcare services, and are seen as major counselling and information centres in Nepal. Given this role, they need to be strengthened and their staff need to be aware of major health issues to minimise harm and deliver healthcare solutions.

Despite the clear government guidelines to use prescribed medical abortion drugs for the termination of pregnancy, unsafe abortion practices take place due to self-medication from unregistered outlets. Due to abortion stigma amongst other factors, women resort to self-induced medical abortion without proper counselling. It is important to recognise the role that pharmacists and pharmacy workers can play in improving the safety, efficiency, and acceptability of medical abortion services. Strengthening the partnership and referral system between pharmacies and providers may be an important opportunity to improve access. As the demand for medical abortion

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continues to increase, it will be imperative to invest in parallel efforts, such as task shifting, supply chain management, and collaboration with pharmacies to ensure that these services are widely available and well-regulated with high quality. To prevent the adverse effects of unregistered drug dispensing, it is necessary to conduct proper orientation to pharmacists and pharmacy workers on the legal conditions for providing medical abortion, including the importance of history taking, gestation period, accurate drug regimen and route, and information and referral for complication management.

Abortion has been legal in Nepal for the past 15 years, while medication abortion has been introduced in 2008, significantly contributing to reducing maternal mortality. Yet, despite the legality and the availability of legally registered medical abortion on the market and actions by the Nepali government,[1] many women continue to face barriers to obtain safe, quality products and services. According to a study conducted by the Center for Research on Environment, Health, and Population Activities (CREHPA) in 2014, 58% of the estimated 323,000 abortions performed in 2014 were illegal, potentially putting women's health at risk.[2]

Dr. R.P Bichha, Director of Family Health Welfare Division, claimed that the open border with neighbouring countries has facilitated illegal entry of various brands of medical abortion pills. There are more than 100 brands of pills available in the market and are sold in pharmacies which are ineffective or unsafe for terminating pregnancies. The 2011 Nepal Demographic and Health Survey showed that among the women who had an abortion in the five years preceding the survey, 19% had used pills for their last abortion. Moreover, 5% of them had obtained the pills from a pharmacist or medicine shop. Nepalese women's knowledge about the correct medication to use for safe abortion is low even in districts where medical abortion services have been introduced by the government. Access to information about medical abortion—its safety, efficacy, and acceptability—is also still limited.[3] Another issue is cost, as the price of medical abortion drugs varies from pharmacy to pharmacy, with women reportedly paying between Rs. 500 (US $4.40) to Rs. 10,000 (US $88). This, despite abortion services being free of charge in government facilities.

Women should be able to access medical abortion to terminate their pregnancy from everywhere. However, they should be made aware of the proper use of abortion pills with counselling. It would be ideal if women could be provided with pictorial instructions to further aid understanding.

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Some recommendations to improve the proper use of self-medication abortion drugs are:

1. Provide orientation on harm reduction approach on safe abortion to pharmacists and pharmacy workers.
2. Provide women with proper counselling and refer them to helplines providing information on medical abortion. The best would be the Meri Saathi helpline (16600119756/9801119756) initiated by Marie Stopes Nepal.
3. Regulate the cost of medical abortion drugs in pharmacies, and widely advertise existing free abortion services in government health facilities.
4. The DDA and Nepal Chemist and Druggists Association (NCDA) should regularly monitor the availability of non-registered medical abortion drugs in the market and strong action is recommended by working closely with Family Health Welfare Division to recommend policy on selling only authorised four medical abortion pills with accurate instructions to women via pharmacies. The pharmacies should be authorised by Family Health Welfare Division to sell MA pills.

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1. Considering the limited access to safe abortion services among women in rural and remote areas, the Health Minister approved the "Strategy for Service Extension for Safe Abortion Using Medicines Following the MA Service Guideline, 2066" on June 4, 2008. Clause 6.1.5 of the guidelines states that "health workers working at different levels in the community level health facilities shall be provided training on safe abortion services using medicine and will be listed at Family Health Welfare for service authorisation." Further, the "Nepal Health Sector Strategy 2015-2020" emphasises service extension for wider reproductive health service coverage under "Universal Health Coverage" and increased accessibility to everyone to reduce maternal mortality rate below 70 (per 100,000 live births) and meet the Sustainable Development Goals.
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SERIOUS THREATS TO REPRODUCTIVE RIGHTS IN POLAND

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Abortion was legalised in Poland in 1956 and, until the early 1990s, services were widely accessible, both for medical and social grounds. At the beginning of the 90s, however, civic groups close to the Polish Catholic Church initiated a campaign against legal abortion. After more than three years of discussions between politicians and the Catholic Church, the Polish Parliament voted for the new abortion act which limited abortion to only three grounds.[1] Polish women were totally neglected in this process.

Since 1993, the Act on Family Planning, Human Embryo Protection, and Conditions of Permissibility of Pregnancy Termination has been in force in Poland. It is one of the most restrictive regulations not only in Europe but also in the world. Moreover, the law is even more restrictive in practice than on paper. Access to legal abortion is extremely limited due to the widespread use of conscientious objection[2] among gynaecologists—the right to avoid referring patients to another hospital[3] where obtaining abortion could be possible—as well as the complicated and often unrealistic hospital procedures applied to prolong the process so that it becomes impossible to conduct abortions.

Yet, the number of illegal abortions in the country ranges from 100 to 150 thousand yearly.[4] The quality of the procedure and the woman's safety depends on her economic status. Those who have more resources and access to information may easily terminate pregnancy abroad or underground,[5] while women from small towns and poorer areas often resort to so-called home methods or services offered by unknown people, risking their health and even lives.

According to the official statistics,[6] 1,055 legal abortions were performed in Poland in 2016. The general public knows little about the dramatic reality of Polish underground abortion, of the women who lose their health or even their lives. Dramatic stories rarely hit the headlines, because women who have been put through such trauma do not often have the will and strength to pursue legal action or talk to the media.

The struggle for women's reproductive rights has only just begun in Poland. It is fundamental that Polish women understand the need to act together, in solidarity, and are determined to continue their fight to regain their rights. They are not going to give up so easily. Their "umbrellas are at the ready."

Shortly after the election of right-wing party Peace and Justice in 2015, the newly appointed Minister of Education announced that sexuality educators from non-governmental organisations would not be allowed to enter public schools as, in her opinion, comprehensive sexuality education leads to the sexualisation of young people. The new Minister of Health withdrew the approval for over-the-counter sales of emergency contraception. It needs to be highlighted that blocking progress not only on abortion, but also sexuality education and emergency contraception, is a form of demanding a "payback" for the support of the Church during the elections.

This was only a preview of the fundamental changes aimed at the complete deprivation of reproductive rights of Polish women. In April 2016, the Stop Abortion civic initiative presented an extremely restrictive draft law introducing a total ban on abortion. Entitled "On Universal Protection of Human Life and Education for Family Life," the draft law introduced the term "unborn child" and offered equal rights both to the foetus and the woman. Moreover, it considered an "unborn child" to be vulnerable, and the woman exactly the opposite. In addition to the total ban on abortion, the draft law introduced criminalisation of up to five years of imprisonment for women (currently the woman is not punished for terminating her pregnancy), physicians, and anyone who provided help. In case of miscarriage, an investigation might be initiated. If the Court found that the woman unintentionally contributed towards the death of the embryo/foetus, she may face up to three years of imprisonment.

It became too much to stand for Polish women who have been silently bearing the restrictive law. As a counterweight to the Stop Abortion proposal, a newly formed citizens' initiative Save the Women[7] submitted the draft law "On Women's Rights and Conscious Parenthood," liberalising the restrictive 1993 Act.

On September 23, 2016, both proposals were put before the Parliament. Stop Abortion was sent for further proceedings, while Save Women was rejected upon first reading. This caused massive women's protests in the whole country. The wave of activism reached its peak moment on October 3 called "Black Monday."[8] Thousands of people dressed in black clothes stood for many hours in protest in the pouring rain (hence the umbrella as the demonstration's emblem) in many Polish cities and even small towns. On October 6, the Parliament somewhat nervously rejected the draft bill on a total ban of abortion in Poland.

Polish women won the battle! Yet this is just the first step. Fundamentalists have been continuing their attacks on women's rights. The Stop Abortion draft bill is pending before the sub-committee of the Parliamentary Committee on Social Policy and Family. A challenge to the constitutionality of some legal grounds for abortion is also now pending before Poland's Constitutional Tribunal. This petition has been brought by a group of MPs from the ruling party, in order to effectively ban women from access to abortion in Poland.

The struggle for women's reproductive rights has only just begun in Poland. It is fundamental that Polish women understand the need to act together, in solidarity, and are determined to continue their fight to regain their rights. They are not going to give up so easily. Their "umbrellas are at the ready."

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1. Polish regulations currently allow abortion in three cases: if the pregnancy constitutes a threat to the life or health of the woman; if the prenatal examination points at the high probability of severe and irreversible damage to the foetus, or on an incurable disease; and if the pregnancy is a result of a criminal circumstance entitling lawful abortion, which has to be confirmed by a prosecutor.
2. The conscientious objection clause as in force in Poland is universally formulated and does not refer directly to any aspect of reproductive rights; however, in practice, it is most widely applied in relation to SRHR.
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COMPASSION OVER COERCION: Ireland Repeals the 8th Amendment by Getting to the Heart of the Matter

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Just after 10 pm on Friday, May 25, 2018, Irish women at home and across the globe were waiting anxiously. It was the day of the referendum to repeal the Eighth Amendment[1] from the Irish Constitution and, for the first time in the history of such referenda, a national media outlet was about to release an exit poll. I do not think mine was the only household where a scream lifted the rafters. The referendum had not only passed, but it had done so with an overwhelming landslide of over two-thirds of the vote.[2]

The Eighth Amendment, introduced in 1983, constitutionally guaranteed that abortion would be illegal in all cases save where the mother's life was at risk. Abortion was not allowed in the case of rape, incest, or when the foetus was guaranteed not to survive birth. It has forced over 170,000 Irish women to leave Ireland to access abortion care, to undergo illegal abortions, or to go through a full pregnancy against their consent.[3]

Despite the enormous social and political change experienced by Ireland during the 35 years of the amendment's existence, the nervousness of those advocating for a Yes vote was palpable during the final weeks. Opposition forces were, as had been expected, throwing everything they could at the campaign, bolstered by a wave of regression across the world from Trump's anti-reproductive freedom crusade in the US to the Russian-influenced push back on human rights in Eastern Europe, including EU states.[4]

Opposition tactics mirrored those being used elsewhere, ugly and ideological. However, an early attempt to co-opt people concerned about disability went awry when many disability rights activists spoke out about the importance of disabled women being able to access abortion care should they need it, while parents of children with disabilities were furious at the imputation that it was only the non-existence of abortion in Ireland that had led them to welcome their much-beloved children into their lives.

This deeper reflection on the complexities of life was mirrored across the country. The sex abuse scandals and resulting cover-ups had rocked once deep loyalty to the Roman Catholic Church. People were already beginning to question an ideology which was prepared to defend a foetus, but which was so obviously uncaring about the suffering of children at the hands of paedophiles.[5]

In 2012, the death of Savita Halappanavar from sepsis due to a miscarriage where an abortion was not permitted in time, despite her family's pleas, was another massive shock to the Irish system. This became a tipping point.[6] Silenced for so long because of the stigma attached to abortion, brave women began to tell their personal stories.

One cannot deny that the road to abortion reform in Ireland has been a long one, and that many different factors played. Work done by non-government organisations like IPPF member, the Irish Family Planning Association, over decades was vital. They and their partners opened spaces for discussion and worked with regional and global human rights mechanisms—including the European Court of Human Rights (ECHR),[7] the UN Treaty Monitoring Bodies, and the Universal Periodic Review—keeping the pressure on during a series of conservative and apathetic governments who preferred to keep the lid on a difficult and divisive issue. Between 2012 and 2016, five UN human rights bodies examined and criticised Ireland's restrictive abortion laws.[8] In 2016, the UN Human Rights Committee found that Ireland's refusal to allow abortion in the case of a fatal foetal abnormality violated the plaintiff's right to freedom from cruel, inhuman, or degrading treatment.[9] It mattered of course that Ireland is a massively different country in 2018 than it was in 1983.

However, if there is one lesson from the campaign that can immediately be embraced by those working to end reproductive coercion across the globe, it is that we must leave our ivory towers and our lofty discourse. It is important to work within a human rights framework, but the language we use is often technical and divorced from the real experience of women. Irish activists went to the heart of the matter, not just focusing the discussion on choice and rights but talking about what happens when people have their choices taken from them.

Women told their own stories about the harm that the 8th Amendment had caused them, emotionally, psychologically, and physically.[10] Men shared how it made them feel to see their partners in distress and be powerless to help them; mothers told of the horrors of a total absence of care for their daughters who had been raped. Many doctors spoke of their frustration at their inability to provide support to their patients when it was most needed and campaigned vigorously for a Yes vote.[11]

As the weeks went by, the campaign against repeal had only their ideology, which rests on the idea of moral absolutes, a world that is only black and white. But the stories and discussions across the country demonstrated that our world is not like that. It is a world of messy realities and difficult decisions, where no one woman's story is the same as another. It is a world that needs empathy, understanding, and compassion.

Irish Prime Minister Leo Varadkar is confident that he will deliver on his commitment to delivering legislation which legalises abortion care on a woman's own indication in the first trimester of pregnancy before the end of this year, bringing it in line with the majority of European countries.[12]

If there is one lesson from the campaign that can immediately be embraced by those working to end reproductive coercion across the globe, it is that we must leave our ivory towers and our lofty discourse. It is important to work within a human rights framework, but the language we use is often technical and divorced from the real experience of women. Irish activists went to the heart of the matter, not just focusing the discussion on choice and rights but talking about what happens when people have their choices taken from them.

However, as anticipated, opposition forces are now turning their sights from maintaining the ban to placing barriers in the way of implementation.[13] Pro-choice activists are all too aware of countries like Italy where abortion is legal in theory, but, where in practice, denial of care on grounds of individual conscience is so institutionalised that more than 70% of gynaecologists refuse women who come to them for care.[14] Those who worked so hard during the campaign will not rest on their laurels but will continue to fight so every woman can access abortion care when and where she needs it. The strong mandate given by the Irish public is the best encouragement possible.

Ultimately, the Yes vote sends a strong message around the world that compassion can win out. When people are informed, when they hear women's voices and listen to their stories, they understand that health and lives are at stake. When they feel in their gut that reproductive coercion is incompatible with their own values, they will reject

it. Part of the reason for the incredible success of the Irish Yes campaign is that it made this connection, enabling ordinary people from all walks of life to stand up for what they knew to be right.

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THE GLOBAL GAG RULE ON SAFE ABORTION SERVICES AND THE CAMBODIAN EXPERIENCE

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Background. The Global Gag Rule (GGR), first announced in 1984, prohibits non-USA non-governmental organisations (NGOs) that receive certain categories of US. foreign assistance from using their own, non-US funds to perform or actively promote abortion as a method of family planning. In May 2017, under President Donald Trump, the policy was reinstated as "Protecting Life In Global Health Assistance."[1] This latest GGR is applied to sectors beyond family planning, including HIV and AIDS prevention and treatment, malaria, and infectious diseases. Trump's Global Gag Rule applies to almost US$9 billion in US foreign assistance.[2]

Imposing a condition on abortion services has a knock-on effect on an array of sexual and reproductive health services since healthcare providers who do abortion services would also integrate other services most needed by women and girls, such as voluntary family planning information, education and services, HIV testing and treatment, cervical cancer screening, and other maternal health services. For example, the International Planned Parenthood Federation (IPPF), a global network of local service providers, delivers more than 300 sexual and reproductive health services every minute daily. During President Trump's term, IPPF does not receive approximately USD$100 million funding from the US government, which would have supported IPPF's family planning and HIV programmes for women with the greatest need for these healthcare services.[3]

High awareness of RHAC's programme and the trust by the community enable RHAC to generate income from its services while keeping approach in addressing the poor and marginalised groups.

The Impact of GGR on the Reproductive Health Association of Cambodia (RHAC). Established in 1996, the Reproductive Health Association of Cambodia's (RHAC) was heavily dependent on USAID with almost 100% of its funding came from the aid agency. RHAC understood the uncertain nature of this funding, however. We then put in place strategies to diversify funding sources, including our own income generation through service fees. Both

donors and the beneficiaries who receive RHAC services are considered "clients," and RHAC always understands that the beneficiaries are RHAC's long-term and loyal clients.

While receiving assistance from USAID and other donors, RHAC was able to establish its reputation among the Cambodian people as the leading women's healthcare provider in the country, and had established good track records in its programme implementation and management. High awareness of RHAC's programmes and the trust by the community enable RHAC to generate income from its services while keeping its approach in addressing the poor and marginalised groups. With this modality, RHAC has been able to continue service provision even after USAID ceased funding RHAC in early 2014.

NGOs at the country level need to have solutions suitable for their own context, in addition to having access to the funding flow through the global and international networks.

NGOs receiving USAID funding to address the population's health must not forget to address the NGO's "health" at the same time. Usually, donors are more interested in the sustainability of their funded projects, and not that of the NGOs; it is the duty of the NGOs to think about organisational sustainability.

Many NGOs have now started discussing about establishing social enterprises as a way to address sustainability issues and the organisation's cost recovery. There are other models addressing funding concerns such as public-private partnership or partnership with private-for-profit organisations.

Nevertheless, our government cannot shy away from their responsibilities of providing universal access to health and SRHR to all, which includes access to safe abortion. Hence, we should not lose sight of holding governments accountable as part of our advocacy work.

Ways Forward to Address the Impact of the GGR. There are reports providing recommendations to overcome the GGR,[4, 5] including: to permanently repeal the GGR through legislation by the US Congress; to improve the understanding of the GGR by direct or prime recipients of US Global Health Funding, sub-recipients, and front line workers, including through translation of the policy into local language; for all relevant groups, including research institutions, to document the impact of the GGR, including the spillover effects of the policy; for donors, governments, and international organisations to increase funding for comprehensive sexual and reproductive health services and to avoid applying conditionality on development funding for health, including counter-conditionality intended to respond to the GGR; and for UN agencies or governments to advocate to the US government or publicly speak out against the GGR.

Immediately after the announcement of the GGR, the Dutch Minister for Foreign Trade and Development Cooperation launched the SheDecides initiative to mobilise funding to help with the funding gap the policy caused. However, most of the funding goes to large and well-known international and UN organisations.

NGOs at the country level need to have solutions suitable for their own context, in addition to having access to the funding flow through the global and international networks. NGOs need to prepare themselves with an understanding that the GGR will continue to come and go for the foreseeable future.

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5. Center for Health and Gender Equity (CHANGE), *Prescribing Chaos in Global Health: The Global Gag Rule from 1984-2018* (Washington, DC: CHANGE, June 2018), accessed June 23, 2018, http://www.genderhealth.org/files/uploads/change/publications/Prescribing_Chaos_in_Global_Health_full_report.pdf.

RESOURCES FROM THE ARROW SRHR KNOWLEDGE SHARING CENTRE

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ARROW's SRHR Knowledge Sharing Centre (ASK-us) *hosts a special collection of resources on gender, women's rights, and sexual and reproductive health and rights (SRHR). It aims to make critical information on these topics accessible to all. ASK-us is also available online at http://www.srhr-ask-us.org/. To contact ASK-us, please email: km@arrow.org.my.*

RIGHTS TO SAFE ABORTION

ARTICLES AND BOOKS

Barot, Sneha. "The Roadmap to Safe Abortion Worldwide: Lessons from New Global Trends on Incidence, Legality and Safety." *Guttmacher Policy Review* 21 (2018): 17-22, https://www.guttmacher.org/sites/default/files/article_files/gpr2101718.pdf.

The article focuses on the evidence that are continually being compiled by researchers and healthcare practitioners on the most effective means to decrease the impact of unsafe abortion globally and the obstacles to implementing these measures. This body of evidence provides a roadmap for policymakers to take concrete measures to protect the health, rights, and lives of women worldwide. Among the concrete measures are adopting clinical guidelines on comprehensive abortion care, increasing access to post-abortion care, facilitating correct use of medication abortion in clandestine settings, combatting stigma, reforming restrictive abortion laws, and investing in services to prevent unintended pregnancies and the often unsafe abortions that may follow.

Cockrill, Kate, Steph Herold, Kelly Blanchard, Dan Grossman, Ushma Upadhyay, and Sarah Baum. *Addressing Abortion Stigma through Service Delivery: A White Paper*. Sea Change Program, Ibis Reproductive Health, and Advancing New Standards in Reproductive Health (ANSIRH), 2013. https://ibisreproductivehealth.org/publications/addressing-abortion-stigma-through-service-delivery-white-paper.

This paper aims to provide the context and background of work done to address abortion stigma through service delivery. Abortion stigma is a major barrier to adequate reproductive healthcare for women and a key challenge for service delivery providers to address. In the first part of the paper, the definition of abortion stigma was discussed with reviews of existing literature around this issue and its interventions. Opinions, experiences, and programmes of reproductive healthcare service delivery organisations follow this. In the final section, recommendations for increasing and expanding programmes to address abortion stigma are provided.

Fiala, Christian and Joyce H. Arthur. "There Is No Defence for 'Conscientious Objection' in Reproductive Health Care." *European Journal of Obstetrics and Gynecology and Reproductive Biology* 216 (2017): 254-258. https://doi.org/10.1016/j.ejogrb.2017.07.023.

This paper argues that "conscientious objection (CO)" in reproductive healthcare should not be considered a right, but an unethical refusal to treat. Defenders of CO often mistakenly assumed that CO in reproductive healthcare is similar to CO in the military, when the two have nothing in common (as objecting doctors are rarely disciplined). The authors further highlighted that refusals to treat are often attributed to religious beliefs, which challenges the medical practices that depend on scientific evidence and ethics. Medical practitioners citing CO represents an abandonment of their professional obligations to patients. Thus countries should strive towards mitigating CO and its harm as much as possible until it can be feasibly abolished.

Ipas. *Access for Everybody: Disability Inclusion in Abortion and Contraceptive Care – Guide*. Chapel Hill, NC: Ipas, 2018. http://www.ipas.org/en/Resources/Ipas%20Publications/Access-for-everyone--disability-inclusion-in-abortion-and-contraceptive-care--guide.aspx.

This guide provides strategies for improving disability inclusion in policy, service delivery, and community engagement interventions, which can be adapted to cater to the specific needs of each context. It is developed as a resource to improve access to abortion and contraceptive care for programme implementers and managers, technical advisors, and trainers. The recommendations highlighted are based on the human rights model of disability that promotes the empowerment of people with disabilities through developing initiatives that are disability-specific, as well as integrating disability inclusion in programmes. A core principle

guiding the recommendations is that people with disabilities should actively and meaningfully participate through all stages of planning, implementing, and evaluating interventions in abortion and contraceptive care.

International Planned Parenthood Federation (IPPF). *Youth and Abortion: Key Strategies and Promising Practices for Increasing Young Women's Access to Abortion Services*. London: IPPF, 2014. https://www.ippf.org/sites/default/files/ippf_youth_and_abortion_guidelines_2014.pdf.

This is an evidence-based guidance document aimed at increasing young people's access to high-quality youth friendly abortion information, services, and referral. It is designed to support organisations who are interested in scaling up their work on young people's access to abortion and abortion-related services. The document was originally developed for the use of IPPF member associations, however, it can also be used by advocates wishing to focus on young women's access to safe, legal abortion.

International Women's Health Coalition (IWHC). *Trump's Global Gag Rule at One Year: Initial Effects and Early Implications*. New York: IWHC, 2018. https://iwhc.org/wp-content/uploads/2018/05/GGR-Policy-Brief_FINAL-May-2018.pdf.

This policy brief is based on the documentation project by IWHC in 2017 aimed at capturing and analysing the impacts of the Global Gag Rule (GGR), in partnership with local organisations in Kenya, Nigeria, and South Africa. The GGR will jeopardise the health of girls and women with organisations and individuals heavily emphasising the potential impacts to women's and girls' access to healthcare, particularly for already-marginalised groups of women. Concerns were also raised that the policy will prevent women from accessing information about referrals for safe abortion services, leading to increased reliance on unsafe services. Recommendations put forth in the brief were directly targeted to the US government; international NGOs including prime recipients and others; donor governments and international and regional organisations; UN agencies; governments in countries that received global health funding; and the African Commission on Human and People's Rights.

Jelinska, Kinga and Susan Yanow. "Putting Abortion Pills into Women's Hands: Realising the Full Potential of Medical Abortion." *Contraception* 97, no. 2 (2018): 86-89. https://doi.org/10.1016/j.contraception.2017.05.019.

According to the authors of this article, in order to realise the potential of medical abortion to reduce maternal mortality and morbidity from unsafe abortion and to expand the reproductive rights of women, information and reliable medicines must be made available to all women, regardless of their location or legal system restrictions. Medical abortion gives control to women who need abortion. Ironically, in legally restrictive settings medical abortion is currently more under women's control than in settings where medical abortion is used within the official healthcare system. The article further highlighted on information and access, barriers, and strategies to overcome these barriers; the reconceptualisation of "provider" and the redefinition of "performing" an abortion, as it is the woman herself who can be in control of the process; and activist strategies to actualise the full potential of abortion pills.

LeTourneau, K. *Abortion Stigma around the World: A Synthesis of the Qualitative Literature; A Technical Report for Members of The International Network for the Reduction of Abortion Discrimination and Stigma (inroads)*. Chapel Hill, NC: inroads, 2016. http://www.safeabortionwomensright.org/wp-content/uploads/2016/05/AbortionStigmaAroundtheWorld-HR-2.pdf.

This report provides grounding in the fundamental concepts of abortion stigma and a synthesis of the qualitative literature around the world exploring the way abortion stigma manifests. An ecological model of abortion stigma that illustrates multiple levels at which stigma manifests—individual, social, institutional, legal, and media-based—was explored in the qualitative literature review. Aside from presenting the findings at each level, the report also explores how stigma at some levels may impact the manifestations of stigma at other levels. Intersections of abortion stigma with other stigmatised characteristics—specifically HIV status and young women's sexuality—were also reviewed.

Pugh, Sarah, Sapna Desai, Laura Ferguson, Heidi Stöckl, and Shirin Heidari. "Not without a Fight: Standing up against the Global Gag Rule." *Reproductive Health Matters* 25, no. 49 (2017): 14-16. https://doi.org/10.1080/09688080.2017.1303250.

This article highlights the implications of the latest Global Gag Rule, which extends far beyond access to safe abortion information and services. The new policy applies not only to funding earmarked to organisations that focus on reproductive health, but to all global health assistance by all departments or agencies. However, despite these challenges, the authors acknowledge and celebrate the creativity, resistance, and perseverance of the SRHR community,

whereby civil society, NGOs, health practitioners, and government actors have taken a strong stance of opposition through joint statements and advocacy efforts to highlight the well-documented and profoundly damaging consequences of this policy in terms of both health and human rights. It also provided an opportunity for governments to step into leadership roles, and for new partnerships in the global SRHR community to develop and ensuring that sustainable SRHR funding mechanisms are put in place to protect the rights of women, girls, and families around the world.

Radhakrishnan, Akila, Elena Sarver, and Grant Shubin. "Protecting Safe Abortion in Humanitarian Settings: Overcoming Legal and Policy Barriers." *Reproductive Health Matters* 25, no. 51 (2017): 40-47. https://doi.org/10.1080/09688080.2017.1400361.

Humanitarian laws, policies, and protocols are not responding to the sexual and reproductive health and rights (SRHR) of women and girls in conflict settings, in particular safe abortion services, which are routinely omitted. This commentary addresses the gap in abortion services within the SRH care in conflict-related humanitarian settings. The authors highlight that abortion services fall within a type of medical care protected by the strongest legal structure in the international community. The existing challenges affecting the realisation of the rights protected by this legal structure are then outlined. Finally, in order to ensure an all-inclusive care for female survivors of armed conflict, an integration of current approaches is proposed.

Skuster, Patty. *When a Health Professional Refuses: Legal and Regulatory Limits on Conscientious Objection to Provision of Abortion Care.* Chapel Hill, NC: Ipas, 2012. http://www.ipas.org/en/Resources/Ipas%20Publications/When-a-health-professional-refuses-Legal-and-regulatory-limits-on-conscientious-objection-.aspx.

The refusal of health professionals to provide services is a significant barrier to women's access to safe abortion and other reproductive health services. Although these providers have the right to refuse service provision under international and, in some, national law, it is necessary to have national-level legal or regulatory limits on conscientious objection to protect women's rights and their access to safe abortion services. This publication contains recommendations for enacting laws and regulations that safeguard women's access to services while still protecting providers' rights of conscience. It also provides information on human rights standards that address provider refusal and includes a list of further resources.

World Health Organization (WHO). *Safe Abortion: Technical and Policy Guidance for Health Systems.* 2nd ed. Geneva: WHO, 2012. http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1

This edition provides policymakers, programme managers, and health service providers with the latest evidence-based guidance on clinical care in relation to the provision of safe abortion services. Information on how to establish and strengthen services is included together with an outline of a human-rights-based approach to laws and policies on safe, comprehensive abortion care.

FILMS/DOCUMENTARIES

Ending Unsafe Abortion in Asia (2012), a 10-minute documentary produced by IPPF-ESEAOR (East and South East Asia and Oceania Region) examining the effects of criminalising abortion in the region through women's lens. More on the documentary at: https://www.ippfeseaor.org/resource/ending-unsafe-abortion-asia.

From Danger to Dignity: The Fight for Safe Abortion (1995), a documentary tracing the movement in the United States to decriminalise abortion of "underground" networks to find illegal abortions and the intensive efforts of activists and legislators to change the law. More on the documentary at: https://en.wikipedia.org/wiki/From_Danger_to_Dignity:_The_Fight_for_Safe_Abortion and https://www.youtube.com/watch?v=Vg4B-UmgfG8.

If These Walls Could Talk (1996), a made-for-cable movie on three different women and their experiences with abortion in the same house in 1952, 1974, and 1996 addressing the views of society in each decade. More on the film at: https://en.wikipedia.org/wiki/If_These_Walls_Could_Talk and https://www.youtube.com/watch?v=PzfHXyk9TTo.

Obvious Child (2014), a film that follows Donna, a stand-up comedian, who has a drunken one-night stand with a man named Max after breaking up with her boyfriend. She subsequently finds out she is pregnant and decides to have an abortion. More on the film at: https://en.wikipedia.org/wiki/Obvious_Child and https://www.youtube.com/watch?v=7nkXWkrTozA.

The Abortion Diaries (2005) is a 30-minute documentary featuring 12 women of diverse backgrounds who speak candidly about their experiences with abortion. More on the documentary at: http://pennylaneismyrealname.com/film/the-abortion-diaries-2005/ and https://www.youtube.com/watch?v=av_vwVYZOqc.

OTHER RESOURCES

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Chavkin, Wendy, Laurel Swerdlow, and Jocelyn Fifield. "Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study." *Health and Human Rights Journal* 19:1 (2017): 55-68. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5473038/pdf/hhr-19-055.pdf.

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Ganatra, Bela, Philip Guest, and Marge Berer. "Expanding Access to Medical Abortion: Challenges and Opportunities." *Reproductive Health Matters* 44S (2015): 1-3. https://doi.org/10.1016/S0968-8080(14)43793-5.

Guttmacher Institute. *Adolescents' Need for and Use of Abortion Services in Developing Countries*. New York: Guttmacher Institute, 2016. https://www.guttmacher.org/sites/default/files/factsheet/fb_adolescent-abortion-services-developing-countries_1.pdf.

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ARROW RESOURCES

All ARROW publications from 1993 to the present can be downloaded at http://arrow.org.my/publications-overview/.

DEFINITIONS

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Abortion: "The World Health Organization (WHO) defines an abortion as safe if it is provided both by an appropriately trained provider and using a recommended method. Less-safe abortions meet only one of these two criteria—for example, if provided by a trained health worker using an outdated method or self-induced by a woman using a safe method (such as the drug misoprostol) without adequate information or support from a trained individual. Least safe abortions meet neither criteria; they are provided by untrained people using dangerous methods, such as sharp objects or toxic substances."[1]

Conscientious Objection (CO): In reproductive health care, CO is defined as "the refusal by a healthcare professional (HCP) to provide a legal medical service or treatment for which they would normally be responsible, based on their objection to the treatment for personal or religious reasons."[2]

Induced Abortion: "The termination of a pregnancy by a procedure or action taken by a provider or a woman herself."[3]

Medical Abortion: "The use of one or more medications to end pregnancy. These medications terminate the pregnancy, which is then expelled by the uterus in a process similar to miscarriage. Medical abortion is sometimes called medication abortion, pharmacological abortion, pharmaceutical abortion, or the abortion pill. Medical abortion does not include emergency contraception (EC), also known as the 'morning-after pill,' which prevents pregnancy from occurring."[4]

Menstrual Regulation (MR): "Uterine evacuation without laboratory or ultrasound confirmation of pregnancy for women who report recent delayed menses."[5]

Post-abortion Care (PAC): "Post-abortion care refers to a specific set of services for women experiencing complications of spontaneous or induced abortion, including retained tissue, hemorrhage and infection. PAC consists of several elements: (1) Uterine evacuation with medications or vacuum aspiration; (2) Counseling to identify and respond to women's emotional and physical health needs and other concerns; (3) Contraceptive information and method provision for women who desire to postpone or limit future pregnancy; (4) Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities in providers' networks; and (5) Community and service provider partnerships to help prevent unwanted pregnancies and unsafe abortion and mobilise resources to help women receive appropriate and timely care for complications of abortion."[6]

Reproductive Health: "A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[7]

Reproductive Rights: "[E]mbrace certain human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human right documents."[8]

Sexual Health: "A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled."[9]

Sexual Rights: "[E]mbrace human rights that are already recognised in national laws, international human rights documents, and other consensus documents. They include the rights of all persons, free of coercion, discrimination, and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek, receive, and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe, and pleasurable sexual life."[10]

Sexuality: "Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is: ...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors."[11]

Spontaneous Abortion: "A miscarriage; the natural, involuntary termination of a pregnancy before viability. Spontaneous abortion occurs in at least 15-20 percent of all recognised pregnancies and usually takes place before the 13th week of pregnancy."[12]

Surgical Abortion: "Use of transcervical procedures for terminating pregnancy, including vacuum aspiration and dilatation and evacuation (D&E). Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. Electric vacuum aspiration (EVA) employs an electric vacuum pump. With manual vacuum aspiration (MVA), the vacuum is created using a hand-held, hand-activated, plastic 60 ml aspirator (also called a syringe). D&E is used after 12–14 weeks of pregnancy. It is the safest and most effective surgical technique for later abortion, where skilled, experienced providers are available. D&E requires preparation of the cervix using osmotic dilators or pharmacological agents and evacuating the uterus using EVA with 12–16 mm diameter cannulae and long forceps. Depending on the duration of pregnancy, preparation to achieve adequate cervical dilatation can require from 2 hours to 2 days. Many providers find the use of ultrasound helpful during D&E procedures, but its use is not essential."[13]

Unsafe Abortion: The World Health Organization (WHO) defines unsafe abortion "as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both". It further highlights that "the health consequences of unsafe abortion depend on the facilities where abortion is performed; the skills of the abortion provider; the method of abortion used; the health of the woman; and the gestational age of her pregnancy. Unsafe abortion procedures may involve insertion of an object or substance (root, twig or catheter or traditional concoction) into the uterus; dilatation and curettage performed incorrectly by an unskilled provider; ingestion of harmful substances; and application of external force. In some settings, traditional practitioners vigorously pummel the woman's lower abdomen to disrupt the pregnancy, which can cause the uterus to rupture, killing the woman."[14]

Notes & References

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2. Christian Fialaa and Joyce H. Arthur, "There is No Defence for 'Conscientious Objection' in Reproductive Health Care," *European Journal of Obstetrics & Gynecology and Reproductive Biology* 216 (2017): 254, http://dx.doi.org/10.1016/j.ejogrb.2017.07.023.
3. Altaf Hossain et al., *Access to and Quality of Menstrual Regulation and Postabortion Care in Bangladesh: Evidence from a Survey of Health Facilities, 2014* (New York: Guttmacher Institute, 2017): 7, https://www.guttmacher.org/report/menstrual-regulation-postabortion-care-bangladesh.
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7. United Nations, *Programme of Action Adopted at the International Conference on Population and Development Cairo, 5–13 September 1994, 20th Anniversary Edition* (New York: UNFPA, 2014), para 7.2, http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.
8. United Nations, *Programme of Action*, para 7.3.
9. This is a working definition, not an official WHO position. See: WHO, "Sexual and Reproductive Health," http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/.
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12. Turner, *Medical Abortion Study Guide*, 89.
13. WHO, *Safe Abortion*, iv, 40-42.
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THE ROLE OF INTERNATIONAL HUMAN RIGHTS INSTRUMENTS IN THE ADVOCACY FOR THE RIGHT TO SAFE ABORTION

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This factfile attempts to map and situate women's right to safe abortion within the broader scope of human rights. It will explore the relevant core human rights treaties to understand and elucidate the rights that are pertinent to abortion.

Sexual and reproductive health and rights (SRHR) advocates have situated abortion within the larger realm of reproductive rights. However, the term "reproductive rights" has not yet been adequately defined by any international human right convention and its content and scope remain controversial even today.

An early, narrow interpretation of the term confined reproductive rights to access to family planning. The International Conference on Population and Development (ICPD) held in Cairo in 1994 marked a paradigm shift in addressing human reproduction and health, where for the first time, "women's reproductive capacity was transformed from an object of population control to a matter of women's empowerment to exercise personal autonomy in relation to their sexual and reproductive health within their social, economic and political contexts."[1] The ICPD Programme of Action presented a wider position on reproductive rights which "embrace certain human rights already recognised in national laws, international human rights documents, and other relevant UN consensus documents."[2] Scholars and organisations supporting this position encapsulates 12 rights within this: the right to life; the right to health; the right to personal freedom, security, and integrity; the right to be free of sexual and gender violence; the right to decide the number of spacing of one's children; the right to privacy; the right to equality and non-discrimination; the right to consent to marriage and equality in marriage; the right to employment and social security; the right to education; the right to be free from practices that harm women and girls; and the right to benefit from scientific progress.[3] It is through this encapsulation of reproductive rights that the right to safe abortion can clearly be positioned in existing treaties and conventions.

Progressive interpretation of human rights by treaty bodies that include abortion puts advocates in a better position to hold state parties accountable towards obligations that ensures access to safe abortion services.

Aspects of the right to safe abortion are cited within different human rights framework. Such international instruments have evolved to recognise the denial of abortion care as a violation of women's and girls' fundamental human rights.[4]

General comments/recommendations[5] published by human rights treaty bodies are not legally binding but have a highly authoritative character with a legal basis.[6] As espoused by Article 31 of the 1965 Vienna Convention on Law of Treaties, upon ratification of a treaty, states agree that instruments such as treaty bodies play a role in the interpretation of the treaty.[7] Therefore, progressive interpretation of human rights by treaty bodies that include abortion puts advocates in a better position to hold state parties accountable towards obligations that ensures access to safe abortion services. In this light, international human rights bodies can, indisputably, be a catalytic tool in advocating for the rights to safe abortion services.

It is imperative that advocates keep pushing for abortion through these existing rights, especially in the absence of an independent recognition of "the right to safe abortion." Advocates must use this trend towards a more progressive interpretation of treaties and conventions by human rights bodies to push for issues such as access to post-abortion care, decriminalisation of abortion for women in general, and women's right to access abortion on request, which is currently not covered by any general comment and recommendation.

The suceeding table demonstrates the areas within core human rights conventions, which maps where the right to abortion stands as per the current interpretation of treaty body experts. This mapping process also identifies the human rights which are clearly interlinked with access to abortion but has not been explicitly recognised by human rights committees through general comments and recommendations.

MAJOR INTERNATIONAL LEGAL INSTRUMENTS AND RIGHTS WITHIN THEM THAT ARE PERTINENT TO ABORTION	SELECTED GENERAL COMMENTS FROM MONITORING COMMITTEE RELATED TO THE RIGHT TO SAFE ABORTION	INTERPRETATION OF GENERAL RECOMMENDATION/COMMENT
THE INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION (ICERD) (DECEMBER 21, 1965)		
The Right to Public Health and Medical Care [Art. 5.e.(iv)] **The Right to Security [Art. 5(b)]** **The Right to Liberty [Art. 5.d.(viii)]**	*Implicit* Theme: Gender-related dimensions of racial discrimination "The Committee will endeavour in its work to take into account gender factors or issues which may be interlinked with racial discrimination" in the areas such as "...the disadvantages, obstacles, and difficulties women face in the full exercise and enjoyment of their civil, political, economic, social, and cultural rights on grounds of race, colour, descent, or national, or ethnic origin."[8]	The Committee will take gender into consideration when analysing how racial discrimination impacts the exercise of all other rights guaranteed by human rights conventions. These rights would entail rights to life and health, which are threatened without access to safe abortion.
THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (ICCPR) (DECEMBER 16, 1966)		
The Right to Life (Art. 6.1)	*Implicit* "State parties need to take measures to increase life expectancy."[9]	As evidence establish the relationship between unsafe abortion and maternal mortality, "measures" to increase life expectancy can be implied to include life-saving safe abortion services.
The Right to Equality and to be Free from Gender Discrimination (Art. 3)	*Implicit* On General Comment 28 (Article 3), the Human Rights Committee called upon States that while reporting on the right to life of women, they should report 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."[10] *Implicit* With regard to protecting children, the Committee requires state party to inform whether it "gives access to safe abortion to women who have become pregnant as a result of rape. The States parties should also provide the Committee with information on measures to prevent forced abortion or forced sterilisation."[11]	The comment situates unsafe abortion in the context of terminating an unwanted pregnancy and does not comment on any aspects of abortion. However, it can be inferred that unsafe abortion impedes women's right to life and therefore, offers a basis to push for activism on the rights to safe abortion. The language used in this comment implicitly calls for expanding the legal grounds for safe abortion services in circumstances such as rape and preventing forced abortions so that young women are guaranteed their basic human rights.
	Explicit "Another area where States may fail to respect women's privacy relates to... impos[ing] a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion."[12]	As stated in General Comment 28 (Article 3), women have the right to privacy and confidentiality while accessing abortion services. It can also be interpreted that as only women and girls become pregnant and require safe abortion, denial of services are construed as gender discrimination.

MAJOR INTERNATIONAL LEGAL INSTRUMENTS AND RIGHTS WITHIN THEM THAT ARE PERTINENT TO ABORTION	SELECTED GENERAL COMMENTS FROM MONITORING COMMITTEE RELATED TO THE RIGHT TO SAFE ABORTION	INTERPRETATION OF GENERAL RECOMMENDATION/COMMENT
The Right to Privacy (Art. 17)		Although the committee has not directly issued comments on Article 17 by linking the right to privacy and abortion, it has raised concern over women's right to privacy while accessing abortion services through comments on Article (3).[13]
THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (ICESCR) (DECEMBER 16, 1966)		
The Right to Health (Art. 12)	*Implicit* State parties are called to implement actions to "improve child and maternal health, sexual and reproductive health services...."[14]	Abortion is considered intrinsically as an integral component of sexual and reproductive health services.
	Implicit State parties are recommended to "remove all barriers to women's access to health services, education, and information, including in the area of sexual and reproductive health."[15]	As abortion is one of the critical domains of sexual and reproductive health, the call to eliminate barriers to the utilisation of health services, education, and information also applies to abortion.
	Implicit State parties should " integrate a gender perspective into their health-related policies, planning, programmes, and research."[16]	The recommendation relates to abortion as it is a health issue.
The Right to Equality and to be Free from Gender Discrimination (Art. 2.2, Art. 3)	*Implicit* The Committee calls state parties for "the removal of legal restrictions on reproductive ealth provisions."[17]	This comment can be interpreted to include the removal of all legal restrictions toward accessing abortion.
The Right to Enjoy the Benefits of Scientific Progress and its Application [Article 15(1)(b)]		The continued criminalisation of abortion denies women's right to enjoy the benefits of scientific progress and application in the area of reproductive health. However, this has yet to be recognised in a comment by the committee.
THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW) (DECEMBER 16, 1979)		
The Right to Equality and to be Free from Gender Discrimination (Art. 1, 2, and 3)		Although there is currently no general recommendation linking abortion to the right to equality and to be free from discrimination under CEDAW, it has been recognised as discrimination in other treaties and conventions in this table.

MAJOR INTERNATIONAL LEGAL INSTRUMENTS AND RIGHTS WITHIN THEM THAT ARE PERTINENT TO ABORTION	SELECTED GENERAL COMMENTS FROM MONITORING COMMITTEE RELATED TO THE RIGHT TO SAFE ABORTION	INTERPRETATION OF GENERAL RECOMMENDATION/COMMENT
Theme: Gender-based Violence	*Explicit* "Violations of women's sexual and reproductive health and rights, such as... criminalisation of abortion, denial or delay or safe abortion and post-abortion care, forced continuation of pregnancy...are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."[18] "Compulsory sterilisation or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of children."	This recommendation explicitly situates the denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy as a form of gender-based violence and, in some circumstances, torture. It also frames women's autonomy in choosing to have an abortion as an integral aspect of that decision-making without which can be a form of gender-based violence.
The Right to Health, Reproductive Health, and Family Planning [Art. 11.1(f), Art. 11.3, Art. 12, Art. 14.2(b)]	*Explicit* "While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception, or for incomplete abortion and in cases where they have suffered sexual or physical violence."[19]	This recommendation suggests that the lack of privacy violates women's right to health and could prevent women from seeking treatment for incomplete and even unsafe abortion procedures.
The Right to Determine Number and Spacing of One's Children [Article 16.1(e)]	*Implicit* "It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[20] States should "prioritise the prevention of unwanted pregnancy....When possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion."[21] States should protect women's rights to autonomy, privacy, confidentiality, informed consent, and choice.[22]	The language in this recommendation suggests that the refusal to provide for legal abortion and measures that protect women's autonomy, privacy, confidentiality, informed consent, and choice could be inferred as a violation of a woman's right to determine the number and spacing of her children. It can also be interpreted that as only women and girls become pregnant and require safe abortion, denial of services are construed as gender discrimination.

MAJOR INTERNATIONAL LEGAL INSTRUMENTS AND RIGHTS WITHIN THEM THAT ARE PERTINENT TO ABORTION	SELECTED GENERAL COMMENTS FROM MONITORING COMMITTEE RELATED TO THE RIGHT TO SAFE ABORTION	INTERPRETATION OF GENERAL RECOMMENDATION/COMMENT
Theme: Women's Access to Justice	*Explicit* "State parties are obliged under articles 2 and 15...to ensure that women have access to the protection and remedies offered through the criminal law and that they are not exposed to discrimination. Some criminal codes or acts and/or criminal procedure codes discriminate against women:...(b) by criminalising behaviour that can only be performed by women such as abortion."[23] "Women are also disproportionately criminalised owing to their situation or status such as...having undergone an abortion."[24]	The language in this recommendation emphasises the need to decriminalise situations and status that solely or disproportionately involve women, specifically mentioning abortion to ensure States obligation under articles 2 and 15 of CEDAW.
THE CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CAT) (DECEMBER 10, 1984)		
Right to be Free from Cruel, Inhuman, and Degrading Treatment (Article 2)	*Implicit* The committee identifies that women and girls are at risk of "deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence" and urges state parties to take necessary actions to prevent it.[26]	This comment recognised that women and girls were at risk of "deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence," which can be interpreted to include the decision to terminate a pregnancy as well.
THE CONVENTION ON THE RIGHTS OF THE CHILD (CRC) (NOVEMBER 20, 1989)		
The Right to Health (Art. 24)	(This is a theme-based general comment) *Explicit* The Committee urges states to "decriminalise abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents, and ensure that their views are always heard and respected in abortion-related decisions."[28] *Explicit* Recognises that the voluntary and informed consent of the adolescent should be obtained whether or not the consent of a parent or guardian is required for any medical treatment or procedure.[29] *Explicit* Recognises that states should remove third authorisation requirements for sexual and reproductive health information and services.[30]	Issued by the Committee on the Rights of the Child, General Comment No. 20 on the implementation of the rights of the child during adolescence is an important tool to advocate for adolescent's right to safe abortion. The committee has strongly advocated that adolescents should have access to safe abortion and post-abortion services irrespective of the legal status of abortion, and have further pledged governments to decriminalise abortion, remove parental authorisation, and obtain informed consent from adolescent while accessing safe abortion services.

MAJOR INTERNATIONAL LEGAL INSTRUMENTS AND RIGHTS WITHIN THEM THAT ARE PERTINENT TO ABORTION	SELECTED GENERAL COMMENTS FROM MONITORING COMMITTEE RELATED TO THE RIGHT TO SAFE ABORTION	INTERPRETATION OF GENERAL RECOMMENDATION/COMMENT
The Right to Life, Liberty, and Security [Art. 6, 37(b), 37(c), 37(d)]		Although abortion is a critical aspect in ensuring these rights, as of now, the committee has not recognised it as such in a general comment.
The Right to be Free from Cruel and Inhuman or Degrading Treatment [Article 37(a)]		
The Right to Equality and to be Free from Gender Discrimination (Art. 2) The Right to Privacy (Art. 16)		
THE CONVENTION ON THE RIGHTS OF PERSON WITH DISABILITIES (CRPD), (13 DECEMBER, 2006)		
The Right to Health (Art. 25)	"Certain forms of violence, exploitation and abuse may be considered as cruel, inhuman or degrading treatment or punishment and as breaching a number of international human rights treaties. Among them are: forced, coerced, and otherwise involuntary pregnancy or sterilisation, any medical procedure or intervention performed without free and informed consent, including procedures and interventions related to contraception and abortion...."[31]	General Comment No. 3 on women and girls with disabilities states that abortion done without the informed consent of women and girls with disabilities is a violation of their human rights.
	"Women with disabilities may also be denied access to information and communication.... Information may also not be available in accessible formats. Sexual and reproductive health information includes information about all aspects of sexual and reproductive health including...safe abortion and post-abortion care."[32]	Through General Comment No. 3, CRPD clearly establishes that women and girls with disabilities are not provided complete information on various sexual and reproductive health issues, including safe abortion, even though they should be, as they are perceived to be asexual.
	"All women with disabilities must be able to exercise their legal capacity by taking their own decisions, with support when desired, with regard to medical and/or therapeutic treatment, including by taking their own decisions on retaining their fertility and reproductive autonomy, exercising their right to choose the number and spacing of children, consenting and accepting a statement of fatherhood, and exercising their right to establish relationships. Restricting or removing legal capacity can facilitate forced interventions, such as sterilisation, abortion...."[33]	It states that all women and girls with disabilities have the rights to bodily autonomy and decision making. The General Recommendation No. 3 on women and girls with disabilities explains that third-party authorisation limits their rights and results in forced abortion.

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