AN ADVOCATE'S GUIDE:

Rights-Based Safe Abortion Policies, Programmes and Services

arrow
asian-pacific resource & research centre for women

AN ADVOCATE'S GUIDE:

Rights-Based Safe Abortion Policies, Programmes and Services

Developed by TK Sundari Ravindran and Subha Sri B

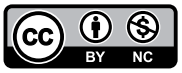
This guide is addressed to SRHR advocates and seeks to facilitate advocacy to ensure that rights-based safe abortion policies, programmes and services are achieved.

This publication has been produced with financial support from RFSU (Riksförbundet för Sexuell Upplysning) – the Swedish Association for Sexuality Education. The contents of this publication are the sole responsibility of the Asian-Pacific Resource & Research Centre for Women (ARROW).

arrow
asian-pacific resource & research centre for women

2021

ASIAN-PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN (ARROW)



ISBN 978-967-0339-52-8

arrow.org.my

PUBLISHED BY
Asian-Pacific Resource & Research Centre For Women (ARROW)
1 & 2 Jalan Scott, Brickfields
50470 Kuala Lumpur, Malaysia

Tel	00 603 2273 9913/9914
Fax	00 603 2273 9916
E-mail	arrow@arrow.org.my
Web	arrow.org.my
Facebook	facebook.com/ARROW.Women
Instagram	arrow_women
Twitter	@ARROW_Women
Youtube	youtube.com/user/ARROWomen
LinkedIn	arrowomen

PRODUCTION TEAM
Authors
TK Sundari Ravindran and Subha Sri B
Overall Supervision
Sivananthi Thanenthiran, Sai Jyothirmai Racherla, and Garima Shrivastava
Internal Reviewers
Sai Jyothirmai Racherla, Garima Shrivastava, and Karell Jo Angelique C. Calpito
External Reviewers
Marevic Parcon, Payal Shah, Leila Hessini, Cecilia Espinoza, and Bia Galli
Publications Coordinator
Garima Shrivastava and Karell Jo Angelique C. Calpito
Publications Technical Support
Garima Shrivastava, Karell Jo Angelique C. Calpito, and Keshia Mamood
Copy Editor
Stefanie Peters
Graphic Designer
Nicolette Mallari

Contents

Abbreviations

CAT	Committee Against Torture
CCPR	UN Committee on Civil and Political Rights
CEDAW	Committee on the Elimination of Discrimination against Women
CESCR	Committee of Economic, Social and Cultural Rights
CHW	Community Health Worker
COVID	Coronavirus disease
CRC	Child Rights Committee
CRPD	Committee on the Rights of Persons with Disabilities
CRR	Center for Reproductive Rights
EVA	Electric Vacuum Aspiration
GAPD	Global Abortion Policies Database
GGR	Global Gag Rule
HRBA	Human Rights-Based Approach
HRC	Human Rights Commission
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IUD	Intra Uterine Device
MA	Medical Abortion
MCH	Maternal and Child Health
MR	Menstrual Regulation
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
OCP	Oral Contraceptive Pills
OHCHR	Office of the United Nations High Commissioner for Human Rights
PAC	Post Abortion Care
PID	Pelvic Inflammatory Disease
PLHIV	People Living with HIV
POCSO	Protection of Children from Sexual Offences Act
RCOG	Royal College of Obstetricians and Gynaecologists
RH	Reproductive Health
RHR	Reproductive Health Rights
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UPR	Universal Periodic Review
VA	Vacuum Aspiration

INTRODUCTION

In 2012, the World Health Organization produced the second edition of Safe abortion: technical and policy guidance for health systems (henceforth, WHO guidance document), with a view to providing guidance on evidence-based best practices for the provision of safe abortion care.

The document not only provided clinical guidance, but also outlined best practices for abortion laws and policies grounded in human rights principles. It recommended adherence to the following principles:

- Laws and policies on abortion should protect women's health and their human rights.
- Regulatory, policy and programmatic barriers that hinder access to, and timely provision of safe abortion care should be removed.
- An enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care. Policies should be geared to respecting, protecting and fulfilling the human rights of women, to achieving positive health outcomes for women, to providing good-quality contraceptive information and services, and to meeting the particular needs of poor women, adolescents, rape survivors and women living with HIV (WHO 2012, p.9, Box 7).

Since 2012, there has been a significant evolution in our understanding of best practices and human rights norms for the provision of comprehensive safe abortion care. In 2019, WHO's guideline on self-care interventions for sexual and reproductive health and rights included early abortion as a procedure that women can self-manage using medical abortion pills, with appropriate health system support (WHO 2019). The mandatory lockdowns during the COVID-19 pandemic appear to have positioned self-managed early abortion as an acceptable option. In the human rights front, by 2020, almost all human rights treaty bodies have issued an unequivocal call for the decriminalisation of abortion in all circumstances.

This Guide, the fourth in the series of advocates' guides produced by ARROW, is addressed to SRHR advocates and seeks to facilitate advocacy to ensure that what has been achieved on paper translates into action on the ground, through monitoring progress on safe abortion access and quality, and the extent to which safe abortion services are informed by the prevailing international human rights standards. This advocates' Guide may be viewed as complementary to the WHO guidance document, which was aimed at policy makers, programme managers and abortion service providers. It draws on the WHO guidance document, updating both the clinical and the policy and human rights information as needed.

The Guide is organised into four chapters. The introductory chapter lays out the public health and human rights imperative for making safe abortion available to all who need it. The second chapter provides a summary of essential evidence-based technical information on abortion methods and procedures and their safety and efficacy, including protocols to be adopted. An overview of abortion laws and policies across the globe is provided in the third chapter. This chapter also examines the regulatory and service delivery barriers to safe abortion access, including examples of strategies used by advocates and activists to work around legal restrictions and expand access to abortion. The fourth and final chapter elaborates on what a rights-based safe abortion service ought to look like, using nine key principles reflecting human rights principles and standards relating to abortion information and services. These nine principles are the same as those used in WHO's guidance on rights-based contraceptive information and services: Non-discrimination; Availability of abortion information and services; Accessibility of abortion information and services; Acceptability of abortion information and services; Quality of abortion information and services; Informed decision-making; Privacy and confidentiality; Participation; and Accountability (WHO 2014).

The second, third and fourth chapters include checklists. The checklists are intended as tools to be used by advocates to assess existing gaps and identify areas for further investigation in terms of technical standards for abortion service provision; laws, policies and regulations on abortion; and adherence to human rights principles in abortion service delivery programmes. It is expected that such an assessment would contribute to the designing of advocacy activities to expand access to safe abortion services for all persons.

USING THE CHECKLISTS:

Each of the checklists uses a colour code to assess adherence to human rights principles. Two (in a few instances, three) colour codes have been provided for grading laws, policies, programmes and services related to safe abortion – red (signifying non-adherence to human rights principles), green (signifying adherence), and yellow (signifying partial adherence). There is also space provided for making additional notes. The higher the number of green boxes filled in the checklists, the better the adherence to human rights principles.

After the checklists have been filled-in, the red boxes may be reviewed to identify areas of non-adherence to human rights principles. These may then be prioritised for further advocacy and action by the group carrying out the review, keeping in mind their own mandate, scope of operation and strengths as a group/organisation/network, as well as the socio-political climate within which they operate. This has to then be followed by drawing up a time-bound action agenda.

CHAPTER 1
Safe Abortion: A Public Health and Human Rights Issue

1.1 INTRODUCTION

The right of every woman to choose freely and responsibly, without coercion, the number and spacing of their children and to have the means to do so has been set out in the ICPD Programme for Action (1994). The ability to exercise this right is contingent on women's access to services to terminate safely any unplanned or mistimed pregnancy. Although women have always needed access to safe abortion services, such services continue to be denied to millions of women across the globe because of restrictive laws that criminalise the voluntary termination of a pregnancy through an induced abortion. Even in settings where the law is relatively less restrictive, services are often inaccessible for a number of reasons. When a pregnant person does not have access to safe abortion services, she often has no option but to seek services that are less than optimal, or 'unsafe'. The consequences are avoidable deaths and morbidity suffered by millions of persons.

The drop in abortion-related mortality and morbidity rates (especially in countries where abortion is illegal), and the replacement of unsafe methods by pharmacological abortions, has led researchers to review the methods of evaluation and classification in relation to safety of abortions in countries with more restrictive laws that have more or less access to abortion performed with drugs. 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 (Ganatra et al. 2017). 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. Worldwide, an estimated 55% of abortions can be categorised as safe, 31% as less safe and 14% as least safe.

Denying a reproductive health service such as abortion, which only women[1] and transgender persons capable of pregnancy need, infringes on their ability to make autonomous decisions about their sexuality, reproductive functions and their lives, violating their right to privacy and equality among other basic human rights. (UNOHCHR 2020).

The Right to Health includes both freedoms and entitlements. Freedoms mandate that States must ensure that individuals have the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation (CESCR 2000). Entitlements include a functional health system with appropriate health care services, community-based services, availability of health care institutions, access to essential medicines, adequate health care providers and provision of health-related education and information especially regarding health (CESCR 2000).

In this chapter, we present the public health and human rights rationale for advocating for universal access to safe abortion services to all women. In the next section (1.1), we discuss the extent of the need for safe abortion services, and the consequences of restricted access to such services across the globe. Following this, in section 1.2, we provide information on international declarations and human rights covenants that affirm women's right to safe abortion services and traces the positive role played by international treaty bodies and UN agencies in advancing women's right to safe abortion services. The final section (1.3) of this chapter provides evidence-based information on some frequently asked questions related to the legality and safety of induced abortion.

1.2 PUTTING SRHR ON THE GLOBAL AGENDA: THE JOURNEY TO CAIRO AND TO THE SDGs

Not all pregnancies are planned and not all persons who become pregnant wish to continue with the pregnancy. Non-consensual sex, contraceptive failure and personal circumstances that make the birth of a child difficult are some common reasons why women decide not to continue with a pregnancy.

It is estimated that during 2015-19, there were 121 million unintended pregnancies every year across the globe. For every 1,000 women of reproductive age (15-49 years), 64 pregnancies were unintended annually. Close to two-thirds of them ended in an abortion (Bearak et al. 2020). The probability that an abortion was unsafe increased in countries where safe abortion services were restricted by law or were difficult to obtain because of limited availability.

1.2.1 Unsafe Abortion: Extent of the Problem

Latest available data (2010-14) show that globally, there were roughly 25 million unsafe abortions happening each year. Fifty percent of all abortions were safe, 31% were less safe and 14% were least safe. Almost all abortions in developed countries and roughly half the abortions in developing countries were safe (Ganatra et al. 2017). A synthesis of findings from studies covering 12 developing countries showed that adolescents were more likely than older women to seek abortion services from untrained providers or to self-induce abortions. As a consequence, they were more likely to make multiple efforts at abortion. All these factors increase the risk of complications from unsafe abortions. Sixteen percent of unsafe abortions in the developing world was among adolescents aged 15-19 years (Darroch et al 2016).

As may be expected, the legal status of abortion in a country made a crucial difference to the percentage of safe abortions. Thus, in countries where abortion was available on request, 87% of all abortions were safe, while only one in four abortions (25.2%) were safe in countries with restrictive abortion laws. (Ganatra et al. 2017).

1.2.2 Morbidity and Mortality Following Unsafe Abortions

Death and disability from complications of unsafe abortion represent an unparalleled public health tragedy because it is a completely preventable cause of death and disability that affects women who are usually healthy and in the prime of their lives. Historical experience shows that when abortion services are available on broad legal grounds or on request, deaths from unsafe abortion declines significantly as women have access to life-saving information to make autonomous choices. This was the case in Romania and more recently in South Africa. In Romania, abortion had been banned for 28 years preceding 1989, and maternal mortality ratio stood at 148 per 100,000 live births. Following legalisation in 1989, there was a plunge in maternal mortality ratio to 9 per 100,000 in 2002, a 16-fold decline over a period of less than 15 years. In South Africa, the number of maternal deaths in public facilities declined 91%, from 425 deaths in 1994 to 40 deaths in 1999 (Guttmacher 2017).

Women who undergo abortions under least safe conditions may experience complications such as incomplete abortion, where the product of conception has not been completely expelled; haemorrhage or heavy bleeding; infection, and life-threatening conditions such as perforation of the uterus as a result of being pierced with a sharp object, and damage to the genital tract and internal organs because dangerous objects were inserted into the vagina or anus in an attempt to induce the abortion (WHO 2019). In settings with restrictive abortion laws, fear of prosecution may deter or delay many women suffering complications from unsafe abortion from seeking post-abortion care. When untreated or treated too late, complications from unsafe abortions may result in long-term morbidity such as inflammation of the reproductive tract, pelvic inflammatory disease (PID) and infertility (Guttmacher 2018).

As of 2012, an estimated seven million women in developing regions (excluding Eastern Asia) were treated in facilities for complications from unsafe induced abortions (Guttmacher 2017). Studies show that both the proportion of unsafe abortions resulting in complications, and the severity of complications has been declining over time. One important reason for this is the availability of medical abortion, and the

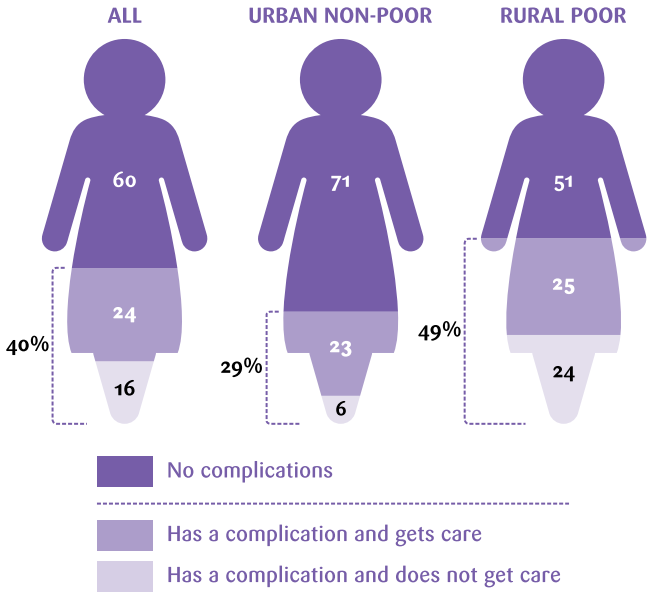
declining use of the more crude and dangerous methods in current times (Singh et al. 2017).

Annually, some 22,800–31,000 women with complications following an unsafe abortion die of these conditions. Sub-Saharan Africa has the highest current case fatality rate of 141 per 100,000, followed by Asia, excluding East Asia, (62 per 100,000), while Latin America and the Caribbean has the lowest rate of 22 per 100,000 (Singh et al. 2017). Unsafe abortions contribute to 4.7–13.2% of all maternal deaths (Say et al 2014). Studies in sub-Saharan Africa indicate a much higher range of 12-31% [Salamonsen 2017]. A 2005 study from Nigeria reported that unsafe abortion was the leading cause of maternal deaths among adolescents aged 15-19 years (Ujah et. al. 2005).

It is often women from low-income and other marginalised groups such as those living in rural areas, migrants and adolescents, who are worst affected when access to abortion is restricted. Those who can afford to pay usually manage to access safe abortion services. Estimates based on studies from 14 developing countries show that women from socially and economically vulnerable groups bear a disproportionate burden (Guttmacher 2017) (Figure 1).

FIGURE 1: DIFFERENTIAL RATES OF ABORTION COMPLICATIONS

In 14 countries where unsafe abortion is prevalent, rural poor women are estimated to be far more likely than urban non-poor women to experience complications.



Source: Adapted from Guttmacher 2017.

1.3 HUMAN RIGHTS OBLIGATIONS TO PREVENT AND ADDRESS UNSAFE ABORTION

The right to decide whether or not to continue with a pregnancy is a basic human right. This is endorsed and supported by several international consensus documents, treaties and instruments. Reproductive rights, including access to safe abortion, are essential for the enjoyment of a wide range of human rights, including the rights to life, health, freedom from torture and ill-treatment, privacy, education, equality and non-discrimination.

Key UN Human Rights Treaty Bodies have interpreted their mandate to include the prevention of avoidable morbidity and mortality from unsafe abortion and affirm the right of women and girls to access safe abortion services. By 2020, the call to decriminalise abortion in all circumstances has come from, inter alia, the Committee on the Elimination of Discrimination against Women (CEDAW Committee), the Working Group on Discrimination against Women and Girls, the Child Rights Committee (CRC), the Committee on the Rights of Persons with Disabilities (CRPD), the Special Rapporteur on the right to the highest attainable standard of physical and mental health, the Special Rapporteur on extrajudicial, summary, or arbitrary executions, and the Special Rapporteur on violence against women (UN 2011; UNOHCHR 2017; UNOHCHR 2018). Regionally, the African Commission on Human and Peoples' Rights has also expressed support for the decriminalisation of abortion and initiated in 2016 a regional campaign to this end (ACHPR 2016).

As early as in 1999, the CEDAW Committee noted that it is a form of gender discrimination for a state party to "refuse to provide legally for the performance of certain reproductive health services for women" or to punish women who seek those services (CEDAW Committee 1999a). The Committee has termed the non-provision of safe abortion services to women even when there is a threat to her life or her physical or mental health to be in violation of Article 12 of the Convention of the rights of women to health and life (CEDAW Committee 1999b). In its General recommendations no. 35 on gender-based violence against women issued in 2017, the CEDAW Committee further observed (paragraph 18) that criminalisation of abortion, denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy are forms of gender-based violence and gender discrimination...(which may in some circumstances) amount to torture or cruel, inhuman or degrading treatment (CEDAW 2017). The report of the Working Group on discrimination against women in law and

practice, again, affirmed the right of women and girls to make autonomous decisions about their own bodies and reproductive functions, as being at the very core of their fundamental right to equality and privacy (Human Rights Council 2018).

In 2013, the Committee on the Rights of the Child (CRC), through its General Comment No. 15 on the child's right to health, recommended that "States ensure access to (sexually active adolescents) safe abortion and post-abortion care services, irrespective of whether abortion itself is legal (Child Rights Committee 2013). The Committee's General Comment 20 issued in 2016 took a much stronger position, urging States to decriminalise abortion so that girls have access to safe abortion and post-abortion services, *and 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*. (Child Rights Committee 2016, paragraph 60).

The Committee of Economic, Social and Cultural Rights (CESCR) adopted General Comment 22 in 2016. elaborating on specific aspects of the right to health. According to this General Comment, access to safe abortion was a component of the right to health, and legislations that denied access to safe abortion services represented a failure by States to respect the right to health of women (Committee on Economic Social and Cultural Rights 2016: Paragraph 57). The General Comment required states to adopt all necessary legislative, budgetary, judicial and administrative measures to make abortion (and other SRH) services available and also ensure the availability of trained healthcare providers willing to provide services in public and in private healthcare facilities (Committee on Economic Social and Cultural Rights 2016: Paragraphs 60 and 14). States were called upon to eliminate and refrain from adopting medically unnecessary barriers to abortion such as mandatory waiting periods and third-party authorisation requirements. States were also to regulate a practitioner's refusal of abortion on grounds of conscience, if such a practice was allowed in the country (Committee on Economic Social and Cultural Rights 2016: Supra note 1, Paragraphs 41 and Supra note 1, paragraph 14).

Denial of abortion services to women, resulting in their taking recourse to unsafe abortion services and risking their lives represents a violation of women's right to health and life. In 2018, the Committee on Civil and Political Rights (CCPR) issued its General Comment 36 on the right to life, explicitly mentioning that State Parties may not regulate access to safe abortion services through measures that could violate the right to life of women and girls. It also urges State Parties to not impose criminal sanctions against women and girls undergoing abortion or medical service providers who assist them in doing so, in order to prevent unsafe abortion (Committee on Civil and Political Rights 2018: Paragraph 8).

Besides these Treaty Bodies, the Committee Against Torture (CAT) has on various occasions identified the complete ban on abortion[2] as constituting torture or ill-treatment (Committee Against Torture 2009a), and has recommended that access to abortion be ensured for women whose life or health is at risk (Committee Against Torture 2009b), who are survivors of rape or incest, or are carrying non-viable foetuses (Committee Against Torture 2011). The Committee on the Rights of Persons with Disabilities (CRPD) in its Article 25 affirms that States have an obligation to provide persons with disabilities the same range, quality and standard of free and affordable sexual and reproductive health care and programmes as provided to others (UN 2006). Seeking to prevent involuntary abortion and sterilisation in persons with disabilities, the CRPD recommended to the government of Argentina that persons with disabilities be provided with the necessary support under guardianship or trusteeship so that women themselves are the persons providing informed consent for abortion and sterilisation (CRPD, 2012).

The Universal Periodic Review (UPR) process was set up as a peer-review process among Member States by the Human Rights Council (HRC) since 2006. The UPR has proved to be an important mechanism for holding States accountable for upholding sexual and reproductive rights, including the right to safe abortion services. Between 2008 and 2016, there were 145 UPR recommendations referring to abortions. These recommendations broadly called for decriminalisation of abortion at the least in cases of risk to the pregnant woman's life or health, in cases of rape or incest and when the foetus is non-viable; to free women imprisoned for seeking abortion; and to remove legal as well as health-system barriers to accessing abortion services (Berro Pizzarossa 2018).

The 2017 Report of the High Level Working Group on Women, Children and Adolescents' Health represents another major landmark in the advancement of abortion as a human right. The report, presented both to the World Health Assembly and the Human Rights Council (WHO 2017), openly called for the legalisation of abortion, based primarily on human rights considerations. It recommended that State Parties: Repeal, rescind or amend laws and policies that create barriers or restrict access to health services (including sexual and reproductive health and rights services) and that discriminate, explicitly or in effect, against women, children or adolescents

as such, or on grounds prohibited under human rights law. This includes repealing laws that criminalise specific sexual and reproductive conduct and decisions, such as abortion, same-sex intimacy, sex work and the delivery or receipt of sexual and reproductive health and rights information. (WHO, 2017: Page 58).

Each of these developments has opened up spaces for sexual and reproductive health and rights advocates to hold their governments accountable to decriminalise abortion and to put in place safe abortion services. Many countries, for example, Bolivia, Chad, Colombia, Ethiopia and Nepal, have had to liberalise their abortion laws and improve access to services. These changes have either been a direct result of recommendations from the Treaty Monitoring Bodies and the UPR process, or resulted from their influence on national-level legal accountability processes (Zorzi 2016; Steven 2018).

1.4 FREQUENTLY ASKED QUESTIONS ABOUT THE RIGHT TO SAFE ABORTION

1.4.1 Does the Foetus Have an Absolute Right to Life, According to International Human Rights Treaties?

Article 1 of the Universal Declaration of Human Rights states that "*[a]ll human beings are born free and equal in dignity and rights*" (United Nations 1948). The explicit mention of "born" implies that human rights apply only after birth (Center for Reproductive Rights 2014). The General Comment 36 on the Right to Life under Article 6 of the International Covenant for Civil and Political Rights (ICPR) upholds women's right to not be denied the right to life because of legal restrictions imposed on abortion (Committee on Civil and Political Rights 2018: Paragraph 8).

> *Although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy (Committee on Civil and Political Rights 2018: Paragraph 8).*

One of the arguments made against abortion is that it violates the right to life of the foetus. The right to life is a fundamental human right, central to the enjoyment of all other human rights. International human rights law recognises this basic right as accruing at birth, and international and regional human rights bodies, as well as courts worldwide, have clearly established that any prenatal protections must be consistent with women's human rights. (Center for Reproductive Rights, 2014)

The Child Rights Convention, and its General Comment no. 15 and no. 20 on the child's right to health, affirm the right of the adolescent to safe abortion services, even in settings where abortion may not be legal, and call upon governments to review their legislations related to abortion to guarantee the best interests of the adolescents and listen to their needs (Child Rights Committee 2013, Child Rights Committee 2016). These General Comments clarify that the language of CRC's preamble stating "*the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth,...* (United Nations 1989)" is not to be misinterpreted as supporting the absolute right to life of the foetus.

The European Court of Human Rights has in several instances ruled that the right to life affirmed in Article 2(1) of the European Convention on Human Rights does not extend to the unborn. For example in VO vs. France the Court clarified that the unborn child was not automatically recognised as a 'person' directly protected by Article 2(1). The Inter-American Commission and the Inter- American Court of Human Rights have also ruled, for example in Artavia Murillo et al. ("In Vitro Fertilisation") v. Costa Rica, 2012) and Baby Boy v. United States, 1981, that the right to life enshrined in the American Convention on Human Rights is not absolute and is compatible with the right to reproductive autonomy. (Center for Reproductive Rights 2014, p. 7-8).

International and regional human rights bodies, as well as courts worldwide, have clearly established that any prenatal protections must be consistent with women's human rights.

Some countries of the world have legislations recognising the rights of the unborn child. For example, the national constitutions of Chile and Guatemala explicitly recognise the right to life before birth. In recent times, there have been attempts to extend the interpretation of the right to life enshrined in national constitutions to include the prenatal stage (Center for Reproductive Rights 2014, Copelon et al. 2005). These developments need to be challenged as inimical to fundamental rights of women and all persons who can get pregnant, because:

> *These efforts, often rooted in ideological and religious motivations, are part of a deliberate attempt to deny women the full range of reproductive health services that are essential to safeguarding women's fundamental rights to life, health, dignity, equality, and autonomy, among others (Center for Reproductive Rights 2014).*

In societies where premarital childbearing is punished by social sanctions and even violence, abortion remains the only recourse.

1.4.2 Do Legal Restrictions on Abortion Reduce the Incidence of Abortions?

One of the proposed justifications for imposing legal restrictions on abortion is to discourage the practice and lower the incidence of abortion.

Nothing can be far from the truth. Evidence shows that irrespective of whether or not abortion is restricted, women seek to terminate a pregnancy if they think it is not possible for them to continue with it. In 2015-19, the incidence of abortion was higher (36 per 1000 women aged 15-49 years) in countries where abortion is restricted as compared to countries where abortion is broadly legal (26 per 1,000 women).[3] Interestingly, the incidence of abortion was 40 per 1,000 women in countries where abortion was banned completely, as compared to 36 per 1000 women where it was permitted to save the life of the women and also in countries where abortion was permitted for health reasons. Further, between 1990-94 and 2015-19, the incidence of abortion increased by 12% in countries with restrictive abortion laws, while it declined by 43% in countries where abortion was broadly legal (Bearak et al. 2020).

1.4.3 Would it Not be Better if Women Were More Responsible and Avoided Unwanted/Unplanned Pregnancy in the First Place?

Unplanned or unintended pregnancies are often the result of circumstances that are unavoidable or beyond the control or will of the woman. Sex is not always voluntary and consensual. A clear example is pregnancy resulting from sexual violence and non-consensual sex, including among married women (Ravindran and Balasubramanian 2004; Subhasri and Ravindran 2012).

Socioeconomic reasons and wanting to stop or space childbearing are some of the most common reasons reported by women for why a pregnancy is unwanted (Singh et al. 2017). Contraceptive use is not always a feasible option for many women. It is influenced by the circumstances of women's lives, such as medical conditions, support from partners, access to healthcare and the trade-off between perceived benefits of contraception and their risks.

The lack of sex education and the unwillingness of the health system to provide contraceptive information and services to adolescents and young people contributes to unintended pregnancies. In societies where premarital childbearing is punished by social sanctions and even violence, abortion remains the only recourse (Sowmini 2013).

In some settings, husbands or male partners are unsupportive of the woman's contraceptive use and unwilling to use a condom, even when they intend to stop or postpone childbearing (Kriel et al. 2019). Many of the reversible methods of contraception for women – such as the oral contraceptive pill, the IUD and the injectable contraceptive have side-effects, and without easy access to quality health services, women are wary of using these methods (Sedgh and Hussain 2014).

1.4.4 Would Widespread Use of Contraception Eliminate the Need for Abortion?

No, it would not. There will always be some women who need abortion, irrespective of how widespread contraceptive use is. One, not all women seek an abortion because their pregnancy was unintended. For some women, a pregnancy that starts off as a wanted one may become unwanted for reasons such as serious foetal anomaly, threat to the pregnant woman's health or life, and changes in her life circumstances including loss or break-up with the partner, or other crises situations. Two, almost all contraceptives tend to fail in a small proportion of women under 'typical' use in real life situations. While one in 100 women using a hormonal implant, an IUD or female

sterilisation are likely to get pregnant under typical use, the proportions are 4, 9 and 17% respectively among users of the injectable contraceptive (Depo-Provera), the oral contraceptive pill and the diaphragm, respectively (CDC 2020).

Historical data from across the world shows that increased contraceptive use does not always result in decreased abortion rates. The aggregate relationship between contraceptive use and incidence of abortion is complex. Many countries (e.g. Cuba, Singapore, Republic of Korea) experienced simultaneous increases in contraceptive prevalence rates and abortion rates during periods of steep fertility decline. This is believed to be because increased contraceptive use alone was not able to meet the need for fertility regulation in situations of rapid fertility decline (Martsen and Cleland 2003).

1.4.5 Are Women Undergoing an Induced Abortion at Risk of Psychological Trauma and Secondary Infertility?

There is a belief among many that an induced abortion is associated with psychological trauma, and several studies are cited in support of this claim. However, methodologically sound and substantive studies, spanning more than three decades, indicate that there is no basis to this claim.

Systematic reviews carried out by the Academy of Medical Royal Colleges in London, and by the American Psychological Association's Task Force on Mental Health and Abortion (TFMHA) have found that abortion does not have any serious emotional effect on women. However, when the woman has a pre-existing emotional or psychological problem before the abortion, or when a wanted pregnancy is terminated for health reasons or because of serious foetal anomaly, there is an increased risk of mental health problems after an abortion (Planned Parenthood Federation of America 2014).

A paper based on a five-year follow-up comparing women who were refused abortion with those who received one, found that being denied an abortion may be associated with greater risk of initially experiencing adverse psychological outcomes. However, there was no significant difference between the two groups at the end of five years (Biggs et al. 2017). Earlier studies from the 1980s conducted in Sweden, Scotland and Czechoslovakia showed that refusal of an abortion frequently resulted in serious psychosocial difficulties in the women for long periods of time following the abortion refusal. Also, case-controlled long-term follow-up studies in Czechoslovakia and Sweden indicated a high risk of psychosocial problems in the unwanted children born following refusal of abortion (Watter 1980).

Historical data from across the world shows that increased contraceptive use does not always result in decreased abortion rates. This is believed to be because increased contraceptive use alone was not able to meet the need for fertility regulation in situations of rapid fertility decline.

There is no proven association between uncomplicated induced abortion and subsequent infertility, according to the abortion guidelines by the Royal College of Obstetricians and Gynaecologists (RCOG 2011, p.43). However, in instances where post-abortion infection occurs, this may later result in tubal infertility. Routine use of prophylactic antibiotics in post-abortion can reduce the risk of infection to less than one percent of the women undergoing the procedure (RCOG 2011, p. 42).

1.4.6 Aren't Abortions Dangerous to Women's Lives?

When performed by trained providers in suitably equipped health facilities, abortion is one of the safest procedures. During 2000-2009 the abortion-related mortality rate in the USA was 0.7 per 100,000 procedures as compared to 0.8-1.7 deaths per 100,000 plastic surgery procedures and 0-1.7 deaths per 100,000 dental procedures (Raymond et al. 2014). According to WHO's recent recommendations, individuals in the first trimester (up to 12 weeks pregnant) can self-administer mifepristone and misoprostol medication without direct supervision of a health-care provider (WHO 2020).

Another study also confirms the relative safety of abortion as a procedure through a comparison of two similar groups of women. The first group was women who sought and received an abortion, and the second, women who were turned away from an abortion service and continued with their unwanted pregnancies. Those giving birth experienced potentially life-threatening complications and one maternal death among 231 women, while there were no instances of morbidity or mortality among women who received abortions. Women who delivered a child reported needing three times as many days of rest as women who had an abortion (Gerdts et al. 2016).

CHAPTER 2
Clinical Care for Persons Undergoing Abortion: Some Points for an Advocate

This chapter introduces technical aspects related to clinical care for persons undergoing abortion. The content included in this chapter does not intend to duplicate existing clinical guidelines, but rather will focus on key technical points that are considered essential knowledge for anyone who is advocating for safe abortion services (but may not necessarily have a medical background). This chapter is relevant also for legally restrictive setting as it details the minimum standards necessary to ensure the technical quality and safety of the abortion procedure carried out to save the life or health of the person. The chapter also provides technical details on self-managed abortion and post-abortion care that can be used in such restrictive settings.

At the end of the chapter, a checklist is presented for assessing the technical quality of abortion services in a particular area. This checklist is meant for SRHR advocates and can be used in combination with the checklists in Chapter 4 to assess the level of adherence to human rights principles in abortion services provided in a specific country.

2.1 SAFE ABORTION

The World Health Organization (WHO) defines an abortion as safe if it is provided both by an appropriately trained provider using a recommended method in an environment that meets all medical standards (WHO, 2012). Over the years, the introduction of simple technologies like medical methods of abortion and vacuum aspiration has led to abortions becoming safer even when performed in primary care settings and by providers other than doctors (Ganatra et al, 2017). Thus, the classification of safety of abortion has moved away from the dichotomous classification of safe and unsafe, to capture a spectrum of safety, with abortions now classified as safe, less safe and least safe (refer Chapter 1 for further details).

It is important to note here that legal abortion and safe abortion are not necessarily the same – legal abortion is one that conforms to the law of the land, while safe abortion is one that is performed under safe conditions as defined above. A legal abortion could at times be unsafe, just as an illegal abortion could possibly be performed safely. However, there is enough evidence that provision of abortion services under the law improves access to safe abortion services (WHO, 2012).

2.2 METHODS OF ABORTION

Broadly, there are two methods to carry out an abortion – surgical or medical.

Surgical abortion is the use of a minor surgical procedure to carry out an abortion. The recommended surgical procedures and their effectiveness vary according to the duration of pregnancy.

> *It is important to note that medical abortion drugs are different from emergency contraceptive pills – emergency contraceptive pills are used after an unprotected sexual intercourse to prevent pregnancy, whereas medical abortion pills are used to terminate an established pregnancy.*

Since surgical abortion involves introduction of surgical instruments into the uterus,

- it needs well-trained and skilled health care providers to perform the procedure,
- care needs to be given to prevention of infection through antibiotics, and
- prevention and management of pain needs to be done through appropriate anaesthesia.

Medical abortion is abortion is carried out using medicines without any surgery. A combination of two drugs, mifepristone and misoprostol, used sequentially, is the most common method. In places where mifepristone is not available, misoprostol alone can be used. When used in the recommended dosage and protocol, medical abortion is highly effective, especially before 12 weeks of pregnancy. Since medical abortion does not require an invasive surgical procedure, it can be provided by health providers even at the primary care-level, or with the right information and dosage,

can be done at home or in a comfortable place by the pregnant persons themselves, and thus has the potential to make abortion more accessible.

More details regarding medical and surgical methods of abortion are given in subsequent sections.

2.3 PRE- ABORTION CARE

It is important to note that any service provided before an abortion should not be obligatory or create additional delays to abortion, thus constituting an unnecessary barrier to access the procedure.

When a person approaches a health care provider seeking to have an abortion, there are several elements of pre-abortion care that should be provided by the health care provider. These include:

- Information provision and counselling,
- History taking, physical examination, and laboratory tests and ultrasound as required,
- Information and counselling on contraception.

Each of these is detailed further below.

2.3.1 Information Provision and Counselling

Any person who is seeking an abortion should be provided complete and scientifically accurate information regarding it. Such information should help the person

- decide on proceeding with the abortion,
- decide on a suitable method for abortion,
- decide on what kind of pain management they would require, and
- what to expect from the procedure.

Counselling should be done in an impartial and non-judgmental manner, irrespective of the person's age and marital status, such that it helps the person make their own decisions. Counselling should NOT be mandatory. If the person has already decided to undergo an abortion, subjecting them to mandatory counselling in an effort to change their mind is a violation of their reproductive right. Providing counselling and information should only be done by persons trained to do so and a counselor should not impose their moral/religious values on abortion on the person seeking to have one. The counselling session must be done under conditions that ensure privacy and confidentiality. Box 1 lists some of the features of good counselling for safe abortion services.

BOX 1:
CHARACTERISTICS OF GOOD COUNSELLING FOR SAFE ABORTION SERVICES

- Counselling must be done in a place that ensures privacy and confidentiality.
- Clients must be provided with scientifically correct and complete information on all the available and appropriate abortion methods.
- Clients must be supported to make an informed and voluntary decision regarding abortion and abortion method.
- Clients must be counselled whenever required in the language they understand.
- Care should be taken to explain to clients what will happen before, during and after the procedure, and potential complications.
- Clients must be encouraged to ask questions to clarify their doubts, if any.
- The counsellor should not impose their own personal values and beliefs on the client. Counselling should be non-judgemental and neutral.
- Counselling should also identify persons with different vulnerabilities – e.g. those facing intimate partner violence, adolescents – and provide them requisite support.

Sourec: Adapted from WHO guidance, 2012.

The information provided as part of pre-abortion care should include the following:

1. The different methods of abortion that are suitable for the person according to gestational age and other criteria, so that they may be able to choose a suitable method.
2. Details of what will be done as part of pre-abortion care before the procedure, including any tests and ultrasound examination.
3. What to expect during the procedure – what will be done, how long will it take, what to expect in terms of pain, bleeding and other symptoms, what kind of pain relief is required, what are the options available for pain management, so the person can choose what they prefer.
4. What happens after the procedure – how long will there be bleeding and any other symptoms, when can normal work be restarted, when can sexual activity be resumed, what

follow up care is needed, what to watch out for in terms of danger signs, when and where to seek health care in case of any complications.

5. Information on contraception in order to prevent future unwanted pregnancies – what are the suitable methods and helping the person choose one, where and when to get access to the contraceptive method.

Counselling should also identify persons under vulnerable circumstances who may need additional support during the abortion process. These include adolescent girls, those with pregnancies outside of marriage, women experiencing domestic violence, women who are coerced to either terminate or continue their pregnancy and transmen. In such circumstances, counsellors should identify the support such persons need or link them with organisations that can offer such support.

Pre-abortion counselling also offers an opportunity to address any concerns the person may have regarding potential health consequences of the abortion – there are several myths regarding the effect of abortion on future pregnancy, infertility, breast cancer and mental health that should be dispelled if the person seeking abortion expresses any concerns about them. Some of these are discussed in Chapter 1.

2.3.2 History Taking, Physical Examination and Laboratory Tests

Pre-abortion care should include a complete history taking by the health care provider and a thorough physical examination. The objectives of this are:

- to estimate the duration of pregnancy,
- identify any specific contraindications for either medical or surgical abortion, and
- to identify any risk factors that may lead to complications during or after the abortion.

2.3.2.1 History

The health care provider should ask for history regarding the date of the last menstrual period in order to ascertain the duration of pregnancy (gestational age). If the woman has irregular periods, that may affect the accurate estimation of the duration of pregnancy; therefore, details of whether the person's menstrual cycles are regular needs to be asked. The estimation of pregnancy duration may not be accurate in persons who are using hormonal contraception and therefore have either no periods (amenorrhoea) or irregular bleeding. Some persons may also experience bleeding during early pregnancy which can affect the accuracy of estimation of gestational age.

Other aspects to be covered in the history include:

- a past medical history to identify any illnesses that may pose risks or cause complications,
- history of any bleeding disorders,
- any medications,
- any allergies,
- obstetric and gynaecological history,
- history to rule out risk factors for ectopic pregnancy, and
- family history for relevant illnesses.
- In addition, the history should cover social aspects including any history of violence and coercion regarding decision to either continue or terminate the pregnancy.

2.3.2.2 Physical Examination

The main purpose of the physical examination is to determine the duration of the pregnancy. This is done by a trained health care provider through both an abdominal examination and a pelvic examination. In addition, basic parameters like pulse rate, blood pressure and temperature are measured. Anaemia status of the person is also checked for. Additionally, the examination rules out any conditions like sexually transmitted infections or malaria.

2.3.2.3 Laboratory Tests

No laboratory tests are routinely required before an abortion. If there is a clinical suspicion of anaemia, a haemoglobin test may be useful. If feasible, blood grouping and typing may be done so that Rh immunoglobulin can be administered as per protocol if the person has an Rh negative blood group.

2.3.2.4 Ultrasound Examination

An ultrasound examination is not routinely required before all abortions. An ultrasound is however useful in clinical circumstances where

- it is unclear whether the person is pregnant,
- there is doubt regarding the duration of pregnancy, either because of
  - irregular periods, or
  - because the size of the uterus is either smaller or bigger than expected according to the menstrual dates, or
- if there is a clinical suspicion of ectopic pregnancy.

Insistence on an ultrasound examination before all abortions is unnecessary, overmedicalises the abortion procedure, and creates unnecessary barriers for those seeking an abortion.

If an ultrasound is needed, it should be done, if possible, in a separate area, away from ultrasound examinations conducted for women seeking antenatal care.

An ultrasound examination is not routinely required before all abortions. It is indicated only under certain clinical conditions. Insistence on an ultrasound examination before all abortions is unnecessary, over-medicalises the abortion procedure, and creates unnecessary barriers for those seeking an abortion.

2.3.3 Contraception

The person seeking an abortion should be provided information on future contraception as part of pre-abortion care so that they may start using a contraceptive method as soon as appropriate after the abortion procedure. The person should be informed that ovulation may occur as early as two weeks after the abortion and a pregnancy can occur if no contraception is used.

The information provided should discuss all suitable methods for the person so they may choose the most appropriate method suitable for them. In addition, information must be provided on when the method should be started and where the service may be accessed.

In case the present unwanted pregnancy has resulted from contraceptive failure, the possible reasons for such contraceptive failure must be discussed and the person should be given help to choose an alternative method if required.

Acceptance of a contraceptive method must NOT be a precondition for abortion services and abortion should not be denied to a person if they choose not to use any contraception. This is discussed further in Chapter 4.

2.4 THE ABORTION PROCEDURE

Different methods of abortion are available and the methods that are suitable for a particular person depend mainly on the duration of pregnancy. Generally, the abortion methods vary based on whether the duration of pregnancy is less than 12-14 weeks or more than 12-14 weeks.

Below 12-14 weeks, the options available are:
1. Medical abortion
2. Vacuum aspiration

Above 12-14 weeks, the options available are:
1. Medical abortion
2. Dilatation and evacuation (D&E)

The different methods and their relative advantages and disadvantages are described in detail below.

2.4.1 Medical Abortion (MA)

Medical abortion is abortion using medication, without any surgical procedure. Medical abortion is commonly done through the combination of two drugs used sequentially – mifepristone and misoprostol.

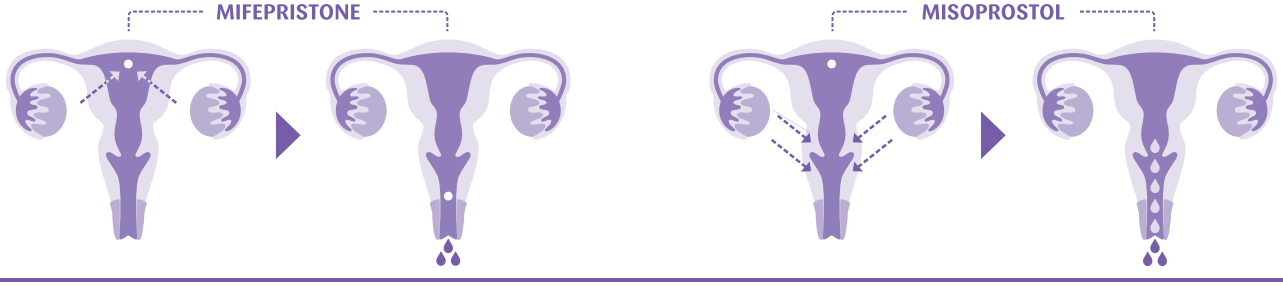
2.4.1.1 MA Medications

1. Mifepristone is an anti-progestin that acts against the hormone progesterone. It prevents a viable pregnancy from continuing.
2. Misoprostol is a type of prostaglandin and causes contractions of the uterus.

As part of the protocol for a medical abortion, mifepristone is taken first – this causes the pregnancy to be become non-viable. When misoprostol is administered after this, the uterus contracts and the pregnancy is expelled from the uterus (Figure 2).

Source: Adapted from RUWSEC/CommonHealth pamphlet.

FIGURE 2: MECHANISM OF ACTION OF MA DRUGS



2.4.1.2 MA Protocol

There are specific protocols for the dosage and timing of administering mifepristone and misoprostol. These are different for a pregnancy less than 12 weeks and for one more than 12 weeks. The most recent WHO guidelines recommend the following protocol (WHO, 2019):

TABLE 1: MEDICAL ABORTION PROTOCOL WITH MIFEPRISTONE AND MISOPROSTOL

Duration of Pregnancy: Less Than 12 Weeks

Recommended Protocol
> Mifepristone 200 mg orally
> Followed 1-2 days later by
> Misoprostol 800 mcg vaginally, buccally (inside the cheek) or sublingually (under the tongue)

Duration of Pregnancy: Above 12 weeks

Recommended Protocol
> Mifepristone 200 mg orally
> Followed 1-2 days later by
> Misoprostol 400 mcg vaginally, buccally (inside the cheek) or sublingually (under the tongue) – repeated every 3 hours

In settings where mifepristone is not available, misoprostol alone can be used as in the following table. However, misoprostol alone regimen has lower success rates than a combination of mifepristone and misoprostol – when given up to nine weeks pregnancy, it is 75-90% effective in causing a complete abortion (WHO, 2019).

TABLE 2: MEDICAL ABORTION PROTOCOL WHEN MIFEPRISTONE IS NOT AVAILABLE

Duration of Pregnancy: Less Than 12 Weeks

Recommended Protocol
> Misoprostol 800 mcg vaginally, buccally (inside the cheek) or sublingually (under the tongue)

Duration of Pregnancy: Above 12 weeks

Recommended Protocol
> Misoprostol 400 mcg vaginally, buccally (inside the cheek) or sublingually (under the tongue) – repeated every 3 hours

The drugs cannot be given to persons who are allergic to them, who have an inherited condition called porphyria, or have chronic adrenal failure. Medical abortion drugs do not work in an ectopic pregnancy (pregnancy that has implanted outside the uterus, e.g. in the fallopian tubes), and therefore this needs to be ruled out during pre-abortion care. In addition, MA drugs should be given with caution in persons who have severe anaemia, heart disease, severe uncontrolled asthma, or a bleeding disorder.

Medical abortion is highly effective, especially in early pregnancy. It is up to 98% effective when used up to nine weeks (63 days of pregnancy) – i.e. complete abortion occurs with the use of MA alone in 98% of MA users; 2-5% of MA users may need some kind of surgical intervention to address either excessive bleeding, incomplete abortion, or a continuing pregnancy.

Mifepristone and misoprostol are both relatively inexpensive drugs and are part of the WHO essential list of medicines (WHO, 2019). They are also stable at room temperature and thus do not need refrigeration. Since medical abortion does not require any surgical procedure involving introduction of instruments into the uterus, it can potentially be provided by health care providers with a lower level of technical skills than required for surgical abortion. This is discussed further in Chapter 4.

2.4.1.3 What to Expect During an MA

A medical abortion procedure resembles a natural miscarriage. The person usually does not experience any symptoms after taking the first medication mifepristone, but within 4-6 hours after the second drug misoprostol is taken, the person experiences lower abdominal pain and cramps and vaginal bleeding. In addition, the person may also experience side effects of misoprostol which include fever with chills, vomiting and diarrhea. The contractions of the uterus then result in the expulsion of the pregnancy products along with the bleeding. Moderate bleeding, slightly more than normal menstrual bleeding, may continue for 10-14 days.

2.4.1.4 Home vs Health Facility for Use of Misoprostol

Medical abortion before nine weeks of pregnancy can be provided at home. The person seeking abortion can be given the mifepristone in a health facility and can then be counseled on how to take the misoprostol at home. This allows the person to self-manage the abortion at home. Clear instructions need to be given as to watching out for potential complications, e.g. excessive bleeding, and when to seek care in a health facility. Studies show that home management of medical abortion is often preferred by women as it allows them to undergo the abortion process in the privacy and comfort of their homes. However, there are also studies to show that where women do not have access to privacy, water or toilet facilities at home, or there is no person to provide supporting care at home, they may prefer to return to the health facility for the misoprostol (Ngo et al, 2011).

2.4.1.5 Self-management of MA

Self-managed abortion is when a person performs their own abortion without clinical supervision. The WHO currently recommends self-managed abortion with medicines as a method of abortion for individuals who are less than 12 weeks pregnant and have "a source of accurate information and access to a health-care provider should they need or want it at any stage of the process." (WHO, 2019)

Especially in settings where abortion is legally restricted, medical abortion offers the person seeking abortion a safe alternative of self-managing the abortion procedure. In settings where mifepristone is unavailable, misoprostol-only regimens can be used for such self-management. This may particularly be useful in settings where abortion is legally restricted since misoprostol may be available in such contexts for other indications. Evidence from trends of abortion from restrictive settings like Latin America and the Caribbean reveal that the use of misoprostol-only regimens by abortion seekers has reduced the incidence of unsafe abortion significantly (Barot S, 2018). More details on self-management of MA are discussed in Chapter 4.

Medical abortion also provides the option of remote provision of the service by health care providers either through online mediums or through telemedicine. This has the potential to increase the availability of and access to safe abortion services, and is detailed in Chapter 4.

Beyond nine weeks of pregnancy, medical abortion has to take place in a health facility as multiple doses of misoprostol are needed to be given under medical supervision. The person must stay in the health facility until expulsion of the pregnancy products takes place.

2.4.1.6 Pain Management During MA

Persons undergoing medical abortion feel pain because of uterine cramps. Pre-abortion counselling should cover adequate pain management options, helping them choose a suitable method for pain relief. Adequate knowledge of what to expect, verbal support and reassurance from a health care provider, and support from a caregiver at home or facility can offer a lot of help in alleviating pain. Pain relief medications (NSAIDs like Ibuprofen) should also be offered for the person to take if needed. For medical abortions over 12 weeks of pregnancy, in addition to these, additional pain relief medication like opioid analgesics or epidural anaesthesia may be given.

2.4.1.7 Pre-procedure Foetal Demise

If medical abortion is sought after 20 weeks, there is a possibility that the foetus may be born alive leading to ethical dilemmas on treating or not treating an extremely premature infant. In order to avoid this, medical procedures that induce foetal death are recommended to be offered pre-procedure. These procedures include injection of medications like Potassium Chloride or Digoxin into the foetal heart, umbilical cord or amniotic cavity. This should be discussed as part of pre-abortion counselling and such procedures offered so the person seeking an abortion can decide accordingly.

2.4.1.8 Common Complications of MA

Medical abortion is a very safe procedure, especially since it avoids invasive surgical procedures and anaesthesia. However, all medical procedures have a small risk of complications and some complications can occur rarely after an MA too.

Bleeding. Bleeding is a part of the MA procedure – bleeding that is heavier than usual menstrual flow, passage of clots, and passage of pregnancy products are part of the process. However, the person should be given clear instruction to recognise excessive bleeding (commonly defined as soaking two or more maxi size pads completely for two hours in a row) and seek care if such excessive bleeding occurs.

Common Side Effects of Misoprostol

Misoprostol that is used as part of the MA procedure can cause some side effects. Fever is one common side effect and can be accompanied by chills, especially when multiple doses of misoprostol are given as in MA over 12 weeks of pregnancy. Paracetamol can be given to reduce the fever. If fever occurs more than 24 hours after intake of misoprostol, it could be a sign of infection and care needs to be sought from a health care provider.

Other common side effects of misoprostol include nausea, vomiting and diarrhoea – these can be treated with adequate rehydration and reassurance.

Incomplete Abortion. One of the potential complications of an MA is an incomplete abortion where the complete pregnancy is not expelled. Retained pregnancy products can cause an infection and also cause excessive bleeding. In such a scenario, additional doses of misoprostol or a vacuum aspiration to remove the retained products may be required, and the person should be instructed to seek health care.

Continuing Pregnancy. Rarely, the pregnancy could continue in spite of the MA procedure. Lack of or very little bleeding during the MA procedure, not passing any pregnancy products, continuing symptoms of pregnancy like nausea and vomiting, increasing uterine size are all signs of a continuing pregnancy. In such a situation, an alternative abortion procedure like vacuum aspiration should be offered. MA drugs might be teratogenic, i.e. they can cause birth defects in the foetus, and hence this must be explained to the person in case pregnancy continues even after the intake of MA drugs.

Infection. Infection after an MA is rare – fever occurring 24 hours after the MA procedure, excessive bleeding, foul smelling vaginal discharge, uterine tenderness can be signs of infection. However, since infection is rare after MA, routine use of prophylactic antibiotics during MA is not recommended.

Uterine Rupture. In persons with a uterine scar, eg. from a previous cesarean section or from previous uterine surgery, misoprostol can rarely cause uterine rupture, especially when given in later pregnancy.

2.4.1.9 Some FAQs about MA

Can a person breastfeed when taking MA drugs?

Both mifepristone and misoprostol are secreted in the breast milk in very small quantities. However, since these are given only as a one-time dose, there is no risk of accumulation in the infant. Therefore, breastfeeding can be continued uninterrupted while taking MA drugs (UK Medicines Information, 2020).

Is it Safe to Have Repeated Medical Abortions?

There is no evidence that having more than one MA in a life time causes any ill effects on health or on future pregnancies. However, if a person needs repeated MAs, it also means they are experiencing repeated unintended pregnancies – this could be because of lack of access to contraceptives, inability to use contraceptives correctly, a non-supportive or violent partner who does not permit or cooperate with contraceptive use. These issues need to be explored and addressed as part of the abortion counselling.

Is it Safe for Adolescent Girls to Have MA?

Studies have shown that medical abortion with mifepristone and misoprostol, or with misoprotol alone, in young women has similar or increased success rates as in older women. They also show that medical abortion is as safe or safer in young women as in older women, with similar or lower complication rates (Ipas, 2020). Therefore, there are no age restrictions to undergo an MA. It is safe for adolescent girls facing an unwanted pregnancy to undergo an MA.

2.4.1.10 Contraception After MA

All methods of contraception can be used after MA. The person undergoing abortion should be counseled on all the contraceptive methods as part of pre-abortion care and supported to choose a suitable method.

- Hormonal methods like OCPs and contraceptive injections can be started immediately after the first pill of the MA regimen.
- IUDs can be inserted and sterilisation can be done as soon it is confirmed that the abortion procedure is complete.
- Diaphragm and cervical cap can be used only six weeks after a second trimester abortion.
- Fertility awareness methods can be used only after normal cycles resume.

2.4.2 Surgical Abortion

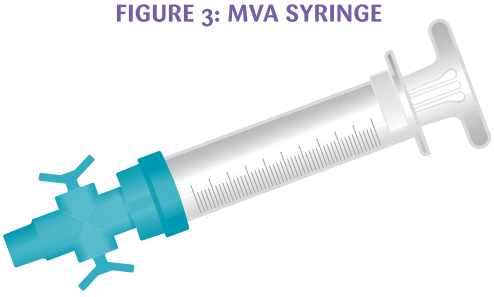
Surgical abortion is an abortion performed through a minor surgical procedure. There are different procedures based on the duration of pregnancy.

- Upto 12-14 weeks of pregnancy – Vacuum aspiration
- Over 12- 14 weeks of pregnancy – Dilatation and evacuation

2.4.2.1 Vacuum aspiration

Vacuum aspiration is a method through which the pregnancy contents in the uterus are sucked out using the negative pressure of vacuum. A plastic or metal cannula is introduced into the uterus through the cervix and is attached to either an electric vacuum pump (Electric Vacuum Aspiration, EVA) or a hand held syringe that generates vacuum (Manual Vacuum Aspiration, MVA, Figure 3). The cannula that is inserted into the uterus comes in different sizes and the appropriate size needs to be chosen based on the duration of pregnancy. Pregnancy tissue is aspirated through the cannula using negative pressure and completion of abortion is assessed by examining the aspirated tissue.

FIGURE 3: MVA SYRINGE



Vacuum aspiration is very effective up to 14 weeks of pregnancy with complete abortion rates of up to 98-100%. The procedure takes less than 10 minutes and the person can leave the health facility after about 30 minutes after the procedure.

A Note on Dilatation and Curettage (D&C)

Dilatation and curettage (D&C) is a procedure where the cervix is dilated using special instruments called dilators and the walls of the uterus are scraped with a sharp instrument called curette. D&C has higher complication rates than vacuum aspiration and is also more painful for the person undergoing it. Therefore, D&C is now considered obsolete (WHO, 2012). There is also sometimes a practice of curetting the uterus after a vacuum aspiration procedure – this does not increase the completion of abortion and has the potential to cause more complications; it is therefore not recommended.

BOX 2:
PAIN MANAGEMENT FOR ABORTION

Appropriate pain management MUST be offered to all persons before medical or surgical abortion.

For medical abortion

< 12-14 weeks

- Verbal reassurance
- Support from health care provider
- Support from family member/friend
- NSAIDs e.g. Ibuprofen

> 12-14 weeks

- All of the above
- Opioid analgesics
- Epidural anaesthesia

For surgical abortion (MVA/EVA and D&E)

- Sedation/anti-anxiety medications
- Local anaesthesia/Paracervical block
- General anaesthesia NOT to be routinely used

Source: WHO guidance, 2012.

2.4.2.2 Dilatation and Evacuation

Dilatation and evacuation (D&E) is a procedure for abortion after 12-14 weeks. In this, the uterus is emptied with vacuum aspiration and the use of a forceps, after dilating the cervix. It is sometimes also done under ultrasound guidance. It can be done as an outpatient procedure and usually takes about half hour to complete.

2.4.2.3 Pre-procedure Considerations in Surgical Abortion Cervical Preparation

Cervical preparation is the procedure whereby the cervix is softened and dilated prior to the abortion so as to make the introduction of instruments into the uterus easier and safer. Cervical preparation reduces the time taken for the procedure, reduces the need for introduction of mechanical dilators, and is especially required after 12 weeks gestation. It is also especially useful in women with prior uterine surgery, those at higher risk of uterine perforation, adolescent girls, and with inexperienced providers. Cervical preparation however adds additional time to the procedure. It can also cause pain due to the cervical dilatation that takes place during the process.

Cervical preparation is done either through the use of osmotic dilators or through the use of medication.

- Osmotic dilators are devices that when placed in the cervix, absorb moisture and swell up, thus physically dilating the cervix. The most commonly used osmotic dilator is laminaria which is made from dried seaweed. Osmotic dilators require at least 4 hours to act and can also be placed overnight before the surgical abortion procedure. Osmotic dilators are preferred over medications for second trimester D&E procedures.
- Alternately, medication like misoprostol can be used for cervical preparation. Misoprostol 400 mcg vaginally is effective for cervical preparation in first trimester surgical abortions when placed 3-4 hours before the procedure. Alternately, oral mifepristone 200 mg can be taken about 36 hours before a first trimester vacuum aspiration.

Pain Management

Persons undergoing surgical abortion experience pain. The level of pain can vary depending on the age of the person, previous childbirth, duration of pregnancy, the type of procedure, the level of cervical dilatation needed and the person's pain tolerance and anxiety levels. Providing good pain relief is a part of good quality care and can be provided with several inexpensive options. There are reports of pain relief not being provided for abortion procedures and this can be considered a violation of the right to good quality care and a form of obstetric violence (Barua and Apte, 2007).

The commonly used pain relief measures for surgical abortion include anti-anxiety medication like diazepam given pre-procedure, along with a local anaesthetic injected around the cervix (paracervical block) at the start of the procedure. Paracervical block must definitely be given if the procedure requires mechanical cervical dilatation. Local anaesthesia in the form of paracervical block is safer and easier than general anaesthesia. It also allows the person to be conscious and therefore keep communication open with the provider during the procedure. Box 2 details the various pain management methods for both medical and surgical abortion.

General anaesthesia is not recommended routinely for surgical abortion as it carries a higher risk of complications than local anaesthesia. It may rarely be required if the person undergoing abortion is highly anxious and requests it, or if the procedure is expected to be especially difficult. Procedures under general anaesthesia must only be undertaken in facilities that are equipped with adequate trained human resource and equipment for the same.

Infection Prevention

In order to prevent infection during surgical procedures, a dose of prophylactic antibiotic is recommended for all persons undergoing surgical abortion just before the procedure. This is not necessary before medical abortion procedures.

In addition, health care providers providing abortion services must adhere to standard infection control practices including handwashing, aseptic precautions and use of sterile instruments.

Health care providers must also practice universal precautions in order to safeguard themselves from infection when performing an abortion procedure. This includes use of necessary Personal Protective Equipment, and safe disposal of soiled linen, sharps and other biomedical waste as per protocol. Box 3 lists the various infection procedures that are to be followed.

BOX 3:
INFECTION PREVENTION FOR SURGICAL ABORTIONS

> **Standard routine infection prevention practices**
  - Handwashing
  - Use of PPE
  - Use of aseptic precautions
  - Use of sterile instruments

> **No-touch technique** (the parts of instruments that enter the uterus should not touch objects or surfaces that are not sterile, including the vaginal walls, before being inserted.)

> **Standard processing of used instruments**
  - Initial soaking and disinfection
  - Cleaning
  - Sterilisation/high level disinfection
  - Prophylactic antibiotic

Source: WHO guidance, 2012.

2.4.2.4 Post-procedure

The health care provider should visually examine the tissue obtained from the abortion to ensure that pregnancy products have been removed. Lack of pregnancy products may be a sign of ectopic pregnancy and should be immediately investigated further. If the volume of pregnancy products removed is less than that expected for the particular gestational age, it may be a sign of incomplete abortion and re-aspiration may be needed.

Post the surgical abortion procedure, the person should stay in the health facility until the effects of sedation or anaesthesia wear off. Overnight admission is not required routinely.

2.4.2.5 Complications of a Surgical Abortion

Abortions are extremely safe when performed by a trained health care provider. However, like all medical procedures, there is a small risk of complications.

Incomplete abortion. Incomplete abortion and continuing pregnancy are very rare with both VA and D&E procedures. In the event of either of these occurring, a re-evacuation should be performed.

Haemorrhage. Excessive bleeding can occur when there are retained products, injury to the cervix or uterus, or infection. Appropriate treatment depending the cause needs to be given – this includes re-evacuation, intravenous fluid replacement, antibiotics, and treatment of any injuries to the genital tract.

Infection. Infection is rare when an abortion is performed by a trained provider in safe conditions. In addition, prophylactic antibiotics given before the procedure also protect from infection. However, since the cervix is dilated and instruments are introduced into the uterus in a surgical abortion, rarely, ascending infection is possible. Signs of infection include fever, excessive bleeding, foul smelling discharge, and abdominal pain and uterine tenderness. Infection is treated with a course of antibiotics. In case retained pregnancy products are present, re-evacuation needs to be carried out.

Uterine injury. A rare complication of surgical abortion is perforation of the uterus. Most uterine perforations are very small and go undetected. However, if there is suspicion of uterine injury, a laparoscopy should be performed to visualise the uterus and the injury and estimate the extent of damage. In case there is suspicion of injury to the bowels or bladder, a laparotomy needs to be performed and appropriate repairs done.

Anaesthesia related complications. Anaesthesia related complications are very rare with local anaesthesia. If general anaesthesia is given, the risks of complications are higher.

Long term effects. There is no evidence of any long term effect from a well performed safe surgical abortion. There are no adverse effects on subsequent pregnancies. There is also no evidence of routine mental health effects after an abortion. Any negative mental health effects are usually a continuation of previous mental health issues, or if the pregnancy was wanted, but the person was forced to undergo an abortion due to reasons like the presence of foetal anomalies.

2.4.3 Decision Making Regarding Method of Abortion

The above sections have described both medical and surgical methods of abortion. Wherever possible, the person seeking an abortion should be given a choice to choose the method they prefer. There is research evidence to show that a person finds the abortion method more acceptable when they have a say in choosing it (Slade et al, 1998).

Table 3 on page 25 compares the relative advantages and disadvantages of medical and surgical abortion. This information should be shared with the person seeking abortion as part of pre-abortion counselling and the person is supported in choosing a suitable method for themselves.

There is no evidence of any long term effect from a well performed safe surgical abortion. There are no adverse effects on subsequent pregnancies. There is also no evidence of routine mental health effects after an abortion. Any negative mental health effects are usually a continuation of previous mental health issues.

TABLE 3: COMPARISON OF MEDICAL AND SURGICAL ABORTION		
Time	**Medical Abortion**	**Vacuum Aspiration**
< 12 – 14 Weeks	> Avoids surgery > Mimics natural miscarriage, person experiences bleeding and uterine cramps > Controlled by the person seeking abortion > Potential for self-management > Can be had at home (< 9 weeks) > May take more time than VA > May require more than one visit to the health facility	> Takes place in a health care facility > Performed and controlled by the health care provider > Involves introduction of instruments into the uterus > Small chance of injury to uterus > Quick procedure, completeness of abortion verified immediately
> 12 – 14 Weeks	> Avoids surgery > Mimics natural miscarriage > Takes place at health care facility > Takes more time than D&E – may take hours to days > Person has to remain in the health facility until expulsion of pregnancy, so may require overnight stay	> Takes place in a health care facility > Performed and controlled by the health care provider > Quick procedure, completeness of abortion verified immediately > Requires cervical preparation > Involves introduction of instruments into the uterus > Small chance of injury to uterus, cervix

2.5 POST-ABORTION CARE

Post-abortion care is important to avoid any morbidity and mortality after an abortion procedure. This is especially important after an unsafe abortion procedure where appropriate post-abortion care can mitigate some of the ill effects of the unsafe procedure.

The objectives of post-abortion care are:

- To ensure adequate follow up of the person who has undergone abortion
- To ensure early detection and management of any complications
- To counsel on and provide contraceptive services

All persons having an abortion should be given clear instructions before going home, both verbally and written, on what to expect in the next few days, and what they can and cannot do. This should include instructions on how long vaginal bleeding will last, when they can resume normal work and sexual activity, and how to recognise any danger signs that will need coming back to the health facility.

Following a safe abortion, a routine follow up visit is not necessary unless the person faces any complication. The major complications following medical and surgical abortion have been discussed in the earlier subsection.

2.5.1 Post-abortion Care as a Harm-reduction Strategy

In settings where abortion is legally restricted, post-abortion care has been used as a strategy to ensure persons who have an unsafe abortion are provided appropriate care to prevent further morbidity and mortality. In such restrictive settings, post-abortion care can be used as an entry point to discuss abortions and prevent unsafe abortions from happening.

There is also an ethical responsibility on health care providers to provide care to persons who present with abortion complications, and refusal to provide such care cannot be justified using conscientious objection. Thus, promotion of good quality post-abortion care can be seen as a harm reduction strategy in legally restrictive settings.

In such a context, post-abortion care that is provided should be of good quality, humane, and non-judgmental, and the treatment should include treatment of complications from spontaneous and induced abortion, counselling, contraceptive services, linking to other Reproductive Health Services including sexually transmitted infection (STI) evaluation and treatment, HIV counseling and testing, and cancer screening. More details and examples of post-abortion care as a harm reduction strategy are given in Chapter 3.

CHECKLIST 1_1		
TECHNICAL ASPECTS OF ABORTION CARE*		
Yes / No		
	PRE-ABORTION CARE	NOTES
	Clear and correct scientifically accurate information is provided to the client in the language they understand.	
	A dedicated counsellor is available for information provision.	
	Adequate privacy and confidentiality is maintained during information provision.	
	Counselling is neutral and non-judgemental.	
	Health care provider asks a clear and complete history covering the following: > Date of last menstrual period > Details of prior menstrual cycles > Past medical history > History of any bleeding disorders > Any medications > Any allergies > Obstetric and gynaecological history > Family history > Social aspects including any history of violence and coercion regarding decision to either continue or terminate the pregnancy	
	Health care provider conducts a complete physical examination including: > General examination including pulse rate and BP > Checks for anaemia > Abdominal examination > Vaginal examination (Bimanual pelvic examination) > Screening for STIs	
	No laboratory tests including ultrasound examination are insisted on unless specific clinical indications are present.	
	Clear and complete information on all appropriate contraceptive methods is provided.	
	The person seeking abortion is given clear, complete and accurate information on a choice of available and appropriate methods and enabled to make a choice of method.	
	ABORTION METHOD: Medical Abortion	NOTES
	Detailed information is provided on how to take the pills and what to expect.	
	For pregnancies less than 9 weeks, an option is given for the person to choose between the use of misoprostol at home or in the health facility.	
	For pregnancies less than 12 weeks, an option is given for the person to choose self-management of MA.	
	Persons undergoing MA are given information on pain management and provided medications for the same.	
	Persons undergoing MA after 20 weeks are given information on pre-procedure foetal demise and services for the same if the client chooses it.	
	Clear and complete information on possible complications of MA and what to do in such an event is provided.	

CHECKLIST 1_2		
	ABORTION METHOD: Surgical Abortion	**NOTES**
	Cervical preparation before surgical abortion is performed where appropriate.	
	Adequate pain relief is offered for surgical abortion including: > Sedation > Local anaesthesia/paracervical block	
	General anaesthesia is NOT used routinely for surgical abortion.	
	Adequate infection prevention methods are use for surgical abortion including: > Routine standard precautions – handwashing, use of aseptic precautions, use of Personal Protective Equipment > No-touch technique > Initial soaking of used instruments > Instrument cleaning > Sterilisation of medical instruments > Prophylactic antibiotic > Adequate bio-medical waste disposal according to local guidelines	
	Obsolete methods like D&C and check curettage are NOT used.	
	Post-procedure examination of tissue obtained from abortion is done.	
	No overnight stay is routinely required unless specific clinical indications exist.	
	The client is given clear and complete information on possible complications after surgical abortion and what to do in the event of complications.	
	POST-ABORTION CARE	**NOTES**
	Contraception is offered routinely as part of post-abortion care.	
	Clear and complete information is given on details of follow-up required– when, where, what to expect.	

**To be used along with checklists in Chapter 4 on rights-based provision of care.*

CHAPTER 3
Law and Policy: Applying a Human Rights Lens

The objective of this chapter is to provide a detailed understanding of the laws, policies (including regulations that govern implementation of laws and policies) that impact access to safe abortion services. The chapter includes a checklist for analysing the policy and legal situation governing access to abortion services in one's country or province/state. In the first section we describe the changes in the legal status of abortion across the globe since ICPD, documenting the progress and pushback since 1994. Following this, the second section gives examples of strategies used by women's and social movements in different countries to liberalise restrictive abortion laws and expand the scope of restrictive abortion laws. It is worth noting that even in countries with relatively liberal abortion laws, abortion services are available only up to a certain gestational period. There may be other restrictions at the level of service delivery. For example, only some methods of abortion may be available in a country; or services may only be available at secondary or tertiary care facilities; or may require spousal consent, and so on. These are discussed in the third section.

3.1 LEGAL STATUS OF ABORTION ACROSS THE GLOBE AND CHANGES SINCE THE ICPD

3.1.1 Legal Status of Abortion Across the Globe

Laws pertaining to the legal status of safe abortion are classified across five categories, from the most to the least restrictive:

Category 1: Twenty-six countries do not permit abortion under any circumstances.

Category 2: Thirty-nine countries permit abortion only to save the life of the woman. Of these, 10 countries permit abortion on additional grounds such as rape and incest and severe impairment of the foetus.

Category 3: In 56 countries, abortion is allowed also on health grounds, and 25 of these countries also explicitly mention mental health grounds. Almost all the countries in this category permit abortions also on the additional grounds mentioned above.

Category 4: Fourteen countries permit abortion for all the above reasons and also on social and economic grounds, as well as in the case of rape, incest or severe foetal impairment.

Category 5: In 66 countries of the world, abortion is available on request (CRR 2019a).

Countries in categories one, two and three are usually referred to as having 'restrictive' abortion laws, and those in categories four and five are seen as having 'broadly liberal' abortion laws.

Globally, a little over two-fifths of the women of reproductive age live in countries with restrictive abortion laws and 59% live in countries where abortion services are available on broadly liberal grounds (CRR 2019a).

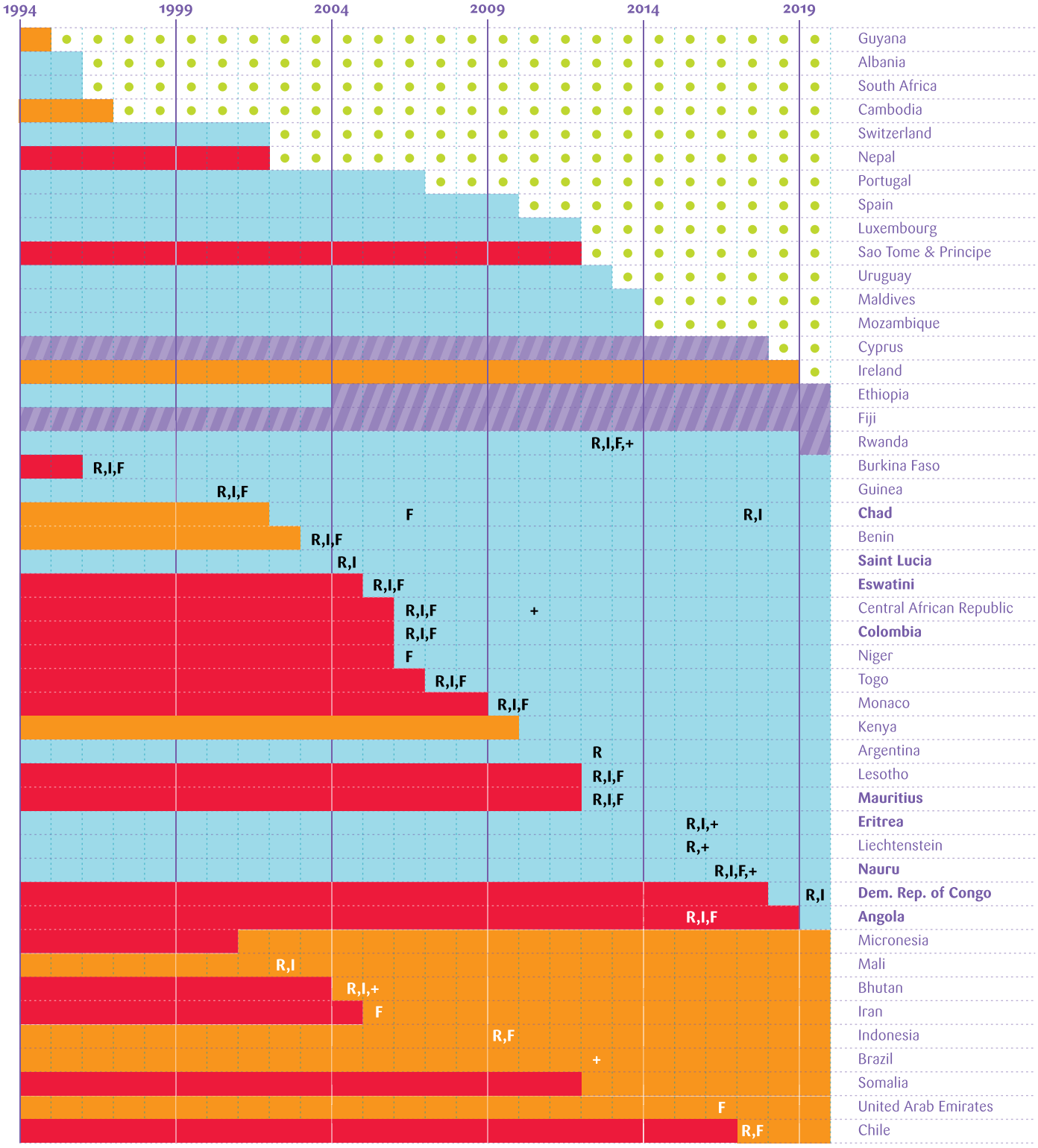
3.1.2 Progress and Setbacks in the Liberalisation of Abortion Laws Since 1994

During the 25 years since ICPD (1994-2020), 48 countries moved from a more to a less restrictive law on abortion. Forty of these were developing countries (CRR 2019b-progress).[4] Figure 4 presents information on the changes in abortion laws over the past two decades and a half in 40 countries around the world.

The most noteworthy legal changes were that abortion became available in 15 countries, and 18 countries removed the total ban on abortion. Two of the countries - Nepal and Sao Tome & Principe - removed the total ban on abortion and moved all the way down to category V, making abortion available on request. In 11 countries which lifted the total ban, abortion became available on health grounds and also on additional grounds such as rape, incest and for foetal impairment. Five countries which lifted the total ban on abortion made it available only to save the life of the pregnant woman and on additional grounds such as rape, incest and foetal impairment. In other instances, the progress has been modest, with additional grounds added but without a change in the category (CRR 2019b).

Unfortunately, there were also countries where the laws pertaining to abortion became more restrictive. In Dominican Republic and Nicaragua, abortion, from being permitted to preserve the life of the woman, is now prohibited under all

FIGURE 4: LIBERALISATION OF ABORTION LAWS SINCE ICPD (40 COUNTRIES)



Prohibited altogether
To save the woman's life
To preserve health
Broad social or economic grounds
On request (gestational limits vary)

R : Rape
I : Incest
F : Fetal impairment
+ : Additional enumerated grounds

Countries in bold explicitly permit abortion to preserve the woman's mental health

Source: Adapted from CRR 2019b.

circumstances, while in Iraq and Congo the shift has been from health grounds to total prohibition (UN, 2014 and CRR 2019b). In the Dominican Republic, a constitutional amendment extended the right to life to apply from the time of conception (Amnesty International 2009). In 2006, Nicaragua passed a bill in the National Assembly, prohibiting abortion altogether (BBC News 29 October 2006).

Seven other countries reduced the number of grounds on which abortion was permitted (Table 4).

TABLE 4: COUNTRIES WHERE ABORTION LAWS HAVE BECOME MORE RESTRICTIVE SINCE ICPD

Country	Restrictions in the Abortion Law Since ICPD
Algeria	Rape and incest removed as grounds
Belize	Rape and incest removed as grounds
Congo (Brazzaville)	Health grounds to total prohibition
Dominican Republic	Preserving life to total prohibition
Ecuador	Rape removed as grounds
Iraq	Health grounds to total prohibition
Japan	Mental health removed as grounds
Nicaragua	Preserving life to total prohibition
Papua New Guinea	Physical and mental health to preserve life

Source: UN 2014 and CRR 2019b.

3.2. PUSHING THE ENVELOPE: EXAMPLES OF STRATEGIES TO EXPAND THE SCOPE OF RESTRICTIVE LAWS ALONG THE PATHWAY TO BROADER REFORM

In this section we present five examples of strategies that have expanded the scope of restrictive abortion laws to expand access to safe abortion services and to reduce mortality and morbidity from unsafe abortions. The first example is of the use of menstrual regulation in Bangladesh to make available early first trimester abortions. The second is the use of Post-abortion care (PAC) as a strategy to reduce mortality and morbidity from unsafe abortions, usually in settings where abortion is severely restricted by law. The third is a description of the 'harm-reduction' strategy that was successfully employed in Uruguay to achieve a significant reduction in maternal mortality from unsafe abortion. This was an experiment happening alongside advocacy and mobilisation for liberalisation of the abortion law. Advocating with health service providers in some Latin American countries for a liberal interpretation of the 'health' grounds under which abortion services were legal, is the fourth example. The fifth example is of feminist initiatives to use telemedicine and self-managed abortion where abortion is legally restricted or access is limited for one or more reasons, which have gained credence as safe and effective options during the mandatory lockdowns related to COVID-19.

3.2.1 Menstrual Regulation for Bringing on Delayed Periods

In Bangladesh, abortion is a crime under the penal code of 1860, except to save the life of the woman. However, Menstrual regulation (MR) has been an approved procedure to "*regulate menstruation when menstruation is absent for a short period*" (Women on Waves 2020) and is a part of the country's family planning programme since 1979. MR was acceptable because in Bangladesh, bringing on the delayed period was an accepted traditional practice, as long as pregnancy had not been confirmed (Dixon-Mueller 1988).

MR is available in more than 5,000 government facilities across the country. It is available to all women who have missed a period. The methods available are manual vacuum aspiration (MVA) when the last menstrual period was delayed for up to 12 weeks; and both MVA and medications (known as MRM) using mifepristone and misoprostol for a delay of up to nine weeks. While medication abortion may be provided by physicians as well as non-physicians trained in MR, MVA may be performed by non-physicians only up to 10 weeks of delayed periods, and only physicians are allowed to perform the MVA procedure for up to 12 weeks (Sultana 2020). A programme to train non-physicians such as midwives, paramedics and family welfare visitors (FWVs) has been in place since the 1980s, and has helped expand access to services.

The introduction of medical menstrual regulation was approved by the Director General, Family Planning through a memo issued in 2015, after operational research studies established its safety and acceptability (Govt. of Bangladesh, 2015). The approval of local manufacture of the drug-combination mifepristone-misoprostol has enabled local supply of the drug.

MR may be a suitable strategy for making first trimester abortions available in settings where bringing on delayed periods is a culturally accepted concept and practice. However, this strategy is not without its limitations. In a recent study, many health facilities that have the trained personnel and equipment to provide MR services did not offer the services, often because health providers did not want or felt unprepared to provide the procedure (Guttmacher Institute 2012). Secondly, MR services are provided only up to 10 weeks

of pregnancy. This leaves out many persons who may seek an abortion later in their pregnancy for a number of well-known reasons such as late detection of pregnancy, difficulties in finding the time and money to reach an MR service. Most importantly, the availability of MR services does not take away the need to advocate for safe abortion services available on request to all persons.

3.2.2 Using Post-abortion Care (PAC) as a Strategy for Minimising Morbidity and Mortality from Unsafe Abortion

The 'post-abortion care model' (PAC) was developed in 1994 under the aegis of the USAID to address the harmful health consequences of unsafe abortion (Curtis 2007). PAC consisted of three components: a) emergency treatment for complications of spontaneous or induced abortion; b) post-abortion family planning counselling and services; and (c) provision of other reproductive health services, mainly STIs and HIV/AIDS. The PAC model has been found acceptable in many countries with restrictive abortion laws (Rasch 2011).

The United Republic of Tanzania has a restrictive abortion law, where abortion is a criminal offence except to save the life of the woman. However, ever since the PAC model was first implemented in Tanzania in the late 1990s, the country's Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) has been strongly committed to PAC. PAC is available from the primary care level upwards, with Manual Vacuum Aspiration and misoprostol administered even by mid-level providers. PAC is included in Tanzania's National Package of Essential Health Interventions. Post-abortion contraceptive services, including long-acting reversible methods are part of the services package (Baynes et. al. 2019).

3.2.3 Harm Reduction Strategies to Reduce Mortality and Morbidity from Unsafe Abortion

The 'harm reduction' approach has origins in the context of HIV/AIDS, to reduce morbidity and mortality related to HIV transmission through drug injection. The approach was first used in Uruguay in the early 2000s, and since then, in many other countries, to reduce morbidity and mortality from unsafe abortion in contexts with restrictive abortion laws.

Uruguay's fight to liberalise abortion laws lasted for almost 30 years, until the passage of the *Voluntary Interruption of Pregnancy Law* on September 25, 2012. The efforts of a strong feminist movement, concerned obstetrician-gynaecologists and progressive political parties had proposed four abortion laws – in 1985, 1993, 2002 and 2004, without success. While mobilisation for legal reform continued, obstetrician gynaecologists from a major tertiary care hospital initiated the 'risk and harm-reduction' programme known as *Iniciativas Sanitarias* in 2002. (Folter 2019).

The risk reduction strategy consisted of giving women with an unwanted pregnancy information already available in the public domain, that would enable them to make a well-informed decision, and, in case they went ahead with an abortion, they would choose a lower-risk rather than a high-risk option. A lower-risk abortion was defined as one where the user:

- "had a counselling visit before reaching a gestational age of 12 weeks and decided to terminate the pregnancy, understanding the information that has been provided to her;
- had access to misoprostol and uses it in accordance with internationally recognised scientific evidence;
- had an uncomplicated complete or incomplete abortion;
- had no immediate complications (within the first month) from the biopsychosocial viewpoint.
- uses a safe, effective contraceptive method that is suitable for her situation and which she herself has chosen." (Labandera et. al. 2016: S8).

The strategy, implemented initially in one major hospital, resulted in a significant decline in morbidity and mortality from complications of unsafe abortion (Labandera et. al. 2016). In 2004, soon after another failed attempt to pass a less restrictive abortion law, the Ministry of Health adopted a protocol on harm reduction related to safe abortion, applicable to the entire country (Woods et. al. 2016).

The risk and harm reduction strategy was a positive way of keeping up the momentum on the struggle for legal reform, while at the same time providing access to scientific evidence-based information to women preventing avoidable mortality and morbidity from unsafe abortion, as well as building the capacity of healthcare providers for humane and respectful abortion care.

Feminist initiatives to use telemedicine and self-managed abortion where abortion is legally restricted or access is limited, have gained credence as safe and effective options during the mandatory lockdowns related to COVID-19.

Advocates need to recognise that post-abortion care and harm-reduction are but interim strategies on the pathway to attaining the goal of safe abortion services for all. In the words of Erdman (2012),

> *"While meeting the needs of women, harm reduction (including PAC) does not discharge government of its responsibility to address the abusive, repressive, or limiting constraints that create these needs.* (Erdman 2012)."

3.2.4 Expanded Interpretation of the 'Health' Grounds for Abortion ("The Health Exception")

In 56 countries with restrictive abortion laws, abortion is allowed on health grounds – i.e. if the continuation of pregnancy poses significant risk to the health of the woman, and in about half of these countries (25), risk to mental health is also a legal ground for abortion (CRR 2019a). 'Risk to health' is however, often narrowly interpreted to mean imminent threat to the life of the woman, thereby restricting access to abortion for many women. The Constitution of the World Health Organization and the International Covenant on Economic, Social and Cultural Rights uphold the "*right of all persons to the highest attainable standard of physical, mental and social well-being*" (WHO, 1946; CESCR 2000). Further, according to WHO, risk of adverse effect is sufficient to consider a person to be at a health risk, harm does not actually need to happen (WHO 2002). Using these broader interpretations of health and health risk would allow for the 'health grounds' or 'health exception to the penal law' to be applied for a wider range of indications, and expand women's access to legal and safe abortion services.

Several human rights treaty bodies including the Child Rights Committee (CRC), Committee on Civil and Political Rights (CCPR), and the Committee Against Torture (CAT), the Committee on the Elimination of Discrimination Against Women (CEDAW Committee) and the Committee on Economic, Social and Cultural Rights (ESCR Committee) have interpreted the 'health grounds' for safe abortion to include pregnancies resulting from rape and incest, (CAT 2011 para 22; CCPR 2014 para 9; CEDAW Committee 2009, para 12; CRC 2007 para 56; CRC 2011 para 64; ESCR Committee 2004 para 53; ESCR Committee 2010, para 29) and in the case of fatal foetal abnormality (CAT 2011 para 22; CCPR 2005; CCPR 2014 para 9; CRC 2011 para 64). In its concluding recommendations to Paraguay's country report, the CAT (2011) observed that when women survivors of sexual violence and incest are denied abortion:

> *"...women concerned are constantly reminded of the violation committed against them, which causes serious traumatic stress and carries a risk of long-lasting psychological problems (CAT 2011, paragraph 22)."*

The same Committee then goes on to say that:

> *"The Committee is also concerned about the denial of medical care to women who have decided to have an abortion, which could seriously jeopardise their physical and mental health (CAT 2011, paragraph 22)"*

Other human rights treaty bodies have similarly taken the view that the general criminalisation of abortion violated women's right to life and health, because it may oblige them to seek clandestine and unsafe abortion that endanger their lives and health (CCPR 2012, paragraph 20; CCPR 2014, paragraph 14). In its concluding observation to the Chad country report (1999), the CRC urged the country to review its abortion legislation with a view to '*preventing illegal abortions and improving protection of the mental and physical health of girls* (CRC 1999, paragraph 30).

The push towards such an expanded interpretation of the health exception first started in Colombia in 2006, spearheaded by La Mesa (Advocates for Women's Life and Health), soon after a Constitutional Court ruling allowing the risk to a woman's life and health as grounds for legal abortion. La Mesa worked with allies in other countries of the region to arrive at a regional consensus document in 2008, on how the health exception may be more broadly interpreted according to established international human rights norms. A training guide was developed and a training of trainers organised in Colombia, Argentina, Mexico and Peru for a wide range of stakeholders: e.g. doctors, health managers, medical educators and civil society actors. Online campaigns, dissemination in academic and professional meetings and through key websites carried the message far and wide across the Latin American Region. A qualitative study carried out in 2012 found that the strategy had significantly increased, both the total number of legal abortions and abortions on health grounds in SRH facilities run across the country by two NGOs (Orientamé and Profamilia) in Colombia. For example, the total number of abortions in Orientamé's facilities rose from 36 in 2006-07 to 4066 in 2011, and the proportion on abortions on health grounds, from 22% to 99.7% (González Vélez 2011).

3.2.5 Using Telemedicine to Facilitate Self-managed Abortion in Situations of Legal Restrictions and Limited Access

Telemedicine in abortion is the use of communications technology to arrange for a clinic-based abortion with the assistance of a health provider or a self-managed abortion, using medical abortion pills (Berer 2020). Feminist organisations around the globe have used telemedicine to expand access to safe abortion services using medical abortion pills. These have been used to help persons living in settings where abortion is legally restricted, access to abortion is limited or facing multiple barriers even where abortion is less restricted and available. In the present times of the COVID-19 pandemic, even while many countries have used the mandatory lockdown as an opportunity to further limit abortion access, a few countries have supported telemedicine and self-managed abortion as provisional, temporary measures.

In 2005, Women on Web set up the first feminist-run telemedicine service to provide information and counselling on self-management of abortion using medical abortion pills, and also provided medical abortion pills by post. Today, 26 countries around the world have information hotlines and they provide information and support for self-managed abortion using a range of telecommunications technology ranging from telephones and emails to apps and social media (Berer 2020).

During the COVID-19 pandemic, Ireland, UK and France have allowed telemedicine for abortion as a way of ensuring access without in-person contact with health providers which may enhance the risk of COVID-19 infection for both parties (Berer 2020). This entails obtaining approval for medical abortion using any mode of telecommunication, following which they receive the abortion pills at home. They are counselled on how to self-manage the abortion and have their abortion at home. Follow-up care is provided through telecommunication.

The World Health Organization's guidelines related to abortion as a part of essential health services during COVID-19 has recommended that safe abortion services must be enabled to the full extent of the law. Further, facility visits and provider-client contact are to be minimised through '*the use of telemedicine and self-management approaches* (WHO 2020).'

The approval by some governments and by the WHO for telemedicine and self-managed abortions as safe options during the pandemic has signalled to the world's women that these are safe and effective options for women.

3.3 BEYOND RESTRICTIVE LAWS: OTHER REGULATORY, CLINICAL AND ADMINISTRATIVE BARRIERS TO ABORTION ACCESS

Even when the abortion law in a country does not fall under the "restrictive" category, there are many clinical and regulatory barriers related to service provision. These include, for example,

- The co-existence of criminal laws alongside health laws, policies or protocols that regulate access to permit abortion services under specific conditions
- Imposition of gestational limits
- Restrictions related to provider, facility and methods
- Mandatory and biased counselling, mandatory waiting periods, and viewing ultra-sound images/listening to foetal heartbeats
- Need for third-party authorisation: authorisation by multiple health professionals; spousal and parental authorisation; the specific case of persons living with mental health conditions or disabilities; need for judicial consent when legal conditions not satisfied
- Lack of guidelines for conscientious objection and abusive use by healthcare providers denying access to safe abortion care.
- Prohibition of sex determination and sex selective abortion

We discuss below the lack of a sound scientific rationale for each of the restrictions and argue that they ought to be removed.

3.3.1 The Co-existence of Criminal Laws Alongside Laws That Permit Abortion Services Under Specific Conditions

In almost all countries of the world, including where abortion services are available on a wide range of grounds, the legality of abortion is established through laws that specify the set of circumstances and conditions under which performing or receiving an abortion is legal. When these circumstances and conditions are not satisfied, then abortion is a criminal offence. For example, in the United Kingdom, where safe abortion services are widely available through the National Health Service (NHS), abortion is a criminal offence under the 'Offences Against the Person Act 1861 (OAPA).

For many decades, women's health advocates had focused attention on expanding the grounds on which abortion was legal. However, in the present era, medical abortion has made self-management of abortion feasible. If the criminal laws

continue, women with self-managed abortions would be in danger of criminal punishment. For example in India, between 63-83% of all abortions during 2015 were done using medical abortion pills obtained from non-healthcare settings, outside the purview of the Medical Termination of Pregnancy Act of 1971 (Singh et. al. 2018)

According to Berer (2017) decriminalisation of abortion refers to the removing specific criminal sanctions against abortion from the law. It means that the law and related policies and regulations are to be changed such that:

- No one is punished for providing safe abortion
- No one is punished for undergoing an abortion
- The police are not involved in investigating or prosecuting the provision of safe abortion
- The courts are not involved in deciding whether or not an abortion may be permitted
- Abortion is treated like any other medical procedure governed by existing laws related to dangerous or negligent practices (Berer 2017).

There is no rationale any longer for abortion to be criminalised. It is time for women's health and SRHR advocates to demand that abortion services should not be regulated by a special law and treated any differently from other forms of healthcare. There are a number of reasons why.

To begin with, the Code of Canon Law, which has influenced the legal status of abortion in many former Spanish colonies dates back to 1398. The criminal statute related to abortion was enacted in the 19th century, at a time when abortion was a dangerous surgical procedure calling for the highest level of technical skills. In The original law may have been intended to protect women from harm. This is no longer the case. Advances in medicine have made abortion one of the safest procedures when carried out by trained healthcare providers according to current approved protocols.

Secondly, a criminal law on abortion enacted at a time when women did not have property rights or the right to vote, and were not considered legal equals of men is outdated in today's world where women's equality has been acknowledged in national constitutions and international human rights norms (Sheldon 2015). For example, General Comments issued by the Human Rights Committee, the CEDAW and CRC Committees and the UN Special Rapporteur for Health have all called upon States to eliminate legislations that criminalise abortion, because they violate women's sexual and reproductive health and rights (CRR 2020a).

Third, laws have been enacted the world over to make exceptions to the criminal laws on abortion, which indicates that as a society, we have chosen to value women's autonomy and health over the sanctity of foetal life. Further, a criminal law is considered to be the most draconian and onerous measure that a State could take, and is considered appropriate only when it is proportionate response to the act that it seeks to prevent or condemn (Sheldon 2015). There is no reason why a special criminal statute is needed to regulate a health procedure like abortion., It could make sense only for example when a woman is forced to have an abortion against her will; is given medical abortion pills without her knowledge; or is subjected to dangerous or negligent procedures causing injury or death (Berer 2017).

Fourth, in many countries where abortion is criminal in all circumstances or permitted only to save the life of the pregnant woman, medical professionals are required by law to report women seeking post-abortion care. Medical professionals may report women outright on the basis of suspicion or coerce confessions as a condition to providing life-saving treatment. These requirements conflict with the medical professionals' ethical responsibility to protect patient confidentiality. Moreover, they are in violation of women's right to health and may in certain circumstances be considered as cruel and inhuman treatment in contravention of the Convention Against Torture (McCarthy 2014).

Canada has the distinction of being the only country which has taken abortion completely out of the law that delimits it and decriminalised abortion altogether. Abortion is treated like any other medical procedure to be decided between the woman and her physician (Shaw and Norman, 2020). Box 4 describes the situation in Canada, which establishes that the absence of a separate law on abortion does not in any way endanger women's lives.

3.3.2 Imposition of Time-limits to Accessing Abortion

In almost all countries of the world, there is a time limit after which abortion is not permitted under the law. The usual upper limit is 20 to 24 weeks. Gestational limits are imposed even in countries which allow abortion without restriction as to reason. The only countries which do not have gestational limits for abortion are Canada, China, North Korea and Vietnam (Baglini 2014).

BOX 4:
ABORTION LAW IN CANADA

In 1988, following earlier rulings in lower courts, the Supreme Court of Canada ruled that Canada's abortion law which permitted abortion only on specific grounds, to be unconstitutional. The law was deemed to violate Section 7 of the Charter of Rights and Freedoms because it violated women's right to "life, liberty and security of person". In the absence of a law, abortion became a matter of provincial-level regulations. In the initial years, many provinces sought to introduce legislations, which restricted access to abortion. However, courts across Canada ruled against imposing any restrictions. Subsequent court rulings also affirmed that the foetus was not a person, and hence did not have the rights of a human being until the time of birth. Abortion services were provided in government facilities free of cost. However, because of the vastness of the country, geographical access to abortion services remained a challenge in some parts of the country.

With the availability of medical abortion in Canada since 2017, access to abortion has improved significantly even in remote areas. A woman who wishes to have a medical abortion may do so within 8-9 weeks of gestation. She would have to visit her closest physician or nurse-practitioner, who would counsel her, and carry out the necessary tests and ultrasound screening. If medical abortion is decided upon, the healthcare provider provides a prescription for a mifepristone – misoprostol combination package to be obtained from a pharmacy. The medical abortion drugs are usually available at no-cost. The woman may self-administer mifepristone and misoprostol at a time and place of her convenience. Early data show that the outcomes are as good as under medical supervision.

Source: Shaw and Norman, 2020.

Abortions above 20 weeks of gestation may be performed safely by trained professionals in a secondary or tertiary care facility. Abortion mortality rates do increase with increasing gestation, but are not higher than mortality rates related to childbirth. For example a 2015 national study from the USA found that during 1998-2010, abortion mortality rates increased from 0.3 per 100,000 abortions for gestations of 8 weeks and less to 6.7 per 100,000 for gestations of 18 weeks and above. The maternal mortality ratio in 2018 in the USA was 8.8 per 100,000 births (Barry 2018). Serious complications – e.g. uterine rupture, major haemorrhage and cervical tear from abortions above 20 weeks' gestation, when performed by trained professionals in well-equipped health facilities, are extremely rare (Grossman et. al. 2008).

Restricting access to later abortions does not reduce their numbers, nor does having no gestational limit increase the proportion of later abortions. For example a 2019 publication reported that in Canada the proportion of abortions above 20 weeks' gestation was 0.3%, as compared to 1.34% in Queensland, Australia, which has an upper limit of 22 weeks (Millar 2019).

On the other hand, restricting access to later abortions disproportionately disadvantages the more vulnerable, especially young women. Studies from the UK, Australia and the USA show that besides foetal abnormality, the reasons why women end up with a need for late second trimester or early third trimester abortions include difficulties in recognition of pregnancy symptoms because of irregular periods or lactational amenorrhea; abusive partners and socio-economic circumstances (Millar 2019; Barry 2018; Marie Stopes International 2005). In countries like India, child rape survivors rank prominently among those seeking abortions in the third trimester (Ravindran 2019).

Thus, it may be safe to say that there are no scientific reasons for imposing an upper gestational limit after which abortion may not be permitted. What is needed is to ensure that trained providers and well equipped facilities exist to cater to the small minority that needs them.

3.3.3 Restrictions Related to Methods, Provider and Level of Health Facility

Restrictions on which methods may be available, who shall provide abortions and at which level of healthcare are used to erect additional formidable barriers to accessing abortion services.

The World Health Organization identifies vacuum aspiration as a safe and effective method of surgical abortion up to 12 to 14 weeks of gestation, dilatation and evacuation (D&E) for surgical abortion for gestations over 12 to 14 weeks, and mifepristone and misoprostol at different recommended dosages for medical abortion below nine weeks, 9-12 weeks and above 12 weeks (WHO 2012: 123-125). However, for one or more reasons, not all methods are available in all countries where abortion is legal, limiting access to abortion services.

For example, of 205 countries for which data are available from the Global Abortion Policies Database of the WHO, vacuum aspiration was available only in 47 countries, including 10 from Africa, 12 from Asia and 12 from Latin America. Mifepristone and misoprostol for medical abortion were available in only 42 countries, and D&E in only 31 countries (GAPD 2020).

According to the WHO, vacuum aspiration up to 12 weeks of gestation and medical abortion services up to nine weeks of gestation may safely be provided at the primary care level as an out-patient procedure.[5] WHO also recommends that a range of mid-level health care providers can safely provide first trimester abortions using vacuum aspiration or medical abortion methods (WHO 2012). Low-income countries which have authorised mid-level providers to perform abortions have found the results to be rewarding (Box 5).

Unfortunately, a vast majority of countries stipulate that abortion may not be provided at the primary care level, or by a healthcare provider other than a doctor. An analysis of data for 158 countries where abortion is legal on one or more grounds found that 12 countries explicitly prohibited the provision of abortion services at the primary care level (Lavelanet et. al. 2020). Exclusion of mid-level providers and primary health centres from providing abortion services runs contrary to many recommendations under international human rights law which call specifically for expansion of the range of providers and service-delivery points.

BOX 5:
ABORTION SERVICES BY MID-LEVEL PROVIDERS

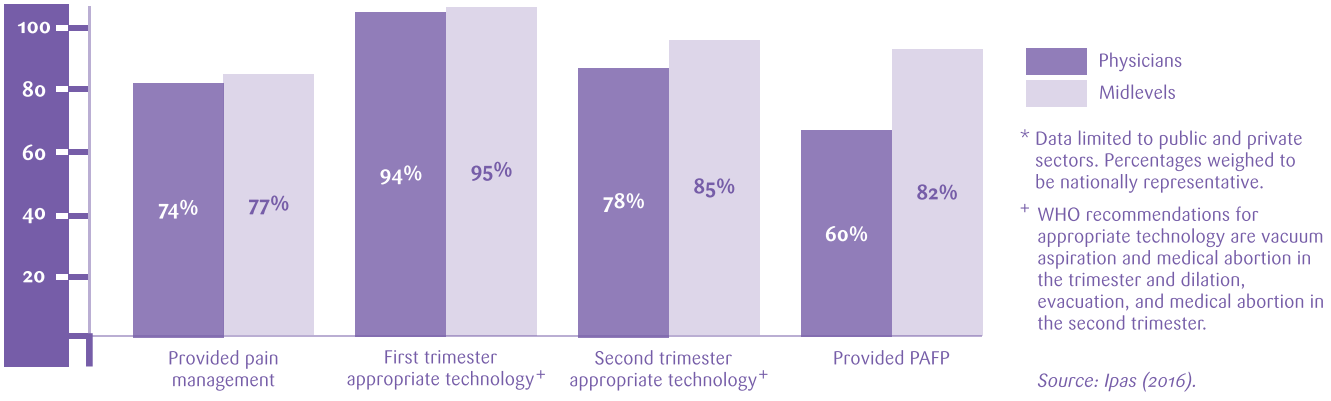
Mid-level providers are health workers with 2-3 years of post- secondary school healthcare training who undertake tasks usually carried out by doctors and nurses, such as clinical or diagnostic functions. Evidence shows that first trimester abortion (up to 12 weeks of gestation may be safely provided by mid-level providers. A Cochrane review of studies on first trimester surgical and medical abortions performed by mid-level providers and physicians respectively found that there was no significant difference between the two categories of providers in the risk of failure or complications from medical abortion and risk of complications from surgical abortion. An elevated risk of failure was found in surgical abortions performed by mid-level providers, but the number of studies was small and data not robust (Barnard et. al. 2015).

In Ethiopia, following the liberalisation of the abortion law in 2005, mid-level providers are permitted to perform first and second trimester abortion. Data from 2014 showed the performance of mid-level providers to be safe and somewhat better than physicians in terms of quality of care (Figure 5).

Mid-level providers also seemed to be able to better cater to women from vulnerable groups. While 55% of the clients of mid-level providers were young women (< 25 yrs. old), 47% were unmarried and 31% were less educated, the comparable figures for clients of physicians were 39%, 34% and 29% respectively (Ipas 2016).

Source: Ipas (2016).

FIGURE 5: ABORTION SERVICE PROVISION BY PROVIDER CADRE IN ETHIOPIA (2014*)



3.3.4 Mandatory and Biased Counselling, Mandatory Waiting Periods, and Viewing Ultrasound Images/Listening to Foetal Heartbeats

In some countries, another set of barriers that women encounter at the level of service delivery include mandatory counselling based on a script, and viewing ultra-sound images of the foetus or listening to Doppler heart sounds before they give informed consent to undergo abortion. Some countries in Europe and many states in the USA insist on a fixed, compulsory waiting period of between one and seven days after consent, before they can receive abortion services (Rowlands and Thomas 2020).

While counselling that provides relevant and unbiased information on all the options available to the woman with an unintended pregnancy is an important component of safe abortion services (see Chapter 2), it should be voluntary and respectful of the woman's decisions. Mandatory counselling is often directive and aimed at dissuading women from obtaining an abortion, and hence biased. Clearly, presenting women with ultrasound images has the same intention. Mandatory waiting periods aim to give women more time to reconsider their abortion decision. All three are paternalistic interventions which imply that women may be making a rash decision that they may later regret (Klick 2006). However, this assumption is not evidence-based. A recent longitudinal study in the USA showed that five years after their abortion, only 1% of the women regretted their abortion, and that most women felt relief throughout the follow-up (Rocca et. al. 2020). A number of studies also show that voluntary ultrasound viewing does not dissuade women from abortion (Upadhyay et. al. 2017, Gatter et. al. 2014, Kimport et. al. 2013).

On the other hand, mandatory waiting periods result in the need for an extra appointment, delays that may increase the cost, and some women may end up being beyond their gestational limit for abortion, with the potential for causing significant distress to the woman (Rowlands and Thomas 2020). A US-based expert panel convened in 2018 found that requiring a waiting period before receiving an abortion may increase both the risk of complications for the patient and cost of the procedure, with no evidence that waiting periods improve abortion safety (National Academies of Sciences, Engineering and Medicine 2018).

The WHO Technical Guidance (2012) advises against such barriers to abortion services: '*Many women have made a decision to have an abortion before seeking care, and this decision should be respected without subjecting a woman to mandatory counselling. Provision of counselling to women who desire it should be voluntary, confidential, non-directive and by a trained person (p. 36)... Mandatory waiting periods can have the effect of delaying care, which can jeopardise women's ability to access safe, legal abortion services and demeans women as competent decision-makers* (p. 96).'

Mandatory counselling, waiting periods and other barriers are in violation of International Human Rights Law. The Human Rights Committee has called upon State Parties to the Covenant on Civil and Political Rights to eliminate procedural barriers to obtaining abortion services, which may result in their seeking unsafe abortions at considerable risk to their lives and health. The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has clearly noted that a state should "[e]nsure access to safe abortion without subjecting women to mandatory counselling and a medically unnecessary waiting period (CRR 2015).

3.3.5 Need for Third-party Authorisation

The WHO technical guide on abortion (2012) clearly states that "*A woman seeking an abortion is an autonomous adult. Autonomy means that mentally competent adults do not require the authorisation of any third party, such as a husband, partner, parent or guardian, to access a health service. Third-party authorisation should not be required for women to obtain abortion services. The requirement for authorisation by spouse, parent or hospital authorities may violate the right to privacy and women's access to health care on the basis of equality of men and women.*" (p. 68)

Besides the WHO, international Human Rights Treaty Monitoring Bodies have also recognised third party authorisation requirement for the provision of sexual and reproductive health services including abortion, as an infringement of women's human rights (CRR 2020b). All the same, a large number of countries require third-party authorisation for accessing abortion services.

3.3.5.1 Authorisation by Healthcare Providers

An analysis of data from 158 countries in the Global Abortion Policy Database (2020) reported that 105 of the 158 countries (66.5%) required the authorisation of one or more health care personnel. It was not always specified whether or not this was in addition to the abortion provider. In 23 of the 105 countries, at least two providers had to authorise the abortion, and in 18 countries, authorisation was needed from three healthcare providers (Lavelanet et. al. 2020). In countries with a low

doctor-population ratio and with few doctors in rural settings, the requirement for authorisation from two or more providers would effectively cut-off abortion access for a large number of women.

3.3.5.2 Spousal Authorisation

In 12 countries - 11 in Asia and one in Africa, the law requires that a woman seeking abortion have the authorisation of her spouse. Spousal consent is also required in a few other countries, but only in special circumstances. For example, in Kyrgyzstan, a woman seeking abortion for social reasons needed spousal authorisation, while in Mongolia it was needed for abortion on grounds of foetal anomaly or threat to the woman's life, and in Malaysia, if the woman is a Muslim (Lavelanet et. al. 2020).

3.3.5.3 Parental Authorisation

Requirement of parental authorisation from minors seeking abortion services is another example of requirement for third-party authorisation. In some countries, for example Ethiopia, Fiji, Finland, France, Guyana, Israel, New Zealand, South Africa and Sweden, the minor alone can consent for her abortion, under provisions of the abortion law (Skuster 2013). About a third of the 158 countries (57/158) in the GAPD require parental authorisation for minors. Only 41 of the 57 countries specify the age limit after which parental consent is required, which ranges from 14 to 18 years with a median of 16 years (Lavelanet et. al. 2020).

The WHO advises that healthcare providers inform, counsel and treat adolescents according to their "*evolving capacities to understand the treatment and care options being offered, and not according to an arbitrary age cut-off* (WHO 2012 p. 68)." Physicians ought to recognise the emerging autonomy of their adolescent client, and understand that she could be sufficiently "mature" to make some or all of her medical decisions. "Mature" in this context means that the person is capable of understanding the nature and consequences of the procedure that she is about to undergo, and provide informed consent for the same (RCPSC 2020).

Box 6 provides some examples of abortion laws and policies that are in the best interest of the adolescent and respect her autonomy.

BOX 6:
EXAMPLES OF ABORTION LAWS AND POLICIES IN THE BEST INTEREST OF THE ADOLESCENT

South Africa: Choice on Termination of Pregnancy Act, 1996

In the case of a pregnant minor, a medical practitioner or a registered midwife or registered nurse, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

Ghana: Ghana Health Service. Prevention and Management of Unsafe Abortion, Comprehensive Abortion Care Services Standards and Protocols, 2012.

The service provider should encourage minors to consult a parent or a trusted adult if they have not done so already, provided that doing so will not put the minor in danger of physical or emotional harm. However, abortion services shall not be denied because such minor chooses not to consult them.

A parent, next of kin, another adult or trained service provider acting in loco parentis (in place of the parent) can give consent on behalf of the minor.
The confidentiality of the minor should be respected, subject to the usual exceptions that apply to patient-provider confidentiality.

Zambia: Ministry of Health. Standards and Guidelines for Reducing Unsafe Abortion Morbidity and Mortality in Zambia. 2009.

Standard 3: Facilities should ensure that adolescents and youths make informed and free decisions without coercion from interested parties.

Guidelines:
1. Ensure respect of autonomy in decision making without third party authorisation.
2. Providers should act in good faith in the interest of the minor and this may involve leaving out parental or guardian consent.

Source: Skuster, 2013.

3.3.5.4 Guardian's Authorisation in Case of Persons With Intellectual or Mental Disability

Although equality and non-discrimination are long-established human rights principles, many countries equate mental and intellectual disabilities with lack of legal capacity. Consequently, a legal guardian is vested with the right to make all decisions on behalf of an adult person living with a mental or intellectual disability (FRA 2013). This includes the right to make decisions on whether or not the person with disability may undergo an abortion.

Autonomy is a central principle and core legal obligation outlined in the UN Convention on the Rights of Persons with Disabilities (CRPD). The CRPD requires that States that have ratified the treaty recognise that persons with disabilities have legal capacity on an equal basis with others in all aspects of life, and that disability alone does not justify the deprivation of legal capacity (FRA 2013). The CRPD Committee has called upon ratifying States to reforms their laws to replace 'substituted' decision-making with 'supported' decision-making, which respects the person's autonomy, preferences and will (CRPD Committee 2014).

Our interpretation of the CRPD's provisions are as follows. The healthcare provider is obliged to provide the person with mental or intellectual disability with the information on the abortion procedure and the consequences of having or not having an abortion. It is the prerogative of the person concerned to make a decision, with the support of the healthcare provider and/or her guardian. Should the person be suffering from severe mental disability that makes such a process impossible, the abortion law should lay out a clear procedure for how the decision would be arrived at. As long as the woman having an abortion is capable of making her wishes and preferences known, it is her decision that ought to prevail.

3.3.6 Conscientious Objection by Healthcare Providers

In the context of abortion care, conscientious objection is when a health care worker or institution refuses to administer abortion services or information on the grounds of conscience or religious belief (CRR 2020c).

The World Health Organization acknowledges that healthcare providers have the right to freedom of thought, conscience and religion under international human rights law. It also points out that the enjoyment of such rights is subject to limitations necessary to protect the human rights of others.

Accordingly, healthcare providers have an obligation to refer women to another easily accessible health facility where they are guaranteed abortion services. In case such referral is not possible, then the healthcare provider who objects is nevertheless required to provide abortion services to save the woman's life and to prevent serious harm to her health (WHO 2012, p. 96).

A study analysing data from the GAPD for countries where abortion is legal on one or more grounds found that 56 of 158 countries permit conscientious objection by healthcare providers to the provision of abortion. In about half of these countries (29/56), healthcare providers are required to refer the woman to another provider who will provide her with legal abortion services, and 21 countries do not permit conscientious objection if there is threat to the woman's life (Lavelanet et. al. 2020). A large number of countries do not specify whether or not conscientious objection is permitted, and this could seriously undermine women's access to safe abortion services.

The right of everyone to the freedom of thought, conscience and religion is protected in domestic legislation and is recognised in international human rights law, but it can be limited to protect public safety, health and the fundamental rights of the others specially to ensure the right to safe abortion care.

International Human Rights Treaty Monitoring Bodies, through their many pronouncements, have taken the position that when a State permits conscientious objection to the provision of a sexual or reproductive health service, the State should:

- "Guarantee an adequate number and appropriate geographic dispersal of willing providers, in both public and private health facilities
- Limit the invocation of conscientious objection to individuals and prohibit institutional refusals of care
- Establish an effective referral system to ensure patients can access another medical professional who is willing and able to provide abortion care
- Impose clear limits on the legality of refusals, such as ensuring they are not permitted in urgent or emergency situations
- Implement adequate monitoring, oversight and enforcement mechanisms, including effective systems to monitor the number and location of refusing medical professionals and to oversee compliance with laws and policies regulating the practice of refusals. They must also establish and implement meaningful enforcement procedures to address, sanction, and prevent non-compliance (CRR-2020d)."

Many of the above conditions would be very difficult to fulfil in a large majority of low and low-middle income countries which do not have robust health infrastructure. In fact, studies suggest that even in high-income countries, providers may not comply with the requirements of conscientious objection. For example, in Victoria, Australia, providers having a conscientious objection to the provision of abortion services were required to refer the women to a provider who would perform the abortion. However, it was common practice for providers not to advise their patients on where they could secure an abortion. Providers also tended to delay women's access to abortion using various stalling tactics, or attempted to make the women feel guilty (Keogh et.al. 2019). A study from Italy, where 71% of the gynaecologists were registered as conscientious objectors, showed that conscientious objection seriously hampered access to abortion especially for women living in low-income regions or having economic disadvantages (Autorinio et. al. 2020).

The converse view is that conscientious objection, a concept related to military services, has no place in the delivery of healthcare services. According to this position, conscientious objection in reproductive health care is not a right but an unethical refusal to treat; and that it represents an abandonment of professional obligations to patients, with the patients having to pay the price. They advocate that States should have policies that refuse conscientious objection to the provision of abortion services (Fiala and Arthur 2017).

Countries such as Sweden, Finland and Iceland which make no mention of conscientious objection in their abortion laws, have successfully banned the practice despite challenges from the anti-abortion movement, because of their unswerving commitment to upholding women's sexual and reproductive rights (Box 7) (Fiala et. al. 2016). Examples such as these should be upheld by women's health advocates so that conscientious objection is eventually disallowed everywhere and considered redundant, as it ought to be.

3.3.7 Other Laws That Interfere With Access to Safe Abortion Services

3.3.7.1 Laws Prohibiting Sex Determination and Sex Selective Abortion

In some parts of the world, the prohibition of sex-determination and sex-selective abortion has erected another barrier to accessing abortion. We argue that such prohibitions need to be ended.

While son preference is a global phenomenon known to have existed historically, it has resulted in gender-biased sex-selection in some countries of South, East and Central Asia. In countries such as India, China, South Korea, Taiwan, Armenia and Azerbaijan, gender-biased sex-selection has resulted in skewed sex-ratios at birth in favour of the male child.

BOX 7:
NO TO CONSCIENTIOUS OBJECTION – THE CASE OF SWEDEN

Sweden has implemented a successful ban on conscientious objection to the provision of abortion services, mainly through policy and practice. The abortion law is rights-based. Women can self-refer and need not state a reason for abortion up to 18 weeks of gestation. The law obligates all hospital obstetrics/gynaecology departments to perform abortion on a woman's request without delay. For Swedish women, the cost of abortion, at 20-30 Euros, is the same as for all other public health services, and is free for refugees, because it is considered emergency care.

Although the abortion law is silent on conscientious objection, the policy is to not allow it. The Swedish parliament has consistently rejected proposals to introduce conscientious objection for healthcare providers. Abortion care is an essential component of medical training. Those who wish to become an Ob/Gyn or midwife undergo mandatory training in abortion care, and do not have an 'opt-out' option. Medical authorities take the position that those who object to performing abortions cannot become Ob/Gyns or midwives. Legal challenges to the ban on conscientious objection have not succeeded thus far. The reason is that courts and tribunals have so far ruled that women's right to reproductive healthcare outweighs the right of healthcare providers to refuse care for reasons of personal belief.

Source: Fiala et. al. 2016.

It is feared that a skewed male to female sex ratio in the population may aggravate social problems such as violence against women and girls, trafficking in women and increase in crime rates among young men (Guttmacher 2012).

Many governments have responded to the problem by banning prenatal and preconception sex-selection and making sex-selective abortions illegal. Such measures have had little impact on reducing the practice of gender-biased sex-selection.

One of the unintended consequences of measures aimed at mitigating gender-biased sex-selection is limiting women's access to abortion services. An inter-agency statement on gender-biased sex-selection clearly states that "*such an outcome (restricted access to abortion) would represent a further violation of their rights to life and health as guaranteed in international human rights treaties, and committed to in international development agreements* (WHO 2011 p. v)." Thus, while gender-biased sex-selection is to be condemned and actively opposed, the solution should not in any way deter women's access to abortion services. Effective action should be based on a more holistic understanding of the problem, and calls for long-term measures to undermine the roots of discrimination and undervaluation of girls and women.

It is also a matter of concern that opponents of abortion rights have been using the platform of gender-biased sex-selection to lobby for banning sex-selective abortions in the name of gender equality. They have succeeded in some instances, for example in passing a resolution in the European Assembly prohibiting sex-selective abortions (Westeston 2012). The lesson for women's health advocates is that the solution to gender-biased sex-selection does not lie in banning sex-selective abortion, but in investing in long-term changes to promote gender equality and prevent gender-based discrimination.

3.3.7.2 Laws Related to Sexual Behaviour

Sometimes, other laws unrelated to abortion can create barriers. In India, the Protection of Children from Sexual Offences Act (POCSO) requires reporting of underage sex. Medical professionals are therefore obliged to report minors who seek abortion services, because pregnancy is proof of sexual activity (Nadimpalli et. al. 2017). In Morocco, it is illegal to have sex outside marriage. As a consequence, although abortion is permitted by law within the first three months if the woman's physical and mental health is in danger, and in cases of rape, incest, or congenital malformation, access is denied to unmarried women (MFPA and ARROW 2016).

3.3.8 The Global Gag Rule and Its Impact on the Availability of Abortion Services in Low and Low-Middle Income Countries

It is not only national laws and policies that erect barriers to women's access to safe abortion services. Since 1984, when President Ronald Reagan first signed the Mexico City Policy, known better as the 'global gag rule (GGR)', various US Presidents have through choosing to renew the GGR, determined the extent of women's access to safe abortion as well as a range of other sexual and reproductive health services.

In January 2017, the Trump administration brought into force 'Protecting Life in Global Health Assistance', the administration's variation on the GGR. The rule applied to all foreign non-governmental organisations (NGOs) receiving US funding and technical assistance. It stipulated that an organisation receiving any funding from the US government (including USAID) for any purpose (not only SRH services but also HIV/AIDS, WASH and so on) was banned from

- providing abortions
- counselling women that abortion may be an option for them
- advocating for abortion, for example advocating to governments for increased access to abortion care or more progressive legislation
- referring women to other organisations that provide abortions (IPPF 2019).'

According to a study by the International Women's Health Coalition based on interviews with more than a hundred stakeholders in Kenya, Nepal, Nigeria and South Africa, the expanded GGR had directly resulted in reduced the availability of abortion and family planning, and also a whole range of sexual and reproductive health services (IWHC 2019). Reports from the International Planned Parenthood Federation (IPPF) and Marie Stopes International talk of the closure of hundreds of family planning clinics and abortion facilities in some of the world's poorest countries, jeopardising the lives and wellbeing of thousands of women (IPPF 2019; Marie Stopes US 2018).

In a welcome move, the new Biden-Harris administration repealed the GGR through a Presidential Memorandum issued on 28 January , 2021. The Memorandum also declared the withdrawal of US from the sponsorship of the anti-abortion and anti-LGBTQ Geneva Consensus Declaration (Kaufman 2021). The repeal of the GGR by the current administration would no doubt help repair some of the damage caused by the highly restrictive GGR imposed by the Trump administration. However, the volatility in funding for SRHR brought about by the imposition and repeal of the GGR every four to eight years - with every change in the party in power in the USA - is a matter of continued concern.

A CHECK-LIST TO ASSESS THE STATUS OF LEGAL, POLICY AND SERVICE-DELIVERY REGULATIONS FOR ACCESSING ABORTION SERVICES

CHECKLIST 2_1

RATIFICATION OF INTERNATIONAL HUMAN RIGHTS TREATIES RELEVANT TO ABORTION

	Ratified / Ratified with reservations / Not ratified	NOTES
	International Covenant on Civil and Political Rights (ICCPR)	
	International Covenant on Economic, Social and Cultural Rights (ICESCR)	
	Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	
	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)	
	Convention on the Rights of the Child (CRC)	
	Convention on the Rights of Persons with Disabilities (CRPD)	

LEGAL GROUNDS ON WHICH ABORTION IS PERMITTED AND TIME LIMIT

	Yes / Yes, with restrictions / No	TIME LIMIT/NOTES
	To save a woman's life	
	To preserve a woman's health (physical/mental/not specified)	
	In cases of rape or incest	
	In cases of foetal impairment	
	For economic or social reasons	
	On request	
	Whether conscientious objection permitted? Yes No	

CRIMINALISATION OF ABORTION

	Yes / No	NOTES
	There is a criminal law on abortion applicable in case of abortions not satisfying the permitted grounds.	
	The law penalises the woman seeking such an abortion.	
	The law penalises the abortion provider of such an abortion.	
	The law penalises any person who assists in such an abortion.	
	There is a “duty to report” that makes it mandatory for healthcare providers to report to the police if they suspect a woman of having had an abortion that is not legal.	

EXISTENCE OF OTHER LAWS THAT MAY INTERFERE WITH ABORTION ACCESS

	Yes / No	NOTES
	Laws preventing sex-selection or sex-selective abortion.	
	Laws requiring mandatory reporting of pregnancy suspected to have resulted from sexual violence.	
	Laws requiring mandatory reporting of women seeking abortion or post-abortion care.	
	Other laws: describe	

CHECKLIST 2_2

THIRD PARTY AUTHORISATION REQUIREMENTS

Yes	No		NOTES
		Authorisation by one or more healthcare providers	
		Spousal authorisation	
		Parental authorisation for minors (specify age)	
		Authorisation by a guardian in case of persons with intellectual or mental disability	

METHODS PERMITTED

Yes	No		NOTES
		Vacuum aspiration	
		Medical abortion using mifepristone and misoprostol	
		Medical abortion using misoprostol alone	
		Dilatation and Evacuation (D&E)	

AUTHORISED PROVIDERS

Yes	No		NOTES
		Nurses	
		Midwives/nurse-midwives	
		Non-specialist physicians	
		Specialist physicians	
		Others (Describe)	

FACILITIES WHERE ABORTION MAY BE PROVIDED

Yes	No		METHODS	GESTATIONAL LIMITS
		Primary Health Centres (Public)		
		Secondary/District level facilities (Public)		
		Tertiary facilities (Public)		
		Special abortion facilities (Public)		
		Private health facilities		
		Non-governmental/ charitable facilities		
		Judicial authorisation when the grounds for abortion are not satisfied.		

CHAPTER 4
Planning and Managing Safe Abortion: A Human Rights-Based Approach

The objective of this chapter is to focus on provisioning of safe abortion services by health systems from a human rights based approach.

4.1 A HUMAN RIGHTS-BASED APPROACH TO ABORTION INFORMATION AND SERVICES

A Human Rights-Based Approach (HRBA) has two major features. One, it takes a position that ensuring access to education and health care and other basic needs and amenities for all its citizens are not acts contingent on the good will of governments, but obligations that they are required to fulfil as signatories to international human rights standards. And two, a rights-based approach integrates the standards and principles of the international human rights system into the plans, policies and programmes (ARROW Advocates Guide).

The HRBA considers all persons as rights-holders, while the government and its agents are duty-bearers with specific obligations to respect, protect, and fulfil. According to the UNFPA, the Human Rights-Based Approach to health programming would be characterised by:

- An emphasis that the processes as well as the outcomes of the programming are informed by human-rights principles and international human rights law
- A focus on the most marginalised populations, such as those living in poverty, adolescents and young people from disadvantaged backgrounds, women engaged in sex work, persons living with disabilities, and religious and ethnic minorities.
- Aiming at universal coverage by the relevant services, starting with the most marginalised populations
- Meaningful participation of all concerned, and at all stages of the programme cycle
- Accountability and transparency on the part of all actors at all stages of the programme cycle, and accountability mechanisms built-into the project design (UNFPA 2010:71-72).

Within the context of people's right to abortion services, HRBA would draw on key human rights principles, elements of the Right to Health, as well as elements of human rights as applicable to patient care. A human rights-based approach to patient care offers a complementary framework to bioethics. The bioethics framework is focused on individual provider-patient relationships and applies philosophical principles such as autonomy, justice, beneficence and non-maleficence. The human rights framework, on the other hand, applies a set of legal norms such as freedom, security of person, right to information and non-discrimination. It takes a systemic approach to the issues encountered in individual provider-patient relationship and focuses attention on the role of the state as a duty-bearer in creating enabling conditions for ethical behaviour (Cohen and Ezer 2013).

> *The human rights-based approach offers advocates a basis to demand safe abortion services even in settings where access to services is restricted by laws and policies. Examples of instances where advocates have used such approaches to push the envelope for access to safe abortion services have been detailed in Chapter 3. In addition, safe abortion services in such settings, even if available in a limited manner, can be monitored to check whether they adhere to the human rights principles detailed in this chapter and advocates can demand that gaps found be addressed.*

In this chapter, we define HRBA in the delivery of abortion services as including the following key human rights principles and standards: (Please note abortion services here also includes post-abortion care offered in legally restrictive settings as a harm reduction strategy.)

- Non-discrimination in the provision of information and services
- Availability of information and services
- Accessibility of information and services
- Acceptability of information and services
- Quality
- Informed decision-making
- Privacy and confidentiality
- Participation, and
- Accountability

These principles and standards are further elaborated below.

- **Non-discrimination in the provision of information and services**
  Abortion information and services must be accessible and provided without discrimination (in intent or effect) based on health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status. The design of programmes should factor-in various barriers to access encountered by vulnerable groups and address these barriers.

- **Availability of abortion information and services**
  Adequate health care infrastructure (e.g. hospitals, community health facilities, trained health care professionals); goods (e.g. drugs, equipment, supplies); human resources (healthcare providers and support staff); basic amenities such as potable drinking water and sanitation; information and services on sexual and reproductive health including contraception; must be available in sufficient quantity within the state, and distributed equitably across geographical areas and communities.

- **Accessibility of abortion information and services**
  All health care must be accessible to all without discrimination. No one shall be denied preventive, promotive or curative health care, including contraceptive services and allied sexual and reproductive health services that s/he needs. Accessibility has three overlapping dimensions: Physical accessibility; economic accessibility or affordability; and access to information.

- **Acceptability of abortion information and services**
  Health care institutions and providers must be respectful of medical ethics and adopt a human-rights based approach to patient-care. They should respect the dignity of all clients, provide culturally appropriate care, be responsive to needs based on gender, age, culture (including religion, belief, values, norms and language), and physical abilities.

- **Quality of abortion services**
  All health care, including abortion information and services must be medically appropriate and guided by technical quality standards and control mechanisms. More importantly they should be characterised by positive attitudes on the part of providers, informed decision-making on the part of the client and provided in a timely and safe manner, and to the client's satisfaction.

- **Informed and autonomous decision-making**
  Informed decision-making is already a component of services that are acceptable and respect medical ethics. It is also a characteristic of good quality of care. However, this element is considered separately because of the many ways in which client-autonomy is compromised in the provision of abortion information and services. Full and informed decision-making is an expression of autonomy, upheld by medical ethics and international human rights law.

- **Privacy and confidentiality**
  Respect for client's privacy, confidentiality and dignity is a fundamental tenet of medical ethics. Upholding the client's privacy and maintaining confidentiality is important in all areas of health care. It is especially critical when providing abortion information and services, failing which several negative consequences can arise. For example, the service loses the client's trust and the client may not return for a service or follow up.

- **Participation**
  Individuals and communities must be able to play an active, free and meaningful part in the design and implementation of abortion policies and programmes. Policies and programmes are therefore required to create structures and mechanisms that will allow and enable such participation by all stakeholders, especially traditionally excluded and marginalised groups.

- **Accountability**
  Governments and public agencies must be held accountable and answerable for their acts or omissions in relation to their duties related to protecting the right to health care, including the right to contraceptive information and services and access to safe and legal abortion, through enforceable standards, regulations, and independent compliance-monitoring bodies. Governments are also accountable for regulating the actions of private entities such as private health care providers, insurance companies and pharmaceuticals so that their actions do not violate citizens' right to health.

4.2 HUMAN-RIGHTS-BASED ABORTION INFORMATION AND SERVICE PROVISION: AN ACTION AGENDA

This section addresses abortion programme design and service provision. It outlines the characteristics of human-rights based and gender-responsive family planning service provision. Many of these characteristics overlap with those defined as "client-centeredness" in service delivery, including empowerment of clients and enabling clients to take an active role in their own health care.

The section is organised in sub-sections that describe how the nine human rights principles and standards defined in 4.1 (non-discrimination; availability; accessibility; acceptability; quality; informed decision-making; privacy and confidentiality; participation and accountability) may be operationalised at the programming and service delivery level.[6] Elaboration of how gender-responsiveness and cultural sensitivity may be integrated within these standards is woven into each of these sections.

Each section presents a checklist for assessing the level of adherence to human rights principles in abortion services provided in a specific country.

Where the gaps in adherence to human rights standards are in the realm of service provision at the local level, the changes may be within the scope of advocates to initiate with programme managers and service providers. Where the gaps call for changes at the policy and programme level, a wide range of stakeholders will have to be engaged. These may include the federal and provincial/state governments; key policy makers; SRH programme managers; organisations of health professionals; community-organisations and opinion makers; and civil society actors concerned with sexual and reproductive health and rights (with special attention to organisations of/working with adolescents and young people; persons with disabilities; PLHIV; sex workers; minority communities; and low income groups).

4.2.1 Non-discrimination in the Provision of Safe Abortion Services

WHO defines the principle of non-discrimination in provision of sexual and reproductive health services to encompass two key principles (WHO, 2017):

- Non-discrimination - Provision of services to all irrespective of their gender, sexuality, age, marital status, caste, ethnicity, race, and economic status.
- Autonomy – Provision of services voluntarily, without coercion or violence

Even where abortion services may be legally available, there are persons belonging to specific vulnerable groups who face increased difficulties in getting access to safe abortion services. The principle of non-discrimination entails identifying these specific groups and ensuring provisions to make abortion services accessible to them.

When faced with an unintended/unwanted pregnancy, adolescent and young persons often delay seeking abortion services because of delays in suspecting and diagnosing a pregnancy, and in arranging resources and seeking care for an abortion. This is especially so if they are unmarried and living in context where sexual activity before marriage carries social stigma (Espinoza et al, 2020). Policies such as mandatory parental consent and laws that criminalise adolescent sexual activity add additional barriers to getting a safe abortion service. There is also evidence that laws that mandate parental information or consent disproportionately affect young women of colour or immigrants, and can push them to seek unsafe methods of abortion (Dennis et al, 2009). Denying young people abortion services or placing such additional barriers violate both the principle of non- discrimination and their autonomy (Refer Chapter 3). Health care providers should be trained to address the specific needs of adolescents in a non-biased manner. Physicians ought to recognise the emerging autonomy of the adolescent client, and understand that she could be sufficiently "mature" to make some or all of her medical decisions. They should also treat them according to their evolving capacity and should be able to support them in their best interest based on their own choices. This is discussed in detail in Chapter 3.

Another group that is often not recognised when planning abortion services is that of trans persons. Trans persons experiencing an unwanted pregnancy often find barriers in accessing services from abortion services that are designed for women and are thus excluded from these services (Lowik AJ, 2017). Special efforts need to be made therefore to ensure abortion services are trans friendly. Box 8 details some suggestions on making an abortion service trans friendly.

Women living with HIV are another group that face specific abortion related issues. Women living with HIV may have reasons specific to their being HIV+ve for terminating a pregnancy in addition to the reasons that other women generally have for choosing an abortion. These include fear of transmission of HIV to the child, wanting to wait until

the viral load is lower before continuing with a pregnancy, concerns about the effects of pregnancy on their own health, and wanting to prioritise scarce financial resources for the care of oneself or other family members (de Bruyn, 2012). There is evidence however of women living with HIV being denied abortion services because of their HIV status. In other instances, women living with HIV may also be coerced to terminate their pregnancy citing the fear of transmission of HIV to the foetus (Orner et al, 2011). Forcing a woman to continue with her pregnancy or coercing her to terminate her pregnancy because of her HIV status are both violations of the principles of non-discrimination and autonomy. Abortion services need to be included as part of comprehensive sexual and reproductive health care for persons living with HIV. Women living with HIV need to be provided neutral, non-directed, non-judgemental pregnancy counselling and their agency and choice regarding their pregnancy needs to be respected and supported.

Women with disability face additional barriers when seeking any sexual reproductive health service. Autonomy is a core principle of the Convention on the Rights of Persons with Disability (CRPD) and the CRPD committee declares that women with disability, like all women, have the right to choose the number and spacing of their children, as well as the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (CRPD, art 1). However, women with disability face discrimination because of harmful stereotypes about them that assumes that disabled persons are asexual, unfit to parent, or that they do not have the capacity to make decisions about their own sexual and reproductive health (WHO, 2009). SRH programmes and services can also reinforce these stereotypes by not recognising the legal capacity of disabled persons to exercise their autonomy. Health staff need to be trained to respect the autonomy of disabled persons themselves in decisions regarding continuing or terminating their pregnancy and in providing respectful care with dignity for them. The specific needs of persons with disability need to be taken into account in the design and delivery of SRH services including safe abortion services. Services need to put in specific measures to increase physical access for the disabled, including ramps and design information, and communication material that are disability friendly.

Survivors of rape need emergency contraception to prevent pregnancy as part of the package of care provided to them. Rape survivors facing an unwanted pregnancy as a consequence of rape must be treated sensitively and offered safe abortion services in a timely manner without delay. These services must be provided as part of a comprehensive package for survivors of sexual assault including emergency contraception, STI/HIV prevention and treatment, and mental health support. Medicolegal and judicial procedures must not be a ground for delaying SRH care, and mandatory reporting of rape must not be made conditional for the provision of SRH services including abortion services. Health care staff must be trained to treat rape survivors sensitively and with dignity and to offer them appropriate medical care including safe abortion services.

BOX 8:
DESIGNING A TRANS-INCLUSIVE ABORTION SERVICE

- Ensure that the service is publicised as being for anyone experiencing an unwanted pregnancy and needing an abortion, rather than for women needing abortion. This should include ensuring that the name of the service does not exclude trans persons (e.g. names like Women's health clinic that can be construed to be exclusively for women), that posters and pamphlets contain images of trans persons.
- Staff should be trained on being trans inclusive in the language they use and while talking to or providing information/counselling to clients who seek an abortion. This should include asking clients for the pronouns they use for themselves, the terms they use to refer to their body parts. Trans inclusive language should also be used in medical forms and documents.
- Staff should be trained on the specific sexual and reproductive health issues of trans persons and on specific measures to include trans persons in their services.
- Staff should be trained on addressing transphobia from other clients – how to address any complaints/ issues raised by other persons seeking services, asserting that the service is trans inclusive and the service believes in non-discrimination.
- Ensure that at least some toilets for clients are gender neutral.
- Ensure adequate privacy and confidentiality for trans clients.

Source: Lowik AJ, 2017.

CHECKLIST 3		
	NON-DISCRIMINATION	
	Yes No	NOTES
	Adolescents and young persons are provided services without insisting on parental information or consent.	
	Adolescents and young persons are presumed to have capacity to make decisions and consent to abortion services without need for parental authorisation or consent.	
	Abortion services are trans-inclusive in the design of infrastructural space (e.g. waiting area, toilets).	
	Health care workers are trained in providing services that are trans-inclusive.	
	Trans-inclusive language is used in the publicity and communication material, medical forms, and by the health care workers during interactions with the clients.	
	Abortion services are part of comprehensive SRH services for women living with HIV.	
	SRH services for women living with HIV include non-judgemental neutral counselling and support to exercise their choice regarding their pregnancy.	
	There are no instances of women living with HIV being coerced to terminate their pregnancy.	
	Abortion services are disabled friendly in terms of their physical access – provision of ramps, wheelchair access, disabled-friendly toilets.	
	Information and communication materials are disabled friendly.	
	Health care providers are trained to and recognise the legal capacity of disabled persons to exercise their own choice regarding continuing or terminating a pregnancy.	
	There are no instances of disabled persons being coerced to terminate their pregnancy.	
	Emergency contraception and abortion services are part of the SRH package provided for rape survivors.	
	Even if there are mandatory reporting clauses of rape, abortion services are not denied if a survivor does not want to report rape.	
	There are no delays in providing emergency contraception and safe abortion services to rape survivors because of medico-legal or judicial procedures.	
	Health care providers are trained in identifying marginalised groups needing SRH services including safe abortion services and in providing them with services respectfully and sensitively.	
	SRH programmes have mapped out the different groups of vulnerable communities in the area that need special attention in the provision of safe abortion and other SRH services.	
	Data related to service provision is disaggregated by special vulnerable groups.	
	Disaggregated data being used to monitor whether services are accessible to these special vulnerable groups.	

A key area where availability of safe abortion services is essential is in emergency and humanitarian settings. Women and girls are targeted as victims of war or other types of conflicts that generate displacement and migration, and unwanted pregnancies arising out of rape are a consequence of this. This can also lead to social stigma and ostracisation. Also, in such settings, barriers to accessing contraception and maternal health care may be greater, leading to higher risk of unplanned pregnancy and adverse pregnancy outcomes. International human rights law provides for the protection of women and girls' medical needs without discrimination in times of conflict (Radhakrishnan et al, 2017). This includes access to sexual and reproductive health services, including safe abortion services. Denying women and girls safe abortion services in emergency and humanitarian settings is discriminatory and can lead to physical and mental suffering and can be considered inhumane treatment. The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations developed by the Inter Agency Working Group is a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. This includes ensuring availability of a range of contraceptive methods, safe abortion care to the extent permitted by law, and post-abortion care. (IAWG, 2020)

4.2.2 Availability of Safe Abortion Services

For all persons needing abortion services to receive them, safe abortion services must firstly be available easily at different levels of the health system. Abortion services must be integrated into existing SRH services both in the public and not-for-profit private sector. This must include a constellation of services including scientifically accurate information, different methods of abortion, post-abortion care, and contraceptive services.

One of the most important barriers for provision of safe abortion services is the shortage of health care workers. Task shifting or task sharing is a key strategy used where a wider range of health care workers are trained in place of specialist doctors to provide various services – this has been shown to improve the availability of services, make services available at lower levels of the health system, and to improve equity in access of services. There is evidence that many of the medical interventions to provide safe abortion services can be provided by non-specialist doctors at the primary care level and/or on an outpatient basis (Barnard et al, 2015). WHO recommends that medical abortion in the first trimester (up to 10 weeks) can be provided safely by Auxiliary Nurse Midwives, Nurses, Midwives and non-specialist doctors, and by doctors belonging to complementary systems of medicine where they are trained to do so and already providing other SRH services. It also recommends that vacuum aspiration for abortion in the first trimester can safely be provided by nurses, midwives and non-specialist doctors (WHO, 2015). Thus, there is enough evidence for first trimester abortions through MVA/EVA and/or medical abortion pills to be made available at primary care level where the above specified cadres of staff are available, with no need for specialist doctors. This is discussed further in Chapter 3.

Second trimester abortions through either medical methods or through Dilatation and Evacuation are recommended to be performed by doctors, either non-specialist or specialist. Some tasks related to second trimester abortions, e.g. cervical preparation or provision of medical abortion, could be performed by midwives and nurses in specific circumstances where they have additional training for this, adequate supervision and monitoring, and adequate surgical back up and referral facilities in case of any complications (WHO, 2015). With medical advancement and modern technologies, second trimester abortions can be safely provided when adequately trained human resources and appropriate supplies and equipment are available (refer to Chapters 2 and 3).

Ensuring that abortion services are available at the lowest possible level of the health system, both in the public and private sectors, is essential to ensure that all persons who need abortion services are able to access them. Ensuring such availability is also a measure of equity as lack of such availability affects disproportionately the most marginalised, persons who live in rural areas, are poor, young and not married.

In addition, community level services for providing contraceptive information and services, pregnancy testing and referral for safe abortion services when needed without delay should be provided through Community Health Workers and pharmacists.

Availability of services also entails ensuring a choice of methods is available for those seeking abortion. Each level of facility should provide at least the methods that it has the capacity to provide safely, and ensure that there are appropriate referral mechanisms available for other methods. In order that safe abortion services can be linked to other SRH services that clients may need, e.g. pregnancy testing, contraception, HIV testing, all of these must be provided under one roof as part of a comprehensive SRH package. Box 9 details the different abortion related services that should be available at each level of the health system.

BOX 9:
SERVICES TO BE AVAILABLE AT DIFFERENT LEVELS OF HEALTHCARE

Community Level:

- Information provision on reproductive health, including contraception and abortion
- Community-based distribution of appropriate methods of contraception
- Pregnancy detection
- Information and referral for safe abortion services
- Recognition, initial management and referral for abortion complications
- Recognition, initial support and referral for survivors of sexual assault

Primary Care Level:

- All the services at community level
- Information provision and counselling on contraception and abortion
- Broad range of contraceptive services including IUD, injectables and implants
- Vacuum aspiration (MVA or EVA) up to 12-14 weeks pregnancy
- Medical abortion up to 9 weeks
- Initial stabilisation and referral of Post-abortion complications

Referral Level Facilities:

- All the services mentioned at lower levels
- Broad range of contraceptive services including sterilisation
- Abortion for all stages of pregnancy
- Management of all abortion complications

Source: WHO guidance document, 2012.

CHECKLIST 4

AVAILABILITY

Yes / No		NOTES
	Indicator for availability of abortion services — number of facilities providing abortion services available per 500,000 population — is reported on regularly as part of the health system's monitoring and reporting of its services.	
	First trimester abortion services through MA and MVA are available at the primary care level in the public and not-for-profit private sector.	
	There are no provisions in law or policy that restrict abortion service provision only to doctors.	
	Mid-level health providers, e.g. nurses, midwives, are trained to and provide safe abortion services through MVA or MA.	
	Second trimester abortion services are available through MA and D&E in secondary and tertiary level facilities.	
	In the absence of specialist doctors, non-specialist doctors in secondary and tertiary facilities are trained to provide second trimester abortions.	
	Facilities providing safe abortion services offer a choice of methods to the extent possible to clients seeking abortion services.	
	Safe abortion services are available as a part of comprehensive SRH services including contraception under one roof.	
	Services for pregnancy testing, contraceptive provision and referral for safe abortion available at community level.	
	CHWs and pharmacists are trained in pregnancy testing, contraceptive provision and referral for safe abortion.	

4.2.3 Accessibility of Safe Abortion Services

Abortion services need to be accessible, in addition to being available. WHO defines accessibility to include physical accessibility, economic accessibility and information accessibility (WHO, 2017).

4.2.3.1 Physical Accessibility

Physical accessibility implies that health services much be within safe physical reach of all those who need them, including for the most vulnerable. In order for safe abortion services to be physically accessible, they need to be available at primary level and where possible, through outpatient services, as detailed under the sub-section on availability. This also means lower level facilities and community level providers should provide appropriate referral services for those needing safe abortion services, post-abortion services or services for abortion complications.

Telehealth/Telemedicine for Safe Abortion

One strategy that has been explored to increase physical accessibility for abortion services is the use of telehealth/telemedicine services. Telehealth/telemedicine involves remote consultation with a health care provider either through telephone or video conferencing. Studies that have assessed the use of telemedicine for providing medical abortion services have found them to be safe, effective and acceptable. They have also found that they increase access to safe abortion services especially for persons residing in remote rural areas (Donovan M, 2019). Different models of telemedicine have been tried for the provision of medical abortion. The no-test model entails consultation with a health care provider from one's home over telephone or video followed by self-administration of MA drugs. Another model involves clients going to a health care facility and consulting remotely with a provider who is not present physically in the clinic (Ramaswamy et al, 2020). During the COVID-19 pandemic, telemedicine has been explored for provision of abortion services in some settings – for e.g. it has been approved through the NHS in the UK for medical abortion services (Department of Health and Social Care, 2020). In Nepal, the Ministry of Health approved the use of telemedicine, self-use and home use of medical abortion services during the COVID-19 pandemic (IPPF, 2020). However, some barriers exist to the use of telemedicine in provision of MA – these include laws and policies that mandate a physical face-to-face visit with a health care provider, mandatory investigations like an ultrasound before an abortion, or restrictions on prescription of medical abortion drugs only by a certified physician (Ramaswamy et al, 2020). These barriers should be addressed to make telemedicine potentially a widely available option for MA services.

Self-care and Self-management of Medical Abortion

Self-management of medical abortion is another strategy that is being explored for increasing access to medical abortion. WHO defines self-care interventions as evidence-based interventions, quality drugs, devices, diagnostics and/or digital products which can be provided fully or partially outside of formal health services and can be used with or without the direct supervision of health care personnel (WHO, 2019). Self-care is seen as bridging a gap in areas where health systems are weak, there is shortage of health care workforce, or where health systems are disrupted due to emergency or humanitarian situations. However, it is important to note that for self-care interventions to be effectively and safely used, an enabling environment is required in the form of a functional health system that provides support and back-up in case of complications.

In the area of abortion, women have been using self-managed medical abortion in many contexts and for many reasons. For example, a study in India in 2015 estimated that close to three quarters of all abortions in the country that year were through medical methods outside of health facilities (Singh et al, 2018). A scoping review of self-managed abortions found that women may opt to self-manage abortion as a preferred method, but that it is also often used as a last resort in the absence of other options. The reasons women gave for choosing self-managed abortions included specific barriers in seeking clinical care including long travel distances, inability to take time off from work or childcare, financial concerns, lack of knowledge of where to get a legal abortion, privacy and confidentiality concerns, fears about being reported to the police, and legal restrictions. Some positive reasons for choosing self-management included choosing medical abortion over surgical methods, perceiving self-management as proactive and empowering, and being able to do the abortion at home along with having someone with them for support (Moseson et al, 2020).

WHO says that self-management and self-assessment approaches can be empowering and also represent a way of optimising available health workforce resources and sharing of tasks. It recommends that managing the mifepristone and misoprostol medication without direct supervision of a health-care provider can be done under specific circumstances where women have a source of accurate information and access to a

health-care provider should they need or want it at any stage of the process. It also recommends that after taking the MA pills, self-management can be used to assess the completeness of the abortion process using pregnancy tests and checklists under very specific circumstances - where both mifepristone and misoprostol are being used (not misoprostol alone), and where women have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process (WHO, 2019). (Please note that the pregnancy tests used to assess completeness of abortion are low sensitivity pregnancy tests specifically used for this purpose and different from those used to diagnose pregnancy).

It is thus important to note that while self-management is being seen as a viable option for first trimester MA, it should not be seen as an alternative to poorly functional and unresponsive health systems leading to an abdication of responsibility by the health system; rather, self-management interventions should be seen and used as empowering approaches for women to take control of their own bodies and health, with adequate support from the health system as and when necessary.

4.2.3.2 Economic Accessibility

Economic accessibility is known to act as a key barrier for abortion seekers. Evidence shows that financial barriers disproportionately affect marginalised groups when seeking health services – adolescents, women in rural areas, poor women and single women face difficulties in arranging resources including for travel and stay expenses for a safe abortion service. In addition, there is evidence that private sector providers charge exploitatively when the person seeking an abortion is from a socially vulnerable group and the pregnancy and abortion carry social stigma (Duggal R, 2004). When persons needing abortion are unable to access safe abortion services because of high out-of-pocket expenses, they are forced to resort to unsafe methods. This can ultimately result in high costs for the health system in addressing the consequences and long term effects of unsafe abortion. It is thus important that safe abortion services are offered in the public sector with free-at-the-point-of-care financing mechanisms. User fees charged at the time of service delivery can act as a key barrier to access. Adequate budgets must be provided in SRH programmes to cover abortion services. In addition, abortion services must be covered under financial protection mechanisms like health insurance programmes. A large number of health insurance programmes do not provide cover for abortion services – for e.g. in the United States, federal funds through Medicaid cannot be used to pay for abortion services except in the case of rape, incest or life endangerment (Henshaw et al, 2009). Legal and policy mandates must be provided to ensure abortion services are included under health insurance programmes.

4.2.3.3 Information Accessibility

Information accessibility includes the right to seek and receive information on health. Lack of knowledge of legal status of abortion acts as a barrier in seeking safe abortion services – for e.g. studies from India show that widespread knowledge on the legality of abortion under the MTP Act is poor (Nidadavolu and Bracken, 2006). Correct information on the legal status of abortion and grounds on which abortion is available legally needs to be communicated widely to the general population. It should also be ensured that health care workers have the correct information on the laws around abortion in the country. In addition to the law, widespread information should be available in the community on where abortion services are available, where to access services for abortion at different periods of pregnancy, and what choice of methods are available where. Community Health Workers and pharmacists can be trained to provide such information.

Medical abortion should not be seen as an alternative to poorly functional and unresponsive health systems leading to an abdication of responsibility by the health system; rather, self-management interventions should be seen and used as empowering approaches for women to take control of their own bodies and health, with adequate support from the health system as and when necessary.

CHECKLIST 5		
	ACCESSIBILITY	
	Yes No	NOTES
	There is a safe abortion service available within 2 hours of travel for all populations in the area.	
	Telemedicine is used for provision of medical abortion services.	
	There are no provisions in law or policy that restrict abortion service provision only to doctors.	
	There are no provisions in law or policy like mandatory face-to-face consultation with health care provider or mandatory ultrasound that are barriers to the use of telemedicine.	
	There are no provisions in law or policy that restrict persons from self-managing their abortion if they choose to do so.	
	Information on self-management of abortion is provided to anyone seeking abortion.	
	Any person choosing to self-manage an abortion has a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.	
	Information on self-assessment of the completeness of the abortion process using pregnancy tests and checklists is provided to persons having an MA with both Mifepristone and Misoprostol.	
	Any person who chooses to self-assess the completeness of the abortion process has a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.	
	Safe abortion services are offered in the public sector with free-at-the-point-of-care financing mechanisms.	
	No user fees are charged at the time of service delivery for safe abortion in the public sector and not-for-profit private sector.	
	Adequate budgets are provided in SRH programmes to cover abortion services.	
	Abortion services are covered under financial protection mechanism like health insurance programmes.	
	Correct information on the legal status of abortion and grounds on which abortion is available legally is communicated widely to the general population.	
	Health care workers have the correct information on the laws around abortion in the country.	
	Widespread information is available in the community on where abortion services are available, where to access services for abortion at different periods of pregnancy, and what choice of methods are available where.	
	Community Health Workers and pharmacists are trained to provide information in the community on where abortion services are available, where to access services for abortion at different periods of pregnancy, and what choice of methods are available where.	

4.2.4 Acceptability of Safe Abortion Services

In order for safe abortion services to be acceptable, they need to address two key dimensions of acceptability - medical and socio-cultural. Services should be respectful of medical ethics and also be gender responsive and culturally appropriate.

Studies on clients' perspectives on quality of care in abortion services have identified several factors that affect the acceptability of a service. These include provider attitudes and friendliness in providing respectful care, provider sensitivity and confidentiality, absence of coercion including in adopting a contraceptive method as conditional for providing abortion service, provision of services without delay. Studies have also shown that providers do not often feel the need to fulfil these concerns, especially when abortion services are provided for free (Barua and Apte, 2007).

When abortion services fail to meet clients' specific needs, clients often choose to prefer a service that does so, even if it does not meet technical quality standards. This is especially true since in many settings, abortion carries social stigma, especially among the unmarried, and confidentiality in seeking services is seen as paramount.

In order for abortion services to be culturally acceptable, a key strategy would be the provision of counsellors who can speak the local language and address any questions or doubts in a sensitive manner. Counselling must include information regarding all aspects of the abortion procedure and must take into account the needs of those from different cultural contexts. The important point to be noted is that counselling is not 'motivation', 'advice' or 'persuasion' to accept the provider's point of view, but rather provision of relevant and appropriate information, enabling the client to make a choice.

Gender responsiveness is another key feature that makes abortion services acceptable. Gender responsive counselling that takes into account gender norms and how these influence reproductive behaviour can equip clients with the necessary information to make choices regarding their pregnancy and abortion procedure. Clients may be coerced in to either terminating or continuing a pregnancy against their wishes when faced with intimate partner violence. Identification and addressing of gender based violence or intimate partner violence should also be a key part of such gender responsive counselling.

CHECKLIST 6		
ACCEPTABILITY		
Yes / No		NOTES
	Health care providers are friendly, sensitive and respectful when interacting with clients seeking abortion services.	
	Health care providers maintain privacy and confidentiality while providing abortion services.	
	There is no coercion to adopt a contraceptive method when seeking abortion.	
	If a client seeking abortion does not want to use a contraceptive method, abortion is not refused to them.	
	There is no delay in providing abortion services to those who seek them.	
	Counsellors are present in abortion services to provide correct and complete information to clients seeking abortion.	
	Counsellors/health care providers are able to speak the local language.	
	Counsellors/health care providers are aware of the local cultural contexts and sensitive to the needs of specific marginalised groups.	
	Counsellors/health care providers spend adequate time with each client and answer any questions or doubts correctly, patiently and sensitively.	
	Counsellors/health care providers are trained to identify clients facing intimate partner violence.	
	Screening for intimate partner violence is integrated into abortion service provision.	
	Counsellors/health care providers are trained on how to support clients facing intimate partner violence.	
	Counsellors/health care providers are trained on how to support a client who is being forced to either continue/terminate their pregnancy against their wishes in a gender responsive manner.	

4.2.5 Quality

WHO's Quality of Care framework for maternal health identifies two broad domains of quality of care – the provision of care and the experience of care (Tuncalp et al, 2015). Based on this, safe abortion services need to be of technically sound quality and also sensitive to the client's specific needs.

4.2.5.1 Standard guidelines and technical quality of care

Standard guidelines for abortion care provision are key to establishing good quality care based on sound clinical principles and ethics and rights based values. Such guidelines help facilities and providers set standards for themselves, help with monitoring and evaluation, and also help demand accountability from them to adhere to the standards in service provision. However, such standard guidelines are not available in many country settings. Standard guidelines should be based on evidence-based principles and should be updated regularly to keep pace with medical advancement.

Current evidence for various technical aspects of safe abortion service provision has been detailed in Chapter 2. Modern methods of abortion – MA and MVA/EVA in the first trimester, and MA and D&E in the second trimester – are safer and more effective than obsolete methods like D&C. Therefore, a choice of the modern methods must be available at various abortion facilities based on the level at which they provide care.

Adequate pain management is a key aspect of technical quality. Providing sexual and reproductive health services without adequate pain relief has been considered a form of disrespect and abuse (WHO, 2014). The different pain management methods for different methods of abortion are discussed in Chapter 2. A choice of appropriate methods must be made available in different facilities.

Similarly, infection prevention is another key aspect of technical quality. Health care providers must be trained in standards of infection prevention and adequate equipment and supplies to ensure disinfection and sterilisation must be ensured.

Providing sexual and reproductive health services without adequate pain relief has been considered a form of disrespect and abuse.

4.2.5.2 Enabling Environment

Ensuring quality of care in provision of abortion care also means ensuring that different components of the health system that are to be functional to ensure an enabling environment for provision of such care are functional.

Adequate numbers of different cadres of health care providers at different levels need to be present. Health care providers also need to be trained adequately in different aspects of providing quality care including competency based training in providing appropriate methods of abortion, pain management techniques, and infection prevention methods. In addition, training also needs to include provision of respectful and sensitive care, maintaining privacy and confidentiality, and addressing the special needs of different groups, e.g. adolescents. Providers' negative values on abortion and on the women who seek them often affect service provision (Refer Chapter 3 for more details). Values clarification exercises need to be held for health care providers so they can recognise how their own personal values impact abortion service provision. Refusals of care also occur due to fear of criminal penalties amongst providers leading to a chilling effect on access to abortion. Such criminal penalties need to be removed in order for providers to have a truly enabling environment to provide safe abortion services. Adequate grievance redress mechanisms that provide scope for timely appeal in case an abortion is denied need to be set up.

Adequate supplies and equipment required for the different methods provided at each level need to be ensured without interruption. Medical abortion drugs – mifepristone and misoprostol – are part of WHO's Model List of Essential medicines and should also be a part of national essential drug lists in order to ensure their continued supply. Supply of pain management medication, syringes and cannulae for MVA, antibiotics, and contraceptive supplies also need to be ensured. These need to be part of routine inventories, procurement, and management information systems.

A key aspect for abortion service provision is timeliness of care. In many contexts, gestational age limits for legal abortion provision mean that any delay can make what was a legal abortion, illegal. Earlier provision of abortion is also safer. Therefore, any delay in provision of care is poor quality care. Laws and policies that contribute to delays like mandatory waiting periods and mandatory ultrasound examinations should be removed. Health care service providers must also be trained to provide care for those seeking abortion in a timely fashion. Some contexts have licensing or certification of providers

and/or facilities for provision of abortion services. In order to ensure wide availability of abortion services, these certification criteria must not be overly stringent and must be concordant with what is expected for other medical procedures.

4.2.5.3 Monitoring and Quality Assurance

Monitoring mechanisms provide oversight to ensure quality of care is maintained. Monitoring of specific abortion related data must be done both at facility level and at the level of different units like district and state. At the level of the facility, monitoring should be done through different methodologies including analysis of service data, case reviews, morbidity and death audits, observation, facility checks and client feedback. The data needs to be disaggregated by gestational age at provision of abortion, abortion methods used, and specific vulnerable groups addressed. Systems for feedback from providers need to be set up so as to identify problems and address them. Monitoring mechanisms need to feed into quality assurance mechanisms that do periodic quality checks and undertake corrective actions. Box 10 lists some of the indicators that could be used to monitor different aspects of abortion service provision.

Service data related to abortion needs to be included in the management information systems at different levels so that this can be monitored. In addition, programme evaluation and monitoring at various levels should include specific indicators related to abortion. This should include both process and outcome indicators (refer to Box 10).

4.2.5.4 Experience of Care

Experience of care includes several domains that studies show are important for clients when choosing abortion services that have been detailed in other sections in this chapter – these include cultural acceptability, gender responsiveness, privacy, confidentiality, and informed decision-making. These domains should be part of training of health care providers and monitoring and quality assurance mechanisms.

Experience of care includes several domains that studies show are important for clients when choosing abortion services – these include cultural acceptability, gender responsiveness, privacy, confidentiality, and informed decision-making.

BOX 10:
SOME SUGGESTED INDICATORS FOR MONITORING ABORTION SERVICES

Availability and Access

- Number of facilities providing safe abortion services per 500,000 population
- Population within 2 hours travel time to a safe abortion facility
- Proportion of health care providers trained to provide safe abortion services

Information Access

- Percentage population with correct knowledge regarding legal status of abortion
- Percentage of health care providers with correct knowledge regarding legal status of abortion

Quality

- Number of facilities that provide evidence based methods of induced abortion
- Number of facilities that provide post-abortion care for complications

Outcomes

- Percentage of admissions due to abortion
- Hospitalisation rate for unsafe abortion per 1,000 women
- Abortions per 1,000 live births
- Proportion of maternal deaths due to unsafe abortion

Source: Lowik AJ, 2017.

CHECKLIST 7		
	QUALITY	
	Yes No	NOTES
	Evidence-based standard guidelines for abortion care provision are available at national level.	
	Standard guidelines for abortion care provision are updated regularly based on recent medical advancements.	
	A choice of the modern methods is available at each facility based on the level at which it provides care.	
	Obsolete methods for abortion like D&C are not used in any facility.	
	Adequate pain management is offered at every facility for those who seek abortion.	
	Health care providers are trained to provide adequate pain management for those seeking abortion.	
	Adequate infection prevention methods are followed at every abortion service facility.	
	Health care providers are trained in adequate and appropriate infection prevention techniques.	
	All supplies and equipment needed for infection prevention are available without interruption and in working condition.	
	Adequate numbers of different cadres of health care providers are present to provide abortion services at different levels.	
	Health care providers have received competency based training on different aspects of abortion service provision.	
	Health care providers have received training on provision of respectful and sensitive care, maintaining privacy and confidentiality, and addressing the special needs of different groups, e.g. adolescents.	
	Values clarification exercises on abortion have been held with health care providers.	
	Adequate supplies and equipment required for the different methods of abortion provided at each level are available without interruption.	
	Medical abortion pills are included in the national list of essential medicines.	
	Abortion pills, supplies and equipment and contraceptive methods are part of routine inventories, procurement, and management information systems.	
	Any certification criteria for abortion are not overly stringent and are concordant with what is expected for other medical procedures.	
	Facilities regularly monitor data related to abortion service provision.	
	Data monitored at facility level is disaggregated by gestational age at provision of abortion, abortion methods used, and specific vulnerable groups addressed.	
	Monitoring mechanisms include systems for feedback from health care providers.	
	Monitoring mechanisms include systems for feedback from clients.	
	Quality assurance mechanisms include periodic checks of abortion service quality and institute corrective action for any gaps identified.	
	Service data related to abortion is included in the management information systems at different levels including facility, district, state and national level.	
	Indicators related to abortion service provision are part of routine programme monitoring and evaluation.	
	Indicators related to experience of abortion care including cultural acceptability, gender responsiveness, privacy, confidentiality, informed decision-making are part of monitoring and quality assurance mechanism.	

4.2.6 Informed Decision-making

The principle of informed decision-making has two elements. One is that clients are provided all the information related to abortion and are enabled to make a decision for themselves based on this information. The second is that the decision whether or not to have an abortion, taken on the basis of full information, is the woman's alone, and not for anyone else to take. This overlaps with the principle of autonomy discussed earlier.

Persons seeking abortion are often in a vulnerable situation as they are faced with an unwanted pregnancy and need to make a decision on it and act on that decision in a time-bound manner. This is especially true when they belong to vulnerable communities like adolescents and young persons, unmarried persons, women living with HIV. Health systems and health care providers need to be sensitive to this vulnerability and provide all information in a sensitive and respectful manner and help clients make a decision. As discussed in Chapters 2 and 3, sometimes, policies that require mandatory counselling based on a pre-defined script are used to pass on misinformation not based on accurate scientific facts in order to dissuade the woman from going ahead with an abortion. Providers' personal beliefs and values on abortion can also influence the counselling in a biased manner. All these are violations of the principle of informed decision-making.

Certain laws and policies that violate the principle of informed decision-making have been discussed in Chapter 3 – these include mandatory parental consent or information, mandatory spousal consent, judicial consent. Spousal authorisation requirements are usually applied exclusively to women and as such, represent a violation of women's right to equality and non-discrimination. Such laws and policies should be removed. At times, even after the laws and regulations have changed, health care providers may continue the practice because of their own beliefs that a woman's reproductive choices have to be approved by her husband. Health care providers need to be sensitised on why such policies are rights violations and not to insist on parental or spousal consent.

There are also studies that report that abortion service provision is sometimes offered only on the condition that the client accepts a contraceptive method (Barua and Apte, 2007). This is also a violation of the principle of informed decision-making.

CHECKLIST 8		
INFORMED DECISION-MAKING		
Yes / No		NOTES
	Health care providers offer information related to abortion service provision to clients seeking abortion services in a sensitive and respectful manner and help clients make a decision.	
	Health care providers ensure the client has provided informed consent to the abortion procedure.	
	There are no laws or policies requiring mandatory third party authorisation including that of parents, spouse or judiciary.	
	Health care providers uphold the client's autonomy and do not insist on mandatory information/consent from parents or spouse.	
	No conditions, for e.g. acceptance of a contraceptive method, are placed to provide abortion services.	
	Health care providers who conscientiously object refer those who need abortion to other services that can provide them and ensure that they receive the appropriate service.	
	Health care providers are not allowed to conscientiously object if the life of the person seeking abortion is in danger.	
	Health care providers have received training on the importance of upholding the client's autonomy and enabling informed decision-making.	
	Informed decision-making is monitored as part of monitoring and quality assurance mechanisms.	

Conscientious objection by providers is a provider-induced barrier where providers' own beliefs and values are used to refuse to provide abortion services. Such refusals are a violation of a woman's autonomy and right to informed decision-making. This has been discussed in detail in Chapter 3.

In order for clients to make an informed decision on abortion, the information that is provided to them needs to be scientifically correct, and provided in a manner in which they can comprehend and understand. Health care providers are often overburdened and short of time to provide detailed information to clients. In such situations, counsellors who speak the local language and understand the local cultural context can play the role of providing information to clients and enabling their decision-making.

Health systems need to make special effort to ensure informed decision-making is enabled in its true spirit. Health care providers need to be trained and sensitised on this, and this should also be part of monitoring and quality assurance mechanisms.

4.2.7 Privacy and Confidentiality

Privacy is a fundamental human right recognised in the Universal Declaration of Human Rights and underpins values such as autonomy and human dignity. The right to privacy includes, inter alia, bodily privacy and privacy related to personal information and communication. The right to privacy is protected through effective regulations and legislations that are enforced (Banisar and Davies, 1999) In the healthcare setting, privacy includes the right to make healthcare choices freely and to consent to treatment or examination without coercion. It also includes protection from bodily exposure against their will or in a manner that compromises personal dignity, and the protection of any information shared with the healthcare provider.

Confidentiality is a term used more in the context of medical practice. The physician's ethical obligation to confidentiality was first articulated in the Hippocratic oath. It constitutes the cornerstone of a relationship of trust between the healthcare provider and the patient, enabling the patient to disclose sensitive information essential for effective diagnosis and treatment (Mendelson et al. 2018).

Within the healthcare setting, confidentiality may be seen as the mechanism through which healthcare providers are able to uphold some aspects of patient privacy, especially those related to information and communication.

Privacy and confidentiality are essential tenets of ethical healthcare. Upholding the client's privacy and confidentiality acquires special significance in the context of a stigmatised procedure such as abortion, where it can make a difference between life and death.

In many settings, lack of privacy and confidentiality deter women from seeking safe abortion services or post-abortion care for complications of unsafe abortion. This is especially true for women from marginalised populations. For example, in a study of women from marginalised communities in Tamil Nadu, India, assurance of secrecy was perceived by women to be an essential component of 'safe' abortion (Subhasri and Ravindran 2012).

When the law or regulations of a country require that a woman's abortion has to be authorised by her spouse, or a parent or guardian in case of minors and persons with mental or intellectual disabilities, these are a violation of the patient's right to privacy and confidentiality. Several human rights treaties such as the ICCPR, CRC and CEDAW uphold women's right to privacy and confidentiality when receiving sexual and reproductive health services including abortion (Dhillon 2014). The WHO's Technical Guidance on Safe Abortion recommends that abortion laws, norms and standards include protections for confidentiality and privacy for all women, including adolescents (WHO, 2012).

In contexts where abortion is restricted by law, health professionals are obliged by professional ethical norms not to refuse emergency medical care to women seeking abortion or post-abortion care because third-party authorisation required by law has not been obtained. They are expected to respect the patient's privacy and confidentiality even after the treatment is completed, and not report the patient to the prosecuting authorities. This is spelt out by the Human Rights Committee as follows:

> *"where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion. In these instances, other rights in the Covenant, such as those in articles 6 and 7 (right to respect of privacy and freedom from torture, and cruel, inhuman and degrading treatment), might also be at stake" (Human Rights Committee, 2000, par. 20).*

The World Medical Association's Ethics Manual encourages physicians to be critical of any legal requirements that require them to breach patient confidentiality, and cautions that "legal requirements can conflict with the respect for human rights that underlies medical ethics (WMA 2005).

SRHR advocates may use international human rights law and norms of medical ethics as tools for holding governments accountable and to pressure governments to reform the country's abortion laws and regulations to be consistent with international norms.

CHECKLIST 9		
PRIVACY		
	Yes / No	NOTES
	The provider-patient interaction takes place in a space with closed doors or curtains.	
	No one besides the concerned healthcare provider(s) and the patient are present in the consulting space unless specifically requested by the client themselves.	
	None of patient's family members are present during the provider-patient interaction, except when she specifically requests for this.	
	The patient has privacy for dressing and undressing.	
	The clinical examination-couch does not face open doors or windows.	
	No one besides the healthcare providers enter the consulting space.	
	No one walks in and out of the examination room.	
	The provider speaks softly.	
	Other patients are not seated where the patient-provider conversations can be overheard.	
CONFIDENTIALITY		
	Yes / No	NOTES
	Medical records of the patient are anonymised.	
	Medical records of the patient are kept securely and under lock and key.	
	Staff providing the services do not discuss the details of the health service sought in a public space, even with the patient herself.	
	Staff involved in service delivery do not share the information about the patient with any member of the community.	
	Information about the patient is never discussed with her partner or family members without the patient's explicit consent, even for securing third-party authorisation.	
	Information about the patient is not reported to the government or other authorities without the patient's explicit consent.	

For information on Third Party authorisation requirements and mandatory reporting by healthcare providers, refer to Checklist No. 2.

4.2.8 Participation

Participation of communities and particularly people directly affected is a key human rights principle. However, people from the opposite end of the political spectrum use the term 'participation' to mean very different things. There are at least two conflicting ways in which participation, and its end goal, is perceived. The first is the utilitarian approach, where participation is a means to a pre-decided end – for example, increasing coverage, changing behaviour. The second is the empowering approach, where participation is seen as a set of empowering practices that enable socially excluded communities to voice their preferences and influence the design, implementation and assessment of interventions (Guareschi, and Jovchelovitch 2004). In a human-rights-based approach, participation refers to the empowering approach, and individuals are to be empowered as "rights-holders". Participation is important to accountability as it provides "... checks and balances which do not allow unitary leadership to exercise power in an arbitrary manner" (WHO 2017).

Meaningful participation calls for forums and structures that make possible sustained engagement and scope for continuing dialogue between duty-bearers and rights-holders. Some examples of structures for participation are Health Committees affiliated to each health facility, and at various levels of government starting from the local level.

CHECKLIST 10		
PARTICIPATION		
	Yes No	NOTES
	There are mechanisms for citizen participation at the health facility level.	
	There are mechanisms for citizen participation in decision-making on health policies and programmes, > at the local government level, > at the state/provincial government level, > at the national government level.	
	Mechanisms for participation are codified in law or government order/rules, > at the health facility level, > at the local government level, > at the state/provincial government level, > at the national government level.	
	Women constitute at least a third of the membership of the mechanisms for participation, > at the health facility level, > at the local government level, > at the state/provincial government level, > at the national government level.	
	Women from marginalised populations are represented in the mechanisms for participation, > at the health facility level, > at the local government level, > at the state/provincial government level, > at the national government level.	
	There have been capacity-building efforts to enable effective participation by women from marginalised populations in the mechanisms for participation during the past year.	
	Women's access to abortion services have been on the agenda of the mechanisms for participation within the last one year, > at the health facility level, > at the local government level, > at the state/provincial government level, > at the national government level.	
	Outcomes of participation have informed abortion services at the local level.	
	Outcomes of participation have informed abortion programmes and policies, > at the state/provincial government level. > at the national government level.	

Although the importance of community participation has been acknowledged and upheld from the time of the Alma-Ata Declaration in 1978, effective participation by communities, especially by women and other marginalised groups, has proven elusive. Lessons from an experiment in enabling community participation in health in the Western Cape suggest that effective participation requires:

A. Legislation codifying the structures for participation; the specific roles and functions of community representatives; and transparent processes through which they should be chosen
B. Specific quotas for representation of women and marginalised communities
C. Regulations specifying the channels for participation and the enforceability of opinions expressed by community representatives
D. Capacity-building efforts that enable effective participation by community-members, including administrative training, with special attention to building the capacity of representatives from marginalised groups (Meler et. al. 2012).

Promoting participation for health within the context of upholding women's right to abortion may call for measures beyond the above. For example, there will have to be equal representation of women in the structures and channels for participation. More importantly, capacity-building for community representatives would have to include knowledge of sexual and reproductive rights as human rights and value-clarification on abortion as a woman's right. The following is a useful resource: *Turner, Katherine L. and Kimberly Chapman Page. 2008. Abortion attitude transformation: A values clarification toolkit for global audiences. Chapel Hill, NC, Ipas. https://ipas.azureedge.net/files/VALCLARE14-VCATAbortionAttitudeTransformation.pdf*.

A range of United Nations Treaty Monitoring Bodies (TMBs) have upheld the rights of women and girls to safe abortion services and have called upon State Parties to effect legislative changes to ensure the realisation of these rights.

4.2.9 Accountability

With reference to public policies, the term 'accountability' usually refers to *the obligation of those in authority to take responsibility for their actions, to answer for them by explaining and justifying them to those affected, and to be subject to some form of enforceable sanction if their conduct or explanation for it is found wanting* (Goetz and Jenkins 2005, p. 8).

Accountability has been upheld as '*the raison d'être of the rights-based approach*' (UNOHCHR 2008). In the context of health, governments and public agencies are accountable for their actions and omissions in relation to their duties to protect the right to health of their people. Governments are also accountable for regulating the actions of private entities such as private health care providers, insurance companies and pharmaceuticals so that their actions do not violate citizens' right to health (UNOHCHR 2000).

Accountability is constituted of three different elements: engagement of rights-holders with power-holders (often also duty-bearers); answerability of power-holders to rights-holders and enforcement of action by power-holders. Accountability mechanisms are structures that enable engagement and answerability (Murthy 2019). Accountability mechanisms exist at many levels: international, national and subnational.
A range of United Nations Treaty Monitoring Bodies (TMBs) have upheld the rights of women and girls to safe abortion services and have called upon State Parties to effect legislative changes to ensure the realisation of these rights (Chapter 3). Advocates for safe abortion may use the mechanism of shadow reports to the TMBs, seek to input into the national reports of their respective governments to the Human Rights Council and others TMBs. They may also appeal to the United Nations Special Rapporteur on Health, whose scrutiny can trigger national political accountability for preventing violation of women's human rights resulting from denial of access to safe abortion services.

There are other mechanisms for tracking and reviewing the global abortion situation as an accountability strategy. The Global Abortion Policy Database of the World Health Organization tracks policy, regulatory and practice-related barriers to safe abortion services at the national level. International non-governmental organisations such as the Guttmacher Institute and the Centre for Reproductive Rights provide regular reviews on abortion laws and policies as well as on the progress made with regard to reduction in the incidence of mortality and morbidity from unsafe abortion.

BOX 11:
LEGAL AND SOCIAL ACCOUNTABILITY STRATEGIES TO EXPAND ACCESS TO ABORTION

In Rwanda, a youth-led organisation, Youth Action Movement (YAM), played a pivotal role in the relative liberalisation of the country's very restrictive abortion law. YAM was the youth branch of Association Rwandaise pour le Bien-Être Familial (ARBEF), affiliated to the International Planned Parenthood Federation (IPPF). During 2009-2012, young activists from YAM received technical and financial support by Rutgers WPF, a Dutch NGO, to work on "sensitive issues in young people's sexuality." The YAM decided to work on unsafe abortion in Rwanda as part of this project. They gathered evidence on the health consequences of unsafe abortion and testimonies from young people imprisoned for undergoing an abortion. The testimonies were made into booklets and widely disseminated to government officials and in public forums. The YAM networked with a wide range of civil society organisations, organised value-clarification workshops and debates; worked with the media; and launched a petition for law reform. This was also politically an opportune moment, because the penal code was coming up for review, and Rwanda had ratified regional human rights conventions around the same time. The abortion law was amended when the law came up for review in 2012 and allows abortion to save the life of the woman; to protect her health; or when the pregnancy is the result of rape, incest, or forced marriage (Umuhoza 2013).

In Colombia, Mesa por la Vida y la Salud de las Mujeres (Advocates for Women's Life and Health, hereinafter La Mesa), worked together with Women's Link Worldwide as part of its strategic litigation project LAICIA (High Impact Litigation in Colombia for the Unconstitutionality of Abortion). LAICIA was launched in 2005, and La Mesa and Women's Link Worldwide filed a constitutionality challenge against Columbia's abortion law, under which abortion was legal only to save the life of the mother. In 2006, the Constitutional Court of Columbia upheld abortion rights on the grounds of equality and ruled on the constitutionality of abortion within a human rights framework. Under the reformed law, abortion is not a crime under three conditions: when the woman's life or health is at risk (as certified by a physician); when there is serious foetal abnormality; and when the pregnancy is the result of sexual violence or non-consensual sex.

Source: Ruibal 2014.

At the national and sub-national levels, use of legal accountability and social accountability strategies have been common in the context of abortion. In social accountability, citizens/community hold the service providers and the government to account. They would, for example, collect and share evidence on the negative consequences of unsafe abortion, mobilise public opinion through media campaigns, hold public hearings of violations of rights, and lobby with policy makers and parliamentarians. Legal accountability is about using the courts of law to hold governments accountable for violations of human rights or for not upholding the constitutional rights of citizens. (Van Belle e. al. 2018). Box 11 describes the successful use of social mobilisation and petition for legal reform in Rwanda and strategic litigation in Colombia to challenge the country's restrictive abortion law (Ruibal 2014).

In a human rights framework, guarantee for access to justice, redress and reparation mechanisms is central to accountability. At the national level, accountability mechanisms for upholding the right to health would include administrative mechanisms for grievance redressal at the facility level and at various levels of governance, ombudsmen , consumer forums, the courts of law, National Human Rights Commissions, and other bodies such as the National Commission for Women (or Women and Children). When national mechanisms do not provide satisfactory redressal, individuals may also take recourse to the complaints procedures which is allowed by some of the TMBs such as the CEDAW Committee and the CRC (Convention on the Rights of the Child), provided that their countries have signed the optional protocol that enables this.

In the context of abortion, enforcing accountability calls for specific recourse and redress measures for addressing abusive practices within the health system such as turning away patients without a justifiable reason and disrespectful and abusive treatment during care provision, including withholding pain-killers.

CHECKLIST 11		
	ACCOUNTABILITY	
	Yes / No	NOTES
	Government's most recent report to Human Rights Treaty Monitoring Bodies included information on women's right to abortion.	Note which reports contained such information.
	Government's most recent report to Human Rights Treaty Monitoring Bodies included information on access to abortion of vulnerable populations.	Note which reports contained such information and about which groups.
	Civil society's most recent shadow-report to Human Rights Treaty Monitoring Bodies included information on women's right to abortion.	Note which reports contained such information.
	Civil society's most recent shadow-report to Human Rights Treaty Monitoring Bodies included information on access to abortion of vulnerable populations.	Note which reports contained such information and about which groups.
	Government produces periodic reports on abortion incidence, morbidity and mortality, > at the district level, > at the state/provincial government level, > at the national government level.	Note the indicators for which data are available.
	There are grievance redress mechanisms for abortion seekers, > at the health facility level, > at the local government level, > at the state/provincial government level, > at the national government level.	Note here the names of the redress mechanisms at different levels.
	There are social accountability initiatives to, > advocate for women's right to safe abortion, > monitor and report human rights violations with regard to women's right to abortion (e.g. abusive behaviour, denial of services), > track budgetary allocations and actual spending on abortion service provision.	Note here the names of the social accountability initiatives.

Endnotes

1 We acknowledge that not only women but also transgender people who are capable of pregnancy may need abortion services. However, this document focuses on women for the most part, because international human rights norms and most of the research evidence pertains to women. We have included information pertinent to transgender people wherever possible.
2 Found in only five countries in the world – Chile, Dominican Republic, El Salvador, Malta and Nicaragua.
3 India and China have been excluded in these calculations because they are atypical but skew the numbers because of their large population sizes.
4 The CRR publication lists 47 countries up to 2019. In addition, in 2020, New Zealand liberalised its abortion law making abortion services available on demand up to 20 weeks of gestation.
5 According to WHO recommendations on self-care interventions, self-management of medical abortion is now deemed safe until 12 weeks of pregnancy, given adequate information and appropriate backup health services.
6 The nine human rights principles and standards contain many overlapping dimensions. To avoid repetition, each dimension is dealt with under only one of the principles/standards and cross-referenced.

References

INTRODUCTION:

WHO (2019). WHO *consolidated guideline for self-care interventions for health: sexual and reproductive health and rights*. Geneva. p. 67.
WHO (2014). *Ensuring human rights in the provision of contraceptive information and services. Guidance and recommendations*. Geneva.
WHO (2012). *Safe abortion: Technical and policy guidance*. Geneva.

CHAPTER 1:

African Commission on Human and Peoples' Rights (2016). Statement by Commissioner Lucy Asuagbor during launch of ACHPR Campaign for the Decriminalization of Abortion in Africa.
Bearak J, Popinchalk A, Ganatra B, Moller A, Tunçalp Ö, Beavin C, Kwok L, Alkema L (2020). Unintended pregnancy and abortion by income, region and the legal status of abortion: estimates from a comprehensive model for 1990-2019. Lancet, July. https://doi.org/10.1016/S2214-109X(20)30315-6.
Biggs MA, Upadhyay UD, McCulloch CE, Foster DG. Women's mental health and well-being 5 years after receiving or being denied an abortion: A prospective, longitudinal cohort study. JAMA Psychiatry. 2017; 74(2):169-178.
Center for Reproductive Rights (2019). Breaking ground: treaty monitoring bodies on reproductive rights. New York. https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf.
Center for Reproductive Rights (2014). Whose right to life? Women's rights and prenatal protections under human rights and comparative law. New York. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/RTL_3%2014%2012.pdf.
Center for Reproductive Rights. Reproductive Rights Violations as Torture or Ill-treatment (2011). New York. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Reproductive_Rights_Violations_As_Torture.pdf.
Centers for Disease Control and Prevention. Reproductive Health: Contraception. https://www.cdc.gov/reproductivehealth/contraception/index.htm#Contraceptive-Effectiveness.
Copelon R, Zampas C, Brusie E & deVore J (2005). Human Rights Begin at Birth: International Law and the Claim of Fetal Rights, *Reproductive Health Matters*, 13:26, 120-129, DOI: 10.1016/S0968-8080(05)26218-3.
Darroch J, Woog V, Bankola A, Ashford L (2016). *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. New York: Guttmacher Institute.
Ganatra B, Gerdts C, Rossier C, Johnson Jr, BR, Tunçalp Ö, Assifi A, Sedgh G, Singh S, Bankole A, Popinchalk A, Berak J, Kang Z Alkema L (2017). Global, regional and sub-regional classification of abortion by safety, 2010-14: estimates from a Bayesian hierarchical model. *Lancet* 390:2372-81. https://pubmed.ncbi.nlm.nih.gov/28964589/.
Gerdts C, Dobkin L, Foster DG and Scwarz EB. (2016). Side effects, physical health consequences, and mortality associated with abortion and birth after an unwanted pregnancy. *Women's Health Issues*. 26(1): 55-59.).
Guttmacher Institute (2018). Abortion in Asia. Fact sheet. New York. https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-asia.pdf.
Guttmacher Institute (2016). Adolescents' need for and use of abortion in developing countries. Fact sheet. New York. https://www.guttmacher.org/fact-sheet/adolescents-need-and-use-abortion-services-developing-countries.
Kriel, Y., Milford, C., Cordero, J. et al. Male partner influence on family planning and contraceptive use: perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. *Reprod Health* 16, 89 (2019). https://doi.org/10.1186/s12978-019-0749-y.
Martsen C and Cleland J. Relationships between contraception and abortion. A review of the evidence. *International Family Planning Perspectives*, 2003, 29(1):6–13).
Organization of African Unity (2003). Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, adopted July 11, 2003 [Maputo Protocol on the Rights of Women in Africa], Article 14, 2(c).
Pizzarossa LB (2018) . Peer-Reviewing Abortion Laws: Lessons from the Universal Periodic Review. ESR REVIEW #03 | Vol. 19.
Planned Parenthood Federation of America (2014). The emotional effects of induced abortion. https://www.plannedparenthood.org/files/8413/9611/5708/Abortion_Emotional_Effects.pdf.
Ravindran TKS, Balasubramanian P. "Yes" to abortion but "no" to sexual rights: the paradoxical reality of married women in rural Tamil Nadu, India. Reprod Health Matters. 2004 May;12(23):88-99. doi: 10.1016/s0968-8080(04)23133-0. PMID: 15242214.

Raymond EG, Grossman D, Weaver M, Toti S and Winikoff B. (2014). Mortality of induced abortion, other outpatient surgical procedures and common activities in the United States. *Contraception* 90(5): 476-479.

Royal College of Obstetricians and Gynaecologists (2011).*The care of women requesting induced abortion*. London. https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf.

Salomonsen E (2017). Unsafe abortion in legally restricted areas – how politics and abortion laws decides women's future. *A literature review on the incidence of induced abortion and adverse health consequences in Sub-Saharan African countries with restrictive abortion laws*. The Faculty of Health Sciences, UiT The Arctic University of Norway, 2017.

Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, Gülmezoglu AM, Temmerman M, Alkema L (2014). Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*. Jun; 2(6):e323-33.

Sedgh G, Hussain R (2014). Reasons for Contraceptive Nonuse among Women Having Unmet Need for Contraception in Developing Countries. *Studies in Family Planning*. 45(2):151–69. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1728-4465.2014.00382.x.

Singh S, Remez L, Sedgh G, Kwok L and Onda T (2019). Abortion worldwide 2017. Uneven progress and unequal access. New York, Guttmacher Institute. https://www.guttmacher.org/report/abortion-worldwide-2017.

Sowmini CV 2013). Delay in termination of pregnancy among unmarried adolescents and young women attending a tertiary hospital abortion clinic in Trivandrum, Kerala, India, *Reproductive Health Matters*, 21:41, 243-250, DOI: 10.1016/S0968-8080(13)41700-7.

Stevens A (2018), Pushing a Right to Abortion through the Back Door: The Need for Integrity in the U.N. Treaty Monitoring System, and Perhaps a Treaty Amendment, 6 Penn State Journal of Law and International Affairs: 71. Available at: https://elibrary.law.psu.edu/jlia/vol6/iss1/6.

Subhasri B and Ravindran TKS (2012). Medical abortion: Understanding perspectives of rural and marginalized women from rural South India. *International Journal of Obstetrics and Gynecology*, 118, S33-S39 (Supp. 1).

Ujah I, Aisien O, Mutihir J, Vanderjagt D, Glew R, Uguru V. (2005). Maternal mortality among adolescent women in Jos, North-Central, Nigeria. Journal of Obstetrics & Gynecology, 25(1), p3-6. 2005;25(1):3-6.

United Nations (2011). *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*. New York. UN Doc. A/66/254 (2011), para. 65(h), (i). https://undocs.org/A/66/254.

United Nations (1995a). Programme of Action of the ICPD, Cairo, Egypt, 5-13 September 1994, para 7.2 and para 8.25, UN Doc.A/CONF.171/13/Rev.1.

United Nations (1995b).The Beijing Declaration and The Platform for Action. Fourth World Conference on Women, Beijing, China, 4-15 September 1995, para 106K, UN Doc. A/CONF.177/20.

United Nations (1989). General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at: https://www.refworld.org/docid/3ae6b38f0.html [accessed 6 September 2020].

United Nations (1948). General Assembly. *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III), available at: https://www.refworld.org/docid/3ae6b3712c.html [accessed 6 September 2020]

UN Committee Against Torture (CAT) (2011). Concluding Observations: Paraguay, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011). https://atlas-of-torture.org/en/document/wgc9npwq50qbwno115ib206r?page=1.

UN Committee Against Torture (CAT) (2009). Concluding Observations: Nicaragua, para 16. U.N. Doc. CAT/C/NIC/CO/1 (2009). https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CAT/C/NIC/CO/1&Lang=En.

UN Committee Against Torture (CAT) (2009). Concluding Observations: El Salvador, para 23. U.N. Doc. CAT/C/SLV/CO/2 (2009). https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CAT/C/SLV/CO/2&Lang=En.

UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) (1999). *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, A/54/38/Rev.1, chap. I, available at: https://www.refworld.org/docid/453882a73.html [accessed 30 August 2020], supra note 10, paras. 11 and 14.

UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) (1999). *Concluding Observations: Colombia*.

UN Committee on the Rights of the Child (CRC) (2016). *General comment No. 20 (2016) on the implementation of the rights of the child during adolescence*. https://uniteforreprorights.org/wp-content/uploads/2018/01/G1640444-3.pdf. (Paragraph 60).

UN Committee on the Rights of the Child (CRC) (2013). *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health* (art. 24), 17 April 2013, CRC/C/GC/15, available at: https://www.refworld.org/docid/51ef9e134.html [accessed 30 August 2020] Paragraph 70.

UN Committee on Economic, Social, and Cultural Rights (CESCR) (2016a). *General Comment No. 22 on the Right to Sexual and Reproductive health* (Art. 12 of the ICESCR), U.N. Doc. E/C.12/GC/22 (Mar. 4, 2016), https://www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health. Para 57.

UN Committee on Economic, Social, and Cultural Rights (CESCR) (2016b). *General Comment No. 22 on the Right to Sexual and Reproductive health* (Art. 12 of the ICESCR), , U.N. Doc. E/C.12/GC/22 (Mar. 4, 2016), https://www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health. Para 60 & Para 14.

UN Committee on Economic, Social, and Cultural Rights (CESCR) (2015). *Concluding Observations: Chile*, paras. 29, 29(a), U.N. Doc. E/C.12/CHL/CO/4. https://www.gi-escr.org/concluding-observations-private-education/chile-cescr-concluding-observations-ec12chlco4-para-30-19-june-2015.

UN Committee on Civil and Political Rights (CCPR),(2018). General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life. Paragraph 8. https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/1_Global/CCPR_C_GC_36_8785_E.pdf.

UN Human Rights Council (2018). *Report of the Working Group on the issue of discrimination against women in law and in practice*. Geneva. https://www.ohchr.org/Documents/Issues/Women/WG/A_HRC_38_46_EN.pdf.

UN Office of the High Commissioner for Human Rights (2020). *Abortion*. Information series on sexual and reproductive rights, Geneva. https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf.

UN Office of the High Commissioner for Human Rights (2017). *International Safe Abortion Day – Thursday 28 September 2017. Safe abortions for all women who need them – not just the rich, say UN experts*. 27 September. https://ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22167&LangID=E.

UN Office of the High Commissioner for Human Rights (2018). Joint Statement by CEDAW and CRPD Committees, 'Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities', 29 August 2018, www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDStatements.aspx.

Watter WW. Mental health consequences of abortion and refused abortion. Canadian Journal of Psychiatry. 1980 Feb;25(1):68-73. https://pubmed.ncbi.nlm.nih.gov/6989474/.

World Health Organization (2019). *Preventing unsafe abortion*. Fact sheet. Geneva. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion.

World Health Organization (2017). Leading the realization of human rights to health and through health: report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents. Geneva: WHO. Annex b. Human rights-related actions under Page 58. https://www.who.int/life-course/publications/hhr-of-women-children-adolescents-report/en/.

Zorzi K (2016), The Impact of the United Nations on National Abortion Laws, 65 Cath. U. L. Rev. 409 (2016). Available at: https://scholarship.law.edu/lawreview/vol65/iss2/122.

CHAPTER 2:

Barot, S., 2018. The roadmap to safe abortion worldwide: Lessons from new global trends on incidence, legality and safety. *Guttmacher Policy Review*, 21, pp.17-22.

Barua, A. and Apte, H., 2007. Quality of abortion care: perspectives of clients and providers in Jharkhand. *Economic and Political Weekly*, pp.71-80.

Ganatra, B., Gerdts, C., Rossier, C., Johnson Jr, B. R., Tunçalp, Ö., Assifi, A., Sedgh, G., Singh, S., Bankole, A., Popinchalk, A., Bearak, J., Kang, Z., & Alkema, L. (2017). Global, regional, and subregional classification of abortions by safety, 2010-2013;14: estimates from a Bayesian hierarchical model. *The Lancet*, 390(10110), 2372–2381. https://doi.org/10.1016/S0140-6736(17)31794-4.

Ipas. (2020). *Clinical Updates in Reproductive Health*. L. Castleman & N. Kapp (Eds.). Chapel Hill, NC: Ipas.

Ngo TD et al. *Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review. Geneva, World Health Organization*, 2011 (Report no. 89).

Slade P et al. A comparison of medical and surgical termination of pregnancy: choice, emotional impact and satisfaction with care. *British Journal of Obstetrics and Gynaecology*, 1998, 105:1288–1295.

UK Medicines Information. Can mothers breastfeed after a medical termination of pregnancy? 15th October 2020. https://www.sps.nhs.uk/articles/can-mothers-breastfeed-after-a-medical-termination-of-pregnancy/.

World Health Organization, 2012. *Safe abortion: technical and policy guidance for health systems*. World Health Organization.

World Health Organization, 2014. *Clinical practice handbook for safe abortion*. World Health Organization.

World Health Organization, 2019. *Medical management of abortion*. World Health Organization.

World Health Organization, 2019. WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. World Health Organization.

World Health Organization Model List of Essential Medicines, 21st List, 2019. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

CHAPTER 3:

Autorino T, Mattioli F, Mencarini L (2020). The impact of gynecologists' conscientious objection on abortion access. *Social Science Research* 87. https://doi.org/10.1016/j.ssresearch.2020.102403.

Baglini A (2014). *Gestational Limits on Abortion in the United States Compared to International Norms*. Virginia (USA), Charlotte Lozier Institute. https://lozierinstitute.org/internationalabortionnorms/ (Accessed 6 October 2020).

Barnard S, Kim C, Park MH, Ngo TD. Doctors or mid-level providers for abortion (Review). *Cochrane Database of Systematic Reviews* 2015, Issue 7. Art. No.: CD011242. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011242.pub2/full.

Barot S (2012). A problem and solution mismatch: son preference and sex-selective abortion bans. *Guttmacher Policy Review*. 15(2): 18-22.

Barry ME (2018). *Abortion over 20 weeks' gestation. Frequently asked questions*. Washington D.C., Congressional Research Service (CRS), April 30, 2018. https://www.everycrsreport.com/reports/R45161.html (Accessed June 4, 2020).

Baynes C, Yegon E, Lusiola G, Kahando R, Ngadaya, E, & Kahwa, J. (2019). Women's Satisfaction With and Perceptions of the Quality of Postabortion Care at Public-Sector Facilities in Mainland Tanzania and in Zanzibar. *Global health, science and practice*, 7(Suppl 2), S299–S314. https://doi.org/10.9745/GHSP-D-19-00026.

Berer M (2020). Telemedicine and self-managed abortion: a discussion paper. https://www.safeabortionwomensright.org/news/telemedicine-and-self-managed-abortion-a-discussion-paper/.

Berer M (2017). Abortion law and policy around the world: In search of decriminalization. *Health and Human Rights* 19(1): 13-27.

Center for Reproductive Rights (2020a). Law and policy guide: criminality. https://reproductiverights.org/law-and-policy-guide-criminality.

Center for Reproductive Rights (2020b). Law and policy guide: third-party authorization. New York, CRR. https://reproductiverights.org/law-and-policy-guide-third-party-authorization. (Accessed 2 June 2020).

Center for Reproductive Rights (2020c). Law and policy guide: conscientious objection. New York, CRR. https://reproductiverights.org/law-and-policy-guide-conscientious-objection. (Accessed 2 June 2020).

Center for Reproductive Rights (2019a). By the Numbers - the legal status of abortion worldwide. https://reproductiverights.org/sites/default/files/documents/World-Abortion-Map-ByTheNumbers.pdf. (Accessed 2 June 2020).

Center for Reproductive Rights (CRR) (2019b). Accelerating progress: liberalization of abortion laws since ICPD. https://reproductiverights.org/sites/default/files/documents/World-Abortion-Map-AcceleratingProgress.pdf. (Accessed 2 June 2020).

Center for Reproductive Rights (2015). *Mandatory waiting periods and biased abortion counseling in Central and Eastern Europe: Restricting access to abortion, undermining human rights, and reinforcing harmful gender stereotypes*. https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR_Fact%20Sheet_Abortion_MWP%20and%20Biased%20Counseling_CEE_Final_0.pdf.

Curtis C (2007). Meeting Health Care Needs of Women Experiencing Complications of Miscarriage and Unsafe Abortion: USAID's Postabortion Care Program. *Journal of midwifery & women's health*, 52(4): 368-375. https://onlinelibrary.wiley.com/doi/abs/10.1016/j.jmwh.2007.03.005.

Dixon-Mueller R. Innovations in reproductive health care: menstrual regulation policies and programs in Bangladesh. Stud Fam Plann. 1988 May-Jun;19(3):129-40. PMID: 3406963.

"*Dominican Republic delivers "huge blow" to women's right to life*" Amnesty International. 18 September 2009. https://www.amnesty.org/en/latest/news/2009/09/republica-dominicana-golpe-tremendo-derecho-mujeres-vida-20090918/. (Accessed 2 October 2020).

Erdman JN (2012). Harm reduction, human rights, and access to information on safer abortion. *Ethical and legal issues in reproductive health*, 118 (1): 83-86. https://doi.org/10.1016/j.ijgo.2012.04.002.

European Union Agency for Fundamental Rights (FRA) (2013). *Legal capacity of persons with intellectual disabilities and persons with mental health problems*. Vienna, FRA.

Fiala C, Arthur JH (2017). There is no defence for 'Conscientious objection' in reproductive health care. *European Journal of Gynecology and Reproductive Biology* 216: 254-258.

Fiala C, Danielsson KG, Heikinheimo O, Guðmundsson JA, Arthur J (2016). Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care, *The European Journal of Contraception & Reproductive Health Care*, 21:3, 201-206, DOI: 10.3109/13625187.2016.1138458.

Folter R. Why Uruguay is one of the only Latin American countries to legalize abortion. https://www.womensmediacenter.com/fbomb/why-uruguay-is-one-of-the-only-latin-american-countries-to-legalize-abortion. (Accessed on April 24, 2019).

Gatter M, Kimport K, Foster DG, Weitz TA, Upadhyay UD. Relationship between ultrasound viewing and proceeding to abortion. Obstet Gynecol. 2014; 123(1):81–7. Epub 2014/01/28. https://pubmed.ncbi.nlm.nih.gov/24463667/.

Global Abortion Policies Database (GAPD), 2020. https://abortion-policies.srhr.org/.

González Vélez AC (2012) "The health exception": a means of expanding access to legal abortion, *Reproductive Health Matters*, 20:40, 22-29, DOI: 10.1016/ S0968-8080(12)40668-1

Government of the People's Republic of Bangladesh. Directorate General of Family Planning: MCH Services Unit. Memorandum No.: DGFP/MCH-RH/pro-sha (admin) 23/05/108. 03 February 2015.

Grossman D, Blanchard K, Blumenthal P (2008). Complications after Second Trimester Surgical and Medical Abortion," *Reproductive Health Matters*, 16: (31 Suppl):173-82. https://doi.org/10.1016/S0968-8080(08)31379-2.

Guttmacher Institute (2012). Menstrual regulation, unsafe abortion and maternal health in Bangladesh. *In Brief* No. 3. New York.

Hunt P. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Human Rights Commission. 60th Session. Theme 10 provisional programme. E/CN.4/2004/49. United Nations; 2004.

International Planned Parenthood Federation (2019). *Policy Briefing: The impact of the global gag rule*. London, IPPF.

International Women's Health Coalition (2019). Crisis in care: year two impact of Trump's global gag rule. NY, IWHC. https://iwhc.org/resources/crisis- care-year-two-impact-trumps- global-gag-rule/. Accessed 17 October 2020.

Kaufman R.E. (2021). The U.S. Recommits to Sexual and Reproductive Health and Rights. American Constitution Society. Blog, 19 March. https://www.acslaw.org/expertforum/the-u-s-recommits-to-sexual-and-reproductive-health-and-rights/.

Keogh LA, Gillam L, Bismark M, McNamee K, Webster A, Bayly C, Newton D (2019). Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers. *BMC Medical Ethics*, 20:11. https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-019-0346-1.

Kimport K, Upadhyay UD, Foster DG, Gatter M, Weitz TA. Patient viewing of the ultrasound image prior to abortion. Contraception. 2013; 88(5):666–70. Epub 2013/09/14. https://doi.org/10.1016/j.contraception.2013.07.006.

Klick J. Mandatory waiting periods for abortions and female mental health. Health Matrix. 2006;16(1):183–208.

Labandera A, Gorgoroso M, Briozzo L. Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: From a university hospital to the entire country. *International Journal of Gynecology and Obstetrics* 2016; 134:S7-S11.

Lavelanet AF, Johnson BR, Ganatra B (2020). Global Abortion Policies Database: A descriptive analysis of the regulatory and policy environment related to abortion. *Best Practice & Research Clinical Obstetrics and Gynaecology* 62 (2020) 25e35. https://doi.org/10.1016/j.bpobgyn.2019.06.002.

Marie Stopes International (2018). *A world without choice: the Global Gag Rule's impact in Madagascar*, 2018. Washington, DC. Marie Stopes US. https://www.mariestopes-us.org/wp-content/uploads/2018/01/MSI_Madagascar_GGR-Fact-Sheet_Jan-2018.pdf.

Marie Stopes International (2004). L*ate abortion: a research study of women undergoing abortion between 19 and 24 weeks' gestation*. London, MSI. http://www.ossyr.org.ar/pdf/bibliografia/247.pdf. (Accessed 10 October 2020).

McCarthy, Angie. "State Obligations to Protect the Lives and Health of Women after Abortion or Miscarriage." Human Rights Brief 21, no. 2 (2014): 16-21. https://digitalcommons.wcl.american.edu/hrbrief/vol21/iss2/3/.

Millar E (2019). Here's why there should be no gestational limit for abortion. *The Conversation*, August 12, 2019. https://theconversation.com/heres-why-there-should-be-no-gestational-limits-for-abortion-121500. (Accessed 17 October 2020).

Moroccan Family Planning Association and Asian-Pacific Resource and Research Centre for Women. *Religious fundamentalism and access to safe abortion services in Morocco*. Rabat and Kuala Lumpur: Moroccan Family Planning Association and Asian-Pacific Resource and Research Centre for Women; 2016.

Nadimpalli S., Venktachalam D., Banerjee S. "India's abortion wars" Deccan Chronicle. 2017 Apr 16; https://www.deccanchronicle.com/opinion/op-ed/160417/indias-abortion-wars.html.

National Academies of Sciences, Engineering and Medicine, *The Safety and Quality of Abortion Care in the United States*, Washington, DC: National Academies Press, 2018.

Nicaragua votes to ban abortions." (26 October 2006). *BBC News*. http://news.bbc.co.uk/2/hi/americas/6089718.stm. Accessed October 2, 2020.

Rasch V (2011). Unsafe abortion and postabortion care - an overview. *Acta Obstetricia et Gynecologica Scandinavica* 90(7). https://doi.org/10.1111/j.1600-0412.2011.01165.x

Ravindran TKS (2019). *Victims twice over: pregnancy due to sexual abuse and forced motherhood due to failed justice*. India, CommonHealth, November 21, 2019. https://safeabortion889409100.wordpress.com/2019/11/21/victims-twice-over-pregnancy-due-to-sexual-abuse-and-forced-motherhood-due-to-failed-justice/.

Rocca CH, Samari G, Foster DG, et al (2020). Emotions and decision rightness over five years following an abortion: an examination of decision difficulty and abortion. *Social Science and Medicine*. https://doi:10.1016/j.socscimed.2019.112704.

Royal College of Physicians and Surgeons of Canada (2020). *Abortion and the mature minor*. Bioethics cases. Reproductive Health. Section 4.2.2. http://www.royalcollege.ca/rcsite/bioethics/cases/abortion-mature-minor-e.

Rowlands S and Thomas K. Mandatory waiting periods before abortion and sterilization: Thoery and Practice. International Journal of Women's Health 2020:12 577–586.

Sheldon S. (2015) The decriminalisation of abortion: an argument for modernisation. *Oxford Journal of Legal Studies*. June: 1-32. https://doi.org/10.1093/ojls/gqv026.

Singh S, Hussain R, Shekhar C, Acharya R, Moore AM, Stillman M, Frost JF, Sahoo H, Alagarajan M, Sundaram A, Kalyanwala S and Ball H (2018). *Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs*. New York, Guttmacher Institute.

Skuster P (2013). *Young women and abortion: avoiding legal and policy barriers*. Chapel Hill, Ipas.

Sultana N (2020). Task-sharing in menstrual regulation services: Implementation efforts and lessons learned in Bangladesh. International Journal of Gynecology and Obstetrics, Vol 150, S1:4-8.

Upadhyay UD, Kimport K, Belusa EKO, Johns NE, Laube DW, Roberts SCM (2017) Evaluating the impact of a mandatory pre-abortion ultrasound viewing law: A mixed methods study. PLoS ONE 12(7): e0178871. https://doi.org/10.1371/journal.pone.0178871.

United Nations, Department of Economic and Social Affairs, Population Division (2014). *Abortion Policies and Reproductive Health around the World* (United Nations publication, Sales No. E.14.XIII.11). https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf.

UN Committee Against Torture (CAT) (2011). Concluding Observations: Paraguay, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011). https://atlas-of-torture.org/en/document/wgc9npwq5oqbwno115ib206r?page=1.

UN Committee on Civil and Political Rights (CCPR) (2005). K.L. v. Peru, Human Rights Committee, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003. https://undocs.org/CCPR/C/85/D/1153/2003.

UN Committee on Civil and Political Rights (CCPR) (2014a). Human Rights Committee, Concluding Observations: Ireland, para. 9, U.N. Doc. CCPR/C/IRL/CO/4. https://undocs.org/CCPR/C/IRL/CO/4.

UN Committee on Civil and Political Rights (CCPR) (2014b). Human Rights Committee, Concluding Observations: Sierra Leone, para. 14, U.N. Doc CCPR/C/SLE/CO/1. https://undocs.org/CCPR/C/SLE/CO/1.

UN Committee on Civil and Political Rights (CCPR) (2012). Human Rights Committee, Concluding Observations: Guatemala, para. 20, U.N. Doc. CCPR/C/GTM/CO/3. https://undocs.org/CCPR/C/GTM/CO/3.

UN Committee on the Rights of the Child (CRC) (2011). Concluding Observations: Costa Rica, para. 64, U.N. Doc. CRC/C/CRI/CO/4. https://undocs.org/CRC/C/CRI/CO/4.

UN Committee on the Rights of the Child (CRC) (2007). Concluding Observations: Chile, para. 56, U.N. Doc. CRC/CHL/CO/3. https://undocs.org/CRC/CHL/CO/3.

UN Committee on the Rights of the Child (CRC) (1999). Concluding Observations: Chad, para. 30, U.N. Doc. CRC/C/15/Add.107. https://undocs.org/CRC/C/15/Add.107.

UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee) (2011). L.C. v. Peru, Communication No. 22/2009, para. 12, U.N. Doc. CEDAW/C/50/D/22/2009. https://undocs.org/CEDAW/C/50/D/22/2009.

UN Committee on Economic, Social, and Cultural Rights (CESCR) (2010). Concluding Observations: Dominican Republic, para. 29, U.N. Doc. E/C.12/DOM/CO/3. https://undocs.org/E/C.12/DOM/CO/3

UN Committee on Economic, Social, and Cultural Rights (CESCR) (2004). Concluding Observations: Chile, para. 53, U.N. Doc. E/C.12/1/Add.105. https://undocs.org/E/C.12/1/Add.105.

UN Committee on Economic, Social and Cultural Rights (2000). General comment No. 14. The right to the highest attainable standard of health. Art. 12. 22nd Session. E/C.12/2000/4. United Nations; 2000.

UN Committee on the Rights of Persons with Disabilities (CRPD Committee) (2014). *Gen. Comment No. 1: Article 12: Equal recognition before the law*, (11th session, 2014), para. 26, U.N. Doc. CRPD/C/GC/1.

Westeson J (2012). IntLawGrrls: *Rights-based approach to sex-selection. Geneva, Center for Reproductive Rights* (Europe).

Women on Waves. Bangladesh Abortion Law [website] (2020). https://www.womenonwaves.org/en/page/4866/bangladesh–abortion-law. Accessed September 28.

Wood S, Abracinskas L, Correa S and Pecheny M. Reform of abortion law in Uruguay: context, process and lessons learned. *Reproductive Health Matters*, 2016; 24:48, 102-110, https://doi.org/10.1016/j.rhm.2016.11.006.

World Health Organization (2020). Maintaining essential health services: operational guidance for the COVID- 19 context interim guidance, 1 June 2020. https://apps.who.int/iris/handle/10665/332240.

World Health Organization (2011). *Preventing gender-biased sex-selection. An interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO*. Geneva, WHO.

World Health Organization (1946). Constitution, adopted during the International Health Conference. New York.

World Health Organization (2002). World Health Report: *Reducing Risks, Promoting Healthy Life*. Geneva, WHO.

CHAPTER 4:

Banisar D and Davies S, (1999). Global Trends in Privacy Protection: An International Survey of Privacy, Data Protection, and Surveillance Laws and Developments. The John Marshall Journal of Information Technology and Privacy Law, 18(1). https://repository.jmls.edu/cgi/viewcontent.cgi?article=1174&context=jitpl/.

Barnard S, Kim C, Park MH, Ngo TD. Doctors or mid-level providers for abortion (Review). *Cochrane Database of Systematic Reviews* 2015, Issue 7. Art. No.: CD011242. https://doi.org/10.1002/14651858.CD011242.pub2.

Barua, A. and Apte, H., 2007. Quality of abortion care: perspectives of clients and providers in Jharkhand. *Economic and Political Weekly*, pp.71-80.

Cohen J and Ezer T (2013). Human rights in patient care: a theoretical and practical framework. *Health and Human Rights*, 15(2).

CRPD, Art 1.

de Bruyn, M., 2012. HIV, unwanted pregnancy and abortion–where is the human rights approach? *Reproductive Health Matters*, 20(39), pp.70-79.

Dennis, A., Henshaw, S.K., Joyce, T.J., Finer, L.B. and Blanchard, K., 2009. The impact of laws requiring parental involvement for abortion: a literature review. New York: *Guttmacher Institute*.

Department of Health and Social Care, Government of UK, 2020. Temporary approval of home use for both stages of early medical abortion. Available from: https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion--2/.

Dhillon, J. (2014). *Protecting women's access to safe abortion care: A guide to understanding the human rights to privacy and confidentiality: Helping advocates navigate 'duty to report' requirements*. Chapel Hill, NC: Ipas.

Donovan, M., 2019. Improving access to abortion via telehealth. *Guttmacher Policy Rev*, 22, pp.23-28.

Duggal, R., 2004. The political economy of abortion in India: cost and expenditure patterns. *Reproductive Health Matters*, 12(sup24), pp.130-137.

Espinoza, C., Samandari, G. and Andersen, K., 2020. Abortion knowledge, attitudes and experiences among adolescent girls: a review of the literature. *Sexual and Reproductive Health Matters*, 28(1), p.1744225.

Goetz A, Jenkins R. *Reinventing accountability: making democracy work for human development*. Hampshire, Palgrave Macmillan, 2005:8.

Guareschi, Pedrinho; Jovchelovitch, Sandra (2004). Participation, health and the development of community resources in southern Brazil [online]. London: LSE Research Online. http://eprints.lse.ac.uk/2629/.

Henshaw, S.K., Joyce, T.J., Dennis, A., Finer, L.B. and Blanchard, K., 2009. Restrictions on Medicaid funding for abortions: A literature review. *Guttmacher Institute*.

Human Rights Committee. (2000). General Comment No. 28: The equality of rights between men and women. CCPR/C/21/Rev.1/Add.10.

Independent Accountability Panel, '2016: Old Challenges, new Hopes: Accountability for the Global Strategy for Women's, Children's and Adolescents' Health' available at http://iapreport.org/downloads/IAP_Report_September2016.pdf.

Inter Agency Working Group. Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. https://iawg.net/resources/misp-reference.

International Planned Parenthood Federation South Asia Region. Safe abortion services amid COVID19 - Agile, adaptive & innovative response from South Asia. May 2020. https://reliefweb.int/sites/reliefweb.int/files/resources/SARO%20COVID19%20Update%203%20%28Safe%20Abortion%29.pdf.

Lowik AJ. Trans-inclusive abortion services: A manual for providers on operationalising trans-inclusive policies and practices in an abortion setting. 2017.

Meler BM, Pardue C, London L. Implementing community participation through legislative reform: a study of the policy framework for community participation in the Western Cape province of South Africa. *BMC International Health and Human Rights* 2012, 12:15. http://www.biomedcentral.com/1472-698X/12/15.

Mendelson D, Rees and Wolf G (2018). Medical Confidentiality and Patient Privacy Chaper 9 in B White, F McDonald & L Willmott (Eds), Health Law in Australia, 3nd Edition, (2018 Thomson Reuters). https://ssrn.com/abstract=3173601/.

Moseson, H., Herold, S., Filippa, S., Barr-Walker, J., Baum, S.E. and Gerdts, C., 2020. Self-managed abortion: a systematic scoping review. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 63, pp.87-110.

Murthy R. Presentation on Accountability mechanisms – SRH services in the context of UHC and inequalities. In: *Technical consultative meeting on guidance for integrating sexual and reproductive health and rights (SRHR) within national UHC plans*, Geneva, 15-16 May 2019. Geneva, World Health Organization, 2019.

Nidadavolu, V. and Bracken, H., 2006. Abortion and sex determination: conflicting messages in information materials in a District of Rajasthan, India. *Reproductive Health Matters*, 14(27), pp.160-171.

Orner, P.J., de Bruyn, M., Barbosa, R.M., Boonstra, H., Gatsi-Mallet, J. and Cooper, D.D., 2011. Access to safe abortion: building choices for women living with HIV and AIDS. *Journal of the International AIDS Society*, 14(1), p.54.

Radhakrishnan, A., Sarver, E. and Shubin, G., 2017. Protecting safe abortion in humanitarian settings: overcoming legal and policy barriers. *Reproductive health matters*, 25(51), pp.40-47.

Ramaswamy, A., Weigel, G., Sobel, L., Salganicoff, A., 2020. Medication Abortion and Telemedicine: Innovations and Barriers during the COVID-19 Emergency. Kaiser Family Foundation. Available from: https://www.kff.org/policy-watch/medication-abortion-telemedicine-innovations-and-barriers-during-the-covid-19-emergency/.

Ravindran TKS (2016). *An advocates' guide: integrating human rights in universal access to contraception*. Kuala Lumpur, Asian and Pacific Resource and Research Centre for Women (ARROW).

Singh, S., Shekhar, C., Acharya, R., Moore, A.M., Stillman, M., Pradhan, M.R., Frost, J.J., Sahoo, H., Alagarajan, M., Hussain, R. and Sundaram, A., 2018. The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health*, 6(1), pp.e111-e120.

Subhasri B and Ravindran TKS (2012). Medical abortion: Understanding perspectives of rural and marginalised women from rural South India. *International Journal of Obstetrics and Gynecology*, 118, S33-S39 (Supp. 1).

Tunçalp, Ö., Were, W.M., MacLennan, C., Oladapo, O.T., Gülmezoglu, A.M., Bahl, R., Daelmans, B., Mathai, M., Say, L., Kristensen, F. and Temmerman, M., 2015. Quality of care for pregnant women and newborns—the WHO vision. *Bjog*, 122(8), p.1045.

United Nations Office of the High Commissioner for Human Rights (2000). *CESCR General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*. Adopted at the twenty-second session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000, (Contained in document E/C.12/2000/4). Geneva, UNOHCHR. https://www.refworld.org/pdfid/4538838do.pdf.

United Nations Office of the High Commissioner for Human Rights (2008). *Claiming the Millennium Development Goals: A Human Rights Approach*. Geneva, UNOHCHR, p.15.

United Nations Population Fund and Harvard School of Public Health (2010). A Human Rights-Based Approach to programming. New York, UNFPA. P. 71-72.

Umuhoza C, Oosters B, van Reeuwijk M, Vanwesenbeeck I. Advocating for safe abortion in Rwanda: how young people and the personal stories of young women in prison brought about change. R*eproductive Health Matters*, 2013, 21:49–56.

Van Belle S, Boydell V, George AS, Brinkerhof DW, Khosla R. Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review. *PLoS One*, 2018, 13:e0196788. https://doi.org/10.1371/journal.pone.0196788/.

World Health Organization, 2009. Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note.

World Health Organization, 2012. *Safe abortion: technical and policy guidance for health systems*. World Health Organization.

World Health Organization, 2014. *The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement* (No. WHO/RHR/14.23). World Health Organization.

World Health Organization, 2015. *Health worker role in providing safe abortion care and post abortion contraception*. World Health Organization.

World Health Organization (2017). *Human Rights and Health*. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

World Health Organization, 2019. WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights.

World Medical Association (2005). *Medical Ethics Manual*. Ch. 2: Physicians and Patients, p. 53. Ferney-Voltaire Cedex, France: WMA.

ISBN 978-967-0339-52-8

ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, engagement, advocacy, and mobilisation.

ARROW envisions an equal, just and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

The 'Claiming the Right to Safe Abortion' project expects to make incremental gains in the implementation of safe abortion legislation and access to services through five countries in Asia to enable greater access to safe abortion services for all women in those countries. The Safe Abortion Advocacy Initiative – A Global South Engagement (SAIGE) is a co-created network of Global South advocates, activists, academics and service providers committed to increase their impact towards ensuring safe abortion through a multi-pronged approach: evidence generation, evidence-based advocacy and accountability strategies to influence the implementation of safe abortion laws and policies at multiple national levels across the region.

This also involves concerted work around dismantling barriers to safe abortion including increasing safe abortion awareness among women and service providers; addressing stigma and refusal of care based on religion and dealing with poor quality and availability of services.

This project is supported and funded by Riksförbundet för Sexuell Upplysning (RFSU) – the Swedish Association for Sexuality Education.

Asian-Pacific Resource & Research Centre for Women (ARROW)
1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

Telephone	(603) 2273 9913/9914/9915
Fax	(603) 2273 9916
E-mail	arrow@arrow.org.my
Web	arrow.org.my
Facebook	facebook.com/ARROW.Women
Instagram	arrow_women
Twitter	@ARROW_Women
Youtube	youtube.com/user/ARROWomen
LinkedIn	linkedIn.com/company/arrowomen

The Safe Abortion Advocacy Initiative A Global South Engagement (SAIGE)
https://saige.arrowadvocacy.org/

Riksförbundet för Sexuell Upplysning (RFSU) – the Swedish Association for Sexuality Education
https://www.rfsu.se/

arrow
asian-pacific resource & research centre for women

rfsu

saige
Safe Abortion Advocacy Initiative
Global South Engagement