

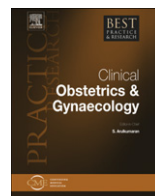


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Abortion and human rights

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Abortion has been a reality in women's lives since the beginning of recorded history, typically with a high risk of fatal consequences, until the last century when evolutions in the field of medicine, including techniques of safe abortion and effective methods of family planning, could have ended the need to seek unsafe abortion. The context of women's lives globally is an important but often ignored variable, increasingly recognised in evolving human rights especially related to gender and reproduction. International and regional human rights instruments are being invoked where national laws result in violations of human rights such as health and life. The individual right to conscientious objection must be respected and better understood, and is not absolute. Health professional organisations have a role to play in clarifying responsibilities consistent with national laws and respecting reproductive rights. Seeking common ground using evidence rather than polarised opinion can assist the future focus.

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Across the world, from the beginning of recorded history, women have been prepared to risk their lives when faced with an unwanted pregnancy. The reality of abortion is often minimised, yet even in current times globally about one in five pregnancies will end in an abortion, regardless of whether it is legal or safe.^{1,2} To consider abortion in isolation from the context of women's lives and in the absence of evidence guarantees acrimony and is a well-documented cause of increased maternal mortality. The last century has been revolutionary in many ways, though for some women, their lives have changed little. The rights of women to vote, to hold public office and to be recognised as persons began in the late 19th century and continue to progress, but are still not universal. Advances in health and technology including antibiotics, blood transfusion, contraceptive methods and safe medical and surgical

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abortion techniques should have meant that women no longer need to put their lives at risk, although they may not have access to such services, nor the autonomy to make decisions on their own sexual and reproductive health. The recent United Nations (UN) resolution on the recognition of maternal mortality as a violation of human rights is a landmark decision in highlighting the need to urgently address unsafe abortion and prevention of unintended pregnancy.³ Human rights are generally considered to have emerged as an internationally agreed concept with the formation of the UN by Charter in 1945⁴ resulting from international consensus on avoidance of the atrocities of the Second World War. Few consider these elements when discussing human rights and abortion, preferring to continue a narrow and polarised stance framed as support of or opposition to abortion, rather than seeking areas of common understanding that will bring us closer to reducing the numbers of abortions and preventing needless deaths and complications.

Background information: private decisions/public debate; how do people know what they know?

Women are recognised as central to the successful development of nations and it is no accident that the World Economic Forum in its annual Global Gender Gap (GGG) report is tracking indicators of gender-based human rights in four areas: economic participation and opportunity, educational attainment, political empowerment and health and survival.⁵ The GGG report includes indicators such as maternal mortality, fertility rates, contraceptive prevalence and adolescent pregnancy, in addition to the representation of women in parliament.⁵ The focus on women and health is also the topic of a World Health Organization (WHO) report in 2009 titled 'Women and Health: today's evidence tomorrow's agenda' that recognises that girls and women have greater needs of health systems due to their gender and reproductive roles and that these needs are not being met, thus impacting their health and that of their children.⁶ This recognition of the broader context of women's lives for them to achieve optimal reproductive health is often lacking in discussions on abortion. It is important to remember that it was only at the end of the 19th and early 20th centuries that women began to gain the right to vote nationally and these rights continue to be granted even into the 21st century, most recently Bhutan, in 2008.^{7,8} The right to vote (suffrage) was explicitly mentioned for women in the Convention for the Elimination of Discrimination Against Women (CEDAW) in 1979.⁹ As an example of the evolution of women's rights, in Canada, women were granted the right to vote in 1917 but were not recognised as persons until 1929, and Aboriginal women (and men) in Canada were not granted the right to vote at the federal level until 1960.¹⁰

According to the 2009 GGG report, no country has yet reached gender equality, although the Nordic countries are the closest.⁵ Progress is being made in all indicators being measured though there are significant gaps between men and women in political decision-making at the highest levels and in economic outcomes, while gaps in education and health are generally closing more quickly in the 130 countries covered by the report. Overall, globally, women represented 18.6% of the parliamentary seats in 2009 and regional averages exceeded the UN target of 30% only in the Nordic region with 42.5%, with the Americas and Europe only reaching around 21–22%.¹¹ It has been argued that equality of women includes, by necessity, a right to access safe abortion. This has not been viewed in isolation but in the context of availability of affordable public childcare, protection from domestic and sexual violence, equal employment opportunities, equal pay for comparable worth and inclusion of women in the public spheres of politics and governance.

Methods of abortion have been documented for thousands of years. Some may be surprised to learn that Hippocrates, whose oath is famous for its wording "...I will not give a woman a pessary to cause an abortion,"¹² also reportedly described methods to terminate a pregnancy for medical indications in his *Corpus Hippocraticum*.¹³ In the 2008 debate on safe and legal access to abortion at the Parliamentary Assembly of the Council of Europe Ms Čurdová of the Czech Republic noted: "The 20th-century scientist, George Devereux, after examining 350 primitive, ancient societies, concluded that abortion was a universal phenomenon and that it was impossible to find or create a social structure in which it would not exist".¹⁴

Modern methods of contraception have only been in existence for the last 40–50 years and today a woman wishing to have two children would typically spend roughly 5 years pregnant, post-partum or

trying to become pregnant, and almost three decades trying to avoid pregnancy.¹⁵ Even if she wished to have four children she would still spend at least 16 years trying to avoid pregnancy.¹⁵ In the period 1965–70 the proportion of married women practicing contraception was 9%.¹⁶ Although globally, it is encouraging that this figure reached 63% by 2003, according to the 2009 report from the Guttmacher Institute, an estimated 215 million women in the developing world still have an unmet need for modern contraceptives, meaning they want to avoid a pregnancy but are using a traditional family planning method or no method.¹⁷ Millions of women have no access to reproductive health services; many have little or no control in choosing whether to become pregnant. Various societal forces are at play that result in women and girls having sex or pregnancies they do not want, including gender-based violence. Faced with life-altering consequences of actions they may not be able to control, many women will seek to end the pregnancy, legally or illegally, by whatever means are accessible, available and affordable. These realities were brought sharply into focus in what could be considered social experimentation in Romania under the Ceauşescu pro-natalist regime.¹⁸

In 1966, Romania, had access to safe abortion removed, concurrent with removal of access to contraception, both being made illegal. Those Romanian women who could afford it would fly to other countries to obtain abortions; those who could not resorted to 'backstreet' methods or gave their unwanted children to orphanages. This rapidly led to an increase in abortion-related mortality that was 10 times higher than other European countries. Ironically, there was a concurrent continuous fall in the crude birth rate after a brief rise. The pro-natalist policy failed in its goal but over the 22 years of the regime, over 10,000 women died from unsafe abortion and thousands of unwanted pregnancies resulted with children placed in institutions because their families could not care for them.¹⁸ Infant mortality also increased as data has shown that child mortality is significantly increased when the mother dies and since many of the women seeking abortion have children, their lives are also at risk, demonstrating that the simplistic goal of preventing an abortion does not mean a child will survive, let alone thrive.^{18,21}

Abortion facts and figures

Worldwide, the lifetime average is about one abortion per woman.^{1,2} In the United States, one in three women will have an abortion by the age of 45 years.¹⁹ Contrary to common belief, most women seeking abortion are married or living in stable unions and already have several children.²⁰ A woman's likelihood of having an abortion is similar regardless of whether she lives in a developed or developing region, but due to population distribution most abortions occur in developing countries. In 2003, there were 26 abortions per 1000 women aged 15–44 in developed countries compared with 29 per 1000 in developing countries.¹ Worldwide, an estimated 5 million women are hospitalised each year for treatment of abortion-related complications, such as haemorrhage and sepsis.¹ Legal restrictions on abortion do not affect its incidence, only its safety. For example, the abortion rate is 29 in Africa, where abortion is illegal under many circumstances in most countries, and is 28 in Europe, where abortion is generally permitted on broad grounds. Legal abortion has gone hand in hand with sharp increases in contraceptive use, which in turn has been a major factor in declining abortion rates.¹⁵ The decline in abortion incidence was greater in developed countries where nearly all abortions are safe and legal (from 39 to 26 abortions per 1000 women aged 15–44) than in developing countries, where more than half are unsafe and illegal (from 34 to 29).^{1,16} Despite what is sometimes portrayed, almost 90% of abortions in the US are within the first trimester, with about 60% in the first eight weeks.²⁰ The proportion of abortions performed after the first trimester dropped rapidly after *Roe vs. Wade*. New medical and surgical technologies increasingly enable women to obtain abortions earlier in pregnancy.²⁰

Brazil, where abortion is very restricted, has one of the highest abortion rates in the developing world.²¹ The Health Ministry estimates that 31% of all pregnancies end in abortion, mostly clandestine. The lowest rates in the world are in Western and Northern Europe, where abortion is accessible with few restrictions.²¹ In the Netherlands, a country with some of the world's most liberal abortion laws, the rate is closer to 10%. As noted by Ms. Gunn Karen Gjøl in the debate on safe and legal access to abortion at the Parliamentary Assembly of the Council of Europe: "At the end of the 1970s all Nordic countries introduced liberal abortion legislation. With the exception of Iceland, the number of

abortions decreased in all those countries after the introduction of that law. Belgium and the Netherlands have had the same experience. Obligatory sex education was introduced in schools and measures were taken to improve access to contraceptives.”¹⁴

Unsafe abortion

It is estimated that of the 210 million conceptions each year, about 1 in 10 result in an unsafe abortion, and an estimated 68 000 women die each year from unsafe abortion, with half of those deaths occurring in Africa.^{21,22} In Africa, one in four unsafe abortions occurs in teenagers.^{22,23} The vast majority of unsafe abortions, 98%, occur in developing countries, most with restrictive legislation.²¹ Unsafe abortion continues to be a recognised public health concern due to the higher incidence and severity of its associated complications, such as incomplete abortion, sepsis, haemorrhage and damage to internal organs. It consequently contributes to 13% of global maternal mortality.^{22,24,25}

Deaths from unsafe abortion are typically correlated with poverty and lack of implementation of women's rights in general. Maternal mortality has additional impact on the estimated 220 000 children worldwide who lose their mothers annually due to abortion-related deaths. There is also growing evidence that, especially in adolescent girls, unintended pregnancy and unsafe abortion are associated with violence and sexual coercion.²² Rights to safe abortion are not equally available in the same country with the same law regulating access. A report by Lane in 1998 documented the relative ease by which wealthy women in Egypt can access safe abortion in such environments, whereas poor women are often faced with no option but to seek less safe alternatives.²⁶

The consequences of stigmatisation and judgement of women seeking or choosing abortion can be fatal in countries with restrictive legislation. In Fig. 1, a review of delays in providing care in Gabon according to the cause of maternal death found that of the women who died, those women presenting with complications of abortion waited almost 24 h for appropriate medical attention compared with those presenting with post-partum haemorrhage or eclampsia. The authors concluded that the stigma associated with illegal abortion may result in health professionals not providing timely attention for women presenting with complications without realising the potential for fatal consequences.²⁷

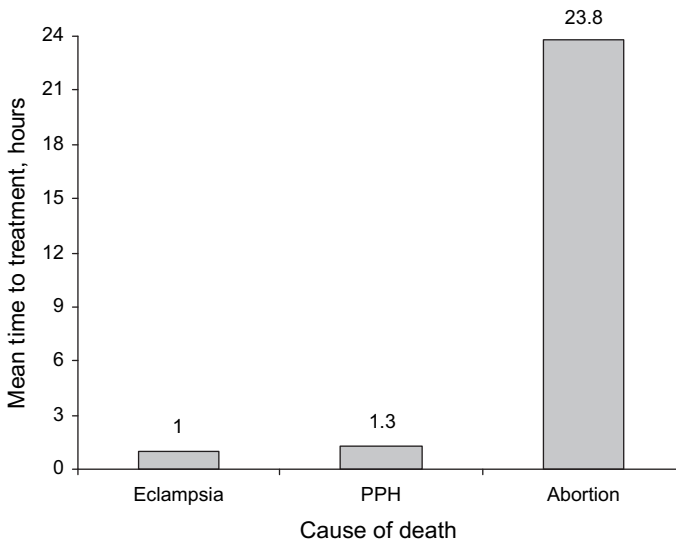


Fig. 1. Delay in providing care according to cause of maternal death. Gabon, 2005–2008. Source: Mayi-Tsonga et al.²⁷ Reprinted with permission granted by the International Federation of Gynecology and Obstetrics (FIGO) from: Faundes A. José Barzelatto lecture: Vision on unsafe abortion. *Int J Gynaecol Obstet* 2009;109(1): In Press.²⁸

Public and personal health costs of unsafe abortion

There may be later costs to the health-care system as well as personal tragedy for women who resort to unsafe abortion, and indeed women with spontaneous abortion who do not access health services. Both may suffer the consequences of Rh iso-immunisation in subsequent pregnancies if they do not receive Rh immune globulin – up to 2% of Rh-negative women who have a spontaneous abortion and 5% of those whose pregnancies are electively terminated.²⁹ There are also significant adverse consequences on the health-care system that far exceed the cost of providing effective contraception and safe abortion as well as impacting the right to access of others by utilising scarce available resources.^{25,30} In Nigeria, an estimated cost of \$19 m spent annually on treating complications of unsafe abortion could be avoided by spending \$4.8 m on providing the contraceptive services necessary.¹⁷

Human rights

This section will consider human rights relevant to discussion on abortion in the context of reproductive health overall as well as related rights that inform the context of women's lives. Religion, ethics and societal moral values have influenced human rights law. The human rights involved in discussion of abortion include: the right to life and survival; the right to equal protection of the law; right of privacy, liberty and security; the right to the highest attainable standard of health; right to benefits of scientific progress; right to private and family life; and the right to non-discrimination on grounds of sex and gender.

International human rights

Defined as 'basic rights and freedoms to which all humans are entitled', the beginning of internationally recognised human rights was in The Charter of the UN signed on 26 June 1945 in San Francisco, with 51 founding members; four of the 160 signatories were women.^{4,31} There was strong support to create an international multi-government entity committed to achieving world peace after the atrocities of the Second World War. Article 1 on human rights relating to women states: "To develop friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, and to take other appropriate measures to strengthen universal peace" and "To achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion."

In 1948, the General Assembly approved the Universal Declaration of Human Rights.³² Article 1 of the UN Universal Declaration of Human Rights states: "All human beings are born free and equal in dignity and rights". The UN is a multi-lateral governmental agency with sole and universally accepted international jurisdiction for universal human rights legislation. In order to address the priorities of different ideologies in enacting the principles of the Universal Declaration in legally binding treaties, two separate covenants were created in 1966, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).^{33,34}

There are committees within the UN responsible for different human rights treaties and compliance of member states that have ratified them. States have the primary obligation to protect and promote human rights and report on measures they have taken to realise the rights enumerated in the ICCPR and other UN treaties. The most senior body of the UN with regard to human rights is the Office of the High Commissioner for Human Rights. The United Nations Human Rights Council, created at the 2005 World Summit to replace the UN Commission on Human Rights, has a mandate to investigate violations of human rights. Non-governmental organisations (NGOs) can submit communications to the Human Rights Committee that has ruled on the problems of unsafe abortion in countries.^{35,36}

Regional

There are three principal regional human rights instruments: the African Charter on Human and Peoples' Rights, the American Convention on Human Rights (the Americas) and the European

Convention on Human Rights. The Inter-American Commission on Human Rights (IACHR) is an autonomous body of the Organization of American States, based in Washington, DC and together with the Inter-American Court of Human Rights, based in San Jose, Costa Rica, is one of the bodies comprising the inter-American system for the promotion and protection of human rights. The European Court of Human Rights was originally unique in being the only international court with jurisdiction to address cases brought by individuals rather than states.

There is also the Arab Charter on Human Rights which does not include the right to health but includes the right to non-discrimination including on the basis of sex in Article 2 as well as the right to life, liberty and security of the person in Article 5.³⁷

There are no regional instruments in Asia or Oceania.

Right to the highest attainable standard of health

The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health 2006³⁸ states “The right to health can be understood as the right to effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution no less than a court or political system”:

Table 1 indicates the international treaties recognising the right to health. The ICESCR recognises the right to health, requiring state parties to ensure the highest attainable standard of physical and mental health.³⁹ The Committee on Economic, Social and Cultural Rights is the body responsible for monitoring the ICESCR where the right to health is articulated in detail. The right to health is also articulated in the CEDAW requiring states to take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.

The Convention on the Rights of the Child (CRC), where child is defined as one upto the age of 18, also recognises the right to health and since infants’ health is so closely linked to women’s reproductive and sexual health, states are directed to ensure access to essential health services for the child and his/her family, including pre- and postnatal care for mothers. CRC also directs governments and health professionals to treat all children and adolescents in a non-discriminatory manner recognising that young girls and adolescent girl in many contexts are prevented from accessing a wide range of services, including health care.⁴⁰ Adolescent girls are vulnerable to early and/or unwanted pregnancies. Adolescents’ right to health is therefore dependent on health care that respects confidentiality and privacy according to their evolving capacity and includes appropriate mental, sexual and reproductive health services and information.³⁹

The Convention for the Elimination of Discrimination Against Women (CEDAW) also notes that violence against women is a widespread cause of physical and psychological harm or suffering among women, as well as a violation of their right to health and requires states to, among other things, enact and enforce laws and policies that protect women and girls from violence and abuse and provide for appropriate physical and mental health services.

Table 1
International human rights treaties recognizing the right to health.³⁸

Year	International Treaty
1948	Universal Declaration of Human Rights: Article 25.1
1965	International Convention on the Elimination of All Forms of Racial Discrimination: Article 5 (e) (iv)
1966	International Covenant on Economic, Social and Cultural Rights: Article 12.1
1979	Convention on the Elimination of All Forms of Discrimination against Women: Articles 11 (1) (f), 12 and 14 (2) (b)
1989	The 1989 Convention on the Rights of the Child: Article 24
1990	The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: Articles 28, 43 (e) and 45 (c)
2006	Convention on the Rights of Persons with Disabilities: Article 25.

The right to health is also recognised in several regional instruments, as noted in Table 2. The American Convention on Human Rights (1969) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms (1950) contain provisions related to health such as the right to life; the prohibition on torture and other cruel, inhuman and degrading treatment; and the right to family and private life. The right to health or the right to health care is recognised in at least 115 constitutions with a further six other constitutions that set out duties in relation to health, such as the duty of the state to develop health services or to allocate a specific budget to them.³⁹

The link between the right to health and other human rights

The right to health goes beyond the right to access health care and includes determinants of health such as safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and not least, gender equality. People living in poverty cannot realise their right to health without realising their other rights, the violations of which are at the root of poverty.

The broadly defined right to health is relevant to the context of a woman's life in considering the matter of the right to abortion. Human rights are interdependent, indivisible and interrelated, thus the right to health is dependent on, and contributes to, the realisation of many other human rights. These include the rights to freedom from discrimination, privacy, access to information, participation and the right to benefit from scientific progress and its applications.

The right to health contains freedoms that include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilisation, and to be free from torture and other cruel, inhuman or degrading treatment or punishment. The right to health also contains entitlements including, but not limited to, a health system that provides equality of opportunity for everyone to enjoy the highest attainable level of health. This means that health services, goods and facilities must be provided to all without any discrimination and they must be available, accessible, acceptable and of good quality, culturally acceptable and respecting medical ethics and gender.

The right to equal protection of the law

As articulated by Cook, in failing to put into effective operation the legal indications for providing health services that only women need, a government might well be in violation of the right of women to equal protection of the law. Failure of a government to provide abortion services for the indications for which it is legally permitted is unfair to those who are entitled to the benefit of the law, and thus a denial of the right to equal protection.^{20,35}

Reproductive rights

Reproductive rights were first established as a subset of human rights at the United Nation's 1968 International Conference on Human Rights in Tehran, and including wording from the International Conference on Population and Development (ICPD) held in Cairo in 1994, are defined by the WHO as follows:

Table 2
Regional human rights treaties recognizing the right to health.³⁸

Year	Regional Treaty
1950	European Convention for the Promotion of Human Rights and Fundamental Freedoms
1961	European Social Charter (revised in 1996)
1969	The American Convention on Human Rights
1981	African Charter on Human and Peoples' Rights
1988	The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the protocol of San Salvador)

“Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.”⁴¹

The Programme of Action (PoA) resulting from ICPD formed the blueprint for reproductive health policy around the world and urged governments and other relevant organisations “to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services” (paragraph 8.25 of the PoA).⁴¹ The ICPD PoA further declared: “In circumstances where abortion is not against the law, such abortion should be safe.”²⁰ The PoA of the ICPD and the Beijing Platform for Action Beijing Declaration and Platform for Action highlighted the right of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning of their choice and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.⁴¹ As noted by Cook, reproductive health integrates respect for human rights with respect for women’s entitlement to health, dignity and reproductive integrity.²⁰ Formal laws and policies are crucial indicators of government commitment to promoting reproductive rights. Each and every woman has an absolute right to have control over her body generally known as bodily rights.

The right to life

Historically the right-to-life provision was meant to require governments to refrain from arbitrarily taking individuals’ lives, but over time its scope has been expanded to include an obligation on the part of states to take appropriate measures to minimise the extent of deaths resulting from socioeconomic factors. Specifically, with regard to unsafe abortion, the United Nations Human Rights Committee has repeatedly invoked the right to life provision of ICCPR, Article 6, when insisting that states minimise the fatal consequences of unsafe abortion.³⁶

Teklehaimanot outlines the approach for the right to life of women, which stresses the duty of states to take affirmative measures to minimise the consequences of unsafe abortion, noting that the alternative approach of right to privacy is not applicable in the African Charter which has no right of privacy provision, since African societies are communal in nature.³⁵ The Maputo Plan of Action agreed to by the African Union in 2007 has as its goal “universal access to comprehensive sexual and reproductive health services in Africa by 2015” and highlights multiple mechanisms by which unsafe abortion can be addressed in output #4.⁴²

Right to abortion

The right of a woman to her private life has been the basis on which a number of international bodies have upheld the right of a woman to have an abortion. The right to freedom of expression and access to information has been used to argue for the right of women to receive information about abortion options. Canada is unique in not having a law regulating abortion after the Supreme Court of Canada struck down Canada’s abortion law as unconstitutional in 1988 because it infringed upon a woman’s right to life, liberty and security of the person, thus violating Section 7 of the Charter of Rights and Freedoms. During an attempt to place abortion in the criminal code again, a tied vote in the Senate in 1991 resulting in defeat of the Bill C-43 and abortion is now treated like any other medical procedure, with no special laws governing it.²⁰ In 1996, the Human Rights Committee ruled that when abortion gives rise to a criminal penalty, even when a woman is pregnant as a result of rape, a woman’s right to be free from inhuman and degrading treatment might be violated.²⁴

Article 1 of the American Declaration of Rights and Duties of Man and the Inter-American Commission of Human Rights state that abortion is legalised until the end of first trimester. In 2004, the United Nations Committee Against Torture called for an end to the extraction of confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion.²⁴

Also in 2004, the Special Rapporteur on the Right to the Highest Attainable Standard of Health reported that all forms of sexual violence are inconsistent with the right to health.²⁴ On 17 November 2005, the UN Human Rights Committee (UNHRC) made a landmark decision in deciding its first abortion case, *Karen Llantoy vs. Peru*. Llantoy was a 17-year-old who was forced to carry an anencephalic foetus to term and breastfeed the infant after birth for 4 days. The decision established that denying access to legal abortion violates women's most basic human rights, the first time an international human rights body has held a government accountable for failing to ensure access to legal abortion services.⁴³

On 16 April 2008, the Parliamentary Assembly of the Council of Europe from the 47 member states of the Council of Europe gathered in Strasbourg to debate and vote upon a historic report aiming to decriminalise abortion across the continent. The resolution on legal abortion was adopted "and invited the 47 member states of the Council of Europe to:

- Decriminalize abortion, if they have not already done so
- Guarantee women's effective exercise of their right to abortion
- Allow women freedom of choice and offer the conditions of a free and enlightened choice
- Ensure that women and men have access to contraception at a reasonable cost, of a suitable nature for them, and chosen by them."¹⁴

In Nicaragua, the change in legislation in 2007 to ban abortion under all circumstances, even to save a woman's life, means that physicians currently face the option of possible imprisonment for performing what would be considered malpractice in the developed world and for which consequences involving licensing bodies and litigation would surely ensue. In a 2009 report, Amnesty International detailed, for example, how physicians are unclear on their legal standing when faced with the need to intervene in acute, life-threatening situations such as ectopic, molar pregnancy, cardiac complications or cervical cancer during pregnancy.⁴⁴ Women who suffer a spontaneous abortion are delaying seeking care as they are vulnerable to accusations that it was an induced abortion, since they may present identically.⁴⁵ In addition to concerns expressed by the UN Committee against torture and the UN Committee on ESCR, the Convention of Belém do Pará was clear that Nicaragua had breached the Convention and the UN Human Rights Committee was categorical in its final recommendation to Nicaragua in October 2008 regarding the prohibition of abortion. "The Nicaraguan State must amend its laws on abortion so that they comply with the Covenant. The state must take measures to help women avoid unwanted pregnancies, so that they are not forced to seek illegal and unsafe abortions which put their lives at risk, or that they have to travel abroad to obtain an abortion. The state must also avoid imposing criminal sanctions on members of the medical profession for carrying out their professional duties as doctors."

The President of the Inter-American Court of Human Rights, has commented that: "In certain cases, such as when continuing the pregnancy would endanger the life of the woman, or when the pregnancy is as a result of rape, the criminalization of abortion would cause a violation of the obligation of the state to protect the life of the woman."⁴⁴

The Special Rapporteur on the Right to Health made the following statement in May 2009 during a visit to Poland: "The respect of physical integrity and freedom to control their own bodies is one of the fundamental rights of all human beings, including women. Undoubtedly, the ultimate decision on whether or not to give birth should be made by the women concerned, who should have the means of enjoying that right effectively."⁴⁵

Foetal rights

International courts and tribunals have been silent on the difficult philosophical issue of when life begins. However, the language of the various treaties is generally understood not to include an unborn foetus in references to every human being or everyone or every person. The status of the foetus in human rights law, that is, whether or not a foetus is a person recognised to have a right to life according to Article 6 of the ICCPR has never been a central issue in cases of abortion considered by any of the UN human rights bodies.⁴⁶ Regional human rights organisations and most national courts are reluctant to discuss

the issue of personhood of a foetus. The European Commission on Human Rights has decided very few abortion cases but it has never discussed the issue of personhood. In *Roe vs. Wade*, the US Supreme Court expressly refrained from determining the status of a foetus. Similarly, the Canadian Supreme Court, in the leading abortion case, said that the issue whether or not the word 'everyone' under Section 7 of the Canadian Charter of Rights and Freedoms included a foetus "was not dealt with."³⁶

Right to religious freedom and conscientious objection

The need for the right to freedom of thought, conscience and religion to be respected can be challenging for the individuals involved since neither should be subjected to restrictions of the religious or other convictions held by other persons. Yet, women exercising their rights to control their fertility or have an abortion, especially where legal, are often subjected to judgements and stigmatisation by other people, including health professionals, who hold religious views that are at odds with their own needs and beliefs.

Perhaps surprisingly, there are no international human rights treaties that expressly guarantee a right to conscientious objection, but the right to exercise conscientious objection has been recognised as being derived from the right to freedom of thought, conscience and religion and protected by the major international human rights treaties. This interpretation has typically been limited to conscientious objection to military service.

Conscientious objection as invoked by health professionals in the reproductive and sexual health-care context can impact the ability of women to access information and health services they need and to which they have rights. Bernard Dickens has written extensively on this topic including the responsibilities of health professionals wishing to exercise their right to conscientious objection when faced with life-threatening emergencies. Here, the 'double effect' ethical and religious principle can apply to situations such as removal of an ectopic pregnancy, where surgery is required to save the woman's life and the objective can only be achieved by an unavoidable harmful effect.³⁵

CEDAW is the one UN treaty monitoring body that has commented on conscientious objection outside the area of military service. In its General Recommendation 24 related to Article 12 of CEDAW, the Committee emphasised that "... if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."⁴⁶

At the regional level, the European Convention has provision for conscientious objection under Article 9, which does guarantee freedom of thought, conscience and religion.⁴⁶ While it is thought by many to be an absolute right, this is in fact not the case, and when there is a conflict with the right of a woman to access information and reproductive health services, states must accommodate those who exercise conscientious objection in order not to impede her access. "Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health and morals, or for the protection of the rights and freedoms of others." Some European states provide health professionals with a right to refuse to perform certain medical procedures, with most of these procedures being reproductive health services that only women need. In many instances, where the right to exercise conscientious objection with respect to abortion is accepted and where abortion is legal, professional associations, licensing bodies, governments and the courts have an important role to play when rights of conscience need to be accommodated without compromising other human rights in the process.³⁵ In addition, objecting providers are generally obliged to perform the relevant procedure in any emergency situation. Some states (Europe) also impose other obligations such as referral to a non-objecting practitioner or the provision of information to the patient about all available alternative services.⁴⁶

At the national level, there was an important Colombia Constitutional Court ruling after the abortion law was liberalised. In May 2008, in the case of a 13-year-old girl who with her mother's support had sought abortion after rape and though she met the legal criteria, the designated institution claimed the right to conscientious objection, claiming it could find no one prepared to provide the abortion. The institution was fined and among the rulings made was that conscientious objection is personal, not institutional.⁴⁷

Contraception

At least in the European Human Rights Court, conscientious objection does not extend to contraception or emergency contraception, as noted by Lamačková.⁴⁶ In 2001, two French pharmacists claimed that their freedom to manifest their religion had been violated when they were convicted by French authorities for refusing to dispense oral contraceptives to three customers. The Court's decision in declaring the case of Pichon and Sajous vs. France inadmissible concluded that the pharmacists' refusal to sell contraceptives was not within the scope of the right to manifest a religion and belief. Further, the Court emphasised that the pharmacists could not give priority to their personal beliefs over their professional obligations "as long as the sale of contraceptive is legal and occurs on medical prescription nowhere other than in a pharmacy."

Health professional organisations: the role of obstetrician gynaecologists

Obstetrician gynaecologists are seen as the experts in matters concerning sexual and reproductive health, including contraception, abortion and its complications. As such, there are greater responsibilities to be weighed alongside individual rights and an evidence-based approach is required in all cases.

The International Federation of Gynecology and Obstetrics (FIGO) has addressed the issue of conscientious objection repeatedly, recognising both the right of individuals to exercise such right and the ethical requirements of professionals including referral, provision of services to avoid harmful delay and provision of care in an emergency. The document titled 'FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights' states: "Assure that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay."⁴⁸ In 2005, the FIGO Ethics committee developed guidelines on conscientious objection as well as two related resolutions^{49,50} and in 2009, FIGO refers to conscientious objection in a position statement on professional standards thus: "Not compel another health professional to act contrary to their moral conviction or religious belief, except as required by law and as delineated in FIGO's position on conscientious objection."⁵¹

In Uruguay, having seen the consequences of unsafe abortion, the Society of Obstetrics and Gynecology, embarked on a strategy of risk reduction within the climate of restrictive laws as an intermediate step.⁵² Women seeking abortions are seen and provided with non-judgemental information, so that they will be in a better position to make the best decision for their specific situation and values. They concluded that risk reduction occurred mostly by providing scientifically based information on the risks associated with different means to induce abortions, including misoprostol. Those who chose to have an abortion returned for a follow-up visit. This information prevented the use of dangerous methods to induce abortion, such as the introduction of sharp, unsterile objects into the pregnant uterus or toxic infusions.⁵²

Building on existing activities to reduce maternal mortality, the FIGO Executive Board in 2007 approved an initiative on the prevention of unsafe abortion. A situational analysis was done in 54 of 113 member associations and subsequent action plans developed in collaboration with Ministries of Health, the International Confederation of Midwives, International Planned Parenthood Federation, Ipas, the World Health Organization (WHO), the United Nations Population Fund and others in 43 countries. These action plans are driven by the countries involved and all focus on reducing the number of abortions as well as maternal mortality from unsafe abortions while respecting the national laws, using the best evidence available.⁵³

Rights and realities

Obstetrician gynaecologists can be inconsistent in their approach to facilitating access to abortion, when the reality of an unwanted pregnancy becomes personal, even when religion is very important to them. According to a survey by Faundes *et al.*, of Brazilian obstetricians and gynaecologists, 26.1% of

those who described religion as very important to them would assist a patient with an unwanted pregnancy to have an abortion. If the unwanted pregnancy affected the physician or the physician's partner, 68.7% would have or assist in access to an abortion. This percentage was higher – 73.6% and 80.1% – for those to whom religion was of some importance.⁵⁴

Education – curriculum of medical schools on contraception and abortion

Undergraduate medical curriculum should be based on a reflection of population needs related to contraception use, unintended pregnancy and abortion. A recent survey of US and Canadian medical students by Steinauer *et al.* noted significant variability in the time and comprehensiveness of curriculum on contraception and abortion, as well as other reproductive health issues.⁵⁵ Elective abortion is the most common surgical procedure among reproductive-aged women in the US, with 1.2 million elective abortions in 2005 and an abortion ratio of 22.4 abortions per 100 live births.⁵⁶ In Canada in 2005, 97 254 abortions were performed representing an abortion ratio of 28.3 abortions per 100 live births.⁵⁷ It is worth questioning why the majority of schools surveyed dedicated more than 30 min to the topic of sildenafil citrate (Viagra), for example, while 31% of schools covered all topics related to elective abortion for less than 30 min. Health professionals have a responsibility for ensuring medical students are sufficiently educated to provide current, evidence-based information and counselling on contraception and pregnancy options.

Conclusion

The simplistic, often media-driven, controversy and vocal polarised opinion that considers a stance in favour of or opposed to abortion is destructive and fails to address the more complex aspects of the problem of unintended pregnancy, especially prevention. The deeply held beliefs involved in discussion of abortion require respectful dialogue. There are multiple human rights relevant to women, including adolescents, accessing safe abortion. These include the right to the highest attainable standard of health. There is no comparable situation where a person may have no legal ability to make an independent decision that inevitably influences their life and health. The consequences of delay in accessing abortion services, especially where unsafe, are measured in increased mortality statistics. The right to conscientious objection to abortion must be respected but is not absolute and is only applicable to individuals, not institutions. Using an evidence-based approach, it is clear that the majority of maternal deaths from abortion globally could be prevented by addressing human rights, especially the right to access family planning information and services. The UN has provided multiple directives on the importance of addressing human rights related to preventing unsafe abortion and unintended pregnancy. While access to comprehensive sexual education, information and modern methods of contraception that meet the needs of people will reduce the likelihood that women will be faced with unintended pregnancy, some women will continue to face the difficult decision not to continue a pregnancy at that point in their lives. Health professionals caring for women have special responsibilities to provide leadership and advocacy for action plans that will work in preventing unsafe abortion, in all settings. Seeking areas of consensus rather than judging women's decisions and entrenching positions is essential if women are to realise their rights, especially their own right to life.

To summarise, abortion has been a reality in women's lives since the beginning of recorded history, typically with a high risk of fatal consequences that continues today, especially in countries where women's rights in general are not respected. Using an evidence-based approach, it is clear that the most effective approach to reduce the number of abortions overall and prevent maternal mortality and morbidity from unsafe abortion globally is by implementing human rights, especially the right to access family planning information and services. The human rights involved while discussing abortion incorporate the context of a woman's life and include the right to life and survival; the right to equal protection of the law; right of privacy, liberty and security; the right to the highest attainable standard of health; right to benefits of scientific progress; right to private and family life; and the right to non-discrimination on grounds of sex and gender. The UN has provided multiple directives on the importance of addressing human rights related to preventing unsafe abortion and unintended pregnancy. There is no comparable situation where a person may have no legal ability to make an

independent decision that inevitably influences their life and health. The right to conscientious objection to abortion must be respected but is not absolute and is only applicable to individuals, not institutions. International and regional human rights instruments are increasingly being invoked where national laws result in violations of human rights such as health and life.

Conflict of interest statement

None declared.

Practice points

- Making access to abortion more restrictive does not reduce the number of abortions.
- Human rights law on conscientious objection in health care is complex and subject to obligations based on the rights of others.
- The number of abortions and deaths from unsafe abortions can be reduced by providing access to information and services on effective methods of contraception.

Research agenda

- Does postgraduate training ensure that obstetrician gynaecologists in the community are competent to provide appropriate care in an emergency, for example, ectopic pregnancy or abortion to save a woman's life?
- What communication models can successfully respect both the rights of physicians who have conscientious objection to abortion (where abortion is legal for some indication) and the rights of the woman to access care?

References

- *1. *Facts on induced abortion worldwide*. The Alan Guttmacher Institute and WHO, http://www.guttmacher.org/pubs/fb_IAW.html [accessed 29.12.09].
2. Sedgh G, Henshaw S, Singh S et al. Induced abortion: rates and trends worldwide. *Lancet* 2007; **370**: 1338–1345.
3. Human Rights Council Eleventh Session Resolution 11/8 Preventable maternal mortality and morbidity and human rights, http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf [accessed 24.12.09].
4. Charter of the United Nations. 1945. <http://www.un.org/en/documents/charter/chapter1.shtml> [accessed 24.12.09].
5. World Economic Forum Global Gender Gap Report 2009 <http://www.weforum.org/pdf/gendergap/report2009.pdf>.
6. *WHO 2009 women and health: today's evidence tomorrow's agenda*. Geneva: World Health Organization, 2009.
7. http://womenshistory.about.com/od/suffrage/a/intl_timeline.htm [accessed 26.12.09].
8. http://en.wikipedia.org/wiki/Women's_suffrage [accessed 26.12.09].
9. The Convention on the Elimination of Discrimination Against Women (CEDAW). United Nations General Assembly, December 18th, 1979. <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm> [accessed 28.12.09].
10. <http://www.chrc-ccdp.ca/en/browseSubjects/aboriginalRights.asp> [accessed 24.12.09].
11. <http://www.ipu.org/wmn-e/world.htm> [accessed 27.12.09].
12. http://en.wikipedia.org/wiki/Hippocratic_Oath.
13. Boer WD. *Private morality in Greece and Rome*. Leiden, The Netherlands: EJ Brill, 1979.
14. Parliamentary Assembly of the Council of Europe debate on safe and legal access to abortion in Europe, <http://www.ippf.org/en/What-we-do/Abortion/Legal+abortion+throughout+Europe.htm>; 16 April, 2008.
15. Boonstra HD, Gold RB, Richards CL et al. *Abortion in women's lives*. New York: Guttmacher Institute, 2006, <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf> [accessed 06.11.06].
16. Look Van, Fa P & von Hertzen H. Demographic aspects of induced abortion. *Curr Obstet Gynaecol* 1993; **3**: 2–10.
- *17. Singh S, Wulf D, Hussain R et al. *Abortion worldwide: a decade of uneven progress*. New York: Guttmacher Institute, 2009.
18. Stephenson P, Wagner M, Badea M et al. Commentary: the public health consequences of restricted induced – abortion lessons from Romania. *Am J Public Health* 1992; **82**: 1328–1331.

19. Guttmacher Institute. *State facts about abortion: Texas* September, 2008, <http://www.guttmacher.org/pubs/sfaa/texas.html> [accessed 24.12.09].
- *20. Warriner IK & Shah IH (eds.). *Preventing unsafe abortion and its consequences: priorities for research and action*. New York: Guttmacher Institute, 2006.
21. *Death and denial: unsafe abortion and poverty*. 2006. London, United Kingdom: International Planned Parenthood Federation, http://www.ippf.org/NR/rdonlyres/8D4783F5-D516-47D3-8B34-61F6D510202A/0/Death_Denial_unsafe_abortion_poverty.pdf [accessed 23.12.09].
22. *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003*. 5th edn. World Health Organization, 2007, http://www.searo.who.int/LinkFiles/Publications_Unsafe_Abortion.pdf [accessed 26.12.09].
23. Shah I & Ahman E. Age patterns of unsafe abortion in developing country regions. *Reprod Health Matters* 2004; **12**(24 Suppl.): 9–17.
24. World Health Organization. *The world health report 2005: making every mother and child count*, Geneva, 2005.
25. Vlassoff M, Singh S, Darroch JE et al. *Assessing costs and benefits of sexual and reproductive health interventions*. Occasional Report No. 11. Guttmacher Institute, 2004, <http://www.guttmacher.org/pubs/2004/12/20/or11.pdf> [accessed 31.12.09].
26. Lane SD, Jok JM & El-Mouelhy MT. Buying safety: the economics of reproductive risk and abortion in Egypt. *Soc Sci Med* 1998; **47**(8): 1089–1099.
27. Mayi-Tsonga S, Oksana L, Ndombi I et al. Delay in the provision of adequate care to women who died from abortion-related complications in the principal maternity hospital of Gabon. *Reprod Health Matters* 2009; **17**(34): 1–7.
- *28. Faundes A. José Barzelatto lecture: vision on unsafe abortion. *Int J Gynaecol Obstet* 2010 Jan 9; S1879–S3479.
29. Cunningham FG, MacDonald PC, Gant NF et al. *Williams obstetrics*. 20th edn. Norwalk, CT: Appleton and Lange, 1997.
30. Faundes A & Hardy E. Illegal abortion: consequences for women's health and the health care system. *Int J Gynaecol Obstet* 1997; **57**: 77–83.
31. Jain Devaki. *Women, development, and the UN. A sixty-year quest for equality and justice*. Bloomington, Indiana: Indiana University Press, 2005.
32. The Universal Declaration of Human Rights, <http://www.un.org/en/documents/udhr> [accessed 31.12.09].
33. UN Covenant on Civil and Political Rights, <http://www2.ohchr.org/english/law/ccpr.htm> [accessed 24.12.09].
34. International Covenant on Economic, Social and Cultural Rights, <http://www2.ohchr.org/english/law/cescr.htm> [accessed 31.12.09].
- *35. Cook RJ, Dickens BM & Fathalla MF. *Reproductive health and human rights: integrating medicine, ethics, and law*. Oxford, Great Britain: Oxford University Press, 2003.
36. Teklehaimanot KI. *Reprod Health Matters* 2002; **10**(19): 143–150.
37. Arab Charter on Human Rights. 1994. <http://www1.umn.edu/humanrts/instree/arabcharter.html> [accessed 31.12.09].
38. Right to Health Fact Sheet. WHO and UNHCHR, http://www2.ohchr.org/english/issues/escr/docs/Right_to_health_factsheet.pdf [accessed 29.12.09].
- *39. The Right to Health. Office of the UN High Commissioner for Human Rights and WHO. <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>.
40. Convention on the Rights of the Child, http://www2.ohchr.org/english/bodies/crc/docs/GC4_en.doc [accessed 27.12.09].
- *41. Cottingham J, Fonn R & Garcia-Moreno C. *Transforming health systems: gender and rights in reproductive health*. WHO, 2001, http://whqlibdoc.who.int/hq/2001/WHO_RHR_01.29.pdf [accessed 31.12.09].
- *42. Maputo Plan of Action, 2007, http://www.africa-union.org/root/au/Conferences/Past/2006/September/SA/Maputo/doc/en/Working_en/SRHR_%20Plan_of_Action_2007_Final.pdf [accessed 29.12.09].
43. Un Ccpr Hrc, 22nd November 2005. <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/KL%20HRC%20final%20decision.pdf>.
44. *The total abortion ban in Nicaragua. Women's lives and health endangered, medical professionals criminalized*. Amnesty International Publications, 2009, <http://www.amnesty.org/en/library/asset/AMR43/001/2009/en/ea2f24b4-648c-4389-91e0-fc584839a527/amr430012009en.pdf> [accessed 31.12.09].
45. United Nations Press Release UN Special Rapporteur on the Right to Health. Visit to Poland, 5–11 May 2009 <http://www.unhchr.ch/huricane/hurricane.nsf/view01/F1269CA5311CDAF3C12575B50041AEBE?opendocument> [accessed 31.12.09].
46. Lamačkova A. Conscientious objection in reproductive health care: analysis of Pichon and Sajous v. France. *Eur J Health Law* 2008; **15**: 7–43.
47. Colombia constitutional Court. http://www.ramajudicial.gov.co:7777/csj_portal/jsp/frames/index.jsp?idsitio=2.
- *48. FIGO professional and ethical responsibilities. 2003 <http://www.figo.org/Codeofethics>.
49. FIGO resolutions <http://www.figo.org/projects/general>.
50. FIGO Ethics committee http://www.figo.org/files/figo-corp/Ethical%20Issues%20-%20English_0.pdf.
51. FIGO position statement: professional standards. 2009. http://www.figo.org/files/figo-corp/Professional%20Standards%20doc_0.pdf.
52. Briozzo L, Vidiella G, Rodríguez F et al. A risk reduction strategy to prevent maternal deaths associated with unsafe abortion. *Int J Gynaecol Obstet* 2005; **95**(2): 221–226.
53. FIGO initiative for the prevention of unsafe abortion, <http://www.figo.org/news/figo-initiative-prevention-unsafe-abortion> [accessed 31.12.09].
- *54. Faundes A, Duarte GA, Andalaft Neto J et al. The closer you are the better you understand: the reaction of Brazilian obstetrician-gynecologists to unwanted pregnancy. *Reprod Health Matters* 2004; **12**(24 Suppl.): 46–56.
55. Steinauer J, LaRochelle F, Rowh M et al. First impressions: what are preclinical medical students in the US and Canada learning about sexual and reproductive health? *Contraception* 2009; **80**: 74–80.
56. Jones RK, Zolna MR, Henshaw SK et al. Abortion in the United States: incidence and access to services, 2005. *Perspect Sex Reprod Health* 2008; **40**(1): 6–16.
57. Induced abortions by area of residence of patients. Statistics Canada 2007, <http://www40.statcan.gc.ca/l01/cst01/health42a-eng.htm> [accessed 21.01.09].