

RAWSA MENA
INTERNATIONAL WOMEN'S DAY

THE LINKAGES BETWEEN SAFE ABORTION
AND SUSTAINABLE DEVELOPMENT GOALS 3 AND 5
AND OTHER INTERNATIONAL CONVENTIONS

WHY SAFE ABORTION IS AN OBLIGATION
POSITION PAPER



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I. Preface

Every individual has the right to decide freely and responsibly – without discrimination, coercion and/or violence – the number, spacing and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health (ICPD 1994).

Each year, almost half of all pregnancies – 127 million (Guttmacher 2019) – are unintended, and six out of ten unintended pregnancies end in induced abortion.

Three out of ten of all pregnancies end in induced abortion. Nearly half of all abortions are unsafe, and almost all of these unsafe abortions take place in developing countries., including MENA region.

When an unsafe abortion is carried out to terminate a pregnancy, there can be devastating and long-term physiological, financial, and emotional costs to the woman and her family, as well as to her community at large. Access to legal, safe and comprehensive abortion care, including post-abortion care, is essential for the attainment of the highest possible level of sexual and reproductive health.

Right & Access for Women to Safe Abortion Network (RAWSA) is a regional network that defends the rights of women to have access to safe abortion in Middle East and North Africa (MENA). Established in 2019, the network brings together feminist human rights organizations and activists for regional advocacy in favor of the right to abortion. In its first position paper to mark the International Woman Day (IWD) 2021, the network highlights and creates linkages between the safe abortion, and the Sustainable Development Goals (SDGs) – particularly SDG 5 and SDG3, as well the as the international conventions and agreements that provides the women the rights to control their bodies, decides on their sexual reproductive health and rights (SRH&Rs) and terminate their pregnancies.

This position paper is paving the way to have justifications for this call aiming at legalizing safe abortion, as in several countries in other regions (Latin America, Africa, Asia and Eastern Europe). However, abortion is illegal for all indications except saving women’s life in almost all the countries of the MENA region. The position paper at the same time builds the ground that is needed to advocate for the access to safe abortion in MENA region. On Other hand, the position paper creates this bridge between the necessity for women to enjoy safe abortion, and the accessibility to its services in their homelands, for the realization of SDGs, as part of the sought health reforms.

II. Context of Abortion in MENA region

¹There are very few publications on abortion in MENA countries, and those that do exist tend to either give a broad overview of the legislation of different states or evaluate Islam’s position on abortion. Detailed fieldwork-based studies on actual medical practices, political debates, local legal implementation, moral and social norms, and the trajectories of individual women in MENA countries are very rare. On other hand, most abortion laws in the region are punitive and were promulgated during the colonial period, when French and British regimes supported patriarchal policies to increase the population of the metropole and of the colonized lands. As colonial laws criminalizing abortion became entrenched in society, legal and medical services for women desiring abortions also became restricted.

¹ Hessini L. “Abortion and Islam: Policies and practice in the Middle East and North Africa.” *Reproductive Health Matters*. 2007;15(29):75–84.

Nonetheless, according to some scholars², abortion was widely practiced in Islamic societies during the colonial period, and the main Islamic schools had different opinions on abortion. Some Islamic trends authorized abortion until 120 days after conception, whereas others were opposed to it. During the 19th century, progressive interpretations of Islam and demographic concerns, coupled later in the 1970s with a desire to lower maternal mortality rates, led to laws allowing for abortion on demand during the first trimester in Tunisia (1973) than in Turkey (1981). However, because these laws were designed not to extend women's rights but to decrease natality rates, they have been applied in some contexts in a coercive way.

In MENA region, social class, marital status, income, age, and education play an important role. The deny of sexual relations for unmarried young girls and boys is a major obstacle. These factors may shape the possibility of accessing abortion care, or, where abortion is legal, they help determine the type of facility women can go to and, consequently, the kinds of experience they have. Access to abortion for Palestinian women for instance depends on a woman's socioeconomic status and whether she is a resident of Jerusalem, the West Bank, or Gaza. Because abortion is illegal under Palestinian law and highly restricted in the occupied Palestinian territories, Palestinian women are forced to turn to Israeli hospitals, to expensive private Palestinian clinics, or to self-induced unsafe procedures when seeking an abortion.

Recently, economic and social capital started to be crucial in Turkey and Tunisia, where cuts in the financing of the health care system have restricted women's access to abortion services in the public sector, although it is free of charge in Tunisia. Furthermore, increases in power of Islamist parties and Islamic conservative repertoires circulating in the MENA region help reinforce moral and social norms that condemn sexuality outside of marriage and assign women the traditional roles of wives and mothers. In both Tunisia and Turkey, these discourses have affected health care providers' attitudes and practices: some of them have begun to refuse to offer the services they should provide. In Tunisia for example, the economic crisis and the emergence of Islamist and conservative forces have made abortion on request—something that has been legal since 1973—increasingly difficult to obtain in the public sector in some occasions³. There are paradoxical effects of the democratization process during the post-revolutionary period, which has contributed to reducing, rather than increasing, women's sexual and reproductive rights.

The legalization of abortion is not a magic bullet but is nonetheless important for advancing women's sexual and reproductive rights in the MENA region. It is very important in this case to show the linkages between abortion, development and Agenda 2030. Since the *ICPD* in Cairo in 1994, 52 countries worldwide have changed their laws to allow for greater access to abortion. However, only three MENA countries are on that list: United Arab Emirates (in 2014), Morocco (in 2017), and Iran (in 2004). They extended the circumstances under which women can seek an abortion to include only fetal impairment, so they do not allow them freely, rather in specific conditions. Rarely is abortion on top of the agenda of local women's

² Hessini L. "Abortion and Islam: Policies and practice in the Middle East and North Africa," *Reproductive Health Matters*. 2007;15(29):75–84. For publications dealing with state legislation, see, for example. [\[PubMed\]](#) [\[Google Scholar\]](#) Hessini L. "Islam and abortion: The diversity of discourses and practices," *IDS Bulletin*. 2008;39(3):18–27.

³ Sarah Raifman, Selma Hajri, Caitlin Gerdtz & Diana Foster (2018) Dualities between Tunisian provider beliefs and actions in abortion care, *Reproductive Health Matters*, 26:52,

movements. This is likely due to a fear of backlash, both from the states, which are often explicitly or implicitly seeking legitimacy within Islam, and from the conservative segments of societies themselves, which often aim to control and confine women and girls to stereotypical gender roles. As a new wave of popular uprisings currently sweeps over some countries in the MENA region this could be a critical moment to put women's sexual and reproductive rights on the political agenda.

III. Why safe abortion is important in MENA region

As stated above, 45 percent of all abortions are unsafe, and almost all of these unsafe abortions occur in developing countries, led by MENA region countries.

There are several reasons why safe abortion is important for women in MENA, some of these reasons are indicated below:

1. Access to safe abortion protects women's and girls' health and human rights

Abortions are safe when they are carried out by modern methods using medication or surgery as recommended by WHO and that is appropriate to the pregnancy duration, and when the person carrying out the abortion has the necessary skills. Such abortions can be done using tablets (medical abortion) or by surgical procedure preferably under local anesthesia, Both with a simple outpatient procedure.

When women with unwanted pregnancies in MENA region do not have access to safe abortion, they often resort to unsafe abortion and risky methods. An abortion is unsafe when it is carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. Characteristics of an unsafe abortion touch upon risky and unhygienic circumstances before, during or after an abortion.

Unsafe abortion can lead to immediate health risks – including death – as well as long-term complications, affecting women's physical and mental health and well-being throughout her life-course. It also has financial implications for women and communities.

Unsafe abortion procedures may involve the insertion of an object or substance (root, twig, or catheter or traditional concoction) into the uterus; dilatation and curettage performed incorrectly by an unskilled provider; ingestion of harmful substances; and application of external force.

2. Negative impact on women's health and well-being

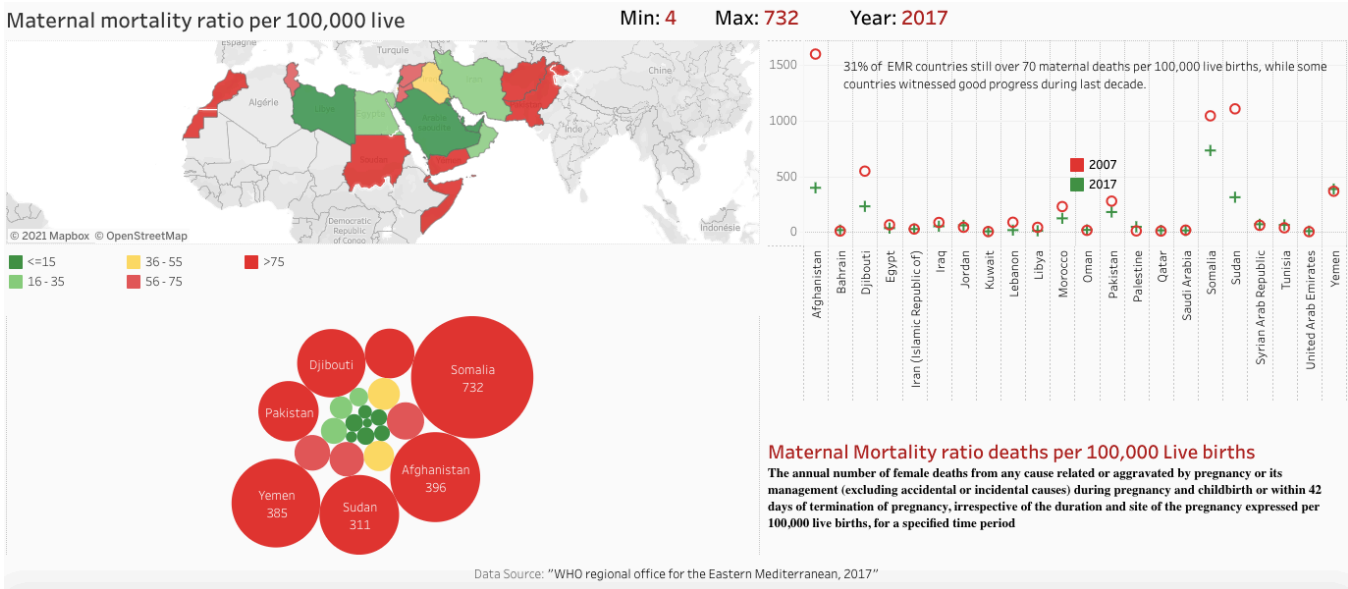
Physical complications of unsafe abortion in MENA region include hemorrhage (heavy bleeding), infection, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs. One in four women who undergo an unsafe abortion is likely to develop temporary or lifelong disability requiring medical care.

3. A cause for maternal death in MENA region

As per UNICEF, the **maternal mortality** ratio (MMR) declined by 50 per cent in the **MENA** region from 1990 to 2015 (from 220 to 110 **maternal deaths** per 100,000 live births); Under-5 **mortality** rates (U5MR) dropped 59 per cent in the **Middle East** and North Africa region from 1990 to 2015 (from 71 to 29 **deaths** per 1,000 live births). Between 4.7% and 13.2% of all maternal deaths can be attributed to

unsafe abortion. Mortality from unsafe abortion is much higher in developing regions, and in particular, disproportionately affects women in Africa.

It is worth-noting that the impact of abortion bans on women’s health in the Middle East and North Africa (MENA) region is understudied, and reliable data on unsafe abortion in countries where access to safe abortion is difficult or nonexistent are lacking. The reason is that states where abortion is illegal do not collect data on that topic (or at least do not make them public). Moreover, some countries such as the occupied Palestinian territory is often absent from official statistics, as it is not recognized as a state. However, a 2008 World Health Organization report estimates the yearly total of unsafe abortions to be 830,000 in Western Asia- including Palestine, causing 600 annual maternal deaths, and 900,000 in Northern Africa (Maghreb), causing 1,500 annual maternal deaths. Overall, the report estimates the total number of maternal deaths in Arab countries to be 14,000 at least in 2007. Wars and displacement in the MENA region also contribute to high levels of maternal deaths (some of which are probably still related to unsafe abortion). In a report of WHO Eastern Mediterranean (2019)⁴ the maternal mortality ratio (MMR) is 166 deaths per 100 000 live births in the Region, less than the global ratio of 216, although it is the second highest among WHO regions. The Fragile States Index, produced by the Fund for Peace, currently places some MENA countries (Iraq, Sudan, Syria, and Yemen) on “very high alert” or “high alert,” suggesting that these factors are likely to continue to affect maternal mortality in the near future.



IV: Abortion in the global development agenda instruments

As mentioned above, abortion is a contested issue on moral grounds. As a result, the need for safe first- and second-trimester abortion is not discussed in the broader public health arena. Opinions differ about up till which pregnancy month abortion should be allowed and about which methods of abortion should

⁴ **The WHO Eastern Mediterranean**
Health and well-being profile of the Eastern Mediterranean Region
An overview of the health situation in the Region and its countries in 2019
<http://www.emro.who.int/entity/statistics/statistics.html>

be allowed, such as the debate on whether women should be at risk to use the same pill for both contraception and medical abortion. Which is completely wrong and demonstrate the lack of knowledge and information as those pills are different

Because of its sensitivity, abortion is not mentioned in the SDGs, neither was it in the millennium development goals, but there are strong linkages between abortion and these goals. However, it has been explicitly addressed in a number of intergovernmental agreements concerning health, population, and women's rights, such as the International Conference on Population and Development (ICPD) Program of Action (1994), the Fourth World Conference on Women (1995), ICPD+5 (1999) and ICPD+10 (2004). These agreements highlight the impact of unsafe abortion as a concern for population, human rights and public health, and urge all governments and relevant intergovernmental and non-governmental organizations to deal with it. The fact that millions of women die or become disabled each year from unsafe abortion reveals that there is an unmet need for safe first and second-trimester abortions. Globally, 10-15% of all induced abortions occur during the second trimester (13 to 28 weeks LMP). Overall, two thirds of all major complications from abortion are attributable to those performed in the second trimester. Unwanted pregnancies are frequently experienced by adolescents. Among the 21.6 million women each year undergoing an unsafe abortion, adolescents also suffer the most from complications. Still, many countries do not consider adolescents eligible for "family planning". In this region young people suffer from a lack of access to knowledge about sex, bodies and fertility as sexual education is absent; They don't know how to negotiate safe, how to express their consent to have sex and refuse unwanted sex; about how to talk to partners about sex and to use a proper contraception. All over the world and equally in countries where abortion is legal the widespread modern contraceptive use will not completely eliminate the need for abortion for several reasons including methods failure and incorrect use that may still result in unwanted and mistimed pregnancies. It is estimated that, annually, approximately 33 million women worldwide may experience an accidental pregnancy while using a method of contraception, and almost 2.5 million women in MENA would face this challenge. Access to emergency contraception can prevent the need for abortion but is still restricted in many countries of the world where conservatism and patriarchy are still controlling women's bodies. As on 2016, 46 countries have no emergency contraceptive pill brands registered, and, even in countries where they are registered, regular supplies are not always available.⁵

1. Abortion in the International Conference on Population and Development ICPD POA:

The 1994 International Conference on Population and Development (ICPD) Program of Action represented a positive step toward legitimizing abortion as a component of basic reproductive health services. In the ICPD PoA reproductive health was defined as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes". The Program of Action of the ICPD in 1994 was the first major international agreement to make recommendations on unsafe abortion. It addressed abortion principally under the heading "Health, Morbidity and Mortality." Paragraph 8.25 called attention to the public health impact of unsafe abortion and the need to expand family planning services to reduce unsafe abortion. The paragraph also provided that women who have unwanted pregnancies should be able to receive reliable information, compassionate counselling and safe abortion services where abortion is not against the law. It also called for access to quality services for the management of complications that may arise from the procedure and post-abortion counselling, education and family planning services aimed at preventing repeat abortions. In the document, governments agreed to support comprehensive reproductive health services including

⁵ The International Consortium on Emergency Contraception (2016). EC status and availability. Countries with no EC pill brands registered. Retrieved from <http://www.cccinfo.org/country-by-country-information/status-availability-database/>

choice of regulation of fertility, with the provision that access should be available for services “which are not against the law”.

Women's access to safe abortion was one of the most difficult issues to negotiate at ICPD and again when progress on implementing ICPD recommendations was reviewed five and ten years later. Governments ultimately agreed to address the public health impact of unsafe abortion, but the problem persists. In 2000, an estimated 19 million women had unsafe abortions and some 68,000 died. Almost 14% of them were under the age of 20 and 95% lived in developing countries. In addition, five million women were temporarily or permanently injured⁶. While these numbers have shown some decrease over the past decade, differences in deaths and injuries from unsafe abortion still constitute one of the greatest disparities in reproductive health between the developed and developing worlds. Lack of political and financial commitment to addressing unsafe abortion, religious and ideological conservatism, and silence and stigma have made this experience life-threatening for 190-200 million women in the past decade alone. Yet abortion is one of the safest medical procedures when performed by a skilled provider in a facility that meets medical standards.

While the PoA represented a breakthrough at the time, internal contradictions and weaknesses in the abortion provisions prevented it from providing governments with a clear directive for action. The PoA fell short of explicitly recognizing women's right to make the decision to terminate a pregnancy. Whether reproductive rights included abortion remained a matter for interpretation, however.*

The PoA also provided that “in no case should abortion be promoted as a method of family planning” (ICPD paragraph 8.25). This language, based on a political compromise, is ambiguous at best, because it is not clear what constitutes “promoting” abortion. It also calls into question the meaning of “family planning;” a woman's decision to have an abortion is always related to her desire to plan whether and when to have children. Furthermore, the sexual act is too often far from consensual, especially for young women under the age of 15, who are also vulnerable to transactional and “sugar daddy” sex. And especially in the context of war and refugees camps

Research, advocacy and mobilization efforts have grown and diversified since the ICPD. Studies in numerous countries have helped to: i) increase knowledge of the magnitude and consequences of unsafe abortion; ii) raise awareness of women's experiences in undergoing unsafe abortions; iii) comprehend the varying needs and circumstances of young women and other subgroups; and iv) link abortion with other key public health and women's rights issues. Advocacy groups are using these findings and incorporating public health, social justice, human rights and legal reform approaches into their work. New groups and actors have become involved in abortion advocacy, including policymakers, government officials, health and medical professionals, women's groups, legal advocates, human rights experts, journalists, young people and in some countries trade unionists. But all these aspects are very scarce and scattered in the MENA region where even basic data and research are difficult to find and collect.

Additional issues have emerged since the ICPD, including the link between abortion and sexual violence. Globally, one in five women has been physically or sexually abused in her lifetime, most frequently by someone she knows. Studies confirm that women survivors of violence are at higher risk of unwanted

⁶ World Health Organization. *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality* in 2000. 4th ed, 2004; WHO: Geneva. At: (www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/estimates.pdf). Accessed 23 November 2004. [[Google Scholar](#)]

pregnancy. In some countries, including MENA, women's groups have linked services on sexual violence, unwanted pregnancy and abortion for vulnerable women which have generated public discussion.

There is another development due to ICPD which is the increased attention to consider the right to abortion as a human right as well as the other reproductive rights, by the UN's Human Rights Committee (HRC), Committee on Economic, Social and Cultural Rights (CESCR), Committee on the Elimination of Discrimination Against Women (CEDAW), and Committee on the Rights of the Child (CRC). CEDAW explains that neglecting health care that only women need is a form of discrimination against women which governments are obliged to remedy.

Regionally and in Africa, in 2003, the African Union adopted the Protocol on the Rights of Women in Africa to supplement the African Charter on Human and Peoples' Rights adopted in 1981. Ten countries* have ratified the Maputo Protocol as of February 2005; 15 are needed for it to enter into force. The broad protection of reproductive rights in the Protocol goes well beyond language agreed in international settings to date and is the first international treaty specifically to recognize abortion. States are called upon to protect women's reproductive rights by authorizing abortion in cases of sexual assault, rape, incest, fetal impairment and where continuing the pregnancy would endanger the life or mental or physical health of the woman.

Since ICPD, new abortion technologies have been introduced around the world. Medical abortion and vacuum aspiration are the two preferred methods of abortion during the first nine and 12 weeks of pregnancy, respectively. MVA is a safe, simple and cost-effective technology, consisting of a plastic cannula connected to a hand-held aspirator, and can be used by a range of qualified providers.⁵⁷ Numerous studies show that MVA is associated with fewer complications, reduced need for pain management and lower costs compared to D&C. As result, MVA is replacing D&C in many developing countries, including MENA, when the abortion is induced for “legal” reasons though far too slowly in many other countries.

Medical abortion regimens using mifepristone and misoprostol are recommended on WHO abortion guidelines and have been approved by several international organizations and in a growing number of countries in all regions, including GCC despite it is prescribed for specific very limited reasons. Misoprostol is also widely available over the counter as a gastric ulcer drug and is being used by women in legally restricted settings on its own to terminate pregnancy. Misoprostol is also used for treatment of post-partum hemorrhage and incomplete abortion. Access to mifepristone in public health systems is impeded by issues of registration and cost in many countries but generic packages containing one pill of 200mg of mifepristone and four pills of 200microg of misoprostol are now widely available at lower prices.

Since ICPD, while nearly 40% of women still live in countries where abortion is restricted by law, over a dozen countries have gone beyond the ICPD recommendations to reform their abortion law, but no one Arab country went this direction. In addition, efforts to improve access to legal services and to reform restrictive laws are underway in some countries but not Arab states. Different approaches to legal reform have been used, including decriminalizing abortion by removing it from penal or criminal codes and legalizing abortion. Legal reform is a long process, often not linear in nature, and sometimes with mixed results. In some countries, campaigns were closely tied to broader national discussions about women's

⁷ Global Progress in Abortion Advocacy and Policy: An Assessment of the Decade since ICPD
[Leila Hessini- Reproductive Health Matters](#) Volume 13, 2005 - [Issue 25: Implementing ICPD: what's happening in countries](#)

rights to equality and non-discrimination, and to human rights violations arising from the criminalization of abortion.



2. Abortion and the Sustainable Development Goals

Whether the language adopted by this SDG target supports safe abortion across the world, this begs the question of the goal's feasibility in developing countries, considering the social prominence of pro-life advocates with a patriarchal control and male domination. As the world transitions from the Millennium Development Goals (MDGs) to the newly introduced SDGs for 2030, there are many lessons to be learned regarding the betterment of women's sexual and reproductive health rights (SRHR). One of the most important issues at hand is the SDGs' commitment to achieving universal access to SRHR as stated by Target 3.7. The ambiguity of this target inherently suggests that SDGs support liberal abortion policies since they are an integral part of SRHR. The new SDGs' preamble clearly states, "As we embark on this collective journey, we pledge that no one will be left behind." The word "collective" stands out as it reinstates the importance of inclusivity for all. However, it can be argued that the gaps created by the vagueness of SDGs in relation to abortion policies do not enhance this collective framework. Instead they are a stark reminder of the MDGs weaknesses in leaving behind those who do not have access to safe abortion services. Though one of the MDGs' target was to reduce maternal mortality and achieve universal access to reproductive health, like the new SDG target 3.7, nothing in its framework specified the prevention of unsafe abortions. Sexual and Reproductive Health (SRH) targets have been included as part of the United Nations Sustainable Development Goals and indicators are important to monitor progress towards these targets. SRH indicators are recommended for setting norms and measuring progress globally. However, given the diverse political, socioeconomic and cultural contexts in different countries, and lack of global agreement on broad indicators, it is important to select appropriate indicators for specific countries. Pro-life advocates warn that SDG's promotion of "universal access" and "SRHR" spell out access to safe abortion, arguing that the implementation of these goals will lead to an expansion of abortion and contraception especially in the developing world. Despite this, the Vatican supported the "coordination of all sources of financing to achieve the SDGs." The backing from the Vatican comes as a surprise because the Catholic Church is a known adamant supporter of the pro-life movement. Some pro-choice advocates have also argued since

the SDGs are too vague in their language they are not progressive in effect. According to Rep. Chris Smith, the ambiguity of the text can easily be interpreted to include abortion, which may result in pro-life donors not supporting development funding on maternal healthcare. Although they do encompass important matters such as family planning and comprehensive sex education, SDGs do not explicitly talk about safe abortion.⁸ Considering that a 2013 United Nations Secretary-General identified unsafe abortions as a “leading cause” of maternal deaths, the SDGs’ 2030 target to reduce maternal mortality by two-thirds is therefore impossible if the issue of safe abortions is not addressed properly.

Global reviews of key interventions related to reproductive and maternal health recognizes that access to safe and legal abortion is an essential component of comprehensive SRHR services and should ideally be available to all women regardless of age, race, religion, geographic location, ethnicity, or migration status. Though abortion is clearly a sensitive topic that traverses boundaries of culture and religion, policy makers, especially in developing countries, will have to make difficult decisions. Policy changes in South Africa than in other countries in the African continent (Ghana, Mozambique, Ethiopia etc..) are a practical example of how liberalizing abortion policies may actually improve maternal healthcare. In MENA, where the SDGs development processes are already facing many hurdles due to high rates of poverty, humanitarian contexts, lack of transparency in governance, and political transformations, abortion-related stigma often causes women to seek abortions outside of the legal system. The reality is that most of the barriers to progress that inhibited the better implementation of MDG 5 in MENA—such as weak health systems, poor access to services, and gender inequalities—still lurk in the SDG era and will without a doubt also impede the achievement of SDG target 3.7 related to abortion, as it is well-explained below.

3. Abortion’s linkages with SDG 3 (good health & well-being)

2015 marks the start of a new development agenda that builds on progress made under the Millennium Development Goals (MDGs), an agenda created through intergovernmental negotiations and a global participatory process with inputs from civil society. The Sustainable Development Goals (SDGs) for 2030 renew governments’ commitments under the MDGs to reduce maternal mortality; achieve universal access to sexual and reproductive health information, education and services; ensure reproductive rights; and achieve gender equality as a matter of women’s and girls’ human rights. According to the Preamble: “As we embark on this collective journey, we pledge that no one will be left behind.”⁹

Advancing women’s access to safe and legal abortion is a priority for women’s reproductive health and rights, in accordance with the new SDGs focused on health and gender equality. This briefing paper presents the SDG goals and targets whose achievement depends on safe and legal abortion and recommends minimum indicators for measuring global progress on abortion access.

Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. The 2030 target calls for a two-thirds reduction in maternal mortality, based on the latest estimate for the maternal mortality ratio globally, at 210 maternal deaths per 100,000 live births. A report by the United Nations Secretary-General in 2013 highlighted unsafe abortion as a “leading cause of maternal deaths” and cautioned that “it is likely that the numbers of unsafe abortion will continue to increase unless women’s access to safe abortion and contraception – and support to empower women (including their freedom to decide whether and when to have a child) – are put in place and further strengthened.” While available

⁸ Cornell Policy Review <http://www.cornellpolicyreview.com/can-policy-language-reduce-unsafe-abortions/?pdf=2299>

⁹ <https://sdgs.un.org/2030agenda>

data point to a decline globally in maternal deaths due to unsafe abortion, inequalities among regions, countries, and within countries continue to be pervasive, with women who are poor, young, or in other vulnerable circumstances suffering the most. Yet unsafe abortion is entirely preventable through ensuring women's access to effective contraception together with safe and legal comprehensive abortion care — essential and cost-effective components of any strategy for reducing maternal mortality and achieving target 3.1.

Improved systems at the national level to record maternal deaths and identify their causes — including unsafe abortion—are required to improve measurement of progress toward this target and identify priority interventions. Improved systems at the national level to record maternal deaths and identify their causes — including unsafe abortion—are required to improve measurement of progress toward this target and identify priority interventions.

Target 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.

Access to safe, legal abortion has been recognized by the global community as an essential intervention in a package of comprehensive sexual and reproductive health (SRH) services that should be available to all women. Adolescents in particular need universal access to youth-friendly and nonjudgmental sexual and reproductive health services that respect their sexual and reproductive health and rights and their rights to confidentiality, privacy and informed consent. In addition, adolescent girls are disproportionately affected by sexual violence; interventions for adolescents therefore must include services to prevent and provide care to those affected by sexual violence, including access to emergency contraception and safe abortion.

Recommended indicator: The proportion of health care facilities in a country that offer a minimum package of SRH services, with quality of care.⁵ This indicator, supported by the global Partnership for Maternal Newborn and Child Health, should be in alignment with the WHO guidelines for evidence-based essential interventions, which include safe abortion and postabortion care at the primary level of the health system.

4. Abortion's linkages with SDG 5 (Achieve gender equality and empower all women and girls)

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

5.C: Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

Gender equality includes recognition of women's autonomy and capacity to make informed and independent decisions about their sexuality and reproduction and the decision on when to have children, through laws and policies allowing access to safe and legal abortion. Women's access to safe and legal abortion is as relevant to gender equality as women's equal access to education, employment, adequate food and housing. International human rights bodies and experts. Over the last 20 years have affirmed women's human rights to life and health when calling on countries where abortion is a crime, to end unsafe abortion—and the resulting deaths and injuries. No woman should be forced to continue a

pregnancy against her will, or face life, health or legal risks as a result of having an abortion. While a number of countries have moved toward liberalization of abortion laws and policies since the Beijing Platform for Action called for review of punitive abortion laws two decades ago, too many countries including MENA region countries, have yet to do so. Where abortion is legally restricted, women who cannot access safe abortion services instead have clandestine, risky procedures and then avoid seeking treatment for complications due to stigma and fear of punishment. In most countries, legalizing abortion is a precursor to plan for and deliver high quality safe abortion services. It is no longer acceptable politically or morally for governments or international bodies to use arguments of culture or religion to avoid creating a supportive policy and legal framework for safe abortion that would lead to elimination of a major cause of maternal death and illness. To fulfill the 2030 agenda, governments and civil society must accelerate actions to repeal laws that criminalize women who seek abortion or who in other ways exercise their sexual and reproductive rights.

Recommended indicators 1. Liberalize abortion procedure or better depenalize it in each country. At least establish that abortion is legal under broad grounds (Physical and mental health, life endangerment, rape, incest, severe fetal abnormalities), coupled with governments' actions to review situations of barriers to access to abortion that discriminate against women or in other ways create barriers to a service that only women need. 2. Development, approval and dissemination by national/sub-national governments of guidelines for health facilities and other policy documents that are supportive for implementation and access to safe abortion care consistent with the latest WHO guidance.¹⁰

Safe and legal abortion: essential facts • Worldwide, an estimated 22 million women obtain unsafe abortions every year, the vast majority in developing countries where abortion is restricted by law. As a result, almost seven million women seek treatment in health facilities, and 47,000 women die annually—making unsafe abortion one of the world's major preventable causes of maternal mortality.⁹ • Deaths and injuries due to unsafe abortion -- and prosecution for seeking illegal abortion -- disproportionately affect women who are young, poor, rural and lack education, as well as those who belong to a racial or ethnic minority or indigenous group. • 25 percent of the world's women live in countries where abortion is still restricted to saving a woman's life or prohibited altogether, with a few of these countries granting limited other exceptions.¹⁰ • Laws that make abortion a crime do not reduce the incidence of abortion. Even worse, there is a proven correlation between countries' restrictive abortion laws and high rates of maternal deaths and injuries. The 82 countries with the most restrictive abortion laws also have the highest incidence of unsafe abortions.

5. Global compact for migration – where SRH&Rs are explained including right to safe abortion

The Global Compact for Safe, Orderly and Regular Migration (A/RES/73/195), adopted at an intergovernmental conference on migration in Marrakesh, Morocco on 10 December 2018, is the first agreement, prepared under the auspices of the United Nations, to cover all dimensions of international migration in a holistic and comprehensive manner. It puts migrants and their human rights at the centre and provides a significant opportunity to strengthen human rights protection for all migrants, regardless of status.

The Global Compact reaffirms States' commitment to respecting, protecting, and fulfilling all human rights for all migrants, including SRH&Rs and the right to access health services.

¹⁰ WHO safe abortion technical and policy guidance – Second edition 2012

The GCM commitments and actions can be seen as a guide for States to meet their human rights obligations when designing migration governance measures to reduce the risks and vulnerabilities migrants face at different stages of migration and to create conducive conditions that empower all migrants to become active members of society.

Key commitments include specifically ensuring migrants' rights to information and to a legal identity; Moreover, the compact emphasizes women rights, including access to education, health services and information, which also entail SRH&Rs and access to abortion when needed.

6. Conventions indicating women right to control her body and family size (CEDAW & CRPD)

CEDAW:

The Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women (CEDAW) have both clearly indicated that women's right to health includes their sexual and reproductive health. States have obligations to respect, protect and fulfill rights related to women's sexual and reproductive health. The Special Rapporteur of the Office of High Commission of Human Rights insisted on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and maintains that women are entitled to reproductive health care services, goods and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality [see report A/61/338].

CEDAW (article 16) guarantees women equal rights in deciding "freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." CEDAW (article 10) also specifies that women's right to education includes "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."

The Beijing Platform for Action states that "the human rights of women include their 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." The CEDAW Committee's General Recommendation 24 recommends that States prioritize the "prevention of unwanted pregnancy through family planning and sex education." The CESCR General Comment 14 has explained that the provision of maternal health services is comparable to a core obligation which cannot be derogated from under any circumstances, and the States have to the immediate obligation to take deliberate, concrete, and targeted steps towards fulfilling the right to health in the context of pregnancy and childbirth.

The CRPD:

On 13 December 2006, the General Assembly of the United Nations adopted the Convention on the Rights of Persons with Disabilities (hereafter the Convention),¹ which entered into force on 3 May 2008. The Convention sought to address the widespread discrimination against people living with disabilities in education, healthcare, politics, employment, and other areas. Although some authors have argued that in the drafting of the Convention the discussion on sexual and reproductive rights was confined to the protection of persons with disabilities from forced sterilization and sexual abuse,^{11, 12} these studies have not adopted a gender perspective for analyzing how the Committee has thereafter attended to issues of sexuality.

In 2011, the Committee drafted its first concluding observations on the initial reports submitted by Tunisia and Spain. As of August 2016, over a five-year period, the Committee had published 40 concluding observations. In this paper, we examine how the Committee has framed the discussion on gender and sexuality, and argue that, despite a revolutionary founding Convention, the Committee has retained a protective, medical, and gender binary model to address the sexual and reproductive rights of persons with disabilities.

CRPD has been emphasizing that the states have to provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs provided to other persons, including in the area of sexual and reproductive health and population-based public health programs. Moreover, it ensures that States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others.

Conclusion and recommendations

a. Intense negotiations:

From what was mentioned above, intense negotiations have to be addressed sooner rather than later in order to find the best solution for moving forward. The challenges of MDG 5 demonstrate how the SRHR of many women and girls are compromised by the stigma and political controversy surrounding abortion practices. Policies that criminalize abortion in developing countries deny women control over their own reproductive decisions, and this lack of control in turn impedes their equal participation in their nations' social, political, and economic activities. If these policies are not revised at the international level and at the national level, the SDGs will not catalyze the improvement of maternal healthcare by 2030, and instead there will be a repetition of the MDGs' weaknesses. The lack of clarity in the SDGs' targets may again hinder implementation of safe and legal abortion procedures for women in high-risk countries, which essentially puts many women at risk of maternal morbidity and mortality.

b. Scaling-up policy and programmatic interventions:

Scaling-up involves expanding the health system's capacity in MENA region for implementation of policy and program interventions that have been demonstrated to improve access and quality of abortion care, in order to achieve population-level impact. Too often, scaling-up is considered a matter of routine program implementation that does not need special attention. Once a package of interventions has proved to be successful in a pilot or demonstration project in any MENA country, it is expected to be taken up by a health system and spread throughout, based on the assumption that success in the pilot phase is sufficient to catalyze large-scale change. Successful scaling-up requires systematic planning, management, guidance and support for the process by which interventions are expanded and institutionalized. Scaling-up also requires sufficient human and financial resources to support the process.

c. Creating an enabling environment in MENA region:

An enabling environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care. The respect, protection, and fulfilment of human rights require that comprehensive regulations and policies be in place and they address all elements to ensure that abortion is safe and accessible. Policies should aim to: 1-Respect, protect and fulfil the human rights of

women, including women's dignity, autonomy and equality; 2-Promote and protect the health of women, as a state of complete physical, mental and social well-being; 3-Minimize the rate of unintended pregnancy by providing good-quality contraceptive information and services, and by including a broad range of contraceptive methods, emergency contraception and comprehensive sexuality education; 4- Prevent and address stigma and discrimination against women who seek abortion services or treatment for abortion complications; 5- Reduce maternal mortality and morbidity due to unsafe abortion, by ensuring that every woman entitled to legal abortion care can access safe and timely services including post-abortion care and contraception; 6- Meet the particular needs of women belonging to vulnerable and disadvantaged groups, such as poor women, adolescents, single women, refugees and displaced women, women living with HIV, women with disabilities and survivors of rape.

d. Healthcare treatment for abortion complications:

States have an obligation to provide immediate and unconditional treatment to anyone seeking emergency medical care and health-care providers are obligated to provide life-saving medical care to any woman who suffers abortion-related complications, including treatment of complications from unsafe abortion, regardless of the legal grounds for abortion. The practice of extracting confessions from women seeking emergency medical care as a result of illegal abortion, and the legal requirement for doctors and other health-care personnel to report cases of women who have undergone abortion is unethical and could lead to a dramatic situation putting in danger the life of the women, and It must be eliminated.

e. Continuous advocacy and networking:

Organizations and networks as RAWSA, have to continue their advocacy and communication efforts to achieve the aspirations related to access safe abortion in MENA region and possibly to legalizing abortion or better to decriminalize it . The continuity to network, advocate and lobby is essential to create a leverage, build capacity among advocates (individuals and groups) and pressurize the governments in the region to be able to provide this human right to all women in the MENA region. Participating in global forums to eliminate social norms and structural barriers facing women to access SRH&Rs including safe abortion is essential to make the voices of the women heard in these international spaces. On other hand, continue to write such analytical papers and policy briefs is important to frame the calls and set a strategic plan for concrete actions on this path.

Author: Mrs Shaima Aly

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