International Campaign for Women's Right to Safe Abortion

28 April 2014

To :
His Excellency Ambassador Gonzalo Koncke Pizzorno
Chair, Commission on Population and Development
uruguay@un.int

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His Excellency Mr. Ban Ki-Moon
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cc. Dr Margaret Chan
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Re: Outcome Resolution, 47th Commission on Population and Development

Dear Ambassador Gonzalo Koncke Pizzorno and esteemed colleagues,
The International Campaign for Women's Right to Safe Abortion is a coalition of organisations and networks that support women's right to safe, legal abortion, with members in 108 countries across the globe. Our aims are to promote universal access to safe, legal abortion as a women's health and human rights issue, and to support women's autonomy to make their own decisions whether and when to have children and have access to the means of acting on those decisions without risk to their health and lives.

We are writing in response to the Outcome Resolution of the 47th Commission on Population and Development.

We would like to congratulate the 47th Commission on many aspects of this document, particularly its emphasis on human rights and women's empowerment in relation to population and development. We agree with many other commentators that support for sexual and reproductive health and reproductive rights has come into its own in this Outcome Resolution, a major achievement since the 1994 ICPD.

However, we feel compelled to express serious concern regarding the way the subject of induced abortion is addressed, specifically in OP12. We recognise that it was a condition of the 47th CPD (PP8) that the ICPD Programme of Action 1994 would not be renegotiated. This has proved to be problematic in relation to abortion and ultimately unacceptable in the following ways:

Firstly, while the Outcome Resolution contains some of the language on abortion found in the ICPD Programme of Action, it does not contain all of it. Abortion was a particularly contentious issue in 1994, and the text on abortion throughout the Programme of Action was negotiated as compromise language, that is, it contained statements proposed by opponents as well as proponents of the right to safe, legal abortion. It is therefore highly problematic to introduce some of that language, but not all of it. We contend that this choice of text does not reflect both sides of the compromise on abortion in a balanced way.

The language included in the Outcome Resolution is the following: *"…quality services for the management of complications arising from abortion, access to reliable information and compassionate counselling for women who have unwanted pregnancies, reducing the recourse to abortion through expanded and improved family planning services and, in circumstances where abortion is not against the law, training and equipping health-service providers and other measures to ensure that such abortion is safe and accessible, recognizing that in no case should abortion be promoted as a method of family planning…".* (OP12)

The Outcome Resolution does not acknowledge unsafe abortion as a *"serious public health concern"* (Programme of Action, Para. 8.25) nor that *"a significant proportion of the abortions carried out are self-induced or otherwise unsafe, leading to a large fraction of maternal deaths or to permanent injury to the women involved*" (Programme of Action, Para. 8.19). Nor does it commit itself: *"On the basis of a commitment to women's health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion"* (Programme of Action, Para. 8.20).

It is hard not to see this as a step backwards, especially considering the potential, serious negative effects on the post-2015 agenda yet to come.

Secondly, although the Outcome Resolution does contain excellent language that is relevant to and applies to safe abortion in numerous places (e.g. as a necessary component of reproductive health and rights) and to unsafe abortion (e.g. as an important cause of maternal mortality and morbidity), it does not acknowledge this connection. This is particularly true with OP11, which calls for: "*particular attention to the areas of shortfall in the implementation of the ICPD Programme of Action… elimination of preventable maternal morbidity and mortality through strengthening health systems, equitable and universal access to quality, integrated and comprehensive sexual and reproductive health services,… access for adolescents and youth to full and accurate information and education on sexual and reproductive health,… evidence-based comprehensive education on human sexuality, and promotion, respect, protection and fulfillment of all human rights, especially the human rights of women and girls, including sexual and reproductive health and reproductive rights; and addressing the persistence of discriminatory laws and the unfair and discriminatory application of laws, and more.*

Thirdly, although PP10 in the Outcome Resolution mentions the need to respond *"to new challenges relevant to population and development…"* and mentions a number of these, e.g. in relation to migration, it fails to do so in relation to induced abortion, in spite of the extensive attention given to induced abortion globally over the past 20 years, both from within the UN human rights system, especially by CEDAW and the Special Rapporteur on the Right to Health, and on the part of UN agencies tasked with public health and health care, particularly WHO and UNFPA, as well as on the part of governments of many Member States who have reformed their laws and policies on abortion in order to reduce deaths and morbidity and in support of women's health and rights.

In spite of stressing the importance of human rights, which by definition are universal and must be understood to apply to everyone without discrimination, the Outcome Resolution does not

acknowledge that women who need an abortion have the right to the highest attainable standard of health, the right to enjoy the fruits of scientific progress, and the right to life.

The "large fraction of maternal deaths" from unsafe abortions mentioned in the ICPD Programme of Action is currently 13% globally, and up to 40% in sub-Saharan Africa, according to the World Health Organization. This proportion has not reduced over time. Furthermore, data show that most women who suffer and die from the complications of unsafe abortions not only live in countries where abortion is legally restricted but are also living in poverty. They are therefore doubly discriminated against. Although the 47th CPD Outcome Resolution is supportive of the right to non-discrimination under the law, again this is not applied to abortion.

Although induced abortion is among the safest of all medical and surgical procedures, and up to one in three women will have at least one abortion in her lifetime, half of the 42 million abortions annually are still unsafe, and since 1994 at least a million women have died from unsafe abortions. Treatment for the complications of unsafe abortion uses up a huge amount of scarce emergency obstetric resources in public health systems where abortion is legally restricted, in countries which can least afford it. This would barely be required if abortions were safe and legal.

Moreover, although everyone agrees that prevention of unwanted pregnancy is desirable, at least 220 million women globally have an unmet need for contraception, and almost all methods of contraception fail some of the time, even when used consistently and correctly. It would not have been out of line for the Outcome Resolution to have given cognisance to at least some of these facts with regard to abortion, all of which are in line with the Programme of Action.

Since 1994, global, regional and national consultations have supported women's right to safe abortion; national laws and policies on abortion and their consequences for women have been studied by a wide range of experts, including UN human rights treaty monitoring bodies; qualitative evidence of the experience of women and health professionals in regard to abortion, safe and unsafe, has been gathered worldwide; and statements in support of women's right to safe abortion have been made in some form by all the key agencies and actors in the UN and UN human rights system.

We attach five Appendices, as follows, quoting from just a fraction of this evidence:

1. The Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014: Global Survey Report – a comprehensive document, packed with excellent recommendations, information and evidence;
2. Statement of the Committee on the Elimination of Discrimination against Women on sexual and reproductive health and rights: Beyond 2014 ICPD review;
3. Comments and recommendations on abortion of three UN human rights treaty monitoring bodies in 2013
4. United Nations ECLAC, First session of the Regional Conference on Population and Development in Latin America and the Caribbean, Consensus statement, Montevideo, 12-15 August 2013;
5. Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 3 August 2011.

We also call your attention to the World Health Organization's *Safe Abortion: Technical and Policy Guidance for Health Systems* (2012), which has been recommended as the premier text for Member States to follow in addressing the issue of induced abortion.

In conclusion, we cannot accept that, even with the best of intentions and efforts not to take us backwards by re-opening the negotiation of the 1994 Programme of Action, the 47th Commission on

Population and Development has *per force* discounted 20 years of extensive evidence and expertise in support of women's right to safe abortion as a necessary component of sexual and reproductive health, as a reproductive right, and as an essential form of health care for the reduction of maternal mortality and morbidity, especially among adolescents and young women.

We urge you and everyone who supports women's right to safe abortion to give this matter the widest possible visibility and support at both UN and country level as we move into future negotiations.

With thanks for all your hard work, your commitment and contributions.

Best wishes,

Marge Berer
Editor, Reproductive Health Matters, London, UK

pp. International Campaign for Women's Right to Safe Abortion

Signatories:

Appendix 1

From: Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014: Global Survey Report

[Report of the Operational Review of the Implementation of the Programme of Action of the International Conference on Population and Development and its Follow-up Beyond 2014] Unedited version.
[All text below are direct quotes from this document.]

http://icpdbeyond2014.org/uploads/browser/files/icpd_global_review_report.pdf

WHO guidelines urge a strengthened multi-pronged health systems response to IPV (intimate partner violence) and sexual violence, improving access to critical treatment services such as emergency contraception, abortion in cases of pregnancy from rape, prophylaxis for HIV and other STIs, and mental health support. (p.38)

A growing number of Security Council resolutions are recognizing and responding to the extent of violence against women and girls, including 2122 (2013) highlighting the need for humanitarian aid to include a full range of health services for women who become pregnant as a result of rape in conflict, which would include access to abortion. (p.38)

States should further ensure that all victims/survivors of gender based violence have immediate access to critical services, including… access to safe abortion services in all cases of violence, rape and incest… (p.40)

The vast majority of governments allow abortion on request, or to save the life of the woman and for at least one other condition such as fetal anomaly, or to safeguard the woman's health. As recognized in the 1999 Key Actions for Further Implementation, in all cases where abortion is not against the law it must be safe. The World Health Organization has however noted that: "*the more restrictive legislation on abortion [is], the more likely abortion [is] to be unsafe and to result in death*." The fundamental human rights to life and to security of the person, as well as freedom from cruel and inhumane treatment, and from discrimination, among others, means that unnecessary restrictions on abortion should be removed and governments should provide access to safe abortion services, both to safeguard the lives of women and girls and as a matter of human rights respect, protection and fulfilment, including the right to health.
Sources: UN Committee on Economic Social and Cultural Rights, Day of General Discussion on the Right to Sexual and Reproductive Health, 26 November 2010, comments by WHO, para. 55.
and: Center for Reproductive Rights, *Whose Right to Life*, 2012; Committee Against Torture, CAT/C/NIC/CO/1; Report of UN Special Rapporteur on Right to Health, A/66/254.

Article 12 of the *Convention on the Elimination of All Forms of Discrimination Against Women* (1979; e.i.f. 1981) provides that States "shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." Further, article 16(1)(e) protects the rights to decide the number and spacing of one's children and to have access to the information, education and means to exercise this right. Building on these standards, recognizing the correlation between unmet need for contraceptives and higher rates of pregnancy among adolescents, abortion, and maternal mortality, and that barriers to access to contraception disproportionately affect certain populations, treaty monitoring bodies since 1994 have urged states to ensure access to medications on the WHO Essential Medicines List, including hormonal contraception and emergency contraception. (p.111)

The use of abortion reflects many circumstances that can be difficult for women to prevent, such as contraceptive failure, lack of knowledge about the fertile period or how to use contraception, shortfalls in access or affordability of contraceptives, changing fertility aspirations, disparities in the desire for a pregnancy between a woman and her partner, fear of asking a partner to use contraception, unplanned or forced sex. Rates of abortion vary dramatically between countries… and recent estimations suggest declines in both the rate of abortion, and abortion-related deaths, with the following trends:

a) The risk of death due to complications of unsafe abortion is decreasing at both global and regional levels… This improvement is widely attributed to improved technologies, increased use of the WHO guidelines for safe abortion and post-abortion care, and greater access to safe abortion.

b) At 460 and 160 deaths per 100,000 unsafe abortions, the death rates from abortion in Africa and Asia respectively are still shockingly high.

c) The overall rate of abortions declined globally from 35 abortions per 1000 women (age 15-44 years) in 1995, to 28 per 1000 in 2003, but has remained stable at 29 per 1000 in 2008.

d) The absolute numbers of estimated abortions declined from 45.6 million in 1995 to 41. 6 million in 2003 and increased to 43.8 million in 2008. This increase in absolute numbers is attributable to stagnation in the rate of abortions from 2003 to 2008 coupled with population growth over time…

e) An estimated 86 per cent of all abortions took place in the developing world in 2008, the last year of available estimates. (p.114)

Governments committed themselves in the Programme of Action, as well as in the Key Actions for the Further Implementation of the Programme of the Action of the ICPD, to place the highest priority on preventing unwanted pregnancies, and thereby making “every attempt to eliminate the need for abortion”. (p.114)

These cases [many Eastern European countries, the Russian Federation, Cuba] underscore that access to contraception is necessary, but may not be sufficient, to reduce abortion, and other cultural behaviours may demand understanding and intervention, including the social and symbolic meaning associated with the use of contraception in certain relationships, norms for communication between partners, social expectations of sexual practice, the local meaning associated with abortion, and the risk of forced sex. (p.118)

Important gains have been made in reducing deaths due to unsafe abortion since 1994, most notably in countries that have undertaken complementary and comprehensive changes in both law and practice to treat abortion as a public health concern (see example from Uruguay…). Nonetheless, the number of abortion-related deaths has held steady in recent years even as maternal deaths overall have continued to fall. As of 2008, an estimated 47,000 maternal deaths were attributed to unsafe abortion, a decline from 69,000 deaths in 1990. But given that the number of deaths due to unsafe abortion has declined more slowly than the overall number of maternal deaths, unsafe abortions appear to account for a growing proportion of maternal deaths globally. (p.118)

Nearly all abortions in Africa (outside of Southern Africa) and in Central and South America remain unsafe (97 per cent). But even this masks dramatic differences in the risk of death due to abortion, which is 15 times higher in Africa than in Latin America and the Caribbean. It is also in Africa where the number of deaths due to unsafe abortion have declined least since 1990. The estimated decline in deaths in Latin America was from 80 to 30 per 100,000 abortions, whereas in Africa it declined

from a staggering rate of 680 to 460 deaths per 100,000 abortions (and to 520 per 100,000 in sub-Saharan Africa). (p.119)

States should take concrete measures to urgently reduce abortion-related complications and deaths by increasing access to non-discriminatory post-abortion care for all women suffering from complications of unsafe abortion and ensure that all providers take action in line with the WHO "Safe Abortion: Technical and Policy Guidelines for Health System", to deliver quality care and remove legal barriers to services. States should remove legal barriers preventing women and girls from access to safe abortion, including revising restrictions within existing abortion laws, in order to safe guard the lives of women and girls, and where legal, ensure that all women have ready access to safe, good-quality abortion services. (p.119-20) [their emphasis]

The Global Survey found that only 50 per cent of countries addressed the issue of "providing access to safe abortion services to the extent of the law" during the past five years. (p.120)

Access to safe and comprehensive abortion services and to the management of abortion complications varies widely across and within countries and regions. Regarding management of abortion complications, evidence based on MNPI data underscore that women dwelling in rural areas have significantly less access to such services across most developing countries.
When grouping countries by the current status of their abortion laws (*Most, Less, Least Restrictive*), the proportion of countries that address the issue of "preventing and managing the consequences of unsafe abortion" is lowest (72 per cent) among countries with the most restrictive laws. Likewise, only 48 per cent of countries with the most restrictive laws address the issue of "access to safe abortion to the extent of the law." (p.120)

Human rights elaborations since the ICPD: Abortion
Other soft law: Since 1994 human rights standards have evolved to strengthen and expand States' obligations regarding abortion. In a series of *Concluding Observations,* treaty monitoring bodies have highlighted the relationship between restrictive abortion laws, maternal mortality, and unsafe abortion; condemned absolute bans on abortion; and urged states to eliminate punitive measures against women and girls who undergo abortions and providers who deliver abortion services. Further, treaty monitoring bodies have emphasized that, at a minimum, state should decriminalize abortion and ensure access to abortion when the pregnancy poses a risk to a women's health or life, where there is severe fetal abnormality, and where the pregnancy is the result of rape or incest. However, the Human Rights Committee noted that such exceptions might be insufficient to ensure women's human rights, and that where abortion is legal it must be accessible, available, acceptable and of good quality. Regardless of legal status, treaty bodies have highlighted that states must ensure confidential and adequate post-abortion care. (p.120-21)

Rights Committee noted that such exceptions might be insufficient to ensure women's human rights, and that where abortion is legal it must be accessible, available, acceptable and of good quality. Regardless of legal status, treaty bodies have highlighted that states must ensure confidential and adequate post-abortion care. (p.121)

Postpartum haemorrhage (PPH), sepsis, obstructed labour, complications of unsafe abortion and hypertensive disorders, all preventable, are among the leading causes of maternal deaths. (p.122-23)

In low-income countries, infertility is often caused by sexually transmitted infections and complications from unsafe abortion. (p.123)

Lack of integration or mainstreaming of sexual and reproductive health into acute emergency responses remains a challenge. In complex emergencies, SRH often takes a back seat, and the quality and range of SRH services suffers. While the latest review by IAWG finds services more available today than ten or twenty years ago, the services are often not comprehensive, and selected components of the MISP are implemented rather than the comprehensive package. There are gaps in the availability of contraceptive methods with no long-term or permanent methods or no contraceptive services available for adolescents or unmarried people, while services addressing gender based violence (GBV), safe abortion care, post-abortion care, STIs, and adolescent SRH are still limited. (p.153)

Rates of STI and HIV infection and AIDS-related mortality; abortion-related deaths; and maternal deaths among young people reveal the urgent need to address of the inadequate access to information and services currently experienced by the largest generation of adolescents and youth in history. (p.156)

Achieve universal access to sexual and reproductive health and rights…
Concrete measures are urgently needed to:
a. Reduce unplanned pregnancies by increasing access to contraception and fulfilling the rights of women and girls to remain free from forced or coerced sex and other forms of gender based violence.
b. Ensure access to quality post-abortion care for all persons suffering from complications of unsafe abortion.
c. Take action as indicated in the WHO Guidance… to remove legal barriers to services.
d. Ensure that all women have ready access to safe, good-quality abortion services. (p.157)

The review has highlighted persistent inequalities in access to health services and resulting poor SRH outcomes for many, especially mortality and morbidity of poor women during pregnancy and childbirth, including from unsafe abortion. (p.230)

Appendix 2

Statement of the Committee on the Elimination of Discrimination against Women on sexual and reproductive health and rights: Beyond 2014 ICPD review

Fifty-seventh session, 10-28 February 2014

"Many Member States of the UN have devised innovative strategies and programmes to advance sexual and reproductive health and rights. However, across all regions, there are still serious deficiencies in the protection of these fundamental rights and freedoms. The right to health, which includes the right to bodily autonomy, and encompasses sexual and reproductive freedom, is often violated. Violence against women and girls (if not outright torture, or cruel and inhuman and degrading treatment) and the multiple and intersectional forms of discrimination based on sex and gender that they experience, impact heavily on their sexual and reproductive health and rights. The Committee continuously addresses discriminatory gender stereotypes and harmful practices that contribute to, and perpetuate, these violations. The Committee, therefore, consistently advises States parties to the Convention to take all practical and legislative measures to prevent, prohibit, punish and redress these acts, whether committed by State or non-State actors.

"Upholding the right to health for women and girls requires health services, including sexual and reproductive information, counselling and services that are available, accessible, affordable and of good quality. The Committee has observed that failure of a State party to provide services and the criminalisation of some services that only women require is a violation of women's reproductive rights and constitutes discrimination against them.

"According to the Committee, protecting human rights related to sexual and reproductive health requires that 'all health services […] be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.' Thus, the empowerment of women and their capacity to decide are at the heart of the protection of their rights in this field. The right to autonomy requires measures to guarantee the right to decide freely and responsibly on the number and spacing of their children, and the right to access sexual and reproductive health information and services with the consent of the individual alone…

*"*Measures are also required to ban and eliminate the practice of forced and child marriages, which often lead to early pregnancies that are risky for the life and/or health of girls. The provision of, *inter alia*, safe abortion and post abortion care; maternity care; timely diagnosis and treatment of sexually transmitted diseases (including HIV), breast and reproductive cancers, and infertility; as well as access to accurate and comprehensive information about sexuality and reproduction, are all part of the right to sexual and reproductive health. Furthermore, access to comprehensive services and a wide range of contraceptive methods, including emergency contraception, is a fundamental aspect of ensuring sexual and reproductive rights. States parties have obligations to enable women to prevent unwanted pregnancies, including through family planning and education on sexual and reproductive health. The Committee has also called upon State parties to address the power imbalances between men and women, which often impede women's autonomy, particularly in the exercise of choices on safe and responsible sex practices.

"Unsafe abortion is a leading cause of maternal mortality and morbidity. As such, States parties should legalize abortion at least in cases of rape, incest, threats to the life and/or health of the mother, or severe fetal impairment, as well as provide women with access to quality post-abortion care, especially in cases of complications resulting from unsafe abortions. States parties should also remove punitive measures for women who undergo abortion. States parties should further organize health services so that the exercise of conscientious objection does not impede their effective access to reproductive health care services, including abortion and post-abortion care…"

http://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/SRHR26Feb2014.pdf

Appendix 3

Some UN human rights treaty monitoring bodies' comments and recommendations in 2013

Committee on the Rights of the Child (CRC) General Comment 2013
In its *General Comment No. 15, on the right of the child to the highest attainable standard of health*, the CRC urged states to *"ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal".* (UN Doc. CRC/C/GC/15, para. 70)

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Committee on the Elimination of Discrimination against Women (CEDAW Committee) General recommendation
In its *General Recommendation No. 30 on Women in Conflict Prevention, Conflict and Post- Conflict Situations*, the CEDAW Committee urged states to *"ensure that sexual and reproductive health care includes access to ... safe abortion services..."* (UN Doc. CEDAW/C/GC/30, para. 52(c)).

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Committee against Torture (CAT Committee) expresses concern about Peru's ban on emergency contraception and physicians reporting women to the authorities for having illegal abortions
The Committee is seriously concerned that illegal abortions are one of the main causes of high maternal mortality in the State party and that the interpretation of therapeutic and legal abortion in cases of medical necessity is too restrictive and lacks clarity, leading women to seek unsafe illegal abortions. The Committee is particularly concerned at the criminalization of abortions in cases of rape and incest as well as the prohibition by the Constitutional Court of the distribution of oral emergency contraception to victims of rape. It is further concerned at the fact that the existing law obliges physicians to bring information on women resorting to post-abortion health services to the attention of the authorities and which may lead to investigation and criminal prosecution, which creates such fear of punishment that, in practice, this constitutes a denial of legal abortion services. (CAT: Peru 15 U.N. Doc CAT/C/PER/CO/5-6 (2013))

From: Reproductive Rights Rundown 2013, Center for Reproductive Rights, New York, NY USA

Appendix 4

United Nations ECLAC
First session of the Regional Conference on Population and Development in Latin America and the Caribbean
Full integration of population dynamics into rights-based sustainable development with equality: key to the Cairo Programme of Action beyond 2014
Montevideo, 12-15 August 2013

http://www.unfpa.org/webdav/site/global/shared/documents/news/2013/Montevideo%20Consensus-15Aug2013.pdf (English version)

Reaffirming that maternal mortality is an affront to human rights and recognizing that the overwhelming majority of maternal deaths are preventable,

Concerned at the high rates of maternal mortality, due largely to difficulties in obtaining access to proper sexual health and reproductive health services or to unsafe abortions, and aware that some experiences in the region have demonstrated that the penalization of abortion leads to higher rates of maternal mortality and morbidity and does not reduce the number of abortions, and that this holds the region back in its efforts to fulfil the Millennium Development Goals… (p.11)

Eliminate preventable cases of maternal morbidity and mortality, including, within the set of integrated benefits of sexual health and reproductive health services, measures for preventing and avoiding unsafe abortion, including sexual health and reproductive health education, access to modern and effective contraceptive methods, counselling and comprehensive care in cases of unwanted and unaccepted pregnancy, as well as comprehensive post-abortion care, where necessary, on the basis of a risk- and harm-reduction strategy… (p.13)

Ensure, in those cases where abortion is legal or decriminalized under the relevant national legislation, the availability of safe, good-quality abortion services for women with unwanted and unaccepted pregnancies, and urge States to consider amending their laws, regulations, strategies and public policies relating to the voluntary termination of pregnancy in order to protect the lives and health of women and adolescent girls, to improve their quality of life and to reduce the number of abortions; (p.13)

Appendix 5

Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Sixty-sixth session
Item 69 (b) of the provisional agenda
3 August 2011

Summary

"In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health considers the interaction between criminal laws and other legal restrictions relating to sexual and reproductive health and the right to health. The right to sexual and reproductive health is a fundamental part of the right to health. States must therefore ensure that this aspect of the right to health is fully realized.

"The Special Rapporteur considers the impact of criminal and other legal restrictions on abortion; conduct during pregnancy; contraception and family planning; and the provision of sexual and reproductive education and information. Some criminal and other legal restrictions in each of those areas, which are often discriminatory in nature, violate the right to health by restricting access to quality goods, services and information. They infringe human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect of decision-making and bodily integrity. Moreover, the application of such laws as a means to achieving certain public health outcomes is often ineffective and disproportionate.

"Realization of the right to health requires the removal of barriers that interfere with individual decision-making on health-related issues and with access to health services, education and information, in particular on health conditions that only affect women and girls. In cases where a barrier is created by a criminal law or other legal restriction, it is the obligation of the State to remove it. The removal of such laws and legal restrictions is not subject to resource constraints and can thus not be seen as requiring only progressive realization. Barriers arising from criminal laws and other laws and policies affecting sexual and reproductive health must therefore be immediately removed in order to ensure full enjoyment of the right to health."

http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement