14 February 2020

**RE: Committee on Economic, Social and Cultural Rights, Call for contributions on Draft Comment on Science**

To the Committee Members:

Ipas submits the following in response to the Committee’s call for contributions to a Draft General Comment on Science. Ipas is a global non-government organization dedicated to the promotion of women’s reproductive health and rights. Ipas wishes to extend our appreciation to the Committee on their work to forward an understanding of the right to sexual and reproductive health and we welcome this opportunity to contribute to the development of a general comment on science.

We wish to focus our submission on **Article 15(1)(b), the right of everyone to enjoy the benefits of scientific progress and its application**. In particular we wish to draw the Committee’s attention to the potential violations of Article 15(1)(b) that result from **criminalization of self-managed medical abortion.** With the advent of medicines for abortion, people are safely ending their pregnancies outside medical facilities with medicine, a practice called self-managed abortion. However, in most countries across the globe, self-managed abortion is criminalized.

We request that the Committee, in the General Comment on Science, (1) recognize access to medical abortion as necessary for the right to enjoy the benefits of scientific progress and its application and (2) identify criminalization of self-managed abortion as a failure to respect the right to the benefits of scientific progress and its application.

1. The right to enjoy the benefits of scientific progress and its application requires access to medical abortion

A gender sensitive approach takes into account the special characteristics and needs of women and girls and must be present throughout all steps of the application of scientific research.[[1]](#footnote-1) Further, according to CESCR General Comment No. 22 on the right to sexual and reproductive health, Article 12 of the Covenant requires that facilities, goods, information and services related to sexual and reproductive health must be sensitive to gender[[2]](#footnote-2) and that states parties ensure that “facilities, goods, information and services related to sexual and reproductive health must be of good quality, meaning that they are evidence-based and scientifically and medically appropriate and up-to-date.”[[3]](#footnote-3)

Scientifically and medically appropriate and up-to-date methods of abortion necessarily include medical abortion. Medical abortion—or abortion with pills—offers a safe and effective method for ending an unwanted pregnancy[[4]](#footnote-4) and is a method of abortion recommended by the World Health Organization.[[5]](#footnote-5) Medical abortion generally involves either a combination of the drugs mifepristone and misoprostol or misoprostol alone and both are on the World Health Organization list of essential medicines.[[6]](#footnote-6) Medical abortion care plays a crucial role in access to safe, effective and acceptable abortion care, in both high- and low-resource settings, and has contributed to more efficient use of resources.[[7]](#footnote-7)

Evidence is growing in support of the fact that people can safely use medical abortion drugs without the involvement of a healthcare professional. Deaths from unsafe abortion continue to fall and researchers have attributed self-managed abortion with medicine to a worldwide decrease in abortion mortality.[[8]](#footnote-8) The World Health Organization recommends self-managed abortion for individuals who have “a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.”[[9]](#footnote-9)

1. States parties must decriminalize self-managed abortion, to respect the right of everyone to the benefits of scientific progress and its application

Article 12 of the Convention requires that “all individuals and groups have equal access to the full range of sexual and reproductive health information, goods and services, including by removing all barriers that particular groups may face.”[[10]](#footnote-10) In General Comment 22, the Committee further states that laws that criminalize abortion undermine autonomy and the right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health.[[11]](#footnote-11) The Special Rapporteur on the Right to Health has expressed concern about legal restrictions that impede access to essential medicines, thereby limiting women’s accessibility to sexual and reproductive health.[[12]](#footnote-12)

The obligation to respect the right to health requires that States not “limit or deny anyone access to sexual and reproductive health, including through laws criminalizing sexual and reproductive health services and information.”[[13]](#footnote-13) Laws that criminalize medical abortion fail to respect not only the right to autonomy, equality, and non-discrimination, but also the right to the benefits of scientific progress and its application.

Increasingly, people seeking abortion are obtaining abortifacient medicines directly through pharmacies, drug sellers, and through new routes like online sellers or telemedicine services, rather than through the formal health care system.[[14]](#footnote-14) However, in most countries across the globe, criminal codes contain legal restrictions on self-managed abortion that violate the human rights of women and pregnant people.[[15]](#footnote-15)

Self-managed abortion is a preferred way to end a pregnancy for many people, based on their experiences and circumstances. People may self-manage their abortion in settings where termination services are restricted or access within formal health care facilities is difficult.[[16]](#footnote-16) With a dearth of health professionals willing and able to provide abortion[[17]](#footnote-17) and with certain countries facing shortages of health care workers,[[18]](#footnote-18) self-managed abortion may be the only accessible option, particularly for marginalized populations. Even where people have access to high-quality legal abortion services provided by a health care professional, they may choose to self-manage their abortion as a matter of preference because of stigma related to the circumstances of the pregnancy or having an abortion, to avoid detection by an abusive partner, or simply to have a more private and self-directed experience.

The majority of abortion laws around the world—even liberal ones—set out requirements for legal abortion that criminalize abortion services for individuals who do not meet such requirements. Legal barriers to self-managed abortion include requirements that a health professional perform the abortion,[[19]](#footnote-19) that the abortion take place within a health care facility,and barriers on provision of information and distribution of drugs.In addition, laws such as those that regulate health care professionals and disposal of fetal remains may be used by prosecutors to criminalize self-managed abortion. Even recently liberalized laws, such as that of Uruguay, contain provisions that criminalize self-managed abortion.[[20]](#footnote-20)

Limited data exists on the law enforcement experiences of people who self-manage their abortions and the people that help them. In the United States, for example, where abortion is legal through the second trimester for all indications, 21 people have been arrested for self-managing their abortions.[[21]](#footnote-21) In Bolivia and Rwanda, Ipas documented arrests of women who ended their pregnancies with pills, even where the abortion law would have deemed the reason for the abortion legal.[[22]](#footnote-22) In Bolivia, a woman was arrested when she attempted to induce abortion with pills. While she received treatment for complications, she was chained to her hospital bed with handcuffs.[[23]](#footnote-23)

Conclusion

The increasing use of medical abortion by individuals outside of formal health facilities requires specific attention by human rights treaty monitoring bodies. Human rights treaty monitoring bodies have consistently affirmed that criminalization of abortion contravenes international human rights standards.[[24]](#footnote-24) However, they have largely been silent on the growing practice of self-managed abortion and the human rights impact of its criminalization.

We request the CESCR Committee take step to address gaps in the application of human rights to the issue of self-managed abortion.

In the present instance, as the Committee drafts a General Comment on Science, we request the Committee

**(1) recognize access to medical abortion as necessary for the right to enjoy the benefits of scientific progress and its application; and**

**(2) identify criminalization of self-managed abortion as a failure to respect the right to the benefits of scientific progress and its application**

1. ESCR Committee, Draft General Comment (2020) on Science and economic, social and cultural rights, para. 40. [↑](#footnote-ref-1)
2. ESCR Committee, General Comment No. 22 (2016) on the right to sexual and reproductive health

(article 12 of the International Covenant on Economic, Social, and Cultural Rights), para. 20, U.N.

Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, Gen. Comment No. 22]. [↑](#footnote-ref-2)
3. ESCR Committee, Gen. Comment No. 22 para. 21. [↑](#footnote-ref-3)
4. Jelinska, K, and Yanow, S. Putting abortion pills into women's hands: realizing the full potential of medical abortion. Contraception, 2018, 97(2):86-89. [↑](#footnote-ref-4)
5. World Health Organization (WHO), Safe Abortion: Technical and Policy Guidance for Health Systems

21-22 (2nd ed. 2012). [↑](#footnote-ref-5)
6. World Health Organization, Model List of Essential Medicines (2019) available at https://apps.who.int/iris/bitstream/handle/10665/325771/WHO-MVP-EMP-IAU-2019.06-eng.pdf [↑](#footnote-ref-6)
7. https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1 [↑](#footnote-ref-7)
8. Ganatra, B, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, Lancet, 2017, 390(101110):2372-2381. [↑](#footnote-ref-8)
9. World Health Organization, Medical management of abortion (2018) available at https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1 [↑](#footnote-ref-9)
10. ESCR Committee, Gen. Comment No. 22, para 34. [↑](#footnote-ref-10)
11. ESCR Committee, Gen. Comment No. 22, para 34. [↑](#footnote-ref-11)
12. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, on access to medicines. U.N. Doc. A/HRC/23/42 (2013). [↑](#footnote-ref-12)
13. ESCR Committee, Gen. Comment No. 22, para 40. [↑](#footnote-ref-13)
14. Dzuba IG, Winikoff B, Pena M. Medical abortion: a path to safe, high‐quality abortion care in Latin America and the Caribbean. Eur J Contracept Reprod Health Care 2013;18:441–50; Gomperts R, van der Vleuten K, Jelinska K, da Costa CV, Gemzell‐Danielsson K, Kleiverda G. Provision of medical abortion using telemedicine in Brazil; Gomperts RJ, Jelinska K, Davies S, Gemzell‐Danielsson K, Kleiverda G. Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services. BJOG 2008;115:1171–5; discussion 5–8; Wilson KS, Garcia SG, Lara D. Misoprostol use and its impact on measuring abortion incidence and morbidity. methodologies for estimating abortion incidence and abortion‐related morbidity: a review. Guttmacher, 2010. pp. 191– 201; Footman KT, Taleb F, Dijkerman S, Mitu SA, Nuremowla S, Reiss K. Assessing the safety and effectiveness of medical abortion medications purchased from pharmacies: methodological challenges and emerging data. Paris: International Union for the Scientific Study of Population (working paper); 2016; see also Kapp, N. et al. A research agenda for moving early medical pregnancy termination over the counter, BJOG, 2017. [↑](#footnote-ref-14)
15. Office of the United Nations High Commissioner for Human Rights, *Technical guidance on the application of human rights-based approach to implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, U.N. Doc. A/HRC/21/22 (2012), para. 16., *See, also e.g.*, K.L. v. Peru*,* Human Rights Committee, Commc’n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.C. v. Peru, CEDAW Committee, Commc’n No. 22/2009, para. 8.15,U.N. Doc. CEDAW/C/50/D/22/2009 (2011); *See, e.g.*, CEDAW Committee, *Concluding Observations: Paraguay*, paras. 30, 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Chile*, paras. 34, 35, U.N. Doc. CEDAW/C/CHI/CO/5-6 (2012); ESCR Committee, *Concluding Observations: Philippines*, paras. 51, 52, U.N. Doc. E/C.12/PHL/CO5-6 (2016) Human Rights Committee, *Concluding Observations: Zambia*, para. 18, U.N. Doc.CCPR/C/ZMB/CO/3 (2007). [↑](#footnote-ref-15)
16. Sneeringer RK, Billings DL, Ganatra B, Baird TL. Roles of pharmacists in expanding access to safe and effective medical abortion in developing countries: a review of the literature. *J Public Health Policy* 2012; **33**: 218– 29. [↑](#footnote-ref-16)
17. Chavkin, W, et al., Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses, 123 INT’L J. GYNAECOLOGY & OBSTETRICS 41 (2013). [↑](#footnote-ref-17)
18. World Health Organization and Global Health Workforce Alliance. A Universal Truth: No Health Without a Workforce. (2014), available at https://www.who.int/workforcealliance/knowledge/resources/GHWA-a\_universal\_truth\_report.pdf. [↑](#footnote-ref-18)
19. In a preliminary analysis by Ipas, out of 149 countries where abortion is legal for any reason, for socio-economic reasons, or in cases of risk to health, 95 require a doctor. [↑](#footnote-ref-19)
20. Uruguay Law 18.987 on Voluntary Termination of Pregnancy. [↑](#footnote-ref-20)
21. The Self-Induced Abortion Legal Team. Roe’s Unfinished Promise: Decriminalizing Abortion Once and for All. (2018) SIA Legal Team. [↑](#footnote-ref-21)
22. Kane, G. (2015). When abortion is a crime: Rwanda. Chapel Hill, NC: Ipas. [↑](#footnote-ref-22)
23. Kane, G., Galli, B., & Skuster, P. (2013). When abortion is a crime: The threat to vulnerable women in Latin America (third ed.) Chapel Hill, NC: Ipas. [↑](#footnote-ref-23)
24. Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), (1999), paras.14, 31(c) U.N. Doc. A/54/38/Rev.1, chap. I; CEDAW Committee, General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, paras. 18, 29(c)(i) CEDAW/C/GC/35; Human Rights Committee General Comment No.36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life, para.8; Committee on Economic, Social and Cultural Rights, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), paras 34, 40, 57. [↑](#footnote-ref-24)