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Advancing Public Health and Human Rights Standards

Safe Abortion through Medical Abortion and Self-Management in Select Asian Countries

Abortion Access

Introduction

Medical abortion is recommended by the World Health Organization (WHO) as a safe and effective method of ending a pregnancy.[1] Its safety and efficacy also extends to self-managed abortions.[2] As access to misoprostol and mifepristone has grown, self-managed abortion through medical abortion has become more widely understood and considered safer.[3] However, despite its safety and efficacy, laws and policies on abortion including on medical and self-managed abortion vary and most are restrictive in nature. The lack of an enabling legal environment to guarantee access to these safe abortion methods fails to consider the specific health needs and diverse realities of pregnant persons who need abortion care, disregards the latest medical standards, and leads to serious violations of their fundamental human rights.

In this paper, we will first outline the existing public health standards and then lay down the current human rights standards on abortion including medical and self-managed abortions. Focusing on **Bangladesh, India, Nepal, Pakistan, Philippines, and Sri Lanka**, we will analyze states' compliance with these public health and human rights standards. Looking at examples of how governments have responded to the need for abortion care during the COVID-19 pandemic, we will then highlight the importance of access to medical abortion including self-managed abortion and the use of telemedicine in these settings and beyond. We will conclude by proposing specific steps that governments must undertake to address the remaining gaps and challenges to ensure abortion access particularly through self-managed medical abortion.

This publication is a collaboration between the Center for Reproductive Rights and South Asia Reproductive Justice and Accountability Initiative (SARJAI). The Center's Asia Unit[4] and SARJAI's Working Group on Abortion[5] prepared the draft with the background legal research conducted by the law firm, Ashurst LLP. The countries covered in the factsheet are countries where SARJAI partners are working in.

DEFINITION OF TERMS

Abortion covers all scenarios in which a pregnancy is deliberately terminated. It may be performed through surgical or medical methods and may be performed within or outside a health care setting by a qualified or non-qualified service provider. Its safety and efficacy depend on how it is performed and provided.

Medical abortion refers to abortion through the use of pharmacological drugs. It is also referred to as medication abortion. The recommended medications for induced abortion by WHO are the drugs mifepristone and misoprostol in combination or misoprostol alone. Both drugs are included in the WHO Model List of Essential Medicines, which means that they should be "available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and adequate information, and at a price the individual and the community can afford".[6]

Self-managed abortion refers to abortion performed through self-care interventions or one that is performed by the pregnant person without clinical

supervision. Its safety and efficacy depend on how it is performed.[7] It is based on an individual's knowledge, access to quality medicines and ability to seek follow-up care. In contexts where abortion including self-managed abortion is criminalized, an individual's safety can also depend on risk of enforcement of the laws penalizing abortion and the degree to which they may face harassment, intimidation, arrest, or prosecution when self-managing their abortion.[8]

WHO recommends self-managed abortion with medicines as a method of abortion for individuals who are less than 12 weeks pregnant and have "a source of accurate information and access to a health-care provider should they need or want it at any stage of the process".[9] Pregnant people can have a range of self-involvement in their medical abortion process, from learning about drug regimens from non-medical sources, to taking medication at home that was given to them by a doctor.[10]

Pregnant persons or those who may need abortion care include women, transgender men and nonbinary individuals who have the capacity to become pregnant.

Key Public Health Standards on Medical Abortion and Self-Managed Abortion

WHO has attributed medical abortion as playing "a crucial role in providing access to safe, effective and acceptable abortion care" more effectively in both high- and low-resource settings.[11] Since 2005, the combined use of mifepristone followed by misoprostol for medical abortion have been included on the WHO Complementary List of Essential Medicines as "important reproductive health medications to decrease maternal mortality and morbidity due to unsafe abortions".[12] In 2020, mifepristone and misoprostol became part of the WHO Core List of Essential Medicines.[13] WHO also removed the requirement for close medical supervision based on the latest scientific evidence that supervision is not necessary for their safe and effective use.[14]

In general, WHO defines self-care as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health- care provider."[15] WHO recognized self-care interventions as "among the most promising and exciting new approaches to improve health and well-being."[16] It further recognized that self-care is particularly important for populations negatively affected by gender, political, cultural, and power dynamics and for vulnerable persons.[17] Self-care interventions for abortion have also recently gained support from public health experts as studies have attributed self-managed medical abortion to a substantial decrease in abortion-related mortality and morbidity and lowered costs for treating abortion-related complications.[18] In these cases, access to information during self-managed medical abortions is crucial and may be provided through telephone hotlines or mobile phone applications.[19] Self-managed abortion is also supported by other medical bodies and experts such as the International Federation of Gynecology and Obstetrics which has recognized abortion as time-sensitive essential healthcare and has called for access to telemedicine and self-managed abortion as safe and private ways to access such needed care.[20]

The use of mifepristone and misoprostol are the safest methods of self-managed abortion. If the pregnant person can access these medicines and is able to perform the termination within 12 weeks of becoming pregnant, then the method of the abortion is likely to be 95-99% effective.[21] Under the same time scale, a misoprostol only abortion is successful in terminating the pregnancy in 71-75% of cases.[22] Studies have also been done on the safety and efficacy of medical abortion beyond 12 weeks of pregnancy.[23]

REASONS FOR SEEKING MEDICAL ABORTION AND SELF-MANAGED ABORTION

Pregnant people may prefer to self-manage their abortion for a variety of reasons, including in contexts where abortion is restricted by law or where access to abortion in the formal health care system is limited. Pregnant persons often face stigma, mistreatment and violence when seeking abortion care, as part of a pattern of violations that occur in the wider context of structural inequality, discrimination, and patriarchy.[24] Self-management of medical abortion empowers persons getting an abortion to have a role in managing their own health especially when it comes to having control over their pregnancy.[25]

A systematic review of the reasons people turn to the informal sector for abortion even where abortion is legal found that the reasons include fear of mistreatment by staff, long waiting lists, high costs, inability to fulfil regulations, privacy concerns, and lack of awareness about the legality of abortion or where to procure a safe and legal abortion.[26] When interviewed, individuals tend to cite the appeal of autonomy, control, scheduling, privacy, and having direct access to the comforts of home or supportive family members and friends throughout the process.[27]

Key International Human Rights Norms and Standards on Abortion and Medical Abortion

The right to safe abortion is a fundamental human right protected under numerous international and regional human rights treaties and national-level constitutions around the world. These instruments ground safe abortion in a constellation of rights, including: the rights to life and the highest attainable standard of health; information; autonomy; liberty; privacy; equality and non-discrimination; freedom from cruel, inhuman, and degrading treatment; and to determine the number and spacing of children. Similar to public health experts and medical professionals, human rights bodies have recognized that abortion care is essential health care. They have noted that akin to other reproductive health services, abortion must be available, accessible, affordable, acceptable, and of good quality.[28] As essential health care, states are obliged to liberalize their abortion laws and remove barriers that deny pregnant persons access to comprehensive abortion care.[29]

While no treaty monitoring body has yet addressed the specific legal and policy barriers to self-managed abortion, access to medical abortion has been recognized. Under international human rights law, access to abortion medicines is specifically protected as part of the right to health and to enjoy the benefits of scientific progress. To realize the right to health,

access to essential medicines including "medicines for abortion and for post-abortion care" must be available.[30] Human rights bodies have noted that quality of care is compromised when states fail or refuse to "incorporate technological advances and innovations in the provisions of sexual and reproductive health services" including abortion medicines.[31] On the right to enjoy the benefits of scientific progress, UN bodies have called for access to the latest scientific technologies including "medication for abortion" on the basis of non-discrimination and equality.[32]

Please see ***Annex A*** *for a summary of the current international human rights standards on abortion and medical abortion.*

EFFECTS OF LEGAL RESTRICTIONS ON MEDICAL AND SELF-MANAGED ABORTIONS

Lack of legal access to abortion care perpetuates and reinforces stigma around abortion and is likely to increase the number of pregnant persons seeking illegal and unsafe abortions. The legal status of abortion influences the number of safe and unsafe abortions in a specific jurisdiction. Legal restrictions lead many pregnant persons to seek services from unskilled providers or under unhygienic conditions, or a clandestine procedure exposing them to a significant risk of maternal mortality and morbidity.[33] However, in countries with restrictive laws, health care providers may continue to be able to render services which are illegal but safer.

Further, restrictions on self-managed medical abortion disproportionately harm pregnant persons such as in Nepal where they have been arrested for self-managing a medical abortion even when the reason for the abortion was legal.[34]

> *A 15-year-girl who got pregnant as a result of rape terminated her pregnancy at around 20 weeks by consuming medical pills bought by her father from a local pharmacist. The young girl stated before the court that she sought an abortion to safeguard her own and family's prestige. The court convicted the girl of committing an illegal abortion and sentenced her based on her admission. However, the court acquitted both the father, as he had asked her not to take the medical pills despite purchasing them for her, and the pharmacists, as their involvement was not proven.*[35]

States' Compliance with Public Health and Human Rights Standards

Access to abortion varies in the region as abortion legal frameworks range from liberal laws e.g., Nepal to highly restrictive ones e.g., Philippines. Abortion is allowed regardless of reason in Nepal up to 12 weeks of pregnancy and up to 28 weeks on certain grounds. Abortion is also expressly permitted to save the life of the pregnant person in all the focus countries except Philippines. Abortion to protect the health of the pregnant person is expressly permitted only in India, Nepal, and Pakistan. For pregnancies involving fetal impairment and those resulting from rape and incest, only Nepal and India expressly allow abortion in these cases.

Please refer to ***Annex B*** *for a comparison of the legal frameworks on abortion in the six focus countries.*

These legal frameworks clearly fall short of complying with the public health and human rights standards discussed above. They have not reduced the number of abortions and resulting deaths and injuries in the region. *Please see box on* ***Abortion in Numbers***. Examining the current laws and policies of the focus countries, most of their legal frameworks limit access to the essential medicines for abortion. For example, only India and Nepal expressly allow medical abortion and only when the pregnancy is below 7-10 weeks. Bangladesh, on the other hand, allows the use of abortion medicines for menstrual regulation only. Further, despite the safety and privacy that telemedicine and self-managed abortion provide, self-managed abortion is criminalized and the use of telemedicine for abortion is not expressly permitted by law for pregnant persons in all six countries.

In reviewing the compliance of the six states to major international human rights treaties, human rights bodies have severally expressed concerns on the limited abortion access in these countries and recommended for governments to address the discriminatory structures and barriers including legal, socio-economic, and cultural ones which prevent pregnant persons from fully accessing abortion care. The impact on maternal morbidity and mortality rates because of unsafe abortions and restrictive laws has been raised in the reviews of Nepal, Philippines, and Sri Lanka. Human rights bodies have called on governments to review their abortion laws e.g., Bangladesh, Nepal, Pakistan, Philippines, and Sri Lanka. In their efforts to reform their laws, governments e.g., Nepal and Philippines have been urged to both decriminalize abortion and legalize it on certain cases. Further, governments e.g., Bangladesh, Pakistan, Philippines, Sri Lanka have been called to guarantee access to post-abortion care, regardless of the legal status of abortion. India has also been specifically called to reform its law to address the requirement of 'consent' for all pregnant persons with disability. Meanwhile, a UN treaty body particularly described the prohibition of misoprostol in the Philippines as "indicative of the ideological environment" and having a "retrogressive impact", and urged the state to reintroduce it, in order to reduce women's maternal mortality and morbidity rates due to unsafe abortion.[36]

Please refer to ***Annex C*** *for a full list of the relevant recommendations received by the six focus countries from treaty bodies.*

ABORTION IN NUMBERS

Between 2015 and 2019, an annual average of 73.3 million induced abortions occurred worldwide.[37] Estimates from 2010 to 2014 suggest that around 45% of all abortions were unsafe.[38] Unsafe abortion accounts for 70,000 maternal deaths worldwide each year and causes a further five million women to suffer temporary or permanent disability.[39] Maternal mortality ratios (number of maternal deaths per 100,000 live births) due to complications of unsafe abortion are higher in regions with restricted abortion laws than in regions with no or few restrictions on access to safe and legal abortion.[40]

The rates for unsafe abortion for Asia are estimated to be 19 per 1,000 women aged 15–44 years.[41] It is estimated that over half of all unsafe abortions globally occur in Asia, most of them in South and Central Asia.[42] In 2014, 6% of maternal deaths (5,400) were the consequence of unsafe abortion in the sub-regions.[43]

However, because of the legal status of abortion and lack of official government data on some countries, information on the total number of abortions per country is limited. Based on available estimates, Bangladesh had 1,194,000 abortions in 2014[44] while India had between 14,100,000 and 17,300,000 abortions in 2015[45]. In 2014, around 323,100 induced abortions occurred in Nepal[46] and 2,250,087 abortions in Pakistan[47]. In the Philippines, approximately 1,261,500 abortions occurred in 2020.[48] Latest available data for Sri Lanka approximates that there are 45 per 1000 women who have abortions.[49] There is also limited data on the number of medical abortions with estimates available only for Nepal (72% of abortions)[50] and India (81% of abortions)[51]. There is no reliable data on self-managed abortions for all countries.

Access to Abortion during COVID-19 Pandemic and Beyond

The COVID-19 pandemic underscored the need for states to improve access to medical abortion and remove restrictions on telemedicine, as well as consider reforming legal frameworks on self-managed medical abortion. UN human rights experts collectively expressed concern at state authorities manipulating the COVID-19 crisis by using emergency orders to restrict women's reproductive rights, by delaying or denying access to abortion, thereby exacerbating patterns of restrictions and retrogressions in access to legal abortion care.[52] To address these barriers to abortion care, human rights bodies and experts called on states to ensure that pregnant persons have access to safe abortion and post abortion services "…at all times, through toll-free hotlines and easy-to-access procedures such as online prescriptions."[53]

Some governments have heeded this call and relaxed regulations on abortion and facilitated access to other reproductive health services by telemedicine. For example, India issued a guidance note referring to a telemedicine hub and how essential services including those relating to reproductive health were to be prioritized.[54] Although abortion in not expressly included in this guidance note, the government clarified that medical and surgical abortion facilities including post-abortion care counselling are considered essential services and therefore clinics providing these services will remain open.[55] However, India failed to take further the implementation of this note as to allow access to medical abortion through telemedicine. Meanwhile, Nepal established the Incident Command System (ICS) and a Health Cluster response to ensure that access to reproductive health and rights are protected during the pandemic. It also adopted two interim guidelines to ensure the continuity of SRH healthcare including through the use of telecommunication to provide access to safe medical abortions; encourage home visits by approved health professionals from non-government organizations; and allow pharmacies to dispense medical abortion pills.[56]

Countries in other regions have also revised their abortion regulations to respond to the pandemic. In March 2020, Ireland authorized remote consultations for medical abortion through telemedicine. [57] Self-administration of medical abortion pills has also been approved in England and now women are allowed to take medical abortion pills at their homes. [58] Most recently, in France, the maximum delay for medical abortion at home has been extended from seven to nine weeks.[59] France also released new guidelines allowing consultations for abortion care to take place via phone or internet. The guidelines also enable individuals to take both medical abortion pills at home when this is preferred by the patient and when there

are not any medical contraindications. Also, doctors and midwives have been authorized to prescribe medications by teleconsultation, and access to medical abortion for home use has been extended from seven to nine weeks of pregnancy.[60] Other countries in other parts of Europe such as in Ireland, and in some parts of the United Kingdom except for Northern Ireland have also adopted similar measures to provide remote consultations prior to abortion and self-administration at home of medical abortion pills.[61] To ensure and expand access to abortion care beyond the COVID-19 pandemic, temporary and interim measures allowing telemedicine, self-managed abortion, and medical abortion must be made permanent.

Recommendations

Pregnant persons in Bangladesh, India, Nepal, Pakistan, Philippines, and Sri Lanka continue to face legal, policy, and practical barriers when seeking abortion care. The challenges that they have to overcome when seeking this essential health care are heightened in cases of medical abortion and self-managed abortion as most of the national legal frameworks highly restrict, if not criminalize, access to them. As a time-sensitive reproductive health care service, effective access to abortion is crucial to sustain at all times particularly in humanitarian settings and including during declarations of pandemics and lockdowns.

Based on the current public health and human rights standards, states must create enabling environments where pregnant persons are not at risk of discrimination, harassment, abuse, arrest, or prosecution for self-managing medical abortion. Governments also have the obligation to provide information and access to scientifically proven, safe, and effective methods of self-managed abortion, and access to medical abortion. To respect, protect, and fulfill the fundamental rights of pregnant persons seeking abortion, states must ensure that all forms of abortion regulations and legal protections are consistent with established public health and human rights standards and expand abortion access including through self-managed medical abortion. Specifically, governments must take immediate steps to:

1. Decriminalize and legalize abortion on request, including self-managed medical abortion, and adopt measures to ensure access to all methods of abortion for everyone who needs one.

2. Guarantee access to abortion pills and information particularly essential medicines for abortion e.g., mifepristone and misoprostol without need for close medical supervision as per WHO guidance and, at the minimum, ensuring their registration in national drug formularies and/or essential medicines list.

3. Repeal legal frameworks which act as barriers to the availability, accessibility, acceptability and quality of medical abortion services and information including by removing medically unnecessary requirements such as third-party consent requirements and repealing provisions criminalizing self-managed abortions.

4. Recognize abortion as an essential health service and ensure the continuity of its provision, including in humanitarian settings, by facilitating abortion access through telemedicine.

5. Ensure non-discriminatory access to post abortion care irrespective of the legal status of abortion including in medical and self-managed abortions.

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Annex A

Key Human Rights Standards on Abortion and Medical Abortion

In this chart, we outline the key human rights norms and standards on abortion and medical abortion from six treaty bodies i.e., Committee on the Elimination of Discrimination Against Women (CEDAW Committee), Committee on Economic, Social, and Cultural Rights (ESCR Committee), Human Rights Committee (HRC), Committee on the Rights of the Child (CRC Committee) and the Committee Against Torture (CAT Committee) and the Committee on the Rights of Persons with Disabilities (CRPD Committee). No treaty monitoring body has yet addressed the specific legal, policy, and other structural barriers to self-managed abortion.

For more information on the standards and jurisprudence from treaty bodies, please see ***Center for Reproductive Rights, Breaking Ground (2020),*** *available at* https://reproductiverights.org/breaking-ground-2020-treaty-monitoring-bodies-on-reproductive-rights/.

RIGHT TO LIFE

Abortion

ESCR Committee

- Lack of access to abortion services can lead to death or injury, which in turn constitutes a violation of the right to life.[62]

HRC

- “States may not regulate pregnancy or abortion…in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and they should revise their abortion laws accordingly.”[63]
- “States parties should give information on any measures taken by the state to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions.”[64]
- “States parties should not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion.”[65]
- “States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable”.[66]

RIGHT TO HEALTH	**Abortion** **CEDAW Committee** • "Laws that criminalize medical procedures only needed by women [and] punish women who undergo those procedures is a barrier to women's access to appropriate health care."[67] **ESCR Committee** • Abortion must be decriminalized, legalized at least on certain grounds, and services must be available, accessible, affordable, acceptable, and of good quality.[68]
	Medical Abortion **ESCR Committee** • Access to medicines on the WHO Model List of Essential Medicines is a core obligation of the right to health.[69] • States have the obligation to ensure access to essential medicines including medicines for abortion and post-abortion care.[70] • States must ensure access to up-to-date scientific technologies necessary for women in relation to the right to sexual and reproductive health, in particular medication for abortion, on the basis of non-discrimination and equality.[71]
RIGHT TO EQUALITY AND NON-DISCRIMINATION	**Abortion** **CEDAW Committee** • Measures to eliminate discrimination are inappropriate if "a health-care system lacks services to prevent, detect and treat illnesses specific to women." It is discriminatory for a state party to refuse to provide women with reproductive health services where such services are legal.[72] • "States should refrain from obstructing action taken by women in pursuit of their health goals."[73] • Laws criminalizing medical procedures needed only by women are discriminatory. Governments should remove punitive provisions imposed on women who undergo such procedures, including abortion.[74] **ESCR Committee** • To ensure non-discrimination against women, governments must remove barriers to reproductive health services, education, and information. States have an "immediate obligation" to address such discrimination in health care.[75] **HRC** • States' compliance with the obligation to ensure non-discrimination in women's enjoyment of the right to life is reflected in information on pregnancy-related deaths as well as on steps taken by governments to prevent unwanted pregnancies and to ensure women do not have to resort to clandestine abortions.[76] **CRPD Committee** • Repeal discriminatory laws, policies, and practices, prohibit all forms of forced sterilization, forced abortion and non-consensual birth control,[77] and adopt affirmative action measures in relation to sexual health and reproductive rights for women and girls with disabilities.[78]

FREEDOM FROM TORTURE AND ILL-TREATMENT	**Abortion** **HRC** • States must provide access to safe abortion for women who became pregnant as a result of rape and prevent forced abortion.[79] • States should at least, provide exceptions in legislation for victims of rape, incest, fatal fetal abnormality, or other serious health risks.[80] • Restrictions on the ability of women or girls to seek abortion must not, among others, jeopardize their lives, subject them to physical or mental pain or suffering which violates the right to be free from torture and ill-treatment, discriminate against them, or arbitrarily interfere with their privacy.[81] **CAT Committee** • When a pregnancy is the result of gender-based violence, denying or prohibiting access to abortion could cause the woman to constantly relive the violation against her and also "causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression."[82]
RIGHT TO PRIVACY	**Abortion** **HRC** • States fail to respect the right to privacy in relation to women's reproductive functions when they "impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion".[83] **CRC Committee** • Parental consent requirements and lack of confidentiality can obstruct access to accurate reproductive health information and abortion services.[84]
RIGHT TO INFORMATION	**Abortion** **HRC** • States must provide access "to quality and evidence-based information and education on sexual and reproductive health."[85] **ESCR Committee** • States should guarantee access to quality, evidence-based sexual and reproductive health education including abortion and post-abortion care. The right to information extends to all individuals and groups including adolescents and youth.[86] **CRPD Committee** • Special measures should be established to ensure that people with disabilities, including transgender and gender-diverse persons with disabilities, have equal access to health services, including surgical and medical abortion services.[87]

RIGHT TO ENJOY THE BENEFITS OF SCIENTIFIC PROGRESS	**Abortion** **ESCR Committee** • States parties should ensure access to medication for abortion on the basis of non-discrimination and equality. "The failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, such as medication for abortion…jeopardizes the quality of care."[88] • States parties must ensure access to up-to-date scientific technologies necessary for women in relation to this right.[89] • Special attention should be given to the protection of women's free, prior and informed consent in treatments or scientific research on sexual and reproductive health.[90] • All persons have a right to enjoy the benefits of scientific progress and its applications, including pharmaceutical and medical advancements.[91]
RIGHT TO BODILY AUTONOMY	**Abortion** **CEDAW Committee** • Conditioning women's access to abortion on the authorization of husbands, partners, parents, or health authorities is also a significant barrier to women's pursuit of their health and life goals.[92] **ESCR Committee** • States must "liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health."[93] **CRPD Committee** • States must ensure that all women and girls with disabilities can exercise their legal capacity by making their own decisions (with support when desired) with regard to medical and/or therapeutic treatment, including decisions on retaining their fertility, reproductive autonomy, their right to choose the number and spacing of children, to consent and accept a statement of fatherhood, and the right to establish relationships.[94]

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Annex B

Summary of Abortion-related Laws and Policies in Focus Countries

In this chart, we lay down the relevant legal provisions on abortion, medical abortion, and self-management of medical abortion in the six focus countries. As reflected below, abortion remains highly restricted and criminal law is largely used to regulate access to it. Pregnant persons who self-manage abortion are penalized in all countries. Medical abortion is only expressly allowed in India and Nepal while Bangladesh allows the use of misoprostol and mifepristone for menstrual regulation procedures. However, there is little clarity in practice even when self-managed medical abortion is available in limited circumstances in Bangladesh and India. Further, the use of telemedicine for abortion access is not expressly allowed under the laws of the six focus countries.

Key sources used for this chart are ***Center for Reproductive Rights, World Abortion Laws Map*** available at https://maps.reproductiverights.org/worldabortionlaws and ***World Health Organization, Global Abortion Policies Database*** available at https://abortion-policies.srhr.org/.

Legend: Yes (green) · No (red) · Limited circumstances (orange) · Silent (dark blue)

Bangladesh	India	Nepal	Pakistan	Philippines	Sri Lanka
Law expressly allows abortion on request/demand regardless of reason					
No	No	Yes Up to 12 weeks	No	No	No
Law expressly allows abortion to save the life of pregnant person/women					
Yes At any stage	Yes At any stage	Yes Up to 28 weeks	Yes Up to 120 days	Limited circumstances As a justifying circumstance i.e., defense of necessity	Yes Only in good faith
Law expressly allows abortion to protect the health of pregnant person/women					
No	Yes Up to 20 weeks (generally) Up to 24 weeks (for specific categories yet to be prescribed by Rules) if there is risk of grave injury to the pregnant woman's physical and mental health	Yes Up to 28 weeks	Yes At any stage for necessary treatment	Limited circumstances As a justifying circumstance i.e., defense of necessity	No

Bangladesh	India	Nepal	Pakistan	Philippines	Sri Lanka
Law expressly allows abortion in cases of serious fetal impairment					
● (red)	● (green) At any stage, if diagnosed by a Medical Board	● (green) Up to 28 weeks	● (red)	● (red)	● (red)
Law expressly allows abortion in cases of pregnancies resulting from rape or incest					
● (red)	● (green) Up to 24 weeks	● (green) Up to 28 weeks	● (red)	● (red)	● (red)
Law expressly requires third-party/parental consent to access abortion					
● (dark blue) Hospitals however require parental or guardian/ accompanying person consent for menstrual regulation of a minor	● (green) Parental or guardian or spousal consent if pregnant person is under 18 or mentally ill	● (green) Parental or guardian consent if pregnant person is under 18, unsound mind, or unable to give consent	● (dark blue)	● (dark blue)	● (dark blue)
Law expressly guarantees post- abortion care					
● (dark blue)	● (green)	● (green)	● (orange) As a policy in Punjab province only	● (green)	● (green)
Law expressly allows telehealth for abortion access					
● (red)	● (red) While COVID-19 related telemedicine guidelines did not include abortion, it was declared as an essential service	● (red) Proposed under the draft safe abortion service program implementation procedural guidelines	● (red)	● (red)	● (red)
Law expressly allows medical abortion					
● (orange) Allows “menstrual regulation with medication” (MRM)	● (green) Under the MTP Rules, up to 7 weeks and must be performed in a clinical setting.	● (green) Up to 10 weeks by listed providers	● (red)	● (red)	● (red)

Bangladesh	India	Nepal	Pakistan	Philippines	Sri Lanka
Law expressly allows self-management of medical abortion					
🟠 Only the second pill for MRM may be taken in a non-clinical setting.	🟠 Only misoprostol can be allowed for home administration following a dose of mifepristone at the medical facility up to 9 weeks	🔴 Proposed in draft safe abortion service program implementation procedural guidelines	🔴	🔴	🔴
Misoprostol registered in the national drug formulary and/or essential medicines list for abortion use					
🟢 Registered for termination of pregnancy following mifepristone	🟢	🟢 Approved for abortion services only in listed sites	🔴 Registered for post-partum hemorrhage and stomach ulcers	🔴	🔴 Registered for inducing labor
Mifepristone registered in the national drug formulary and/or essential medicines list for abortion use					
🟢 Allowed for medical termination of intrauterine pregnancies up to 49 days gestation	🟢 Approved for use up to 9 weeks of gestation	🟢 Approved for abortion services only in listed sites	🔴	🔴	🔴
Law penalizes pregnant persons for self-managing abortion					
🟢 Up to 3 years imprisonment or 7 years imprisonment if pregnant woman is “quick with child”	🟢 Up to 3 years imprisonment or 7 years imprisonment if pregnant woman is “quick with child”	🟢 Imprisonment ranging from 1-5 years depending on the weeks of gestation	🟢 Up to 3 years imprisonment	🟢 Up to 6 years imprisonment	🟢 Up to 3 years imprisonment or 7 years imprisonment if pregnant person is “quick with child”

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Annex C

Summary of Concluding Observations and Recommendations on Abortion

This table enumerates the concerns and recommendations related to abortion received from different treaty bodies and the Human Rights Council on Universal Periodic Review by the six focus countries. Among the list, Philippines is the only country which had received a recommendation related to medical abortion. No country has received any express recommendation on self-managed abortion. Nepal is the sole country among the focus countries which has received and accepted a recommendation on abortion from the Human Rights Council, as part of its Universal Periodic Review.

	Abortion
BANGLADESH	**CEDAW Committee** • "Legalize abortion, at least in cases involving rape, incest, risk to the life or health of the pregnant woman or severe fetal impairment, decriminalizing abortion in all other cases, as well as provide women with access to high-quality post-abortion care, especially in cases involving complications resulting from unsafe abortions, and also remove punitive measures for women who undergo abortion."[95] **HRC** • "Revise its legislation to provide for additional exceptions to the legal ban on abortion, including in cases of rape, incest, fatal fetal impairment and for therapeutic reasons, and to ensure that women are not denied medical services and are not prompted by legal obstacles, including criminal provisions, to resort to unsafe abortions that put their lives and health at risk."[96] **CAT Committee** • "Review its legislation in order to allow for legal exceptions to the prohibition of abortion in specific circumstances in which the continuation of pregnancy is likely to result in severe pain and suffering, such as when the pregnancy is the result of rape or incest, or in cases of fatal fetal impairment, ensure the provision of post-abortion health care for women, irrespective of whether they have undergone an illegal or legal abortion, and ensure that neither patients nor their doctors face criminal sanctions or other threats for seeking or providing such care."[97]

INDIA	**Abortion** **CEDAW Committee** • "Provide women with access to high-quality and safe abortion services, including to manage complications arising from unsafe abortion, and to increase access to and use of effective and affordable methods of contraception, including by subsidizing them, in order to reduce the use of abortion as a method of family planning."[98] **CRC Committee** • "Take measures to ensure that adolescent girls and boys have effective access to confidential sexual and reproductive health information and services, such as modern contraception and legal abortions for girls, in practice. In that context, the State party should guarantee that the views of pregnant teenagers are always heard and respected in abortion decisions."[99] **CRPD Committee** • Repeal exception to the legal requirement of consent to abortion in women with "severe" disabilities and legislation authorizing medical treatment based on third-party consent and provide all persons with disabilities with supported decision-making mechanisms for expressing prior and informed consent to medical treatment.[100]
NEPAL	**Abortion** **CEDAW Committee** • "Amend the Safe Motherhood and Reproductive Health Rights Act to fully decriminalize abortion in all cases, to legalize it at least in case of risk to the health of the mother, in addition to the cases for which it is already legalized, including in cases of rape, incest, severe fetal impairment, and risk to the life of the mother, and allocate sufficient resources to raise awareness of safe abortion clinics and services."[101] **ESCR Committee** • "Concerned that, in spite of the positive interventions by the State party to improve maternity services and neonatal care, approximately 5 per cent of maternal deaths are caused by unsafe abortions or antepartum haemorrhage, owing to low awareness of the legality of abortion and the existence of safe abortion services as well as the lack of access to trained health assistants and adequate services, which leads many women, in particular those living in rural areas and from disadvantaged and marginalized groups, to seek unsafe abortions."[102] • "Ensure access to sexual and reproductive health services and to safe abortion services."[103] **Human Rights Council** • Decriminalize abortion and concretely protect the rights and sexual and reproductive health of women and girls.[104]

PAKISTAN	**Abortion** **CEDAW Committee** • "Review its abortion legislation with a view to legalizing abortion in cases of rape, incest, threat to the life or health of the pregnant woman or severe fetal impairment, and with a view to decriminalizing it in all other cases, and prepare guidelines to ensure that women and girls have access to safe post-abortion care."[105] **ESCR Committee** • "Amend its legislation on abortion to ensure its compatibility with other fundamental rights, such as women's rights to life and physical and mental health, that it broaden the permitted circumstances for legal abortion and that it not make women undergoing abortion criminally liable."[106] • "Ensure that women are able to easily access post-abortion health-care services."[107] **HRC** • "Review its legislation to ensure that legal restrictions do not prompt women to resort to unsafe abortions that may endanger their lives and health. It should also take all measures necessary to combat the stigma associated with abortion; ensure the provision of safe voluntary termination of pregnancy by trained medical providers; and ensure ready and affordable access to post-abortion health-care services throughout the country."[108] **CRC Committee** • "Review its legislation with a view to ensuring that children, including unmarried girls, have access to contraception, safe abortion and post-abortion care services, and that the views of girls should always heard and respected in abortion-related decisions."[109]
PHILIPPINES	**Abortion** **CEDAW Committee** • "Consider reviewing the laws relating to abortion with a view to removing punitive provisions imposed on women who have abortions and provide them with access to quality services for the management of complications arising from unsafe abortions."[110] • "Amend articles 256 to 259 of its Criminal Code in order to legalize abortion in cases of rape, incest, threats to the life and/or health of the mother, or serious malformation of the foetus and to decriminalize all other cases in which women undergo abortion, as well as to adopt the procedural rules necessary to guarantee effective access to legal abortion."[111] **ESCR Committee** • "Concerned that under state party's legal system, abortion is illegal in all circumstances, even when the woman's life or health is in danger or pregnancy is the result of rape or incest, and that complications from unsafe, clandestine abortions are among the principal causes of maternal deaths. State party should address, as a matter of priority, the problem of maternal deaths as a result of clandestine abortions and consider reviewing its legislation criminalising abortion in all circumstances."[112]

PHILIPPINES	**HRC** • "Regrets the absolute ban on abortions, which compels pregnant women to seek clandestine and harmful abortion services, and accounts for a significant number of maternal deaths. State party should review its legislation with a view to making provision for exceptions to the prohibition of abortion, such as protection of life or health of the mother, and pregnancy resulting from rape or incest, to prevent women from having to seek clandestine harmful abortions."[113] **CAT Committee** • "Review its legislation to allow for legal exceptions to the prohibition of abortions in specific circumstances such as when the pregnancy endangers the life or health of the woman, when it is the result of rape or incest and in cases of foetal impairment."[114] **Medical Abortion** **CEDAW Committee** • "Provide women with access to high-quality post-abortion care in all public health facilities, especially in case of complications resulting from unsafe abortions, including by reintroducing misoprostol, to reduce women's maternal mortality and morbidity rates."[115]
SRI LANKA	**Abortion** **CEDAW Committee** • "Amend its legislation to legalize abortion not only in cases in which the life of the pregnant woman is threatened, but also in all cases of rape, incest and severe fetal impairment, and to decriminalize abortion in all other cases; remove barriers to women's access safe abortion services, such as the requirement of a judicial inquiry as to whether there should be a medical termination of the pregnancy and the need for a medical certificate authorizing an abortion."[116] **ESCR Committee** • "Amend abortion laws and to consider providing for exceptions to the prohibition on abortion in cases of therapeutic abortion or pregnancies resulting from rape or incest to help women not to have to resort to illegal abortions that expose them to a high risk of morbidity and mortality."[117] • "Establish basic sexual and reproductive health services throughout the state party, to set up comprehensive educational programmes on sexual and reproductive health, including public awareness-raising campaigns about safe contraceptive methods programmes and inclusion of appropriate information on sexual and reproductive health in the curricula of the Sri Lankan education system."[118] **HRC** • "Revise its legislation on abortion by making further exceptions to the ban on abortion, including for therapeutic reasons and cases where the pregnancy is the result of rape or incest."[119] **CRC Committee** • "Ensure access to safe and confidential abortion without stigmatization and post-abortion care services for adolescent girls, making sure that their views are always heard and given due consideration."[120]

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5 South Asia Reproductive Justice and Accountability Initiative (SARJAI) is a network of organizations, independent lawyers and legal experts from the region working to advance reproductive rights. Members of SARJAI's Working Group on Abortion are Naripokkho (Samia Afrin), Bangladesh; Dr. Syeda Nasrin, Lawyer, Bangladesh; ARROW (Garima Shrivastava), Malaysia; Hidden Pockets (Jasmine George) India; The YP Foundation (Souvik Pyne), India; Shruti Arora, Youth Activist, India; Anubha Rastogi, Lawyer, India; Asha Bajpai, Professor, India; Pratigya Campaign (Debanjana Chaudhary), India; Forum for Women, Law, and Development (FWLD) (Sabin Shrestha), Nepal; Greenstar Social Marketing and Pakistan Alliance for Post-Abortion Care (Dr. Sana Durvesh), Pakistan; and Center for Equality and Justice (Shyamala Gomez), Sri Lanka.
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