Unsafe abortion accounts for approximately 13% of the global burden of maternal mortality, or an estimated 47,000 maternal deaths, and 5 million hospitalizations per year. The World Health Organization (WHO) defines unsafe abortion as “a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both.” Refugees and internally displaced persons (IDPs) are particularly vulnerable to unintended pregnancies and unsafe abortions as a result of increased sexual violence, along with disruptions or absence of health services, including family planning (FP), safe abortion care (SAC), and post-abortion care (PAC). UNPFPA estimates that 25-50% of maternal deaths in refugee settings are due to complications of unsafe abortion.

**Influences on Safe Abortion Provision in Humanitarian Settings**

**International law**

**Human rights law:** The international community recognized the need to address unsafe abortion at the 1994 International Conference on Population and Development (ICPD) in Cairo (Principle 8). Further, international human rights treaties uphold rights relevant to SAC access, including:

- **Universal Declaration of Human Rights:** upholds the “right to life, liberty and security of person” (Art. 2 & 3).
- **International Covenant on Civil and Political Rights:** maintains the right to privacy (Art. 17.1);
- **International Covenant on Economic, Social and Cultural Rights:** affirms the right to health (Art. 12.1);
- **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW):** recognizes women’s “right to decide on the number and spacing of their children” (Art. 16.1).

**Humanitarian law:** Article 3 of the Geneva Conventions, which covers the rights of the “wounded and sick” during armed conflicts has been interpreted to include the availability of SAC as part of rightful medical care for women who have been raped. This article and its elaborations are considered customary international law and binding on all actors in a conflict situation. Denial of safe abortion to a rape survivor can be considered in violation of her rights to care and humane treatment. Medical providers caring for rape survivors during armed conflicts are immune from prosecution under domestic law. In 2013, the UN Security Council unanimously adopted Resolution 2106 (later reinforced by Resolution 2122), which cites the “need for access to the full range of sexual and reproductive health services, including regarding pregnancies resulting from rape, without discrimination.” These recent Resolutions build on prior Security Council Resolutions 1325 and 1820, which aim to strengthen protections for women and girls in conflict.

**The African Union: Maputo Protocol**

**The Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (Maputo Protocol) was developed in 2003.**

Countries that have ratified the Maputo Protocol are obligated to “protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.”

It has been signed and ratified by 36 African Union member states and signed by an additional 15; three member states have yet to sign the Protocol.

**National law**

Although national abortion laws differ, 99% of the world’s population lives in countries where abortion is permitted under one or more circumstances. There are only 6 countries that prohibit abortion under all circumstances (Chile, Dominican Republic, El Salvador, the Holy See, Malta, and Nicaragua).

**Circumstances in which abortion is allowed**

<table>
<thead>
<tr>
<th>National law permits abortion under the following circumstances:</th>
<th>Number of countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>To save the life of the woman*</td>
<td>60</td>
</tr>
<tr>
<td>To preserve health*</td>
<td>59</td>
</tr>
<tr>
<td>For economic or social reasons*</td>
<td>13</td>
</tr>
<tr>
<td>Without restriction*</td>
<td>61</td>
</tr>
<tr>
<td>Prohibited in all circumstances*</td>
<td>6</td>
</tr>
</tbody>
</table>

*Circumstances are cumulatively inclusive, i.e. each category includes that specific circumstance in ADDITION to the more restrictive categories above.

**On-the-ground practices**

Access to safe abortion care varies widely by country, and many countries experiencing humanitarian emergencies continue to fall short of following best practices. In particular, legal and supply barriers may hinder access to the least invasive methods of SAC, creating unnecessary health risks.

Use of misoprostol, both in combination with mifepristone and alone, has increased, resulting in a shift toward increasing use of medical rather than surgical methods of abortion. However, neither misoprostol nor mifepristone is registered for this purpose in most low-resource settings. Similarly, while vacuum aspiration is recommended by WHO as the preferred method for surgical procedures, access to manual and electric vacuum aspirators varies greatly. As a result, health providers in most low resource settings continue to rely primarily on the more invasive dilatation and curettage (D&C).

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Additional factors that shape the relative safety of abortion procedures include: availability of trained providers, cost of services, stigma surrounding the procedure, the degree to which restrictive laws are enforced, and providers’ understanding of the legal grounds under which the procedure may be performed.1

Humanitarian guidelines

The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings includes a specific chapter on Comprehensive Abortion Care, and the WHO/UNHCR Clinical Management of Rape Survivors manual for refugees and IDPs, includes the delivery of safe abortion information and options whenever possible. In 2013, the UN Committee on CEDAW, an expert body charged with monitoring the progress of women’s issues covered under CEDAW, issued General recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, recommending that SAC and PAC be included in comprehensive sexual and reproductive health services offered in crisis settings.20

WHO Guidance on safe abortion

Policy: WHO recognizes unsafe abortion as a public health threat, and advises governments to ensure that safe and affordable abortion services are available to the full extent of the law, with regular updates to evidence-based policy and programming guidance, noting that the cost of integrating safe abortion into existing health services “is likely to be low, relative to the costs to the health system of treating complications of unsafe abortion.”21

Medical methods: Misoprostol is included on WHO’s model Essential Medicines List (EML) for prevention and treatment of postpartum hemorrhage and PAC. WHO further recommends that misoprostol and mifepristone be included in national EMLs for use in induced medical abortion and PAC where national law and custom permit.22

Surgical methods: The WHO advises the use of manual vacuum aspiration (MVA) and electric vacuum aspiration (EVA) as preferred surgical methods for both safe abortion and PAC.23

Donor policies

United States: The United States is the largest national donor for humanitarian aid. The 1973 Helms Amendment forbids the use of U.S. government funds “to pay for the performance of abortion as a method of family planning (FP) or to motivate or coerce any person to practice abortions.”24 Provision of abortion for non-FP reasons is not forbidden by the amendment. However, administrative policy within the United States Agency for International Development (USAID) effectively prohibits the use of U.S. government funds to provide abortion services under any circumstances.25 Under the Helms Amendment, an organization can still use funding from other sources to provide SAC and organizations are permitted to provide information or counseling on pregnancy options as “consistent with local law.”26 The Helms Amendment does not restrict provision of PAC.27 If an organization does not receive U.S. government funds, the Helms Amendment does not apply to its activities.

The Mexico City Policy, also known as the “Global Gag Rule,” was repealed in 2009. When in place, it barred non-U.S.-based grantees from engaging in abortion-related activities, including with funds from other sources.28

United Kingdom: The UK, a major source of bilateral and multilateral humanitarian assistance funding, has publicly acknowledged that it expects all recipients of UK humanitarian aid to treat survivors of rape during conflict according to international humanitarian law rather than national law.27 This stance was further elaborated in a 2011 practice paper in which DFID, the UK development assistance agency, indicates that it will support activities to improve the quality, safety, and accessibility of abortion services in settings where it is legal, as well as certain locally-led efforts to enable legal and policy reform in settings where restrictions on abortion contribute to high maternal mortality and morbidity.28

Advocacy: A coalition of NGOs, led by the Center for Health and Gender Equity (CHANGE) is participating in Break the Barriers, a campaign that advocates for the U.S. government to reinterpret the Helms Amendment.29 In addition, the global August 12th Campaign, with support from the European Parliament, Norway and the UK, is working to ensure that women in crisis settings have access to SAC. It calls on the U.S. to lift its ban on funding for abortion services, and urges all bilateral and multilateral donors to fulfill their obligations under the Geneva Conventions by including explicit provisions for SAC for rape survivors in their humanitarian assistance policies.30 During the ICPD Beyond 2014 review process, a number of prominent gender/reproductive rights advocacy bodies, including the UN Committee on CEDAW, have promoted safe abortion as a critical component for the reduction of global maternal morbidity and mortality. The outcomes of the review will influence the inclusion of safe abortion provisions in the Sustainable Development Goals (SDGs), which will be finalised in September 2015.31,32

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