

31 August 2020

Re: Call for submissions: Women's and girls' sexual and reproductive health and rights in situations of crisis

## **UN Working Group on discrimination against women and girls**

Dear members of the Working Group, we are writing to you regarding the call for contributions to the thematic report on women's and girls' sexual and reproductive health and rights (SRHR) in situations of crisis, to be presented in the 47th session of the Human Rights Council in June 2021.

This submission aims to provide the WG with good practices to ensure timely, safe, effective and acceptable access to medical abortion services, which in turn reflect a long-standing trend towards the demedicalization of women's rights.

In a joint press-statement issued in early May, dozens of country representatives expressed that sexual and reproductive health needs “must be prioritized to ensure continuity” and called for governments “to ensure full and unimpeded access to all sexual and reproductive health services for all women and girls”.<sup>1</sup> In line with this, the World Health Organization defined sexual and reproductive care as essential health services to be assured in the context of the COVID-19 pandemic. It urged States to reduce barriers that could delay care, consider the option of using noninvasive medical methods and “minimize facility visits and provider–client contacts through the use of telemedicine and self-management approaches.”<sup>2</sup>

As a way to tackle the difficulties posed by the current health crisis -especially those arising from the confinement measures and to avoid crowding health facilities- some countries temporarily lifted some of the non-therapeutic restrictions for access to medical abortions, allowing self-managed medical abortions at home.

These decisions are consistent with scientific evidence over self-managed medical abortion's safety and effectivity, as well as with the State's human rights obligations over the accessibility and acceptability of sexual and reproductive health goods and services and women's dignity and autonomy.

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<sup>1</sup> Government Offices of Sweden, *Joint press statement Protecting Sexual and Reproductive Health and Rights and Promoting Gender-responsiveness in the COVID-19 crisis*, (May 06, 2020). Available at <https://www.government.se/statements/2020/05/joint-press-statement-protecting-sexual-and-reproductive-health-and-rights-and-promoting-gender-responsiveness-in-the-covid-19-crisis/>

<sup>2</sup> World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context* (Geneva: WHO, 2020), p. 29. Available at <https://www.who.int/publications/i/item/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak>

## Self-managed medical abortion safety and acceptability

The pervasiveness of the over-medicalization of women's rights is incompatible with international human rights law and with the standard of health services' acceptability, which requires that health regulations are governed by scientific and therapeutic considerations, not based on ideological or essentialist conceptions of women. This UN Working Group has already expressed special concern in this regard, warning against laws and policies that “provide for overmedicalization of certain services that women need to preserve their health without a justified medical reason”.<sup>3</sup>

Numerous studies have shown that medical abortion outside of health facilities is a safe, effective, and acceptable method for women who choose to terminate their pregnancy. A 2011 review found that “there is no evidence that home-based medical abortion is less effective, safe or acceptable than clinic-based medical abortion”. The review examined three acceptability criteria -satisfaction with the method, likelihood of choosing it again and likelihood of recommending it to a friend- and noted that home-based medical abortion may actually improve the acceptability of abortion by allowing for greater privacy, giving women more control over the timing and making it possible for family or friends to be present to provide emotional support.<sup>4</sup> Likewise, it's been found that the possibility to take the pills at home “could enhance patient autonomy and privacy, and could provide women an opportunity to start the process with a partner or friend”.<sup>5</sup> A qualitative study on misoprostol-only self-use conducted in Argentina -where abortion is legally restricted and mifepristone is not available- revealed that women greatly appreciated the possibility of keeping their abortions private and being able to choose the day, place and time to perform it. Also, they valued having the abortion without the intervention of strangers and without a surgical procedure, and the chance of being looked after by someone they chose, involving their partners, family and/or friends in the process. These women chose self-managed medical abortion after a thoughtful process of decision-making, driven by the perceived advantages of the pills use.<sup>6</sup> These findings are consistent with previous studies on women's experiences with medical abortion in Argentina and aligned with women's experiences reviews in other legally restricted contexts.<sup>7</sup> This is also consistent with self-managed approaches endorsed by the World Health Organization.

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<sup>3</sup> UN Working Group on the issue of discrimination against women in law and in practice, UN Doc. No. A/HRC/32/44 (2016), para. 74

<sup>4</sup> T. D Ngo, M. Hae Park, H. Shakur and C. Free, “Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: A systematic review,” *Bulletin of the World Health Organization* 89:5 (2011), pp. 360-70. DOI: 10.2471/BLT.10.084046.

<sup>5</sup> E. Chong, L. Frye, J. Castle, et al., “A prospective, non-randomized study of home-use of mifepristone for medical abortion in the U.S.,” *Contraception* 92/3 (2015), pp. 215-9. DOI: 10.1016/j.contraception.2015.06.026.

<sup>6</sup> S. Ramos, M. Romero and L. Aizenberg, “Women's experiences with the use of medical abortion in a legally restricted context: the case of Argentina,” *Reproductive Health Matters* 22/sup44 (2014), pp. 4-15, DOI: 10.1016/S0968-8080(14)43786-8.

<sup>7</sup> N. Zamberlin, M. Romero and S. Ramos, “Latin American women's experiences with medical abortion in settings where abortion is legally restricted,” *Reproductive Health* 9/34 (2012), pp. 1-11; M. Lafaurie, D. Grossman, E. Troncoso, et al., “Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and

According to the World Health Organization medical abortion plays a crucial role in providing access to safe, effective and acceptable abortion care and offers several advantages as a non-invasive and highly acceptable option to pregnant individuals, particularly useful in low-resource settings.<sup>8</sup> Because of their proven safety and efficacy, mifepristone and misoprostol were included for the first time in the 2005 World Health Organization Model List of Essential Medicines. Given limited available clinical evidence at the time, the list included a specific requirement for “close medical supervision”.<sup>9</sup>

Since then, numerous studies have documented medical abortion safety and effectivity through self-managed approaches, without the need for specialized medical care and direct supervision, which was reflected in World Health Organization’s guidelines updates. World Health Organization 2015 Guidelines described the importance of health professionals other than physicians in providing safe abortions and specified that women can play a role in self-managing medical abortion outside health-care facilities, stating that it “can be empowering for women and help to triage care, leading to a more optimal use of health resources”.<sup>10</sup> This has been reaffirmed in other guidelines and protocols issued by the World Health Organization over the years.<sup>11</sup> Retrieving the evidence gathered over the years, the 2019 List of Essential Medicines removed the note requiring “close medical supervision”. The experts Committee explained that this decision was “based on the evidence presented that close medical supervision is not required for its safe and effective use”.<sup>12</sup>

The confirmation by scientific evidence over the last thirty years that medical abortion is safe, effective and acceptable, that it can be delivered by health professionals other than physicians and that pregnant women can actively participate through self-evaluation and self-management is fundamentally connected to State’s duties under international human rights law, which command to take explicit measures to promote and fulfill women’s right to health, so as their sexual and reproductive rights.

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Peru: A Qualitative Study,” *Reproductive Health Matters* 13/26 (2005), pp. 75-83, DOI: 10.1016/S0968-8080(05)26199-2

<sup>8</sup> World Health Organization, *Medical management of abortion* (Geneva: WHO, 2018). Available at <https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1>

<sup>9</sup> World Health Organization Expert Committee on the Selection and Use of Essential Medicines, *The selection and use of essential medicines* (Geneva: WHO, 2005). Available at [https://extranet.who.int/iris/restricted/bitstream/handle/10665/43292/WHO\\_TRS\\_933\\_eng.pdf?ua=1](https://extranet.who.int/iris/restricted/bitstream/handle/10665/43292/WHO_TRS_933_eng.pdf?ua=1)

<sup>10</sup> World Health Organization, *Health worker roles in providing safe abortion care and post-abortion contraception* (Geneva: WHO, 2015), p. 41. Available at [https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1)

<sup>11</sup> World Health Organization, *Expanding health worker roles for safe abortion in the first trimester of pregnancy*, (Geneva: WHO, 2016). Available at [https://apps.who.int/iris/bitstream/handle/10665/206191/WHO\\_RHR\\_16.02\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/206191/WHO_RHR_16.02_eng.pdf?sequence=1); World Health Organization (see note 8) pp. 3, 26, 27 and 40; World Health Organization, *Consolidated guidelines on self-care interventions for health: sexual and reproductive health and rights* (Geneva: WHO, 2019). Available at <https://www.who.int/reproductivehealth/publications/self-care-interventions/en/>

<sup>12</sup> World Health Organization Expert Committee on the Selection and Use of Essential Medicines, *The Selection and Use of Essential Medicines* (Geneva: WHO, 2019). Available at: <https://apps.who.int/iris/bitstream/handle/10665/330668/9789241210300-eng.pdf?ua=1>

International human rights bodies have paid special attention to the World Health Organization definitions about the minimum contents of a health system, so to outline State's obligations. The UN Committee on Economic, Social and Cultural Rights (ESCR Committee) established that States have an immediate obligation to ensure the provision of medicines in accordance with the World Health Organization List of Essential Medicines.<sup>13</sup> The UN Special Rapporteur on the right to health has also cautioned that States have a progressive obligation to guarantee accessibility to both essential and non-essential drugs, but they do have "a core obligation of immediate effect to make essential medicines available and accessible throughout its jurisdiction".<sup>14</sup>

Meanwhile, in its 2016 General Observation 22 on the right to sexual and reproductive health, the ESCR Committee reasserted State's obligation "to provide medicines, equipment and technologies essential to sexual and reproductive health, including based on the WHO Model List of Essential Medicines". It also warned that ideology-based policies and practices should not be an obstacle to access to sexual and reproductive health services, including access to abortion medicines.<sup>15</sup> Also, in 2020 the ESCR Committee highlighted that States must ensure access to up-to-date scientific technologies necessary for women in relation to their sexual and reproductive health.<sup>16</sup> This demands not to rely on prejudices but in science, and not to hinder access to safe, effective and acceptable abortion methods according with the up-to-date scientific consensus.

Likewise, the ESCR Committee noted that health goods and services must be available (with a sufficient number throughout the country, with trained personnel and considering World Health Organization definitions), accessible (in geographic and economic terms and without discrimination), of quality (scientifically and medically appropriate) and acceptable (culturally appropriate, gender and life-cycle sensitive, respectful of personal autonomy and confidential).<sup>17</sup>

Regarding the acceptability element, the Committee explained that all health facilities, goods and services must be "respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements". Also, the Committee warned that there is a breach of State obligations when it fails to adopt "gender-sensitive approach to health".<sup>18</sup> Concerning sexual

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<sup>13</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14, The right to the highest attainable standard of health, UN Doc. No. E/C.12/2000/4 (2000), para. 43.d).

<sup>14</sup> Paul Hunt, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. No. A/61/338 (2006), para. 58.

<sup>15</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, UN Doc. No. E/C.12/GC/22 (2016), paras. 13, 14, 17 and 49.

<sup>16</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 25 on science and economic, social and cultural rights, UN Doc. No. E/C.12/GC/25 (2020), para. 33.

<sup>17</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14, The right to the highest attainable standard of health, UN Doc. No. E/C.12/2000/4 (2000), para. 14.

<sup>18</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14, The right to the highest attainable standard of health, UN Doc. No. E/C.12/2000/4 (2000), para. 11c. and 52.

and reproductive health, the Committee reaffirmed that all facilities, goods, information and services shall comply with the acceptability requirement.<sup>19</sup>

The acceptability requirement demands to build evidence-based health systems which are respectful of patient's autonomy and preferences in regarding to any health services, such as abortion. Health regulations that are not based on therapeutic considerations, that is, overmedicalization policies, are incompatible with this requirement.

### **Good practices to promote self-managed medical abortions**

As mentioned, dozens of states agreed that in the current crisis it is crucial to ensure continuity in the provision of sexual and reproductive health services, qualifying them as essential services.<sup>20</sup> In the same way, the WHO recommended that the States adopt measures to remove obstacles in the exercise of these rights, so that options are implemented that minimize visits to health centers, through telemedicine and self-management approaches.<sup>21</sup>

In line with these recommendations, some countries allowed more space for self-managed medical abortions as a response to pandemic's restraints. Countries such as England and France, reviewed their regulations and enabled women to have medical abortions at home, both for the use of mifepristone and misoprostol.<sup>22</sup>

In other places, such as the United States, local governments considered abortion as non-essential services, curtailing women access to services which are particularly time-sensitive.<sup>23</sup> Notwithstanding, a US federal judge recently granted a preliminary injunction pursued by medical associations, which challenged the FDA's Risk Evaluation and Mitigation Strategy (REMS) which imposes requirements not based on therapeutic reasons. The Court order suspended the FDA in-person-provision requirements, at least during the public health emergency based on COVID-19 declared by the Secretary of HHS pursuant to

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<sup>19</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health, UN Doc. No. E/C.12/GC/22 (2016), para. 20

<sup>20</sup> Government Offices of Sweden, *Joint press statement Protecting Sexual and Reproductive Health and Rights and Promoting Gender-responsiveness in the COVID-19 crisis*, (May 06, 2020). Available at <https://www.government.se/statements/2020/05/joint-press-statement-protecting-sexual-and-reproductive-health-and-rights-and-promoting-gender-responsiveness-in-the-covid-19-crisis/>

<sup>21</sup> World Health Organization, *Maintaining essential health services: operational guidance for the COVID-19 context* (Geneva: WHO, 2020), p. 29. Available at <https://www.who.int/publications/i/item/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak>

<sup>22</sup> H. Margolis, "England Leads Way in UK after U-Turn on COVID-19 Abortion Access," *Human Rights Watch* (March 31, 2020). Available at <https://www.hrw.org/news/2020/03/31/england-leads-way-uk-after-u-turn-covid-19-abortion-access>; Haute Autorité de Santé, *Interruption Volontaire de Grossesse (IVG) médicamenteuse à la 8ème et à la 9ème semaine d'aménorrhée (SA) hors milieu hospitalier* (April 10, 2020). Available at [https://www.has-sante.fr/jcms/p\\_3178808/fr/interruption-volontaire-de-grossesse-ivg-medicamenteuse-a-la-8eme-et-a-la-9eme-semaine-d-amenorrhée-sa-hors-milieu-hospitalier](https://www.has-sante.fr/jcms/p_3178808/fr/interruption-volontaire-de-grossesse-ivg-medicamenteuse-a-la-8eme-et-a-la-9eme-semaine-d-amenorrhée-sa-hors-milieu-hospitalier)

<sup>23</sup> D. Keating, "In these states, pandemic crisis response includes attempts to stop abortion," *Washington Post* (April 23, 2020). Available at <https://www.washingtonpost.com/nation/2020/04/21/these-states-pandemic-crisis-response-includes-attempts-stop-abortion/?arc404=true>

the Public Health Service Act. Those who need it, will be able to access the medication in pharmacies or by mail, without having to go to a special health facility.<sup>24</sup>

Even before COVID-19 crisis, there was an in-course trend to liberalize access to abortifacient drugs, given its self-use proven safety, effectivity and acceptability. Countries like Canada<sup>25</sup> and Australia<sup>26</sup> improved self-managed medical abortion allowing access in pharmacies to both mifepristone and misoprostol. Elsewhere women began to be allowed to complete the medical process with misoprostol at home, such as in the UK, where it was approved first for Scotland, then Wales, England and finally Northern Ireland.<sup>27</sup>

Meanwhile, since 2015 at least, Argentina's health protocols provide for outpatient medical abortions in public health facilities and women are able to perform the procedure in their homes, if they want to and when therapeutically appropriate.<sup>28</sup> Also, misoprostol remains available by prescription in pharmacies, since 1998.<sup>29</sup>

Following the call to ensure the continuity of sexual and reproductive health services during the Covid-19 pandemic, the province of Buenos Aires, the most populated in Argentina, issued special guidelines for health teams. In these, the health authority ordered measures to ensure timely access to the termination of pregnancy in cases allowed by Argentine law. In particular, it recommended that health teams prioritize medical abortion procedures and the possibilities of outpatient treatment.<sup>30</sup>

## Conclusion

As cautioned by the WG Questionnaire, it's fundamental to prevent future roll-backs in policies for women's and girls' sexual and reproductive health and rights. We have seen how during the pandemic public health systems in various jurisdictions have incorporated or

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<sup>24</sup> US District Court, District of Maryland, Preliminary Injunction, July 13, 2020, Civil Action No. TDC – 20 – 1320, American College of Obstetricians and Gynecologists, Council of University Chairs of Obstetrics and Gynecology, New York State Academy of Family Physicians, SisterSong Women of Color Reproductive Justice Collective, and Honor Mac Naughton, M.D. v. the United States Food and Drug Administration (FDA) and the United States Department of Health and Human Services (HHS).

<sup>25</sup> LaRoche and A. Foster, "It gives you autonomy over your own choices': A qualitative study of Canadian abortion patients' experiences with mifepristone and misoprostol," *Contraception* 102/1 (2020), pp. 61-65. DOI: 10.1016/j.contraception.2020.04.007; L. Vogel, "More doctors providing abortion after federal rules change.," *CMAJ*, vol. 190, no. 5, pp. 147-148, 2018.

<sup>26</sup> D. Grossman and P. Goldstone, "Mifepristone by prescription: a dream in the United States but reality in Australia," *Contraception*, 92/3 (2015), pp. 186-9. DOI: 10.1016/j.contraception.2015.06.014

<sup>27</sup> J. Parsons, "2017–19 governmental decisions to allow home use of misoprostol for early medical abortion in the UK", *Health Policy* 124/7 (2020), pp. 679-683. DOI: 10.1016/j.healthpol.2020.04.014.

<sup>28</sup> Ministerio de Salud de la Nación Argentina, *Protocolo para la atención integral de las personas con derecho a la interrupción legal del embarazo 2ª edición revisada y actualizada* (Buenos Aires, 2015), p. 34, available at [https://www.argentina.gob.ar/sites/default/files/protocolo\\_ile.pdf](https://www.argentina.gob.ar/sites/default/files/protocolo_ile.pdf) and *Protocolo para la atención integral de las personas con derecho a la interrupción legal del embarazo, 2ª edición* (Buenos Aires, 2019), p. 43, available at <http://www.msal.gob.ar/images/stories/bes/graficos/0000001792cnt-protocolo-ILE-2019-2edicion.pdf>

<sup>29</sup> Administración Nacional de Medicamentos, Alimentos y Tecnología Médica (ANMAT), Argentina, disposiciones 3646/98, 6726/2018 and 946/2018.

<sup>30</sup> Ministerio de Salud Provincia de Buenos Aires, Argentina, *Protocolo para la atención integral de las personas con derecho a interrumpir el embarazo y el acceso a métodos anticonceptivos, en el marco de la pandemia por coronavirus*, Resolución 577/2020.

expanded their policies for outpatient medical abortions, enabling women to perform the procedure in their homes when therapeutically appropriate, including in Argentina. These cases should be included in the report by the Working Group as good practices do guarantee the right to safe abortion during the crisis.

This is important not only for an accurate evaluation of States' responses during this period. As has been discussed in the last months regarding all areas of public policy, the exceptional circumstances posed by the Covid-19 pandemic may open space for the incorporation of new policy solutions that further enhance the protection of rights. Avoiding the over-medicalization of women's rights should be a fundamental principle in the design of health policies. Building from the existing scientific evidence and the experiences held in different countries, self-managed medical abortion should be promoted not only as a provisional measure for the exceptional circumstance of crisis faced by national health systems, but rather as a permanent policy, that could greatly enhance women's rights protection.