World Health Organization

hrp

Safe abortion: Technical & policy guidance for health systems

Legal and policy considerations

Laws and policies on abortion should protect women's health and their human rights

Key messages

- Laws and policies on abortion should protect women's health and their human rights.
- Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed.
- An enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care.
- Policies should be geared to respecting, protecting and fulfilling the human rights of women; to achieving positive health outcomes for women; to providing good-quality contraceptive information and services; and to meeting the particular needs of poor women, adolescents, rape survivors and women living with HIV.

I. Introduction

Over the past two decades, the health evidence, technologies and human rights rationale for providing safe, comprehensive abortion care have evolved greatly. However, despite these advances, based on 2008 data, WHO estimates that there are approximately 22 million unsafe abortions annually, resulting in 47 000 deaths and 5 million complications resulting in hospital admission (*1,2*). Nearly all unsafe abortions (98%) occurred in low- and middle-income countries. One of the factors driving unsafe abortion is the lack of safe abortion services, even where they are legal.

Restriction in access to safe abortion services results in both unsafe abortions and unwanted births. Almost all deaths and morbidity from unsafe abortion occur in countries where abortion is severely restricted in law and/or in practice. In countries where induced abortion is legally restricted and/or otherwise unavailable, safe abortion has frequently become the privilege of the rich, while poor women have little choice but to resort to unsafe providers. This results in a large number of unnecessary deaths and morbidities, resulting in a social and financial burden for public health systems.

Where there are few restrictions on access to safe abortion, deaths and illness are dramatically reduced (*3*). To realize women's human rights, and to save their lives and health, programmatic, legal and policy aspects of the provision of safe abortion need to be adequately addressed.

This evidence brief highlights the inextricable link between women's health and human rights and the need for laws and policies that promote and protect both. It provides information on how laws, regulations and policies should be geared to respect, protect and fulfil the human rights of women, to achieving positive health outcomes for women, and to meeting the needs of women in particularly vulnerable situations, including poor women, adolescents, rape survivors, refugees, women living with disabilities, and women living with HIV.

II. Ensuring comprehensive legal grounds for abortion

Whether abortion is legally restricted or not, the likelihood that a woman will have an abortion for an unintended pregnancy is about the same. Legal restrictions on abortion do not result in fewer abortions, nor do they result in significant increases in birth rates (*4,5*). However, a lack of legal access to abortion services is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality (*6–9*). Legal restrictions lead many women to seek services from unskilled providers or under unhygienic conditions, exposing them to a significant risk of death or disability. Legal restrictions also lead many women to seek services in other countries/states (*10,11*), which is costly, delays access and creates social inequities.

Conversely, laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principle effect is to shift previously clandestine, unsafe procedures to legal and safe ones (*4,12*). The accumulated evidence shows that the removal of restrictions on abortion results in a reduction of maternal mortality from unsafe abortion and, thus, a reduction in the overall level of maternal mortality (*13–16*).

In a small number of countries, where maternal mortality is low despite restrictive abortion laws, many women have access to safe or relatively safe abortion through neighbouring countries, domestically through safe but illegal abortion care, or through self-use of misoprostol (*11,17,18*).

Abortion laws have been liberalized since the beginning of the 20th century, when the extent of the public health problems caused by unsafe abortion began to be recognized (*19*). Since 1985, over 36 countries have liberalized their abortion laws, while only a few countries have imposed further restrictions in their laws (*20*). These reforms have come about through both judicial and legislative action; and/or through broader legal interpretations and applications (*19,20*). In some criminal and penal codes, abortion throughout pregnancy, or up to a set gestational limit, is no longer subject to criminal regulation. In these situations, abortion services have usually been integrated into the health system and are governed by the laws, regulations and medical standards that apply to all health services (*20,21*).

When there is a threat to the woman's life:

Almost all countries (95%) allow abortion to be performed to save the life of the pregnant woman (*22*). This is consistent with the human right to life, which requires protection by law, including when pregnancy is life-threatening or the pregnant woman's life is otherwise endangered (*23*).

Even where protecting a woman's life is the only allowable reason for abortion, it is essential that there are trained providers of abortion services, that services are available and known, and that treatment for complications of unsafe abortion is widely available. Saving a woman's life might be necessary at any point in the pregnancy and, when required, abortion should be undertaken as promptly as possible to minimize risks to a woman's health.

When there is a threat to the woman's health:

Sixty-seven per cent of countries allow women to seek abortion to preserve their physical health and 64% to preserve their mental health (*22*).

Since all countries that are members of WHO accept its constitutional description of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (*24:1*), this is implied in the interpretation of laws that allow abortion to protect women's health.

When pregnancy is the result of rape or incest:

The protection of women from cruel, inhuman and degrading treatment requires that those who have become pregnant as the result of coerced or forced sexual acts can lawfully access safe abortion services (*23*). Fifty-one per cent of countries reflect this standard and permit abortion in the specific cases of rape and incest (*22*). Some countries require as evidence the woman's report of the act to legal authorities. Others require forensic evidence of sexual penetration or a police investigation to confirm that intercourse was involuntary or exploitative. Either situation can lead women to resort to clandestine, unsafe services to terminate their pregnancy.

Prompt, safe abortion services should be provided on the basis of a woman's complaint, rather than requiring forensic evidence or police examination (*25–27*). Administrative requirements should be minimized and clear protocols established for both police and health-care providers, as this will facilitate referral and access to care (*28–30*).

When there is fetal impairment:
Fifty per cent of countries allow abortion upon diagnosis of fetal impairment (*22*). Several countries specify the kinds of impairment, such as those considered to be incompatible with life or independent life, while others provide lists of impairments. In some countries, no reference is made in the law to fetal impairment; rather, health protection or social reasons are interpreted to include distress of the pregnant woman caused by the diagnosis of fetal impairment (*31,32*).

Prenatal tests and other medical diagnostic services cannot legally be refused because the woman may decide to terminate her pregnancy. A woman is entitled to know the status of her pregnancy and to act on this information.

For economic and social reasons:
Thirty-five per cent of countries allow abortion based on a woman's social and economic circumstances (*22*). In countries that permit abortion for economic and social reasons, the legal grounds are interpreted by reference to whether continued pregnancy would affect the actual or foreseeable circumstances of the woman, including her achievement of the highest attainable standard of health.

On request:
Thirty per cent of countries allow abortion upon request of the pregnant woman (*22*). Allowing abortion on request has emerged as countries have recognized that women seek abortions on one – and often more than one – of the above grounds, and they accept all of these as legitimate, without requiring a specific reason. This legal ground recognizes the conditions for a woman's free choice and that the ultimate decision on whether to continue or terminate her pregnancy belongs to the woman alone.

III. Planning and managing safe abortion care

When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure. Unsafe abortion and associated morbidity and mortality in women are avoidable. Safe abortion services should be readily available and affordable to all women to the full extent of the law. This means services should be available at primary care level, with referral systems in place for all required higher-level care.

Actions to strengthen policies and services related to abortion should be based on the health needs and human rights of women and a thorough understanding of the service-delivery system and the broader social, cultural, political and economic context.

National standards and guidelines for safe abortion care should be evidence based and periodically updated, and should provide the necessary guidance to achieve equitable access to good-quality care.

Human rights bodies recommendations to States regarding legal grounds for safe abortion

- amend laws that criminalize medical procedures needed only by women, including abortion, and/or that punish women who undergo those procedures (23, 33–46).
- take actions to prevent unsafe abortion and reduce maternal deaths related to abortion, including by amending restrictive laws that threaten the lives of women, including adolescents (*27,33,36,40,41,47–58*).
- provide legal abortion in cases where the continued pregnancy endangers the health of women, including adolescents (*35,36,42,47,52,58–64*).
- provide legal abortion in cases of rape and incest (*30,35,37,42,43,47,48,51,55,58,60,62–71*).

Human rights bodies recommendations to States regarding planning and managing safe abortion care

- ensure timely access to a range of good-quality sexual and reproductive health services, including for adolescents, which are delivered in a way that ensures a woman's fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives (*33–35,37–40,53,72–74*).
- reduce maternal morbidity and mortality in adolescents, particularly caused by early pregnancy and unsafe abortion practices, and develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law (*37,40,43,48,58,59,61,74–77*).
- provide information on sexual and reproductive health, as well as mechanisms to ensure that all women, including adolescents, have access to information about legal abortion services (*46,59*).

IV. Eliminating regulatory policy and access barriers to safe abortion care

The legal grounds, and the scope of their interpretation, are only one dimension of the legal and policy environment that affects women's access to safe abortion. Health system and service-delivery barriers may also be codified in laws, regulations, policies and practices. Laws, policies and practices that restrict access to abortion information and services can deter women from care seeking and create a chilling effect (suppression of actions because of fear of reprisals or penalties).

Examples of barriers include:

- prohibiting access to information on legal abortion services, or failing to provide public information on the legal status of abortion;
- requiring third-party authorization from one or more medical professionals or a hospital committee, court or police, parent or guardian or a woman's partner or spouse;
- restricting available methods of abortion, including surgical and medical methods through, for instance, lack of regulatory approval for essential medicines;
- restricting the range of health-care providers and facilities that can safely provide services, e.g. to physicians in inpatient facilities with sophisticated equipment;
- failing to assure referral in case of conscientious objection;
- requiring mandatory waiting periods;
- censoring, withholding or intentionally misrepresenting health-related information;
- excluding coverage for abortion services under health insurance, or failing to eliminate or reduce service fees for poor women and adolescents;
- failing to guarantee confidentiality and privacy, including for treatment of abortion complications;
- requiring women to provide the names of practitioners of illegal abortion before providing them with treatment for complications from the procedure;
- restrictive interpretation of legal grounds.

These barriers contribute to unsafe abortion because they:

- deter both women from seeking care and providers from delivering services within the formal health system;
- cause delays in access to services, which may result in denial of services due to gestational limits on legal grounds;
- create complex and burdensome administrative procedures;
- increase the costs of accessing abortion services;
- limit the availability of services and their equitable geographic distribution.

Human rights bodies recommendations to States on eliminating regulatory and policy barriers to safe abortion care

- remove third-party authorization requirements that interfere with women's and adolescents' right to make decisions about reproduction, including on abortion, and to exercise control over their bodies (23,*59,61*).
- eliminate barriers that impede women's access to health services, such as high fees, the requirement for preliminary authorization by spouse, parent or hospital authorities, long distances from health facilities, and the absence of convenient and affordable public transport; and ensure that the exercise of conscientious objection does not prevent women from accessing services to which they are legally entitled *(35,40,59,76,78–81*).
- implement a legal and/or policy framework that enables women to access abortion where the medical procedure is permitted under the law (*71,82,83*).
- ensure abortion services that are allowable by law are accessible in practice (*35,47,58,59,63,64,71,83,84*).
- institutional and administrative mechanisms should be in place and should protect against unduly restrictive interpretations of legal grounds (*71,83,84*).

V. Providing treatment of abortion complications

Health-care providers are obligated to provide life-saving medical care to any woman who suffers abortion-related complications, including treatment of complications from unsafe abortion, regardless of the legal grounds for abortion. However, in some cases, treatment of abortion complications is administered only if the woman provides information about the person(s) who performed the illegal abortion. This has been considered torture and inhuman and degrading treatment (*85*).

Every service-delivery site at each level of the health system should be equipped and have personnel trained to recognize abortion complications and to provide or refer women for prompt care, 24 hours a day, regardless of

Human rights bodies recommendations to States regarding providing treatment of abortion complications

- provide immediate and unconditional treatment to anyone seeking emergency medical care (*33,34,37,39,70,85*).
- provide timely treatment for abortion complications regardless of the law on induced abortion, to protect a woman's life and health (*33,34,37,39,68,70,76,85,87*).
- eliminate the practice of extracting confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion, as well as court authorization and the legal requirement for doctors and other health-care personnel to report cases of women who have undergone abortion (*23,73,85,88*).
- provide quality treatment for complications from unsafe abortion in ways that preserve women's privacy, confidentiality and dignity (*41,46,68*).

the legal grounds for abortion (*33,34,37,39,70,85,86*). The facilities and skills required to manage most abortion complications are similar to those needed to care for women who have had a spontaneous abortion (miscarriage).

VI. Creating an enabling environment

An enabling environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care. The respect, protection and fulfilment of human rights require that comprehensive laws, regulations and policies be in place to ensure that abortion is safe and accessible.

Laws, regulations and policies should aim to:

- respect, protect and fulfil the human rights of women, including women's dignity, autonomy and equality;
- promote and protect women's health as a state of complete physical, mental and social well-being;
- minimize the rate of unintended pregnancy by providing good-quality contraceptive information and services, including a broad range of contraceptive methods, emergency contraception and comprehensive sexuality education;
- prevent and address stigma and discrimination against women who seek abortion services or treatment for abortion complications;
- reduce maternal mortality and morbidity due to unsafe abortion, by ensuring that every woman entitled to legal abortion care can access safe and timely services, including post-abortion contraception;
- meet the particular needs of women belonging to vulnerable and disadvantaged groups, such as poor women, adolescents, single women, refugees and displaced women, women living with HIV, and survivors of rape.

While States differ in prevailing national health system conditions and constraints on available resources, all States can take immediate and targeted steps to elaborate comprehensive polices that expand access to sexual and reproductive health services, including safe abortion care.

Unsafe abortion and associated morbidity and mortality in women are avoidable. Nearly every death and harm from unsafe abortion can be prevented through sexuality education, use of effective contraception, provision of safe, legal abortion and emergency treatment of abortion complications.

References

1. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008, 3rd edition. Geneva: World Health Organization; 2011 (http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en, accessed 7 April 2015).
2. Singh S. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. Lancet. 2006;368:1887–92. doi:10.1016/s0140-6736(06)69778-x.
3. Shah I, Ahman E. Unsafe abortion: global and regional incidence, trends, consequences and challenges. J Obstet Gynaecol Can. 2009;31:1149–58.
4. Sedgh G, Singh S, Shah IH, Ahman E, Henshaw SK, Bankole A. Induced abortion: incidence and trends worldwide from 1995 to 2008. Lancet. 2012;379:625–32. doi: http://dx.doi.org/10.1016/S0140-6736(11)61786-8.
5. Levine PB, Staiger D. Abortion policy and fertility outcomes: the Eastern European experience. J Law Econ. 2004;XLVII:223–43.
6. David HP. Soviet Union. In: David HP, editor. Abortion research: international experience. Lexington (MA): Lexington Books, 1974:209-16.
7. Serbanescu F, Morris L, Stupp P, Stanescu A. The impact of recent policy changes on fertility, abortion, and contraceptive use in Romania. Stud Fam Plann. 1995;26(2):76–87.
8. Zhirova IA, Frolova OG, Astakhova TM, Ketting E. Abortion-related maternal mortality in the Russian Federation. Stud Fam Plann. 2004;35(3):178–88.
9. Millennium development goals in Russia: looking into the future. Moscow: United Nations Development Programme; 2010.
10. Joyce TJ, Henshaw SK, Dennis A, Finer LB, Blanchard K. The impact of state mandatory counselling and waiting period laws on abortion: a literature review. New York (NY): Guttmacher Institute; 2009 (https://www.guttmacher.org/pubs/MandatoryCounseling.pdf, accessed 7 April 2015).
11. Payne D. More British abortions for Irish women. BMJ. 1999;318(7176):77.
12. Grimes D, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, et al. Unsafe abortion: the preventable pandemic. Lancet. 2006;368:1908–19. doi:http://dx.doi.org/10.1016/S0140-6736(06)69481-6.
13. David HP. Abortion in Europe, 1920–91 – a public-health perspective. Stud Fam Plann. 1992;23:1–22.
14. Jewkes R, Brown H, Dickson-Tetteh K, Levin J, Rees H. Prevalence of morbidity associated with abortion before and after legalisation in South Africa. BMJ. 2002;324:1252–3. doi:http://dx.doi.org/10.1136/bmj.324.7348.1252.
15. Jewkes R and Rees H. Dramatic decline in abortion mortality due to the Choice on Termination of Pregnancy Act. S Afr Med J. 2005;95(4):250.
16. Suvedi BK, Pradhan A, Barnett S, Puri M, Chitrakar SR, Poudel P, et al. Nepal maternal mortality and morbidity study 2008/2009: summary of preliminary findings. Kathmandu, Nepal: Family Health Division, Department of Health Services, Ministry of Health; 2009 (http://www.dpiap.org/resources/pdf/nepal_maternal_mortality_2011_04_22.pdf, accessed 7 April 2015).
17. Kulczycki A. Abortion in Latin America: changes in practice, growing conflict, and recent policy developments. Stud Fam Plann. 2011;42(3):199–220.
18. Briozzo L, Vidiella G, Rodríguez F, Gorgoroso M, Faúndes A, Pons JE. A risk reduction strategy to prevent maternal deaths associated with unsafe abortion. Int J Gynaecol Obstet. 2006;95(2):221–6.
19. Dickens BM. Human rights dynamics of abortion law reform. Hum Rights Q. 2003, 25:1–59.
20. Boland R, Katzive L. Developments in laws on induced abortion: 1998–2007. Int Fam Plan Perspect. 2008;34:110–20. doi:10.1363/3411008.
21. Cook RJ, Dickens BM. Human rights dynamics of abortion law reform. Hum Rights Q. 2003;25:1–59.
22. World abortion policies 2013. New York (NY): Population Division, United Nations Department for Economic and Social Affairs; 2013.
23. General Comment No. 28: The equality of rights between men and women. Geneva: United Nations Human Rights Committee; 2000 (CCPR/C/21/Rev.1/Add.10).
24. WHO Constitution. 47th edition. Geneva: World Health Organization; 2009:1 (http://apps.who.int/gb/bd/PDF/bd47/EN/basic-documents-47-en.pdf, accessed 13 May 2015).

25. Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons. Revised edition. Geneva: World Health Organization/United Nations High Commissioner for Refugees; 2004 (http://whqlibdoc.who.int/publications/2004/924159263X.pdf, accessed 7 April 2015).

26. Cook RJ, Dickens BM, Fathalla MF. Reproductive health and human rights: integrating medicine, ethics and law. Oxford: Oxford University Press; 2003.

27. Concluding observations: Argentina. New York (NY): United Nations Committee on the Rights of the Child; 2010 (CRC/C/ARG/CO/3–4).

28. Billings D, Moreno C, Ramos C, González de León D, Ramírez R, Villaseñor Martínez L, et al. Constructing access to legal abortion services in Mexico City. Reprod Health Matters. 2002;10:87–95.

29. Villela WV, Oliveira Araujo M. Making legal abortion available in Brazil: partnership in practice. Reprod Health Matters. 2000;8:77–82.

30. Concluding observations: Peru. New York (NY): United Nations Committee on Economic Social and Cultural Rights; 2012 (E/C.12/PER/CO/24).

31. Cook RJ, Ngwena CG. Women's access to health care: the legal framework. Int J Gynaecol Obstet. 2006;94:216–25.

32. Cook RJ, Erdman JN, Hevia M, Dickens BM. Prenatal management of anencephaly. Int J Gynaecol Obstet. 2008;102:304–8. doi:10.1016/j.ijgo.2008.05.002.

33. Concluding comments: Brazil. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2007 (CEDAW/C/BRA/6).

34. Concluding comments: Chile. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2006 (CEDAW/C/CHI/CO/4).

35. Concluding comments: Colombia. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 1999 (A/54/38/REV.1[SUPP] paras. 337–401).

36. Concluding comments: Democratic Republic of Congo. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2013 (CEDAW/C/COD/CO/6–7).

37. Concluding comments: Honduras. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2007 (CEDAW/C/HON/CO/6).

38. Concluding comments: Liechtenstein. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2007 (CEDAW/C/LIE/CO/3).

39. Concluding comments: Mauritius. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2006 (CEDAW/CMAR/CO/5).

40. Concluding comments: Nicaragua. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2007 (CEDAW/C/NIC/CO/6).

41. Concluding comments: Paraguay. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2011 (CEDAW/C/PRY/CO/6).

42. Concluding comments: United Kingdom of Great Britain and Northern Ireland. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2013 (CEDAW/C/GBR/CO/7).

43. Concluding observations: Costa Rica. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2011 (CEDAW/C/CRI/CO/5–6).

44. Concluding observations: El Salvador. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2008 (CEDAW/C/SLV/CO/7).

45. Concluding observations: Guatemala. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2001 (CEDAW/C/GUA/CO/6).

46. Concluding observations: Kenya. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2011 (CEDAW/C/KEN/Q/7).

47. Concluding comments: Dominican Republic. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2013 (CEDAW/C/DOM/CO/6–7).

48. Concluding observations: Chile. New York (NY): United Nations Committee on the Rights of the Child; 2007 (CRC/C/CHL/CO/3).

49. Concluding observations: Chile. Geneva: United Nations Human Rights Committee; 2007 (CCPR/C/CHL/CO/5).

50. Concluding observations: Colombia. Geneva: United Nations Human Rights Committee; 2004 (CCPR/CO/80/COL).

51. Concluding observations: Costa Rica. New York (NY): United Nations Committee on Economic Social and Cultural Rights; 2008 (E/C.12/CRI/CO/4/CORR.1).

52. Concluding observations: Ecuador. Geneva: United Nations Human Rights Committee; 1998 (CCPR/C/79/Add.92).

53. Concluding observations: Guatemala. Geneva: United Nations Human Rights Committee; 2001 (CCPR/CO/72/GTM).

54. Concluding observations: Madagascar. Geneva: United Nations Human Rights Committee; 2007 (CCPR/C/MDG/CO/3).

55. Concluding observations: Nepal. New York (NY): United Nations Committee on Economic Social and Cultural Rights; 2001 (E/C.12/1/Add.66).

56. Concluding observations: Poland. Geneva: United Nations Human Rights Committee; 2004 (CCPR/CO/82/POL).

57. Karen Noella Llantoy Huaman v. Peru. Communication no. 1153/2003. Special Rapporteur's rule 91 decision, transmitted to the State party on 8 January 2003 (not issued in document form). Geneva: United Nations Human Rights Committee; 2005 (CCPR/C/85/D/1153/2003).

58. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Article 14.2. Maputo, Mozambique: African Commission on Human and People's Rights; 2003 (http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf, accessed 7 April 2015).

59. General Recommendation No. 24: Article 12: Women and health. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 1999 (A/54/38/Rev.1, Chapter I).

60. Concluding observations: El Salvador. New York (NY): United Nations Committee on Economic Social and Cultural Rights; 2007 (E/C.12/SLV/CO/2).

61. Concluding comments: Indonesia. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2012 (CEDAW/C/IDN/CO/6–7).

62. Concluding observations: Ireland. Geneva: United Nations Human Rights Committee; 2014 (CCPR/C/IRL/CO/4).

63. Concluding observations: Malta. New York (NY): United Nations Committee on Economic Social and Cultural Rights; 2004 (E/C.12/1/Add.101).

64. Concluding observations: Monaco. New York (NY): United Nations Committee on Economic Social and Cultural Rights; 2006 (E/C.12/MCO/CO/1).

65. Concluding comments: Algeria. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2012 (CEDAW/C/DZA/CO/3–4).

66. Concluding observations: Andorra. New York (NY): United Nations Committee on the Rights of the Child; 2012 (CRC/C/AND/CO/2).

67. Concluding observations: Chile. New York (NY): United Nations Committee on Economic Social and Cultural Rights; 2004 (E/C.12/1/Add.105).

68. Concluding comments: Costa Rica. New York (NY): United Nations Committee on the Rights of the Child; 2011 (CRC/C/CRI/CO/4).

69. Concluding observations: Djibouti. Geneva: United Nations Human Rights Committee; 2013 (CCPR/C/DJI/CO/1).

70. Concluding comments: Sri Lanka. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2011 (CEDAW/C/LKA/CO/7).

71. LC. v. Peru. Communication No. 22/2009, decided on 4 November 2011. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2011 (CEDAW/C/50/D/22/2009).

72. Concluding observations: Dominican Republic. Geneva: United Nations Human Rights Committee; 2012 (CCPR/CO/71/DOM).

73. Concluding observations: El Salvador. Geneva: United Nations Human Rights Committee; 2010 (CCPR/C/SLV/CO/6).

74. Concluding observations: Liberia. New York (NY): United Nations Committee on the Rights of the Child; 2012 (CRC/C/LBR/CO/2–4).

75. General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child. New York (NY): United Nations Committee on the Rights of the Child; 2003 (CRC/GC/2003/4).

76. General Comment No. 15: The rights of the child to the highest attainable standard of health. Geneva: United Nations Committee on the Rights of the Child; 2013 (CRC/C/GC/15).

77. Concluding observations: Jamaica. Geneva: United Nations Human Rights Committee; 2011 (CCPR/C/JAM/CO/3).
78. Concluding comments: Hungary. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2013 (CEDAW/C/HUN/CO/7-8/Corr.1).
79. Concluding observations: Zambia. Geneva: United Nations Human Rights Committee; 2007 (CCPR/C/ZMB/CO/3).
80. P. and S. v. Poland. Application No. 57375/08, decided on 30 October 2012. Strasbourg: European Court of Human Rights; 2012.
81. RR. v. Poland. Application No. 27617/04, decided on 28 November 2011. Strasbourg: European Court of Human Rights; 2011.
82. A.B. and C. v. Ireland. Application No. 25579/05, decided on 16 December 2010. Strasbourg: European Court of Human Rights; 2010.
83. Tysiąc v. Poland. Application No. 5410/03, decided on 24 September 2007. Strasbourg: European Court of Human Rights; 2007.
84. Paulina del Carmen Ramírez Jacinto, Mexico. Friendly Settlement, Report No. 21/07, Petition 161–01, 9 March 2007. Washington (DC): Inter-American Commission on Human Rights; 2007.
85. Concluding observations: Chile. Geneva: United Nations Committee against Torture; 2004 (CAT/C/CR/32/5).
86. Clinical management of abortion complications: a practical guide. Geneva: World Health Organization; 1994.
87. Concluding comments: Samoa. New York (NY): United Nations Committee on the Elimination of Discrimination against Women; 2012 (CEDAW/C/WSM/CO/4–5).
88. Concluding observations: Plurinational State of Bolivia. Geneva: United Nations Human Rights Committee; 2013 (CCPR/C/BOL/CO/3).

For more information, please contact:
Department of Reproductive Health and Research
World Health Organization
Avenue Appia 20, CH-1211 Geneva 27, Switzerland
E-mail: reproductivehealth@who.int

www.who.int/reproductivehealth

WHO/RHR/15.04

© World Health Organization 2015

All rights reserved. Publications of the World Health Organization are available on the WHO web site (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications –whether for sale or for non-commercial distribution– should be addressed to WHO Press through the WHO web site (www.who.int/about/licensing/copyright_form/en/index.html).

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.