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COMMENTARY

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Abortion in the context of COVID-19: a human rights imperative

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Introduction

Past global health emergencies show that access to safe abortion can be negatively impacted during crises.[1] While states' COVID-19 responses are still evolving, increasing burdens on health systems are likely to substantially reduce abortion access.[2] As providers become infected, clinics providing abortion in some countries have already closed down. Lockdown and quarantine orders restricting movement may also exacerbate the harm of existing abortion restrictions that require multiple clinic visits, such as mandatory waiting periods, and increase women's[†] risk of COVID-19 infection, as well as impede confidentiality and disrupt supply-chains for abortion medication.

Yet abortion services are more essential now than ever. Preliminary reports indicate that states' COVID-19 responses may lead to increased unintended and unwanted pregnancies due to quickly diminishing contraceptive supplies, increased incidence of domestic violence, and rising income insecurity. Compelling continuation of unwanted pregnancies is recognised as a human rights violation in several circumstances, including where there are foreseeable physical or mental health impacts for pregnant persons. Further, pregnancy carries heightened risks during crises and COVID-19 may create new barriers to pregnancy-related care.[3]

Abortion is a time-sensitive service, with delays and denials leading to unsafe abortions. Evidence shows that where abortion is restricted or safe abortion is unavailable, people turn to other, often unsafe means to end their pregnancies, such as ingesting herbal concoctions or medications from unknown sources. Some countries are recognising this risk and have started allowing remote consultation with patients seeking abortions during the COVID-19 pandemic, such as in Ireland, England, and France. Scotland now permits home use of mifepristone and misoprostol. Medical societies and advocates including in India and Brazil are seeking similar clarifications. This aligns with World Health Organization (WHO) guidance which confirms that self-managed abortion is safe if pregnant individuals have information on effective protocols and access to follow up health care if needed.[4,p.xviii]

Conversely, some US law and policy-makers are working to effectively ban abortion, under the cover of the COVID-19 pandemic, by misleadingly categorising abortion as "non-essential" and not "medically necessary" care. Courts in the US and the Netherlands have had mixed responses to petitions to safeguard abortion access during this time. Further, many governments are remaining silent on how the health system should prioritise abortion at this time, leading to shrinking access as resources are reallocated and providers are quarantined.

Incorporating measures to ensure safe abortion services into state pandemic responses and eliminating barriers to abortion is not just a matter of harm reduction – it is a human rights imperative. States have a duty to ensure that individuals do not have to undertake unsafe abortions when faced with a pregnancy that is unwanted and/or threatens their life or health.[5,‡] These obligations are not waived in times of crisis; in fact, they become

*These authors equally drafted and contributed to this work.

[†]Women in this Commentary is intended to be construed inclusively to include girls and all persons who can become pregnant.

more pressing. Enabling self-managed abortion by guaranteeing access to medications and telemedicine counselling and ensuring women are not criminalised for inducing their own abortions could be a critical step towards fulfilling states' binding human rights obligations and avoiding preventable abortion complications, including during the COVID-19 crisis.[6]

State obligations to ensure abortion access during COVID-19

International human rights law explicitly recognises the rights to sexual and reproductive health and bodily autonomy. These rights give rise to positive state obligations to ensure abortion-related information and services and to remove medically unnecessary barriers that deny practical access.[7,p.12–14] Introducing additional barriers to abortion and/or failing to ensure abortion access during the COVID-19 pandemic contravenes UN treaty bodies' consistent critique of states' denial of safe abortion services, and recommendations that states both refrain from introducing new barriers and eliminate existing barriers to abortion.

States' international human rights obligations to respect, protect and fulfil the rights to health, life and non-discrimination, among other rights, are not suspended in times of crisis. Measures to prevent unsafe abortion and to ensure access to critical sexual and reproductive health services, including abortion services, are non-derogable core obligations of states, even in emergencies. Fulfilling this core obligation requires repealing laws and policies that criminalise, obstruct or undermine access to sexual and reproductive services; guaranteeing universal access to services; and preventing unsafe abortions.[8,9] Meeting these core obligations is essential and mandatory in the time of COVID-19.

Under international human rights law, states must mitigate any discriminatory impacts of their emergency responses, including concerning women's health. While states are permitted and, at times, required, to take extraordinary measures during public health crises, they do not have free reign to restrict rights, nor do they fully relinquish their binding legal obligations. As affirmed by the Siracusa Principles[10] and the UN Human Rights Committee,[11] any public health measures taken that limit individuals' rights and freedoms must be lawful, necessary, and proportionate, and cannot have a discriminatory impact on specific persons or marginalised groups.

Restricting abortion access as a response to COVID-19 violates states' human rights obligations during crises. Failing to ensure abortion access, a core component of guaranteeing people's health and well-being, has a disparate impact on those with low or no incomes and/or who lack housing, migrants, refugees, people with disabilities and adolescents, and compelling pregnancy worsens health outcomes, particularly in the context of COVID-19. Further, abortion restrictions discriminate against women more broadly by compelling pregnancy, thus eliminating their bodily autonomy, and worsening their health by increasing unsafe abortion.

Additionally, given the time sensitivity of abortion and the health risks at stake, prohibiting access to abortion is a disproportionate response. Abortion must, therefore, be considered an essential medical service and made available at this time. Along these lines, WHO has explicitly classified reproductive health care as an essential health service that must be accorded high priority in COVID-19 response.[12] WHO's Model List of Essential Medicines includes the active drugs for medical abortion, misoprostol and mifepristone, which human rights bodies have recognised states are obligated to ensure.

Given states' international legal obligations to ensure abortion access, even during crises, governments' COVID-19 planning must integrate abortion care from the outset. States cannot simply refrain from passing restrictive policies, but rather should introduce bold, innovative measures to maintain and expand access in accordance with human rights. Additionally, states must prioritise critical measures that fulfil their legal obligations while also lessening demands on facility-based resources, reducing women's exposure to coronavirus, and increasing abortion safety. WHO recognises that self-managed abortion can "help to triage care, leading to a more optimal use of health-care resources",[4,p.68] as well as the empowering role self-managed abortion can play, which is vital to restoring power and dignity during a period when women are otherwise facing higher levels of discrimination. States could facilitate self-managed medical abortion via telemedicine by waiving requirements that entail one or more clinic visits, including mandatory waiting periods; removing bans on telemedicine abortion counselling or mail delivery of abortion medications; and removing or suspending criminal penalties for self-managed abortions.

[‡]Some states exclude threats to life or health for a pregnant person from such restrictions.

State responses that have facilitated access to self-managed abortion are important measures that can increase compliance with human rights obligations. States must implement similarly evidence-based and transformative solutions to ensure abortion access for those who need/prefer surgical abortion, or those who do not have autonomy or structural support to undertake self-managed abortion. Abortion must also be guaranteed where health and technology systems may not be able to support telemedicine abortion. States must further anticipate and confront medication shortages due to disrupted supply-chains. Other crucial steps include ensuring that telemedicine and other abortion services are available free or at low cost and to marginalised groups.

Conclusion

As states move to halt the devastation of COVID-19, women's right to safe abortion must not be forgotten. With reducing contraceptive supplies, overburdened health systems, job losses, and increasing risks of violence, women must be able to prevent and/or manage unwanted pregnancies, not only for their own health and well-being, but also to support effective public health responses to prevent and treat COVID-19. The pandemic has placed a spotlight on the ways in which existing legal frameworks – even in countries with "liberal" abortion laws – continue to undermine access to this essential health service by failing to recognise the safety of medical abortion, including through telemedicine. Permitting women to undertake safe self-managed abortion with telemedicine counselling, is not simply about harm reduction; it is a human rights imperative and would also be a critical step toward complying with states' binding international legal obligations.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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