Research Report — Chair's Brief

Committee: HRC
Topic: Establishing frameworks to ensure safe access to pregnancy termination for individuals with a uterus, while maintaining adequate regulations to prevent misuse
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Introduction

Ensuring safe, equitable access to pregnancy termination (abortion) while preventing coercion or non-medical misuse is both a public-health and human-rights challenge. Delegates must balance clinical safety, individual autonomy, legal clarity, and safeguards against coercion or fraudulent practices. This report provides background, clear definitions, an outline of key issues, pragmatic policy options, principal country examples, and targeted questions to prepare delegates for debate and resolution drafting.

Background information

In 2022–2023 international health authorities consolidated evidence-based recommendations on abortion care that emphasize safety, task-sharing, and removing non-evidence-based regulatory barriers (e.g., arbitrary provider restrictions) to increase access and reduce unsafe procedures. The WHO's Abortion Care Guideline provides comprehensive law-and-policy as well as clinical recommendations that many states and health systems reference when designing frameworks.

The global landscape is highly mixed: some states have liberal, regulated access to termination services (with telemedicine and medication abortion increasingly common), while others maintain strict bans or strong restrictions that force people to travel, seek unsafe care, or self-manage without clinical support. Medication abortion (mifepristone + misoprostol) now constitutes a large and growing share of abortions in many jurisdictions where it is available, and telemedicine provision has expanded access but raised regulatory and cross-jurisdictional questions.

Human-rights bodies and major health organizations frame access to safe abortion as linked to rights to health, privacy and non-discrimination; they also warn that criminalization and overly restrictive regulation exacerbate unsafe care and maternal mortality.

Definition of key terms

Pregnancy termination / Abortion: The medical or surgical termination of a pregnancy. (Used here neutrally and clinically.)

Safe abortion / safe care: Abortion services provided according to evidence-based clinical standards, by appropriately trained personnel or via WHO-endorsed self-management protocols for early medication abortion, with access to emergency care if needed.

Medication abortion: Use of pharmaceuticals (commonly mifepristone followed by misoprostol) to terminate an early pregnancy.

Telemedicine abortion / TMAB: Provision of medication abortion using remote consultation and (where permitted) mailing of medications or supervised self-management.

Provider restrictions: Legal or regulatory rules that limit which health workers may provide abortions (e.g., only physicians), regardless of evidence that trained mid-level providers can safely deliver care.

Misuse (in this context): Non-medical or coercive practices (including sex-selection where illegal), fraudulent distribution of medication, coerced abortion, commercial exploitation, or other practices that violate patient autonomy or safety.

Decriminalization (of abortion): Removing criminal penalties for individuals seeking or providing abortions; regulation remains possible through health/law frameworks.

Potential issues / challenges

Access disparities and geography: Restrictive laws, provider shortages, and uneven telemedicine legality produce urban/rural and cross-border disparities. (E.g., post-Dobbs changes in the US created sharp state-by-state variation.)

Regulatory mismatch and evidence gaps: Laws that impose unnecessary provider or facility requirements conflict with WHO recommendations and limit safe access.

Medication security & supply-chain integrity: Ensuring quality, preventing counterfeit or diverted medications, and regulating online pharmacies without restricting legitimate access.
Guttmacher Institute

Telemedicine and cross-jurisdiction legal conflict: Remote provision raises questions about which jurisdiction's law applies and the legality of mailing medicines across borders.

Safeguarding against coercion and sex-selection: Balancing privacy and access with safeguards to detect and prevent coerced abortions or unlawful sex-selective practices.

Data protection and confidentiality: Protecting patient data (including digital records and telehealth logs) from misuse or legal exposure.

Stigma, conscientious objection, and workforce issues: Provider refusal on conscience grounds can limit services unless regulated with referral duties and minimum service coverage.

Enforcement & unintended criminalization: Poorly drafted laws can criminalize patients or health workers, driving care underground and raising human-rights concerns.

Possible solutions / policy options

Below are pragmatic, evidence-based policy options delegates may combine in draft resolutions or national position papers.

A. Rights-centred legal framework

Decriminalize abortion for people seeking care and health-care providers (retain civil/administrative oversight for safety). Align criminal law only with non-medical harms (e.g., coercion, trafficking).
Center for Reproductive Rights

B. Evidence-based regulation

Adopt WHO guidance on provider scopes; allow trained mid-level providers and self-managed early medication abortion with back-up access to care. Remove arbitrary facility or hospital-only rules.

C. Safe medication access and supply oversight

Create regulated distribution channels (including licensed online pharmacies), track quality, and criminalize counterfeit distribution, while enabling legitimate mail/delivery where clinical standards and patient privacy are protected.

D. Telemedicine & cross-border cooperation

Establish clear rules for telemedicine provision (licensing, prescribing, emergency referrals). Develop bilateral/ regional agreements to respect patient movement for care and clarify legal responsibilities.

E. Safeguards against misuse without restricting access

Require informed consent processes, accessible counselling (non-coercive), and record-keeping that protects privacy; implement targeted measures (not broad bans) to prevent documented harms like sex-selection where relevant. Use risk-based auditing and oversight rather than blanket prohibitions.

F. Workforce & training

Invest in training, task-sharing, and supportive supervision; define conscientious-objection rules that require timely referral and ensure service coverage.

G. Monitoring, evaluation & research

Fund routine monitoring (quality indicators, adverse events, access metrics), with anonymized reporting to protect individuals but allow policy refinement.

H. Public education & stigma reduction

Public health campaigns about legality, safety, and where to access services, and education of frontline providers and law-enforcement to avoid harmful enforcement actions.

I. Financial and social support

Ensure public or insurance coverage for abortion care and travel/ accommodation support for those who must travel, plus post-abortion care and contraception counseling.

Main countries / actors involved (examples & rationale)

World Health Organization (WHO): Provides consolidated clinical and policy guidance used by states.

United Nations human-rights bodies / OHCHR: Frame access as linked to rights to health, non-discrimination and privacy; issue recommendations and concluding observations.

United States: Post-2022 legal landscape shows dramatic state-level variation; medication abortion and telemedicine policy are contested and influential globally. Use KFF and Guttmacher analyses for current trends.

Poland: Recent rollbacks and restrictive rulings make it an example of human-rights concerns arising from severe legal restrictions.

France / Western Europe / Canada / Argentina: Examples of jurisdictions that have taken steps to protect or expand access (France recently strengthened protections; Argentina legalized abortion in 2020 after activism). Use reproductive-rights trackers for country specifics.

Regional blocs & NGOs (e.g., EU institutions, Guttmacher Institute, Center for Reproductive Rights, Amnesty): Influence norms, provide data, and support capacity building.

Questions for delegates (for preparation & solution-finding)

What legal model best balances safe access and prevention of misuse in your country's context: full decriminalization with health-care regulation, a rights-based conditional model, or a restricted model with strong safeguards? Defend with evidence.

How would your state regulate medication abortion distribution to prevent counterfeit drugs while preserving access (e.g., licensing online pharmacies, postal rules, cross-border supply)?

What concrete safeguards would you propose to prevent coercion or sex-selective abortion without creating barriers for autonomous decision-making?

Would you permit telemedicine abortion nationwide? If so, what clinical, legal and cross-jurisdictional limits would you set (licensing, age limits, emergency referral pathways)?

How should conscientious objection be handled to protect provider conscience while guaranteeing timely access for patients? What minimum service coverage rules would you require?

What monitoring and evaluation indicators (access, safety, adverse events, equity) would you include in a resolution, and how would you protect patient privacy in data collection?

How can international cooperation (WHO guidance, bilateral agreements, technical assistance) be structured to help countries with limited health systems expand safe services while mitigating misuse?

What financing mechanisms (public funding, insurance mandates, international aid) are acceptable in your country to ensure access and equity?

How should criminal law be used (if at all) — for example, to combat trafficking or coercion — without punishing people who seek abortion or providers following clinical guidance?

What role should education and community engagement play in implementation, and how would you measure success?

Chair's guidance on drafting operative clauses

Prioritize evidence-based language (cite WHO guidance) and human-rights language (OHCHR).

Avoid overly prescriptive, one-size-fits-all mandates; instead propose flexible, context-sensitive instruments (technical annexes, pilot programs, capacity building).

Include monitoring, funding, and technical assistance mechanisms to make commitments actionable.

Protect confidentiality and non-criminalization of seekers of care; reserve criminal penalties for coercion, trafficking, or counterfeit distribution where clearly demonstrated.

Sources

Key references delegates should consult (selected — full bibliographies welcome in position papers):

WHO — Abortion Care Guideline (consolidated recommendations on law, policy, clinical services).

Guttmacher Institute — country and global data on abortion incidence and medication abortion trends.

Reproductive Rights / Center for Reproductive Rights — interactive map of abortion laws worldwide.

Office of the UN High Commissioner for Human Rights / OHCHR — statements and findings linking access to abortion with human-rights obligations.

KFF / peer-reviewed literature — policy analyses on state and federal interactions, telemedicine, and regulatory barriers (useful for country-level case studies).

Closing note from the Chair

This committee will need to balance clinical evidence, human-rights obligations, and practical enforcement concerns. Delegates are encouraged to consult the WHO guideline and country data, to craft nuanced, implementable clauses (pilot programs, monitoring metrics, funding lines), and to prioritize the dignity, privacy and health of people seeking care while proposing narrow, targeted measures to prevent documented harms. Use the questions above to structure your research and be ready to negotiate practical, rights-respecting compromise language in draft resolutions.

Good luck — and remember: the best solutions are those that are evidence-based, rights-respecting, and practically enforceable.