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COMMISSION ON THE STATUS OF WOMEN

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Letter from the Chairperson

Dear Delegates,

It is with great pleasure and deep respect that I welcome you to the United Nations Commission on the Status of Women (UNCSW) at this edition of our Model United Nations Conference. As your Chairperson for this intellectually stimulating and profoundly significant committee, I look forward to an enriching journey with each one of you.

The agenda before us — "Addressing the Loss of Bodily Autonomy of Women with Special Emphasis on the Criminalization of Abortion Laws and Maternal Mortality" — is not merely a topic of international relevance, but a pressing humanitarian concern that strikes at the heart of human rights, gender equality, and ethical governance. As future diplomats, thinkers, and changemakers, your role in exploring, debating, and resolving this issue is both a challenge and a responsibility. Our committee will be a space of rigorous research, articulate diplomacy, and respectful engagement. I expect each delegate to approach this platform with open-mindedness, empathy, and intellectual honesty. The diversity of opinions — rooted in the cultural, legal, and moral frameworks of your respective nations — will be the very foundation of our discourse. However, let us not forget that behind the statistics and laws lie the lived realities of millions of women across the world.

Your preparation will define the quality of debate. Dive deep into your country's stance, explore both progressive and conservative perspectives, and come equipped with not only problems but solutions — innovative, realistic, and inclusive. Policy suggestions that bridge ideology with practicality will be valued the most.

Committee dynamics will be governed by mutual respect, sharp diplomacy, and structured debate. From moderated caucuses to working papers and resolutions, every moment will be an opportunity to learn and lead. We encourage delegates to rise beyond scripted speeches — to think, to respond, and to act diplomatically in real-time.

This MUN is not just a competition; it is a canvas for growth. Whether you are a seasoned delegate or a first-timer, you are here because you belong. I urge you to engage fully, ask questions fearlessly, and support one another throughout the process. The friendships and memories you make here may last much longer than the conference itself. On behalf of the Executive Board, I welcome you once again to UNCSW. Let's make this committee a space of thoughtful debate, transformative ideas, and most importantly, human connection.

Warm regards,

Devansh Jaiswal

Chairperson, UNCSW

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Letter from the Vice-Chairperson

Dear Delegates,

Greetings!

It is with great pleasure and enthusiasm that I welcome you to the United Nations Commission on the Status of Women (UNCSW) to be simulated at the 11th annual edition of the Seth Anandram Jaipuria Model United Nations. As your Vice-Chairperson, I am both excited and humbled to embark on this journey alongside each of you.

At SAJMUN, year after year, delegates from across the country come together in pursuit of engaging in dialogue and devising pragmatic solutions to the persistent problems of our time. This year, at the UNCSW, we deliberate an agenda that strikes at the very core of justice and human dignity: "Addressing the Loss of Bodily Autonomy of Women, with special emphasis on the Criminalization of Abortion Laws and Maternal Mortality."

In a world where women still fight to be heard over laws made about their bodies, the question of bodily autonomy has become a global emergency. From near-total bans on abortion to unlawful norms, women's rights are being legislated, silenced, and in many cases, buried. In this committee, we are here to discuss centuries of silence- to question and challenge systems that criminalize women for seeking control of their bodies.

This committee is not convening for semantics and surface-level resolutions. As delegates, you are stepping into the shoes of another nation, with immense power and prowess. You will be tasked with confronting real-world injustices through informed policy-making, practical solutions, and most importantly, unwavering integrity. I urge you not to just argue with facts, but with the weight of real lives behind your words.

The Executive Board has prepared this guide to serve as just a foundation for your research. We encourage you to extensively research your country's stance and protect your foreign policy with utmost rectitude. Understand the cultural, political, and economic frameworks that shape national laws. The connection between your policy and outputs in the committee will be primarily evaluated. We strongly suggest you come prepared with realistic solutions, substantive research and diplomatic conduct. This is not just a discussion about policy; it is a defence of dignity. This conference will be a platform that will surpass typical debate, challenge perspectives, and inspire meaningful discussions. I, therefore, hope that the extensive research sessions, heated arguments, and moments of laughter in between serve as indelible memories, a drop of knowledge, or both.

Looking forward to a productive conference!

With immense gratitude,

Angira Purwar

Vice - Chairperson, UNCSW

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Letter from the Rapporteur

Dear Delegates,

Greetings!

I extend to you all my warmest regards and appreciation for your commitment to advancing gender equality and protecting the rights of women and girls around the globe. As we convene under the auspices of the United Nations Commission on the Status of Women (UNCSW), we are called to address a pressing and deeply sensitive issue: the loss of bodily autonomy among women, with special emphasis on the criminalization of abortion and the impact of restrictive maternity laws.

Bodily autonomy means having control over your own body. For women, this includes the right to make decisions about their health, including whether or not to have children. Unfortunately, in many countries, laws take that right away. When abortion is illegal, women are often forced to seek unsafe and dangerous procedures. This can lead to serious health problems, or even death. It can also lead to women being punished or even imprisoned for trying to make a choice about their own bodies.

Across various regions, abortion remains criminalized, not only jeopardizing women's health and lives but also denying them agency over their reproductive choices. These laws do not reduce the number of abortions—they only make them unsafe. Women in countries with restrictive laws are often forced to seek clandestine procedures, placing them at risk of severe health complications, incarceration, or death. The criminalization of abortion disproportionately affects marginalized women—those with limited access to healthcare, information, and legal protection. All of these issues take away women's freedom and limit their opportunities in life.

This background guide provides essential context, key terms, global case studies, and potential solutions to support your research and preparation. I strongly encourage all delegates to read it thoroughly, as it will serve as the foundation for our discussions and resolutions during committee sessions.

As delegates, your job is to speak up for women's rights and help come up with solutions that protect women's choices, health, and futures.

Looking forward to our time together!

Sincerely,

Varnika Agarwal

Rapporteur, UNCSW

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Introduction to UNCSW

1. Mandate and Role

The United Nations Commission on the Status of Women (UNCSW) is the principal global intergovernmental body exclusively dedicated to the promotion of gender equality, the rights and the empowerment of women. A functional commission of the Economic and Social Council, it was established by ECOSOC resolution 11(II) of 21 June 1946. It forged a close relationship with non-governmental organisations, with those in consultative status with the UN Economic and Social Council (ECOSOC) invited to participate as observers. The CSW is an instrumental body in promoting women's and girls' rights, documenting the reality of their lives throughout the world, and shaping global standards on gender equality and the empowerment of women and girls. It was established with a mandate to prepare recommendations on promoting women's rights in political, economic, social, civil and educational fields. The Commission is also responsible for monitoring, reviewing and appraising progress achieved and problems encountered in the implementation of the Beijing Declaration and Platform for Action of 1995 and of the outcomes of the twenty-third special session of the General Assembly of 2000, at all levels, and to support gender mainstreaming. The Commission also contributes to the follow-up to the 2030 Agenda for Sustainable Development to accelerate the realisation of gender equality and the empowerment of women and girls. At every annual session, usually held in March, members meet to review progress towards gender equality and the empowerment of women, identify challenges, set global standards and norms and formulate policies to promote gender equality and women's empowerment worldwide.

2. Structure and Reporting Mechanisms

The Commission consists of 45 members who are elected for a period of four years by ECOSOC based on equitable geographical distribution, according to the following pattern:

(a) 13 members from African States,
(b) 11 members from the Asia-Pacific States,
(c) 9 members from Latin American and Caribbean States,
(d) 8 members from Western European and other States,
(e) 4 members from Eastern European States.

The Bureau of the Commission plays a crucial role in facilitating the preparation for and in ensuring the successful outcome of the annual sessions of the Commission. Bureau members serve for two years.

In addition to this, the Commission accepts **communications** from any individual, organisation, group or network containing information relating to alleged violations of

human rights that affect the status of women in any country in the world.
The UN Commission on the Status of Women (UNCSW) receives reports primarily through national reports submitted by Member States on the implementation of the Beijing Platform for Action. These are reviewed during its annual sessions to monitor progress on gender equality.

3. Past work and resolutions

The most prominent works of the UNCSW include drafting international legal instruments, primarily the **Convention on the Elimination of All Forms of Discrimination against Women** and its **Optional Protocol**, and the global normative and policy framework, such as the **Beijing Platform for Action**. The Commission also made progress in the follow-up to the Fourth World Conference on Women (1995) in putting key gender equality issues onto the global agenda and in encouraging action and implementation at the national level.

1- During the first session of the Commission, members affirmed that it should engage in upcoming discussions on the **Universal Declaration of Human Rights.** Contributing to the drafting of the International Bill of Rights became one of the Commission's first tasks.

2- The **Convention on the Political Rights of Women**, drafted by the Commission, was adopted by the General Assembly on 20 December 1952.

3- A study launched in collaboration with the ILO (International Labour Organisation) led to the 1951 **Convention on Equal Remuneration for Men and Women Workers for Work of Equal Value**, which became the principle of equal pay for men and women in areas of work.

4- To mark its 25th anniversary, the Commission, in 1972, recommended that 1975 be designated the **International Women's Year.** The World Conference defined a World Plan of Action for the Implementation of the Objectives of the International Women's Year, which offered comprehensive guidelines for the advancement of women until 1985.

5- The Commission has regularly considered the issue of women in armed conflicts, thus contributing to the work that led to the adoption of **Security Council Resolution 1325** (2000) on women, peace and security. [1]

Additional Resources:

Beijing Declaration and Platform for Action(2015) https://www.unwomen.org/en/digital-library/publications/2015/01/beijing-declaration

Resolution 1325

https://www.un.org/womenwatch/osagi/wps/

Footnotes:

[1] UN Women. (2019). *A short history of the Commission on the Status of Women*

Understanding Bodily Autonomy

1. Definition and Scope

Bodily autonomy is defined as the right to make decisions about your own body, life and future without coercion or violence. It is about being empowered to make informed decisions. Not only is bodily autonomy a human right, it is the foundation upon which other human rights are built. Having bodily autonomy does not mean any person gets to undermine the health, rights or autonomy of others. No one has the right to violate the rights, autonomy or bodily integrity of anyone else. Bodily autonomy is concerned with the welfare of humanity and therefore cannot be termed as a "women's issue". Every individual should be empowered to claim their bodily autonomy. This includes men, women, boys and girls, people of diverse sexual orientations and different gender expressions. It includes people of all races, faiths, nationalities and disability status. [1]

2. Historical context and evolution of the concept

"Bodily autonomy," as an abstract philosophical principle, dates back at least to the ancient Greek philosophers. Over the centuries, legal scholars and political philosophers have thought hard about the relationship between rights and laws, the individual and the group, and the sovereign state and the autonomous individual. Historically, the concept has been limited due to societal assumptions and prejudices. The key role in the evolution of bodily autonomy as a concept has been played by **The Women's Liberation Movement**. It embraced bodily autonomy as a fundamental principle by advocating for women's rights to make decisions about their bodies, particularly concerning reproductive health. This movement fought against restrictive laws that limited access to contraception and abortion, emphasising that women should have the freedom to choose what happens to their bodies without coercion. By linking bodily autonomy with broader gender equality goals, activists worked to raise awareness of how societal norms often controlled women's choices. [2]

3. Relevance in international law and human rights instruments

The Universal Declaration of Human Rights, along with other international human rights instruments, highlights that bodily autonomy is a fundamental right. A United Nations Population Fund report has suggested that roughly half of all women are denied bodily autonomy. In the 57 countries surveyed, the proportion of women aged between 15 and 49 able to make autonomous decisions when it comes to sex with partners or husbands, contraception, and seeking health care ranged from 87% to as low as 7%. Meanwhile, laws that compel women to continue non-viable pregnancies or force them to leave a

country to terminate those pregnancies violate recognised human rights, according to the report. [3]

According to OHCHR, key human rights principles of non-discrimination, equality, empowerment, participation and accountability must be respected. Bodily autonomy and human rights are closely connected and cannot exist without one another. The International Conference on Population and Development (1994) emphasised reproductive rights as central to development. These frameworks mandate states to uphold individuals' rights to make informed choices about their bodies, free from discrimination, coercion, or violence. Ensuring bodily autonomy is vital for achieving gender equality and safeguarding human rights globally.

Additional Resources:

Women's Liberation Movement
https://www.lse.ac.uk/library/collection-highlights/womens-liberation-movement

The War on Bodily Autonomy is a Testament to Resilience- Sophie Arseneault
https://youtu.be/xQGEK4ZpiuA?si=VAylAcUPIXSHSlaS

Footnotes:

[1] United Nations Population Fund. (14 April, 2021).
[2] The Nation. (2017). David M. Perry. My Body, My Choice.
[3] UNFPA. State of World Population report 2024. *Interwoven lives, threads of hope.*

Criminalisation of Abortion : A Global Overview

1. History and Background

The criminalization of abortion is rooted in centuries-old social, religious, and political structures. In pre-modern societies, abortion was often practiced with the assistance of midwives and traditional healers. However, as modern nation-states consolidated power, especially in the 19th and 20th centuries, abortion became increasingly regulated and criminalized.

The early legal frameworks in Western countries were primarily influenced by Christian religious doctrines, particularly Catholicism, which regarded abortion as morally impermissible. The British Offences Against the Person Act of 1861 and the American Comstock Laws of the 1870s laid the groundwork for criminal abortion statutes across former colonies and allied countries.[1]

Throughout the 20th century, shifts toward liberalization were often propelled by feminist movements and public health imperatives. Nevertheless, significant pushbacks persist, fueled by conservative ideologies and religious fundamentalism.

2. Regional Perspectives

a. Latin America

Latin America is home to some of the world's most restrictive abortion laws. Until recently, countries like El Salvador and Nicaragua criminalized abortion under all circumstances. However, landmark rulings in Colombia (2022) and Mexico (2021) have partially decriminalized abortion, reflecting a shift toward reproductive rights in some parts of the region.[2]

Religious influence, particularly from the Catholic Church and Evangelical movements, remains a dominant factor in shaping policy.

b. Africa

Abortion laws across Africa vary dramatically. South Africa permits abortion on request up to 12 weeks under the Choice on Termination of Pregnancy Act (1996). Conversely, countries like Egypt and Senegal criminalize abortion except when the mother's life is at risk. Many African nations operate under colonial-era penal codes, reinforced by contemporary religious and cultural norms.[3]

c. Middle East

In most Middle Eastern nations, abortion is strictly prohibited or allowed only in life-threatening cases. Sharia law plays a substantial role, and cultural conservatism enforces strict gender norms. Tunisia is an exception, with liberal abortion laws since the 1970s,

showcasing how secularism in governance can influence policy.[4]

d. South Asia

India presents a complex case. Though abortion has been legal under the Medical Termination of Pregnancy Act since 1971, access is often hindered by socio-cultural stigma and medical gatekeeping. Pakistan and Bangladesh restrict abortion heavily, permitting it only to save the mother's life or for early-stage menstrual regulation.[5]

e. United States of America

The overturning of Roe v. Wade by the U.S. Supreme Court in Dobbs v. Jackson Women's Health Organization (2022) marked a seismic shift. Abortion laws are now determined by individual states, resulting in a patchwork legal landscape — from near-total bans in Texas and Alabama to protected rights in California and New York.[6]

3. Legal Frameworks and Categories of Abortion Laws

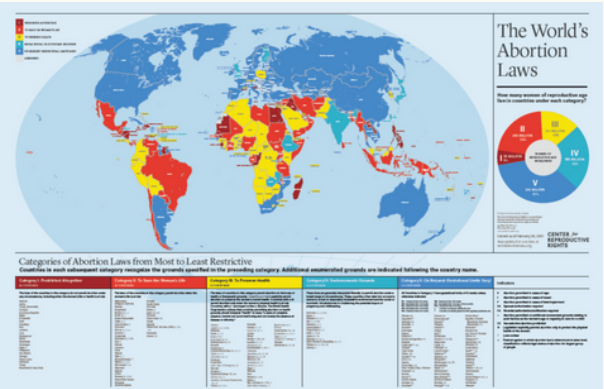
Globally, abortion laws fall into five broad categories:

- **Prohibited altogether** - No legal access (e.g., El Salvador, Malta)
- **To save a woman's life** - Permitted only in life-threatening cases (e.g., Nigeria, Lebanon)
- **To preserve health** - Includes physical and mental health (e.g., India, Zambia)
- **On socioeconomic grounds** - Consideration of economic and social factors (e.g., Great Britain)
- **On request** - No restrictions based on reason, usually up to a gestational limit (e.g., Canada, South Africa)

Many countries also differ on gestational limits, parental/spousal consent, and required medical approvals, significantly impacting access.

4. Impact of Religious and Cultural Norms

Religious doctrines — particularly conservative interpretations of Islam, Christianity, and Judaism — have played a pivotal role in shaping abortion laws. In many societies, abortion is not just a legal issue but a deeply moral one, tied to notions of sin, family honor, and gender roles. Cultural stigma often discourages women from seeking abortion even where it is legally permitted. In patriarchal societies, the notion of female autonomy, especially over reproduction, is perceived as a threat to traditional values. Religious leaders and institutions frequently exert significant influence over legislative and judicial decisions, contributing to the polarization of abortion debates. In contrast, secular movements and feminist organizations continue to advocate for decriminalization and reproductive justice.



Global Map of Abortion Laws (Source: Center for Reproductive Rights)

Some useful resources:

"Why Access to Safe Abortion is a Human Rights Issue" - UN Human Rights Office [https://youtu.be/WmjEgyCqShU]

Center for Reproductive Rights Global Database [https://reproductiverights.org/maps/worlds-abortion-laws/]

WHO Guidelines on Safe Abortion (2022) [https://www.who.int/publications/i/item/9789240039483]

Footnotes:

[1] Sheldon, S. (1997). *Beyond Control: Medical Power and Abortion Law*. Pluto Press.

[2] Center for Reproductive Rights. (2022). *Latin America Abortion Laws Overview*.

[3] Berer, M. (2004). *National Laws and Unsafe Abortion: The Parameters of Change*. Reproductive Health Matters.

[4] United Nations Population Fund (UNFPA) Report, 2020.

[5] Guttmacher Institute. (2018). Abortion in South Asia.

[6] Supreme Court of the United States. (2022). D*obbs v. Jackson Women's Health Organization*, 597 U.S. ___ (2022).

Consequences of Restrictive Abortion Laws

1. Unsafe abortions and maternal health risks

Unsafe abortion is an important cause of maternal deaths and morbidities. Between 4.7% and 13.2% of maternal deaths each year are caused by unsafe abortion. Every year, unsafe abortions result in the hospitalisation of more than 7 million women in impoverished countries. According to studies, women frequently engage in risky abortion procedures and employ the same inexperienced personnel and traditional techniques that pose health risks.[1]

Global estimates from 2010-2014 demonstrate that 45% of all induced abortions are unsafe. Of all unsafe abortions, one-third were performed under the least safe conditions, i.e. by untrained persons using dangerous and invasive methods. [2]

Complications as a result of unsafe abortions include life-long injuries, severe disability, heavy bleeding, damage to internal organs, or the loss of the ability to become pregnant in the future. Economic consequences also pose a great difficulty, with medical costs forcing women into making a financial sacrifice or simply making abortion inaccessible to those with fewer resources.

- Unsafe abortion is a significant contributor to maternal mortality worldwide.
- Over 29,000 women and girls die annually due to unsafe abortion.
- People resort to unsafe abortion due to a lack of safe options and unbearable pregnancies.
- Legal limitations, moral judgment, and stigma can inhibit access to safe abortion care. [3]

2. Criminalisation and imprisonment of women and healthcare providers

People defending the right to abortion and providing necessary healthcare services, including human rights workers and healthcare providers, are prone to being attacked, intimidated and even subjected to wrongful prosecution and imprisonment. They face disrespect for their rights to work and provide essential healthcare services, which must be protected. While progressive abortion law reform continues, anti-abortion regressions impede access with the promotion of disinformation and toxic narratives – smear campaigns that hijack public discourse and agitate against the right to abortion and against those who defend it. Criminalising abortion is the biggest contributing factor to the estimated 35 million unsafe abortions happening every year. This shows that healthcare staff are constantly caught in the conflict between their ethical and professional duty to provide the best available care and being criminally liable if they do

not follow harmful laws. Venezuelan teacher and human rights defender Vannesa Rosales was criminalised for helping a woman and her 13-year-old daughter get access to abortion.

- In Poland, Justyna Wydrzyńska, a member of Abortion Without Borders and the Abortion Dream Team, was convicted for helping a woman access abortion pills earlier this year - a safe way of terminating a pregnancy.
- In Ghana, an advocate for sexual and reproductive rights said service providers have experienced physical violence and public shaming by members of the public for educating people about contraception. [4]

3. Access to post-abortion care

The World Health Organisation recommends that:

- Regardless of whether abortion is legal, States are required to ensure access to post- abortion care where it is needed.
- Post-abortion care must be available on a confidential basis, including in situations where abortion is illegal.
- Post-abortion care must be available without the threat of criminal prosecution or punitive measures. States must not require health workers to report persons suspected of undertaking unlawful abortion, or require them to provide any potentially incriminating information during or as a prerequisite to receiving post-abortion care. [5]

Despite these guidelines, the rise in mortality rates due to unsafe abortion and lack of access to proper post-abortion care continues to exist. Acute complications such as uterine perforation or the perforation or injury of other internal organs may be fatal if emergency care is not urgently provided. Infection will progress locally and systemically as long as the proper medical and surgical therapy is not given. The later and the less efficient the care received, the more severe the consequences are likely to be, and the greater the risk of death. Therefore, it is recommended that the assessment of the woman's condition and the provision of post-abortion care should be available on a 24-hour basis and provided with the urgency demanded by the severity of the condition.

Inaccessibility to post-abortion care is due to various factors, some of which include, shortage of funds, a lack of hospitals in smaller countries, discrimination, stigma, and mistreatment. Globally, a lack of appropriate post-abortion care contributes to preventable maternal deaths, especially in regions with limited healthcare infrastructure.

4. Socioeconomic and psychological consequences

Psychological consequences of abortion have been considerably neglected, including higher rates of anxiety, low self-esteem, and stress. Women denied an abortion are more

likely than women who received an abortion to experience economic hardship and insecurity lasting years. Laws that restrict access to abortion may result in worsened economic outcomes for women. Women denied abortions were nearly four times more likely to live below the federal poverty line and had a 63% lower chance of full-time employment six months post-denial. Additionally, they were over six times more likely to rely on public assistance. These disparities persisted for at least four years. Moreover, denied women faced increased financial instability, with a 78% rise in overdue debts and an 81% uptick in negative financial events like bankruptcies and evictions. This showcases the profound and lasting economic consequences of restrictive abortion laws on women's lives. [6]

Footnotes:

[1] International Journal of Reproduction, Contraception, Obstetrics and Gynaecology (2024)

[2] World Health Organisation. (2024). Abortion.

[3] Doctors without Borders. (2019). *Unsafe abortion: A preventable danger.*

[4] Amnesty International. (2023). *Human rights defenders and health workers who face widespread abuse and criminalization for defending the right to abortion must be better protected.*

[5] World Health Organisation. (2022). *Abortion care guideline.*

[6] National Library of Medicine. PubMed Central. (2018). *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States.*

Maternal Mortality & Its Link with Bodily Autonomy

Maternal mortality is not merely a health statistic—it is a human rights issue. The ability of a woman to survive childbirth, access reproductive care, or make decisions about her own body is intrinsically tied to her autonomy. In many countries, systemic neglect, legal restrictions, and social inequities contribute to thousands of preventable maternal deaths every year.

Causes of Maternal Mortality

According to the World Health Organization (WHO), the **leading direct causes** of maternal deaths include:

- Severe bleeding (mostly after childbirth)
- Infections (usually after childbirth)
- High blood pressure during pregnancy (pre-eclampsia and eclampsia)
- Complications from delivery
- Unsafe abortion[1]

Many of these conditions are **completely preventable or treatable** with access to quality care. However, in areas where bodily autonomy is compromised, women face hurdles in accessing timely and adequate medical support.

Preventable Deaths and the Role of Access to Reproductive Healthcare.

Globally, an estimated **287,000 women died during and following pregnancy and childbirth in 2020**, with **95% of these deaths occurring in low and lower-middle-income countries**[2]. Most of these deaths are **avoidable** through access to:

- Safe abortion services
- Emergency obstetric care
- Family planning and contraception

Where abortion is criminalized or stigmatized, **delays in seeking care, denial of services, and fear of prosecution** all contribute to increased mortality. For instance, in **Nigeria**, a country with highly restrictive abortion laws, maternal mortality stands at **512 deaths per 100,000 live births**, one of the highest in the world[3].

Restrictive laws also inhibit access to **misoprostol and mifepristone**, WHO-recommended drugs for managing miscarriages and safe medical abortions[4].

Intersectionality: Impact on Marginalized Groups

Maternal mortality is also shaped by **intersecting identities** such as race, caste, class, disability, and geography. For example:

- In the **United States**, Black women are **three times more likely to die from pregnancy-related causes** than white women, due to systemic racism and

inequities in healthcare access[5].

- In **India**, Dalit and Adivasi women face discrimination within public health systems and are more likely to give birth without skilled medical support[6].
- Adolescent girls, disabled women, and refugees are **even more vulnerable**, often ignored in policy making and resource allocation.

These injustices highlight that bodily autonomy is not only about the legal right to abortion, but also the **real-life ability to exercise reproductive choices** with dignity and without fear.

Some useful resources:

- *Why Are So Many Women Dying From Pregnancy?* – Vox (YouTube)

[https://www.youtube.com/watch?v=wlDDDwHQdZ0]

Footnotes:

[1] World Health Organization. (2022). *Maternal Mortality.*
[2] United Nations Maternal Mortality Estimation Inter-Agency Group. (2023). *Trends in Maternal Mortality: 2000 to 2020.*
[3] Amnesty International. (2021). *Nigeria: Maternal Mortality and Unsafe Abortion.*
[4] WHO. (2023). *Medical Management of Abortion.*
[5] CDC. (2022). *Racial and Ethnic Disparities in Maternal Mortality in the U.S.*
[6] Human Rights Watch. (2020). *India: Caste Discrimination in Maternal Health.*

International Legal Framework & Bodies

The global response to the criminalization of abortion and the broader issue of bodily autonomy is anchored in a complex yet robust international legal and institutional framework. Various conventions, covenants, and UN agencies have sought to safeguard reproductive rights, framing them as an integral part of women's human rights. This section outlines the key legal instruments and the roles of major international bodies committed to ensuring reproductive autonomy and reducing maternal mortality.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Adopted in 1979 by the UN General Assembly, the **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)** is often referred to as the *international bill of rights for women*. It obliges states to eliminate discrimination against women in all spheres, including health and reproductive rights. Article 12 of CEDAW specifically mandates that states must ensure women equal access to healthcare services, including those related to family planning[1].

The **CEDAW Committee**, which monitors state compliance, has clarified in its General Recommendation No. 24 that laws criminalizing abortion violate women's rights to health and equality and can constitute discrimination[2]. It has consistently urged states to decriminalize abortion and ensure access to safe and affordable abortion services, particularly in cases of rape, incest, or threat to the woman's life or health.

International Covenant on Economic, Social and Cultural Rights (ICESCR)

The **ICESCR**, adopted in 1966, guarantees the right of everyone to the highest attainable standard of physical and mental health (Article 12). The **Committee on Economic, Social and Cultural Rights (CESCR)** has emphasized that access to reproductive health services, including safe abortion, is essential to fulfilling this right[3].

In General Comment No. 22, the CESCR stated that laws which criminalize abortion or otherwise hinder access to reproductive services violate the covenant and disproportionately affect marginalized and impoverished women[4].

WHO Guidelines on Safe Abortion

The **World Health Organization (WHO)** plays a central role in establishing evidence-based medical and ethical guidelines on abortion. The latest **WHO Abortion Care Guidelines (2022)** assert that abortion is a fundamental healthcare need and emphasize that restrictive laws, mandatory waiting periods, and third-party authorization requirements create barriers that can lead to unsafe abortions[5].

The WHO underscores that safe abortion services are essential to reducing maternal mortality and morbidity and that governments must ensure access to these services without discrimination or stigma.

Role of OHCHR, UNFPA, WHO

Several UN bodies work collaboratively to uphold reproductive rights as part of the broader human rights framework:

- **Office of the High Commissioner for Human Rights (OHCHR):** Advocates for the integration of sexual and reproductive health rights (SRHR) within international human rights discourse. It provides legal interpretations, engages with treaty bodies, and assists states in aligning domestic laws with international norms[6].
- **United Nations Population Fund (UNFPA):** Works in over 150 countries to expand access to reproductive health services, including contraception and post-abortion care. UNFPA emphasizes the importance of bodily autonomy and supports governments in achieving Sustainable Development Goal (SDG) Target 3.1: reducing the global maternal mortality ratio[7].
- **World Health Organization (WHO):** Beyond its technical guidelines, WHO engages in advocacy, training, and monitoring efforts to improve the quality and availability of abortion services. It also provides data that helps shape international understanding of maternal health and unsafe abortion trends.

Together, these frameworks and institutions represent a consensus among the international community that **bodily autonomy is a non-negotiable component of human dignity and equality**. While challenges remain in implementation, the normative direction is clear: criminalizing abortion contradicts the spirit of these legal commitments and endangers the health and lives of women worldwide

Recommended Visuals/Resources:

- WHO chart on global maternal deaths due to unsafe abortion – Link
- OHCHR explainer video on SRHR – YouTube Link
- CEDAW General Recommendation 24 (Full PDF) – Download

Footnotes:

[1] CEDAW, Article 12, United Nations General Assembly (1979).
[2] CEDAW General Recommendation No. 24 (1999) – Women and Health.
[3] ICESCR, Article 12, United Nations General Assembly (1966).
[4] CESCR, General Comment No. 22 (2016) on the right to sexual and reproductive health.
[5] WHO (2022), "Abortion care guideline".
[6] OHCHR, "Sexual and Reproductive Health and Rights: A Human Rights-Based Approach."
[7] UNFPA, "State of World Population 2022."

Notable Case Studies & Examples

1. USA: Roe v. Wade and Dobbs v. Jackson

Roe v. Wade, legal case in which the U.S. Supreme Court on January 22, 1973, ruled (7–2) that unduly restrictive state regulation of abortion is unconstitutional. Repeated challenges to *Roe* v. *Wade* after 1973 narrowed the decision's scope but did not overturn it. Simply put, the Supreme Court ruled that the Constitution of the United States protected the right to have an abortion till the point of foetal viability. This decision sparked continuous debate and division in society.

The Dobbs v. Jackson Women's Health Organisation case was filed in 2018. In 2022, the U.S. Supreme Court abandoned decades of precedent and overturned Roe v. Wade ruling there is **no constitutional right to abortion**. Many states seized the opportunity presented by the Court's 2022 decision in Dobbs v. Jackson Women's Health Organisation to enact daunting new **restrictions on abortion:** twelve adopted near-total bans, and four more imposed gestational limits of six weeks, a point at which many people may not yet realise they are pregnant. This led to a sudden push in the anti-abortion movement. [1]

2. El Salvador: Women imprisoned for miscarriages

El Salvador, in Central America, has some of the world's harshest **anti-abortion laws**, which ban all kinds of terminations even if the pregnancy poses a risk to the mother's life or results from rape or incest. The current legislation results in the prosecution of women who did not seek abortions. Women's rights organisations in El Salvador add that the issue disproportionately affects women who do not have the economic resources for private healthcare. El Salvador has considered legalising medically necessary abortions as part of a constitutional reform package, but plans were scuppered last September by a decision made by President Nayib Bukele. Women who suffer miscarriages can still be imprisoned in El Salvador. As recently as May this year, a woman who suffered a miscarriage, identified only as "Esme", was sentenced to 30 years in jail. Such harsh laws prove to be inhumane and show that fragmented legal systems in countries across the world, more specifically, El Salvador. [2]

3. Poland: Abortion ban and protests

Hundreds of thousands of people have joined protests in Poland since a **near-total ban** on abortion. Police used violence to disperse rallies and detain the protestors. Protesters described being "hit in the face", "hit with a truncheon" and "kicked in the groin" by

police, in some cases after being pinned to the ground, according to a 2021 report from Poland's independent torture prevention body. The anti-abortion ruling was made by the country's Constitutional Tribunal, which claimed that abortion because of "severe and irreversible foetal defect or incurable illness that threatens the foetus's life" was unconstitutional. The law unless pregnancy threatens the pregnant person's life or health, or is the result of rape or incest. Even in such cases, the requirement to show proof of rape makes it impossible for survivors to obtain abortions. Many medical professionals also refuse to provide abortions, including on grounds of conscientious objection, in some cases, when a woman's life has been at risk. [3]

4. Ireland: Repeal of the 8th Amendment

The 8th Amendment to the Irish Constitution was ratified in 1983. It states that- "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right." This effectively banned abortion in the Republic of Ireland. In a historic referendum, the Eighth Amendment was repealed in 2018, with the Irish government recommending that women be able to access a termination within the first **12 weeks** of their pregnancy. However, only the fair implementation of such laws and abortion services will lead to accessibility for women.

5. India: MTP Act 1971 & 2021 Amendment progress and gaps

The MTP Act of 1971 stated that "a pregnancy may be terminated on the advice of one registered medical practitioner if the length of the pregnancy does not exceed twelve weeks; or on the advice of two medical practitioners if the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks." As time elapsed, advances in technology occurred both in ultrasonography and genetics, enabling prenatal diagnosis of a large number of foetal disorders. For various scientific and biological reasons, diagnosis of a foetal anomaly is often made after 20 weeks of gestation, and this underscores the need for raising the upper gestational limit for terminating pregnancies. The MTP Act, 2021, which has now become law, contained significant amendments to the MTP Act of 1971. This extended the **upper gestational limit** for abortion from 20 to **24 weeks**. Although the amendment did not recognise abortion on demand as a pregnant person's right, it was heralded as the next step in making Indian abortion laws more progressive. This also enhanced maternal health by ensuring the provision of **safe abortion services** for women. This act not only offered protection to medical practitioners but also decriminalized individuals seeking abortion. [4]

6. Sub-Saharan Africa: Impact on maternal mortality

Sub-Saharan Africa continues to possess the highest rates of maternal mortality across the globe. In recent years, it was estimated that almost half of all global maternal fatalities from pregnancy-related complications occurred in Sub-Saharan Africa. Most of the common causes of maternal mortality are due to a lack of resources to provide quality maternal health care, in addition to patient-related factors such as acceptability and affordability of maternal health services. According to **WHO**, Sub-Saharan Africa and southern Asia accounted for around 87% (225,000) of the estimated global maternal deaths in 2023. Sub-Saharan Africa alone accounted for around **70% of maternal deaths (182,000)**. The striking number of women who have prematurely died during pregnancy in Sub-Saharan Africa is largely due to gender biases in the distribution of health services and marginalisation of women in these societies. **Gender, education, and economics** continue to have implications on maternal health in Sub-Saharan Africa. [5]

7. Latin America: Green Wave movement

The Green Wave (Marea Verde) is a feminist movement that has transformed reproductive rights across Latin America. Originating in **Argentina**, it uses green bandanas as a symbol of hope and bodily autonomy. Through persistent grassroots activism, the movement achieved major legal victories: **Argentina** legalised abortion up to 14 weeks in 2020; **Colombia** decriminalised it up to 24 weeks in 2022; and **Mexico's Supreme Court** decriminalized abortion federally in 2023, mandating public health facilities to provide services even in restrictive states. The Green Wave reframed abortion as a public health and human rights issue, mobilising mass protests and shifting cultural narratives. Its success offers a model for reproductive justice movements globally. [6]

Additional Resources:

Roe v. Wade and Dobbs v. Jackson- an important landmark in the evolution of abortion laws
https://www.brennancenter.org/our-work/research-reports/roe-v-wade-and-supreme-court-abortion-cases

Footnotes:

[1] The New Yorker. (2025). *Does a foetus have constitutional rights?*.

[2] BBC. (2022). *Abortion laws: The women jailed for suffering miscarriages.*

[3] Human Rights Watch. (2022).

[4] Indian Journal of Medical Ethics. (2022). *The Medical Termination of Pregnancy (Amendment) Act, 2021: A step towards liberation.*

[5] National Library of Medicine. PubMed Central. (2019). *An intersectional analysis of maternal mortality in Sub-Saharan Africa: a human rights issue.*

[6] Centre for Reproductive Rights. (2025). *Latin America's Green Wave.*

Success Stories & Best Practices

1. Countries with progressive laws and their outcomes

1.1 Canada

There is currently no abortion law in Canada, making it the only country in the world where the procedure is free of legal restrictions. It is publicly funded as a medical procedure under the combined effects of the federal Canada Health Act and provincial health-care systems. In 1988, the Supreme Court of Canada ruled in R. v. Morgentaler that any law that restricted a woman's right to life, liberty, and security of person was unconstitutional, paving the way for progressive abortion laws and facilities. According to CBC, experts and advocacy groups have roundly criticised the idea of creating any sort of stand-alone law on abortion, saying that this could lead to a plethora of unintended consequences. A key positive outcome of legal abortion in Canada is the significant reduction in maternal mortality and morbidity related to unsafe procedures. Studies show that Canada has one of the lowest abortion complication rates globally, and most abortions occur early in pregnancy due to accessible services. [1]

1.2 Sweden

Abortion is available on request in Sweden until 18 weeks of pregnancy and thereafter in severe cases of medical risk. Abortions must be carried out by a qualified medical doctor in a general hospital or private clinic approved by the National Board of Health and Welfare. Counselling must be offered to the pregnant person, but it is not mandatory. Services are publicly funded, ensuring universal access regardless of socioeconomic status. The country's use of trained midwives for medical abortions has improved accessibility and maintained safety. Abortion-related maternal mortality has significantly declined since legalisation. Sweden's progressive laws demonstrate that reproductive rights can coexist with excellent public health outcomes. universal access regardless of socioeconomic status. The country's use of trained midwives for medical abortions has improved accessibility and maintained safety. Abortion-related maternal mortality has significantly declined since legalisation. Sweden's progressive laws demonstrate that reproductive rights can coexist with excellent public health outcomes.

1.3 Nepal

Nepal legalised abortion in 2002 to address high maternal mortality from unsafe procedures. Women can now access abortion up to 12 weeks on request, and up to 28 weeks in cases of rape, incest, fetal anomalies, or health risks. Since legalisation, maternal mortality has decreased significantly, with abortion-related deaths declining. The government provides free abortion services in public facilities, enhancing access

for marginalised groups. However, challenges remain, as many women still seek unsafe abortions due to stigma and limited awareness. Overall, Nepal's progressive laws have improved women's health and autonomy. [2]

2. Impact of sex education and access to contraceptives

Comprehensive sex education and accessible contraceptive services are pivotal in reducing unintended pregnancies and, consequently, abortion rates. In Finland, the implementation of mandatory sex education in schools coupled with the provision of free contraception to adolescents led to a 66% decrease in teenage abortions between 2000 and 2023. Among those under 18, the reduction was even more pronounced at 78%. [3]

Moreover, comprehensive sex education programs have been effective in increasing contraceptive use among adolescents, thereby reducing unintended pregnancies and abortions. This highlights that comprehensive sex education and access to contraception are effective strategies in reducing abortion rates by preventing unintended pregnancies.

3. Role of civil society and grassroots movements.

The involvement of civil society institutions is crucial to this process. Their voice of accountability for community health needs is essential
to ensure universal coverage and equitable access to reproductive, maternal and child health. Despite the success of international bodies, abortion rights in many countries have not been expanded. Across Latin America, professional feminist NGOs have played a key role in securing access to abortion. The most significant example is the Green Wave Movement:

- The Inter-American Court of Human Rights 2024 ruling that El Salvador violated the rights of a woman, Beatriz, by denying her abortion care for her high-risk pregnancy. The Court ordered El Salvador to provide legal certainty to health personnel so they can proceed in cases where life or health is at risk.
- A 2021 ruling by the Supreme Court of Mexico declared unconstitutional the absolute criminalisation of abortion. The Court unanimously recognised a constitutional right to legal, safe, and free abortion services at the initial stages of pregnancy, as well as in other situations.
- The Constitutional Court of Ecuador ruling in 2021 expanding the exceptions for legal abortion, including access in case of rape. Previously, exceptions were only considered when the woman's health or life was at risk. [4]

Beyond this, the NGO Reproductive Health Uganda combined a broad range of interventions to prevent unintended pregnancies and unsafe abortions. [5]

Global institutions such as the WHO and local organisations together contribute immensely to progress, even in the face of concerted efforts to undermine women and girls' agency and rights.

Footnotes:

[1] Museum of Contraception and Abortion. *Canada leads the way: fewer abortions, reduced maternal mortality.*

[2] National Library of Medicine. PubMed Central. (2013). *Effects of Abortion Legalization in Nepal, 2001-2010.*

[3] Reuters. (June 3, 2024).

[4] Center for Reproductive Rights. (2025). *Latin America's Green Wave.*

[5] World Health Organisation. (2023). *Widening access to quality abortion care from the grassroots up.*

Stakeholders Involved

The issue of bodily autonomy—particularly in relation to abortion rights and maternal health—is deeply embedded in political, social, cultural, and institutional dynamics. It demands multi-level cooperation and often contends with powerful resistance. Understanding the key stakeholders is vital to shaping nuanced and actionable policy responses.

1. Governments and National Legislatures

National governments and parliaments hold the primary legal authority to draft, amend, and enforce abortion laws. Their role is pivotal in either facilitating or restricting women's access to reproductive health services. Some states have adopted progressive legislation decriminalizing abortion and providing universal reproductive healthcare, while others have imposed outright bans or limited access under narrow conditions (such as threat to life or rape).

- **Legislatures** are responsible for aligning domestic laws with international treaties such as CEDAW and the ICESCR.
- **Judicial bodies**, like constitutional courts or supreme courts, often interpret these laws and serve as critical arenas for rights-based advocacy (e.g., Roe v. Wade in the US, or India's 2022 Supreme Court judgment affirming abortion rights for unmarried women).
- **Healthcare ministries** influence abortion policy implementation through funding, guidelines, and medical regulation.

Government inaction or regression on reproductive rights often correlates with increased maternal mortality, unsafe abortions, and gender-based inequalities.

2. International Organizations (UN, WHO, IPPF)

Several intergovernmental and transnational bodies play an essential role in setting global standards, providing technical support, and advocating for reproductive rights:

- **United Nations (UN)**: Through bodies like the UN Women, OHCHR, UNFPA, and treaty committees (e.g., CEDAW Committee), the UN works to integrate bodily autonomy into the global human rights framework.
- **World Health Organization (WHO):** Acts as the foremost authority on medical standards and publishes comprehensive abortion care guidelines. WHO also monitors maternal health indicators globally and advises governments on improving safe abortion access.

- **International Planned Parenthood Federation (IPPF):** A global non-governmental organization that works with national affiliates to provide direct sexual and reproductive health services, especially in low-resource settings.

These organizations not only support capacity building and knowledge dissemination but also fund initiatives that counter unsafe abortion practices and promote maternal healthcare access.

3. Religious and Cultural Institutions

Religious and traditional institutions often exert a profound influence on public opinion and policy making, particularly in societies where religion plays a central role in identity and governance.

- **Conservative religious authorities**—whether from Christianity, Islam, Hinduism, or other belief systems—may oppose abortion on moral or doctrinal grounds, promoting laws that criminalize it.
- **Cultural norms** in certain communities reinforce patriarchal notions of women's roles as child-bearers and caretakers, making it difficult for women to access reproductive choices without stigma.

However, there are also **progressive faith-based groups** advocating for gender justice and women's autonomy, proving that religion and rights-based approaches need not be mutually exclusive.

Religious interpretations often shape political narratives and electoral outcomes, making dialogue with these stakeholders both challenging and necessary.

4. Civil Society and Advocacy Groups

Civil society organizations (CSOs) have been the driving force behind the recognition and realization of reproductive rights globally. They act as watchdogs, service providers, and change agents through:

- **Legal advocacy** (e.g., petitioning courts to overturn restrictive abortion laws).
- **Public education campaigns** that address stigma, misinformation, and myths around abortion and contraception.
- **Community-based services** that provide post-abortion care, safe abortions (where legal), and mental health support.

Key players include organizations like **Center for Reproductive Rights**, **Marie Stopes International**, **Ipas**, and countless grassroots collectives across the Global South.

In some contexts, civil society faces criminalization or funding cuts due to rising authoritarianism or religious backlash. Despite such challenges, their work remains crucial in ensuring that women's rights are not just guaranteed on paper but realized in practice.

The complexity of bodily autonomy stems from the intersectionality of its stakeholders. No one actor can address maternal mortality or abortion rights in isolation. Only a **collaborative, rights-based, and culturally sensitive approach**—rooted in law, ethics, and public health—can uphold the dignity and well-being of women worldwide.

Challenges to Addressing the Issue

1. Political and religious resistance

Backlash from society, particularly religious and cultural norms, is a key factor in controlling the perception of abortion amongst women. This often leads to discouragement among women who wish to obtain an abortion, even in conditions of appropriate care and facilities. Political and religious resistance significantly hampers abortion access worldwide. In the United States, the 2022 overturning of Roe v. Wade was influenced by coordinated efforts between conservative political actors and religious groups. Abortion is often framed as a moral transgression or sin in many religious and politically conservative communities. Religious leaders and organisations have historically wielded significant influence over political structures, embedding these beliefs into law and policy. For example, in countries like Poland and El Salvador, abortion is almost completely banned, largely due to pressure from religious institutions, despite high public support for more liberal laws. In traditional patriarchal societies, female agency is often discouraged, and abortion becomes not just a medical decision but a challenge to the established social order. Such an imbalance highlights how abortion restrictions are often less about "life" and more about control. This also shows how political and religious alliances can influence reproductive rights, often sidelining public opinion and women's health needs.

2. Health infrastructure gaps

Inadequate healthcare infrastructure poses a significant barrier to safe abortion services. This increases unsafe abortions, maternal mortality rates, and has life-threatening implications. In India, there's a reported 70% shortfall of obstetricians and gynaecologists, particularly in rural areas, making access to abortion services challenging. [1]

This shortage forces many women to seek unsafe procedures, increasing the risk of complications. Moreover, the lack of trained personnel and facilities in underserved regions exacerbates health disparities. 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. Restrictions in access to safe abortion services result in both unsafe abortions and unwanted births, for example, restricting available methods of abortion, including surgical and medical methods through, for instance, a lack of regulatory approval for essential medicines; prohibiting access to information on legal abortion services, or failing to provide public information on the legal status of abortion, etc,. [2]

3. Stigma and Misinformation

Stigma and misinformation surrounding abortion significantly impact women's access to safe services. In India, media coverage often sensationalises abortion, portraying it negatively and contributing to societal stigma. This stigma discourages women from seeking legal and safe abortions, leading to secrecy and potential health risks. Additionally, misinformation, especially online, spreads false narratives about abortion's safety and legality, further deterring women from accessing services. A high volume of misinformation that travels quickly on the internet and social media obstructs a patient's ability to find medically accurate information to inform their health care decisions, and this can have dire consequences. In the case of abortion, patients may conduct a self-managed abortion based on misinformation on the internet about "home remedy" abortions (eg, using insect repellent or illicit drugs). Marginalised communities may be the most negatively impacted by an abortion epidemic because they have higher rates of abortion, greater barriers to care, lower health literacy, less access to evidence-based health information, and less trust in health care providers, resulting from a long legacy of systemic racism in health care. [3]

4. Lack of data and research

Insufficient data and lack of medical research are an enormous challenge in addressing abortion-related issues. Due to inadequate information, women seeking an abortion become victims of unsafe practices, complications in the procedure, and do not have exposure to the correct medical resources.

The extent of missing pregnancies varied across demographic groups and was highest among Black women and unmarried women (18% each); differences reflect both the patterns of abortion underreporting and the share of pregnancies ending in abortion. Efforts to improve abortion reporting are needed to strengthen the quality of pregnancy data to support maternal, child, and reproductive health research. [4]

Globally, many countries have incomplete or unreliable abortion statistics, hindering effective policy-making and service provision. This data gap prevents the development of targeted interventions and the allocation of resources where they're most needed.

Additional Resources:

World Health Organisation: Legal and Policy Considerations

Safe abortion: Technical & policy guidance for health systemsWorld Health Organisation (WHO)https://apps.who.int › iris › bitstream

International Federation of Gynaecology and Obstetrics: Addressing barriers to safe abortion

Addressing Barriers to Safe Abortion - FIGO.orgFIGO.orghttps://www.figo.org › resources › figo-statements › addr...

Footnotes:

[1] Business Today. (29 Sep, 2022).

[2] World Health Organisation. (2015). *Safe abortion: Technical & policy guidance for health systems.*

[3] National Library of Medicine. PubMed Central. (2023). *The Next Infodemic: Abortion Misinformation.*

[4] National Library of Medicine. PubMed Central. (2021). *The Impact of Abortion Underreporting on Pregnancy Data and Related Research.*

UN Action & Previous Resolutions

The United Nations, through its various organs and frameworks, has consistently recognized sexual and reproductive health rights as central to women's empowerment, gender equality, and sustainable development. Across resolutions, declarations, and action programs, the UN has reaffirmed that bodily autonomy and access to reproductive healthcare, including safe abortion, are integral to human rights. This section highlights key resolutions, declarations, and frameworks that have shaped the international consensus on these issues.

1. Resolutions by UNCSW, UNGA, and HRC

The **United Nations Commission on the Status of Women (UNCSW)** has adopted numerous resolutions emphasizing the importance of reproductive rights in achieving gender equality and eradicating violence and discrimination against women.

- CSW65 (2021) reaffirmed the commitment to eliminating violence against women and girls and emphasized the importance of access to sexual and reproductive health services as a part of this commitment.
- CSW60 (2016) focused on women's empowerment and linked reproductive rights directly to sustainable development goals.

The **United Nations General Assembly (UNGA)** and **Human Rights Council (HRC)** have also adopted various resolutions upholding women's reproductive rights:

- UNGA Resolution 71/175 (2016) on **"Intensifying global efforts for the elimination of female genital mutilations"** acknowledged bodily autonomy as a human right.
- HRC Resolution 39/10 (2018) addressed the preventable maternal mortality and morbidity and emphasized the importance of access to reproductive health services.
- Although not all resolutions explicitly address abortion, they implicitly support access to safe and legal abortion by stressing reproductive health and rights.

2. Beijing Declaration and Platform for Action (1995)

Adopted at the **Fourth World Conference on Women in Beijing**, this landmark document remains one of the most comprehensive global commitments to women's rights, including sexual and reproductive health:

"Women have the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."- **Beijing Platform for Action, Paragraph 96.**

The Beijing Platform called on governments to:

- Review laws containing punitive measures against women seeking abortion.
- Ensure women's access to quality healthcare, including family planning and maternal care.
- Combat unsafe abortion and reduce maternal mortality.

Though not legally binding, the declaration serves as a powerful normative guide for UN Member States.

3. International Conference on Population and Development (ICPD) Programme of Action (1994)

Held in Cairo, the **ICPD Programme of Action** was groundbreaking in shifting the focus from population control to individual rights and reproductive health. It explicitly affirmed that:

- Reproductive rights are human rights.
- Unsafe abortion is a major public health concern.
- In circumstances where abortion is not against the law, it should be safe and accessible.

The Programme urged countries to **"consider reviewing laws containing punitive measures against women who have undergone illegal abortions."**

It further emphasized the need for post-abortion care and services irrespective of legal status.

4. 2030 Agenda for Sustainable Development

Adopted in 2015, the **Sustainable Development Goals (SDGs)** underscore the intersectionality of health, gender equality, and justice. Several goals directly relate to bodily autonomy and reproductive rights:

- **SDG 3** – Ensure healthy lives and promote well-being for all at all ages, specifically targets **reducing maternal mortality** (Target 3.1) and **universal access to sexual and reproductive healthcare services** (Target 3.7).
- **SDG 5** – *Achieve gender equality and empower all women and girls*, includes targets on **eliminating harmful practices**, ensuring **universal access to reproductive rights**, and **ending violence** (Targets 5.3, 5.6).
- **SDG 10** – *Reduce inequality within and among countries*, supports equal access to healthcare services and social protections.
- **SDG 16** – *Promote peaceful and inclusive societies*, indirectly contributes by ensuring **legal identity, access to justice**, and strong institutions that can uphold women's rights.

These goals collectively create a rights-based framework for UN Member States to achieve equitable access to reproductive healthcare.

Conclusion

While considerable progress has been made, the implementation of UN resolutions and action plans remains uneven across regions. As such, delegates must explore:

- Why these frameworks have not translated into uniform access to abortion and reproductive services.
- How to strengthen international cooperation to ensure bodily autonomy is respected universally.

Understanding these instruments not only provides context but also empowers delegates to propose **feasible, rights-based, and precedent-rooted solutions.**

Bloc Positions

The international debate surrounding abortion rights and bodily autonomy is deeply influenced by political ideologies, cultural values, religious doctrines, and developmental priorities. Member States within the United Nations often align into identifiable blocs based on their domestic policies and international stances regarding reproductive rights. Understanding these bloc positions helps illuminate the patterns of support and opposition that shape global policymaking in forums like UNCSW, HRC, and UNGA.

1. Liberal Bloc

This bloc is characterized by a strong commitment to **human rights-based approaches to reproductive health**, with a focus on **legal access to safe abortion**, **gender equality**, and **comprehensive sexuality education**. They frequently push for the depoliticization of women's health and advocate for universal access to sexual and reproductive healthcare.

Key Members:

- **European Union (EU) nations**: France, Sweden, the Netherlands, Germany, Belgium
- **Canada, Australia, New Zealand,** and **Nordic countries**

Position Highlights:

- Support unrestricted access to abortion up to a specified gestational period.
- Fund global initiatives promoting family planning, safe abortion, and post-abortion care (e.g., SheDecides, Global Safe Abortion Fund).
- Consistently vote in favor of resolutions that affirm reproductive rights at the UN.

Example:

Sweden and the Netherlands often co-sponsor HRC resolutions related to maternal mortality and the decriminalization of abortion[1].

2. Conservative Bloc

This group typically upholds **traditional values**, often influenced by religious or nationalist ideologies. While some may allow abortion under restricted conditions (such as risk to the mother's life), they generally oppose UN resolutions that directly support abortion access.

Key Members:

- **USA** (especially under conservative administrations like the Trump era)
- **Poland, Hungary, Russia**
- **Middle Eastern countries**: Saudi Arabia, Iran, Egypt
- **Latin American nations** with strong Catholic influence: El Salvador, Nicaragua, Honduras

Position Highlights:

- Oppose language in UN documents that explicitly refers to "abortion" or "sexual rights".
- Emphasize sovereignty, the family unit, and cultural particularism.

Example:

Under the Trump administration, the USA launched the **Geneva Consensus Declaration** in 2020, which asserted "there is no international right to abortion"[2].

3. Developing Nations

Developing countries often occupy a **nuanced middle ground**, balancing between socio-economic constraints, public health imperatives, and cultural or religious beliefs. Many of these states recognize the **public health risks of unsafe abortions** but face **legal, political,** and **infrastructural challenges** in reforming abortion laws.

Key Members:

- **India, South Africa, Brazil, Kenya, Indonesia, Philippines**

Position Highlights:

- **Su**pport improving maternal healthcare and reducing unsafe abortions, often without explicitly legalizing abortion.
- May support or abstain from UN resolutions on reproductive rights depending on domestic politics.
- Push for international funding and technical assistance for healthcare system strengthening.

Example:

- India allows abortion up to 24 weeks under the **Medical Termination of Pregnancy (Amendment) Act, 2021,** but access remains inequitable[3]. Brazil permits abortion in very limited cases, yet experiences one of the highest rates of unsafe abortions in the region[4].

Example:

Before legalizing abortion in 2020, **Argentina** served as a bridge between liberal and conservative blocs by advocating for improved access to post-abortion care while stopping short of supporting full decriminalization[5].

The bloc dynamics in international policymaking reflect how abortion rights continue to be **politicized, moralized, and contested**. Delegates must analyze not only legal frameworks but also **ideological alliances** when formulating resolutions, forging partnerships, and pushing for pragmatic, inclusive outcomes.

Footnotes:

[1] United Nations Human Rights Council. (2018). *Resolution on Preventable Maternal Mortality and Morbidity and Human Rights.*

[2] U.S. Department of Health and Human Services. (2020). *Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family.*

[3] Government of India. (2021). *Medical Termination of Pregnancy Amendment Act.*

[4] Guttmacher Institute. (2018). *Abortion in Brazil.*

[5] Center for Reproductive Rights. (2020). *Argentina: Milestone Decision Legalizing Abortion.*

Questions a Resolution Must Address

These questions serve as the foundation for problem identification, solution development, and implementation planning. Delegates are encouraged to reflect on the following as they negotiate, debate, and collaborate:

Key Questions for Delegates to Consider

1. What are the root causes of bodily autonomy violations, and how do legal, social, and cultural frameworks perpetuate them?
2. To what extent do current abortion laws align with international human rights standards such as those enshrined in CEDAW and ICESCR?
3. How can governments balance cultural or religious norms with their international legal obligations toward women's rights?
4. What measures can be implemented to ensure universal access to safe, affordable, and stigma-free reproductive healthcare, especially in low-resource settings?
5. How can criminalization of abortion be addressed without infringing on national sovereignty or cultural identities?
6. What role should international organizations play in setting standards versus directly intervening in national policy?
7. How can we ensure accountability for violations of bodily autonomy, especially in regions where legal protections are minimal or non-existent?
8. What educational and social awareness programs are effective in reducing stigma and misinformation about reproductive rights?

Gaps in Current Frameworks

- **Inconsistent Implementation of CEDAW & Other Treaties**: While many countries are signatories, actual domestic implementation remains weak, non-existent, or symbolic in several regions.
- **Lack of Universal Definitions**: Terms such as "bodily autonomy," "safe abortion," or even "maternal mortality" are interpreted differently across cultures and jurisdictions.
- **Data Deficiencies**: Limited data collection on unsafe abortions, maternal deaths, and access to services continues to hamper targeted policy action.
- **Exclusion of Marginalized Voices:** Frameworks often fail to reflect the intersectional experiences of rural women, LGBTQ+ individuals, adolescents, and women with disabilities.
- **Weak Enforcement & Monitoring Mechanisms:** Existing resolutions and guidelines lack binding power or face resistance from states, particularly on issues perceived as culturally sensitive.

Implementation Mechanisms:

To strengthen the enforceability and impact of resolutions, the following mechanisms should be explored:

- **Monitoring by UN Treaty Bodies and Special Rapporteurs**

Regular country reports, shadow reporting by NGOs, and independent assessments by Special Rapporteurs can drive accountability.

- **Technical and Financial Assistance to Developing Nations**

Many countries lack the infrastructure or resources for safe reproductive healthcare—solutions must address this through international cooperation.

- **Regional Legal Harmonization Initiatives**

Encouraging the development of regional standards (e.g., Maputo Protocol in Africa) can generate normative pressure for reform.

- **Multi-Stakeholder Partnerships**

Collaboration with civil society, academia, private healthcare sectors, and community leaders can enhance implementation efforts and local ownership.

- **Legal and Policy Reform Toolkits**

Model legislation and context-sensitive policy toolkits from international organizations like the WHO, UNFPA, or IPPF can support national capacity-building.

Suggested Moderated Caucus Topics

To facilitate structured and meaningful debate, the following moderated caucus themes may be proposed during committee sessions:

1. **Improving Access to Reproductive Healthcare in Post-Conflict Zones**
2. **Incorporating Intersectionality in Policy Frameworks**
3. **Analyzing the Effectiveness of Current UNCSW and HRC Resolutions**
4. **Innovative Funding Models for Reproductive Health Infrastructure**
5. **Mechanisms for Holding Governments Accountable for Preventable Maternal Deaths**
6. **Role of Religious Institutions in Shaping Public Discourse and Law**

Conclusion

The loss of bodily autonomy, particularly in the context of criminalized abortion laws and maternal mortality, represents not only a violation of individual rights but also a profound failure of public health systems, legal frameworks, and societal structures. Through the lens of international law and human rights, it is clear that upholding bodily autonomy is essential for achieving gender equality, health equity, and social justice.

As we have explored, the landscape surrounding this issue is deeply complex—intertwined with cultural norms, legal inconsistencies, gaps in healthcare infrastructure, and persistent inequalities. The international community has laid crucial groundwork through CEDAW, the ICESCR, the ICPD Programme of Action, and the SDGs. Yet, much remains to be done.

This committee challenges each delegate to think critically, act compassionately, and negotiate diplomatically. A truly impactful resolution must not only address the legal and health dimensions but must also consider the socio-economic, cultural, and psychological aspects that hinder women and marginalized communities from exercising their fundamental rights.

The need for **multilateral cooperation**, **intersectional policymaking**, and **inclusive implementation** is greater than ever. Only by working together—governments, civil society, international bodies, and individuals—can we create a world where bodily autonomy is respected, protected, and fulfilled for all.

Thank you for choosing to be a part of this vital conversation within the United Nations Commission on the Status of Women.

We wish you all the best for a meaningful and engaging session.

Warm regards,

The Executive Board**.**

MATRIX

United States of America
Kingdom of Saudi Arabia
Islamic Republic of Iran
French Republic
United Kingdom of Great Britain and Northern Ireland
Russian Federation
People's Republic of China
Republic of India
Representative of Vatican City (Holy See) (Observer)
The Federative Republic of Brazil
The Federal Republic of Nigeria
Republic of Poland
United Mexican States
Republic of South Africa
Republic of Argentina
Japan
Republic of Indonesia
Kingdom of Thailand
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Republic of Peru
Republic of Turkey
Arab Republic of Egypt
People's Republic of Bangladesh
Islamic Republic of Pakistan
Dominion of Canada
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Commonwealth of Australia
Republic of Kenya
Ireland
Republic of South Korea
Republic of Colombia
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Islamic Emirate of Afghanistan
Republic of Uganda
Federal Democratic Republic of Ethiopia
Kingdom of Sweden
Kingdom of Denmark
Republic of Finland
Kingdom of the Netherlands
Kingdom of Norway
Federal Democratic Republic of Nepal
Hungary
Republic of Tunisia
Republic of Chile
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