Submission of Brief to the Standing Committee on Foreign Affairs and International Development (FAAE) on Sexual and Reproductive Health and Rights of Women Globally

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Thank you, Mr. Chair for giving me the opportunity to address the committee on FAAE on the 21st of March 2023 on Sexual and Reproductive Health and Rights ("SRH") for Women globally. During the session I was unable to give responses to the questions addressed to me and on other matters that arose due to virtual transmission challenges. I shall endeavor to do so in this brief.

Abortion is a contentious topic, perhaps increasingly so, in light of recent judicial decisions worldwide. But opposing views about the ethics and politics of abortion do not prevent us from understanding some of the basic *empirical* facts about abortion from a medical and sociological perspective. This brief looks at three common arguments about abortion and demonstrates that we can have consensus about the empirical facts even if we disagree about the politics of abortion. It highlights three myths about abortion which are commonly repeated but have little to no empirical basis. I will use the United Kingdom (UK), the United States of America (US), and Poland as case studies on the points I wish to make.

Myth 1: Abortion is healthcare

It is increasingly claimed not only that abortion is permissible, but that it is healthcare – and hence denying access to abortion is denying access to healthcare. But whether or not abortion is a woman's right and an essential part of her autonomy, it is not true to suggest that abortion is, in general, something which is required for her *health*.

This claim about healthcare is certainly a recent innovation: after all, the Hippocratic Oath explicitly forbids abortion, and in response to the war crimes and crimes against humanity revealed at the Nuremberg trials (among which were included the Nazis' nullification of Poland's law protecting unborn children[1]) the World Medical Association formulated a revised version of the Oath. This required doctors to vow to 'maintain the utmost respect for human life from the time of conception'. The British Medical Association – now very supportive of abortion – in 1947 declared that the 'greatest crime' a doctor could commit was 'the destruction of life by murder, suicide and abortion'.

It is extremely rare for a mother's life to be threatened by pregnancy, healthcare in these circumstances is actually better described as premature delivery with the foreseen but unintended death of a baby instead of 'abortion'.

Data from the UK, where there is high quality abortion reporting, clearly indicates that only a tiny proportion of abortions are performed because the mother's life is at risk –

[1] The prosecution summarised: '**Abortions were also prohibited under the Polish penal code… and under the Soviet penal code. But protection of the law was *denied to the unborn children* of the Russian and Polish women in Nazi Germany**. Abortions were encouraged and even forced on these women.' Tuomala, JC (2011). 'Nuremberg and the Crime of Abortion,' *University of Toledo Law Review*, 42: 283-394.

fewer than 0.05% of abortions (fewer than 100 out of 200,000 each year).[2] Moreover, many abortions performed on these grounds in the UK do not appear to be medically necessary: many are for mental health reasons, for example, or in only one case, 'high blood cholesterol'.[3]

2% of abortions in the UK are eugenic abortions, but of course we have learnt in the last century that eugenics is not healthcare – quite the opposite. So what about the other 98%?

The remaining 98% are ostensibly for health reasons, since the UK technically requires a health indication (or eugenic indication) for abortion. But this health clause is widely interpreted to include any reason at all, including sex-selective abortion.[4] Hence 200,000 abortions occur each year, 40% of which are repeat abortions.[5] 1 in 3 women will have a miscarriage in their lifetime, and 1 in 4 pregnancies ends in abortion.[6]

This is reflected in the official data, which records that 99.9% of these abortions for health reasons are for mental health, not physical health.[7] Hence only a small fraction of 1% of abortions are to preserve the mother's physical health.

The fact that in Poland legal abortions dropped from over 100,000 in the 1980s (during the abortion on demand era) to fewer than just over 100 by the year 2000[8] (abortion only to save the mother's life, for eugenic purposes and in cases of rape) suggests that a similarly tiny proportion of abortions were for these purposes in Poland too. Even when abortion was first legalised and medical indications for abortion were more common, they were still a tiny proportion of legal abortions, with social reasons predominating.[9]

But of course, mental health is a part of health. So shouldn't these 98% of abortions be counted as healthcare? They should not. We know that, in the UK, abortions for any reason are described as mental health reasons because the law requires them to be described as such – even if they have nothing to do with mental health. This is why virtually all of these abortions are given the ICD code 'F99 – mental disorder, not otherwise specified',[10] rather than a substantive psychiatric diagnosis. In other jurisdictions, when abortion is available for social reasons or on demand, only a tiny

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[2] Department of Health (2022). 'Abortion statistics, England and Wales: 2021,' available online at https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021.
[3] Freedom of Information request.
[4] Greasley, K (2016). 'Is sex-selective abortion against the law?' *Oxford Journal of Legal Studies*, 36(3): 535-564.
[5] Department of Health (2022).
[6] Excluding miscarriages.
[7] Department of Health (2022).
[8] Sejm Rzeczypospolitej Polskiej (2002). *Sprawozdanic Rady Ministrow z wykonywania w roku 2001 Ustawy z dnia 7 stycznia 1993 roku*. Warsaw: Sejm Rzeczypospolitej Polskiej.
[9] Lesinski, W (1960). 'Die Abortsituation in der Volksrepublik Polen,' in Mehlan, KH (ed.). *Internationale Abortsituation, Abortbekämpfung, Antikonzeption*. Leipzig: Thieme; Okolski, M (1983). 'Abortion and contraception in Poland,' *Studies in Family Planning*, 14(11): 263-274.
[10] Department of Health (2022).

percentage are described as being for mental health reasons.[11] I submit that F99 claims are merely convenient, but do not reflect the true state of the mothers' mental health.

Another reason – perhaps even more decisive – that the mental health explanation is unconvincing is that there is no evidence that abortion is beneficial for a woman's mental health in the case of an unwanted pregnancy. Perhaps surprisingly, all the major academic reviews from pro-abortion researchers agree that there is not convincing evidence that abortion is beneficial for one's mental health:[12] The world's leading pro-abortion researcher in this area declared that 'at the present time there is no credible scientific evidence demonstrating that abortion has mental health benefits'.[13] In fact, the best recent meta-analysis, from the same researcher, suggests that abortion is on average *harmful* for a woman's mental health compared with continuing an unwanted pregnancy, with significantly increased risks of anxiety, suicide, drug abuse and alcohol abuse, after controlling for confounding factors.[14] The risk of abortion-specific post-traumatic stress disorder (PTSD) is 1.5-14% after abortion,[15] making it a common or very common complication of abortion according to the standard classification of adverse effects – and resulting in potentially millions of cases of PTSD globally per year. PTSD is a particularly illustrative example since the causal relationship between a traumatic event and the condition is incontrovertible when the symptoms are specific to that trauma.

By contrast, it is often assumed that women who continue an unwanted pregnancy after seeking an abortion will have their lives ruined and forever be resentful. But the evidence we have suggests the opposite – that women in this situation are virtually always eventually glad that they had the baby and were denied the abortion. In a recent study of women denied abortions in the US, a large majority continued with their pregnancies. Of the women who raised their children, 98% were glad they were denied the abortion 5 years later.[16] Unwanted pregnancies can certainly be very distressing in the short-term, and women in that situation must be given the utmost support and care. But the evidence indicates that if women are given time and support, almost all of them are eventually glad they were denied an abortion and had a child instead.

Because suicide is the leading cause of maternal death in many developed countries, and because it is associated with abortion, the overall mortality rate after abortion is significantly higher than the mortality rate after a continued pregnancy. Data from Finland shows that the mortality rate after abortion is triple the mortality rate after continued

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[11] Alvare, HM (2022). 'Nearly 50 years post-*Roe v. Wade* and nearing its end: what is the evidence that abortion advances women's health and equity?' *Regent University Law Review*, 34(2): 165-217.

[12] American Psychological Association (2008). *Report of the task force on mental health and abortion*. Washington, DC: American Psychological Association; National Collaborating Centre for Mental Health (2011). *Induced abortion and mental health*. London: Academy of Medical Royal Colleges; Fergusson, DM et al. (2013). 'Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence,' *Australia & New Zealand Journal of Psychiatry*, 47(9):819–827.

[13] Fergusson et al. (2013).

[14] Fergusson et al. (2013).

[15] Major, B et al. (2000). 'Psychological responses of women after first-trimester abortion,' *Archives of General Psychiatry*, 57(8):777–784; Rue, VM et al. (2004). 'Induced abortion and traumatic stress: a preliminary comparison of American and Russian women,' *Medical Science Monitor*, 10(10):SR5–SR16.

[16] Foster, DG (2020). *The Turnaway study: ten years, a thousand women, and the consequences of having—or being denied—an abortion*. New York: Scribner.

pregnancy,[17] and record-linkage studies from other countries confirm that abortion has a higher overall mortality rate when all causes of death – not only direct obstetric complications – are considered.[18]

Myth 2: Legalising abortion reduces maternal mortality

One of the most commonly believed claims about abortion is that legalising it will make it safe, and therefore reduce the number of women dying from unsafe backstreet abortions. Indeed, even many people who support restrictions on abortion often concede this claim, but maintain that the life of the unborn must still be protected.

The argument typically says that a) huge numbers of illegal abortions take place; b) huge numbers of women die from illegal abortions; c) legalising abortion won't increase the abortion rate; and d) it will stop women from dying.

There is a huge amount to say on this argument, with an ongoing research project being gradually published over the next few years.[19] It turns out that the evidence for these claims is limited to non-existent – in fact, there is compelling evidence that they are generally false.

It is not widely known that the UK's Royal College of Obstetricians and Gynaecologists – now very supportive of abortion – debunked these claims in 1966, just before abortion was legalised in the UK in 1967.[20]

Contrary to the assertion that there were 50,000-250,000 illegal abortions in the UK prior to 1967, the RCOG pointed out that there was no empirical basis for these claims, and that abortions were relatively uncommon in the experience of many gynaecologists.

In response to the claim that there were many hospitalisations from illegal abortion, they pointed out that 'most cases of abortion treated in hospital are spontaneous in onset' – and probably fewer than 20% were induced. Nor were there many deaths, as there had been in earlier decades.[21]

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[17] Karalis, E et al. (2017). 'Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012,' *British Journal of Obstetrics and Gynaecology*, 124(7):1115–1121.

[18] Reardon, DC and Thorp, JM (2017). 'Pregnancy associated death in record linkage studies relative to delivery, termination of pregnancy, and natural losses: a systematic review with a narrative synthesis and meta-analysis,' *SAGE Open Medicine*, 5: 2050312117740490.

[19] Miller (2022); Miller, C (2021). 'Maternal mortality from induced abortion in Malawi: what does the latest evidence suggest?' *International Journal of Environmental Research and Public Health*, 18: 10506.

[20] Royal College of Obstetricians and Gynaecologists (1966). 'Legalised abortion: Report by the Council of the Royal College of Obstetricians and Gynaecologists,' *British Medical Journal*, 1(5491): 850-54.

[21] We know now that abortion death statistics were entirely fabricated in the US as well: the leading advocate for abortion prior to *Roe v Wade*, Bernard Nathanson, eventually changed his mind and admitted that they had invented exaggerated statistics: 'How many deaths were we talking about when abortion was illegal? In NARAL we generally emphasized the drama of the individual case, not the mass statistics, but when we spoke of the latter it was always 5,000 to 10,000 a year. I confess that I knew the figures were totally false, But in the "morality" of our revolution, it was a useful figure, widely accepted, so why go out of our way to correct it with honest statistics?' Nathanson, BN and Ostling, RN (1979). *Aborting America*. New York: Doubleday.

Against the claim that legalising abortion doesn't increase the abortion rate, they pointed out that not only does the number of legal abortions massively increase, but in some cases even illegal abortions increase as well.

Finally, in response to the claim that legalising abortion will stop women dying from abortion, they made the same point: that 'except in those countries where abortion on demand and without inquiry is permissible, the legalization of abortion often resulted in no reduction and sometimes in a considerable increase in the number of illegal abortions.' Of course, if illegal abortions do not decrease upon legalisation, then legalisation cannot reduce the deaths from backstreet abortion. The RCOG noted further that in Hungary and Czechoslovakia, where abortion is induced freely, the number of abortions other than those performed legally in hospital in 1961 was approximately the same as in the years before the introduction of abortion restriction laws.

It is therefore no surprise that by 1970, the RCOG expressed regret about the legalisation of abortion and noted that it had not worked in reducing maternal deaths in the UK either[22] 50 years later, the current evidence base further confirms the RCOG's claims.

How many illegal abortions?

First, the deceptive inflation of illegal abortion rates continues, usually by using the debunked Abortion Incidence Complications Method.[23] This method guesses (or, occasionally, measures) the number of women with miscarriage complications actually presenting to hospital and compares this with a theoretical **expected** number of miscarriages presenting to hospital (estimated as 3.41% of pregnancies). It infers that the discrepancy between these represents the amount of illegal abortions performed. But it is well-known that significantly more than 3.41% of pregnancies end in a hospital presentation for miscarriage,[24] and hence this method drastically overestimates abortion complications by classifying many miscarriage complications as induced abortion. It then drastically overestimates overall abortion numbers as a result (which are estimated by guessing – again, usually with no evidential basis – the proportion of women having abortions who present to hospital).

Second, the inflation of deaths from illegal abortion persists to the present day. This often occurs by using outdated data from the 1980s or 1990s, it almost always occurs by conflating deaths from induced abortion and miscarriage (and sometimes ectopic pregnancy) and calling them all 'unsafe abortion', and sometimes it occurs even by wholesale fabrication. A few examples are illustrative.l

It was claimed by a Kenyan parliamentarian in a 2020 Reuters article that 'ten years since the promulgation of the constitution', which permitted abortion for limited reasons, 'we are still losing the lives of women and girls in great numbers… We are condemning them to

[22] Royal College of Obstetricians and Gynaecologists (1970). 'The Abortion Act (1967): findings of an inquiry into the first year's working of the Act conducted by the Royal College of Obstetricians and Gynaecologists,' *British Medical Journal*, 2(5708): 529-535.
[23] Miller (2021); Koch, E et al. (2012). 'Methodological flaws on abortion estimates for Latin America: Authors' reply to Singh and Bankole,' *Revista Ginecología Obstetricia México*, 80(11): 740–747.
[24] Miller (2021).

death by unsafe abortion'.[25] The article claimed that 35% of maternal deaths in Kenya were due to unsafe abortion.

The first problem with this claim is that the ultimate source for it was the Kenya Demographic and Health Survey of 1998, 12 years before the new constitution, and nearly quarter of a century before the news article. Hence it can hardly demonstrate any failure of the new constitution. The second problem is that the Kenya DHS of 1998 said nothing about deaths from abortion at all. The statistics appears to have been completely fabricated.

More reputable professional sources make similar mistakes. The International Federation of Gynecology and Obstetrics claimed in 2019 that 17% of maternal deaths in Kenya are from complications of unsafe abortion.[26] But their source was a paper claiming only that 'up to' 17% of maternal deaths may be associated with induced abortion.[27] The source for this, in turn, was the WHO's global survey of maternal deaths from 2003-2009,[28] which gave no figures specific for Kenya, but estimated that 5.1-17.2% of maternal deaths in Sub-Saharan Africa were from abortion. Moreover, the WHO survey explicitly noted that 'abortion' in their usage included miscarriages and ectopic pregnancies. Hence FIGO: a) used outdated data; b) claimed that data regarding Sub-Saharan Africa were specific to Kenya; c) attributed deaths from miscarriage and ectopic pregnancy to unsafe abortion; and d) cited the upper end of the confidence interval rather than the actual estimate – four fatal inaccuracies in just one statistic!

Another recent example comes from *The Telegraph*, which claimed that 12,000 women die in Malawi from unsafe abortion each year.[29] This article and claim were cited by the Royal College of Obstetricians and Gynaecologists. Since the real number is fewer than 100, (*total* maternal deaths in Malawi are only 1,000-2,000 a year),[30] *The Telegraph* and the RCOG were challenged on this claim which they retracted and conceded to the facts after a complaint to the Independent Press Standards Organisation[31]

Will legalisation prevent deaths?

Similar misinformation on maternal mortality and abortion is extremely common, even in academic and professional circles. But even if deaths from illegal abortion are uncommon, could legalisation still help?

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[25] Bhalla, N (2020). 'Kenya condemns women to 'death by unsafe abortion', campaigners warn,' available online at https://www.reuters.com/article/us-kenya-women-rights-idUSKBN25M1ZC.

[26] International Federation of Gynecology and Obstetrics (2019). 'Reducing unsafe abortion in Kenya: where are we?' available online at https://www.figo.org/news/reducing-unsafe-abortion-kenya-where-are-we.

[27] Mutua, MM et al. (2018). 'Policy, law and post-abortion care services in Kenya,' *PLoS One,* 13(9): e0204240.

[28] Say, L et al. (2014). 'Global causes of maternal death: a WHO systematic analysis,' *The Lancet Global Health,* 2: E323-333.

[29] Mhango, HK (2021). 'Thousands of women dying 'like chickens' as efforts to change Malawi's strict abortion law stall,' previously available online at https://www.telegraph.co.uk/global-health/women-and-girls/thousands-women-dying-like-chickens-efforts-change-malawis-strict/ (accessed on 21 September 2021).

[30] Miller (2021).

[31] The Telegraph (2022). 'Clarification: Malawi back street abortions,' available online at https://www.telegraph.co.uk/global-health/women-and-girls/clarification-malawi-back-street-abortions/.

There are many reasons to think that abortion's legalisation will not prevent many (or any) deaths[32] for example, abortion mortality is already low (particularly in Poland, where deaths from abortion are now virtually non-existent) because post-abortion care prevents most deaths, and because illegal abortion is now much safer than in the 1990s. Moreover, legal abortion is now very similar to illegal abortion because of the introduction of telemedicine. And we know that in many countries, women still seek illegal abortions even when abortion is legal – sometimes even at higher rates than before legalisation.[33]

Indeed, legalisation can increase morbidity and mortality from abortion, as it did in the Netherlands, Rwanda, Ethiopia, and elsewhere.[34] The main reason for this is that when abortion is legalised, more unwanted pregnancies occur, and more abortions occur – so more women are put at risk.

There are many other ways in which the legalisation of abortion contributes to maternal mortality and mortality among women more generally, i.e. through its impact on suicide, homicide, alcohol abuse, drug abuse, disease transmission through sexual activity, delayed childbearing, family breakdown and subsequent poverty, diversion of funding from emergency obstetric care to abortion, etc.[35]

The empirical evidence reflects these considerations, demonstrating clearly that mortality from abortion primarily depends on a country's overall healthcare system, not on the legal status of abortion. Hence poorer countries with legal abortion like India, Ethiopia, South Africa, Zambia, Bangladesh (in the form of menstrual regulation) and Ghana, still have much abortion mortality, while wealthier countries with abortion prohibited like Malta, Chile, United Arab Emirates, Egypt, (pre-decriminalisation) South Korea, and (pre-legalisation) Ireland have minimal abortion mortality.

Malta and Poland are particularly good examples of this. Both have the lowest maternal mortality ratio in the world – far lower than Germany, France, the UK and the US[36] – with Malta having no maternal deaths from any cause in over ten years.[37] Poland achieved this despite being significantly less wealthy than its neighbours in Western Europe, and despite new restrictions on abortion in 1993.[38] Prior to legalisation, in Poland the maternal mortality ratio dropped from 50.0 in 1951 to 22.5 in 1951, and then halved again in the next 5 years over the period of legalisation to 11.0 in 1960,[39] before a dramatic increase in 1962, the reasons for which are unclear.[40]

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[32] Miller (2022).
[33] Because abortion is made less stigmatised, appears safer (medically and legally), and so on.
[34] Miller (2022).
[35] Miller (2022).
[36] World Bank (2022). 'Maternal mortality ratio,' available online at https://data.worldbank.org/indicator/SH.STA.MMRT.
[37] Gatt, M (2021). *NOIS Annual Report 2020*. National Obstetric Information System. Available online at https://deputyprimeminister.gov.mt/en/dhir/Documents/Births/NOIS%20Annual%20Report%202020z.pdf.
[38] Tietze, C (1967). 'Abortion in Europe,' *American Journal of Public Health*, 57(11): 1923-32; Frejka, T (1983). 'Induced abortion and fertility: a quarter century of experience in Eastern Europe,' *Population and Development Review*, 9(3): 494-520.
[39] Maciejewski, TM and Troszyński, M (2015). 'Zgony matek w Polsce w latach 2009, 2010, 2011, 2012 i 2013,' XXXII Congress of the Polish Gynecological Society, Łódź.
[40] Reporting changes could be included among the possible explanations.

After the fall of communism, Poland restricted its abortion law in 1993, with some restrictive practice starting in 1990. Rather than the threatened dramatic increase in deaths from illegal abortion, Poland's maternal deaths from abortion remained at minimal levels: Poland's abortion mortality ratio (AMR) from 2006-2010 was 0.30, lower than that of Brussels (0.85), Latvia (2.7), and Romania (4.2), and comparable to that of Spain (0.34), the UK (0.31), and France (0.36).[41] Abortion mortality eventually decreased further to 0 – there are no known abortion deaths in Poland today – though there are in most Western countries with permissive abortion laws.[42] Maternal deaths in general fell from 80 in 1991 to 48 by 1994 and 33 by 1996 – a 59% drop in just 5 years over the period of prohibition.[43]

Nor was there an increase in women presenting with complications of abortions. In fact, while in 1989 59,549 'other' abortions were recorded (complications of illegal abortion and spontaneous abortions would be recorded here combined), by 1994 this had fallen in line with the birth rate to 46,970.[44] Likewise, infant mortality dropped precipitously,[45] as did perinatal mortality[46] and infanticide rates.[47]

Myth 3: banning abortion doesn't stop abortion

The final myth is that banning abortion doesn't work – women will get abortions anyway. Of course, nothing will stop **ALL** abortion, but the evidence is absolutely decisive – and has been for decades now – that abortion restrictions prevent *many* abortions. Hence even leading pro-abortion researchers have implored their colleagues to stop making this argument.[48] They do this by at least five means, i.e. providing direct prohibitions (and hence reducing both supply and demand); increasing the (financial or other) cost of abortions; reducing supply by regulating abortion providers; shaping community attitudes towards abortion; and reducing risky sexual behaviour.

When Poland first legalised abortion, the evidence suggests that criminal abortions did not significantly fall – at least in the early years. Hence, since legal abortions massively increased – from 1,400 in 1955 to 190,000 in 1963[49] – the total number of abortions must have significantly increased. Moreover, it has been noted that this estimate of legal abortions is a significant underestimate, since abortions at physicians' offices were not reported[50] – yet many women preferred the privacy of physicians' offices, and the higher

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[41] Euro Peristat (2013). 'European Perinatal Health Report (2010),' available online at https://www.europeristat.com/images/doc/EPHR2010_w_disclaimer.pdf.
[42] Knight, M et al. (2021). *Saving Lives, Improving Mothers' Care*. Oxford: MBRRACE-UK.
[43] Sejm Rzeczypospolitej Polskiej (2002).
[44] Sejm Rzeczypospolitej Polskiej (2002); in line with the fall in births.
[45] Sejm Rzeczypospolitej Polskiej (2002).
[46] Statistics Poland (2021). *Demographic Yearbook of Poland*. Warsaw: Statistics Poland.
[47] Mikolajczyk, RT (2004). 'Recent experiences with legal restrictions and the incidence of abortion in Poland,' *Linacre Quarterly*,' 71(3): 245-253.
[48] Foster, DG (2018). 'Stop saying that making abortion illegal won't stop people from having them,' available online at https://rewirenewsgroup.com/2018/10/04/stop-saying-that-making-abortion-illegal-doesnt-stop-them/.
[49] David and McIntyre (1981).
[50] In part because abortions were so financially lucrative for private doctors, and hence there was a considerable incentive for tax evasion by underreporting (Okolski, 1983).

likelihood of receiving general anaesthesia there. Hospitals were, at times, similarly lax in reporting.[51]

Given the minimal decline in abortion complications presenting to hospital, therefore, while legal abortions ran into the hundreds of thousands, it is profoundly unlikely that these legal abortions were merely replacing illegal abortions. Hence the mathematics is simple: criminal abortions did not fall much (if at all) in the early years, but legal abortion increased dramatically. Hence, the total number of abortions massively increased.

A second key piece of evidence that legalisation increased the abortion rate is that the birth rate plummeted significantly upon legalisation. After increasing steadily from 622,000 in 1946 to a post-war high of 793,000 in 1955, births immediately began to fall rapidly upon legalisation: 779,999 in 1956, 669,999 in 1960, and 546,000 in 1965.[52]

When abortion was restricted again in the early 1990s, legal abortions dropped precipitously: from 82,137 in 1989 to 874 in 1994.[53] But complications from 'other' abortions (spontaneous and illegal) likewise fell – suggesting that the legal abortions were not merely converted to illegal abortions. Even the Federation for Women and Family Planning – a pro-abortion organisation which might therefore be expected to exaggerate the scale of illegal abortion – estimated that by 1996 there were only 40,000-50,000 illegal abortions[54] – far fewer than the number of legal abortions taking place prior to the restrictions.[55]

Other countries show the same trend e.g. in the UK, there were an estimated 20,000 illegal abortions, at most, prior to legalisation in 1967.[56] Yet by 1973, just 6 years after legalisation, there were 175,000 legal abortions per year. Similar observations have been made in Ethiopia.[57] Likewise, in various other countries, illegal abortions have also risen or stayed constant upon legalisation, rather than decreasing in line with the increase in legal abortions. All these cases demonstrate that abortions increase when abortion is legalised.

Perhaps the most direct and unassailable evidence that abortion restrictions work are studies observing women who seek an abortion and are refused their request. Myriad studies invariably show that not only some, but most women – usually 50-90% - continue their pregnancies in such instances.[58]

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[51] Ziolkowski (1974); David and McIntyre (1981).
[52] Ziolkowski (1974).
[53] Sejm Rzeczypospolitej Polskiej (2002).
[54] Nowicka, W (1996). 'The effects of the 1993 anti-abortion law in Poland,' *Entre Nous*, 34-35: 13-15.
[55] Mikolajczyk (2004) offers further evidence of a low number of illegal abortions.
[56] Goodhart, CB (1969). 'Estimation of illegal abortions,' *Journal of Biosocial Science*, 1(3): 235-245.
[57] Moore, AM et al. (2016). 'The Estimated Incidence of Induced Abortion in Ethiopia, 2014: Changes in the Provision of Services Since 2008,' *International Perspectives on Sexual and Reproductive Health*, 42(3): 111-120.
[58] DePiñeres, T et al. (2017). ''I felt the world crash down on me': women's experiences being denied legal abortion in Colombia,' *Reproductive Health*, 14: 133; Hajri, S et al. (2015). ''This is real misery': experiences of women denied legal abortion in Tunisia,' *PLoS One*, 10(12): e0145338; Harries, J et al. (2015). 'An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa,' *Reproductive Health*, 12: 21; Hossain, A et al. (2016). ''How shall we survive': a qualitative study of women's experiences following denial of menstrual regulation (MR) services in Bangladesh,' *Reproductive Health*, 13: 86; Puri, M et al. (2015). '"I need to

The evidence also demonstrates that other restrictions or regulations on abortion have a significant impact. A systematic review by the Guttmacher Institute found that cutting public funding of abortions leads to an 18-37% reduction in the abortion rate, with the single best study finding a 37% reduction.[59]

Conclusion

Abortion is a sensitive and delicate issue, affecting a huge number of women. It is therefore of utmost importance that misinformation and fake news from both sides is challenged and rejected. Whatever we believe about the ethics or politics of abortion, we can be agreed that it is typically not a form of healthcare, that restricting it does prevent many abortions, and that restricting it does not lead to more deaths from unsafe backstreet abortions. With these facts in mind, doctors and policy makers will be much better equipped to understand the policy debates on this difficult topic. Mr. Chair, for good policy formation, diverse interests need to be taken into consideration and preserved. I do hope that I add to the abortion debate from the point of view of women who struggle for basic necessities, and women who love babies and want to keep their babies, and who value family, and understand its role in society.

I also want to state categorically that I in no way support the invasion of Ukraine by Russia. The tweet Hon. Rachel Bendayan referred to was in the context of President Biden calling President Putin a Butcher. The tweet considers the killing of innocent babies in the womb butchery and in no way was it supportive of Russian invasion.

Standing up for women's rights and the rights of unborn children (including girls) are not mutually exclusive. I propose that funding should go to the real needs of women and girls which boils down to access to primary health care with the objective of reducing maternal and infant mortality especially in developing countries. Also funding for diseases like malaria, tuberculosis, HIV/AIDS etc. together with the strengthening of our healthcare systems.

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