THE LEGAL REFLECTIONS ON ABORTION
THROUGH THE PRISM OF THE CHILD’S RIGHT TO LIFE

Abstract. Abortions represent one of the most controversial issues in contemporary society. Some states have adopted restrictive legislation on interruption of pregnancy to diminish the number of abortions performed annually. Other states have adopted abortion-on-demand rules guaranteeing women free access to abortions. Based on the statistical dates, the problem of interruption of pregnancy remains a crucial one and requires prompt action undertaken by the state. This article is dedicated to the analysis of measures undertaken by the state to reduce the number of abortions and stimulate population growth. This study highlights the effectiveness of remedies taken by some states, e.g. the USA, and presents a multitude of measures that states regulated in national law.

Keywords: abortion, demographic crisis, maternity protection, social policy, restrictive legislation

Introduction

In the XXI century, abortion represents one of the demographical, social, economic, and moral problems. Now, the European countries, SUA, Russia, and China face a negative increase in the population, which is expressed in the population ageing and the lack of a working population. These trends subsequently lead to the stagnation of the economy, the crisis of production and the inability of the state to guarantee citizens a decent standard of living, as the number of the aging population that needs social payment is growing and the number of working people is decreasing.
Fertility in Russia, for example, has hovered near or below replacement level (negative population growth) for several decades, and the population is expected to decline in coming decades from 143 million to 107 million in 2050. President Vladimir Putin has vowed to fight Russia's “demographic crisis” by creating incentives for women to have more than two children, by reducing the male death rate from alcoholism, and by enticing Russians living abroad to return home. (Weir Fred, 2012) He also signed a law banning advertisements for abortion. (Castuera I., 2017)

China’s demographic crisis was determined by introducing the “one family-one child” policy in 1979. (Guillaume, A. & Rossier, C., 2018) The birth control represents the official purpose of this policy. The authorities introduced the ban on having more than one child addressed to married couples in cities except for multiple pregnancies. (Castuera I., 2017) The policy included sterilization of couples with two or more children and abortion in case of unauthorized pregnancies. In 2013, the Chinese National Health and Family Planning Commission claimed that the "one family - one child" policy "prevented" the birth of about 400 million people. (Guillaume, A. & Rossier, C., 2018) The negative consequences of this policy were manifested in 2013, when for the first time authorities recorded a decrease in the working-age population. Now the population of the country is 1.3 billion people, with an increase of 0.5%. There are about 210 million people over the age of 60, which is 15.5% of the total population. It was expected that by 2020, this group of people will reach 20%, by 2050-38%. (Guillaume, A. & Rossier, C., 2018) Currently, the authorities are trying to achieve balanced economic growth and overcome the progressive decline of the working-age population. However, critical population growth, distortions of the gender and age structure, even social problems such as selfishness and infantilism of the generation of “little emperors” – the single children in families – are largely associated with the “one family – one child” policy. (Denisov I., 2021)

The demographic crisis is also determined by the increase in the number of abortions performed in the world. Between 2015 and 2019, on average, 73.3 million induced (safe and unsafe) abortions occurred worldwide each year. There were 39
induced abortions per 1000 women aged between 15–49 years. 3 out of 10 (29%) of all pregnancies, and 6 out of 10 (61%) of all unintended pregnancies, ended in an induced abortion. (Bearak J, 2020) Among these, 1 out of 3 were carried out in the least safe or dangerous conditions. Over half of all estimated unsafe abortions globally were in Asia, most of them in south and central Asia. 3 out of 4 abortions that occurred in Africa and Latin America were unsafe. The risk of dying from an unsafe abortion was the highest in Africa. (Ganatra B., 2017) Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion. (Say L., 2014) Estimates from 2010 to 2014 showed that around 45% of all abortions were unsafe. Almost all of these unsafe abortions took place in developing countries. (Ganatra B., 2017) Around 7 million women are admitted to hospitals every year in developing countries, as a result of unsafe abortion. (Singh S., 2015) The annual cost of treating major complications from unsafe abortion is estimated at USD 553 million. (Vlassoff et al., 2008) (WHO, 2019) The analysis of these statistical data shows the importance of measures undertaken by states to diminish the number of abortions performed annually. In this study, we aimed to analyze the remedies implemented by states to reduce the number of artificial interruptions of pregnancies and investigated the social policy of states aimed at increasing the birth rate.

**Measures undertaken by states to reduce the number of abortions**

There are two key ways, which influence the number of artificially interrupted pregnancies and lead to reduce the number of abortions performed. One way is manifested by restricting access to artificial termination of pregnancy. Jessica Arons and Shira Saperstein started that those who oppose abortion in all or most circumstances generally think the best way to reduce the number of abortions is to make it illegal. By eliminating legal availability, they believe abortion will cease to exist. (Arons J., Saperstein S., 2006) In this context we should mention the experience of the SUA that introduced the following measures to reduce the number of abortions: barring public funding, increasing the cost with unnecessary clinic regulations, decreasing the number of available doctors and clinics, imposing waiting periods, and mandating rigid parental involvement laws. (Arons J., Saperstein S., 2006)
On the other hand, the number of abortions decreases if they become less necessary. The first way to do so is to reduce the incidence of unintended pregnancy. Half of all pregnancies in SUA are unintended, and, of those, half end in abortion. (Arons J., Saperstein S., 2006) Unintended pregnancy could be reduced significantly if we showed true commitment to:

1) comprehensive sexuality education that includes medically accurate information about abstinence and contraception;

2) insurance coverage of and public funding for family planning services;

3) greater access to emergency contraception (which prevents pregnancy and does not cause abortion); and

4) programs that curb domestic violence and sexual abuse. Clearly, women who are able to avoid unintended pregnancy do not have to make the difficult decision of whether to have an abortion. (Arons J., Saperstein S., 2006)

Unfortunately, even with the supports listed above, there will always be some unintended pregnancies; birth control methods are fallible. Therefore, once a woman finds herself with an unexpected pregnancy, a second positive way to reduce abortion is to ensure that she has the means to have and raise a child in health and safety should she wish to do so. According to the Alan Guttmacher Institute, one of the two most common reasons women choose abortion is because they cannot afford a(nother) child. (Arons J., Saperstein S., 2006) Unintended pregnancy rates are highest among low-income women (i.e., women with incomes less than 200% of the federal poverty level), women aged 18–24, cohabiting women and women of color. Rates tend to be lowest among higher-income women (at or above 200% of poverty), white women, college graduates and married women. The rate of unintended pregnancy among women with incomes less than 100% of the poverty was 112 per 1,000 in 2011, more than five times the rate among women with incomes of at least 200% of poverty (20 per 1,000 women). Women without a high school degree had the highest unintended pregnancy rate among those of any educational level in 2011 (73 per 1,000), and rates were lower with each level of educational attainment. (Finer LB and Zolna MR, 2016)

By providing low-income and young women with genuine education and career opportunities, health care, child care, housing, services for disabled children, and
other basic supports, many would have the resources they need to fulfill the serious obligations that parenting brings. (Arons J., Saperstein S., 2006)

Complicating prevention strategies is Christine Overall’s contention that the primary reason pregnant women seek abortions is that they do not want a child of theirs to exist that they have responsibility for—they do not want to reproduce. (Overall, C., 2015) For such women, financial incentives to continue with pregnancy seem unlikely to be persuasive, and so the only measure likely to dramatically reduce the number of abortions would be prohibition. This would meet the Siracusa criteria—prohibition is certainly proportionate to the gravity of the issue, and there are no alternatives that are likely to have an appropriate impact. Finally, changing the law to prohibit abortions ensures this is not an arbitrary measure. (Blackshaw, B., & Rodger, D., 2021)

How drastic might the measures taken to protect fetuses be? Because abortion maximally harms millions of fetuses, Mill’s harm principle justifies the abrogation of individual rights for their protection should this be necessary. Abortion also satisfies the Siracusa Principles’ public health and public safety criteria (Siracusa Principles), permitting derogation of rights if required. Whatever measures are taken, the requirement is that the number of abortions be reduced to the extent that abortion is no longer a public health crisis. As a comparison, let us consider the leading cause of death for adults—ischemic heart disease. (WHO, 2020) A 90% reduction in abortion numbers would be required to bring them to a similar number of deaths. (Blackshaw, B., & Rodger, D., 2021)

Significantly reducing abortion numbers would require a dramatic change in public behavior towards abortion. Public education campaigns could be tried to both discourage abortion and to encourage contraceptive use. Governments could also provide generous financial incentives and support to pregnant mothers to encourage them not to have abortions, and continue to do so once children are born to ensure that financial considerations were not an influence on their decision. While such approaches may help to reduce abortion numbers, it seems unlikely that they will have the dramatic effect necessary to deal with such a public health crisis in the short-term. (Blackshaw, B., & Rodger, D., 2021)
According to World Health Organization (WHO) unsafe abortion can be prevented through: comprehensive sexuality education; prevention of unintended pregnancy through use of effective contraception, including emergency contraception; and provision of safe, legal abortion. In addition, deaths and disability from unsafe abortion can be reduced through the timely provision of emergency treatment of complications. (Haddad L., 2009) (WHO, 2019) We should note that WHO does not fight for diminishing of the total number of abortions that lead to demographic crises, especially in European countries, but, on the contrary, opposes to illegal abortions. Despite this, the legal abortion could lead to complications and even the death of a woman. In this context, states are taking steps to reduce the number of women who make legal and illegal abortions.

**Restrictive regulation of interruption of pregnancy as a measure to reduce the number of abortions**

Access to abortion is always subject to a limit in terms of gestational age or weeks of amenorrhea. These limits can be extended or waived if the woman’s life or health is in danger and in certain other situations (rape, malformation, etc.) (WHO, 2017). We should mention the Poland's abortion laws that are among the strictest in Europe. Now, the interruption of pregnancy in this state is allowed in cases of rape or incest, or if the mother's health is at risk. (Poland abortion: Top court bans almost all terminations, 2020)

Most countries allow abortion up to 12 weeks of gestation, while some allow it up to 18 weeks (Sweden), 22 weeks (the Netherlands), or 24 weeks (United Kingdom) (Bajos Nathalie, 2004) (Hassoun Danielle, 2011, , pp. 213–221).

Authorizations are sometimes required for a legal abortion. In 25 European countries, consent is required from a parent or guardian for a woman who has not reached the age of majority (WHO, 2017). In France, following the 2001 reform of the abortion law, if a woman under the age of 18 is unable to obtain such consent, another adult can substitute for the parental authority; in other countries (Italy, Denmark, Norway, Spain), this role is played by a commission (Hassoun Danielle, 2011, , pp. 213–221). In 37 states in the United States, women under the age of 18 need consent from at least one of their two parents (in some cases both parents),
and/or the parents must be notified. (Parental Involvement in Minors’ Abortions) This is also a requirement in four countries in Latin America, nine in Africa, and 17 in Asia.¹

When a woman is in a union, the spouse’s consent is required in some African and Asian countries (WHO, 2017). (Bahrain, Indonesia, Japan, Kuwait, Morocco, Qatar, Republic of Korea, Saudi Arabia, Syria, East Timor, Turkey, United Arab Emirates, Yemen.) (WHO, 2017)

To end a pregnancy for health reasons, medical approval (and sometime sworn certification) may be required, notably from one or more physicians or from a psychiatrist in case of mental health problems. Abortion after rape or incest often requires legal authorization from a prosecutor or judge and sometimes a police or medical report. (Guillaume, A. & Rossier, C., 2018)

Some legislation also stipulates a waiting period of several days or weeks before authorization is granted; in some cases, this applies only to minor-aged women. While no such waiting period is required in the majority of European countries, it does exist in nine countries and ranges from three to seven days (Nisand Israël, etc., 2012, pp. 5–20). Three days in Albania, Germany, Spain, Hungary, and Portugal, five days in the Netherlands, six days in Belgium, and seven days in Italy and Luxembourg. In France, the seven-day waiting period was rescinded in 2017. (Guillaume, A. & Rossier, C., 2018)

In plus, health professionals sometimes invoke the conscience clause to avoid performing abortions or treating women with complications. Practitioners may invoke the right to freedom of conscience if they consider abortion to violate their professional ethical commitment to respect for life (Fiala Christian, Arthur Joyce H., 2014, pp. 12–23). This right is enshrined in law in some countries, (It is included in the majority of European countries: Denmark, France, Italy, Norway, etc.; in the United States; in Latin America: Bolivia, Colombia, Panama, Uruguay, Mexico City; in Asia: Nepal, Singapore; and in Africa: Ghana,

¹ Argentina, Angola, Armenia, Bahrain, Bangladesh, Barbados, Brazilia, Cambodia, Capul Verde, Cuba, RDC, Georgia, India, Coasta De Fildeș, Kazakhstan, Kârgâstân, Malaezia, Mauritania, Mongolia, Maroc, Mozambic, Nepal, Panama, Rwanda, Sao Tome şi Principe, Arabia Saudită, Siria, Tadjikistan, Turcia, Uzbekistan, Yemen
Guinea, Mozambique, etc.; it also features in the Harmonised Codes of Ethics and Practice for Medical and Dental Practitioners of the ECOWAS (Economic Community of West African States), where its recognition is combined with an obligation to refer women to non-objecting professionals.) (Cook Rebecca J., etc. 2009, p. 249-252) Nevertheless, even where this right to conscientious objection is legally recognized, health professionals have obligations, such as referring patients to non-objecting practitioners, or treating women in critical condition. (Cook Rebecca J., etc. 2009, p. 249-252)

**Measures taken by the USA to reduce the number of abortions**

We would like to analyze the USA policy that aims to reduce the number of abortions. In 1973, the United States was part of a global trend to reform restrictive abortion laws that resulted in the unnecessary deaths and injuries of millions of women. After the Supreme Court decision in Roe v. Wade secured the right to abortion, access to safe abortion care dramatically reduced maternal deaths and injuries. (Hessini L., 2006) Abortions in the U.S. are at the lowest rate since the Roe v. Wade decision in 1973, while teen birth rates are the lowest they’ve ever been since the country started recording that data. (Almendrala A., 2017)

According to the point of view of Jessica Arons and Shira Saperstein, many moderate and progressive politicians have begun to voice a fairly consistent message about abortion. Wanting to distance themselves from the stereotype that the “Pro-Choice” position equals “abortion on demand,” they have put forth a so-called moderate, “compromise” position: maintain *Roe v. Wade* but work to reduce the number of abortions in this country. At a rate of more than 1 million a year, reducing the annual number of abortions is certainly an admirable goal. (Arons J., Saperstein S., 2006)

At the same time, SUA adopted the restrictive regulation of the right to abortion. In 2016, 19 states passed more than 60 restrictions on abortion. And 2017 is starting to offer more of the same: Kentucky passed a bill banning abortion after 20 weeks and Arkansas just passed a law that allows a man to stop his wife from having an abortion if he is the father of the fetus. Supporters of these laws believe that outlawing certain abortion procedures protects the mental and physical health
of the mother and the fetus’ right to thrive and be born. (Almendrala A., 2017) In 2019, conservative state legislators raced to enact an unprecedented wave of bans on all, most or some abortions, and by the end of the year, 25 new abortion bans had been signed into law, primarily in the South and Midwest. Along with this new strategy, legislators also continued their efforts to adopt other types of abortion restrictions, including requirements for abortion providers to give patients information about the potential to reverse a medication abortion as part of abortion counseling. Nearly half of the 58 new abortion restrictions enacted in 2019 would ban all, most or some abortions. (Nash E., e.t.c. 2019)

The 25 abortion bans enacted in 12 states in 2019 vary in scope, with some prohibiting abortion after a specific point in pregnancy, others prohibiting a specific method of abortion, and other bans hinging on the patient’s reason for seeking an abortion. Nine states enacted gestational age bans: Alabama enacted a total ban on abortion, at any point in pregnancy. Georgia, Kentucky, Louisiana, Mississippi and Ohio banned abortion when a fetal heartbeat can be detected, which could be interpreted to be as early as six weeks of pregnancy. Missouri banned abortion at eight weeks and included additional bans at three other gestational ages in anticipation of litigation over each ban’s constitutionality. Arkansas and Utah banned abortion at 18 weeks of pregnancy. In all of these states except Louisiana, lawsuits were filed to challenge the legislation. Two states enacted bans on a specific method of abortion: Indiana and North Dakota banned the method that is the standard of care for surgical abortion after about 14 weeks of pregnancy. Four states enacted bans based on the patient’s reason for seeking an abortion: Arkansas, Kentucky, Missouri and Utah banned abortion of a fetus that has or may have Down syndrome. Kentucky and Missouri also banned abortion based on the race or predicted sex of the fetus, and Kentucky banned abortion for a diagnosis of a genetic anomaly. The bans in Arkansas and Kentucky have been blocked from going into effect during ongoing legal proceedings. The Missouri bans are in effect. Including the new Missouri bans, nine states currently ban abortion for purposes of sex selection. Two of those states also have a ban based on race selection, and two states have a ban in effect based on genetic anomaly. (Nash E., e.t.c. 2019) In this context
we should mention that these laws should reduce the number of abortion procedures carried out every year.

An obvious decrease in the number of abortions is generated by "The Contraceptive CHOICE Project", launched in St. Louis, Missouri in 2007 with the goal of reducing unintended pregnancies. A large proportion of unintended pregnancies, which are defined as either mistimed or unwanted, (Unintended Pregnancy in the United States, 2019) tend to end in abortion; in 2011, about 45 percent of pregnancies in the U.S. were unintended, of which 42 percent ended in abortion. (Almendrala A., 2017)

To prevent such pregnancies, the CHOICE project enrolled over 9,000 women between 2007 and 2011 to receive free contraceptive counseling and the contraception of their choice for two to three years. The researchers found that from 2006 to 2010, teen study participants had an average annual abortion rate of 9.7 per 1,000 teens – significantly lower than the 41.5 abortions per 1,000 sexually active teens nationwide in 2008. (Secura, G. M., e.t.c, 2014)

The state Colorado organized the similar project. After handing out free IUDs and implants to teens and poor women over six years, the statewide teen birthrate dropped 40 percent from 2009 to 2013, while the abortion rate dropped 42 percent. The results were especially dramatic in the state’s poorest regions, The New York Times reported. (Almendrala A., 2017)

Therefore, the USA, on the one hand, has adopted the legislation that restricts the right to abortion and, on the other hand, has provided women with complete and medically accurate information on contraceptives and free access to them. As a result, the United States managed to reduce the number of abortions performed and reach the minimum number of abortions made annually per year throughout the 1973 statistics period.

**Social policy aimed at increasing the birth rate**

Demographers believe that the direct stimulation of fertility is impossible, so Western Europe governments are taking certain measures to stimulate the increase in the number of births and to support families with many children. The essence of social policy aimed at promoting powerful families with several children represents
the measures undertaken to create the most favorable conditions for the birth and upbringing of children. The policy aimed at supporting of families manifests at the level of a political discourse, and actual practices implemented for effective help to families and their members by material and social help for families.

States could implement the following activities: provision of medical care to women during pregnancy, childbirth and the post-natal period, granting of maternity leave and benefits of the monthly period in which the mother/ father is not working; the supervision of the health of new-born children, minors, the granting of allowances for children; providing paid parental leave for child-rearing; the loans, and tax incentives for the purchase or rental of housing, the provision for other grants. (Zacutin A., 2016)

In the UK, Denmark, Ireland, Spain, Italy, Norway, Portugal, Finland and Sweden, maternity protection covers the entire female population. These states pay the monthly allowances from the state budget and these indemnities not depend on the payment of social insurance. Other EU countries grant allowances only to women who have paid for medical insurance. In general, European states undertake the economic measures of stimulation of the birth rate. The states that do not grant monthly allowances grant tax breaks. For example, in Iceland, social policy aimed at supporting families is manifested in the provision of tax facilities managed by the Tax Service. (Zacutin A., 2016)

The amount of the allowance in most European Union countries depends on the age of the child. It is increased with the growth of the child. The exception to this rule represents Denmark, where the monthly allowance decreases with increasing age of the child. Among other measures, we can mention the establishment of monthly payments for minor children. In Sweden, the promotion of Social Security and the provision of monthly allowances to all families, including emigrants, have led to a significant increase in the number of people. (Zacutin A., 2016)

France achieved one of the highest birth rates in Europe, thanks to the implementation of active demographic policies aimed at increasing fertility. In 1946 France gave numerous allowances and tax breaks to families to encourage the birth
of the first, second and, in particular, the third child. Until 1975, France banned abortion. As a result of these measures, between 1946 and 1974, the population of France increased by 12.1 million people (by 8.5 million people because of natural population growth and only by 2.4 million due to immigration). According to official dates, the highest fertility in France is registered among immigrants. The child allowance is allocated to all people living in France and that have at least two children under the 20-year-old living in the country, regardless of citizenship. (Zacutin A., 2016)

**Conclusion**

From that exposed above, we could conclude that states position abortions as a major issue and take the necessary actions to reduce the number of interruption of pregnancies. The measures undertaken by states range from legislative restrictions to the economic support of families with one or more children. In addition, the actions of states vary from the region, demographic, economic, social and current political situation, find adapted to contemporary realities.

**References:**

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