Study Guide – World Health Organization (WHO) / United Nations Population Fund (UNFPA)

Universal Access to Reproductive Healthcare: Between Law and Care

Guiding question: How can we ensure universal access to healthcare – and, more specifically, to reproductive healthcare – particularly in countries where abortion remains criminalised or inaccessible?

Open to all levels (with "Challenge" boxes for advanced delegates) · English · Pairs welcome

Figures in this guide come mainly from the WHO, UN inter-agency reports, the World Bank, and research and advocacy organisations (2024–2026). They are starting points: every delegation must check and update them, and always cite the source, the year and the type of source.

1. Welcome and objectives

You sit on a joint committee of the **World Health Organization (WHO)** and the **United Nations Population Fund (UNFPA)**. The wider conference is about women's access to equal rights. Your committee looks at one essential right: the **right to health**, and in particular **reproductive healthcare** (contraception, safe pregnancy and childbirth, and abortion care). Your task is to debate and negotiate a text that answers two linked questions:

- **Rights in law**: what do national laws say about contraception, maternity care and abortion? Which acts are crimes, who can be punished (women, doctors, anyone who helps), and which international texts has each State accepted?
- **Rights in practice**: even where care is legal, can a woman or a girl actually get it? Is it available, affordable, safe, confidential and respectful, including in rural areas, in crises and for adolescents?

By the end of your preparation you should be able to:

- explain universal health coverage (UHC) and the main international texts on reproductive health in your own words;
- present your country's laws, health system, ratifications and position, with sources;
- present your government's view with the best arguments that this government would really make, and answer objections;
- write and amend clauses of a resolution, and build compromises that countries with very different laws can accept.

> ***Ground rules for a sensitive topic.*** *This subject touches law, medicine, religion, family and personal life, and opinions inside any group will differ. In this simulation you defend a* ***national position, not your personal opinion****. Nobody is asked to share personal experiences. Use respectful vocabulary, no graphic images and no mockery of any position. Any delegate may ask the chairs for a pause or a role change. Organisers: tell*

> *your school administration and families about the topic in advance, and plan a short debrief at the end in which delegates step out of their roles.*

2. WHO and UNFPA in brief

The WHO

- The WHO is the UN specialised agency for health, founded in **1948** and based in **Geneva**. It has **194 Member States**.
- The **World Health Assembly (WHA)** meets every year, usually in May, and adopts resolutions and sets policy. The **Executive Board** prepares its work. The Secretariat is led by the Director-General.
- The WHO rarely uses binding treaties. Most of its influence comes from **technical guidelines**, standards and **non-binding resolutions** that ministries of health use to write their own policies.
- On abortion, the WHO published a consolidated **Abortion care guideline** in 2022 (second edition in 2025) covering law and policy, clinical services and service delivery. It also keeps the **Global Abortion Policies Database**, which lists laws and policies by country. Comprehensive abortion care is part of the list of essential health services the WHO published in 2020.
- The WHO co-sponsors **HRP**, the UN research programme on human reproduction.

UNFPA

- UNFPA is the UN agency for sexual and reproductive health. It works on family planning, safe childbirth and midwifery, adolescents, and the prevention of gender-based violence, often in fragile and humanitarian settings.
- It is a **fund, not a specialised agency**. It is financed **entirely by voluntary contributions**, so donor decisions strongly shape what it can do. It is governed by an Executive Board shared with UNDP and UNOPS.
- UNFPA bases its work on the **1994 Cairo Programme of Action (ICPD)**. Check how the agency itself describes its position on abortion (it refers to paragraph 8.25 of the Cairo text) and compare this with what supporters and critics say about it.

In this simulation your committee is made up of **35 government delegations**. In real life the WHO and UNFPA have separate governing bodies; here they are combined to allow a broad debate. Observers (for example midwives' and doctors' associations, youth groups, faith-based health providers and civil society) can be added by the organisers to speak without voting. Follow your organisers' rules of procedure.

3. Decoding the topic

Universal health coverage (UHC) means that everyone can get the health services they need, **of good quality, without financial hardship**. It is target 3.8 of the Sustainable Development Goals. **Reproductive healthcare** is one of the core services of UHC: contraception, antenatal care, safe delivery, emergency obstetric care, treatment of complications, and, where the law allows, abortion care.

There is a gap between **what the law says** and **what a woman can actually obtain**. The UN Committee on Economic, Social and Cultural Rights uses four tests for the right to health (known as **AAAQ**). They are a useful lens for your whole topic.

Test	Question	Example
Availability	Do the facilities, trained providers and medicines exist?	Midwives, clinics, essential medicines, emergency obstetric care
Accessibility	Can women reach them physically, financially, legally and through information?	Distance, fees, criminal penalties, waiting periods, parental or spousal consent, accurate information
Acceptability	Is care respectful, confidential and culturally appropriate?	Stigma, confidentiality, conscientious objection without referral
Quality	Is care scientifically sound and safe?	WHO-recommended methods, trained staff, post-abortion care

Glossary

Term	Meaning
Sexual and reproductive health and rights (SRHR)	Health, services and rights linked to sexuality and reproduction, including the ability to decide whether and when to have children. The term itself is debated: some States accept "reproductive health" but not "rights".
Universal health coverage (UHC)	Access to needed quality health services for all without financial hardship.
Essential benefit package	The list of services a health system commits to provide (and pay for) for everyone.
Out-of-pocket spending	Money patients pay directly at the point of care.
Primary health care	First-level, community-based care; the base of most UHC strategies.
Maternal mortality ratio (MMR)	Maternal deaths per 100,000 live births. SDG target 3.1: below 70 by 2030.
Induced abortion / miscarriage	Deliberate ending of a pregnancy / spontaneous loss of a pregnancy (also called spontaneous abortion). Do not mix them up in your statistics.
Unsafe abortion	WHO definition: a termination carried out by persons lacking the necessary skills or in an environment below minimal medical standards, or both.
Comprehensive abortion care	Information, abortion management (including care

Term	Meaning
	after miscarriage) and post-abortion care.
Post-abortion care	Treatment of complications (bleeding, infection) after an abortion or miscarriage. It is legal and expected in almost every country, whatever the abortion law.
Medical abortion / self-management	Termination with medicines. The WHO says that in the first 12 weeks it can be self-managed outside a clinic with accurate information, quality medicines and access to a health worker if needed.
Legalisation / decriminalisation	Legalisation sets the conditions under which abortion is allowed. Decriminalisation removes criminal penalties. They are not the same thing.
Grounds-based law / on request	A law that allows abortion only for listed reasons (life, health, rape, fetal condition, etc.) / a law that allows it up to a time limit without needing a reason.
Gestational limit	Maximum pregnancy duration (in weeks) for abortion under the law.
Waiting period, mandatory counselling, third-party authorisation	Procedural requirements that some countries add. The WHO considers some of them medically unnecessary barriers; some governments defend them as safeguards.
Conscientious objection	A provider's right to refuse to take part in a procedure for reasons of conscience. The debate is about referral and emergencies.
Unmet need for contraception	Women who want to avoid pregnancy but do not use modern contraception.
Comprehensive sexuality education	Age-appropriate school education on the body, relationships, consent and health. Its content is contested in some countries.
Mexico City Policy ("global gag rule")	A US policy, applied by Republican administrations since 1984, that withholds US global health funding from foreign NGOs that provide or promote abortion. Proponents and opponents use different names for it.
Geneva Consensus Declaration	A non-binding 2020 declaration, originally promoted

Term	Meaning
	by the United States, Brazil, Egypt, Hungary, Indonesia and Uganda, that states there is no international right to abortion and stresses the family and national sovereignty. Membership has changed over time: check each country.
Maputo Protocol	The African Union's 2003 protocol on women's rights. Its Article 14 covers health and, in limited circumstances, access to medical abortion.

4. Legal and policy framework

WHO and UN texts

- **WHO Constitution (1946)**: enjoyment of the highest attainable standard of health is a fundamental right of every human being.
- **WHO Abortion care guideline (2022; 2nd edition 2025)**: recommends full decriminalisation, removal of medically unnecessary barriers (such as mandatory waiting periods and third-party authorisation) and service delivery through trained health workers and self-care options. These are recommendations, not binding rules.
- **ICPD Programme of Action, Cairo (1994)**: recognised reproductive health as a part of primary health care. It states that abortion should not be promoted as a method of family planning, and that where it is not against the law it should be safe (paragraph 8.25). It also describes unsafe abortion as a major public health concern. Both sides of the debate quote this text.
- **Beijing Declaration and Platform for Action (1995)**: invited governments to consider reviewing laws that punish women who have had illegal abortions.
- **2030 Agenda**: SDG 3.1 (maternal mortality), 3.7 (universal access to sexual and reproductive health services), 3.8 (UHC) and 5.6 (universal access to sexual and reproductive health and reproductive rights, in line with Cairo and Beijing).
- **UN political declaration on UHC (September 2023)**: the latest high-level commitment to UHC. Check what it says on sexual and reproductive health and which States made reservations or interpretive statements.

Human rights treaties

- **CEDAW (1979)**, article 12 (health) and the Committee's general recommendations: States must remove discrimination in health care. Check whether your country has ratified it and with which reservations.
- **UN Human Rights Committee, General Comment 36 (2018)** on the right to life: States should not regulate pregnancy in ways that push women towards unsafe abortions. It is an interpretation by an expert body, not a treaty.
- **Regional instruments**: the **Maputo Protocol** (Africa); the **Inter-American Court of Human Rights** ruling in *Beatriz v. El Salvador* (2024), which concerned a woman denied life-saving care and asked the State to give legal certainty to health personnel; the European system, where States

set their own laws but the European Court of Human Rights has ruled on access in individual cases.

Political texts that are not binding

- The **Geneva Consensus Declaration (2020)** expresses the position of States that stress protection of the unborn, the family and sovereignty. Several States have signed, left or rejoined it.
- UN resolutions and declarations differ in legal force. A binding treaty obliges only the States that ratified it. A WHA resolution or a political declaration is a commitment of a political kind. Be precise about which one you are quoting.

5. Key figures (check and update)

- **Abortion worldwide**: about **73 million induced abortions** take place each year; 6 in 10 unintended pregnancies and 3 in 10 pregnancies end in induced abortion (WHO fact sheet, December 2025).
- **Safety**: the WHO estimates that around **45% of abortions are unsafe** (modelled for 2010–2014). In Latin America and Africa about 3 in 4 abortions were estimated to be unsafe. A 2022 WHO news release said that where abortion is most restricted only about 1 in 4 abortions is safe, against nearly 9 in 10 where it is broadly legal.
- **Deaths**: a WHO-led review of causes of maternal death (2009–2020) linked about **8% of maternal deaths to abortion**; the WHO notes that such deaths are often misclassified and under-reported because of stigma. Older estimates were higher (up to 13%). State which source and year you use.
- **Effect of laws**: the WHO says that restricting access does not reduce the number of abortions but affects whether they are safe. Some governments and organisations dispute how far laws change abortion rates and stress the protection of unborn life. Be ready to discuss the evidence and the values separately.
- **Maternal deaths**: an estimated **260,000 women died** of pregnancy or childbirth causes in 2023, about 712 a day. Sub-Saharan Africa accounted for about **70%** (around 182,000). **Nigeria, Pakistan, Ethiopia and the Democratic Republic of the Congo** together accounted for about 47%. The 37 countries classed as fragile or in conflict accounted for 64%. Maternal mortality fell about 40% since 2000 but progress has slowed, and the world is off track for SDG target 3.1 (UN inter-agency estimates, April 2025).
- **Universal health coverage**: **4.6 billion people** still lack full coverage of essential health services, **2.1 billion** face financial hardship from health costs, and **1.6 billion** are pushed into or further into poverty. In the poorest segment of the population 3 in 4 people faced hardship in 2022, against fewer than 1 in 25 among the richest. Progress in reproductive, maternal, newborn and child health coverage has been modest (WHO–World Bank, UHC Global Monitoring Report 2025).
- **Cost of unmet needs**: the Guttmacher Institute (a research institute widely seen as aligned with reproductive rights advocacy) estimates that meeting all sexual and reproductive health needs in low- and middle-income African countries would cut maternal deaths by about two-thirds (*Adding It Up 2024*).

- **Law around the world**: the Center for Reproductive Rights (an advocacy organisation) counts **77 countries** that allow abortion on request and 12 that allow it on broad social or economic grounds; it reports that more than 60 countries and territories have liberalised their laws in 30 years and that only four have reduced legal grounds since 1994 (the United States, El Salvador, Nicaragua and Poland). Counts vary with the definitions used: compare with the WHO Global Abortion Policies Database.
- **Africa and the Maputo Protocol**: 46 of the 55 African States have ratified the Maputo Protocol; Burundi, Chad, Egypt, Eritrea, Madagascar, Morocco, Niger, Somalia and Sudan have not (as reported in 2026 by the Center for Reproductive Rights). Some ratifying States made reservations on Article 14, and sources do not list exactly the same States: check the African Union treaty status page.
- **Funding**: UNFPA depends on voluntary contributions. The United States reinstated the Mexico City Policy in January 2025, rejoined the Geneva Consensus Declaration, and stopped funding UNFPA. In September 2025 it launched an "America First" global health strategy based on bilateral agreements; critics, including the journal *The Lancet* and Human Rights Watch, worry about the effect on reproductive health, while supporters stress national sovereignty and shared financing by recipient countries. UN agencies warned in 2025 that aid cuts threaten progress on maternal health.

> ***Challenge:*** *The WHO says restrictions do not reduce abortions, while some governments say protecting unborn life justifies restrictions whatever the effect on numbers. In six sentences, write the strongest argument of each side, and say what kind of evidence (if any) would make each side change its mind.*

6. Debate axes

Axis 1. Universal health coverage and financing reproductive care

Essential benefit packages, public financing, out-of-pocket costs, medicines, primary health care, insurance schemes.

- Which reproductive health services should every national benefit package contain, and who should pay?
- How can poorer countries finance services when aid is falling?

Axis 2. Preventing unintended pregnancy: contraception, information and education

Modern contraception, emergency contraception, adolescents, comprehensive sexuality education, unmet need.

- How can States reduce unmet need for contraception in a way that respects family and cultural values?
- At what age and with what parental role should adolescents receive information and services?

Axis 3. Safe pregnancy and childbirth, and post-abortion care

Midwives, emergency obstetric care, referral systems, maternal death reviews, treatment of complications.

- How can referral and emergency care reach rural areas and conflict zones?
- Post-abortion care is accepted almost everywhere: can it be the basis of a consensus text?

Axis 4. Criminal law and legal frameworks

Total bans, grounds-based laws, laws on request, penalties for women and for health workers, prosecution of miscarriages and obstetric emergencies, constitutional protection.

- Should the WHO call for full decriminalisation, or only encourage States to review criminal penalties?
- How should clinicians be protected when the law is unclear about life-threatening emergencies?

Axis 5. Medication abortion, telemedicine and self-care

Essential medicines lists, regulation of pills, remote consultations, misinformation, quality control of medicines.

- Do self-managed methods widen access safely, and what safeguards should States set?
- How can States fight falsified medicines and unreliable online information?

Axis 6. Providers, conscience and training

Shortage of trained staff, task-sharing with midwives and nurses, conscientious objection, protection of providers from stigma and violence.

- How can respect for conscience be balanced with the patient's right to timely care?
- Should a provider who refuses be required to refer, or to act in an emergency?

Axis 7. Crises, adolescents and groups left behind

Humanitarian settings, refugees and displaced women, sexual violence in conflict, girls, women with disabilities, rural and poor women, migrants.

- What is the minimum package of reproductive care that must exist in every crisis?
- How should services for survivors of sexual violence be organised and funded?

Axis 8. Aid, accountability and data

Donor policies and conditions, role of UNFPA and the WHO, bilateral versus multilateral aid, domestic resources, data collection and monitoring.

- Should donors attach conditions on abortion-related services to health funding, and what are the effects on recipient countries?
- How can the WHO and UNFPA protect core services such as contraception and maternal care from funding shocks?

Tensions to anticipate

- **Right to life and right to health**: some States stress the protection of unborn life from conception; others stress women's health, autonomy and non-discrimination. Both frame their position as a matter of human rights.

- **Sovereignty and international standards**: some States say laws on abortion belong to national decision-making and that no international right to abortion exists; others say States must follow the interpretation of human rights bodies and the WHO guidelines.
- **Evidence and values**: the WHO bases its guidance on public health evidence; some delegations argue that moral, religious or cultural values must come first. A strong delegate separates the two.
- **Conscience and access**: freedom of conscience for providers against the patient's right to care.
- **Wording**: terms such as "sexual and reproductive health and rights", "gender", "safe abortion" and "family" are contested. Small word changes can decide whether a text is adopted.
- **Adolescents and consent**: parental involvement against confidentiality and protection from harm.
- **Fiscal space and aid**: care costs money; debt, aid cuts and donor conditions matter, and recipient governments face difficult trade-offs.
- **Integrated or targeted services**: whether reproductive health should be part of general UHC packages or ring-fenced, and what that means for funding.

7. Delegations and positioning guide

The 35 delegations of the committee

Region	Delegations
Europe (7)	France, Germany, Sweden, Netherlands, United Kingdom, Poland, Malta
Americas (8)	United States, Canada, Mexico, Brazil, Argentina, Colombia, Chile, El Salvador
Africa (8)	Nigeria, Democratic Republic of the Congo, Ethiopia, Kenya, South Africa, Rwanda, Senegal, Sierra Leone
Asia (8)	India, Pakistan, Bangladesh, Indonesia, Philippines, Thailand, Japan, China
Middle East and North Africa (3)	Egypt, Iran, Morocco
Oceania (1)	Australia

This list mixes countries with very different laws (from total bans to abortion on request), very different health systems (from near-universal public coverage to heavy out-of-pocket costs), large donors and large recipients of aid, and recent reformers and countries where rights have been reduced or reform has stalled. That mix is what makes negotiation realistic.

Delegation profiles

Use the next table as a starting point for your own research. It lists *research angles*, not official positions. Several countries appear in more than one profile.

Profile	Delegations and research angles

Profile	Delegations and research angles
Total or near-total bans, prosecutions	**El Salvador, Philippines, Malta, Poland, Senegal, Nigeria, Egypt**: wording of the law, exceptions to save life, treatment of women and doctors, effect on emergency care, sovereignty arguments.
Recent liberalisation or legal protection	**France** (constitution, 2024), **Argentina** (2020), **Colombia** (2022), **Mexico** (2021 and 2023 rulings), **Thailand** (2021), **United Kingdom** (England and Wales, 2026): what changed it (parliament, courts, referendum), what opposition remains, whether services followed.
Rollback, contest or stalled reform	**United States** (2022), **Chile** (new government, 2026), **Poland**, **Brazil** (stalled court case), **Sierra Leone** (bill unpassed in 2026), **Argentina** (political opposition): how rights can be lost or blocked, and what protects them.
Maternal mortality hotspots	**Nigeria, DR Congo, Ethiopia, Pakistan, Sierra Leone, Kenya**: causes of death, health workforce, emergency care, conflict, funding.
Large donors and funders	**United States, Germany, Sweden, Netherlands, United Kingdom, France, Canada, Japan, Australia**: aid priorities, conditions, shift between multilateral and bilateral aid, effect of aid cuts.
UHC models	**Thailand, Rwanda, Japan, Colombia, South Africa, United Kingdom, France, Brazil**: how reproductive care is included in the package and paid for.
Practical middle paths	**Bangladesh** (menstrual regulation), **Indonesia**, **India**, **Ethiopia**, **Kenya**: narrow or ambiguous laws combined with real services; what such arrangements can and cannot do.
Geneva Consensus Declaration	**United States, Brazil, Egypt, Indonesia** (original supporters; check each country's current stance), and others you identify: the sovereignty and family-based arguments, and what these governments would accept in a WHO text.
Maputo Protocol	**Kenya, Senegal, Nigeria, DR Congo, Ethiopia, Rwanda, South Africa, Sierra Leone** (check ratification and reservations); **Egypt, Morocco** (not

Profile	Delegations and research angles
	ratified, according to 2026 reports).
Population policy and big systems	**China, India, Iran, Japan**: falling fertility, state pronatalism, and what it does to access to contraception and abortion.

Country starting points

Laws and policies change quickly. **Verify every line below** in the WHO Global Abortion Policies Database, your government's official sources and recent news before you use it.

Delegation	Starting point (verify)	Research angles
France	Abortion on request up to 14 weeks; the freedom to access abortion is written into the Constitution (2024); care is reimbursed.	A model of constitutional protection; how to promote a national model without imposing it.
Germany	Abortion remains in the Criminal Code (section 218) but is not punished in early pregnancy after compulsory counselling and a waiting period; reform debated.	Why reform is slow; major health donor; balance between protection of unborn life and access.
Sweden	On request up to 18 weeks; long-standing donor to sexual and reproductive health.	Current aid priorities; constitutional protection debate; role as bridge-builder.
Netherlands	On request, but the woman must state she is in a situation of distress (according to the Center for Reproductive Rights); strong funding history, including the "She Decides" initiative (2017).	Gap between a liberal practice and legal wording; replacing lost funding.
United Kingdom	England and Wales removed criminal liability for women in April 2026; Northern Ireland reformed in 2019; Scotland is discussing reform; NHS care is free.	Decriminalisation versus full liberalisation; effect of the aid budget cut announced in 2025.
Poland	Highly restrictive law; the 2020 Constitutional Tribunal ruling ended the fetal-impairment ground; in October 2026 the Sejm voted limited changes whose passage is uncertain.	Travel abroad for care; politics inside the EU; role of constitutional courts.
Malta	Very restrictive law, with a narrow exception for serious risks to life or health introduced in 2023.	Smallest EU State with a strict law; EU health competence is national; women travelling abroad.

Delegation	Starting point (verify)	Research angles
United States	Since June 2022 (*Dobbs*) States set their own laws; 13 States ban abortion (Center for Reproductive Rights, 2026). Federal foreign policy: Mexico City Policy reinstated (January 2025), UNFPA funding halted, Geneva Consensus rejoined.	Largest historical health donor; federalism; bilateral health agreements; sovereignty and "co-investment" arguments; risk to multilateral cooperation.
Canada	No federal criminal abortion law since 1988; abortion is treated as health care under the Canada Health Act; access is uneven between provinces and in rural areas.	Funding of global sexual and reproductive health; access gaps inside a universal public system.
Mexico	Supreme Court rulings (2021, 2023) hold criminalisation unconstitutional and require federal health services to provide abortion; States update their codes at different speeds.	Implementation in a federal system; Latin American "green wave"; cross-border context.
Brazil	Legal only for rape, risk to life and anencephaly; a Supreme Court case on decriminalisation up to 12 weeks has been stalled since 2017.	Co-initiator of the Geneva Consensus in 2020 (check current stance); the public Unified Health System; unsafe abortion among poorer women.
Argentina	Law 27.610 (2020): on request up to 14 weeks. The Milei government is critical, but no repeal had been reported (verify).	How a law survives political change; health budget cuts; implementation in the provinces.
Colombia	In 2022 the Constitutional Court decriminalised abortion up to 24 weeks, building on a 2006 ruling that allowed it on three grounds.	Court-led reform; insurer-based health system and rural access; conscientious objection.
Chile	Three grounds since 2017 (life, non-viability, rape); the government in office since March 2026 opposes abortion; the previous government introduced a bill for abortion on request up to 14 weeks.	Conscientious objection among providers; rollback through administrative rules; limits of grounds-based laws.
El Salvador	Total ban without exceptions; the Constitution protects life from conception; women have been prosecuted after obstetric emergencies. The Inter-American Court ruled against the State in the *Beatriz* case (2024).	Reaction to a regional court ruling; fear among doctors; the State's sovereignty arguments.

Delegation	Starting point (verify)	Research angles
Nigeria	Federal criminal laws allow abortion only to save a woman's life (check State variations). About 75,000 maternal deaths in 2023, over a quarter of the world total. Signed a US bilateral health agreement.	Fiscal space; federal system; faith communities; post-abortion care.
Democratic Republic of the Congo	One of four countries with about half of all maternal deaths; conflict in the east; has ratified the Maputo Protocol (check how Article 14 is applied).	Reproductive care in humanitarian crises; sexual violence; health workforce.
Ethiopia	2005 law allows abortion for rape, incest, health risk, fetal impairment and minors; one of four countries with about 47% of maternal deaths; signed a US bilateral health agreement.	Gap between the law and services; community health workers; funding.
Kenya	The 2010 Constitution allows abortion when life or health is in danger or in an emergency; the Center for Reproductive Rights lists a reservation to Maputo Protocol Article 14(2)(c).	Ambiguity of "health" and prosecution of providers; first country to sign a US bilateral health agreement (December 2025).
South Africa	Choice on Termination of Pregnancy Act (1996): on request up to 12 weeks, later on grounds; National Health Insurance Act (2024).	Liberal law but few willing providers; HIV and adolescents; financing national health insurance.
Rwanda	Legal grounds widened since 2012 (check the current list); high health insurance coverage through community-based schemes.	A UHC success story; community health workers; law versus everyday access.
Senegal	Abortion banned except to save the woman's life with medical approval; has ratified the Maputo Protocol (check how it applies Article 14).	Debate after cases of sexual violence; community health; religious leaders.
Sierra Leone	An 1861 law criminalises abortion; the Safe Motherhood and Reproductive Health Bill (2024; draft allowed termination up to 14 weeks) remained unpassed in mid-2026 amid religious opposition.	Government-led reform and backlash; high maternal mortality; role of interfaith councils.
India	Medical Termination of Pregnancy Act (amended 2021): broad grounds, up to 24 weeks for specific categories; a 2022 Supreme Court ruling extended access to unmarried women.	Liberal law yet unsafe abortion persists; providers, stigma, sex-selection concerns.
Pakistan	Law permits abortion to save life or for "necessary treatment" (interpretations vary); one of four countries with about 47% of maternal deaths.	Religious interpretation; community midwives; family planning and financing.

Delegation	Starting point (verify)	Research angles
Bangladesh	Abortion is a crime, but "menstrual regulation" in early pregnancy is a government-supported service.	A pragmatic model and its limits; contraception and community care.
Indonesia	Health Law (2023) permits abortion for medical emergencies and rape, with time limits (verify); co-initiator of the Geneva Consensus (2020).	Religious norms and health policy; implementation of narrow grounds; decentralised services.
Philippines	Near-total ban; the Constitution protects the unborn from conception; post-abortion care is available.	Hospital complications of unsafe abortion; contraception debate; church and State.
Thailand	2021 reform: on request up to 12 weeks, later with conditions (verify); universal coverage scheme since 2002.	UHC model for a middle-income country; turning law into services; provider training.
Japan	Abortion permitted on health or economic grounds but spousal consent is usually required; medication abortion approved in 2023; generally not covered by insurance.	Host of the UHC High-Level Forum (Tokyo, December 2025); consent rules; low birth rate.
China	Abortion widely available; national policy documents since 2021 aim to reduce "non-medically necessary" abortions amid low fertility; past controversy over UNFPA's work in China.	Pronatalism; role of the State in reproduction; relationship with UNFPA.
Egypt	Abortion criminalised (check exceptions to save life); has not ratified the Maputo Protocol; co-initiator of the Geneva Consensus (2020); UHC service index of 71 and 36.9% of people in financial hardship (WHO–World Bank 2025, as reported).	Regional leadership; new universal insurance system; role of religious institutions.
Iran	Therapeutic abortion allowed with medical approval in limited cases; a 2021 population law restricts contraception and sterilisation (verify).	Shift to pronatalist policy; effect on maternal health; supply of medicines under sanctions.
Morocco	Abortion allowed only to protect the woman's health, with conditions (verify); reform debate since 2015; has not ratified the Maputo Protocol; UHC service index of 65 and 27.1% in financial hardship (WHO–World Bank 2025, as reported).	Gradual reform; extension of social protection; North African context.

Delegation	Starting point (verify)	Research angles
Australia	Abortion decriminalised in all States and Territories (South Australia last, in 2021); cost and regional access vary.	Donor in the Pacific; rural access; telehealth.

Possible substitutes or extra delegations (not researched here): Hungary and Uganda (original Geneva Consensus sponsors), Nicaragua, Honduras and the Dominican Republic (total bans), Benin (2021 reform), Nepal (reform since 2002), Russia, Norway, Denmark.

Note for organisers: brief delegates that they are defending a *national position*, not their personal opinion. A delegation may be asked to argue a view it dislikes: that is part of the exercise. Observers (midwives, doctors, youth, faith-based providers, civil society) can be added to bring in voices that States do not always represent.

8. Research method

Step 1. Build a country profile

Item	What to find	Sources
Basics	Population, income level, region, main health challenges	World Bank, WHO Global Health Observatory
Maternal health	Maternal mortality ratio, share of births with skilled attendants, emergency care	UN maternal mortality estimates, WHO, national health surveys
Contraception	Use of modern methods, unmet need, adolescent access	UN Population Division, UNFPA, national surveys
Abortion law	Grounds, time limits, penalties for women and providers, procedural requirements	WHO Global Abortion Policies Database, national legislation
Practice	Estimates of unsafe abortion, complications, post-abortion care, conscientious objection	WHO, national ministry of health, peer-reviewed studies
Health system and UHC	Service coverage index, out-of-pocket spending, insurance scheme	WHO–World Bank UHC reports, national health accounts
Commitments	CEDAW, Maputo Protocol (if African), regional courts, Cairo and Beijing positions	UN Treaty Collection, African Union, regional bodies
Funding	Donor or recipient; relation with UNFPA and the WHO; bilateral agreements	OECD, UNFPA donor data, ministry of foreign affairs

Item	What to find	Sources
Allies and opponents	Regional groups and likely partners on each axis	Your analysis

Step 2. Read primary sources first

Start with the WHO fact sheet on abortion and the Abortion care guideline summary, the UN report on maternal mortality (2025), the WHO–World Bank UHC report (2025), the text of paragraph 8.25 of the Cairo Programme of Action, Article 14 of the Maputo Protocol (if relevant) and the Geneva Consensus Declaration. Read the texts themselves, not only summaries.

Step 3. Evaluate sources (and their perspective)

- Distinguish **official and UN sources** (WHO, UN agencies, World Bank, national statistics offices), **research institutes**, **advocacy organisations** and **news media**.
- Many organisations that publish on this topic have a declared position. Reproductive-rights organisations (for example the Center for Reproductive Rights, Ipas, Guttmacher) and family-values or pro-life organisations (for example C-Fam) both produce useful documents, but each presents facts to support a view. Note the position of the source.
- **Read at least one source that comes from the opposite perspective to your delegation's**, so you can answer it in debate.
- Always note the **year**, the **definition** and the **method** of a figure. Cross-check key claims with two sources, and compare estimates (for example 8% versus 13% of maternal deaths).
- Be careful with rankings and press summaries; trace them back to the original.

Step 4. Define your strategy

For each axis: your priority, your red lines, what you can offer (funding, expertise, best practice) and what you ask for. Identify wording your government cannot accept and an acceptable alternative.

Step 5. Position paper (1–2 pages)

1. **National situation**: laws, health system, data, achievements and challenges.
2. **International commitments and past actions**, including ratifications and positions in previous UN texts.
3. **Positions on the debate axes** with concrete proposals.
4. **Areas for compromise** and wording you cannot accept.

9. Drafting a resolution

A resolution has **preambular clauses** (context and principles) followed by numbered **operative clauses** (actions). In a WHO or UNFPA text, operative clauses typically **invite Member States**, **request the Director-General** of the WHO or the **Executive Director** of UNFPA to act, and **call upon donors and partners**.

Preambular clauses (sentence starters)

Recalling… · Reaffirming… · Recognizing… · Deeply concerned that… · Noting with appreciation… · Emphasizing… · Aware that… · Taking into account national legislation…

Example: *Recalling the Programme of Action of the International Conference on Population and Development and targets 3.1, 3.7 and 3.8 of the 2030 Agenda for Sustainable Development,*

Operative clauses (verbs)

Urges… · Invites… · Encourages… · Calls upon… · Requests the Director-General… · Requests the Executive Director of UNFPA… · Recommends… · Decides to remain seized of the matter.

Example: *1. Invites Member States to include contraception, maternity care and post-abortion care in the essential services covered by public financing, in accordance with national legislation, and requests the WHO and UNFPA to provide technical assistance to that end;*

Wording that helps build consensus

Common compromise formulas are “in accordance with national legislation”, “where permitted by law”, “taking into account national priorities” and “in line with the Programme of Action of the ICPD”. They let States with different laws vote for the same text, but critics may say they empty a clause of force. Decide, clause by clause, whether you want the formula or not.

Strength of language

Level	Verbs	When to use
Soft	Encourages, invites, notes	To win wide support
Medium	Urges, calls upon, recommends	For commitments already widely accepted
Firm	Demands, condemns	Rarely used in WHO and UNFPA texts addressed to Member States

Qualities of a strong resolution

- **Specific**: who does what, with what resources and by when.
- **Realistic** for countries at different levels of development and with different laws.
- **Balanced**: covers prevention, care, law, financing and data.
- **Measurable**: indicators, reporting, follow-up.
- **Inclusive**: considers adolescents, rural women, women with disabilities, migrants and women in crises.
- **Evidence-based**: cites WHO guidance, and is clear where a clause rests on values rather than data.
- **Financed**: states how the measures will be funded.

> ***Challenge:*** *Draft one operative clause on complications of unsafe abortion that could be accepted both by a State where abortion is available on request and by a State with a total ban. (Hint: look at what is legal and accepted everywhere.)*

10. Flow of debate and tips

1. **Roll call and opening speeches** (one minute each).
2. **General debate** (speakers' list).
3. **Moderated and unmoderated caucuses** for discussion, alliances and drafting.
4. **Submission of draft resolutions**, sponsors and signatories.
5. **Amendments** and points of procedure.
6. **Voting** on the resolution (follow your organisers' rules).

Tips for delegates

- Open with two figures and two proposals.
- Speak as your country ("the delegation of…"), stay courteous and avoid personal attacks. Never say "I believe": say "my Government believes".
- Look for allies across regions and across legal systems, not only in your own group. Common ground often exists on contraception, maternal care and post-abortion care.
- Separate evidence from values in your speeches; name the source and year of every figure.
- Have a plan B wording for clauses that may be rejected.
- In pairs, share roles: one speaks while the other tracks amendments and drafts.
- Remember that many delegates are not native English speakers: speak clearly and avoid jargon.
- Use neutral, medical vocabulary. If a point makes you uncomfortable, ask the chairs for a pause.

11. Recommended sources

- **WHO**: fact sheet *Abortion* (December 2025); *Abortion care guideline* (2022; 2nd edition 2025); *Global Abortion Policies Database*; fact sheets on maternal mortality and family planning; Global Health Observatory.
- **WHO–World Bank**: *UHC Global Monitoring Report 2025*.
- **UN inter-agency report**: *Trends in maternal mortality 2000 to 2023* (WHO, UNICEF, UNFPA, World Bank, UN DESA; April 2025).
- **UNFPA**: *State of World Population* reports; ICPD Programme of Action (1994); donor and country data.
- **UN treaty bodies**: CEDAW Committee, Human Rights Committee General Comment 36, CESCR General Comment 14 (right to health).
- **African Union**: Maputo Protocol and status of ratification and reservations.
- **World Bank**: Gender data portal; health expenditure data.
- **Research and advocacy organisations** (note each one's perspective): Guttmacher Institute (*Adding It Up*); Center for Reproductive Rights (world abortion laws); Human Rights Watch; Amnesty International; Ipas; and on the other side, organisations such as C-Fam and the texts and signatory lists of the Geneva Consensus Declaration.
- **News**: recent reports from reputable outlets on aid cuts, the US bilateral health agreements and national law reforms; always trace back to the original source.

12. Delegate checklist

- ☐ I have read this guide and the key sections of the WHO and UN reports.

- ☐ I have completed my country profile and noted the source, the year and the type of source of each figure.
- ☐ I know my country's abortion law, its penalties and its health financing system, and I have checked them in two sources.
- ☐ I know which of CEDAW and the Maputo Protocol (if relevant) my country has ratified, and with which reservations.
- ☐ I can explain the difference between legalisation and decriminalisation, and between a law and access in practice.
- ☐ I have a position on each debate axis, with red lines and compromises.
- ☐ I have read at least one source from the opposite perspective.
- ☐ I have written my position paper (1–2 pages).
- ☐ I have prepared a one-minute opening speech.
- ☐ I have drafted at least three operative clauses, with a plan B.
- ☐ I have identified three possible allies and two delegations to negotiate with.

Good luck, and enjoy the negotiations!