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Abortion care guideline executive summary

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Executive summary

Sexual and reproductive health is fundamental to individuals, couples and families, and to the social and economic development of communities and nations. As provided in the Constitution of the World Health Organization (WHO), the organization's objective is "the attainment by all peoples of the highest possible level of health", and to fulfil that objective, WHO's functions include providing technical assistance to countries in the field of health. Universal access to sexual and reproductive health (SRH) information and services is central to both individual and community health, as well as the realization of human rights. In the wake of the COVID-19 pandemic and based on lessons learnt from previous disease outbreaks – when SRH services have been severely disrupted, causing individuals to feel disempowered and be exposed to preventable health risks – WHO has included comprehensive abortion care in the list of essential health services in certain recent technical publications.[1]

Comprehensive abortion care includes the provision of information, abortion management (including induced abortion, and care related to pregnancy loss/spontaneous abortion and post-abortion care. Strengthening access to comprehensive abortion care within the health system is fundamental to meeting the Sustainable Development Goals (SDGs) relating to good health and well-being (SDG3) and gender equality (SDG5). WHO's Global Reproductive Health Strategy, which seeks to accelerate progress towards achievement of international development goals, identifies elimination of unsafe abortion[2] as a priority mandate. The importance of quality abortion care to health is similarly underscored by the United Nations Global Strategy for Women's, Children's and Adolescents' Health, which includes evidence-based interventions for abortion and post-abortion care as one effective way to help individuals thrive and communities transform.

Quality of abortion care is foundational to this abortion care guideline. Quality of care (see Glossary) encompasses multiple components. It is defined as care that is: effective, efficient, accessible, acceptable/patient centred, equitable and safe. Effective care includes the delivery of evidence-based care that improves the health of individuals and communities, and is responsive to their needs. Efficient care optimizes resource use and minimizes waste. Quality abortion care must also be both accessible (timely, affordable, geographically reachable, and provided in a setting where skills and resources are appropriate to medical need) and acceptable (incorporating the preferences and values of individual service users and the cultures of their communities). It is imperative that access to abortion care is equitable, and that the quality of care does not vary based on the personal characteristics of the person seeking care, such as their gender, race, religion, ethnicity, socioeconomic status, education, if they are living with a disability, or based on their geographic location within a country. And finally, quality abortion care implies that it is safely delivered and minimizes any risks and harms to service users.

1 When considering the concept of "essential health services", it is important to note that different areas, even within the same country, may require different approaches to designate essential health services and to reorient health system components to maintain these services. Please refer to: *Maintaining essential health services: operational guidance for the COVID-19 context, interim guidance, 1 June 2020* (https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1). For additional relevant references, see Chapter 1, section 1.1.

2 "Unsafe abortion" refers to abortion when it is carried out by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Abortion is a safe and non-complex health-care intervention that can be effectively managed using medication or a surgical procedure in a variety of settings. Complications are rare with both medical and surgical abortion, when abortions are safe – meaning that they are carried out using a method recommended by WHO, appropriate to the gestational age, and by someone with the necessary skills. Globally, abortion is a common procedure, with 6 out of 10 unintended pregnancies and 3 out of 10 of all pregnancies ending in induced abortion. However, global estimates demonstrate that 45% of all abortions are unsafe. This is a critical public health and human rights issue; unsafe abortion is increasingly concentrated in developing countries (97% of unsafe abortions) and among groups in vulnerable and marginalized situations. Legal restrictions and other barriers mean many women find it difficult or impossible to access quality abortion care and they may induce abortion themselves using unsafe methods or seek abortion from unskilled providers. The legal status of abortion makes no difference to a woman's need for an abortion, but it dramatically affects her access to safe abortion. Between 4.7% and 13.2% of all maternal deaths are attributed to unsafe abortions, which equates to between 13 865 and 38 940 deaths caused annually by the failure to provide safe abortion.

Medical abortion has revolutionized access to quality abortion care globally. Medicines for abortion can be safely and effectively administered at a health-care facility or self-administered outside of a facility (e.g. at home) by individuals with a source of accurate information and quality-assured medicines. Those managing their abortions safely at home in the first 12 weeks of gestation may still need or want support from a trained health worker at some stage of the process. Service delivery with minimal medical supervision can significantly improve access to – and privacy, convenience and acceptability of – the abortion process, without compromising safety or effectiveness.

Multiple actions are needed at the legal, health system and community levels so that everyone who needs it has access to comprehensive abortion care. A person's environment plays a crucial role in shaping their access to care and influencing their health outcomes. An enabling environment is the foundation of quality comprehensive abortion care. The three cornerstones of an enabling environment for abortion care are:

1. respect for human rights including a supportive framework of law and policy
2. availability and accessibility of information, and
3. a supportive, universally accessible, affordable and well functioning health system.

Abortion is lawful in almost all countries, although there is variation in the specific circumstances under which an individual may access abortion. In addition, almost all countries where abortion is lawfully available regulate abortion differently to other forms of health care. Unlike other health services, abortion is commonly regulated to varying degrees through the criminal law in addition to regulation under health-care law. This has an impact on the rights of pregnant individuals, and can have a chilling effect (e.g. suppression of actions due to fear of reprisals or penalties) on the provision of quality care. This is why clear, accessible and rights-based law and policy is part of ensuring an enabling environment.

Objectives, scope and conceptual structure of the guideline

Guidelines are the fundamental means through which WHO fulfils its technical leadership in health. WHO guidelines are subject to a rigorous quality assurance process that generates recommendations for clinical practice or public health policy with the aim of achieving the best possible individual or collective health outcomes. Towards this aim, WHO has made a commitment to integrate human rights into health-care programmes and policies at national and regional levels by looking at underlying determinants of health as part of a comprehensive approach to health and human rights.

The objective of this guideline is to present the complete set of all WHO recommendations and best practice statements relating to abortion. While legal, regulatory, policy and service-delivery contexts may vary from country to country, the recommendations and best practices described in this document aim to enable evidence-based decision-making with respect to quality abortion care.

This guideline updates and replaces the recommendations in the following previous WHO guidelines:

- *Safe abortion: technical and policy guidance for health systems, second edition* (2012)
- *Health worker roles in providing safe abortion care and post-abortion contraception* (previously known as the "task sharing" guidance) (2015), and
- *Medical management of abortion* (2018).

This guidance contains new recommendations consolidated here in an integrated manner with existing recommendations that remain unchanged and those that have been updated after re-assessment using the same rigorous methods for both new and updated recommendations (see more information in the "Guideline development methods" section below).

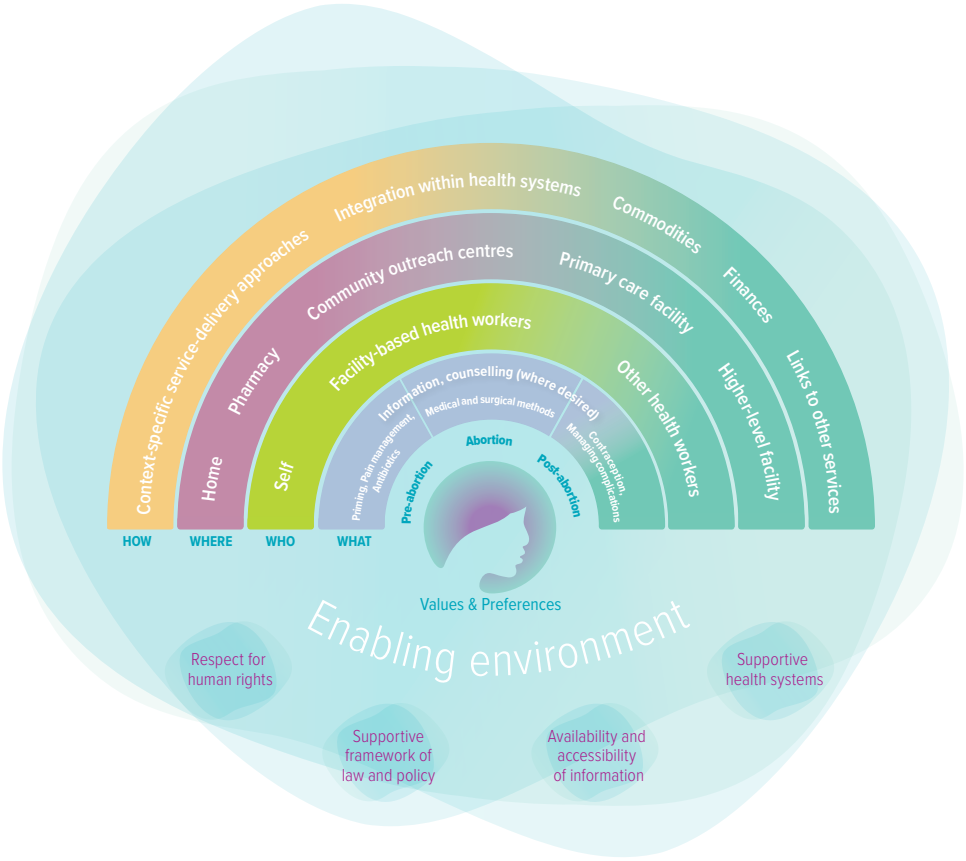
In this guideline, recommendations are presented across three domains that are essential to the provision of abortion care: Law and policy, Clinical services and Service delivery. The recommendations concerning the laws and policies that should or should not be in place in order to fully implement and sustain quality abortion care cover seven areas: criminalization of abortion, grounds-based approaches to permitting abortion, gestational age limits set for abortion, mandatory waiting periods before receiving a requested abortion, third-party authorization for abortion, restrictions on which health workers can provide abortion services, and conscientious objection/refusal by providers.[3] Clinical service recommendations address methods of abortion and related clinical care – from provision of information, counselling and pain management to methods and regimens for abortion (including for different clinical indications) – and provision of post-abortion care, including all methods of contraception.[4] Service delivery recommendations include those relating to which categories of health workers can provide the relevant clinical services. Self-management recommendations are also presented relating to tasks that can be managed by the woman herself: medical abortion in early gestation and use of many contraceptives, including self-administration of injectable contraceptives. A recommendation relating to telemedicine to facilitate early medical abortion has also been formulated, alongside best practice statements on other service-delivery approaches for abortion care. Together, the guidance presented in this document reflects recent changes in all these aspects of abortion care. Research gaps and priorities and emerging areas of interest are identified in the final chapter.

As indicated by the arrangement of the guidance in this document, as a woman, girl or other pregnant person moves through the abortion care pathway – pre-abortion, abortion and post-abortion care – health services must be integrated within the health system to ensure that service delivery meets their needs equitably and without discrimination. The conceptual framework for abortion care in this guideline (see Figure 1) recognizes and acknowledges the needs of all individuals with respect to abortion and is centred on the values and preferences of abortion seekers, considering them as active participants in – as well as beneficiaries of – health services. Individual health preferences may vary; no one model of abortion care will meet the needs of everyone seeking abortion care. However, the core values of dignity, autonomy, equality, confidentiality, communication, social support, supportive care and trust are foundational to abortion care and are reflected throughout this guidance. Important work is still needed to incorporate linkages to quality abortion care throughout the health system, and the focus on human rights and gender equality must be applied in all contexts providing services to people seeking health care.

3 The previous edition of the *Safe abortion* guidance (WHO, 2012) addressed these issues and related interventions and provided a composite recommendation. In this guideline, these have each been addressed separately as seven individual recommendations (Recommendations 1,2,3,6,7,21,22).

4 A full consideration of all contraceptive methods is beyond the scope of this guideline, but all contraceptive methods can be considered after an abortion, including a range of self-administered methods.

Figure 1: Conceptual framework for abortion care



Target audience and inclusivity

This guidance seeks to provide recommendations for national and subnational policy-makers, implementers and managers of sexual and reproductive health (SRH) programmes, members of nongovernmental organizations and other civil society organizations and professional societies, as well as health workers and other stakeholders in the field of sexual and reproductive health and rights (SRHR), to support them in ensuring that evidence-based, quality abortion care is available and accessible globally.

All individuals have the right to non-discrimination and equality in accessing SRH services. The right to be free from discrimination is stated in the Universal Declaration of Human Rights and in other universal human rights treaties and regional human rights instruments. It has been affirmed that the right to non-discrimination guaranteed by the International Covenant on Economic, Social and Cultural Rights (ICESCR) includes sexual orientation, gender identity and sex characteristics. As stated in the 2018 report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity to the United Nations General Assembly, "the right to effective recognition of one's gender identity is linked to the right to equal recognition before the law".

In this guideline, we recognize that most of the available evidence on abortion can be assumed to be derived from research among study populations of cisgender women, and we also recognize that cisgender women, transgender men, nonbinary, gender-fluid and intersex individuals with a female reproductive system and capable of becoming pregnant may require abortion care. To be concise and facilitate readability of this guideline, when referring to all gender diverse people who may require abortion care, we use the word "women" most often, although we also variously use the terms "individual", "person" and "abortion seeker". Providers of SRH services, including abortion care, must consider the needs of – and provide equal care to – all individuals; gender identity or its expression must not lead to discrimination.

Guideline development methods

The WHO Guideline Steering Group and wider WHO Secretariat, including staff members from both WHO headquarters and regional offices, led a wide-ranging guideline development process involving a vast range of expert contributors and support personnel. The process began in September 2018 with an online survey on the subject of updating WHO guidance on safe abortion, followed by scoping meetings between November 2018 and June 2019 to determine the key topic areas and to formulate key questions to be assessed through searches and analysis of the evidence base, for each of the three domains: Law and policy, Clinical services and Service delivery. In order to ensure broad representation, the following meetings were convened to further inform our guideline: (i) Implementation considerations for abortion care in humanitarian settings, (ii) Global values and preferences relating to abortion care, and (iii) Youth and safe abortion.

Global experts were invited by the Steering Group to convene three expert panels – the Evidence and Recommendation Review Groups (ERRGs) for each domain – involving active participation in a series of two-day meetings to discuss and draft the new and updated recommendations, based on the evidence provided by the Evidence Synthesis Teams (ESTs). The Guideline Development Group (GDG) members were selected and invited by the Steering Group from among the ERRG members for each domain, to bring together a single multidisciplinary group, including a youth representative and a human rights adviser, to finalize the recommendations.

In accordance with the WHO guideline development process, the formulation and refinement of recommendations by the ERRGs and the GDG was based on the available evidence (with quality of evidence ranging from high to very low), using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to recommendation development, with reference to the Evidence-to-Decision (EtD) tables prepared by the ESTs, and also guided by the participants' own expertise and experience. The WHO-INTEGRATE framework was used as a basis for deciding on the direction and strength of each recommendation (see notes accompanying the summary table below). For the law and policy recommendations, this same framework was used but an innovative approach was developed to evaluate the evidence in a manner that effectively integrated human rights protection and enjoyment as part of health outcomes and analysis.

After the conclusion of the ERRG and GDG meetings, the revised draft recommendations and full draft guideline were reviewed by GDG members and members of the External Review Group of peer reviewers. The GDG meeting observers and individual reviewers from several implementing organizations were also invited to comment on the same draft. Further revisions were made and the guideline was submitted to and approved by the WHO Guidelines Review Committee, followed by final revisions from the Office of the United Nations High Commissioner for Human Rights (OHCHR), final editing and planning for publication and launch. The full guideline development methods are presented in Annex 4.

Summary table of recommendations presented in this guideline

Important notes:

i. Each recommendation and its direction (for or against) and strength (strong or weak) has been determined by the panels of experts convened by WHO for this purpose. The determinations were based on the six substantive criteria of the WHO-INTEGRATE framework as applied to each intervention for the specified population – balance of health benefits and harms; human rights and sociocultural acceptability; health equity, equality and non-discrimination; societal implications; financial and economic considerations; and feasibility and health system considerations – while also taking into account the meta-criterion, quality of evidence (i.e. type, size and limitations of the available studies used as evidence). Wording used is as follows:

- **Recommend** – a strong recommendation in favour of the intervention
- **Suggest** – a weak recommendation in favour of the intervention
- **Recommend against** – a strong recommendation against the intervention/in favour of the comparison.

ii. Most of the recommendations are labelled as LP for "Law and policy", CS for "Clinical services" or SD for "Service delivery", referring to the broad domain under which the evidence for these recommendations was reviewed and evaluated by the respective expert panels (ERRGs). In addition, five recommendations are labelled as SELF-MANAGEMENT.

iii. The SD recommendations that refer to health worker categories assume that the people working within the categories mentioned have the skills and competencies required for the intervention specified. The roles, skills and competencies of each type of health worker mentioned in these recommendations are described in the table on health worker categories and roles in Annex 5, and further information can be found in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care*, which describes the competencies (including skills and knowledge) required for each task.

iv. Recommendations were considered "new" (as labelled in this table and in Chapter 3) if no recommendation existed in a previous WHO guideline on the specific topic or intervention in question. In particular it should be noted that the 2012 *Safe abortion* guidance provided a composite recommendation related to law and policy; in this guideline, this has been developed this into seven separate recommendations, but they are not considered to be "new" (i.e. Recommendations 1,2,3,6,7,21,22).