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Abortion care guideline, second edition

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ISBN 978-92-4-010420-4 (electronic version)
ISBN 978-92-4-010421-1 (print version)

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Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Design and layout: Little Unicorns (Seattle, WA)

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- Web annex A. Key international human rights standards on abortion
- Web annex B. Technical meetings during guideline development
- Supplementary material 1. Evidence-to-Decision frameworks for the law and policy recommendations:
- Supplementary material 2. Evidence-to-Decision frameworks for the clinical service recommendations:
- Supplementary material 3. Evidence-to-Decision frameworks for the service delivery recommendations

Acknowledgements

United Nations Development Programme (UNDP)-United Nations Population Fund (UNFPA)-United Nations Children's Fund (UNICEF)-World Health Organization (WHO)-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) and the World Health Organization gratefully acknowledges the contributions of many individuals and organizations to the development of this consolidated guideline.

WHO extends sincere thanks to the **chair and members of the Guideline Development Group (GDG)**: Laura Castleman (Chair) and Fauzia Akhter Huda, Karla Berdichevsky, Marge Berer, Michalina Drejza, Joanna Erdman, Kristina Gemzell Danielsson, Caitlin Gerdts, Laura Gil, Selma Hajri, Guyo Jaldesa, Godfrey Kangaude, Vinoj Manning, Hiromi Obara, Alongkone Phengsavanh, Akila Radhakrishnan, Michelle Remme and Chi Chi Undie; and also the **human rights adviser** for the GDG meeting and all three Evidence and Recommendation Review Group (ERRG) meetings: Christina Zampas. Sincere thanks also to the following additional **ERRG members**: Nana Yaa Appiah, Suchitra Dalvie, Jemima Araba Dennis-Antwi, Surendra Dhital, Daniel Maceira, Sybil Nkeiru, Karan Parikh, Dhammika Perera, Judiac Ranape, Kitihoun Serge and Karthik Srinivasan; and to the following **human rights advisers** who contributed to the ERRG on law and policy: Abhijit Das, Sara Hossain, Karima Khalil, Primah Kwagala, Monica Arango Olaya and Xian Warner. Thanks are also due to the members of the **External Review Group**: Safia Ahsan, Traci Baird, Sharon Cameron, Jane Harries, Thoai Ngo, Yvette Raphael, Mariana Romero, Rachel Simon-Kumar and Beverly Winikoff. Institutional affiliations for these and other contributors are provided in Annex 1 of this guideline.

Special thanks are due to the **Evidence Synthesis Teams**, who prepared the Grading of Recommendations Assessment, Development and Evaluation (GRADE) systematic reviews, especially the **lead researchers**: Alison Edelman, Taylor King, Makalapua Motu'apuaka, Robyn Paynter, Maria Rodriguez (Clinical services domain); Nicholas Henschke, Yanina Sguassero and Gemma Villanueva (Service delivery domain); Scott Burris, Amanda Cleeve, Fiona de Londras and Maria Rodriguez (Law and policy domain). Special thanks also to the **guideline methodologists**, Jeppe Schroll (Clinical services domain); Nicholas Henschke, Yanina Sguassero and Gemma Villanueva (Service delivery domain), and Maria Rodriguez (Law and policy domain). We also thank the team from the London School of Hygiene and Tropical Medicine, led by Veronique Filippi, for their work on monitoring and evaluation issues related to quality abortion care. We thank the "Economics of abortion" review team, led by Ernestina Coast, Samantha Lattof, Brittany Moore and Yana Rodgers, for their collaboration and contributions to the guideline. We also extend our thanks to the International Youth Alliance for Family Planning (IYAFP) for their close collaboration and contributions from their Youth Taskforce members to the guideline development process.

We acknowledge the following **GDG meeting observers** including representatives from United Nations agencies: Patricia Lohr (British Pregnancy Advisory Service, and member of the Royal College of Obstetricians and Gynaecologists [RCOG] Making Abortion Safe Programme Advisory Group), Jaydeep Tank (Federation of Obstetrics and Gynaecological Societies of India and International Federation of Obstetrics and Gynaecology

[FIGO] Working Group for safe abortion, India), Francelle Toedtli (United Nations Population Fund, USA), Ann Yates (International Confederation of Midwives, the Netherlands); and the following **individual reviewers from implementing organizations** who provided feedback on the draft guidelines: Bethan Cobley (MSI Reproductive Choices, United Kingdom), Rasha Dabash (Ipas, USA), Eva Lathrop (Population Services International, USA), Steve Luboya (Pathfinder, USA) and Rebecca Wilkins (International Planned Parenthood Federation, United Kingdom of Great Britain and Northern Ireland).

The following WHO staff members contributed as members of the **WHO Guideline Steering Group**, which managed the guideline development process (all from WHO's Department of Sexual and Reproductive Health and Research [SRH], Prevention of Unsafe Abortion [PUA] Unit): Mekdes Daba Feyssa (provided support for the clinical services domain and overall guideline development process), Bela Ganatra (PUA Unit head, co-lead coordinator for the service delivery domain), Heidi Johnston (provided support for the service delivery domain, especially monitoring and evaluation work), Caron Kim (responsible technical officer, lead coordinator for the clinical services domain and co-lead for the service delivery domain, and overall coordinator for the guideline development process), Antonella Lavelanet (lead coordinator for the law and policy domain and human rights). During initial stages of guideline planning, Steering Group members also included Roopan Gill and Lemi Tolu (formerly with the PUA Unit) and Rajat Khosla (formerly with the Office of the SRH Department's Director).

Writing was provided by Fiona de Londras, Bela Ganatra, Heidi Johnston, Caron Kim, Antonella Lavelanet, Jane Patten and Maria Rodriguez. WHO administrative support was provided by Claire Garabedian and Hannah Hatch, and communications support was provided by Sarah Kessler and Elizabeth Noble, all from the SRH Department, with additional communications support from Laura Keenan and Sarah Russell of the WHO Director of Communications Office and from Helen Palmer of Weber Shandwick. We are grateful to the following additional WHO headquarters staff and consultants, who provided input at various stages during the development of the guideline: Laurence Codjia, Fahdi Dkhimi, Carolin Ekman, Veloshnee Govender, Lisa Hedman, Laurence Läser, Bruno Meessen, Ulrika Rehnström Loi, Marta Schaaf, Patricia Titulaer; and also colleagues from WHO regional offices: Chilanga Asmani, Ibadat Dhillon, Rodolfo Gómez Ponce de León and Nilmini Hemachandra. Review and comments were kindly provided by Ian Askew, Director of the SRH Department.

Special acknowledgement to the Office of the United Nations High Commissioner for Human Rights (OHCHR) for their review of the final draft of the guideline, in particular on the aspects relevant to international human rights standards and the integration of a human rights-based approach.

Special thanks to the **WHO Guidelines Review Committee (GRC)** and in particular to the WHO GRC Secretariat, Rebekah Thomas-Bosco, Marion Blacker and Maria Pura Solon, for their valuable feedback at every stage of the guideline development process.

Editing and proofreading was provided by Green Ink, United Kingdom.

Funding for the development of the guideline was provided by HRP, a cosponsored programme executed by the WHO.

Acronyms and abbreviations

AAAQ	availability, accessibility, acceptability and quality
AN	auxiliary nurse
ANM	auxiliary nurse midwife
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	United Nations Committee on Economic, Social and Cultural Rights
CRC	United Nations Convention on the Rights of the Child
CRVS	civil registration and vital statistics
CSE	comprehensive sexuality education
D&C	dilatation and (sharp) curettage
D&E	dilatation and evacuation
EML	WHO Model List of Essential Medicines (or Essential Medicines List)
EmOC	emergency obstetric care
ERG	External Review Group
ERRG	Evidence and Recommendation Review Group
EST	Evidence Synthesis Team
EtD	Evidence to Decision
EVA	electric vacuum aspiration
GDG	Guideline Development Group
GRADE	Grading of Recommendations Assessment, Development and Evaluation
GRC	Guidelines Review Committee
HMIS	Health management information systems
IUD	intrauterine device
IUFD	intrauterine fetal demise
IV	intravenous
LMIS	logistics management information systems
LMP	last menstrual period
MVA	manual vacuum aspiration
NEML	national essential medicines list
NGO	nongovernmental organization
NMRA	national medicines regulatory authorities
NSAID	non-steroidal anti-inflammatory drug
OCP	oral contraceptive pill
PCB	paracervical block
PHC	primary health care
PICO	population, intervention, comparator, outcome(s)
Rh	Rhesus (blood group)
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
STI	sexually transmitted infection
UHC	universal health coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VAS	visual analogue scale
WHO	World Health Organization

Glossary

For the sake of mutual understanding and consistency, below follows a list of how key terms and concepts are used throughout the guideline:

- **Community-based care**: Services delivered by a broadly defined community health workforce, according to their training and capacity, encompassing a range of health workers, lay and professional, formal and informal, paid and unpaid, as well as facility-based personnel who support and supervise them and provide outreach services and campaigns *(1)*.
- **Comprehensive abortion care (CAC)**: Provision of information, abortion management (including induced abortion and care related to pregnancy loss), and post-abortion care.
- **Concluding observations**: Following submission of a State report and a constructive dialogue with the State party to the particular convention, treaty monitoring bodies issue concluding observations to the reporting State, which are compiled in an annual report and sent to the United Nations General Assembly *(2)*.
- **Conscious sedation**: The use of a combination of medicines – a sedative to relax and an anaesthetic to block pain – to induce a depressed level of consciousness during a medical procedure.
- **Conscientious objection or conscientious refusal**: The practice of health-care professionals refusing to provide abortion care on the basis of personal conscience or religious belief.
- **Decriminalization**: Removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.
- **Dilatation and evacuation (D&E)**: D&E is used after 12–14 weeks of pregnancy. It is the safest and most effective surgical technique for later abortion, where skilled, experienced practitioners are available. D&E requires preparation of the cervix using osmotic dilators and/or pharmacological agents, and evacuating the uterus primarily with forceps, using vacuum aspiration (refer to entry in this list) to remove to remove any remaining blood or tissue.

- **Gestational age (duration of pregnancy)**: The number of days or weeks since the first day of the woman's last normal menstrual period (LMP) in women with regular cycles (see Table 1). For women with irregular cycles or when LMP is unknown, gestational age is the size of the uterus, estimated in weeks, based on clinical examination or ultrasound, that corresponds to a pregnant uterus of the same gestational age dated by LMP.

Table 1. Equivalent gestational ages in weeks and days during early pregnancy

Weeks of gestation	Days of gestation
0	0–6
1	7–13
2	14–20
3	21–27
4	28–34
5	35–41
6	42–48
7	49–55
8	56–62
9	63–69
10	70–76
11	77–83
12	84–90
13	91–97
14	98–104

Note: Day 0 is the first day of the last menstrual period (LMP), and is also the first day of Week 0 of gestation (*not* Week 1).

Source: Adapted from 2012 *Safe abortion* guidance *(2)* based on International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10), 2004 *(3)*.

- **General comments/recommendations**: A treaty monitoring body's interpretation of the content and operation of human rights conventions. General comments seek to clarify the reporting duties of States Parties with respect to certain provisions, and suggest approaches to implementing treaty provisions *(2)*.
- **Health**: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity *(4)*.
- **Health system:** A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health *(5)*.
- **Health workers**: All people engaged in actions whose primary intent is to enhance health. While, strictly speaking, this includes unpaid carers (e.g. parents caring for sick children, and self-carers), the data available on health worker numbers are generally limited to people engaged in paid activities *(6; Chapter 1: Health workers)*.
- **Human rights standards**: The meaning and scope of human rights as provided for in international human rights treaties and as interpreted and applied by the human rights bodies tasked with this work, which can include international, regional and national courts, and human rights committees *(2)*.
- **Incomplete abortion**: Clinical presence of an open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus, or the expelled products are not consistent with the estimated duration of pregnancy. Common symptoms include vaginal bleeding and abdominal pain. Uncomplicated incomplete abortion can result after an induced or spontaneous abortion (i.e. miscarriage).
- **International human rights treaty** (also sometimes called a covenant or a convention): An international legal instrument adopted by the international community of States, normally at the United Nations General Assembly. Each treaty sets out a range of human rights and corresponding obligations which are legally binding on States that have ratified the treaty *(2)* (Annex 2 includes a list of relevant treaties).

- **Intrauterine fetal demise (IUFD; fetal death)**: The intrauterine death of a fetus at any point in time during the pregnancy *(7)*.
- **Mandatory waiting period**: A requirement imposed by law or policy, or in practice, to wait a specified amount of time between requesting and receiving abortion care.
- **Medical methods of abortion (medical abortion)**: Use of pharmacological agents to terminate a pregnancy *(2)*.
- **Mental health**: A state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community *(8)*.
- **Miscarriage (spontaneous abortion)**: Spontaneous loss of a pregnancy before the fetus is usually viable outside the uterus. The clinical signs of miscarriage are vaginal bleeding, usually with abdominal pain and cramping. If the pregnancy has been expelled, the miscarriage is termed "complete" or "incomplete" depending on whether or not tissues are retained in the uterus *(9)*.
- **Missed abortion**: Arrest of pregnancy development where the embryo/fetus/embryonic tissue or empty gestational sac remains in the uterus and the cervical os is closed. Symptoms may include pain and/or bleeding, or there may be no symptoms at all *(10)*.
- **Osmotic dilators**: Short, thin rods made of seaweed (laminaria) or synthetic material. After placement in the cervical os, the dilators absorb moisture and expand, gradually dilating the cervix *(2)*.
- **Policy**: A law, regulation, procedure, administrative action, incentive or voluntary practice of governments and other institutions *(11)*.
- **Post-abortion care**: Provision of services after an abortion, such as contraceptive services and linkage to other needed services in the community or beyond. It can also include management of complications after an abortion.
- **Primary health care (PHC)**: A whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and preferences as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment *(12)*.
- **Quality of care**: QOC encompasses six areas or dimensions of quality that are required in relation to health care:
    - *effective*, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
    - *efficient*, delivering health care in a manner which optimizes resource use and avoids waste;
    - *accessible*, delivering health care that is timely, geographically reachable, and provided in a setting where skills and resources are appropriate to medical need;
    - *acceptable/person-centred*, delivering health care that takes into account the preferences and aspirations of individual service users and the cultures of their communities;
    - *equitable*, delivering health care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status;
    - *safe*, delivering health care that minimizes risks and harm to service users *(13; p. 9)*.
- **Regulation of abortion**: All formalized laws, policies and other instruments (e.g. facility-level protocol) that regulate pregnancy and abortion.
- **Self-care**: The ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health worker. The scope of self-care thus includes health promotion, disease prevention and control, self-medication, providing care to dependent people, seeking hospital/specialist/primary care if necessary, and rehabilitation, including palliative care. It includes a range of self-care practices and approaches *(14)*.

- **Self-management of abortion**: Self-management of the entire process of medical abortion or one or more of its component steps, such as self-assessment of eligibility for medical abortion, self-administration of medicines without the direct supervision of a health worker, and self-assessment of the success of the abortion process.
- **Social enterprise (social business)**: Defined as a business that has specific social objectives that serve its primary purpose. Social enterprises seek to maximize profits while maximizing benefits to society and the environment. Their profits are principally used to fund social programmes *(15)*.
- **Social franchising**: Defined as a system of contractual relationships usually run by a nongovernmental organization which uses the structure of a commercial franchise to achieve social goals. The overarching difference between social and commercial franchising is that social franchising seeks to fulfil a social benefit whereas commercial franchising is driven by profit *(16, 17)*.
- **Social marketing**: Broadly defined as the application of marketing techniques to social problems. Aims to persuade or motivate people to adopt specific courses of action or behaviour which are generally accepted as being beneficial. It is the design, implementation and control of programmes seeking to increase acceptability of a social idea or practice in a target group(s). It cannot create the behaviour, it can only help to gain acceptance and a willingness to adopt the behaviour. Its strategy is predominately preventive *(18)*.
- **Surgical methods of abortion (surgical abortion)**: Use of transcervical procedures for terminating pregnancy, including vacuum aspiration, and dilatation and evacuation (D&E). (See definitions in this list) *(2)*.
- **Telemedicine (or Telehealth)**: A mode of health service delivery where providers and clients, or providers and consultants, are separated by distance *(19)*. That interaction may take place in real time (synchronously), e.g. by telephone or video link. But it may also take place asynchronously (store-and-forward), when a query is submitted and an answer provided later, e.g. by email or text/voice/audio message.
    - **Client-to-provider telemedicine**: Provision of health services at a distance; delivery of health services where clients/patients and health workers are separated by distance (e.g. consultations between remote client/patient and health worker; clients/patients transmit medical data [images, notes, videos] to health worker) *(20)*.
- **Third-party authorization**: A requirement imposed by law or policy, or in practice, that a party other than the woman, girl or other pregnant person (typically a parent, guardian, spouse, partner, health worker, health authority or judicial authority) must authorize an abortion where other applicable legal requirements for lawful abortion have been met.
- **Treaty monitoring body**: Each of the international human rights treaties (see above) is monitored by a designated treaty monitoring body (see Annex 2). The treaty monitoring bodies are committees composed of independent experts. Their main function is to monitor the States' compliance with the treaty in question, including through the examination of State reports *(2)*.
- **Universal health coverage (UHC)**: Ensuring that all people have access to needed promotive, preventive, curative, rehabilitative, and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship *(12)*.
- **Vacuum aspiration (electrical or manual; EVA or MVA)**: Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. Electric vacuum aspiration (EVA) employs an electric vacuum pump. With manual vacuum aspiration (MVA), the vacuum is created using a hand-held, hand-activated, plastic 60 ml aspirator (also called a syringe). MVA aspirators accommodate 4–12 mm cannulae. Suction tubing for EVA can be used with cannulae up to 16 mm in diameter, permitting VA to be used up to 15–16 weeks of pregnancy or for post-abortion care cases presenting with dilated cervix where a higher number of cannulae is required for effective vacuum.

References

See Annex 3 for all references for this glossary.

Executive summary

The second edition contains the updated remarks for Recommendation 22. There have been no other changes made to the recommendation itself nor any other recommendations contained in this document.

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).

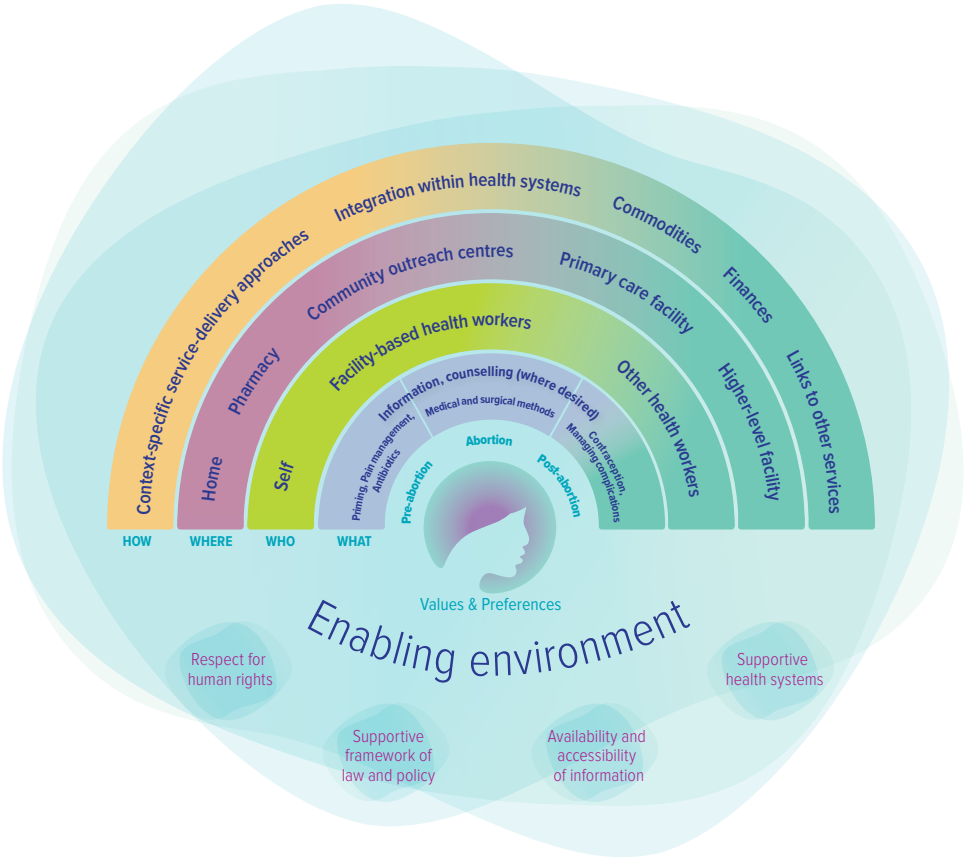
In this guideline, recommendations are presented across three domains that are essential to the provision of abortion care: Law and policy, Clinical services and Service delivery. The recommendations concerning the laws and policies that should or should not be in place in order to fully implement and 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).

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
ABORTION REGULATION		
Criminalization		
1 (LAW & POLICY; LP)	**Recommend** the full decriminalization of abortion. **Remarks:** • Decriminalization means removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors. • Decriminalization would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care. • Decriminalization of abortion does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute serious assaults as these would be non-consensual interventions.	24
Grounds-based approaches		
2 (LP)	**a. Recommend against** laws and other regulations that restrict abortion by grounds. **b. Recommend** that abortion be available on the request of the woman, girl or other pregnant person. **Remarks:** • Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person. • Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This means that the content, interpretation and application of grounds-based law and policy should be revised to ensure human rights compliance. This requires that: i. existing grounds are defined, interpreted and applied in a human rights-compliant way; ii. abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest or the pregnancy is not viable; iii. abortion is available where the life and health of the woman, girl or other pregnant person is at risk; iv. health grounds reflect WHO's definitions of health and mental health (see Glossary); and v. there are no procedural requirements to "prove" or "establish" satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information, refer to Web annex A: Key international human rights standards on abortion).	26
Gestational age limits		
3 (LP)	**Recommend against** laws and other regulations that prohibit abortion based on gestational age limits.	28
SERVICES ACROSS THE CONTINUUM OF CARE		
Provision of information on abortion care		
4 (SERVICE DELIVERY; SD)	Across the continuum of abortion care: **a. Recommend** provision of information on abortion care by community health workers, pharmacists, traditional and complementary medicine professionals, auxiliary nurses/auxiliary nurse midwives (ANMs), nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** provision of information on abortion care by pharmacy workers. • Condition: In contexts where the pharmacy worker is under the direct supervision of a pharmacist and there is access or referral to appropriate health services.	35
Provision of counselling		
5 (SD)	Across the continuum of abortion care: **a. Recommend** provision of counselling by community health workers, traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** provision of counselling by pharmacy workers and pharmacists. • Condition: Balanced counselling is provided (i.e. about both medical and surgical methods) and there is access or referral to appropriate health services should the woman choose a surgical method.	38

SECTION Topic area Recommendation or best practice statement number and type	Recommendation or best practice statement	Page number
PRE-ABORTION		
Mandatory waiting periods		
6 (LP)	**Recommend against** mandatory waiting periods for abortion.	41
Third-party authorization		
7 (LP)	**Recommend** that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution. **Remark:** • While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements.	43
Rh isoimmunization for abortion at gestational ages < 12 weeks		
8 (CLINICAL SERVICES; CS) (NEW)	For both medical and surgical abortion at < 12 weeks: **Recommend against** anti-D immunoglobulin administration. **Remark:** • Standard of care applies for anti-D administration at gestational ages ≥ 12 weeks.	44
Antibiotic prophylaxis for surgical and medical abortion		
9 (CS)	**a.** For surgical abortion, regardless of the individual's risk of pelvic inflammatory infection: **Recommend** appropriate prophylactic antibiotics pre- or perioperatively. **b.** For medical abortion: **Recommend against** the use of prophylactic antibiotics. **Remark:** • Lack of antibiotics should not limit access to abortion services.	46
Determining gestational age of pregnancy: pre-abortion ultrasound scanning		
10 (CS)	For both medical and surgical abortion: **Recommend against** the use of ultrasound scanning as a prerequisite for providing abortion services.* **Remark:** • Legal regulation that limits the availability of abortion by gestational age may require or result in ultrasounds being used to verify gestational age prior to abortion, even though this is not necessary from a clinical perspective. Removing legal gestational age limits on access to abortion (see Recommendation 3) should result in unnecessary pre-abortion ultrasound being avoided, and increase the availability of abortion in settings where ultrasound is difficult to access. * On a case-by-case basis, there may be clinical reasons for using ultrasound scanning prior to abortion.	47`

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
Pain management for abortion		
11–14 (CS) for surgical abortion and for prior cervical priming *NOTE: NEW recommendations 12, 13 and 14 indicate pain management that is ADDITIONAL to NSAIDS (11a)*	11. For pain management for surgical abortion at any gestational age: **a. Recommend** that pain medication should be offered routinely (e.g. non-steroidal anti-inflammatory drugs [NSAIDS]) and that it should be provided to those who want it; and **b. Recommend against** the routine use of general anaesthesia. 12. (NEW) For pain management for surgical abortion at < 14 weeks: **a. Recommend** the use of a paracervical block; and **b. Suggest** that the option of combination pain management using conscious sedation plus paracervical block should be offered, where conscious sedation is available. 13. (NEW) For pain management for cervical priming with osmotic dilators prior to surgical abortion at ≥ 14 weeks: **Suggest** the use of a paracervical block. **Remark:** • For cervical priming, additional pain medication can be considered, such as the use of intravaginal gel. (See Recommendations 17–20 below on cervical priming) 14. (NEW) For pain management for surgical abortion at ≥ 14 weeks: **a. Recommend** the use of a paracervical block; and **b. Suggest** that the option of combination pain management using conscious sedation plus paracervical block should be offered, where conscious sedation is available.	49
15 and 16 (CS) for medical abortion *NOTE: NEW recommendation 16 indicates pain management that is ADDITIONAL to NSAIDS (15)*	15. For medical abortion at any gestational age: **Recommend** that pain medication should be offered routinely (e.g. non-steroidal anti-inflammatory drugs [NSAIDs]) and that it should be provided for the individual to use if and when wanted. 16. (NEW) For pain management for medical abortion at ≥ 12 weeks: **Suggest** consideration of additional methods to control pain or discomfort due to increased pain with increasing gestational age. Such methods include certain anti-emetics and epidural anaesthesia, where available. **Remark:** • For medical abortion at gestational ages < 14 weeks, if NSAIDS (e.g. ibuprofen) are not available or not an option, then acetaminophen can be considered for pain control.	51
Cervical priming prior to surgical abortion		
17 (CS) at < 12 weeks	Prior to surgical abortion at < 12 weeks: **a.** If cervical priming is used: **Suggest** the following medication regimens: • Mifepristone 200 mg orally 24–48 hours prior to the procedure • Misoprostol 400 µg sublingually 1–2 hours prior to the procedure • Misoprostol 400 µg vaginally or buccally 2–3 hours prior to the procedure **b. Recommend against** the use of osmotic dilators for cervical priming. **Remarks:** • The sublingual route is more effective for misoprostol administration. • Appropriate pain medication should be provided.	54

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
18 (CS) (NEW) at ≥ 12 weeks	Prior to surgical abortion at later gestational ages: **a.** For surgical abortion at ≥ 12 weeks: **Suggest** cervical priming prior to the procedure. **b.** For surgical abortion between 12 and 19 weeks: **Suggest** cervical priming with medication alone (a combination of mifepristone plus misoprostol is preferred) or with an osmotic dilator plus medication (mifepristone, misoprostol, or a combination of both). **c.** For surgical abortion between 12 and 19 weeks, when using an osmotic dilator for cervical priming: **Suggest** that the period between osmotic dilator placement and the procedure should not extend beyond two days. **d.** For surgical abortion at ≥ 19 weeks: **Recommend** cervical priming with an osmotic dilator plus medication (mifepristone, misoprostol, or a combination of both). **Remark:** • There was limited evidence for cervical priming for gestational ages between 12 and 14 weeks and therefore health workers should use clinical judgement to decide on the most convenient method for cervical priming prior to vacuum aspiration for this gestational age range.	55
19 (SD) with medication, at any gestational age	Prior to surgical abortion at any gestational age: **a. Recommend** cervical priming with medication by traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** cervical priming with medication by community health workers, pharmacy workers and pharmacists. • Condition: Provision of medication for the purpose of cervical priming is part of the surgical abortion process so the health worker needs to ensure continuity of care of the woman obtaining the medicines prior to the abortion procedure.	56
20 (SD) with osmotic dilators, at ≥ 12 weeks	Prior to dilatation and evacuation (D&E) at ≥ 12 weeks: **a. Recommend** cervical priming with osmotic dilators by auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** cervical priming with osmotic dilators by traditional and complementary medicine professionals. • Condition: Health worker ensures continuity of care from the time of cervical priming to the D&E.	57
Provider restrictions		
21 (LP)	**Recommend against** regulation on who can provide and manage abortion that is inconsistent with WHO guidance. **Remark:** • Where law or policy regulate who may provide or manage abortion, that regulation should be consistent with WHO guidance, which is presented throughout Chapter 3 of this guideline.	59
Conscientious objection		
22 (LP)	**Recommend** that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. **Remarks:** • Health services should be organized in such a way as to ensure the exercise of conscientious objection does not prevent people from accessing available abortion services. • Where conscientious objection is permitted, international human rights law requires States to take steps to ensure that it does not operate as a barrier to access to abortion care. The mere existence of regulation of conscientious objection is not sufficient. In practice, this means that if States permit conscientious objection, they must regulate it in a way that is effective in ensuring that abortion is available and accessible in practice. • International human rights law provides some guidance as to how States can ensure that human rights of abortion seekers are respected, protected and fulfilled (see details in main text). • Accordingly, States that permit conscientious objection should reform the regulation of conscientious objection to ensure that the human rights of pregnant people are respected, protected and fulfilled, and that abortion is available and accessible. • If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. In such circumstances, it may be appropriate to consider prohibiting conscientious objection and/or revising national law and policy frameworks that govern health workers' professional and ethical obligations. *Note on updating of the recommendation:* This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion guidance* provided a composite recommendation related to law and policy *(19);* in this guideline, this has been developed into seven separate recommendations using GRADE methodology.	60

SECTION Topic area Recommendation or best practice statement number and type	Recommendation or best practice statement	Page number
ABORTION		
Methods of surgical abortion		
23 (CS) at < 14 weeks	For surgical abortion at < 14 weeks: **a. Recommend** vacuum aspiration. **b. Recommend against** the practice of dilatation and sharp curettage (D&C), including sharp curette checks (i.e. to "complete" the abortion) following vacuum aspiration. **Remarks:** • Observational studies indicate that vacuum aspiration is associated with fewer complications than D&C; however, randomized controlled trials were underpowered to detect a difference in complication rates. • No evidence supports the use of sharp curette checks following vacuum aspiration. • The quality of the evidence based on randomized controlled trials is low to moderate.	63
24 (SD) vacuum aspiration at < 14 weeks	For surgical abortion at < 14 weeks: **a. Recommend** vacuum aspiration by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** vacuum aspiration by auxiliary nurses/ANMs. • Condition: In contexts where established health system mechanisms involve auxiliary nurses/ANMs in providing basic emergency obstetric care, and where referral and monitoring systems are strong.	64
25 (CS) at ≥ 14 weeks	For surgical abortion at ≥ 14 weeks: **Recommend** dilatation and evacuation (D&E). **Remark:** • Vacuum aspiration can be used during a D&E (i.e. for the purpose of amniotomy or tissue removal at the end of the D&E).	65
26 (SD) D&E at ≥ 14 weeks	For surgical abortion at ≥ 14 weeks: **a. Recommend** D&E by generalist medical practitioners and specialist medical practitioners. **b. Suggest** D&E by traditional and complementary medicine professionals, midwives and associate/advanced associate clinicians. • Condition: In settings where established health system mechanisms exist to include these health workers in other tasks related to maternal and reproductive health.	65
Medical management of induced abortion		
27 (CS) at < 12 weeks	For medical abortion at < 12 weeks: **a. Recommend** the use of 200 mg mifepristone administered orally, followed 1–2 days later by 800 µg misoprostol administered vaginally, sublingually or buccally. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.* **b.** When using misoprostol alone: **Recommend** the use of 800 µg misoprostol administered vaginally, sublingually or buccally.* **c.** (NEW) **Suggest** the use of a combination regimen of letrozole plus misoprostol (letrozole 10 mg orally each day for 3 days followed by misoprostol 800 µg sublingually on the fourth day) as a safe and effective option.*‡ **Remarks:** • Evidence from clinical studies demonstrates that the combination regimen (Recommendation 27a) is more effective than misoprostol alone. • All routes are included as options for misoprostol administration, in consideration of patient and provider preference. • The suggested combination regimen of letrozole plus misoprostol may be safe and effective up to 14 weeks of gestation. * Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. In this guideline we do not provide a maximum number of doses of misoprostol. ‡ Further evidence is needed to determine the safety, effectiveness and acceptability of the letrozole plus misoprostol combination regimen at later gestational ages, especially in comparison with that of the mifepristone plus misoprostol combination regimen (the available evidence focused on comparison with the use of misoprostol alone).	68

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
28 (SD) at < 12 weeks* in whole or in part (i.e. performing all or some of the subtasks)‡	For medical abortion at < 12 weeks: **Recommend** medical management by self (see Recommendation 50), community health workers, pharmacy workers, pharmacists, traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. * Available evidence for the independent provision of medical abortion by non-physicians is for pregnancy durations up to 10 weeks (70 days). ‡ For this recommendation, the medical abortion regimens covered in the available evidence were mifepristone plus misoprostol, or misoprostol alone (the regimen using letrozole was not included).	69
29 (CS) at ≥ 12 weeks	For medical abortion at ≥ 12 weeks: **a. Suggest** the use of 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.*‡ The minimum recommended interval between use of mifepristone and misoprostol is 24 hours. **b.** When using misoprostol alone: **Suggest** the use of repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.*‡ **Remarks:** • The combination regimen (Recommendation 29a) is more effective than use of misoprostol alone. • Evidence suggests that the vaginal route is the most effective. Consideration for patient and provider preference suggests the inclusion of all routes. • Pregnancy tissue should be treated in the same way as other biological material unless the individual expresses a desire for it to be managed otherwise. * Misoprostol can be repeated at the noted interval as needed to achieve success of the abortion process. Providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with later gestational age. ‡ The dose of misoprostol should be reduced for induced abortion beyond 24 weeks due to limited data. Clinical judgement should be used to determine the appropriate dosage, recognizing the greater sensitivity of the uterus to prostaglandins.	71
30 (SD) at ≥ 12 weeks	For medical abortion at ≥ 12 weeks: **a. Recommend** medical management by generalist medical practitioners and specialist medical practitioners. **b. Suggest** medical management by traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives and associate/advanced associate clinicians. • Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	71
Missed abortion		
31 (CS) (NEW) Medical management at < 14 weeks	For missed abortion at < 14 weeks, for individuals preferring medical management: **Recommend** the use of combination mifepristone plus misoprostol over misoprostol alone. • Recommended regimen: 200 mg mifepristone administered orally, followed by 800 µg misoprostol administered by any route (buccal, vaginal or sublingual).* • Alternative regimen: 800 µg misoprostol administered by any route (buccal, vaginal or sublingual).‡ **Remarks:** • The decision about the mode of management (expectant, medical or surgical) of missed abortion should be based on the individual's clinical condition and preference for treatment. • Expectant management can be offered as an option on the condition that the woman, girl or other pregnant person is informed of the longer time for expulsion of the pregnancy tissue and the increased risk of incomplete emptying of the uterus. • Pregnancy tissue should be treated in the same way as other biological material unless the individual expresses a desire for it to be managed otherwise. * The minimum recommended interval between use of mifepristone and misoprostol is 24 hours. ‡ If using the alternative regimen (misoprostol alone), it should be noted that at gestational ages ≥ 9 weeks, evidence shows that repeat dosing of misoprostol is more efficacious to achieve success of the abortion process. In this guideline we do not provide a maximum number of doses of misoprostol.	74

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
Intrauterine fetal demise		
32 (CS) Medical management at ≥ 14 to ≤ 28 weeks	For medical management of IUFD at ≥ 14 to ≤ 28 weeks: **Suggest** the use of combination mifepristone plus misoprostol over misoprostol alone. • Suggested regimen: 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.*‡ The minimum recommended interval between use of mifepristone and misoprostol is 24 hours. • Alternative regimen: repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.*‡ **Remarks:** • Evidence from clinical studies indicates that the combination regimen is more effective than the use of misoprostol alone. • Pregnancy tissue should be treated in the same way as other biological material unless the individual expresses a desire for it to be managed otherwise. * Misoprostol can be repeated at the noted interval as needed to achieve success of the abortion process. Providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with later gestational age. ‡ The dose of misoprostol should be reduced for IUFD beyond 28 weeks due to limited data. Clinical judgement should be used to determine the appropriate dosage, recognizing the greater sensitivity of the uterus to prostaglandins.	76
33 (SD) (NEW) Medical management at ≥ 14 to ≤ 28 weeks	For IUFD at ≥ 14 to ≤ 28 weeks: **a. Recommend** medical management by generalist medical practitioners and specialist medical practitioners. **b. Suggest** medical management by traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives and associate/advanced associate clinicians. • Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	76
POST-ABORTION		
Follow-up care or additional services		
34 (CS)	Following uncomplicated surgical abortion or medical abortion: **Recommend** that there is no medical need for a routine follow-up visit. However, information should be provided about the availability of additional services if they are needed or desired. **Remarks:** • Women, girls and other pregnant persons must be adequately informed about symptoms of ongoing pregnancy (which may or may not indicate failure of the abortion) and other medical reasons to return for follow-up, such as prolonged heavy bleeding, no bleeding at all with medical management of abortion, pain not relieved by medication, or fever. • The quality of the evidence was low (observational studies and indirect evidence).	80
Incomplete abortion		
35 and 36 (CS)	**35.** For incomplete abortion at < 14 weeks: **Recommend** either vacuum aspiration or medical management. **36a.** For the medical management of incomplete abortion at < 14 weeks uterine size: **Suggest** the use of 600 µg misoprostol administered orally or 400 µg misoprostol administered sublingually. **36b.** For the medical management of incomplete abortion at ≥ 14 weeks uterine size: **Suggest** the use of repeat doses of 400 µg misoprostol administered sublingually, vaginally or buccally every 3 hours.* **Remarks:** • The decision about the mode of management of incomplete abortion should be based on the individual's clinical condition and preference for treatment. • Expectant management of incomplete abortion can be as effective as misoprostol; it can be offered as an option on the condition that the woman, girl or other pregnant person is informed of the longer time for expulsion of the pregnancy tissue and the increased risk of incomplete emptying of the uterus. • Recommendation 35 was extrapolated from research conducted in women with reported spontaneous abortion. * Misoprostol can be repeated at the noted interval as needed to achieve success of the abortion process. At gestational ages ≥ 14 weeks, providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with advanced gestational age.	81

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
37 (SD) Medical management with misoprostol at < 14 weeks	For uncomplicated incomplete abortion at < 14 weeks: **Recommend** medical management with misoprostol by community health workers, pharmacy workers, pharmacists, traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.	82
38 (SD) Vacuum aspiration at < 14 weeks	For uncomplicated incomplete abortion at < 14 weeks: **a. Recommend** vacuum aspiration by traditional and complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** vacuum aspiration by auxiliary nurses/ANMs. • Condition: In contexts where established health system mechanisms involve auxiliary nurses/ANMs in providing basic emergency obstetric care, and where referral and monitoring systems are strong.	83
Management of non-life-threatening complications		
39 (SD) Infection	For non-life-threatening post-abortion infection: **Recommend** initial management by traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.* * For the pharmacists, pharmacy workers and community health workers, it is important that they are equipped with the knowledge to recognize signs and symptoms of this complication.	85
40 (SD) Haemorrhage	For non-life-threatening post-abortion haemorrhage: **Recommend** initial management by traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.* * For the pharmacists, pharmacy workers and community health workers, it is important that they are equipped with the knowledge to recognize signs and symptoms of this complication.	86
Timing of post-abortion contraception		
41 (CS) Medical eligibility criteria (MEC) for contraceptive use	The following contraceptive methods may be started immediately (MEC Category 1 – no restrictions) after a surgical or medical abortion (first and second trimester, and also after a septic abortion): combined hormonal contraceptives (CHCs), progesterone-only contraceptives (POCs) and barrier methods (condoms, spermicide, diaphragm, cap – note: The diaphragm and cap are unsuitable until 6 weeks after second-trimester abortion). Intrauterine devices (IUDs) may be started immediately after a first-trimester surgical or medical abortion (MEC Category 1 – no restrictions) or after second-trimester abortion (MEC Category 2 – the advantages generally outweigh the risks), but should not be started immediately after septic abortion (MEC Category 4 – insertion of an IUD may substantially worsen the condition). Fertility-awareness-based (FAB) methods: Symptom-based methods should only be started after abortion with "caution" (special counselling may be needed to ensure correct use of the method in this circumstance) and the use of calendar-based methods should be delayed (until the condition is evaluated; alternative temporary methods of contraception should be offered).	88
42 (CS) Contraception and surgical abortion	For individuals undergoing surgical abortion and wishing to use contraception: **Recommend** the option of initiating the contraception at the time of surgical abortion. **Remark:** • The quality of evidence based on randomized controlled trials was very low.	89

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
43 (CS) Contraception and medical abortion	For individuals undergoing medical abortion with the combination mifepristone and misoprostol regimen or with misoprostol alone: **a.** For those who choose to use **hormonal contraception** (pills, patch, ring, implant or injections): **Suggest** that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. **b.** For those who choose to have an **IUD** inserted: **Suggest** IUD placement at the time that success of the abortion procedure is determined. **Remark (for Recommendations 43a and b):** • This recommendation applies to the combination mifepristone plus misoprostol regimen and the use of misoprostol alone. The letrozole plus misoprostol combination regimen is not mentioned here because the included studies informing these recommendations did not assess this regimen. **Remarks (for Recommendation 43a only):** • Immediate initiation of intramuscular depot medroxyprogesterone acetate (DMPA) is associated with a slight decrease in the effectiveness of medical abortion regimens. However, immediate initiation of DMPA should still be offered as an available contraceptive method after an abortion. • Indirect evidence was used as a basis for decision-making on initiation of hormonal contraception as an option for individuals undergoing medical abortion with misoprostol alone. • No data were available on the use of combined hormonal contraception (pills or injections) by those undergoing medical abortion. • Individuals who choose to initiate the contraceptive ring should be instructed to check for expulsion of the ring in the event of heavy bleeding during the medical abortion process.	89
44 (SD) Intrauterine devices (IUDs)	For intrauterine devices (IUDs): **a. Recommend** insertion/removal by auxiliary nurse midwives, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** insertion/removal by traditional and complementary medicine professionals (TCMPs) and auxiliary nurses (ANs). • Condition (TCMPs): In contexts with established health system mechanisms for the participation of these professionals in other tasks related to maternal and reproductive health. • Condition (ANs): In the context of rigorous research.	90
45 (SD) Contraceptive implants	For contraceptive implants: **a. Recommend** insertion/removal by nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** insertion/removal by community health workers (CHWs), traditional and complementary medicine professionals (TCMPs), auxiliary nurses (ANs)/ANMs. • Condition (CHWs): In the context of rigorous research. • Condition (TCMPs): In contexts with established health system mechanisms for the participation of these professionals in other tasks related to maternal and reproductive health and where training in implant removal is given along with training in insertion. • Condition (ANs/ANMs): In the context of targeted monitoring and evaluation.	90
46 (SD) Injectable contraceptives	For injectable contraceptives (initiation and continuation): **Recommend** administration by self (see Recommendation 51), community health workers, pharmacy workers, pharmacists, traditional and complementary medicine professionals, auxiliary nurses/ANMs, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners.	91
47 (SD) Tubal ligation	For tubal ligation: **a. Recommend** tubal ligation by associate/advanced associate clinicians, generalist medical practitioners and specialist medical practitioners. **b. Suggest** tubal ligation by nurses and midwives. • Condition: In the context of rigorous research.	92

SECTION Topic area Recommendation or best practice statement number and type	Recommendation or best practice statement	Page number
SERVICE-DELIVERY OPTIONS AND SELF-MANAGEMENT APPROACHES		
Telemedicine approaches to delivering medical abortion care		
48 (SD) (NEW)	**Recommend** the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part. **Remarks:** • The above recommendation applies to assessment of eligibility for medical abortion, counselling and/or instruction relating to the abortion process, providing instruction for and active facilitation of the administration of medicines, and follow-up post-abortion care, all through telemedicine. • Hotlines, digital apps or one-way modes of communication (e.g. reminder text messages) that simply provide information were not included in the review of evidence for this recommendation.	95
Service-delivery approaches for provision of information, counselling and medical abortion		
49 (SD) (NEW)	**Best Practice Statement on service delivery** **Part 1.** There is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual themself, and the location of service provision (from among the recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. A plurality of service-delivery approaches can co-exist within any given context. **Part 2.** Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide: • access to scientifically accurate, understandable information at all stages; • access to quality-assured medicines (including those for pain management); • back-up referral support if desired or needed; • linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception.	96
Self-management of medical abortion at < 12 weeks		
50 (SELF-MANAGEMENT)	For medical abortion at < 12 weeks (using the combination of mifepristone plus misoprostol or using misoprostol alone): **Recommend** the option of self-management of the medical abortion process in whole or any of the three component parts of the process: • self-assessment of eligibility (determining pregnancy duration; ruling out contraindications) • self-administration of abortion medicines and management of the abortion process outside of a health-care facility and without the direct supervision of a trained health worker • self-assessment of the success of the abortion. **Remarks:** • There was more evidence for self-management of medical abortion (with either of the regimens) for pregnancies before 10 weeks of gestation. • This recommendation applies to the combination regimen of mifepristone plus misoprostol, and the use of misoprostol alone. The included studies informing these recommendations did not assess the letrozole plus misoprostol regimen. • All individuals engaging in self-management of medical abortion must also have access to accurate information, quality-assured medicines including for pain management, the support of trained health workers and access to a health-care facility and to referral services if they need or desire it. • Restrictions on prescribing and dispensing authority for abortion medicines may need to be modified or other mechanisms put in place for self-management within the regulatory framework of the health system.	98

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**	**Page number**
Self-management approaches for post-abortion contraception (see also Timing of post-abortion contraception, Recommendations 41–47 above)		
51 (SELF-MANAGEMENT) Injectable contraception (initiation and continuation)	**Recommend** the option of self-administration of injectable contraception in the post-abortion period. **Remark:** • The administration of an injectable contraceptive involves using a syringe and may be intramuscular or subcutaneous. Compact pre-filled auto-disable devices have been developed to facilitate the self-administration process.	100
52 (SELF-MANAGEMENT) Over-the-counter oral contraceptive pills	**Recommend** that over-the-counter oral contraceptive pills (OCPs) should be made available without a prescription for individuals using OCPs.	101
53 (SELF-MANAGEMENT) Over-the-counter emergency contraceptive pills	**Recommend** making over-the-counter emergency contraceptive pills available without a prescription to individuals who wish to use emergency contraception.	101
54 (SELF-MANAGEMENT) Condom use	The consistent and correct use of male and female condoms is highly effective in preventing the sexual transmission of HIV; reducing the risk of HIV transmission both from men to women and women to men in serodiscordant couples; reducing the risk of acquiring other STIs and associated conditions, including genital warts and cervical cancer; and preventing unintended pregnancy.	101

Chapter 1.

Introduction

The second edition contains the updated remarks for Recommendation 22. There have been no other changes made to the recommendation itself nor any other recommendations contained in this document.

1.1 Background and context

Sexual and reproductive health is fundamental to individuals, couples and families, and to the social and economic development of communities and nations *(1)*. 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 *(2, Articles 1 and 2)*. 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, including the right to the highest attainable standard of SRH *(3)*. In addition, the increased SRH risks in humanitarian settings, including armed conflict, require specific attention from a human rights perspective *(4 [para. 7], 5, 6 [paras 19-24])*.

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 and guidance *(7-12)*.[1] Abortion care encompasses management of various clinical conditions including spontaneous and induced abortion (of both non-viable and viable pregnancies) and intrauterine fetal demise, and also post-abortion care, including management of incomplete abortion. Strengthening access to 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) *(13)*. 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 *(1)*. 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 *(14)*.

Quality abortion care is foundational to this guidance. Quality of care (see Glossary) encompasses multiple components: effectiveness, efficiency, accessibility, acceptability (e.g. patient centred), equity and safety. 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 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 abortion care is equitable, and that health care does not vary in quality based on the personal characteristics of the person seeking care, such as their gender, race, ethnicity, socioeconomic status, education, if they are living with a disability, or based on

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 *(7)*.

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.

their geographic location within a country. And finally, quality abortion care implies that it is safely delivered and minimizes risks and harms to service users *(15)*. Underpinning these components is the principle that provision of quality abortion care would be in compliance with human rights.

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 *(16)*. When abortion is safe – defined as being carried out using a method recommended by WHO, appropriate to the gestational age, and by someone with the necessary skills *(17)* – the risks are very low. However global estimates demonstrate that 45% of all abortions are unsafe, including 14.4% considered to be "least safe" *(18)*. This is a critical public health and human rights issue; unsafe abortion is increasingly concentrated in developing countries and among groups in vulnerable and marginalized situations. In countries where induced abortion is highly restricted by law or unavailable due to other barriers, safe abortion has often become the privilege of the rich, while poor women have little choice but to resort to the services of unskilled providers in unsafe settings, or induce abortion themselves often using unsafe methods, leading to deaths and morbidities that become the social and financial responsibility of the public health system, and denial of women's human rights. The legal status of abortion has no effect on a woman's likelihood of seeking induced abortion, but it dramatically affects her access to safe abortion *(19)*.

Between 4.7% and 13.2% of all maternal deaths are attributed to unsafe abortions *(20, 21)*. This equates to between 13 865 and 38 940 lives lost annually, due to the failure to provide safe abortion, with many more experiencing serious morbidities. Developing countries bear the burden of 97% of unsafe abortions *(18)*. The proportion of abortions that are unsafe is also significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws *(18)*. Over half (53.8%) of all unsafe abortions occur in Asia (the majority of those in south and central Asia), while another quarter (24.8%) occur in Africa (mainly in eastern and western Africa), and a further fifth (19.5%) in Latin America and the Caribbean *(18)*. The subregions where the highest proportions of abortions have been categorized as "least safe" are northern, eastern, western and middle Africa (approximately 45–70% of all abortions are "least safe"), followed by the Caribbean, Oceania and Central America (approximately 25–30% of all abortions are "least safe") *(18)*. A review of facility-based treatment for complications of unsafe abortion in 26 developing countries in 2012 indicated that 7 million women were treated in developing countries for complications of unsafe abortion that year – a rate of 6.9 per 1000 women aged 15–44 years *(22)*.

Abortion, using medication or a simple outpatient surgical procedure, is a safe health-care intervention, when carried out with a method appropriate to the gestational age of pregnancy and – in the case of a facility-based procedure – by a person with the necessary skills. In these circumstances, complications or serious adverse effects are rare. Medical abortion has revolutionized access to quality abortion care globally. Studies have demonstrated that medicines for abortion can be safely and effectively self-administered outside of a facility (e.g. at home). Individuals with a source of accurate information and access to a trained health worker (in case they need or want support at any stage of the process) can safely self-manage their abortion process in the first 12 weeks of gestation. Service delivery with minimal medical supervision can significantly improve access, particularly in restricted settings and crisis situations, as well as improve privacy, convenience and acceptability of the abortion process without compromising safety and effectiveness *(23)*.

However, in both low- and high-resource settings, law, policy and practical barriers can make it difficult to access quality abortion care. Multiple actions are needed at the legal, health system and community levels so that everyone who needs it has access to comprehensive abortion care (CAC), i.e. information, abortion management (including induced abortion, and care related to pregnancy loss/spontaneous abortion) and post-abortion care.

1.2 Guideline objective, rationale, target audience, inclusivity and structure

Guidelines are the fundamental means through which WHO fulfils its technical leadership in health (24). 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.

1.2.1 Objective and rationale

The objective of this guideline is to present the complete set of all WHO recommendations and best practice statements relating to abortion, with the goal of enabling evidence-based quality abortion care globally.

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

- *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 guideline is intended to provide concrete information and guidance, integrating aspects of care across all domains needed to provide quality abortion care: Law and policy, Clinical services and Service delivery. This guidance contains new recommendations consolidated with existing recommendations that remain unchanged and some that have been updated after re-assessment, using the same rigorous methods for both new and updated recommendations (see Annex 4: Methods). Among the recommendations are seven concerning the laws and policies that should or should not be in place, in order to fully implement and sustain quality abortion care: three recommendations relating to abortion regulation are presented in Chapter 2 and four more relating to laws and policies affecting clinical and health worker practices are presented in Chapter 3. All the other recommendations address methods of abortion and related clinical care as well as service delivery by a range of health workers and approaches, including self-management by the abortion seeker, reflecting recent changes in all these aspects of abortion care. Emerging areas of interest and research priorities in abortion care are identified in Chapter 4.

As a key part of the rationale for developing this updated and consolidated guideline, important contextual information – which is integral to this guidance, as context for the recommendations and best practice statements – is presented in the remainder of this first chapter. This information is not in the form of WHO recommendations but rather it describes the underlying determinants of quality abortion care, and thus must be carefully considered. Section 1.3 below describes an enabling environment for comprehensive abortion care (i.e. a law and policy framework supportive of human rights; access to information; and health system factors) and section 1.4 delves further into key health system considerations (universal health coverage and primary health care; health financing; health workforce training; health-care commodities; and monitoring and evaluation). Where relevant, this document incorporates and builds upon considerations captured in other existing WHO guidance, including *Consolidated guideline on the sexual and reproductive health and rights of women living with HIV (25)* and *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights (26).*

1.2.2 Target audience

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.

1.2.3 Equity, inclusivity and people-centred care

The needs of all individuals with respect to abortion are recognized and acknowledged in this guidance. A human rights approach that advances gender equality is essential and must be applied in all contexts providing services to people seeking health care. To provide quality abortion care throughout the health system, services should also be integrated where possible with other SRH services, such as evidence-based HIV and sexually transmitted infection (STI) testing and treatment, and family planning/contraception, and should be friendly and welcoming to youth and people from sexual and gender minorities, people living with disabilities, and all groups in vulnerable and marginalized situations.

WHO guidelines systematically incorporate consideration of the values and preferences of end-users of the recommended or suggested interventions into the process of developing the guidance. To gain more in-depth understanding of the values and preferences of individuals seeking abortion care, WHO conducted a global

survey and convened a technical meeting on this subject with stakeholders in September 2019 attended by 19 participants from 15 different countries/organizations. The key themes that emerged were the importance of equity, inclusivity and meeting the needs of those living in the most vulnerable and marginalized situations. In addition, a youth-led technical meeting was convened in April 2021 with 16 youths (representing 13 countries across all WHO regions) from the Youth for Abortion Task Force, to learn about the concerns of youth. The Task Force was formed by the International Youth Alliance for Family Planning (IYAFP) – a collective of young individuals, youth associations, organizations and communities with a common mission to support provision of and access to comprehensive reproductive health services (see Web annex B: Technical meetings during guideline development). Women living with HIV are one example among many of a marginalized population with unique vulnerabilities in the context of abortion care. Women living with HIV face unique challenges and are vulnerable to SRH-related human rights violations within their families and communities, as well as at health-care facilities where they seek care. An enabling environment is essential to promote more effective interventions and better health outcomes for all abortion seekers (see section 1.3).

All individuals have the right to non-discrimination and equality in SRH care and 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. The international human rights system has been strengthening the promotion and protection of human rights without distinction. The protection of persons based on their sexual orientation and gender identity are based on international law, complemented and supplemented by State practice *(27).* 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" *(28, para. 20).*

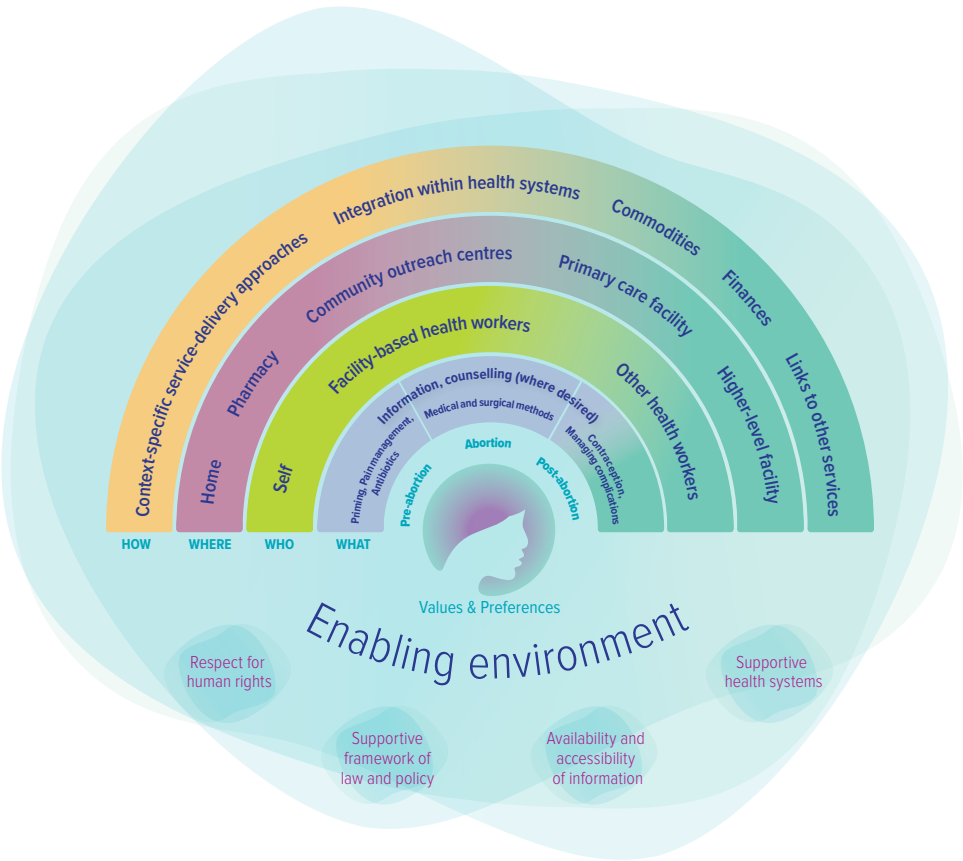
In this guideline, we recognize that most of the available evidence on abortion can be assumed to be derived from research among study populations of cisgender women, and we also recognize that cisgender women, transgender men, nonbinary, gender-fluid and intersex individuals with a female reproductive 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.

This guideline takes an integrated, people-centred approach to health services *(29).* People-centred care requires that individuals have the education and support they need to make decisions and participate in their own health care *(30).* Individual health preferences may vary; no one model of abortion care will meet the needs of everyone seeking abortion care. 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 *(31).*

1.2.4 Conceptual structure of the guideline

As illustrated in Figure 1.1, this guideline is centred on the values and preferences of abortion seekers, and considers them as active participants in as well as beneficiaries of health services. This guidance emphasizes that – as a woman, girl or other pregnant person moves through the abortion care pathway (pre-abortion, abortion, post-abortion) – health services must be integrated within the health sector to ensure that service delivery meets their needs equitably and without discrimination. As each individual moves through this pathway, the guideline provides specific recommendations on the interventions needed (i.e. the "what"), and guidance on the individuals who may safely carry them out (i.e. the "who"). The guideline also provides information on the locations where services can be provided (i.e. the "where") and outlines service-delivery models that can be used (i.e. the "how"). The enabling environment, described in the remainder of this chapter, provides the context for the effective implementation of these interventions.

Figure 1.1: Conceptual framework for abortion care



1.3 An enabling environment for 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 outlined in Box 1.1 and elaborated in the text of this section:

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

For clarification, this section of the guideline document does not provide recommendations – rather it details the components and aspects that would comprise an overall enabling environment for quality abortion care, based on WHO best practices, which would provide the ideal context to best facilitate the recommendations in the later sections of this chapter and in Chapter 3. While this enabling environment represents an ideal context, complete implementation of the components of this enabling environment is not necessarily a precondition to implementation and application of the recommendations contained in this guideline.

BOX 1.1: Core components of an enabling environment for abortion care

Respect for human rights including a supportive framework of law and policy

- Countries ratify international and regional human rights treaties and conventions addressing health, including sexual and reproductive health (SRH).
- Laws and policies promote SRH for all, and are consistent with sexual and reproductive health and rights.
- There are appropriate administrative, political and judicial arrangements to facilitate quality abortion care, including accessible, transparent and effective mechanisms providing remedies. These include:
  - accessible mechanisms for women to challenge denial of abortion in a timely manner, and
  - appropriate monitoring mechanisms for failure to facilitate quality care, including regular review and reform of law and policy to recognize and remove barriers to quality abortion care.
- Policies minimize the rate of unintended pregnancy by providing quality contraceptive information and services, including a full range of contraceptive methods (emergency, short-acting and long-acting methods).
- All people and communities receive the health services they need, without suffering financial hardship and without any discrimination.

Availability and accessibility of information

- Evidence-based comprehensive sexuality education (CSE) is provided for all individuals and made available in multiple and accessible forms and languages.
- Accurate, non-biased and evidence-based SRH information, including on abortion and contraceptive methods, is widely available in multiple and accessible forms and languages.

Supportive, universally accessible, affordable and well functioning health system

- Universal health coverage (UHC) ensures that all individuals can receive the care they need without financial hardship (see section 1.4.1).
- The health system is adequately resourced, meaning that resources including essential medicines, supplies, equipment, workforce and financial allocations are available, accessible, acceptable, affordable and of good quality.
- Equitable access to quality-assured essential medicines and health products is ensured.
- Leadership and clinical standards promote evidence-based SRH services.
- The organization of the health system ensures respect for SRH and human rights, including non-discrimination and equality, and for autonomy in decision-making.
- The workforce is robust and receives competency-based training and is skilled in the provision of evidence-based SRH counselling and service delivery.
- In addition to technical training, SRH services are provided by persons who are trained in the content and meaning of the law and trained and empowered to interpret and apply law and policy in rights-compliant ways.
- Confidentiality and privacy of care are ensured, and there are efforts to counteract abortion stigma.
- There is access to safe and timely comprehensive abortion care and women do not have to resort to unsafe abortion.
- Health financing policies should avoid making access to SRH services conditional on direct payment from patients at the point of service.
- Care is always provided respectfully and with compassion.
- Communities are engaged and supportive.

1.3.1 Human rights including a supportive framework of law and policy

An enabling environment is one in which the human rights of individuals are respected, protected and fulfilled. This entails regular review and, where necessary, revision of regulatory, law and policy frameworks, and the adoption of measures to ensure compliance with evolving international human rights standards (see Annex 2).

Throughout this guideline we refer to human rights standards in international law, the applicability of which in a specific setting will depend on factors such as the State's ratification of relevant human rights instruments. The sources of these human rights standards are detailed in Web annex A: Key international human rights standards on abortion.

(i) Sexual and reproductive health and rights

Sexual and reproductive health and rights are grounded in a range of human rights recognized and guaranteed in national and international law, and are inextricably linked to the achievement of public health policy goals, including the SDGs *(32, 33)*. People have a range of sexual and reproductive rights, which are relevant to information and services across the continuum of care for abortion (see Box 1.2). Overarching all of them are principles of non-discrimination and equality, and the right to the highest attainable standard of physical and mental health, including in the provision of SRH services *(3, para. 7)*. These are all underpinned by States' obligations to ensure that laws and policies, institutional arrangements and social practices do not prevent people from the effective enjoyment of their right to SRH *(3, para. 8)*.

Box 1.2 provides a general description of certain human rights as established by international law instruments and their associated obligations and principles relevant to SRH.

(ii) Prevention of unsafe abortion and reduction of maternal mortality and morbidity

Taking measures to prevent unsafe abortion is a core obligation of the right to SRH *(3, para. 49)*. International human rights law requires States to take steps to reduce maternal mortality and also to effectively protect women from the physical and mental risks (morbidity) associated with unsafe abortion *(43, paras 6, 9, 24, 30-33)*. Treaty monitoring bodies (see Annex 2) have confirmed that States must revise their laws to ensure this protection *(36, para. 8)*. Thus, the United Nations Committee on Economic, Social and Cultural Rights (CESCR) has confirmed that States must liberalize restrictive abortion laws, guarantee access to quality abortion and post-abortion care, and respect the right of women to make autonomous decisions about their SRH *(3, para. 28)*. In all situations, States have a duty under international human rights law to ensure that the regulation of abortion (see Chapter 2) does not cause women and girls to resort to unsafe abortions *(36, para. 8)*. As a matter of international human rights law, States must provide essential medicines listed under WHO's Action Programme on Essential Drugs *(46, para. 12a)*. States must also take steps to prevent the stigmatization of people seeking abortion *(36, para. 8)*. In addition, policies must seek to minimize the rate of unintended pregnancy by ensuring provision of quality contraceptive information and services, including a full range of contraceptive methods (emergency, short-acting and long-acting methods).

(iii) Rights-based regulation of abortion

The right to SRH requires States to ensure that health-care facilities, goods and services are available, accessible, acceptable and of good quality *(46, paras 8, 12)*. This should inform all parts of the regulation of abortion.

Treaty monitoring bodies have called for the decriminalization of abortion in all circumstances. They have further clarified States' human rights obligations in relation to abortion. These include that:

- States may not regulate pregnancy or abortion in a manner that runs contrary to their core obligation to ensure that women and girls do not have to resort to unsafe abortions. If they do, their restrictions on access to abortion must be revised *(36, para. 8)*.
- The regulation of abortion must not jeopardize the lives of pregnant women, subject them to physical or mental pain or suffering (including where this constitutes torture or cruel, inhuman or degrading treatment or punishment), discriminate against them, or interfere arbitrarily with their privacy *(36, para. 8)*.
- The regulation of abortion must be evidence based and proportionate to ensure respect for human rights *(37, para. 18)*.

BOX 1.2: Selected human rights, as specified in relevant international law instruments, and their associated obligations and principles relevant to sexual and reproductive health and rights and abortion in particular

Human right	Selected human rights principles and obligations relevant to abortion
The right to the highest attainable standard of physical and mental health, including sexual and reproductive health and rights	• States have an obligation to respect, protect and fulfil the right of everyone to sexual and reproductive health and rights *(34, Article 12)*. This includes: ▫ the removal of legal provisions, including criminal laws, which penalize women who have undergone abortion or medical practitioners who offer these services *(3, 35-38)*; ▫ ensuring that women are not prevented from accessing health services by health professionals' exercise of conscientious objection (e.g. where abortion is legal, if a doctor refuses to perform it, the health system must provide a referral to an alternative health-care provider) *(3, 39)*; ▫ eliminating barriers to the provision of abortion services including barriers that lead women to resort to unsafe abortions – this should include eliminating unacceptable delays in providing medical attention *(3, 36, 38, 40-42)*; ▫ undertaking measures to prevent unsafe abortions and ensure access to post-abortion care in all circumstances, on a confidential basis and without the threat of criminal prosecution or punitive measures *(3, 36-38, 40, 41, 42 [para. 33], 43-47);* ▫ undertaking measures to prevent and eliminate discrimination, stigmatization and negative stereotyping that hinder access to sexual and reproductive health (SRH), including against people seeking abortion and health-care providers offering abortion care services *(36, 38)*. • States must ensure that sexual and reproductive health-care facilities, goods and services are available, acceptable and of good quality. This includes: ▫ ensuring an adequate number of sexual and reproductive health-care facilities, goods and services (e.g. trained and skilled medical and health-care personnel *[42, 46, 48]* and scientifically approved and unexpired medicines for abortion and post-abortion care *[49]*, as well as the availability of safe abortion in cases of rape and incest *[3, 36, 42, 50, 51]*); ▫ ensuring that health care and services, including SRH and essential medicines are physically and geographically accessible and affordable to all individuals, either provided at no cost or based on ensuring that health expenses do not expose individuals to suffering financial hardship *(46)*; ▫ ensuring that information about SRH is accessible *(3, 52)* (e.g. institutions and individuals should be able to provide accurate health-care information, including information on abortion, without fear of criminal sanction *[41, 50, 51]*); ▫ ensuring that delivery of services is respectful of the culture of individuals, minorities, peoples and communities, and sensitive to gender, age, disability, sexual diversity and life-cycle requirements *(53, para. 20)*.
The right to non-discrimination and equality	• States must ensure that individuals enjoy equal access to the same range, quality and standard of SRH information, goods and services *(36, 45, 52)*. • States must acknowledge and take measures to address access to safe abortion and post-abortion care for particular groups of individuals, especially those who are marginalized, have limited resources, live in rural areas, and/or are from minorities, as they are more likely to experience intersecting forms of discrimination *(3, 36-38, 40, 41, 42 [para. 33], 43-47, 49, 54 [para. 45])*. • States must repeal or reform discriminatory laws, policies and practices that nullify or impair the ability of individuals to access SRH, such as criminalization of abortion and restrictive abortion laws *(3, 35-38, 41, 42 [para. 22], 55)*. • States must remove all legal, procedural, practical and social barriers impeding individuals' equal and non-discriminatory access to SRH, including abortion, and should repeal measures such as third-party authorization requirements (i.e. from husbands, partners, parents or guardians, or health authorities), biased counselling, mandatory waiting periods, and restrictions based on being an unmarried woman *(3, 35-38)*. • States must take steps to prevent the imposition of forced abortion, in particular on women and girls from marginalized groups *(37, 40, 47, 52, 56)*.
The right to life	• States must ensure that measures designed to regulate access to abortion do not jeopardize the life of the woman, girl or other pregnant person, subject them to physical or mental pain or suffering or discriminate against them, or arbitrarily interfere with their privacy *(36)*. • States must provide effective and confidential access to safe, legal abortion where the life or health of the woman, girl or other pregnant person is at risk, or where carrying a pregnancy to term would cause the pregnant individual substantial pain or suffering, and in cases where the pregnancy is the result of rape or incest or where the pregnancy is not viable *(36)*. • States must take steps to reduce maternal morbidity and mortality, including addressing unsafe abortion, taking into account exacerbated challenges in certain settings *(3, 36-38, 40, 43)*.

Human right	Selected human rights principles and obligations relevant to abortion
The right to privacy	• States must respect the right of individuals to make autonomous decisions about their sexual and reproductive health, including whether or not to undergo an abortion *(35, 36, 57)*. • SRH services including abortion and post-abortion care must be provided in a way that respects fully the woman's, girl's or other pregnant person's privacy and guarantees confidentiality *(35, 36)*. • Medical and health-care professionals must not be required or mandated to report cases of women who have undergone abortions *(36, 37, 40, 48)*. • Denial of therapeutic abortion may interfere arbitrarily with the right to privacy *(57)*. • Third-party authorization requirements may violate the right to privacy *(3, 36, 38)*.
The right to be free from torture, cruel, inhuman and degrading treatment and punishment, including the right to physical and mental integrity	• Forced abortion, criminalization of abortion, denial or delay of safe abortion care and/or post-abortion care, and abuse and mistreatment of women and girls seeking SRH information, goods and services are forms of gender-based violence *(44, 55)*, which – depending on the circumstances – may amount to torture, cruel, inhuman or degrading treatment *(55)*. • States must ensure that measures regulating abortion do not subject individuals to substantial physical or mental pain or suffering, such as where a pregnancy is the result of rape *(36)*. • State laws and policies must not permit abortions without the free and informed consent of the concerned individual *(40, 41, 48, 52, 56, 58)*. • States must prevent and prosecute forced abortions conducted by public officials and private actors, including when conducted on women with disabilities or according with coercive family planning laws and policies as well as in the context of a conflict *(40, 41, 48, 52, 56, 58)*. • States should ensure that individuals seeking a safe legal abortion are not subjected to humiliating and judgemental attitudes leading to the denial or delay of such services in a context of extreme vulnerability for these individuals and where timely health care is essential *(35)*. • Criminalization of abortion may amount to torture, cruel, inhuman or degrading treatment, including the practice of extracting confessions for prosecution purposes from individuals seeking emergency medical care because of illegal abortion in a particular context *(55)*.
The right to decide freely and responsibly on the number, spacing and timing of children and to have the information and means to do so	• States must ensure access to family planning and SRH information and services, including affordable contraceptive methods to enable women and adolescents to make autonomous and informed decisions on their reproductive health *(42 [para. 33], 49 [para. 33])*. • States must ensure that women with disabilities can exercise their right to decide on the number and spacing of children *(52, 59 [Article 3(3)])*.
The right to information and education including on sexual and reproductive health	• States must take measures to ensure up-to-date, accurate information on SRH is publicly available and accessible to all individuals, in appropriate languages and formats *(3, 50-52)*. • States must ensure that educational institutions incorporate unbiased, scientifically accurate, evidence-based, age-appropriate and comprehensive sexuality education into their required curricula *(3, para. 63)*. • States must make accurate, evidence-based abortion information available to individuals on a confidential basis *(3 [para. 63], 50-52)*. • This information must be presented in a way that can be understood by the person receiving it *(3, 52)*. • The choice by an individual to refuse information when offered must be respected. • States must ensure that informed consent is provided freely, safeguarded effectively, and based on complete provision of high-quality, accurate and accessible information.
The right to benefit from scientific progress and its realization	• States must ensure adequate access to essential medicines in an affordable manner *(46, 49, 54)*. • States must ensure access to necessary, up-to-date scientific technologies, in particular contraception and medicines for abortion, without discrimination *(42, 49)*.

Note: For further information, see Web annex A: Key international human rights standards on abortion. Wording used in this box reflects original language used in the source documents (human rights treaties).

- Access to abortion must be available when carrying a pregnancy to term would cause the woman substantial pain or suffering. This includes but is not limited to situations where her life and health are at risk, where the pregnancy is the result of rape or incest, or where the pregnancy is not viable *(36, para. 8)*. Treaty monitoring bodies have also recommended making abortion available in cases of fetal impairment, while putting in place measures to protect against discrimination on the basis of disability in society *(60)*.
- States should not criminalize having an abortion, those who have an abortion, or those who support someone having an abortion *(3 [paras 20, 34], 36 [para. 8], 55 [para. 18], 61 [para. 51(l)], 62 [para. 60], 63 [paras 82, 107])*.
- States should not require health workers to report women who have had or who are suspected to have had an abortion *(40, para. 20)*.
- States must provide essential primary health care *(64, para. 10)* (see also section 1.4.1: Universal health coverage and primary health care; section 1.4.4: Commodities; Annex 2: Selected human rights treaties and their treaty monitoring bodies; and also Web annex A: Key international human rights standards on abortion).

(iv) Accessibility of abortion care

Where it is lawful, abortion must be accessible in practice. This requires both ensuring that health-care facilities, commodities and services are accessible (including sufficient providers; see section 3.3.8 on provider restrictions), and that law and policy on abortion is formulated, interpreted and applied in a way that is compatible with human rights. Thus, where abortion is currently available on the basis of grounds, meaning under specified circumstances, and in anticipation of moving to a system of abortion on request as recommended (see Recommendation 2: Grounds-based approaches, section 2.2.2), those grounds must be defined and interpreted in a way that gives full effect to women's human rights and that aligns with the following WHO definitions:

> **Health**: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity *(2)*.
>
> **Mental health**: a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community *(65)*.

States must take effective steps to prevent third parties (e.g. parent, spouse, health authority) undermining a person's enjoyment of their right to SRH (see section 3.3.2: Third-party authorization) *(3, para. 59)*, and must also ensure that provider refusal is not a barrier to accessing abortion care (see section 3.3.9: Conscientious objection) *(3 [paras 14, 43], 39 [Ch.1, paras 11, 13])*.

(v) Free and informed consent

International human rights law requires that the provision of abortion be based on the free and informed consent of the person having the abortion with no further authorization required.

International human rights law obliges States to ensure that accurate, evidence-based abortion information *(3 [para. 9], 36 [para. 8])* is available to individuals on a confidential basis *(36 [para. 8], 43)*, and also that their choice to refuse such information when offered is respected *(58, para. 15)*. Receipt of such information is vital as this underpins the right and the ability to make informed decisions and choices about matters regarding one's body and SRH, and to give informed consent (see also section 1.3.2 below).

As a matter of international human rights law, States are obligated to ensure that "informed consent" is:

- documented in advance of a health-care intervention, and provided without coercion, undue influence or misrepresentation *(58, para. 13)*;
- safeguarded through legislative, political and administrative means *(58, para. 7)*, as a fundamental aspect of a range of human rights (i.e. the rights to health, information, freedom from discrimination, and security and dignity of the person);
- based on provision of complete information about the associated benefits, risks and alternatives;
- based on information that is of high quality, accurate and accessible (including ensuring it is available in a range of formats and languages, and in forms that make it accessible to people with reduced capacity), and presented in a manner acceptable to the person consenting.

Further relevant information is provided in section 3.2 on information provision and counselling related to abortion for individual abortion seekers, and in section 3.5.1 on follow-up care and section 3.5.4 on post-abortion contraception. States are obliged to protect women from arbitrary interference when they seek SRH services, and to ensure respect for autonomous decision-making by women, including women with disabilities, regarding their SRH and well-being *(60)*.

Even though women have a right to accurate information, some health workers who object to abortion on the basis of conscience either provide deliberately misleading information or refuse to provide any information about abortion *(66-68)*. States where health workers are allowed to invoke conscientious objection *(3, para. 43)* must regulate and monitor such refusals of abortion care to ensure that women can access accurate information and appropriate services (refer to section 3.3.9: Conscientious objection).

As a matter of international human rights law, States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents/guardians or health authorities, because they are unmarried, or because they are women *(39 [Ch.1, paras 14, 21], 3 [paras 41, 43])*. For adolescents, the authorization or consent of parents should not be required before the provision of abortion care (see also section 3.3.2: Third-party authorization). As a general matter, States must recognize children's and adolescents' evolving capacity and their associated ability to take decisions that affect their lives *(69, Article 5)*. In order to ensure protection of adolescents' sexual and reproductive health and rights, the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has suggested that States should consider introducing "a legal presumption of competence that an adolescent seeking preventive or time-sensitive health goods or services, including for sexual and reproductive health, has the requisite capacity to access such goods and services" *(35, para. 60)*. The United Nations Committee on the Rights of the Child (CRC) has also urged States to "review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver or guardian, such as ... sexual and reproductive health services, including ... safe abortion" *(45, para. 31)*.

People with disabilities have a right to autonomy *(59, Article 3a)*, but face continuing and systemic discrimination in access to SRH services. States are obliged to prohibit and prevent discriminatory denial of SRH services to people with disabilities *(70, para. 66)*. States may not undertake, and must take steps to prevent forced or coerced abortion *(40, para. 11)*, which constitutes torture, cruel, inhuman or degrading treatment *(40 [para. 11], 52 [para. 62])*.

(vi) Post-abortion care

Provision of post-abortion care is a core obligation of States under the right to SRH *(3, para. 49e)*. Regardless of whether abortion is legal or restricted, States are required to ensure access to post-abortion care *(45, para. 70)*. Such care must be available on a confidential basis, without discrimination, and without the threat of criminal prosecution or other punitive measures *(36, para. 8)*. States must also ensure access to a wide range of modern, safe and affordable contraceptive methods *(36 [para. 8], 49 [para. 33])*.

(vii) Accountability for human rights violations

Accountability mechanisms are essential to the protection, respect and fulfilment of sexual and reproductive health and rights. Monitoring and accountability for human rights compliance takes place at national, regional and international levels, as appropriate to the law in question. Monitoring and accountability involve a variety of actors, such as the State itself, civil society organizations, national human rights institutions or international or regional human rights mechanisms. Some such accountability mechanisms include administrative mechanisms for recording and monitoring relevant health outcomes relating to abortion law and policy, and including them in reports to human rights institutions *(39, Ch.1, paras 9, 10, 12, 17)* (see also section 1.4.5 on monitoring and evaluation of abortion care). States must ensure that all persons have access to justice and to a meaningful and effective remedy where their human rights are violated *(39, Ch.1, para. 13)*. These remedies can include adequate, effective and prompt reparation in the form of restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition *(3, para. 64)*, including by reform of law and policy. Mindful of the above, an enabling environment for abortion care would ensure that there are appropriate accountability mechanisms for failures to facilitate quality abortion care, including accessible, transparent and effective accountability mechanisms for women to challenge denial of abortion in a timely manner. In addition, an enabling environment would include appropriate remedies for failure to facilitate quality abortion care, including regular review and reform of law and policy to recognize and remove barriers to quality abortion care. As confirmed by the Committee on the Elimination

of Discrimination against Women (CEDAW), such reform should include "[a]bolish[ing] discriminatory criminalization and review[ing] and monitor[ing] all criminal procedures… [and] decriminaliz[ing] forms of behaviour that can be performed only by women, such as abortion" *(61, para. 51[l]).*

1.3.2 Availability and accessibility of information

An essential first step in improving access to and quality of abortion care is ensuring that all individuals can access relevant, accurate and evidence-based health information and counselling if and when desired. This is required by international human rights law – grounded in the right to information and the right to privacy (see Box 1.2) – and facilitates individual decision-making relating to SRH services, including abortion. Two different types of information about abortion must be available: (i) information of a general nature for the public (described below), and (ii) specific information tailored to be relevant to each person seeking abortion (see section 3.2.1) and underpinning free and informed consent, which was described in section 1.3.1(v).

States parties are to ensure that everyone has a right to receive accurate, non-biased and evidence-based information on SRH. Relatedly, as part of their obligation to reduce maternal mortality and morbidity, States must ensure the provision of comprehensive, non-discriminatory, scientifically accurate and age-appropriate education on sexuality and reproduction, including information on abortion, both in and out of schools *(46, 71 [Articles 10, 16], 72)* and must ensure that comprehensive sexuality education (CSE) is available to minors without the consent of their parents or guardians *(45, para. 31)*. In an enabling environment all persons would be provided with all the necessary information to make an informed decision regarding the use of contraception, including information on where and how to obtain an abortion or contraception, the costs of services, and the specifics of any local laws. The growing use of self-management of abortion (see section 3.6.2) underlines the need to ensure that accurate information about abortion is available to all who may seek it.

As a matter of international human rights law, the provision of information on abortion should not be criminalized, even in contexts where the procedure itself may be illegal (see section 2.2.1: Criminalization of abortion). To ensure that accurate information is broadly accessible, including for those with low literacy, an enabling environment would provide that such information is shared using a variety of formats/media as appropriate for the intended audience (e.g. videos, social media). The United Nations CESCR has confirmed that "[t]he dissemination of misinformation and the imposition of restrictions on the right of individuals to access information about SRH also violates the duty to respect human rights. … Such restrictions impede access to information and services, and can fuel stigma and discrimination" *(3, para. 41)*.

1.3.3 Health system factors

Within the health system, multiple actions are needed to realize human rights obligations. Actions to facilitate and strengthen abortion-related service delivery should be based on human rights, local health needs and a thorough understanding of the service-delivery system and the broader social, cultural, political and economic context. National standards and guidelines for abortion care should be evidence based and periodically updated, and should provide the necessary guidance to achieve equal access to comprehensive abortion care. Leadership should also promote evidence-based SRH services according to these standards and guidelines.

The right to the highest attainable standard of physical and mental health includes the right to respectful health care as well as the right to be free from violence and discrimination *(73).* The right to benefit from scientific progress and its realization entitles women to access to up-to-date scientific technologies necessary for women. This means States must ensure access to modern and safe forms of contraception (including emergency contraception), abortion medicines, assisted reproductive technologies, and other SRH goods and services, on the basis of non-discrimination and equality *(49, para. 33)*. To achieve a high standard of respectful care, health systems should be organized and managed in a manner that ensures respect for people's SRH and human rights *(73).* Respectful health care recognizes individuals' rights, respects their agency and autonomy in decision-making, and incorporates their values and preferences into care.

In addition to policy and regulatory barriers, other barriers may further limit the availability of abortion services, including: stigma; formal and informal costs; lack of commodities, services, trained providers and information; and/or the unwillingness of some health workers to provide care. This leaves particular groups of people – such as those living in rural settings, those facing financial hardship, adolescents, unmarried, transgender or nonbinary individuals, those with less access to education and those living with HIV – disproportionately vulnerable to

barriers to obtaining abortion care. As part of an enabling environment, a health system should be adequately resourced, meaning that resources (e.g. essential medicines, supplies, equipment, workforce, financial allocations) are available, fairly distributed and efficiently used. In this way, adequate and equitable access to quality-assured essential medicines and equipment should be assured. Relatedly, health financing policies should avoid making access to SRH services conditional on direct payment from patients at the point of service, and the health workforce should be skilled in providing evidence-based SRH services, including counselling.

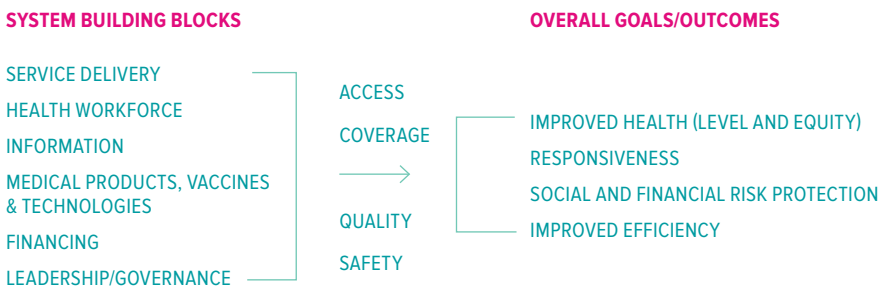
Abortion stigma is common, and has negative psychological consequences for individuals seeking abortion and health workers providing abortion care *(31, 74, 75),* and can also be detrimental to health outcomes. Abortion stigma is a social process, and is dependent upon the context, but may be considered as an exercise of power and control of one group over members of a less powerful group, who are considered different, negatively stereotyped, discriminated against and marginalized within society *(75, 76).* Work is needed across sectors to counteract stigma; health systems should recognize the risks and effects of stigma, and implement solutions to not only ensure privacy and confidentiality, but also to support health workers. Care should always be provided respectfully and with compassion. In an enabling environment, communities are also engaged and supportive. Those who assist and support abortion seekers – their partners, friends, family members – also require support within the health system and broader environment.

More in-depth consideration of key health system factors is provided in section 1.4 below.

1.4 Health system considerations

The health system refers to all organizations, people and actions whose *primary intent* is to promote, restore or maintain health *(77).* The health system consists of the six core building blocks, as listed in Figure 1.2, which support four overall goals and outcomes, as shown below. This section addresses in detail health system considerations relevant to an enabling environment for abortion care.

Figure 1.2: The WHO health system framework



Source: WHO, 2007 *(77).*

A well functioning health system, with all the "blocks" working in harmony, depends upon having trained and motivated health workers, a well maintained infrastructure and a reliable supply of medicines and technologies, backed by adequate financing, strong health plans and evidence-based policies. Health-care services provided via the health system are not restricted to those provided at a health-care facility; health care and services can also be received through community-based providers (e.g. health visitors, pharmacists), digital interventions or self-care approaches (e.g. telemedicine).

1.4.1 Universal health coverage and primary health care

Universal health coverage (UHC) means ensuring that all people have access to the promotive, preventive, curative, rehabilitative and palliative health services they need, which must be of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship *(30).* UHC is integral to the achievement of SDG target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable

essential medicines and vaccines for all. The aim of this target is to accelerate efforts to ensure that all people and communities receive the full spectrum of essential, quality health services they need across the life course, without suffering financial hardship.

To establish an enabling environment, there is a need for abortion care to be integrated into the health system across all levels (including primary, secondary and tertiary) – and supported in the community – to allow for expansion of health worker roles, including self-management approaches. Such integration is a complex process that can occur through service delivery, financing mechanisms and/or inclusion in health benefits packages. While inclusion in health benefits packages may enhance access to and delivery of abortion care, in many countries abortion care is not explicitly recognized in the standard package, contributing to inequitable access to services *(78)*.

From a health financing perspective, improving access to comprehensive abortion care, as part of UHC, requires shifting the burden of financing away from individuals towards domestic public funding, which combines tax revenue and prepayment schemes to cover the costs of care *(78)*. Further information is provided in section 1.4.2 below. Meanwhile, from a service-delivery perspective, integrating abortion care within national maternal care and family planning programmes is technically the most straightforward option as abortion services require few, if any, additional provider skills, medicines, equipment or supplies. Furthermore, it is the most efficient option, as it minimizes any additional/marginal costs of implementing abortion services.

Health systems strengthening, by improving performance across all six health system building blocks (see above), is essential to progress towards UHC *(77)*. The use of new and innovative technologies and approaches for providing, facilitating or supporting abortion services must be incorporated into country programmes and health benefits packages. WHO's UHC Compendium provides a list of all interventions related to abortion care to be considered for inclusion within a country's UHC package *(79)*.[3]

To ensure both access to abortion and achievement of UHC, abortion must be centred within primary health care (PHC), which itself is fully integrated within the health system, facilitating referral pathways for higher-level care when needed. PHC is a multisectoral, societal approach to health that aims to ensure the highest possible level of health and well-being for all individuals, by focusing on people's needs and preferences (as individuals, families and communities) along the continuum of care from health promotion and disease prevention to treatment, rehabilitation and palliative care *(30)*. Quality PHC is evidence-informed, community-delivered and person-centred. Making abortion available and accessible within PHC is a safe and effective strategy to advance equitable access to, and provide an enabling environment for, abortion.

1.4.2 Health financing

Health financing is a core function of health systems that can enable progress towards UHC by improving effective service coverage and financial protection. To improve effective service coverage, health financing arrangements for abortion services should ensure the production costs are met so that health-care providers have the means to carry out these activities without financial constraints. To improve financial protection, the health system must guarantee that the share of the costs – production costs and the costs of access to services – borne by patients is not a barrier to full use of services. WHO's approach to health financing focuses on the following core functions:

- raising revenue – establishing sources of funds, including government budgets, compulsory or voluntary prepaid insurance schemes, direct out-of-pocket payments by users, and external aid;
- pooling funds – the accumulation of prepaid funds on behalf of some or all of the population; and
- purchasing services – the payment or allocation of resources to health-care providers.

In addition, all countries have policies indicating which services the population is entitled to, even if not explicitly stated by the government, and by extension any services not covered are usually paid for out of pocket by patients as user fees or co-payments.

To provide an enabling environment, financing of abortion services should take into account costs to the health system while ensuring that services are free or affordable and readily available to all who need them, in support of the goal of achieving UHC. A recent scoping review captured the costs to the health system and to the woman

3 Available by selecting "Sexual and reproductive health" at this link: https://www.who.int/universal-health-coverage/compendium/interventions-by-programme-area or by searching the database at this link: https://www.who.int/universal-health-coverage/compendium/database

by categorizing the economic consequences of abortion and abortion policies through three levels: micro-, meso- and macroeconomic. Assessment of the micro-, meso- and macroeconomic levels provided insight into the documented economic consequences of abortions at the individual, community and health system levels *(80-82)*.

Cost to the facility or health system

In regard to costs to the health-care facility and health system, the findings of the review on the mesoeconomic outcomes confirmed that limited resources negatively affect facilities' ability to meet demand and provide quality services *(81)*. Furthermore, the costs of post-abortion care, including treatment of post-abortion complications, consume a disproportionate amount of facilities' resources in many settings, posing a burden to health systems by further depleting their overstretched resources. Therefore, financial savings can be made by maintaining or even improving the quality of abortion care services, and also by decentralizing services and legalizing abortion, as indicated in the macroeconomic assessment *(82)*.

Providing access to quality abortion care is considerably less costly than treating the complications of unsafe abortion *(83-87)*. Costs for providing abortion care with vacuum aspiration include infrequent, modest capital investments, such as purchase of a suction machine for electric vacuum aspiration (EVA) or manual vacuum aspiration (MVA) equipment, an examination table, a steam sterilizer or autoclave, and possibly also renovation of waiting, consultation and recovery rooms, and toilets. Recurrent costs for surgical or medical abortion include those associated with purchasing instruments and supplies that will need to be restocked regularly, such as cannulae and MVA aspirators, antiseptic solutions and high-level disinfectants used for instrument processing, and medicines for pain management, infection prevention and medical abortion.

Decisions about which abortion methods to offer and how to organize services directly influence the cost of providing services and their affordability. Two organizational issues are of particular importance for both increasing safety and reducing costs: (i) preferential use of either vacuum aspiration or medical abortion, and (ii) facilitating the provision of abortion (e.g. improved access to abortion services, integration into primary health care). Expanding the role of health workers in abortion provision and exploring innovative modes of service-delivery, such as telemedicine and hotlines, have also been identified as cost-saving strategies for national health systems *(82)*.

Making services affordable for women

In countries where legal access to abortion is available, it remains a challenge to provide abortion services that are publicly funded and free at the point of care *(88)*. Furthermore, in some settings, financial protection is restricted to specific demographic groups of individuals seeking abortion or certain legal categories of abortion. Abortion seekers may be charged substantial additional fees (on top of the official charges), creating a barrier for many, especially when combined with travel expenses and opportunity costs, such as time lost from paid and unpaid work. In some settings, reimbursement rates for private or public providers working with nongovernmental organizations are well below the cost of providing care. The barrier of high costs of abortion medicines and/or services is likely to generate higher costs for the health system, since these costs force many – especially among the adolescent population *(89)* – to present at a later gestational age or to use unsafe providers or methods, thus increasing the rates of hospitalization for serious complications *(80, 90-92)*. Higher rates of complications, additional fees and high costs all also contribute to the stigmatization of abortion.

Respect, protection and fulfilment of the right to health requires States to guarantee, at a minimum, universal and equitable access to affordable, acceptable and quality SRH services, goods and facilities, in particular for women and disadvantaged and marginalized groups *(3, para. 49)*. Thus, in order to provide an enabling environment for abortion care, ability to pay should not have any bearing on women's ability to access legal abortion services *(3 [para. 17], 35 [para. 31], 39 [Ch.1, para. 21])*.

As part of an enabling environment, considerations of gender equality, human rights and equity should guide the design of health financing policy to reduce if not eliminate the financial barriers for the most vulnerable, and to ensure equitable access to good-quality services *(93)*. The CEDAW Committee has described fees for abortion as being burdensome to women's informed choice and autonomy *(94, para. 37)*. Where user fees are charged for abortion, this should be based on careful consideration of ability to pay, and fee waivers should be available for those who are facing financial hardship and adolescent abortion seekers. It should be noted, however, that evidence on the success of fee waivers in addressing financial barriers and improving access to quality

abortion care is mixed and inconclusive *(95)*. Numerous treaty monitoring bodies (see Annex 2) have recognized that abortion services must be economically accessible, recommending that States lower the cost of abortion or otherwise provide financial support when needed *(96 [paras 37(b), 38(b)], 97 [para. 24], 98 [paras 38, 39])*. Relatedly, the Committee against Torture (CAT) has called on States to ensure free access to abortion in cases of rape *(99, para. 15a)*. With the above in mind, as far as possible, abortion services and supplies should be mandated for coverage under insurance plans as inability to pay is not an acceptable reason to deny or delay abortion care. Furthermore, having transparent procedures in all health-care facilities can ensure that informal charges are not imposed by staff.

1.4.3 Health workforce competencies and training

Health workers are all people engaged in actions whose primary intent is to enhance health *(100)*. The delivery of high-quality care requires an adequate supply of competent health workers, who are equitably distributed, and with an optimal skills mix at the facility, outreach and community levels *(101)*. All health workers need to be adequately supported to provide competent care. The competencies required to provide or support abortion care align with competencies required in many different areas of health *(102, 103)*. WHO is currently developing a global competency framework for universal health coverage (UHC), which identifies the required competencies for primary health care workers to provide the full spectrum of promotive, preventive, diagnostic, curative and palliative care *(104, 105)*.

Delivery of care and treatment services should be accomplished in a people-centred, non-judgemental and non-directive way, allowing individuals to lead the decision-making about their own care in an informed and supported fashion *(106)*. As part of ensuring an enabling environment, it is particularly important that training for health workers involved with SRH services incorporates:

- the unique competencies required for SRH services, in particular for abortion care;
- provision of people-centred care;
- human rights, and the content and meaning of the law, and how to interpret and apply law and policy in rights-compliant ways;
- communication to enable informed decision-making;
- values clarification;
- interprofessional teamworking; and
- empathetic and compassionate approaches to care *(105)*.

These skills should be included in training programmes and promoted by professional societies. It is especially critical that the attitudes and behaviours of health workers be inclusive, non-judgemental and non-stigmatizing, and that they promote safety and equality. Managers of health care – whether in the public or private sector – are responsible for delivering services appropriately and meeting standards based on professional ethics and internationally agreed human rights principles.

1.4.4 Commodities

Provision of primary health care includes access to safe, effective, quality-assured and affordable medicines, including medicines for abortion and post-abortion care (i.e. antibiotics and pain control medicines as well as abortion medicines and post-abortion contraceptives).

The WHO Model List of Essential Medicines (also known as the Essential Medicines List, or EML) includes the minimum medicines needed for a basic health-care system, listing the most efficacious, safe and cost-effective medicines for priority conditions. Priority conditions are selected based on current and estimated future public health relevance, and potential for safe and cost-effective treatment. Both mifepristone and misoprostol have been included in the WHO Model Lists of Essential Medicines since 2005. In 2019, these medicines were moved from the complementary to the core list of essential medicines in the 21st EML and the requirement for "close medical supervision" for their use was removed *(107)*. The relevant abortion medicines included in the 21st EML and also the more recent 22nd EML are indicated in Table 1.1.

Table 1.1 Medicines included in the WHO Model List of Essential Medicines (EML) and their indications

Indication included in EML	Medicines included in the EML
Induced abortion	• Mifepristone (200 mg) and misoprostol (200 µg) • The medicines are available individually or co-packaged. • The EML specifically mentions the following co-packaged formulation: 1 tablet mifepristone (200 mg) + 4 tablets misoprostol (200 µg).
Management of incomplete abortion and miscarriage	• Misoprostol (200 µg)

Source: WHO EML – 21st list, 2019 *(107)*, 22nd list, 2021 *(108)*.

Within a country, the key elements of a commodity strategy include policy, regulation, procurement and supply chain, as well as links to financing and reimbursement systems *(109)*.

Mifepristone and misoprostol should be listed in relevant national EMLs (NEMLs) or their equivalent, and should be included in the relevant clinical care/service delivery guidelines. In the case of pregnancy tests and MVA equipment, countries may have an Essential Medical Devices List or a similar list for medical devices. Pregnancy tests and quality MVA devices should be included on these lists as part of a commodity strategy.

Inclusion in the NEML is one important component of ensuring that quality medicines are available. Misoprostol, mifepristone, surgical abortion equipment and other relevant health products should be included in national procurement tenders as well as in supply chain monitoring activities. Procurement activities should include forecasting methods that are appropriate to the products and to the country context with a goal of ensuring continuous supply *(110)*. Central Medical Stores (CMS) entities should ensure that specifications for the procurement of safe abortion medicines are coordinated with national medicines regulatory authorities (NMRAs) and that they clearly specify quality assurance standards and all other requirements, such as strength, packaging and shelf life.

WHO recommends that the highest level of quality assurance be pursued but recognizes that risk-based approaches may be needed in countries where access to international markets is limited. Risk-based approaches will depend on the context of a given country but may include exceptions based on prior information about a manufacturer, or reliance on information from other regulators *(111)*. Quality-assured medicines include those approved by stringent regulatory authorities (SRAs) *(112)*[4] or listed through WHO Prequalification (PQ).[5] Where such medicines are not available, approval by an NMRA that includes inspection and testing according to accepted standards should be undertaken for mifepristone and misoprostol.[6]

NMRAs are the bodies that provide registration and market authorization for specific products. The NMRA reviews the safety, efficacy and quality of medicines as part of granting market authorization. Such authorization is specific to each medicine made in a particular location by a particular manufacturer. Market authorizations are granted based on an evaluation of a technical dossier presented by the manufacturer, or their agent, confirming the efficacy, quality and safety of the product. Through prequalification, WHO supports a regulatory reliance mechanism where it provides detailed assessment information to NMRAs on products that have been prequalified by WHO, so that the regulatory decision can be made based on WHO's assessment rather than having to duplicate it. Based on the same principle, WHO also supports the sharing of assessment information for SRA-approved products. These processes are both known as WHO Collaborative Registration Procedures (CRPs).[7]

Regulators make determinations regarding the authority to prescribe and dispense medicines. There are examples, including emergency contraception, where regulators have made decisions to change the prescribing authority to improve access and appropriate use, including "over the counter" sales or prescription by a pharmacist without physician consultation. The information that is typically considered includes whether a condition can be reasonably self-diagnosed, the overall safety of the medicine, and the likelihood of misuse or complications with

4 SRAs are listed at this web page: https://www.who.int/initiatives/who-listed-authority-reg-authorities/SRAs. In the cited reference (pp. 34–35), SRAs are defined as "a regulatory authority which is a member or an observer of ICH [International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use], or is associated with an ICH member through a legally-binding mutual recognition agreement" (as before 23 October 2015).

5 WHO Prequalification is one standard for all types of products, including medicines (pharmaceuticals and biotherapeutics), vaccines and immunization devices, in vitro diagnostics and vector control products. This listing implies a recommendation but not market authorization.

6 For further information, refer to The International Pharmacopoeia, available at: https://digicollections.net/phint/2020/index.html#p/home

7 For further information, see: https://extranet.who.int/pqweb/medicines/collaborative-procedure-accelerated-registration

less supervised or unsupervised use of the medicine, among others *(113, 114)*. National programmes should work with regulators to determine the most appropriate evidence-based prescribing and dispensing authorities for the medicines. Restrictions on prescribing authority for some categories of health workers may need to be modified or other mechanisms put in place to make the medicines available for these health workers within the regulatory framework of the health system.

A comprehensive commodity strategy and effective approach to access will require: inclusion of the necessary commodities in the NEML; approval from the NMRA (i.e. market authorization or registration); development of mechanisms for forecasting, procurement, distribution and guidance on prescribing and dispensing; and a plan for post-marketing surveillance.

1.4.5 Monitoring and evaluation of quality abortion care

Effective monitoring and evaluation (M&E) are essential for measuring abortion quality and trends, as a basis for policy dialogue and evidence-based decision-making to further improve service delivery and quality. To support national scale M&E of the quality of abortion care, WHO is developing a quality abortion care M&E framework based on WHO's *Monitoring and evaluation of health systems strengthening: an operational framework (115).* The structure, domains and indicator areas of the framework, categories for inequality disaggregation and standard data sources are presented in Table 1.2. A set of abortion care indicators is under development and will be published in the near future (see Annex 6 for a summary about the progress of this M&E work).

The quality abortion care M&E framework will support M&E at the levels of health system input, service delivery, population outcome and impact. M&E of abortion-related services remains weak in most national health systems. Specific gaps in data collection and use must be identified and addressed.

Health system input monitoring covers governance, health financing, health workforce, health commodities and health information. Within these five categories, quality abortion care health system inputs to track over time include among others:

- Governance: clarification of the legal status of abortion, adherence of induced abortion protocols in national guidelines to global normative guidance (see also section 1.3.1[vii]);
- Financing: inclusion of health financing arrangements for abortion-related care in leading health benefits packages (see section 1.4.2);
- Health workforce: inclusion of competency-based induced abortion care (in line with global normative guidance) in national curricula for relevant categories of health workers (see section 1.4.3);
- Health commodities: inclusion in national essential medicines lists (NEMLs) of mifepristone and misoprostol, monitoring of stock-outs of abortion service commodities at service-delivery points (see section 1.4.4);
- Health management information systems (HMIS): integration of indicators for quality abortion care into the national HMIS.

For this level of input monitoring, data are typically available from administrative sources, including national policy documents, health finance tracking systems, national curricula, logistics management information systems (LMIS) and HMIS.

Service-delivery monitoring tracks the availability of providers trained in and providing induced abortion care, availability of necessary medicines and products at service-delivery points, readiness of the system to provide abortion care to a defined minimum standard, and quality of service delivery, including person-centred care, assessed in part through user and community perspectives. National-level abortion service-delivery monitoring data should be included in health-care facility-level assessments, HMIS and population-based surveys.

Population outcome monitoring for abortion care assesses coverage including (i) access to quality, affordable abortion care, and (ii) population knowledge of access to quality, affordable abortion care. Efforts should be made to disaggregate data by dimensions of inequality, such as ability, age, caste, education, ethnicity, gender, geography and wealth. Population outcome data sources typically include health-care facility-level assessments and population-based surveys and can include HMIS and education management information systems. In many settings, abortion-related population outcome data is a neglected area of data collection and reporting.

Impact measurement for quality abortion care includes abortion-related mortality and morbidity. Estimates in these areas should be disaggregated by dimensions of inequality as much as possible. Data sources include population-based surveys, HMIS and civil registration and vital statistics (CRVS) registries.

Where gaps in data availability are identified, investment should be made to address these. In the short term, statistical modelling may be required to estimate indicator values, particularly at the impact level.

Table 1.2 Monitoring and evaluation of the quality of abortion care

Categories	Indicator areas	Inequality disaggregation	Data sources
Health system input	Governance	Geography: intranational, international	Administrative sources (including national policy documents, health finance tracking systems, national curricula, LMIS and HMIS)
	Health financing		
	Health workforce		
	Health commodities		
	Health information		
Service delivery	Availability of services	Geography: intranational, international	Health-care facility assessment (including patient interviews), population-based survey, HMIS
	Readiness for service delivery		
	Quality of services		
Population outcome	Access to quality, affordable abortion care	Ability, age, caste, education, ethnicity, gender, geography, wealth	Health-care facility assessment, population-based survey, HMIS, education management information systems
	Population knowledge of access to quality, affordable abortion care		
Impact	Abortion-related mortality	Ability, age, caste, education, ethnicity, gender, geography, wealth	CRVS, HMIS, population-based survey
	Abortion-related morbidity		

CRVS: civil registration and vital statistics; HMIS: health management information system; LMIS: logistics management information system

Chapter 2.

Abortion regulation including relevant recommendations

As outlined in Chapter 1, section 1.3, one element of an enabling environment is that law and policy promote and protect sexual and reproductive health and rights (SRHR). A number of common approaches to law and policy on abortion mentioned in Chapter 1 (section 1.3.1) pose barriers to access to abortion, are inconsistent with international human rights legal instruments, and can have negative effects on the exercise of human rights. This chapter reflects evidence on the impacts of these law and policy approaches, considers their human rights implications, and presents evidence-based recommendations to improve law and policy relating to abortion as part of an enabling environment for universal access to quality abortion care. Box 2.1 summarizes the principles of abortion law and policy that would be consistent with key principles of human rights law.

BOX 2.1: Abortion law and policy that are consistent with key principles of human rights law

States must respect, protect and fulfil abortion seekers' rights, including their sexual and reproductive health and rights (SRHR).

States should take positive steps to secure an enabling regulatory and policy environment that will ensure the universal availability, accessibility, acceptability and quality (AAAQ) of abortion and post-abortion care.

Abortion should be fully decriminalized. Regulatory, policy and programmatic barriers – as well as barriers in practice – that hinder access to and timely provision of quality abortion care should be removed. These include grounds-based approaches, gestational age limits, mandatory waiting periods, third-party authorization requirements and provider restrictions. States should also protect access to and continuity of abortion care against barriers created by conscientious objection (refer to Recommendations 1,2,3,6,7,21 and 22 in this guidance).

The regulation of abortion should have the objective of respecting, protecting and fulfilling the SRHR of women; achieving positive health outcomes for women; providing good-quality contraceptive information and services; and meeting the particular needs of marginalized persons, including women facing financial hardship, adolescents, women with disabilities, survivors of sexual and gender-based violence, transgender and non-binary persons, women from ethnic, religious and racial minorities, migrant and displaced women, and women living with HIV, among others. The regulation of abortion should be grounded on and should promote equality and non-discrimination.

Source: Refer to Box 1.2 for references.

2.1 Common approaches to abortion regulation

Almost all countries where abortion is lawfully available regulate abortion differently to other forms of health care *(116)*. Unlike other essential health services, abortion is commonly regulated to varying degrees through the criminal law in addition to regulation under health-care law. Even where abortion is available on certain grounds or until specified gestational ages (often linked to particular grounds), it is usually designated in those cases as a criminal offence if it occurs outside of those specific permitted situations. As a result, people can experience significant barriers in accessing abortion and post-abortion care in such contexts. These barriers persist even though abortion is a safe, effective and non-complex part of sexual and reproductive health (SRH) care, in spite of significant advancements in international human rights law, and notwithstanding the growing frequency with which self-management of abortion occurs safely with little or no contact with the formal health system.

Typical barriers to access to quality abortion care, which may or may not be codified in law, include lack of access to accurate information, the provision of biased information or counselling, the imposition of mandatory waiting periods, third-party authorization requirements, restrictions on the type of facilities or settings where abortion services can lawfully be provided, restrictions on the type of health workers that can lawfully provide services, lack of affordable services, breaches of confidentiality and privacy, failure to safeguard access to and continuity of care where health workers refuse care on the basis of conscientious objection, failure to license or make available essential medicines, and failure to recognize women as individuals who can manage their own abortions.

Restrictive laws, policies and practices often have the effect of making health workers, health-care facilities, committees, ethics boards, police, courts or others the "gatekeepers" for access to quality abortion care by requiring them to determine whether someone "qualifies" for legal abortion. In many cases, this introduces delay in accessing abortion. Such gatekeepers are not always sufficiently informed about the law or willing to interpret and apply law and policy in a way that respects, protects and fulfils abortion seekers' rights. Criminalization of abortion can also have a "chilling effect" more broadly, as it can result in narrow interpretation of applicable law by health workers, including to avoid possible criminal liability (i.e. suppression of actions due to fear of reprisals or penalties). As a consequence, in many settings women's experiences of seeking, accessing and managing abortion are highly variable, with much depending not only on the law but also on the approach of the gatekeeper with whom they interact. Thus, including information on relevant rights, laws and policies in the training and education of health workers is a crucial part of ensuring an enabling environment for quality abortion care (see also Chapter 1, section 1.4.3).

As described above, clear, accessible and rights-based laws and policies are part of an enabling environment for abortion care (see section 1.3). However, in some countries the law on abortion is incoherent, with seemingly conflicting provisions articulated in constitutions, penal codes, health legislation or policy guidance *(117)*. Furthermore, in some cases domestic laws are inconsistent with international human rights standards and incompatible with current public health evidence. Additionally, in certain cases there is a lack of guidance from government to assist providers in identifying when abortion is lawful. Such incoherence can create uncertainty about the law for both those seeking and providing abortion care. The recommendations in this guideline build on human rights law and public health evidence to outline an approach under which abortion is regulated similarly to other health-care interventions, that is, by general health-care law and policy, best practice, training and evidence-based guidelines.

2.2 Recommendations relating to regulation of abortion

Three recommendations relating specifically to the regulation of abortion are presented in this section (Recommendations 1–3) and four additional recommendations, also relating to law and policy and abortion, are presented in Chapter 3, section 3.3: Pre-abortion (Recommendations 6,7,21 and 22). These seven recommendations were formulated by the expert panels formed for the development of this guideline, including expert human rights advisers (all contributors are listed in Annex 1 and the roles of the contributing groups are described in Annex 4).[8] The evidence was first systematically reviewed for each prioritized topic and question, and

8 The expert panels included the Evidence and Recommendations Review Groups (ERRGs) for each of the three domains (Law and policy, Clinical services and Service delivery) and later the Guideline Development Group (GDG), and each phase and each meeting of these groups also involved at least one human rights adviser. For further details on the roles of these groups and the full methodology for the guideline development process, see Annex 4: Methods.

the level of certainty of that evidence was assessed (i.e. based on the quality of the evidence, including the types and sizes of studies conducted and their various limitations).

The direction (in favour or against) and strength of each recommendation was determined by the panel of experts 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, non-discrimination and equality; societal implications; financial and economic considerations; feasibility and health system considerations – while also taking into account the meta-criterion: quality of evidence *(118)*.

Recommendations in favour of an intervention are qualified as either strong or weak (with the conditions of use specified for the latter), with the third alternative being a recommendation against the intervention. To clearly indicate the strength and direction of each recommendation, the following wording is used:

- **Recommend** – a strong recommendation in favour of the intervention
- **Suggest** – a weak recommendation in favour of the intervention (requiring additional wording to qualify the recommendation, specifying the conditions of use)
- **Recommend against** – a strong recommendation against the intervention/in favour of the comparison.

For each topic covered, both in this chapter and also in Chapter 3, first brief background information is presented, then the recommendation itself, followed next by a list of remarks (if any) from the expert panel that reviewed the evidence in detail, explaining the conditions and context relevant to the recommendation, and then the rationale, or summary of the evidence base and decision-making process for the recommendation, and finally a box listing any key human rights considerations relevant to the recommendation or broader topic. 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 into seven separate recommendations using GRADE methodology, but they are not considered to be "new" (i.e. Recommendations 1,2,3,6,7,21,22). The methods are described in full in Annex 4, including the differences in the methods applied for the seven recommendations relating to law and policy issues compared with the other types of recommendations. A summary table linking the topics covered, the research questions, the systematic reviews conducted and the recommendation numbers is provided in Annex 7. The full Evidence-to-Decision (EtD) frameworks are provided online as supplementary material and hyperlinked cross-references to these are supplied with the rationale for new and updated recommendation presented.[9]

9 Supplementary material 1: EtD frameworks for law and policy topics, available at: https://www.who.int/publications/i/item/9789240039483.

2.2.1 Criminalization of abortion

Unlike other health services, abortion is commonly regulated to varying degrees through the criminal law (i.e. criminalized), in addition to regulation under health-care law.

Abortion remains a criminal offence in most countries, with penalties against those who have abortions and/or those who provide abortion services or assist with accessing or managing abortion, sometimes including those who provide information about abortion. In some countries, all of these actions are criminal offences.

Decriminalization is a necessary step for the legalization of abortion, but ensuring that abortion is available, accessible and of high quality may require further legal or regulatory changes beyond decriminalization, including, as applicable, implementing the other recommendations contained in this guideline.

LAW & POLICY Recommendation 1: Criminalization

Recommend the full decriminalization of abortion.

Remarks:

- Decriminalization means removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.
- Decriminalization would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care.
- Decriminalization of abortion does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute serious assault as these are non-consensual interventions.

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion* guidance provided a composite recommendation related to law and policy *(19)*; in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

Rationale

Numerous human rights bodies and mandate holders, including the CEDAW Committee *(38)*, the CESCR *(3)*, the United Nations Human Rights Committee *(36)*, and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health *(37)*, support the full decriminalization of abortion. They have clarified that States should not criminalize medical procedures needed only by women, including abortion nor criminalize those who have undergone an abortion, or punish or apply criminal sanctions against those who assist women in having abortions. Under international human rights law, States must not require health workers to report cases of women or girls who have had abortions, or whom they suspect of having had abortions, and States must provide post-abortion care in all circumstances and without the risk of criminal sanction. In addition, States must take steps, including revising laws, to reduce maternal morbidity and mortality (including abortion-related morbidity and mortality), and to effectively protect women and girls from the physical and mental risks associated with resorting to unsafe abortion due to the criminalization of abortion (see also Chapter 1, section 1.3.1 on human rights, and Web annex A: Key international human rights standards on abortion, which provides further information as well as references for the above assertions).

In order to identify the impacts of criminalization of abortion on abortion seekers and health workers, a systematic review of studies published between 2010 and 2019 was undertaken, identifying 22 studies conducted in Australia, Brazil, Chile, El Salvador, Ethiopia, Ireland, Mexico, Northern Ireland (United Kingdom), the Philippines, Rwanda, Senegal, the United Republic of Tanzania, Uruguay and Zambia. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Criminalization. The evidence from these studies demonstrated that criminalization delayed access to abortion, including in some cases causing providers to wait until a woman's life was in danger so that abortion could be provided within the legal exceptions to criminal prohibitions. Furthermore, criminalization imposes a range of burdens on women including unnecessary travel and cost, delayed or no access to post-abortion care, distress and stigma. The evidence indicated that criminalization did not impact the decision to have an abortion, prevent women having abortions, or prevent women from seeking information on and referral to services abroad where they can access abortion. Instead, criminalization limits

access to safe and legal abortion, and increases recourse to unlawful and unsafe abortion. When prosecutions take place they may be disproportionately pursued against young, unmarried women and those facing financial hardship and with less access to education. Some countries require health workers to report women and girls when they seek abortion or post-abortion care.

Criminalization can cause health workers to act cautiously, fearing criminal prosecution. As a result, they may be hesitant to provide abortion care even in cases of rape, incest and fatal fetal impairment, when denial of abortion could constitute torture, cruel and inhuman treatment or punishment.

Criminalization contributes to the lower availability of trained abortion providers and a loss of relevant skills in the health workforce. This can have negative effects on health workers who do provide abortion, and can increase bureaucracy within health systems.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO CRIMINALIZATION OF ABORTION

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health (SRH) services.
- Seeking, having, assisting with, or providing abortion to which the pregnant person has provided free and informed consent should never be criminalized.
- States must not require health workers to report cases of women or girls who have had abortions, or whom they suspect of having had abortions.
- Post-abortion care must always be available without the risk of criminal sanction.
- Seeking or providing accurate, evidence-based and non-biased information on abortion must never be criminalized.
- States must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with resorting to unsafe abortion.
- Everyone has a right to non-discrimination and equality in accessing SRH services.
- SRH services must be provided in a way that ensures privacy and confidentiality.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

2.2.2 Grounds-based approaches to controlling access to abortion

National laws in most countries permit some abortions, even in settings where abortion is criminalized. Usually abortions will still be permitted under prescribed "grounds", or specific circumstances. The circumstances under which abortion is permitted vary widely across different countries. Some of these circumstances reflect clinical indications (e.g. risk to the health of the pregnant woman or fetal impairment), some relate to the circumstances of conception (e.g. rape), and some relate to socioeconomic circumstances (e.g. economic hardship). Grounds-based approaches are commonly accompanied by gestational age limits, often varying depending on the specific condition under which abortion is permitted. In some countries, abortion is available on request up to a specified gestational age and then limited to specific grounds thereafter.

LAW & POLICY Recommendation 2: Grounds-based approaches

a. Recommend against laws and other regulations that restrict abortion by grounds.

b. Recommend that abortion be available on the request of the woman, girl or other pregnant person.

Remarks:

- Grounds-based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person.
- Until they are replaced with abortion on request, any existing grounds should be formulated and applied in a manner consistent with international human rights law. This means that the content, interpretation and application of grounds-based law and policy should be revised to ensure human rights compliance. This requires that:
  - i. existing grounds are defined, interpreted and applied in a human rights-compliant way;
  - ii. abortion is available when carrying a pregnancy to term would cause the woman, girl or other pregnant person substantial pain or suffering, including but not limited to situations where the pregnancy is the result of rape or incest or the pregnancy is not viable;
  - iii. abortion is available where the life and health of the woman, girl or other pregnant person is at risk;
  - iv. health grounds reflect WHO's definitions of health and mental health (see Glossary); and
  - v. there are no procedural requirements to "prove" or "establish" satisfaction of grounds, such as requiring judicial orders or police reports in cases of rape or sexual assault (for sources to support this information, refer to Web annex A: Key international human rights standards on abortion).

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion* guidance provided a composite recommendation related to law and policy *(19)*; in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

Rationale

International human rights law requires that abortion be available where carrying a pregnancy to term would cause a woman substantial pain or suffering, or where her life or health is at risk. States may not regulate abortion in a manner that forces women to resort to unsafe abortion and must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with unsafe abortion (for further information, please refer to Chapter 1, section 1.3.1[i] and Web annex A: Key international human rights standards on abortion). Grounds-based approaches are often (i) too narrowly defined or (ii) too conservatively applied to ensure abortion is available in these circumstances. The aim to reduce maternal morbidity and mortality, and protect women and girls from the risks associated with unsafe abortion, can be effectively achieved by making abortion available on the request of the pregnant woman or girl.

In order to identify the impacts of grounds-based approaches on abortion seekers and health workers, a systematic review of studies published between 2010 and 2021 was undertaken, identifying 21 studies conducted in Argentina, Australia, Brazil, Chile, Colombia, Ethiopia, Ghana, the Islamic Republic of Iran, Ireland, Israel, Mexico, Rwanda, Thailand, the United Republic of Tanzania, the United Kingdom of Great Britain and Northern Ireland, Uruguay and Zambia. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Grounds-based approaches. The reviewed evidence showed that grounds-based laws contributed to delayed abortion, with delays occurring because of inconsistencies in interpretation or application of health grounds, women waiting for determination of their eligibility for abortion or having their claim that pregnancy resulted from rape

questioned or disbelieved, overly restrictive interpretation of grounds, or disagreement within a medical team about whether a woman satisfies a legal ground. Misinterpretation of the law can also result in denial of abortion. In some cases, health workers waited for a health condition to deteriorate sufficiently to ensure that a woman satisfied a "risk to life" ground, clearly endangering the right to life and potentially violating the right to be free from torture, cruel, inhuman and degrading treatment.

Interpretation of grounds, and thus eligibility for lawful abortion, varies between providers, and providers are not always certain about the law or how it should be applied; interpretation is often narrow and incompatible with human rights law and/or with WHO's definitions of health and mental health, leading to denial of abortion. Women reported significant challenges in accessing care in circumstances where they could not obtain legal support and advice on the permitted grounds. Grounds-based approaches were found to have a particularly negative impact on women facing financial hardship and women with lower educational attainment.

The evidence reviewed for this guidance showed that grounds-based approaches have a disproportionate negative impact on women who seek abortion following rape. These women were often subjected to questioning, protracted delay and bureaucratic processes due to requirements such as reporting the crime to the police or need for a court order, even though it is not human rights compliant to make such reporting or processes a prerequisite for accessing abortion. Even where the law provides that a woman's claim of rape is sufficient to satisfy the legal requirement, providers may require a document or authorization (e.g. court order or police report). In reality this means that obtaining an abortion following rape is laborious and time-consuming. In some cases, delays are so long that women give birth before legal eligibility is determined; in others, women choose instead to resort to unsafe abortion. Thus, "rape grounds" do not satisfy the requirement from international human rights law that abortion be available and accessible in situations of rape. These restrictions also subject the individual to unnecessary trauma, may put them at increased risk from the perpetrator, and may cause women to resort to unsafe abortion.

The evidence also showed that grounds-based approaches that require fetal impairments to be fatal for abortion to be lawful frustrate providers who wish to support patients and leave women no choice but to continue with pregnancy. Being required to continue with a pregnancy that causes significant distress violates numerous human rights. States are obligated to revise these laws to make them compatible with international human rights law.

Under international human rights law, States are required to ensure that women do not have to resort to unsafe abortion. The evidence from the studies described above suggests that grounds-based laws may contribute to an increase in the incidence of unsafe abortion, with people who do not satisfy a ground resorting to unlawful abortion, including unlawful self-management of abortion, some of which may be unsafe. The evidence from the studies also indirectly suggests that grounds-based laws contribute to maternal mortality, because when States shift from a grounds-based approach to permitting abortion on request in the first trimester there is a reduction in maternal mortality (especially for adolescents) as well as a reduction in fertility (birth rates). This suggests a connection between the international obligation to take steps to reduce maternal mortality and morbidity and a shift away from grounds-based approaches.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO GROUNDS-BASED APPROACHES

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health (SRH) services.
- Abortion must be available where carrying a pregnancy to full term would cause a woman substantial pain or suffering, where pregnancy is a result of rape or incest, or where her life or health is at risk.
- States may not regulate abortion in a manner that forces women to resort to unsafe abortion.
- States must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with resorting to unsafe abortion.
- Everyone has a right to non-discrimination and equality in accessing SRH services.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

2.2.3 Gestational age limits

Gestational age limits are commonly specified in both liberal and restrictive abortion laws and policies. Imposed through formal law, institutional policy or personal practice by individual health workers, these limits restrict when lawful abortion may be accessed by reference to the gestational age of a pregnancy. In many countries gestational age limits are linked to grounds-based approaches, with gestational age limits varying according to the grounds or circumstances under which abortion is permitted. While methods of abortion may vary by gestational age (see Chapter 3, section 3.4), pregnancy can safely be ended regardless of gestational age. Gestational age limits are not evidence-based; they restrict when lawful abortion may be provided by any method.

International human rights law requires that quality of care be central to the provision and regulation of SRH, and thus that regulation of abortion is evidence-based, scientifically and medically appropriate, and up to date *(3, para. 21)*. Under international human rights law, States may not regulate pregnancy or abortion in a manner that is contrary to their duty to ensure that women and girls do not have to resort to unsafe abortion, and are required to revise their laws accordingly (see Web annex A: Key international human rights standards on abortion).

LAW & POLICY Recommendation 3: Gestational age limits

Recommend against laws and other regulations that prohibit abortion based on gestational age limits.

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion* guidance provided a composite recommendation related to law and policy *(19)*; in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

Rationale

In order to identify the impacts of gestational age limits on abortion seekers and health workers, a systematic review of studies published between 2010 and 2020 was undertaken, identifying 21 studies conducted in Australia, Belgium, Mexico, Nepal, South Africa, the United Kingdom and the United States of America (USA). A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Gestational age limits. The reviewed evidence demonstrated that – alone or in combination with other regulatory requirements, including grounds-based approaches – gestational age limits delayed access to abortion, especially among women seeking abortions at later gestational ages, women close to the gestational age limit and those living in areas with limited access to clinics. Gestational age limits have been found to be associated with increased rates of maternal mortality and poor health outcomes. International human rights law requires States to reform law in order to prevent unsafe abortion and reduce maternal mortality and morbidity.

The studies also showed that where women requested an abortion and were denied care due to gestational age this could result in the unwanted continuation of pregnancy, especially among women with cognitive impairments or those who presented at 20 weeks' gestation or later. This outcome can be viewed as incompatible with the requirement in international human rights law to make abortion available when carrying a pregnancy to term would cause the woman substantial pain or suffering, regardless of pregnancy viability.

The evidence from these studies showed that women with cognitive impairments, adolescents, younger women, women living further from clinics, women who need to travel for abortion, women with lower educational attainment, women facing financial hardship and unemployed women were disproportionately impacted by gestational age limits. This points to the disproportionate impact of gestational age limits on certain groups of women, with implications for States' obligation to ensure non-discrimination and equality in provision of SRH services.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO GESTATIONAL AGE LIMITS

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health (SRH) services.
- States may not regulate abortion in a manner that forces women to resort to unsafe abortion.
- States must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with resorting to unsafe abortion.
- Everyone has a right to non-discrimination and equality in accessing SRH services.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Chapter 3.
Recommendations and best practice statements across the continuum of abortion care

3.1 Background

As a standard approach to human rights-based health care, all norms, standards and clinical practice related to abortion should promote and protect:

- individuals' health and human rights
- informed and voluntary decision-making
- autonomy in decision-making
- non-discrimination (including intersectional discrimination) and equality
- confidentiality and privacy
- adequate referral mechanisms
- the continuum of care.

New and updated recommendations presented in this guideline were formulated by the expert panels formed for the development of this guideline, including expert human rights advisers (all contributors are listed in Annex 1, and the roles of the groups of contributors are described in Annex 4).[10] The evidence was first systematically reviewed for each prioritized topic and question, using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology *(24, 119),* and the level of certainty of that evidence was assessed (i.e. based on the quality of the evidence, including the types and sizes of studies conducted and their various limitations).

The direction (in favour or against) and strength of each recommendation was determined by the panel of experts 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, non-discrimination and equality; societal implications; financial and economic considerations; and feasibility and health system considerations – while also taking into account the meta-criterion: quality of evidence *(118)*. The methods are described in full in Annex 4, including the differences in the methods applied for the recommendations relating to law and policy issues (Recommendations 1,2,3,6,7,21,22) compared with the other types of recommendations. The full Evidence-to-Decision (EtD) frameworks are provided online as supplementary materials, and hyperlinked cross-references to these are supplied with the rationale for each new and updated recommendation presented.[11]

10 The expert panels included the Evidence and Recommendations Review Groups (ERRGs) for each of the three domains (Law and policy, Clinical services and Service delivery) and later the Guideline Development Group (GDG), and each phase and each meeting of these groups also involved at least one human rights adviser. For further details of the roles of these groups and the full methodology for the guideline development process, see Annex 4: Methods.

11 EtD frameworks for this guideline can be accessed online: Supplementary material 1: EtD frameworks for law and policy topics https://www.who.int/publications/i/item/9789240039483; Supplementary material 2: EtD frameworks for clinical service topics https://www.who.int/publications/i/item/9789240039483; Supplementary material 3: EtD frameworks for service delivery topics https://www.who.int/publications/i/item/9789240039483.

Recommendations in favour of an intervention are qualified as either strong or weak (with the conditions of use specified for the latter), with the third alternative being a recommendation against the intervention. To clearly indicate the strength and direction of each recommendation, the following wording is used:

- **Recommend** – a strong recommendation in favour of the intervention
- **Suggest** – a weak recommendation in favour of the intervention (requiring additional wording to qualify the recommendation, specifying the conditions of use)
- **Recommend against** – a strong recommendation against the intervention/in favour of the comparison.

New and updated recommendations resulted from the review of the PICO questions (i.e. population, intervention, comparator, outcomes) that had been identified during the scoping meetings for this guideline. While 10 recommendations in this guideline are completely "new" (as labelled in the Executive summary table and in this chapter), updated recommendations are those that had been published in prior WHO guidance but had undergone an updated process of scoping, search and review of relevant evidence, application of the GRADE methodology and reconsideration of the WHO-INTEGRATE criteria for the purposes of this guideline, which may or may not have resulted in any substantive change to the strength, direction or substance of the recommendation *(19, 23, 120)*. Finally, there are some existing recommendations that are carried forward unchanged from previous WHO guidance;[12] in these cases, the topic had not been scoped prior to the development of this guideline and thus no new search or review was conducted or, in some cases, an updated literature search *was* conducted to review the current evidence base but did not lead to any change in the existing recommendation. 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 into seven separate recommendations using GRADE methodology, but they are not considered to be "new" (i.e. Recommendations 1,2,3,6,7,21,22). A summary table linking the topics covered, the research/PICO questions, the systematic reviews conducted and the recommendation numbers is provided in Annex 7.

3.1.1 Structure of information in this chapter

The information and recommendations in this chapter are presented in sections that reflect the continuum of abortion care and modes of service delivery: (i) services applicable across the continuum of care, (ii) pre-abortion, (iii) abortion, (iv) post-abortion, (v) service-delivery options and self-management approaches. In each section, the following aspects are covered as appropriate: "what" (specific clinical interventions), "who" (which type of health worker can provide the intervention, or self-management), "where" (facility-based versus off-site/remote service-delivery models/no requirement for on-site versus off-site location), and "how" (service-delivery models, implementation considerations). It should be noted that four recommendations relating to law and policy considerations are presented in the pre-abortion section (section 3.3), while three were presented in Chapter 2, section 2.2.

For each topic covered in this chapter, brief background information is first supplied, followed by the recommendation boxes or tables, providing information on the "what" and the "who" for the intervention in question. Each recommendation is immediately followed by a list of related remarks (if any) from the expert panel that reviewed the evidence in detail, explaining the conditions and context in which the recommendation applies. When appropriate, there is also a section indicating where the intervention can be carried out – in particular whether the intervention must be undertaken at a particular level of health-care facility, or whether there is no such requirement and an "off-site" location (e.g. at home, or other location) would be appropriate if preferred by the individual or if that is the only option available (the "where" is often closely tied to the "who", e.g. tasks provided by pharmacists would be provided in a pharmacy). The remarks for existing unchanged recommendations are repeated from the original cited guidance where still relevant, including revisions as appropriate, based on the results of any relevant updated evidence reviews conducted.

12 Existing recommendations are presented exactly as in previous guidance or with wording updated to use the wording "recommend/recommend against" for strong recommendations and "suggest" for weak recommendations (previously termed "conditional" recommendations), and reference is provided to the original guidance for further details.

For each of the new/updated recommendations, additional information is presented in the following order after the box presenting the recommendation(s) and remarks:

i. Rationale: This includes a brief summary of the type and extent of the evidence included in the review(s) that form the evidence base, and an explanation of the rationale for the direction (for or against) and strength of the recommendation (strong or weak), with reference to the key judgements on effects of the intervention (benefits and risks), the level of certainty of the evidence and any relevant information on the other criteria of the WHO-INTEGRATE framework. Any additional evidence of potential harms or unintended consequences is highlighted. Such considerations may have been derived from studies and additional evidence that may not directly address the PICO question but provide pertinent information in the absence of direct evidence. This may be extracted from single studies, systematic reviews or other relevant sources.

ii. Implementation considerations: Points to bear in mind regarding implementation, including those relating to "how".

Finally, in each topic section, a box is presented listing any key human rights considerations relevant to the recommendation or broader topic, as well as a box providing cross-references and hyperlinks to related topics within this guideline.

Full details for all related PICO questions can be found in Annexes 8, 9 and 10, and the summaries of the evidence (i.e. from the systematic reviews; listed in Annex 7) and the EtD frameworks relevant to each new or updated recommendation are made available online as supplementary material.

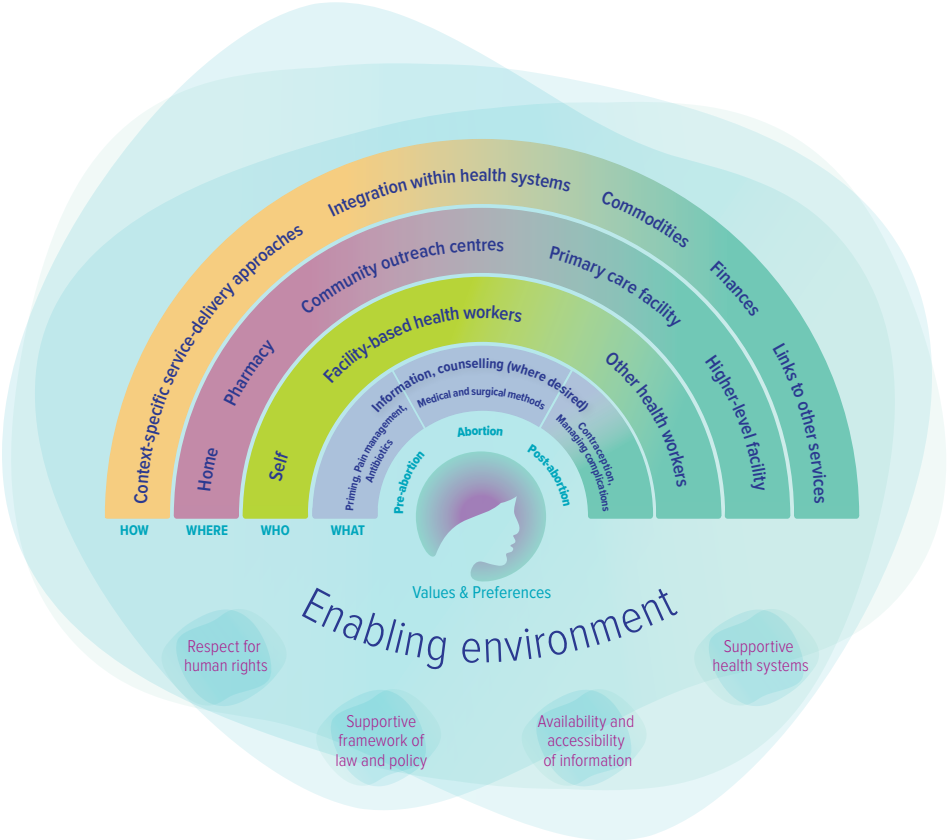
3.1.2 Underlying principles and assumptions relating to recommendations on health worker roles

Health workers are all people engaged in actions whose primary intent is to enhance health *(100)*. This includes all categories of health workers listed and described in Annex 5, from community health workers all the way through to specialist medical practitioners (e.g. obstetricians and gynaecologists), and including traditional and complementary medicine professionals (i.e. non-allopathic physicians). Abortions can be done safely using tablets (medical abortion) or a simple outpatient procedure, such that most no longer require a specialist or even a general practice doctor. The recommendations presented in this guideline provide guidance on how to involve a wider range of health workers and pregnant individuals themselves in the provision or self-management of abortion care, to encourage optimization of the available health workforce, address health system shortages of specialized health-care professionals, reduce costs and improve affordability, improve equity and equality in access to health care and increase the acceptability of health services for those who need them.

The following principles and assumptions apply to all health workers:

- The recommendations are appropriate for and intended for all resource settings, i.e. high-, middle- and low-resource settings.
- The recommendations refer to a range of types of health workers who can safely, effectively and satisfactorily perform some or all of the specific abortion-related tasks mentioned. The options for who can perform the same task are intended to be inclusive and do not imply either a preference for or an exclusion of any particular type of health worker. The choice of health worker for a specific task will depend upon the needs, preferences and conditions of the individual, and the local context.
- Training of health workers must ensure that they have the competencies to provide good-quality, gender-sensitive care in accordance with national standards and guidelines and human rights. Ensuring quality abortion care requires ongoing supervision, quality assurance, monitoring and evaluation, as well as access to the necessary equipment and commodities.
- It is assumed that any health worker discussed in this guideline has the basic training required of that type of health worker (and in the case of individuals acting as their own provider – i.e. self-management – that they have the appropriate information and understanding). In addition, the recommendations all assume that health workers who are in a category that is recommended or suggested to perform specific tasks will have received the appropriate task-specific training and information prior to performing that task.

3.2 Services applicable across the continuum of care



This section covers information, counselling and linkage to additional care or services, any or all of which may be needed or desired before, during and/or after the abortion procedure or process.

The provision of scientifically accurate and easy-to-understand information to all women undergoing an abortion, and non-directive voluntary counselling to anyone who requests it, is a core element of good-quality, human rights-compliant abortion services (see Chapter 1, section 1.3.2). The provision of information and counselling (where desired), as well as access or referrals to other related services, starts pre-abortion but should continue across the continuum of care. In addition, everyone should be provided with all the necessary information to make an informed decision regarding the use of contraception.

3.2.1 Providing information

Abortion-related information for individuals considering or seeking abortion or in the post-abortion period should include:

- the available options for abortion methods and pain management;
- information related to free and informed consent;
- what will occur before, during and after the abortion procedure or process, including any tests and/or pain relief that may be needed and any aspects of the care that could be self-managed if desired, with or without remote support;
- what the individual is likely to experience during and after the abortion procedure or process, and how long the procedure/process and the recovery are likely to take;

- when normal activities can be resumed, including sexual intercourse;
- how to recognize potential side-effects and symptoms of ongoing pregnancy (which may persist temporarily even when abortion has been successful, or which may indicate failure of the abortion), and other medical reasons to return for follow-up care, including complications such as prolonged heavy bleeding or fever; and
- when, where and how to access follow-up care or additional services that may be desired such as counselling (section 3.2.2), contraception (see section 3.5.4) and other services (section 3.2.3).

Who

SERVICE DELIVERY Recommendation 4: Provision of information on abortion care

Type of health worker	Recommendation	Rationale[a]
Community health workers (CHWs)	**Recommend**	Provision of health promotion interventions by CHWs is generally well accepted and feasible in many contexts where there is a strong CHW programme (moderate-certainty evidence). The potential to expand equitable access to information and quality abortion care by equipping CHWs to provide essential information on abortion is high.
Pharmacy workers	**Suggest** Condition: In contexts where the pharmacy worker is under the direct supervision of a pharmacist and there is access or referral to appropriate health services.	Insufficient direct evidence was found for the safety, effectiveness and acceptability of this option. However, in many contexts, pharmacy workers are often consulted by women seeking advice on how to deal with delayed menstruation (moderate-certainty evidence). Although the effectiveness of training interventions with pharmacy workers is uncertain, the potential benefits of equipping them to provide essential information outweighs the potential harms of them not providing information or providing incorrect information.
Pharmacists	**Recommend**	Pharmacists are qualified to provide information about the medicines they dispense. Evidence was found for the effectiveness of provision of education and counselling on chronic illnesses by pharmacists (low to moderate certainty). In many contexts, pharmacists are often consulted by women seeking advice on how to deal with delayed menstruation (moderate-certainty evidence).
Traditional and complementary medicine professionals **Auxiliary nurses/auxiliary nurse midwives (ANMs)** **Nurses** **Midwives** **Associate/advanced associate clinicians** **Generalist medical practitioners** **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to pharmacy workers was reviewed using GRADE methodology, since that was the only category of health worker that didn't already have a strong recommendation ("recommend") for this task. After review, no change was made to the existing weak recommendation ("suggest"). A summary of the evidence is presented in Supplementary material 3, EtD framework on Information provision by pharmacy workers.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

There is no requirement for location (on-site vs off-site), but privacy and confidentiality should be ensured during the provision of information, with particular attention needed to this requirement in the off-site (out-of-facility) settings, such as pharmacies and community-based sites, where infrastructure and procedures may make this more challenging.

How

Implementation considerations

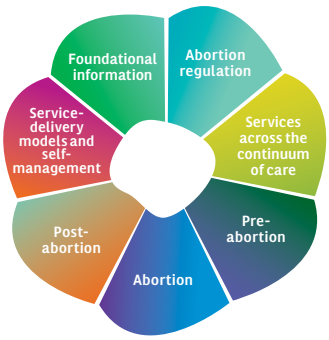
- Different modalities exist for the provision of information on abortion, e.g. remote access via hotlines and telemedicine, and through approaches such as harm reduction and community-based outreach (see section 3.6) as well as in-person interactions with health workers.
- Information should be accessible and understandable, including formats catering to low-literacy and differently abled populations.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO THE PROVISION OF INFORMATION

- Informed consent requires the provision of complete and accurate, evidence-based information.
- Accurate information on abortion must be available to individuals in a way that respects privacy and confidentiality.
- The right to refuse such information when offered must be respected.
- Abortion information should be available to all persons without the consent or authorization of a third party. This includes abortion information being available to adolescents without the consent or authorization of a parent, guardian or other authority.
- Information must be non-discriminatory and non-biased and presented in a respectful manner. It should not fuel stigma or discrimination.
- Dissemination of misinformation, withholding of information and censorship should be prohibited.
- Information should be acceptable to the person receiving it and of high quality; it should be presented in a way that can be understood and it must be accurate and evidence based.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations related to law and policy (Recommendations 1,2,3,6,7,21,22)

Informed consent (section 1.3.1: Human rights)

Availability and accessibility of information (section 1.3.2)

What

3.2.2 Offering and providing counselling

Some individuals may wish to receive counselling before or after an abortion. Counselling is more than information provision. It is a focused, interactive process through which a person voluntarily receives support, information and non-directive guidance from a trained person *(122)*, in an environment that is conducive to openly sharing thoughts, feelings, perceptions and personal experiences. In addition to the specific knowledge about abortion services and care required for both information provision and counselling, the latter also requires specialized counselling training. Counselling is a core element of provision of abortion and post-abortion care.

When offering and providing counselling, it is essential to apply the following guiding principles:

- ensure that the individual is requesting the counselling and make it clear that counselling is not required;
- ensure privacy and confidentiality;
- ask the individual what they want or need, what their concerns are, given them the time they need, and actively listen to their expressed needs and preferences;
- highlight relevant information during the counselling session (such as the information provided in section 3.2.1);
- communicate information respectfully and non-judgementally, and in a manner understandable to/tailored to the individual;
- support the individual and check to ensure they receive adequate responses to their questions and that they understand the information provided;
- present all suitable options tailored to individual's needs, while avoiding imposing one's personal values and beliefs onto them; and
- make it clear that the individual will need to decide what services to receive.

SERVICE DELIVERY Recommendation 5: Provision of counselling

Type of health worker	Recommendation	Rationale[a]
Community health workers (CHWs)	**Recommend**	Insufficient direct evidence was found for the safety, effectiveness or acceptability of this option, but indirect evidence did show that health promotion interventions by CHWs are generally well accepted, effective and feasible in many contexts, and that CHWs are often intermediaries between the health system and women seeking abortion-related care (moderate-certainty evidence). The expert panel affirmed the feasibility of this option and its ability to expand equitable access to quality abortion care.
Pharmacy workers	**Suggest** Condition: Balanced counselling is provided (i.e. about both medical and surgical methods) and there is access or referral to appropriate health services should the woman choose a surgical method.	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed the feasibility of this option and its ability to expand equitable access to quality abortion care.
Pharmacists	**Suggest** Condition: Balanced counselling is provided (i.e. about both medical and surgical methods) and there is access or referral to appropriate health services should the woman choose a surgical method.	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.a Pharmacists are qualified to provide information about the medicines they dispense. There is evidence for the effectiveness of provision of counselling on the management of chronic illnesses by pharmacists (low certainty evidence). In many contexts, pharmacists are often consulted by women seeking advice on how to deal with delayed menstruation (moderate-certainty evidence). Pharmacists have been recommended to provide medical abortion at < 12 weeks across all three subtasks (Recommendation 28). Therefore, the expert panel affirmed that it is feasible for pharmacists to provide balanced counselling on abortion, including surgical options.
Traditional and complementary medicine professionals	**Recommend**	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a]
Auxiliary nurses/ANMs **Nurses**	**Recommend**	Counselling is a core competency for these health workers [a] and this task is within their typical scope of practice.[b]
Midwives	**Recommend**	Counselling is a core competency for midwives [a] and this task is within their typical scope of practice.[b]
Associate/advanced associate clinicians	**Recommend**	Counselling is a core competency for these clinicians [a] and this task is within their typical scope of practice.[b]
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to traditional and complementary medicine professionals, pharmacists, pharmacy workers and community health workers was reviewed using GRADE methodology, since the other health workers already had a strong recommendation for this task. After review, the recommendations were upgraded for all four of those health worker categories, from "recommend against" to "suggest" for pharmacists and pharmacy workers, and from "suggest" to "recommend" for traditional and complementary medicine professionals and CHWs. A summary of the evidence is presented in Supplementary material 3, EtD framework on Pre- and post-abortion counselling.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

There is no requirement for location (on-site vs off-site), but privacy and confidentiality should be ensured during counselling, with particular attention needed to this requirement in the off-site (out-of-facility) settings, such as the pharmacies and community-based sites, where infrastructure and procedures may make this more challenging.

How

Implementation considerations

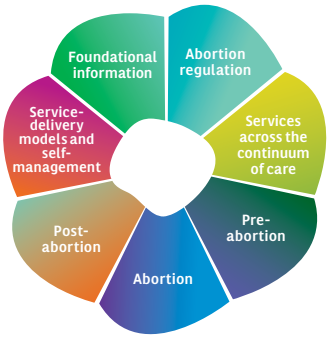
- Counselling can be provided to those seeking abortion services but also jointly to their partners, family members or other individuals, should the woman wish them to be present.
- While counselling should be made available and accessible, it should always be voluntary for women to choose whether or not they want to receive it.
- Counselling should be person-centred and may need to be tailored according to the needs of the individual; young people, survivors of sexual and gender-based violence or members of marginalized groups may have different information or counselling requirements.
- The content of and approach to counselling will need to be adjusted depending on the reason for seeking abortion services (e.g. induced abortion, intrauterine fetal demise [IUFD], fetal anomaly). Therefore, it is important for the counsellor to be aware of and sensitive to the individual's situation and needs.
- Different service-delivery models exist for pre- and post-abortion counselling, e.g. remote access via hotlines and telemedicine and through approaches such as harm reduction counselling and community-based outreach.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO COUNSELLING

- Counselling must be entered into freely and voluntarily, i.e. it should not be mandatory. The right to refuse counselling when offered must be respected.
- Where provided, counselling must be available to individuals in a way that respects privacy and confidentiality.
- Counselling must be acceptable and of good quality, i.e. it must be provided in a way that can be understood by the recipient and it must be accurate and evidence based.
- Counselling must be non-discriminatory and non-biased.
- Dissemination of misinformation, withholding of information, and censorship should be prohibited.
- Counselling should be available to all persons without the consent or authorization of a third party. This includes counselling being available to adolescents without the consent or authorization of a parent, guardian or other authority.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations related to law and policy (Recommendations 1,2,3,6,7,21,22)

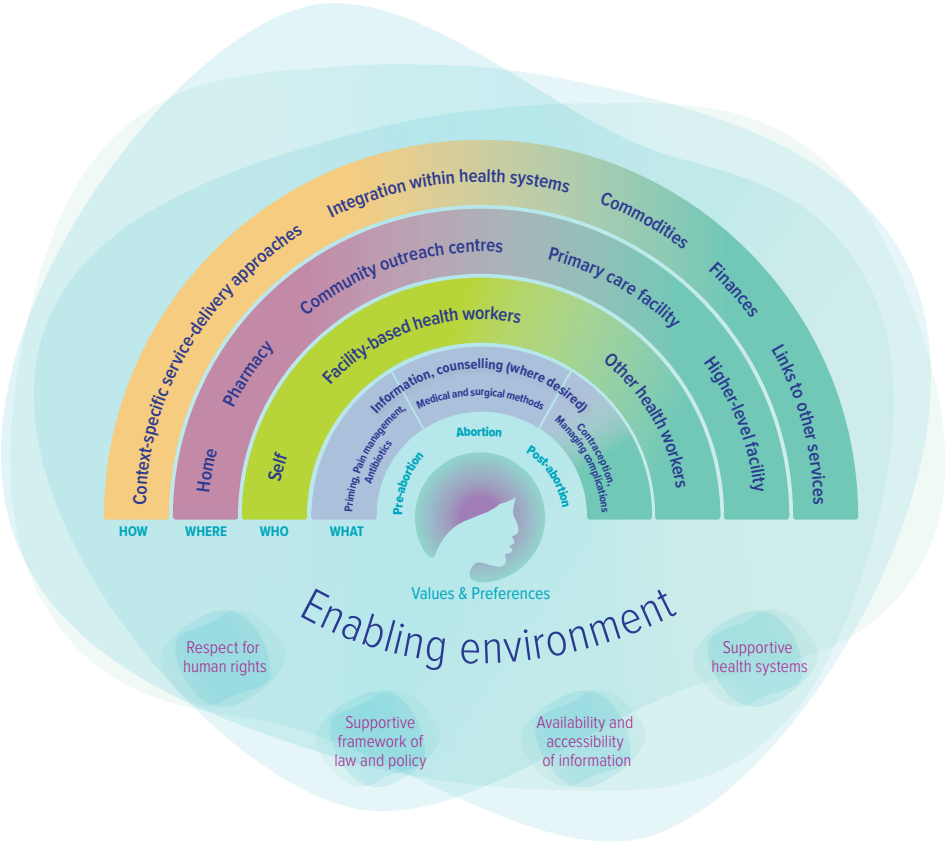
Information provision (section 3.2.1)

Recommendations 41, 42 and 43 on post-abortion contraception

3.2.3 Links to additional services

Individuals seeking abortion may require additional services *(122)*. As needed, provide management or referral to other service providers for other health conditions or urgent needs. This includes facilitating linkages (access or referrals) to counselling and testing for sexually transmitted infections including HIV, contraception where desired, and support services for survivors of gender-based violence.

3.3 Pre-abortion



This section includes information and recommendations first on the issues of mandatory waiting periods and third-party authorization, followed by recommendations on Rh isoimmunization, antibiotic prophylaxis, determination of gestational age of pregnancy, pain management, and cervical priming prior to surgical abortion, and finally also recommendations on the issues of restrictions on health workers who can provide abortions and conscientious objection.

3.3.1 Mandatory waiting periods imposed by States, health-care facilities or health workers

In a number of countries, health-care facilities or health workers require women to wait a specified amount of time between requesting and receiving an abortion. These imposed delays are known as mandatory waiting periods. In some cases, women must also receive (sometimes biased) counselling or advice (see sections 3.2.1 and 3.2.2), attend the facility at the start and end of the waiting period, and/or undergo mandated ultrasound during these waiting periods (see section 3.3.5, Recommendation 10 on pre-abortion ultrasound).

LAW & POLICY Recommendation 6: Mandatory waiting periods

Recommend against mandatory waiting periods for abortion.

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion* guidance provided a composite recommendation related to law and policy *(19)*; in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

Rationale

In order to identify the impacts of mandatory waiting periods on abortion seekers and health workers, a systematic review of studies published between 2010 and 2020 was undertaken, identifying 33 studies all conducted in the USA. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework on Mandatory waiting periods. The evidence reviewed showed that mandatory waiting periods delayed access to abortion, sometimes to the extent that women's access to abortion or choice of abortion method was restricted in that setting.

The evidence also indicates that mandatory waiting periods increase the cost of abortion and they may make abortion unattainable, resulting in the continuation of pregnancy against the wishes of the abortion seeker, especially among women with fewer resources, adolescents, younger women, those from racial or ethnic minorities and those who need to travel further for an abortion.

Among those seeking an abortion, the studies showed that mandatory waiting periods were experienced negatively, as a restriction on their access to abortion. For some women, the logistical and economic challenges of completing a mandatory waiting period, such as the need for time off work or education, extra travel and/or childcare, meant that they were forced to disclose their pregnancy to others even though international human rights law requires States to ensure that SRH services are provided in a way that ensures privacy and confidentiality. The evidence did not establish any benefits of mandatory waiting periods for women.

For health-care facilities, mandatory waiting periods increase staffing costs and logistical difficulties, by mandating additional visits or interventions outside of standard clinical practice (e.g. unnecessary ultrasound, specific counselling that is not evidence-based).

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO MANDATORY WAITING PERIODS

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health (SRH) services.
- States may not regulate abortion in a manner that forces women to resort to unsafe abortion.
- Everyone has a right to non-discrimination and equality in accessing SRH services.
- SRH services must be provided in a way that ensures privacy and confidentiality.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

3.3.2 Third-party authorization for abortion

Third-party authorization requirements exist where there is a requirement imposed by law or policy, or in practice, that a party other than the pregnant woman must authorize an abortion, even though other applicable legal requirements for lawful abortion have been met (e.g. grounds or gestational age limits, see sections 2.2.2 and 2.2.3). Common third parties required to provide authorization include a parent, guardian, spouse, partner, health worker, health authority or judicial authority. Third-party authorization requirements operate without regard to whether the person who seeks to end a pregnancy has capacity to consent to medical treatment.

Regardless of whether third-party authorization requirements apply, informed consent of the person availing of abortion is a prerequisite for the provision of abortion (refer to Chapter 1, section 1.3.1[v] for information on free and informed consent, and also Web annex A: Key international human rights standards on abortion).

LAW & POLICY Recommendation 7: Third-party authorization

Recommend that abortion be available on the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution.

Remark:

- While parental or partner involvement in abortion decision-making can support and assist women, girls or other pregnant persons, this must be based on the values and preferences of the person availing of abortion and not imposed by third-party authorization requirements.

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion* guidance provided a composite recommendation related to law and policy *(19)*; in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

Rationale

In order to identify the impacts of third-party authorization requirements on abortion seekers and health workers, systematic reviews of studies published between 2010 and 2019 were undertaken. A total of 32 studies were included, conducted in Hong Kong Special Administrative Region (China), Türkiye and the USA. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Third-party authorization. The reviewed evidence showed that third-party authorization requirements were associated with delays to abortion. For minors, these delays were sometimes, although not always, reduced when judicial authorization was used to bypass parental authorization requirements. However, bypass can be burdensome and time-consuming, and minors from ethnic minorities or of lower socioeconomic status are significantly more likely to need to use it. The evidence showed that adolescents and women sought to bypass parental/spousal authorization requirements to avoid anticipated violence, reproductive coercion and family disharmony.

A number of studies described "parental notification" or "parental involvement" rather than using the term "parental authorization". As these terms may encompass parental authorization requirements and mandate the disclosure of the fact that a minor is seeking an abortion, thus creating opportunities for parental veto, these studies were included within the evidence base for this topic. These studies reinforced the associations between mandated parental involvement (including authorization) and barriers to accessing abortion (including delay, continuation of pregnancy, anticipated interpersonal violence or exploitation, reproductive coercion, family disharmony and recourse to unsafe abortion).

Third-party authorization requirements are incompatible with international human rights law, which provides that States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women. Therefore, the evidence underlines the importance of the requirements stated in international human rights law that SRH services be provided in a way that respects and maintains women's and girls' privacy and confidentiality, that States protect women and girls seeking abortion, and that States recognize adolescents' evolving capacity (see section 1.3.1[v], Box 1.2 and Web annex A: Key international human rights standards on abortion).

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO THIRD-PARTY AUTHORIZATION

- States may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women.
- Sexual and reproductive health (SRH) services must be provided in a way that ensures privacy and confidentiality.
- States may not regulate abortion in a manner that forces women to resort to unsafe abortion.
- States must take steps, including revising laws, to reduce maternal morbidity and mortality, and to effectively protect women and girls from the physical and mental risks associated with resorting to unsafe abortion.
- Everyone has a right to privacy and confidentiality in accessing SRH services.
- Availability, accessibility, acceptability and quality must be central to the regulation of SRH services.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

3.3.3 Rh isoimmunization

Rh isoimmunization is a type of haemolytic disease of the fetus and newborn (HDFN). Specifically, it is the development of antibodies against the Rh antigens on the surface of red blood cells of another individual (i.e. one's own fetus) *(123)*.

CLINICAL SERVICES Recommendation 8 (NEW):
Rh isoimmunization for abortion at gestational ages < 12 weeks

For both medical and surgical abortion at < 12 weeks: **Recommend against** anti-D immunoglobulin administration.

Remark:

- Standard of care applies for anti-D administration at gestational ages ≥ 12 weeks.

Not applicable.

Rationale

A systematic review assessed the effect of routine anti-D administration among unsensitized Rh-negative individuals undergoing an abortion. There are few studies examining Rh isoimmunization in unsensitized Rh-negative individuals seeking abortion before 12 weeks of gestation. Only two studies, conducted in Israel and the USA, met the inclusion criteria for the review, both published in 1972 *(124, 125)*. A summary of the evidence is presented in Supplementary material 2, EtD framework on Rh isoimmunization.

The evidence on the effectiveness of the intervention may favour the intervention, because fewer women in the intervention group (anti-D administration) had antibody formation after the initial pregnancy compared to the women in the comparison group (no anti-D), and no harms (undesirable effects) of the intervention were noted. However, after consideration of the resources required, cost-effectiveness and feasibility of administering anti-D, as well as the very low certainty of the evidence on effectiveness, the expert panel concluded that overall, the evidence does not favour the intervention and decided to recommend against it for gestational ages < 12 weeks, rather than < 9 weeks, as mentioned in the 2012 guidance *(19)*. The justification for this new recommendation is outlined in the following points: (i) The presence of fetal blood in Rh-negative women at early gestational ages does not necessarily correlate with development of Rh alloimmunization and if we apply the results of an experimental study to this scenario, then theoretically there is zero chance of antibody formation if the Rh-negative woman is exposed to the Rh antigen of the fetal blood cells *(126)*; (ii) A study comparing Rh alloimmunization rates in two countries demonstrated the safety of not treating Rh-negative women with spontaneous abortion under 10 weeks of gestation *(127)*; (iii) WHO only recommends antenatal prophylaxis with anti-D immunoglobulin in non-sensitized Rh-negative pregnant women at 28 and 34 weeks of gestation to prevent RhD alloimmunization in the context of rigorous research *(128)*.

How

Implementation considerations

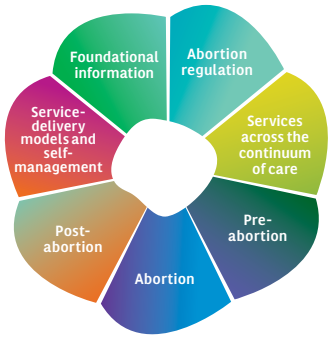
- Routine laboratory testing, including Rh testing, is not a requirement for abortion services at any gestational age.
- Determination of Rh status and the offer of anti-D prophylaxis are not considered prerequisites for early medical abortion at gestational ages before 12 weeks.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO Rh ISOIMMUNIZATION

- States must ensure access to up-to-date scientific technologies necessary for women.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations related to law and policy (Recommendations 1,2,3,6,7,21,22)

3.3.4 Antibiotic prophylaxis

The role of antibiotics is pertinent for surgical abortion. The presence of infection in the lower reproductive tract at the time of surgical abortion is a risk factor for post-abortion reproductive tract infections *(129)*. Provision of antibiotics at the time of abortion (prophylaxis) is to prevent such complications after a surgical abortion.

CLINICAL SERVICES Recommendation 9: Antibiotic prophylaxis for surgical and medical abortion

a. For surgical abortion, regardless of the individual's risk of pelvic inflammatory infection: **Recommend** appropriate prophylactic antibiotics pre- or perioperatively.

b. For medical abortion: **Recommend against** the use of prophylactic antibiotics.

Remark:

- Lack of antibiotics should not limit access to abortion services.

Source: Recommendation 11 carried forward from WHO (2012) *(19)*. The wording has been revised to use the word "recommend" to clarify that these are strong recommendations, and the former wording "routine use" (in 9b) has been changed to "use", following discussion among the expert panel.

Implementation consideration

- Single-dose administration of nitroimidazoles, tetracyclines or penicillins has been shown to be effective when used as prophylactic antibiotics for surgical abortion.

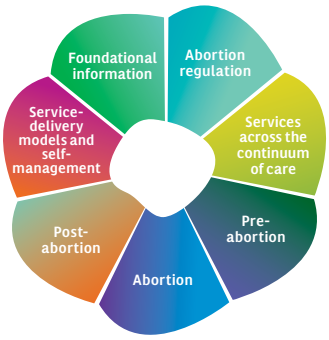
For information regarding which health workers can provide this intervention, refer to Recommendation 24 on vacuum aspiration (< 14 weeks) and Recommendation 26 on dilatation and evacuation (D&E) (≥ 14 weeks).

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO ANTIBIOTIC PROPHYLAXIS

- States must ensure adequate access to essential medicines in an affordable and non-discriminatory manner.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



Recommendations 24 (on vacuum aspiration) and 26 (on D&E)

3.3.5 Determining gestational age of pregnancy

Determining the gestational age of the pregnancy is a preliminary step before selecting the most appropriate abortion method. There are multiple ways to determine gestational age. Pregnancy dating can be done based on last menstrual period (LMP) alone or in combination with the use of a validated tool (i.e. mobile app, checklist or pregnancy wheel), thus enabling the option of self-assessment of gestational age. When LMP is uncertain, gestational age can be determined by way of a clinical/physical examination (i.e. bimanual pelvic and abdominal examination) or by ultrasound, both of which are used to assess the size of the uterus, estimated in weeks, that corresponds to a pregnant uterus of the same gestational age dated by LMP. In general, the least invasive method that is appropriate in the circumstances and available in the setting should be used.

Routine screening for ectopic pregnancy is not necessary prior to medical abortion. The incidence of ectopic pregnancy is lower in abortion seekers then in the general population *(130)*. Even for continuing pregnancies, WHO only recommends one ultrasound scan before 24 weeks of gestation (early pregnancy ultrasound) to estimate gestational age, improve detection of fetal anomalies and multiple pregnancies, reduce induction of labour for post-term pregnancy, and improve a woman's pregnancy experience *(128)*.

What

CLINICAL SERVICES Recommendation 10: Pre-abortion ultrasound scanning

For both medical and surgical abortion: **Recommend against** the use of ultrasound scanning as a prerequisite for providing abortion services.*

Remark:

- Legal regulation that limits the availability of abortion by gestational age may require or result in ultrasounds being used to verify gestational age prior to abortion, even though this is not necessary from a clinical perspective. Removing legal gestational age limits on access to abortion (see Recommendation 3) should result in unnecessary pre-abortion ultrasound being avoided, and increase the availability of abortion in settings where ultrasound is difficult to access.

* On a case-by-case basis, there may be clinical reasons for using ultrasound scanning prior to abortion.

Source: Recommendation 12 carried forward from WHO (2012) *(19)*. The wording has been revised to use the word "recommend against" to clarify that this is a strong recommendation against the intervention, and the former wording "routine" has been changed to use "prerequisite" for greater clarity, following discussion among the expert panel.

Who

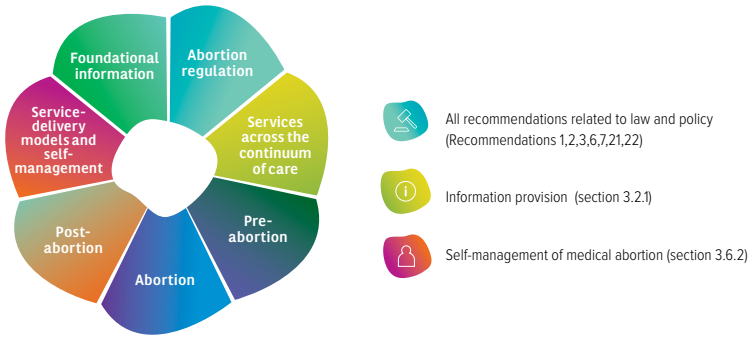
Not applicable.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO DETERMINING THE GESTATIONAL AGE OF PREGNANCY

- Any information on gestational age should be complete, accurate and evidence based. It should not be provided with the aim of directing decision-making.
- As a form of health information, information on gestational age should be of high quality, accurate and accessible. It should be presented a respectful manner and acceptable to the person receiving it. It should not fuel stigma and discrimination.
- Where information on gestational age is made available, it must be provided to individuals in a way that respects privacy and confidentiality.
- The right to refuse such information when offered must be respected. This includes the right to refuse to view ultrasound images.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



3.3.6 Pain management for abortion

There is generally some degree of pain with abortion. The need for pain management increases with gestational age. The degree of the pain varies with the age, parity, prior vaginal delivery, history of dysmenorrhoea and anxiety/fear level of the woman undergoing the abortion *(131-134)*. A shorter procedure time has been associated with less pain *(131)*. Neglecting this important element of care needlessly increases anxiety, discomfort and pain, thereby seriously compromising the quality of care and potentially increasing the difficulty of performing the procedure. Pain management should always be available and it should be administered in advance, in anticipation of the onset of pain, or provided to the woman in case it is needed for later use at home.

What

CLINICAL SERVICES Recommendations 11–14: Pain management for surgical abortion and for prior cervical priming

11. For pain management for surgical abortion at any gestational age:

a. Recommend that pain management should be offered routinely (e.g. non-steroidal anti-inflammatory drugs [NSAIDS]) and that it should be provided to those who want it; and

b. Recommend against the routine use of general anaesthesia**.**

NEW RECOMMENDATIONS BELOW INDICATE PAIN MANAGEMENT THAT IS *ADDITIONAL* TO NSAIDS.

12. (NEW) For pain management for surgical abortion at < 14 weeks:

a. Recommend the use of a paracervical block; and

b. Suggest that the option of combination pain management using conscious sedation[13] plus paracervical block should be offered, where conscious sedation is available.

13. (NEW) For pain management for cervical priming with osmotic dilators prior to surgical abortion at ≥ 14 weeks:

Suggest the use of a paracervical block. (See also section 3.3.7 on cervical priming prior to surgical abortion.)

Remark:

- For cervical priming (Recommendation 13), additional pain medication can be considered, such as the use of intravaginal gel.

14. (NEW) For pain management for surgical abortion at ≥ 14 weeks:

a. Recommend the use of a paracervical block; and

b. Suggest that the option of combination pain management using conscious sedation plus paracervical block should be offered, where conscious sedation is available.

Source: Recommendation 11 updated from WHO (2012) *(19)*. Recommendations 12–14 are new.

Note on updating of the recommendation: Recommendation 11a was previously published as part of Recommendation 14 in WHO (2012) *(19)*, and evidence for it was reviewed using GRADE methodology. After review, in this updated version, we have split the first part of the original recommendation wording to apply to surgical abortion here (11a) and medical abortion in a separate recommendation (15) and revised the wording to mention provision, and we have separated and revised the wording of the second part of the recommendation referring to general anaesthesia (Recommendation 11b).

13 Conscious sedation is also known as intravenous (IV) sedation or moderate sedation. See definition in Glossary.

Where

In a health-care facility.

Rationale for Recommendations 11b and 12

An update of an existing Cochrane Review[14] served as the evidence base for assessing the pain management regimens for surgical abortions at < 14 weeks of gestation. Thirty studies reporting on pain management for surgical abortion were identified by the search strategy. Of these studies, nine studies – conducted in France, the Islamic Republic of Iran, Norway, Türkiye and the USA – are the focus of the evidence base for these recommendations. Six studies compared the paracervical block (PCB) with a placebo. One study compared the PCB with general anaesthesia. Two studies compared conscious sedation[15] plus PCB versus PCB alone. A summary of the evidence is presented in Supplementary material 2, EtD framework for Pain management for surgical abortion < 14 weeks.

Combination pain management using conscious sedation plus PCB: Mean pain scores were lower in the group of women who received conscious sedation and PCB compared with the women who received a PCB alone, based on moderate-certainty evidence. In addition, satisfaction with their pain management was higher among the former group of women, based on high-certainty evidence.

Paracervical block (PCB): Both with and without conscious sedation, mean pain scores were lower in the group of women who received a PCB compared with the women who received a placebo, based on moderate-certainty evidence. Fewer women required additional analgesic medication, based on high-certainty evidence, and satisfaction in the former group of women was high, based on moderate-certainty evidence.

General anaesthesia: Pain scores were lower in the group of women who received general anaesthesia compared with PCB alone, based on moderate-certainty evidence. However, discussions on the resources required, cost effectiveness, feasibility and equity related to administering general anaesthesia resulted in a conclusion that did not favour the intervention. In addition, Recommendation 11b aligns with the existing statement that vacuum aspiration does not require an operating theatre *(19)*.

Rationale for Recommendations 13 and 14

A systematic review assessed the pain management regimens for surgical abortions at gestational ages ≥ 14 weeks. Three studies reporting on pain management for D&E were identified by the search strategy, all of which focused on pain management during the cervical priming prior to the surgical procedure. A summary of the evidence is presented in Supplementary material 2, EtD framework for Pain management for surgical abortion ≥ 14 weeks.

Mean pain scores were lower in the group of women who received a PCB compared with the women who received a placebo, based on high-certainty evidence. Satisfaction in the former group of women was high, based on moderate-certainty evidence. An intravaginal gel can be used as an alternative method of pain control; more women had a lower pain score after receiving the gel compared with those who had a PCB, based on low-certainty evidence. Cervical priming was performed with laminaria. Discussions on the values and preferences of women regarding pain management during surgical abortion, and on the resources required and the feasibility of PCB administration resulted in a determination that favoured the intervention.

No studies were identified that focused on pain management for the D&E procedure. Therefore, the the expert panel came to a consensus to align the recommendations to those for pain management for surgical abortion at < 14 weeks of gestation (see Recommendation 12).

Who

For information regarding which health workers can provide this intervention, refer to Recommendations 24 and 26 for surgical abortion (vacuum aspiration and D&E).

14 A Cochrane Review is a systematic review of research in health care and health policy that is published in the *Cochrane Database of Systematic Reviews*.

15 Conscious sedation is also known as intravenous (IV) sedation or moderate sedation. See definition in Glossary.

How

Implementation considerations

- Sufficient supplies and stocks of pain medications should be ensured.
- Training of providers in abortion care should include pain management, in particular the technique for administration of paracervical block.

What

CLINICAL SERVICES Recommendations 15 and 16: Pain management for medical abortion

15. For medical abortion at any gestational age:

Recommend that pain management should be offered routinely (e.g. non-steroidal anti-inflammatory drugs [NSAIDs]) and that it should be provided for the individual to use if and when wanted.

NEW RECOMMENDATION BELOW INDICATES PAIN MANAGEMENT THAT IS *ADDITIONAL* TO NSAIDS.

16. (NEW) For pain management for medical abortion at ≥ 12 weeks:

Suggest consideration of other methods to control pain or discomfort due to increased pain with increasing gestational age. Such methods include certain anti-emetics and epidural anaesthesia, where available.

Remark:

- For medical abortion at gestational ages < 14 weeks, if NSAIDS (e.g. ibuprofen) are not available or not an option, then acetaminophen can be considered for pain control.

Source: Recommendation 15 updated from WHO (2012) *(19)*. Recommendation 16 is new.

Note on updating of the recommendation: Recommendation 15 was previously published as part of Recommendation 14 in WHO (2012) *(19)*, and evidence for it was reviewed using GRADE methodology. After review, in this updated version, we have split the first part of the original recommendation wording to apply to surgical abortion (see Recommendation 11a) and medical abortion (here in Recommendation 15), and revised the wording to mention provision.

Where

No requirement for location (on-site vs off-site).

Rationale for Recommendation 15 (specifically for gestational ages < 14 weeks)

A Cochrane Review served as the evidence base for this key question. Five studies reporting on pain management for medical abortion at gestational ages < 14 weeks were identified by the search strategy, conducted in Israel, the United Kingdom and the USA. A summary of the evidence is presented in Supplementary material 2, EtD framework for Pain management for medical abortion < 14 weeks.

Of these studies, three were assessed using the following comparisons:

- ibuprofen versus placebo
- prophylactic versus therapeutic NSAIDs
- ibuprofen versus paracetamol.

Women who received NSAIDs had lower mean pain scores and fewer women from that group required additional analgesic medication, based on high-certainty evidence. Discussions on the values and preferences of women with pain management during medical abortion and the resources required, cost-effectiveness and feasibility for NSAID administration resulted in a determination that favoured the intervention.

Rationale for Recommendations 15 (specifically for gestational ages ≥ 14 weeks) and 16

A systematic review was undertaken to address this key question. Eleven studies reporting on pain management for medical abortion at gestational ages ≥ 14 weeks were identified by the search strategy, conducted in Belgium, Canada, Germany, Israel, Italy, Sweden, Thailand and the USA. A summary of the evidence is presented in Supplementary material 2, EtD framework for Pain management for medical abortion ≥ 14 weeks.

Using data from these studies, the following comparisons were made:

- paracervical block (PCB) versus oral pain medication
- NSAIDs versus non-NSAIDs/placebo
- anti-emetics versus placebo
- anti-epileptics versus anxiolytics
- intermittent versus continuous epidural
- patient controlled epidural versus patient-controlled intravenous (IV) fentanyl
- patient controlled fentanyl versus patient-controlled morphine
- patient controlled IV tramadol versus patient-controlled IV fentanyl.

Comparison of PCB versus oral pain medication: In the studies that assessed this comparison, fewer women experienced severe pain and there was a lower expulsion time with the use of oral pain medication compared with PCB, based on moderate-certainty evidence.

Comparison of NSAIDs versus non-NSAIDs/placebo: In the studies that assessed this comparison, fewer women required supplemental narcotics after the use of NSAIDs, based on high certainty of evidence. In addition, fewer women receiving NSAIDs experienced side-effects, based on moderate-certainty evidence.

Comparison of anti-emetics versus placebo: In the studies that assessed this comparison, there was lower use of supplemental narcotics and lower expulsion time with the use of anti-emetics, based on moderate-certainty evidence.

Comparison of anti-epileptics versus anxiolytics: In the studies that assessed this comparison, there were lower mean pain scores, lower use of additional analgesics and lower mean expulsion times with the use of anti-epileptics, based on moderate-certainty evidence.

Comparison of intermittent versus continuous epidural: In the studies that assessed this comparison, there were fewer side-effects with the use of intermittent epidural, based on low- to high-certainty evidence. Satisfaction was higher among women who had intermittent epidural for their pain management, based on high-certainty evidence.

Comparison of patient-controlled epidural (PCE) versus patient controlled IV fentanyl: In the studies that assessed this comparison, there were lower mean pain scores and fewer side-effects of vomiting and sedation with the use of PCE, based on moderate-certainty evidence. In addition, satisfaction was higher among women in the PCE group, based on moderate-certainty evidence.

Comparison of patient-controlled morphine versus patient-controlled IV fentanyl: In the studies that assessed this comparison, there were lower pain scores and fewer side-effects with the use of patient-controlled fentanyl (50 µg), based on moderate- to high-certainty evidence.

Comparison of patient controlled IV tramadol versus patient controlled IV fentanyl: In the studies that assessed this comparison, pain control was comparable with the use of patient-controlled tramadol and fentanyl, based on low- to moderate-certainty evidence. Satisfaction ratings were also similar between the two groups, based on high-certainty evidence.

Discussions on the values and preferences of women regarding pain management during medical abortion, and on the resources required, cost-effectiveness and feasibility for NSAID administration resulted in a determination that favoured the intervention.

For information regarding which health workers can provide this intervention, refer to Recommendations 28 and 30 on medical abortion.

Implementation consideration for Recommendations 15 and 16

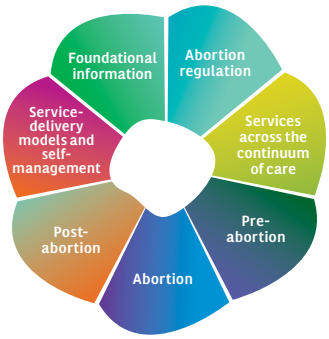
- Regardless of the service modality, there should be clear communication to the woman on the pain she may experience, which may vary based on pain perceptions and tolerance. In any event, she should be provided with information on pain management, and access to adequate pain medicines should be ensured.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO PAIN MANAGEMENT

- States must ensure adequate access to essential medicines in an affordable and non-discriminatory manner.
- Denial of pain medication may violate a wide range of human rights, including the right to health and autonomy in decision-making.
- Denial of pain medication as punishment for abortion or because it is part of abortion care may violate the right to equality and non-discrimination.
- Denial of pain medication may violate the right to be free from cruel, inhuman and degrading treatment.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



Universal health coverage (UHC) (section 1.4.1)

Commodities (section 1.4.4)

Information provision (section 3.2.1)

3.3.7 Cervical priming prior to surgical abortion

Prior to surgical abortion, cervical priming (also known as cervical preparation) may be considered for all women with a pregnancy of any gestational age, in particular for women with a pregnancy over 12 weeks of gestation. Cervical priming before surgical abortion is especially beneficial for women with cervical anomalies or previous surgery, adolescents and those with advanced pregnancies, all of whom have a higher risk of cervical injury or uterine perforation that may cause haemorrhage *(135, 136)*. It may also facilitate the abortion procedure for inexperienced providers. However, cervical priming has disadvantages, including additional discomfort for the woman, and the extra cost and time required to administer it effectively.

Whether osmotic dilators or medication is used for cervical priming prior to the surgical abortion, this is done in advance of the procedure. As such, cervical priming may be initiated by a health worker other than the provider who will conduct the D&E.

CLINICAL SERVICES Recommendation 17: Cervical priming prior to surgical abortion at < 12 weeks of gestation

Prior to surgical abortion at < 12 weeks:

a. If cervical priming is used: **Suggest** the following medication regimens:

- Mifepristone 200 mg orally 24–48 hours prior to the procedure
- Misoprostol 400 µg sublingually 1–2 hours prior to the procedure
- Misoprostol 400 µg vaginally or buccally 2–3 hours prior to the procedure

b. Recommend against the use of osmotic dilators for cervical priming.

Remarks:

- The sublingual route is more effective for misoprostol administration.
- Appropriate pain medication should be provided.

Source: Recommendation updated from Recommendation 7.2 in WHO (2012) *(19)*.

Note on updating of the recommendation: This recommendation was reviewed using GRADE methods. The suggested mifepristone regimen is unchanged, but the misoprostol regimens have been updated, in terms of timing and route of administration, and laminaria is no longer a recommended option; these recommendations therefore replace the prior recommendation.

Rationale

An update of an existing Cochrane Review serves as the evidence base for this key question. The update identified 8 new studies, which makes a total of 61 included studies that assessed cervical priming methods for vacuum aspiration. From this review, approximately half of the included studies were evaluated to contribute towards the development of the Evidence-to-Decision (EtD) framework. The review includes the following cervical priming methods: medication with mifepristone and/or misoprostol and mechanical methods (i.e. natural or synthetic osmotic dilators). A summary of the evidence is presented in Supplementary material 2, EtD framework for Cervical priming prior to surgical abortion < 12.[16]

For Recommendation 17a, we suggest the option of misoprostol or mifepristone as a cervical priming agent prior to surgical abortion less than 12–14 weeks. For the studies that compared misoprostol versus mifepristone, time to complete the procedure was less for misoprostol, based on moderate-certainty evidence. However, the pre-procedure cervical dilation was greater with mifepristone use, based on moderate-certainty evidence. The side-effects profile was comparable between the two groups, based on very low-certainty evidence.

Regarding the timing of misoprostol administration, studies that compared the interval timing for administration of misoprostol for cervical priming revealed that the highest efficacy was seen (i.e. greater pre-procedure cervical

16 For the sake of consistency across the recommendations, the cut-off gestational age is 12 weeks, but evidence did include women with pregnancies up to 14 weeks of gestation who underwent vacuum aspiration.

dilation) with the 3-hour interval. This finding was based on high-certainty evidence. Although the 3-hour interval is considered optimal, the 1-hour interval is also included as a result of the expert panel members' discussions on the feasibility and acceptability of the shorter duration of waiting time prior to a woman's surgical abortion.

For Recommendation 17b, the reasoning is due to the longer time to complete the procedure if osmotic dilators are used compared with when misoprostol is used for cervical priming, based on high-certainty evidence. In addition, satisfaction rates were higher among those who received misoprostol compared with the laminaria group, based on moderate-certainty evidence.

The expert panel added the buccal route (this was added along with the vaginal route due to buccal and misoprostol concentration curves being similar in pharmacokinetics data), and their remark highlights the sublingual route as being the more effective route.

What

CLINICAL SERVICES Recommendation 18 (NEW): Cervical priming prior to surgical abortion (MVA or D&E) at ≥ 12 weeks of gestation

Prior to surgical abortion at later gestational ages:

a. For surgical abortion at ≥ 12 weeks: **Suggest** cervical priming prior to the procedure.

b. For surgical abortion between 12 and 19 weeks: **Suggest** cervical priming with medication alone (a combination of mifepristone plus misoprostol is preferred) or with an osmotic dilator plus medication (mifepristone, misoprostol, or a combination of both).

c. For surgical abortion between 12 and 19 weeks, when using an osmotic dilator for cervical priming: **Suggest** that the period between osmotic dilator placement and the procedure should not extend beyond two days.

d. For surgical abortion at ≥ 19 weeks: **Recommend** cervical priming with an osmotic dilator plus medication (mifepristone, misoprostol, or a combination of both).

Remark:

- There was limited evidence for cervical priming for gestational ages between 12 and 14 weeks and therefore health workers should use clinical judgement to decide on the most convenient method for cervical priming prior to vacuum aspiration for this gestational age range.

Note: These are new recommendations and they replace Recommendations 8.1 and 8.2 in WHO (2012) *(19)*, which were for D&E after 14 weeks; these new recommendations now include information on methods/regimens for cervical priming at different gestational age ranges.

Rationale

A Cochrane Review provided the evidence base on cervical priming methods for surgical abortion at later gestational ages. From this review, 16 studies were included in the development of the EtD framework relating to the following cervical priming methods: medication with mifepristone and/or misoprostol; mechanical methods with osmotic dilators and synthetic dilators; one-day versus two-day procedures with laminaria. The study settings included Israel, South Africa, Spain, the United Kingdom and the USA. A summary of the evidence is presented in Supplementary material 2, EtD framework for Cervical priming prior to surgical abortion ≥ 12 weeks.

The inclusion of all medication options for cervical priming was based on the expert panel's discussion of the feasibility and acceptability of these interventions. The use of mifepristone with misoprostol is favoured over misoprostol alone for cervical priming due to higher pre-procedure cervical dilatation and shorter time to complete the procedure, based on moderate-certainty evidence. The combined use of medication and laminaria is favoured over laminaria alone due to the higher pre-procedure cervical dilatation, decreased need for further dilatation and shorter time to complete the procedure. This is based on high-certainty evidence. Sub-analyses of the included studies showed that the combined use of medication and laminaria appears to be more effective at higher gestational ages.

How

Implementation consideration

- The use of medication for cervical priming prior to surgical abortion beyond 12–14 weeks of gestation can be self-managed and can save travel time for the woman and staff time spent on insertion of osmotic dilators.

Who

SERVICE DELIVERY Recommendation 19: Cervical priming with medication prior to surgical abortion at any gestational age

Type of health worker	Recommendation	Rationale[a]
Community health workers (CHWs)	**Suggest** Condition: Provision of medication for the purpose of cervical priming is part of the surgical abortion process so the health worker needs to ensure continuity of care of the woman obtaining the medicines prior to the abortion procedure	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, CHWs have been recommended to provide medical abortion at < 12 weeks (see Recommendation 28), which requires similar skills and knowledge as for this task.
Pharmacy workers	**Suggest** Condition: Provision of medication for the purpose of cervical priming is part of the surgical abortion process so the health worker needs to ensure continuity of care of the woman obtaining the medicines prior to the abortion procedure	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, pharmacy workers have been recommended to provide medical abortion at < 12 weeks (see Recommendation 28), which requires similar skills and knowledge as for this task.
Pharmacists	**Suggest** Condition: Provision of medication for the purpose of cervical priming is part of the surgical abortion process so the health worker needs to ensure continuity of care of the woman obtaining the medicines prior to the abortion procedure	Although no evidence was found on the safety, effectiveness or acceptability of this option, dispensing medicines with a prescription is within the typical scope of practice of pharmacists. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, pharmacists have been recommended to provide medical abortion at < 12 weeks (see Recommendation 28), which requires similar skills and knowledge as for this task.
Traditional and complementary medicine professionals **Auxiliary nurses/ANMs** **Nurses** **Midwives**	**Recommend**	Evidence was found for the safety and effectiveness of this option (low-certainty evidence). Cervical priming is part of the training for provision of manual vacuum aspiration. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a]
Associate/advanced associate clinicians	**Recommend**	Evidence was found for health workers with similar or less comprehensive basic training (e.g. midwives, nurses, ANMs) using such medicines to provide medical abortion (moderate-certainty evidence). Cervical priming is part of the training for provision of manual vacuum aspiration. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a]
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to all types of health workers was reviewed using GRADE methodology, except for specialist and generalist medical practitioners, which were already "recommend". After review, the recommendations were upgraded for all reviewed health workers, from "recommend against" to "suggest" for pharmacists, pharmacy workers and CHWs, and from "suggest" to "recommend" for all other health worker categories. The gestational age for this recommendation was also amended from "beyond 12 weeks" to "at any gestational age" after conferring with the expert panel. A summary of the evidence is presented in Supplementary material 3, EtD framework for Cervical priming using medication and osmotic dilators.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

No requirement for location (on-site vs off-site).

How

Implementation consideration

- Given that cervical priming initiates the process and is done prior to a surgical procedure, with an interval of up to 1–2 days, it is important that the health worker ensures the continuity of care for the woman by ensuring that there is a clear plan for the surgical abortion prior to the woman taking the priming agent and she has access to the existing health system should she desire or need additional support during that interval.

Who

Table Continues

SERVICE DELIVERY Recommendation 20: Cervical priming with osmotic dilators prior to D&E at gestational ages ≥ 12 weeks

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Suggest** Condition: Health worker ensures continuity of care from the time of cervical priming to the D&E	Although insufficient direct evidence was found for the safety and effectiveness of this option, these health workers have been suggested to do other transcervical procedures (e.g. inserting an IUD and vacuum aspiration; see Recommendations 43 and 24). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that this option has the potential to increase equitable access to quality abortion care in regions where these professionals constitute a significant proportion of the health workforce.
Auxiliary nurses/ANMs	**Recommend**	Although insufficient direct evidence was found for the safety and effectiveness of this option, ANMs have been recommended to do other transcervical procedures (e.g. inserting an IUD; see Recommendation 43), and auxiliary nurses have been recommended in certain contexts to do other transcervical procedures (e.g. inserting an IUD; see Recommendation 43). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that this option may help optimize workflow within a facility and decrease waiting times for women.
Nurses	**Recommend**	Although insufficient direct evidence was found for the safety or effectiveness of this option, nurses have been recommended to do other transcervical procedures (e.g. inserting an IUD; see Recommendation 43), and there is evidence that provision of manual vacuum aspiration by nurses is safe and effective (moderate-certainty evidence). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that this option may help optimize workflow within a facility and decrease waiting times for women.
Midwives	**Recommend**	Although insufficient direct evidence was found for the safety or effectiveness of this option, midwives have been recommended to do other transcervical procedures (e.g. inserting an IUD; see Recommendation 43), and there is evidence that provision of manual vacuum aspiration by midwives is safe and effective (moderate-certainty evidence). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that this option may help optimize workflow within a facility and decrease waiting times for women.
Associate/advanced associate clinicians	**Recommend**	Indirect evidence was found for the safety and effectiveness of these clinicians providing vacuum aspiration (moderate-certainty evidence), which includes cervical priming with osmotic dilators for select cases. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that this option may help optimize workflow within a facility and decrease waiting times for women.
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to all types of health workers was reviewed using GRADE methodology, except for specialist and generalist medical practitioners, which were already "recommend". After review, the recommendations were upgraded for associate/advanced associate clinicians, midwives and nurses from "suggest" to "recommend", for auxiliary nurses and ANMs from "recommend against" to "recommend", and for traditional and complementary medicine professionals from "recommend against" to "suggest". For pharmacists, pharmacy workers and community health workers, the recommendations remain "recommend against" (not listed). The gestational age for this recommendation was also amended from "beyond 12 weeks" to "12 weeks and above" (≥ 12 weeks) to align this recommendation with Recommendation 18. A summary of the evidence is presented in Supplementary material 3, EtD framework for Cervical priming using medication and osmotic dilators.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

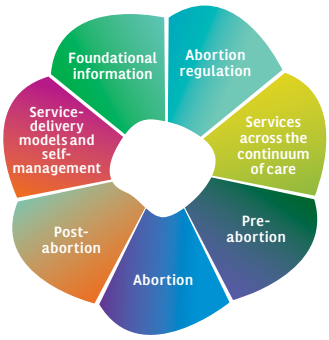
In a health-care facility.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO CERVICAL PRIMING

- Denial of cervical priming as punishment for abortion or because it is part of abortion care may violate the right to non-discrimination and equality.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



Recommendations 11–15: Pain management

Recommendation 23–26: Surgical abortion (vacuum aspiration and dilatation and evacuation)

3.3.8 Restrictions (in law or policy) on health workers who may lawfully provide abortion care

In a number of countries, law and policy restrict which type of health workers may lawfully provide abortion care *(137),* most often limiting this to gynaecologists. Since the advent of vacuum aspiration and medical abortion, however, abortion can be safely provided by a wide range of health workers in diverse settings, and safely self-managed in earlier pregnancy (see Recommendations 24, 28, 30, 33). Provider restrictions are inconsistent with WHO's support for the optimization of the roles of health workers; such restrictions are arbitrary and not evidence based *(138)*. Reflecting States' obligation to respect, protect and fulfil the right to health, health-care facilities, goods and services must be available, accessible, adequate and of good quality *(46)*. This includes facilities, goods and services for SRH care. Thus, States must ensure an adequate number of medical and professional personnel and skilled providers in the health system as well as adequate stocks of essential medicines *(46)*. Furthermore, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, has stressed that abortion law must be evidence based *(37)* (see Chapter 1, section 1.3.1[i], and also Web annex A: Key international human rights standards on abortion).

LAW & POLICY Recommendation 21: Provider restrictions

Recommend against regulation on who can provide and manage abortion that is inconsistent with WHO guidance.

Remark:

- Where law or policy regulate who may provide or manage abortion, that regulation should be consistent with WHO guidance, which is presented throughout this chapter.

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion* guidance provided a composite recommendation related to law and policy *(19)*; in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

Rationale

In order to identify the impacts of provider restrictions on abortion seekers and health workers, a systematic review of studies published between 2010 and 2019 was undertaken, identifying seven studies conducted in Australia, Ethiopia, Nepal and the USA. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Provider restrictions. The reviewed evidence showed that restrictions on who can provide and manage abortion resulted in delays to and burdens in accessing abortion. By contrast, expanding the range of health workers who can provide abortion care improved timely access to early medical and surgical abortion; reduced costs, travel and waiting time; shifted components of care away from physicians; made abortion more available including in rural areas and at primary health care level; prevented unsafe self-management of abortion; and reduced system costs. This evidence indicates that provider restrictions produce inefficiencies, administrative burdens and workload burdens within health systems, and reduce in practice the number of available providers.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO PROVIDER RESTRICTIONS

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health care.
- Abortion regulation should be based on human rights and evidence.
- States must ensure an adequate number of medical and professional personnel and skilled providers in the health system as well as adequate stocks of essential medicines.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

3.3.9 Conscientious objection or refusal by health workers to provide abortion care

Refusal of abortion care on the basis of conscience operates as a barrier to access to safe and timely abortion *(3 [para. 14], 36 [para. 8], 139 [para. 109], 140 [para. 353], 141 [paras 42, 43])*, and unregulated conscientious refusal/objection can result in human rights violations, or lead women to seek unsafe abortion *(142 [para. 23], 143 [para. 106], 144)*. In some countries conscientious objection is expressly regulated through employment law, employment contracts or the law on abortion. As a matter of international human rights law, States that allow conscientious objection must organize their health system and abortion provision in a way that ensures that conscientious objection does not result in the refusal of legally available abortion care, and regulate the exercise of conscientious objection in a way that reflects best international clinical practice, protects abortion seekers, and ensures that provider refusal does not undermine or hinder access to quality abortion care *(145 [para. 12], 146 [para. 28])*. WHO has also advised that "health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation" *(19)*.

LAW & POLICY Recommendation 22: Conscientious objection

Recommend that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.

Remarks:

- Health services should be organized in such a way as to ensure the exercise of conscientious objection does not prevent people from accessing available abortion services.
- Where conscientious objection is permitted, international human rights law requires States to take steps to ensure that it does not operate as a barrier to access to abortion care. The mere existence of regulation of conscientious objection is not sufficient. In practice, this means that if States permit conscientious objection, they must regulate it in a way that is effective in ensuring that abortion is available and accessible in practice.
- International human rights law provides some guidance as to how States can ensure that human rights of abortion seekers are respected, protected and fulfilled. These include:
    - putting in place clear and enforceable regulation of conscientious objection *(147 [paras 30, 31], 148 [para. 41(f)], 149 [para. 37(b)]);*
    - ensuring adequate enforcement of the regulation of conscientious objection, including identifying, addressing and sanctioning non-compliance *(147 [paras 30, 31], 148 [para. 41(f)], 149 [para. 37(b)]);*
    - outlining clearly who may object to what components of care *(150 [paras 30-31], 148 [para. 41(f)], 3 [para. 43]);*
    - organizing the health system to ensure that sufficient, non-objecting providers are employed and distributed fairly across the country *(3);*
    - prohibiting institutional claims of conscience *(147, 150 [para. 33(c)], 148 [para. 41(f)]);*
    - requiring objectors to provide prompt referral to accessible, non-objecting providers *(3 [para. 43], 37 [para. 65(m)], 39 [para. 11], 150 [para. 33(c)], 146 [para. 28]);*
    - requiring conscientious objection to be exercised in a respectful and non-punitive manner; and
    - prohibiting conscientious objection in urgent or emergency situations *(3, para. 43)*.
- Accordingly, States that permit conscientious objection should reform the regulation of conscientious objection to ensure that the human rights of pregnant people are respected, protected and fulfilled, and that abortion is available and accessible.
- If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible. In such circumstances, it may be appropriate to consider prohibiting conscientious objection and/or revising national law and policy frameworks that govern health workers' professional and ethical obligations.

Note on updating of the recommendation: This and other law and policy recommendations are not new recommendations. WHO's 2012 *Safe abortion guidance* provided a composite recommendation related to law and policy *(19)*; in this guideline, this has been developed into seven separate recommendations using GRADE methodology.

Rationale

In order to identify the impacts of conscientious objection on abortion seekers and health workers, a systematic review of studies published between 2010 and 2020 was undertaken, identifying 26 studies conducted in Australia, Brazil, Colombia, Ghana, Italy, Mexico, Nigeria, Norway, Portugal, South Africa, Slovakia, Switzerland, Tunisia, the United Kingdom, the USA and Zambia. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for Conscientious objection. The evidence reviewed established that conscientious objection may delay timely access to abortion and abortion care. Delay in care is exacerbated where there is a higher proportion of objecting health workers, and sometimes even in emergency cases where abortion is needed to save a woman's life. Delays are sometimes deliberately imposed by objectors. The evidence also suggests that conscientious objection contributes to increased abortion-related morbidity and mortality, and that some health workers claim conscientious objection and refuse abortion in the public sector, while providing abortion for payment in their private practices.

The studies showed that conscientious objection imposes increased barriers on populations in specific settings: rural areas; settings where abortion law has recently been changed and there is insufficient clarity on who may object to what aspects of abortion care; places where conscientious objection is not effectively regulated; and settings where objecting health workers intentionally refuse referrals or use biased counselling, or inaccurate legal and medical information to try to dissuade and obstruct people from accessing abortion (refer to section 3.2.1: Provision of information).

Refusal of abortion on the basis of conscience has been shown to impose significant burdens on women and girls, especially uncertainty about whether and where they can access abortion. Some objectors decide whether to provide abortion on a case-by-case basis depending on their view of the reason a woman seeks abortion, which means availability is not clear or consistent. Furthermore, objectors' referral practices are highly variable. The evidence demonstrated that while most objectors were willing to refer, this was not true for all, with some objectors referring on a case-by-case basis. Additionally, referral pathways may be circuitous and burdensome, which imposes additional difficulties and delays.

Conscientious objection has significant workload implications for health workers. Where there are many objectors, non-objecting health workers have an increased workload, abortion provision is often stigmatized, and those who do provide abortion care may experience career limitation or discrimination. Unclear, unenforced or non-existent regulation and legal frameworks for conscientious objection can create burdens on health workers, including in navigating challenges associated with their conscience or ethics, cause workplace conflicts, result in non-clinical staff attempting to claim conscientious objection, and undermine organizational models for the delivery of abortion.

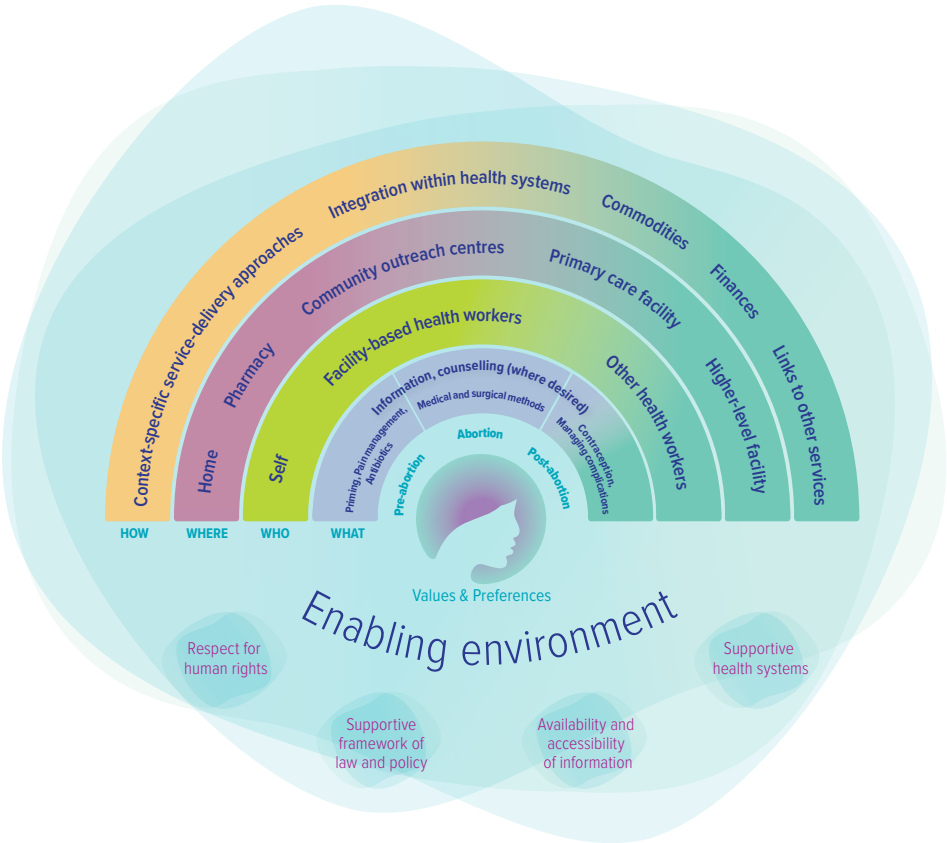
To identify whether and how regulation of conscientious objection mitigates its impacts, a systematic review of studies published between 2010 and 2022 was undertaken, identifying 11 studies conducted in Argentina, Australia, Bolivia, Italy, Norway, Mexico, Portugal, South Africa, the United Kingdom, the USA and Zambia. A summary of the evidence from these studies is presented in Supplementary material 1, EtD framework for regulation of Conscientious objection. The evidence reviewed did not identify any country or setting where conscientious objection was regulated in a way that was effective in ensuring the availability and accessibility of abortion in practice. Approaches to regulation included some or all of the following: specifying who may exercise conscientious objection; stating whether or not institutions may claim conscientious objection; requiring conscientious objectors to refer abortion seekers to a willing provider; prohibiting conscientious objection in cases of emergency; and specifying how conscientious objection may be exercised (e.g. requirements to declare or register one's status as a non-providing objector). Across the studies, the regulation of conscientious objection was still associated with refusal of access to abortion; opportunity costs for abortion seekers (including associated delays); disproportionate impacts (especially between public and private health-care provision); and unequally distributed workloads among health workers. The studies identified issues including lack of enforcement of existing regulations, limited accountability for non-compliance, lack of regulatory clarity about whether and how conscientious objection may be exercised, and impositions on health workers' ethics or beliefs.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO CONSCIENTIOUS OBJECTION

- Availability, accessibility, acceptability and quality must be central to the regulation of sexual and reproductive health (SRH) services.
- States that allow conscientious objection must organize their health system and abortion provision in a way that ensures that conscientious objection does not hinder access to or result in the refusal of legally available abortion care.
- States that allow conscientious objection should regulate the exercise of conscientious objection in a way that reflects best international clinical practice, protects abortion seekers, and ensures that provider refusal does not undermine or hinder access to quality abortion.
- Everyone has the right to accurate information on SRH.
- Everyone has a right to privacy and confidentiality in SRH services.
- Everyone has a right to non-discrimination and equality in accessing SRH services.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

3.4 Abortion



Abortion management is needed for both induced and spontaneous abortion, including for clinical indications such as missed abortion and intrauterine fetal demise (fetal death).

Recommended management options include medical management, or surgical management using manual or electric vacuum aspiration (MVA or EVA) or dilatation and evacuation (D&E). The method of surgical abortion would depend on gestational age: generally vacuum aspiration at < 14 weeks of gestation and D&E at ≥ 14 weeks, but there is flexibility in the use of these methods between 12 and 16 weeks. Medical abortion regimens include sequential use of mifepristone followed by misoprostol or, in settings where mifepristone is not available (or is restricted for certain clinical indications), the use of misoprostol alone. A new alternative medical method, in particular using letrozole in combination with misoprostol, is also available.

For missed abortion and intrauterine fetal demise (see sections 3.4.5 and 3.4.6), in addition to the options of medical and surgical management, expectant management can be offered as an option on the condition that the woman is first informed of the longer time for expulsion of the pregnancy tissue and the increased risk of incomplete emptying of the uterus (the same applies in the case of incomplete abortion, which is addressed in section 3.5.2 on post-abortion care).

Medical abortion care for all indications plays a crucial role in providing wider access to safe, effective and acceptable abortion care. This may increase the availability and accessibility of abortion and realization of the right to SRH. Across all resource settings, the use of medical abortion has contributed to the expansion of health worker roles, more efficient use of resources and reduced maternal mortality and morbidity from unsafe abortions. Moreover, medical abortion – particularly in early pregnancy – can now be provided at the primary-care level and on an outpatient basis, or from a pharmacy, which further increases access to abortion care. Medical abortion care

reduces the need for skilled surgical abortion providers and offers a non-invasive and highly acceptable and safe option to pregnant women. As a matter of international human rights law, States must provide essential medicines listed under WHO's Action Programme on Essential Drugs, which include abortion medicines *(46, para. 12a)*.

The recommendations presented below address surgical and medical management of abortion. Implementation of all of the recommendations in this section are conditional upon women's values and preferences, the acceptability of each intervention, and the availability of resources to provide the chosen method safely. It should be noted that a woman's choice of method for abortion management may be limited or not applicable if she has medical contraindications to one of the methods. The recommendations below relate only to the method of abortion, and should not be read as suggesting gestational age limits for the availability of abortion.

3.4.1 Methods of surgical abortion

The provision of vacuum aspiration includes the assessment of gestational age, cervical priming (if needed), the actual procedure, pain management including the provision of a paracervical block and the assessment of completeness of abortion through the visual inspection of products of conception. Health workers with the skills to perform a bimanual pelvic examination to diagnose and date a pregnancy, and to perform a transcervical procedure such as intrauterine device (IUD) insertion, can be trained to perform vacuum aspiration.

Recommended methods of surgical abortion at later gestational ages are vacuum aspiration and dilatation and evacuation (D&E). Although the recommendations in this section indicate differences before and after 14 weeks of gestation, it should be noted that there is flexibility in the use of one surgical method versus the other between the gestational ages of 12 and 16 weeks.

CLINICAL SERVICES Recommendation 23: Vacuum aspiration for induced abortion at gestational ages < 14 weeks

For surgical abortion at < 14 weeks:

a. Recommend vacuum aspiration.

b. Recommend against the practice of dilatation and sharp curettage (D&C), including sharp curette checks (i.e. to "complete" the abortion) following vacuum aspiration.

Remarks:

- Observational studies indicate that vacuum aspiration is associated with fewer complications than D&C; however, randomized controlled trials were underpowered to detect a difference in complication rates.
- No evidence supports the use of sharp curette checks following vacuum aspiration.
- The quality of the evidence based on randomized controlled trials is low to moderate.

Source: Recommendation 1 carried forward from WHO (2012) *(19)*. Some of the wording has been revised, and the gestational age range has been changed from "up to 12 to 14 weeks" to "before 14 weeks" (< 14 weeks).

Who

SERVICE DELIVERY Recommendation 24: Vacuum aspiration for induced abortion at gestational ages < 14 weeks

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Recommend**	Very low-certainty evidence was found for the effectiveness of this option for components of the task (e.g. assessing uterine size with bimanual examination as part of medical abortion provision). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] These professionals perform transcervical procedures (e.g. IUD insertion) in some settings. The expert panel affirmed that the benefits outweigh possible harms and this option has the potential to increase equitable access to quality abortion care in regions where these professionals constitute a significant proportion of the health workforce.
Auxiliary nurses/ANMs	**Suggest** Condition: In contexts where established health system mechanisms involve auxiliary nurses/ANMs in providing basic emergency obstetric care, and where referral and monitoring systems are strong.	Although insufficient direct evidence was found for the safety and effectiveness of this option, the benefits outweigh any possible harms. This option has been shown to be feasible, including at scale in low-resource settings, and has the potential to decrease inequities by extending quality abortion care to rural and underserved populations.
Nurses	**Recommend**	Evidence was found for the safety and effectiveness (low certainty) and for women's satisfaction (low certainty) with this option. Women often consider care received from nurses as more supportive compared with other health workers (moderate-certainty evidence). This option is feasible and may decrease inequities by extending quality abortion care to underserved populations.
Midwives	**Recommend**	This task is recognized as a core competency in midwifery.[a] Evidence was found for the safety and effectiveness (moderate certainty) and for women's satisfaction with the overall abortion experience (low certainty) with this option. Women often consider care received from midwives as more supportive compared with other health workers (moderate-certainty evidence). This option has been shown to be feasible, including in low-resource settings.
Associate/advanced associate clinicians	**Recommend**	Evidence was found for the safety and effectiveness (moderate certainty) and for women's satisfaction with the overall abortion experience (low certainty) with this option. This option is feasible in all resource settings, and may decrease inequities by extending quality abortion care to underserved populations.
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to traditional and complementary medicine professionals, auxiliary nurses and auxiliary nurse midwives was reviewed using GRADE methodology. After review, only the recommendation for traditional and complementary medicine professionals was upgraded, from "suggest" to "recommend"; the recommendations for all the other health worker categories remained unchanged. A summary of the evidence is presented in Supplementary material 3, EtD framework for Vacuum aspiration for all indications < 14 weeks.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

In a health-care facility. Both types of vacuum aspiration can be performed in a primary care facility and on an outpatient basis.

How

Implementation considerations

- While MVA is more commonly used and more likely in primary care settings, the skills required for EVA are similar, thus the recommendations above apply to the provision of either form of vacuum aspiration.
- MVA is used earlier in pregnancy and in the absence of access to a stable source of electricity.
- Dilatation and sharp curettage (D&C) should be replaced with MVA.

What

CLINICAL SERVICES Recommendation 25: Methods of surgical abortion at gestational ages ≥ 14 weeks

For surgical abortion at ≥ 14 weeks: **Recommend** dilatation and evacuation (D&E).

Remark:

- Vacuum aspiration can be used during a D&E (i.e. for the purpose of amniotomy or tissue removal at the end of the D&E).

Source: Recommendation 5 carried forward from WHO (2012) *(19)*. The wording has been revised to use the word "recommend" to indicate that this is a strong recommendation, and the gestational age has been changed from "over 12 to 14 weeks" to "14 weeks and above" (≥ 14 weeks), and medical methods were removed (medical methods at later gestational ages are covered in Recommendation 29 in this guidance).

Who

SERVICE DELIVERY Recommendation 26: Dilatation and evacuation (D&E) for surgical abortion at gestational ages ≥ 14 weeks

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Suggest** Condition: In settings where established health system mechanisms exist to include these health workers in other tasks related to maternal and reproductive health.	Although no direct evidence was found for the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] This type of health worker has been suggested (weak recommendation) to do other transcervical procedures, such as cervical priming with osmotic dilators, vacuum aspiration and inserting an IUD (see Recommendations 20, 24 and 43). The expert panel affirmed that this option has the potential to increase equitable access to quality abortion care in regions where these professionals constitute a significant proportion of the health workforce.
Midwives	**Suggest** Condition: In settings where established health system mechanisms exist to include these health workers in other tasks related to maternal and reproductive health.	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] This type of health worker has been recommended to do other transcervical procedures, such as cervical priming with osmotic dilators, vacuum aspiration and inserting an IUD (see Recommendations 20, 24 and 43).
Associate/advanced associate clinicians	**Suggest** Condition: In settings where established health system mechanisms exist to include these health workers in other tasks related to maternal and reproductive health.	Although no direct evidence was found on the safety or effectiveness of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that the potential benefits outweigh the possible harms, and this option has the potential to increase equitable access to quality abortion care beyond 14 weeks of gestation.

Table Continues

Table Continued

Type of health worker	Recommendation	Rationale[a]
Generalist medical practitioners	**Recommend**	No direct evidence was found on the safety or effectiveness of this option as compared with provision by specialist medical practitioners. However, it appears to be feasible in both high- and low-resource settings where D&E use is common. Such doctors routinely perform other surgical procedures, such as caesarean section, vacuum aspiration and tubal ligation. The potential benefits of this option outweigh the harms. A specialist provider may not always be available on-site and this option may therefore increase equitable access to quality abortion care.
Specialist medical practitioners	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to associate/advanced associate clinicians (previously only suggested in the context of rigorous research), midwives and traditional and complementary medicine professionals (both previously recommended against) was reviewed using GRADE methodology. After review, the recommendations were upgraded for all of them to a weak recommendation ("suggest"). The gestational age range was also amended from "beyond 12 weeks" to "14 weeks and above" (≥ 14 weeks) to align with Recommendation 25 on this topic. A summary of the evidence is presented in Supplementary material 3, EtD framework for D&E for surgical abortion ≥ 14 weeks.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

In a health-care facility. The procedure can be provided on an outpatient basis.

How

Implementation considerations

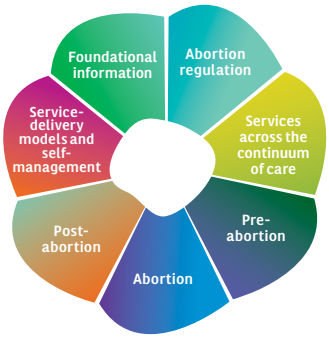
- For all providers, skills needed for D&E provision are greater than for a vacuum aspiration done in earlier pregnancy and training needs are higher.
- D&E includes the use of vacuum aspiration and therefore skills and knowledge of vacuum aspiration are relevant for this task.
- Health workers providing abortion or caring for women undergoing abortion at gestational ages ≥ 12 weeks may have additional needs for professional and mentoring support.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO SURGICAL ABORTION

- Health-care facilities, commodities and services must be available, accessible, acceptable and of good quality. This means they must be evidence-based and scientifically and medically appropriate and up to date.
- **AT < 14 WEEKS OF GESTATION:** As dilatation and sharp curettage (D&C) causes pain and suffering to women and is not recommended for use, its use is incompatible with numerous human rights including the right to health.
- **AT ≥ 14 WEEKS OF GESTATION:** States must ensure adequate access to essential medicines in an affordable and non-discriminatory manner.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations related to law and policy (Recommendations 1,2,3,6,7,21,22)

Health financing (section 1.4.2)

Commodities (section 1.4.4)

Recommendations 11–15 on pain management

3.4.2 Medical management of induced abortion

Medical management of spontaneous and induced abortion (for both viable and non-viable pregnancies) at early or later gestational ages involves the use of a single-dose regimen or a combination regimen of medicines used in sequence, with specific dosages and routes of administration.

The medicines that have been used for some decades for medical abortion are mifepristone in combination with misoprostol, or misoprostol alone. Similar to mifepristone, letrozole can be used in combination with misoprostol for medical abortion at early gestational ages. Letrozole is a third-generation selective aromatase inhibitor. Its mechanism of action involves suppression of estrogen levels, which modifies the progesterone receptor concentration, subsequently leading to pregnancy loss.

Medical abortion is a process that takes place over a period of up to several days rather than being a discrete procedure. In addition to information provision (including reasons to seek urgent care at any point during the process), medical abortion includes the following components or subtasks:

i. assessing eligibility for medical abortion (diagnosing and dating the pregnancy, ruling out medical contraindications);

ii. administering the abortion medicines with instructions on their appropriate use and managing the common side-effects;

iii. assessing whether the abortion process has had a successful outcome and whether any further intervention is required.

One health worker can provide the whole package of care for medical abortion, but it is equally possible for the subtasks to be carried out by different health workers and at different locations, including remotely. In addition, given the nature of the medical abortion process, it is also possible for women to manage the process by themselves outside of a health-care facility (e.g. at home), with support if and when needed. Such self-assessment and self-management approaches can be empowering for women and help to triage care, leading to a more woman-centred and more optimal use of health resources.

Routes of administration for misoprostol used for medical abortion:

- Oral – pills are swallowed immediately
- Buccal – pills are placed between the cheek and gums and swallowed after 20 to 30 minutes
- Sublingual – pills are placed under the tongue and swallowed after 30 minutes
- Vaginal – pills are placed in the vagina

What

CLINICAL SERVICES Recommendation 27: Medical management of induced abortion at gestational ages < 12 weeks

For medical abortion at < 12 weeks:

a. **Recommend** the use of 200 mg mifepristone administered orally, followed 1–2 days later by 800 µg misoprostol administered vaginally, sublingually or buccally. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.*

b. When using misoprostol alone: **Recommend** the use of 800 µg misoprostol administered buccally, sublingually or vaginally.*

c. **(NEW) Suggest** the use of a combination regimen of letrozole plus misoprostol (letrozole 10 mg orally each day for 3 days followed by misoprostol 800 µg sublingually on the fourth day) as a safe and effective option.*‡

Remarks:

- Evidence from clinical studies demonstrates that the combination regimen (Recommendation 27a) is more effective than misoprostol alone.
- All routes are included as options for misoprostol administration, in consideration of patient and provider preference.
- The suggested combination regimen of letrozole plus misoprostol may be safe and effective up to 14 weeks of gestation.

* Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. In this guideline we do not provide a maximum number of doses of misoprostol.

‡ Further evidence is needed to determine the safety, effectiveness and acceptability of the letrozole plus misoprostol combination regimen at later gestational ages, especially in comparison with that of the mifepristone plus misoprostol combination regimen (the available evidence focused on comparison with the use of misoprostol alone).

Source: Recommendations 27a and 27b carried forward from WHO (2018) where they were Recommendation 3a *(120)*. Recommendation 27c is new.

Rationale for Recommendation 27c (combination regimen of letrozole plus misoprostol)

A systematic review assessed the efficacy, safety and acceptability of alternative methods of medical abortion to the standard regimens using mifepristone and/or misoprostol. The literature search identified seven studies, all of which reported on the combination of letrozole plus misoprostol (intervention) versus misoprostol alone (comparison) for medical abortion. No studies were identified that compared letrozole plus misoprostol versus mifepristone plus misoprostol. The study settings included China, Egypt and the Islamic Republic of Iran. A summary of the evidence is presented in Supplementary material 2, EtD framework for New medical methods for abortion.

Overall, the evidence favoured the intervention. The use of letrozole in combination with misoprostol showed lower rates of ongoing pregnancy and higher rates of successful abortion, based on low- to very low-certainty evidence. In addition, fewer women experienced side-effects, based on moderate-certainty evidence.

Discussion on the cost-effectiveness, equity, feasibility and acceptability favoured the intervention. Letrozole's typical use for infertility and cancer treatment makes it more readily accessible than mifepristone in certain parts of the world. In addition, the low cost of letrozole is another contributing factor to making this an alternative method for medical abortion.

Who

SERVICE DELIVERY Recommendation 28: Medical management of induced abortion at gestational ages < 12 weeks,* in whole or in part (i.e. performing all or some of the subtasks; see list at start of section 3.4.2) using mifepristone plus misoprostol, or misoprostol alone‡

Type of health worker	Recommendation	Rationale[a]
Community health workers (CHWs)	**Recommend**	Evidence was found for the safety, effectiveness and acceptability of this option, for all three subtasks of medical abortion (moderate certainty). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] Indirect evidence also demonstrated the feasibility and acceptability of CHWs facilitating assessment of eligibility and outcome.
Pharmacy workers	**Recommend**	Limited evidence was found for the safety, effectiveness, acceptability or feasibility of this option (non-comparative studies). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] Indirect evidence on CHWs was applied to support the feasibility of this option.
Pharmacists	**Recommend**	Although insufficient evidence was found for the safety, effectiveness and acceptability of pharmacists performing the three subtasks of medical abortion, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] Dispensing medicines on prescription is within their typical scope of practice. The expert panel affirmed that, with the aid of tools for assessment of eligibility and outcome, it would be feasible for pharmacists to provide all three subtasks of medical abortion.
Traditional and complementary medicine professionals	**Recommend**	Evidence was found for the safety and effectiveness of this option, and for women's satisfaction with this type of provider and services provided by them (very low certainty). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that the benefits outweigh any possible harms, and the potential to increase equitable access to quality abortion care in regions where these professionals constitute a significant proportion of the health workforce is high.
Auxiliary nurses/ANMs	**Recommend**	Evidence was found for the safety and effectiveness of this option (moderate certainty). This option is feasible and is already being implemented in some low-resource settings.
Nurses	**Recommend**	Evidence was found for the safety and effectiveness of this option, and for women's satisfaction with abortion services with this option (moderate certainty).
Midwives	**Recommend**	Evidence was found for the safety and effectiveness of this option (moderate certainty). More women are satisfied with the provider when midwives provide medical abortion (moderate-certainty evidence). This option is feasible and is already being implemented in several countries.
Associate/advanced associate clinicians	**Recommend**	Insufficient direct evidence was found for the effectiveness of these clinicians carrying out components of the task, e.g. assessing gestational age as part of provision of manual vacuum aspiration. Evidence was also found that health worker types with similar or less comprehensive basic training (e.g. midwives, nurses, auxiliary nurse midwives) can provide medical abortion safely and effectively (moderate certainty). This option is feasible and the potential to expand access to underserved populations is high.
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Table Continues

Table Continued

Type of health worker	Recommendation	Rationale[a]
Individual/self		
Pregnant woman, girl or other pregnant person	**Recommend**	Please refer to Recommendation 50 in section 3.6.2 for rationale, remarks and implementation considerations for this recommendation and further information on self-management approaches.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to traditional and complementary medicine professionals (previously only recommended in contexts with established health system mechanisms for the participation of these health workers in other tasks related to maternal and reproductive health), pharmacists (previously only suggested in the context of rigorous research), pharmacy workers (previously "recommend against"), community health workers (previously only suggested in the context of rigorous research) and individual/self (self-management; previously "suggest") was reviewed using GRADE methodology. After review, the recommendations were upgraded for all of those health worker categories to "recommend", including all three subtasks of this intervention. A summary of the evidence is presented in Supplementary material 3, EtD framework for Medical abortion at < 12 weeks.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

* Available evidence for the independent provision of medical abortion by non-physicians is for pregnancy durations up to 10 weeks (70 days).

ǂ For this recommendation, the medical abortion regimens covered in the available evidence were mifepristone plus misoprostol, or misoprostol alone (the regimen using letrozole was not included).

No requirement for location (on-site vs off-site).

Implementation considerations

- It is not essential that the person providing the medical abortion should also be trained and competent in vacuum aspiration provision.
- Restrictions on prescribing and dispensing authority for some categories of health workers may need to be modified within the regulatory framework of the health system or other mechanisms put in place to allow these providers to make the medicines available to abortion seekers.
- Privacy should be ensured in all settings, in particular in places where a private space may be challenging (e.g. pharmacies).
- Support tools can be used to assess eligibility and outcome (e.g. high-sensitivity pregnancy tests, checklists).
- A range of service-delivery models exist to facilitate the medical abortion process, such as telemedicine or community outreach (see section 3.6.1).
- Mechanisms to ensure access to quality medicines need to be set up. Development of tools like point-of-care tests to assess quality could support both the pharmacy worker and the individual.
- It is important to note that as with all other medicines, pharmacy workers should dispense mifepristone and misoprostol as indicated by prescription.
- The person undergoing medical abortion should have access/referral to emergency care in case this becomes necessary.
- As part of the enabling environment, health workers should recognize self-management as a legitimate pathway to abortion care and to adapt health systems to facilitate and support women in their self-management of abortion, e.g. adapting clinical protocols.
- Mechanisms need to be established to ensure access or referrals to post-abortion contraception services and provision of contraceptives for women who want them.

What

CLINICAL SERVICES Recommendation 29: Medical management of induced abortion at gestational ages ≥ 12 weeks

For medical abortion at ≥ 12 weeks:

a. **Suggest** the use of 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered buccally, sublingually or vaginally every 3 hours.*‡ The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

b. When using misoprostol alone: **Suggest** the use of repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.*‡

Remarks:

- The combination regimen (Recommendation 29a) is more effective than use of misoprostol alone.
- Evidence suggests that the vaginal route is the most effective. Consideration for patient and provider preference suggests the inclusion of all routes.
- Pregnancy tissue should be treated in the same way as other biological material unless the individual expresses a desire for it to be managed otherwise.

* Misoprostol can be repeated at the noted interval as needed to achieve success of the abortion process. Providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with a prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with later gestational age.

‡ The dose of misoprostol should be reduced for induced abortion beyond 24 weeks due to limited data. Clinical judgement should be used to determine the appropriate dosage, recognizing the greater sensitivity of the uterus to prostaglandins.

Source: Recommendation 3b carried forward from WHO (2018) *(120).*

Who

SERVICE DELIVERY Recommendation 30: Medical management of induced abortion at gestational ages ≥ 12 weeks

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, these professionals have been recommended to provide medical abortion at < 12 weeks (Recommendation 28). The potential to increase equitable access to quality abortion care in regions where these professionals form a significant proportion of the health workforce is high.
Auxiliary nurses/ANMs	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, these health workers have been recommended to provide medical abortion at < 12 weeks (Recommendation 28). This option is feasible and acceptable and has the potential to increase equitable access to quality abortion care.

Table Continues

Table Continued

Type of health worker	Recommendation	Rationale[a]
Nurses	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although insufficient direct evidence was found for the safely and effectiveness of nurses providing this intervention as a whole, these health workers are often responsible for the monitoring and care of women from the time of misoprostol administration to completion of the abortion. Women often find abortion care provided by nurses to be more acceptable (moderate-certainty evidence).
Midwives	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although insufficient direct evidence was found for the safety and effectiveness of midwives providing this intervention as a whole, these health workers are often responsible for the monitoring and care of women from the time of misoprostol administration to completion of the abortion. Women often find abortion care provided by midwives to be more acceptable (moderate-certainty evidence).
Associate/advanced associate clinicians	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although insufficient direct evidence was found for the safety of effectiveness of this option, these clinicians routinely carry out tasks of similar complexity (e.g. vacuum aspiration and manual removal of placenta) *(138)*. These clinicians are often present at higher-level facilities where care during advanced gestation is provided. A trained specialist medical practitioner may not always be present at higher-level facilities and the potential to sustain services for advanced gestational ages is increased with more than one trained provider on site.
Generalist medical practitioners	**Recommend**	Although insufficient direct evidence was found for the safety and effectiveness of this option, generalist medical practitioners routinely carry out tasks of similar or greater complexity (e.g. conducting deliveries, manual removal of placenta, vacuum aspiration). The potential benefits of this option outweigh the harms and the intervention has proven feasible in several settings. A specialist medical practitioner may not always be available on-site and therefore this option may increase equitable access to quality abortion care.
Specialist medical practitioners	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Notes on updating of the recommendation: This was an existing recommendation for which evidence relating to all health worker categories was reviewed using GRADE methodology, except for specialist and generalist medical practitioners, for whom there was already a strong recommendation for this task. After review, the recommendations were upgraded for traditional and complementary medicine professionals and auxiliary nurses/ANMs from "recommend against" to "suggest" with specified conditions. For the other health worker categories reviewed, the recommendations remain unchanged. A summary of the evidence is presented in Supplementary material 3, EtD framework for Medical abortion at ≥ 12 weeks.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Medical abortion for pregnancies at gestational ages ≥ 12 weeks has been practised and researched as a facility-based procedure during which women should remain under observation until the process is complete.

Implementation consideration

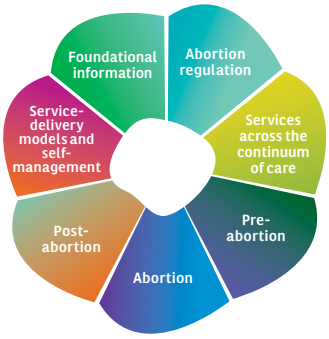
- Health workers providing abortion or caring for women undergoing abortion at gestational ages ≥ 12 weeks may have additional needs for professional and mentoring support.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO MEDICAL ABORTION

- Everyone has a right to privacy and confidentiality in sexual and reproductive health (SRH) care.
- Abortion regulation should be human rights and evidence based.
- States must ensure adequate access to essential medicines in an affordable and non-discriminatory manner.
- Everyone has the right to scientific progress and right to health, which requires the availability and accessibility, acceptability, and quality of medical abortion. This means that States should ensure access to abortion medicines, and that evidence-based standards and guidelines for the provision and delivery of SRH services, are (i) in place and (ii) routinely updated to incorporate medical advancements.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



- All recommendations related to law and policy (Recommendations 1,2,3,6,7,21,22)
- Information provision and counselling (section 3.2.1 and 3.2.2)
- Determining gestational age (section 3.3.5)
- Pain management for abortion (section 3.3.6)
- Self-management of medical abortion (section 3.6.2)

3.4.3 Missed abortion

Missed abortion is when a pregnancy stops developing, where the embryo/fetus/embryonic tissue or empty gestation sac remains in the uterus and the cervical os is closed. Symptoms may include pain, bleeding or no symptoms at all. If an ultrasound is done, the scan may show an embryo or fetus without cardiac activity, or what appears to be an early developing pregnancy, with only a fluid-filled sac visible within the uterus *(151)*. Medical, surgical (vacuum aspiration) and expectant management are all options for management of missed abortion.

What

CLINICAL SERVICES Recommendation 31 (NEW): Medical management of missed abortion at gestational ages < 14 weeks

For missed abortion at < 14 weeks, for individuals preferring medical management: **Recommend** the use of combination mifepristone plus misoprostol over misoprostol alone.

- Recommended regimen: 200 mg mifepristone administered orally, followed by 800 µg misoprostol administered by any route (buccal, sublingual, vaginal).*
- Alternative regimen: 800 µg misoprostol administered by any route (buccal, sublingual, vaginal).‡

Remarks:

- The decision about the mode of management (expectant, medical or surgical) of missed abortion should be based on the individual's clinical condition and preference for treatment.
- Expectant management can be offered as an option on the condition that the woman, girl or other pregnant person is informed of the longer time for expulsion of the pregnancy tissue and the increased risk of incomplete emptying of the uterus.
- Pregnancy tissue should be treated in the same way as other biological material unless the individual expresses a desire for it to be managed otherwise.

* The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

‡ If using the alternative regimen (misoprostol alone), it should be noted that at gestational ages ≥ 9 weeks, evidence shows that repeat dosing of misoprostol is more effective to achieve success of the abortion process. In this guideline we do not provide a maximum number of doses of misoprostol.

Rationale

A systematic review was undertaken to address this key question. Twenty studies reporting on management for missed abortion were identified by the search strategy. These studies were conducted in China, Germany, India, Israel, Malaysia, Pakistan, Sweden, Thailand, United Kingdom, USA and Yemen. A summary of the evidence is presented in Supplementary material 2, EtD framework for Medical management of missed abortion at < 14 weeks.

Of these studies, 19 were assessed that included one of the following comparisons:

- Mifepristone and misoprostol versus misoprostol alone
- Medical versus expectant management
- Surgical versus medical/expectant management

Medical management in comparison to expectant management produced lower rates of ongoing pregnancy and higher rates of successful abortion (uterine evacuation without surgical intervention), based on moderate- to high-certainty evidence. When comparing the combination regimen with misoprostol alone, the combination regimen produced higher rates of successful abortion. This recommendation is based on moderate-certainty evidence. Complications and side-effects were also fewer, based on moderate- to high-certainty evidence. Women expressed greater satisfaction with the combination mifepristone plus misoprostol regimen, based on high-certainty evidence. Surgical management in comparison to medical and expectant management produced higher rates of successful abortion, based on low- to moderate-certainty evidence. Discussion of women's values and preferences underlined the importance of offering the option of all three types of management to the woman. For the medical regimen, the expert panel determined that given the varied regimens of the included studies, the recommended and suggested regimens for induced abortion at < 12 weeks of gestation can be applied (see Recommendation 27).

Who

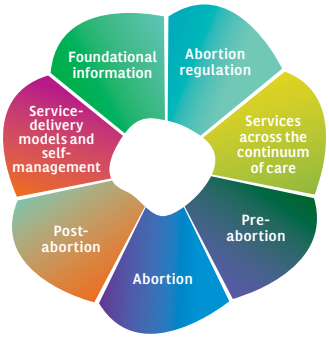
Regarding who is recommended to provide medical management of missed abortion at < 14 weeks of gestation, refer to Recommendation 28 for medical management of induced abortion at gestational ages < 12 weeks.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO MANAGEMENT OF MISSED ABORTION

- Everyone has a right to privacy and confidentiality in sexual and reproductive health (SRH) care.
- Abortion regulation should be human rights and evidence based.
- States must ensure adequate access to essential medicines in an affordable and non-discriminatory manner.
- Everyone has the right to scientific progress and right to health, which requires the availability and accessibility, acceptability, and quality of medical abortion. This means that States should ensure access to abortion medicines, and that evidence-based standards and guidelines for the provision and delivery of SRH services, are (i) in place and (ii) routinely updated to incorporate medical advancements.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



Commodities (section 1.3.4)

Information provision and counselling (sections 3.2.1 and 3.2.2)

Recommendation 27: Medical management of induced abortion < 12 weeks

3.4.4 Intrauterine fetal demise (IUFD)

Fetal demise (fetal death) refers to situations in which the fetus is no longer alive, but the uterus has not yet started to expel its contents and the cervical os remains closed *(152)*. The diagnosis is made by ultrasound scan following the clinical findings, which can include vaginal bleeding, absent fetal heart sounds on electronic auscultation, a failure to feel fetal movements or a uterus that is significantly smaller than the expected size *(152)*. IUFD may be managed expectantly, or treated surgically (D&E) or medically.

CLINICAL SERVICES Recommendation 32: Medical management of IUFD at gestational ages ≥ 14 to ≤ 28 weeks

For medical management of IUFD at ≥ 14 to ≤ 28 weeks: **Suggest** the use of combination mifepristone plus misoprostol over misoprostol alone.

- Suggested regimen: 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.*‡ The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.
- Alternative regimens: repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.*‡

Remarks:

- Evidence from clinical studies indicates that the combination regimen is more effective than the use of misoprostol alone.
- Pregnancy tissue should be treated in the same way as other biological material unless the individual expresses a desire for it to be managed otherwise.

* Misoprostol can be repeated at the noted interval as needed to achieve success of the abortion process. Providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with later gestational age.

‡ The dose of misoprostol should be reduced for IUFD beyond 28 weeks due to limited data. Clinical judgement should be used to determine the appropriate dosage, recognizing the greater sensitivity of the uterus to prostaglandins.

Source: Recommendation 2 carried forward from WHO (2018) *(120)*. Wording has been revised to match that used for Recommendation 31 on missed abortion.

SERVICE DELIVERY Recommendation 33 (NEW): Medical management of intrauterine fetal demise (IUFD) at gestational ages ≥ 14 to ≤ 28 weeks

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, these professionals have been recommended to provide medical abortion at < 12 weeks (Recommendation 28). The expert panel affirmed that the potential to increase equitable access to quality abortion care in regions where such professionals constitute a significant proportion of the health workforce is high.
Auxiliary nurses/ANMs	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although no direct evidence was found on the safety, effectiveness or acceptability of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, these health workers have been recommended to provide medical abortion at < 12 weeks (Recommendation 28). The expert panel determined that this option is feasible and acceptable with the potential to increase equitable access to quality abortion care.

Table Continues

Table Continued

Type of health worker	Recommendation	Rationale[a]
Nurses	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although insufficient direct evidence was found for the safety and effectiveness of this option, these health workers are often responsible for the monitoring and care of women from the time of misoprostol administration to completion of the abortion. Women often find abortion care provided by nurses to be more acceptable compared with other health workers (moderate-certainty evidence).
Midwives	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although insufficient direct evidence was found for the safety and effectiveness of this option, these health workers are often responsible for the monitoring and care of women from the time of misoprostol administration to completion of the abortion. Women often find abortion care provided by midwives to be more acceptable compared with other health workers (moderate-certainty evidence).
Associate/advanced associate clinicians	**Suggest** Condition: In contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although insufficient direct evidence was found for the safety and effectiveness of this option, these clinicians routinely carry out tasks of similar complexity, such as vacuum aspiration and manual removal of placentas *(138)*. These clinicians are often present at higher-level facilities where care is provided in advanced gestation. A trained specialist medical practitioner may not always be present at a higher-level facility and the potential to sustain services for advanced gestational ages is increased with more than one trained provider on site.
Generalist medical practitioners	Recommend	Although insufficient direct evidence was found for the safety and effectiveness of this option, these professionals routinely carry out tasks of similar or greater complexity (e.g. conducting deliveries, manual removal of placentas, vacuum aspiration). The potential benefits of this option outweigh the harms, and the intervention has proven feasible in several settings. A specialist medical practitioner may not always be available on site and therefore this option may increase equitable access to quality abortion care.
Specialist medical practitioners	Recommend	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Note: This is a new recommendation. There was no recommendation on medical management of IUFD in WHO's 2015 guideline on health worker roles *(23)*, but a clinical services recommendation on this intervention was provided in WHO's 2018 guideline, *Medical management of abortion (120)*. Due to the lack of direct evidence on this topic and the similarity between the two tasks, Recommendation 30 for medical abortion at ≥ 12 weeks of gestation was applied here. A summary of the evidence is presented in Supplementary material 3, EtD framework on Medical management of intrauterine fetal demise.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Medical abortion for pregnancies at gestational ages ≥ 12 weeks has been practised and researched as a facility-based procedure during which women should remain under observation until the process is complete.

Implementation consideration

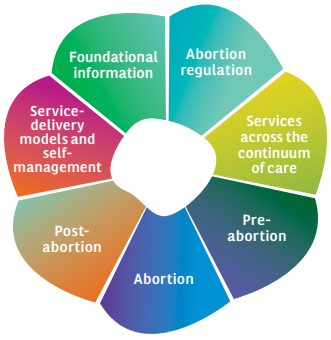
- Any regulation around the management/disposal of pregnancy remains and birth or death certificates should not pose a burden or a breach of confidentiality for women or providers.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO MANAGEMENT OF IUFD

- Everyone has a right to privacy and confidentiality in sexual and reproductive health (SRH) care.
- Abortion regulation should be human rights and evidence based.
- States must ensure adequate access to essential medicines in an affordable and non-discriminatory manner.
- Everyone has the right to scientific progress and right to health, which requires the availability and accessibility, acceptability, and quality of medical abortion. This means that States should ensure access to abortion medicines, and that evidence-based standards and guidelines for the provision and delivery of SRH services, are (i) in place and (ii) routinely updated to incorporate medical advancements.

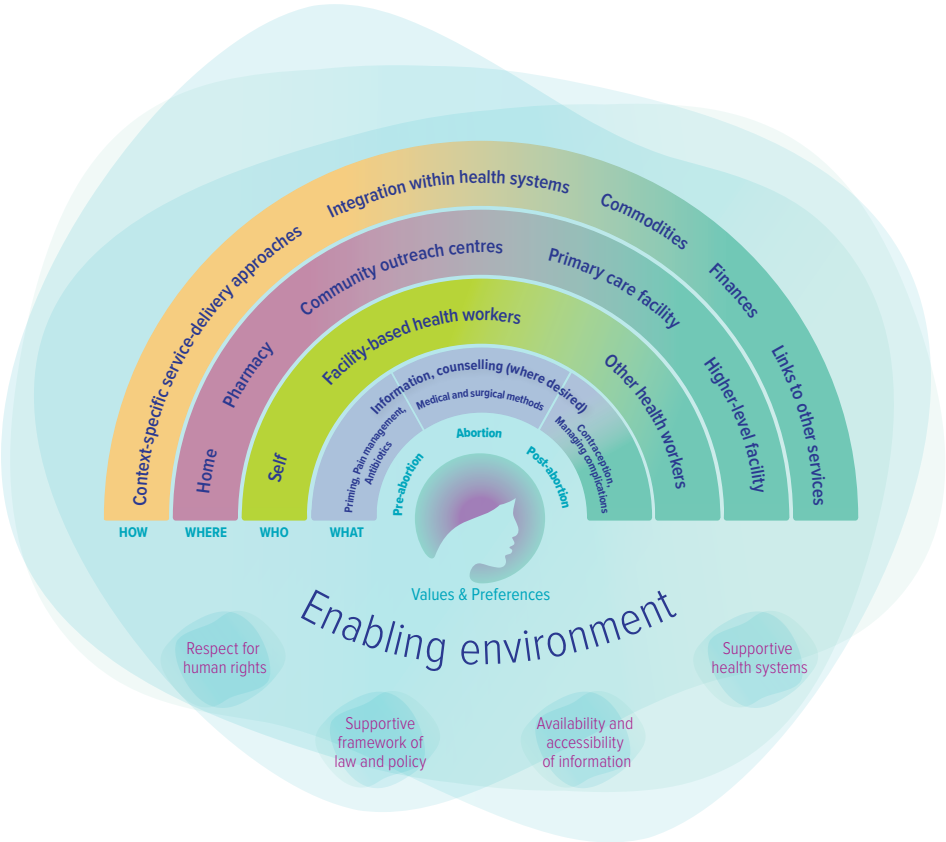
For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations relating to law and policy (Recommendations 1,2,3,6,7,21,22)

3.5 Post-abortion



The post-abortion period is the third and final part of the continuum of care for abortion. Post-abortion care includes any or all of the following, as needed or desired: optional follow-up check-up, management of residual side-effects or complications, and contraception services. When done safely, abortion complications are rare, but they can include incomplete abortion, haemorrhage, infection, uterine perforation, anaesthesia-related complications, uterine rupture. In line with international human rights law and medical best practice, post-abortion care should always be provided regardless of whether abortion is restricted in a particular setting.

3.5.1 Follow-up care after abortion

Routine follow-up is not necessary following an uncomplicated surgical or medical abortion, if the individual has adequate information about when to seek care for complications and has received any appropriate supplies or information to meet contraceptive needs. However, an optional follow-up visit 7–14 days after the procedure may be offered to provide contraceptive services, emotional support or management of any medical concerns.

If the woman chooses to attend a follow-up appointment, then use the contact to:

- assess the individual's recovery and inquire about any signs or symptoms of ongoing pregnancy;
- review any available medical records and referral documents;
- ask about any symptoms experienced since the procedure;
- perform a focused physical examination if needed to assess any complaints; and
- assess the individual's fertility goals and need for contraceptive services.
    - If no contraceptive method was provided or started at the time of the abortion, provide information on contraception and offer contraceptive counselling and provision of contraceptive services, if desired by the woman.
    - If a contraceptive method was already started, assess the method used and address any concerns or resupply as needed *(122)*.

What

CLINICAL SERVICES Recommendation 34: Follow-up care or additional services after abortion

Following uncomplicated surgical abortion or medical abortion: **Recommend** that there is no medical need for a routine follow-up visit. However, information should be provided about the availability of additional services if they are needed or desired.

Remarks:

- Women, girls and other pregnant persons must be adequately informed about symptoms of ongoing pregnancy (which may or may not indicate failure of the abortion) and other medical reasons to return for follow-up, such as prolonged heavy bleeding, no bleeding at all with medical management of abortion, pain not relieved by medication, or fever.
- The quality of the evidence was low (observational studies and indirect evidence).

Source: Recommendation 9 updated from WHO (2012) *(19)*.

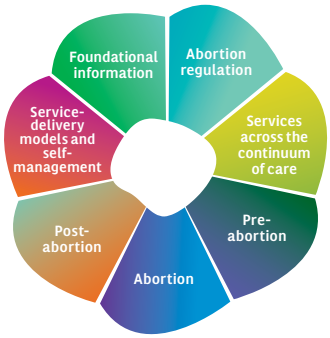
Note on updating of the recommendation: This was an existing recommendation for which an updated literature search was conducted, but GRADE methodology was not applied. The wording of the recommendation was revised to remove the medical abortion regimen that was mentioned (this recommendation now applies to all abortion methods and regimens, see section 3.4) and to use the word "recommend" to make clear this is a strong recommendation.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO FOLLOW-UP CARE

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

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations relating to law and policy (Recommendations 1,2,3,6,7,21,22)

Information provision (section 3.2.1)

3.5.2 Incomplete abortion

Incomplete abortion is defined by clinical presence of an open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus, or the expelled products are not consistent with the estimated duration of pregnancy. Common symptoms include vaginal bleeding and abdominal pain. Uncomplicated incomplete abortion can result after an induced or spontaneous abortion (i.e. miscarriage); the management in both cases is the same. Incomplete abortion may be managed expectantly, medically or surgically (vacuum aspiration). Managing uncomplicated incomplete abortion with vacuum aspiration (when uterine size is less than 14 weeks) includes recognizing the condition, assessing uterine size, the actual procedure and pain management.

What

CLINICAL SERVICES Recommendation 35 and 36:
Management of incomplete abortion

35. For incomplete abortion at < 14 weeks: **Recommend** either vacuum aspiration or medical management.

36a. For the medical management of incomplete abortion at < 14 weeks uterine size: **Suggest** the use of 600 µg misoprostol administered orally or 400 µg misoprostol administered sublingually.

36b. For the medical management of incomplete abortion at ≥ 14 weeks uterine size: **Suggest** the use of repeat doses of 400 µg misoprostol administered sublingually, vaginally or buccally every 3 hours.*

Remarks:

- The decision about the mode of management of incomplete abortion should be based on the individual's clinical condition and preference for treatment.
- Expectant management of incomplete abortion can be as effective as misoprostol; it can be offered as an option on the condition that the woman, girl or other pregnant person is informed of the longer time for expulsion of the pregnancy tissue and the increased risk of incomplete emptying of the uterus.
- Recommendation 35 was extrapolated from research conducted in women with reported spontaneous abortion.

* Misoprostol can be repeated at the noted interval as needed to achieve success of the abortion process. At gestational ages ≥ 14 weeks, providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with advanced gestational age.

Source: Recommendation 35 carried forward from WHO (2012) where it was Recommendation 10 *(19)*. The wording has been revised to amend the gestational age from "13 weeks or less" to "before 14 weeks" (< 14 weeks). Recommendations 36a and 36b carried forward from WHO (2018) where they were Recommendations 1A and 1B *(120)*. The gestational ages have also been updated to change the cut-off point from 13 weeks to 14 weeks.

Who

SERVICE DELIVERY Recommendation 37: Medical management of uncomplicated incomplete abortion with misoprostol at gestational ages < 14 weeks

Type of health worker	Recommendation	Rationale[a]
Community health workers (CHWs)	**Recommend**	No direct evidence was found for this option, but some indirect evidence was found that CHWs can use simple tools and checklists to determine gestational age (based on patient history), and to assess eligibility for and the outcome of medical abortion (low to moderate certainty). CHWs are often involved in advising women seeking abortion care (moderate-certainty evidence). In general, CHW interventions are acceptable and have proved feasible in many contexts. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a]
Pharmacy workers **Pharmacists**	**Recommend**	Although insufficient evidence was found for the safety and effectiveness of this option, the skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] In addition, the skills required for managing incomplete abortion with misoprostol are similar to those for provision of medical abortion at < 12 weeks, which is a recommended task for these health workers (see Recommendation 28).
Traditional and complementary medicine professionals	**Recommend**	Evidence was found for the safety and effectiveness of these professionals providing medical abortion at gestational ages < 12 weeks (low certainty), and the skills required for managing incomplete abortion with misoprostol are similar. In addition, the skills and knowledge for this task (according to the competency framework) align with the competencies of this type of health worker.[a]
Auxiliary nurses/ANMs	**Recommend**	Evidence was found for the safety and effectiveness of these health workers providing medical abortion at gestational ages < 12 weeks (moderate certainty), and the skills required for managing incomplete abortion with misoprostol are similar.
Nurses	**Recommend**	Indirect evidence was found for the safety, effectiveness and acceptability of nurses providing medical abortion (moderate certainty), and the skills required for managing incomplete abortion with misoprostol are similar. The option is feasible and has the potential to increase equitable access to quality abortion care.
Midwives	**Recommend**	Evidence was found from a low-resource setting for the safety and effectiveness of this option (moderate to high certainty). Women's overall satisfaction with the provider was high when midwives manage incomplete abortion (moderate-certainty evidence). This option is feasible and has the potential to increase equitable access to quality abortion care.
Associate/advanced associate clinicians	**Recommend**	Moderate-certainty indirect evidence was found for the safety and effectiveness of medical management of incomplete abortion by midwives, and moderate-certainty evidence was also found for the safety and effectiveness of medical abortion provision by health worker types with similar or less comprehensive basic training. Additionally, direct evidence was found that these clinicians can assess gestational age (by uterine size) as part of provision of manual vacuum aspiration. This option is feasible and the potential to increase equitable access to quality abortion care is high.
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendations for which evidence relating to traditional and complementary medicine professionals (previously "suggest"), pharmacists and pharmacy workers (both previously "recommend against") and community health workers (previously "within the context of rigorous research") was reviewed using GRADE methodology, since the other health workers already had a strong recommendation for this task. After review, the recommendations were upgraded to "recommend" for all of the reviewed health worker categories. A summary of the evidence is presented in Supplementary material 3, EtD framework on Medical management of incomplete abortion.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

No requirement for location (on-site vs off-site).

How

Implementation considerations

- Restrictions on prescribing authority for some categories of providers may need to be modified or other mechanisms put in place for making the medicines available for these providers within the regulatory framework of the health system.
- The evacuation of retained products is a signal function of basic emergency obstetric care (EmOC); thus training and implementation of these tasks can be integrated with EmOC services.

Who

SERVICE DELIVERY Recommendation 38: Vacuum aspiration for management of uncomplicated incomplete abortion at gestational ages < 14 weeks

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Recommend**	Evidence was found for the effectiveness of these professionals carrying out components of the task, such as assessing uterine size with bimanual examination as part of medical abortion provision (very low certainty). The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] These professionals perform other transcervical procedures (e.g. IUD insertion) in some settings. This option has the potential to increase equitable access to quality abortion care in regions where these professionals constitute a significant proportion of the health workforce.
Auxiliary nurses/ANMs	**Suggest** Condition: In contexts where established health system mechanisms involve auxiliary nurses/ANMs in providing basic emergency obstetric care, and where referral and monitoring systems are strong.	Insufficient direct evidence was found for the safety and effectiveness of this option. However, the option of this type of health worker delivering emergency obstetric care (which includes removing retained products as a signal function) or post-abortion care using manual vacuum aspiration has been shown to be feasible in programmes in several low-resource settings.
Nurses	**Recommend**	Evidence was found for the safety and effectiveness of these health workers providing vacuum aspiration for induced abortion (low certainty), and the skills required for the management of uncomplicated incomplete abortion with vacuum aspiration are similar. The option is feasible, including in low-resource settings.
Midwives	**Recommend**	Indirect evidence was found for the safety and effectiveness of these health workers providing vacuum aspiration for induced abortion (moderate certainty), and the skills required for the management of uncomplicated incomplete abortion with vacuum aspiration are similar. The option is feasible, including in low-resource settings.

Table Continues

Table Continued

Type of health worker	Recommendation	Rationale[a]
Associate/advanced associate clinicians	**Recommend**	Indirect evidence was found for the safety and effectiveness of these clinicians providing of vacuum aspiration for induced abortion (moderate certainty), and the skills required for the management of uncomplicated incomplete abortion with vacuum aspiration are similar.
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to traditional and complementary medicine professionals and for auxiliary nurses and auxiliary nurse midwives was reviewed using GRADE methodology. After review, only the recommendation for traditional and complementary medicine professionals was upgraded from "suggest" to "recommend". For all the other health worker categories, the recommendations remain unchanged from the previous guidance. A summary of the evidence is presented in Supplementary material 3, EtD framework on Vacuum aspiration for management of incomplete abortion.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

In a health-care facility.

How

Implementation considerations

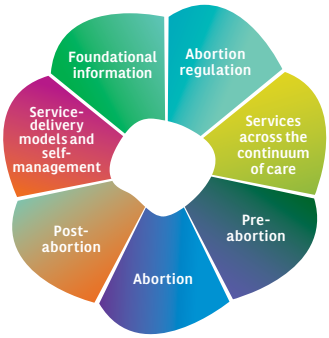
- The skills required for the provision of both MVA and EVA are similar, so the recommendations above apply to both. MVA is more commonly used and more likely to be used in primary care settings.
- Uncomplicated incomplete abortion can result after an induced or spontaneous abortion (i.e. miscarriage). The management is identical and the above recommendations apply to both.
- The evacuation of retained products is also a signal function of basic emergency obstetric care (EmOC) and training and implementation can be integrated with EmOC services.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO MANAGEMENT OF INCOMPLETE ABORTION

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

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations relating to law and policy (Recommendations 1,2,3,6,7,21,22)

Commodities (section 1.4.4)

3.5.3 Management of non-life-threatening complications: infection and haemorrhage

Initial and basic management includes recognizing the complication, stabilizing the woman, providing oral or parenteral antibiotics and intravenous fluids prior to referral to an appropriate health worker/facility.

Who

SERVICE DELIVERY Recommendation 39: Initial management of non-life-threatening post-abortion infection*

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Recommend**	Although no direct evidence was found for the management of post-abortion infection by these health workers, their basic training covers the skills required for this task. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] The expert panel affirmed that this option is feasible and that it has the potential to increase equitable access to post-abortion care.
Auxiliary nurses/ANMs **Nurses** **Midwives** **Associate/advanced associate clinicians**	**Recommend**	Although no direct evidence was found for the management of post-abortion infection by these health workers, the management of puerperal sepsis with intramuscular antibiotics, which requires similar skills, is within their typical scope of practice *(138)*.[b]
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to traditional and complementary medicine professionals, pharmacists, pharmacy workers and community health workers was reviewed using GRADE methodology. After review, the recommendation was only upgraded for traditional and complementary medicine professionals, from "suggest" to "recommend." For all other health worker categories reviewed, the recommendations remain "recommend against" (not listed). A summary of the evidence is presented in Supplementary material 3, EtD framework on Diagnosis and management of abortion-related complications.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

* For the pharmacists, pharmacy workers and community health workers, it is important that they are equipped with the knowledge to recognize signs and symptoms of this complication.

Where

No requirement for location (on-site vs off-site).

How

Implementation considerations

- It is important that pharmacists, pharmacy workers and community health workers are equipped with the knowledge to recognize signs and symptoms of the complications of unsafe abortion and to know where to refer women in their communities.
- Restrictions on prescribing authority for some categories of providers may need to be modified or other mechanisms put in place for allowing such providers to administer the antibiotics within the regulatory framework of the health system.

Who

SERVICE DELIVERY Recommendation 40: Initial management of non-life-threatening post-abortion haemorrhage*

Type of health worker	Recommendation	Rationale[a]
Traditional and complementary medicine professionals	**Recommend**	No direct evidence was found for the management of post-abortion haemorrhage by these professionals, but their basic training covers the skills required for this task. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a]
Auxiliary nurses/ANMs	**Recommend**	Although no direct evidence was found for the management of post-abortion haemorrhage by these health workers, the initial management of post-partum haemorrhage with intravenous (IV) fluids, which requires similar skills, is a task that these health workers are recommended to do *(138)*.
Nurses **Midwives** **Associate/advanced associate clinicians**	**Recommend**	Although no direct evidence was found for the management of post-abortion haemorrhage by these health workers, the initial management of post-partum haemorrhage with IV fluids, which requires similar skills, is within their typical scope of practice *(138)*.
Generalist medical practitioners **Specialist medical practitioners**	**Recommend**	Within their typical scope of practice,[b] therefore no assessment of the evidence was conducted.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to traditional and complementary medicine professionals, pharmacists, pharmacy workers and community health workers was reviewed using GRADE methodology. After review, the recommendation was only upgraded for traditional and complementary medicine professionals, from "suggest" to "recommend". For all other health worker categories reviewed, the recommendations remain "recommend against" (not listed). A summary of the evidence is presented in Supplementary material 3, EtD framework on Diagnosis and management of abortion-related complications.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

* For the pharmacists, pharmacy workers and community health workers, it is important that they are equipped with the knowledge to recognize signs and symptoms of this complication.

Where

No requirement for location (on-site vs off-site).

How

Implementation consideration

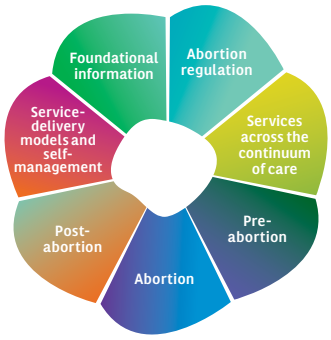
- Initial management of haemorrhage and infection is also a signal function of basic emergency obstetric care (EmOC) and training and implementation can be integrated with EmOC services.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO NON-LIFE-THREATENING COMPLICATIONS

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

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations relating to law and policy (Recommendations 1,2,3,6,7,21,22)

3.5.4 Post-abortion contraception

Following an induced or spontaneous abortion, ovulation can return as early as 8–10 days later and usually within one month, and thus contraception initiation as soon as possible within the first month is important for women who desire to delay or prevent a future pregnancy *(153, 154)*. All contraceptive options may be considered after an abortion. The client's wishes are paramount; if the individual wishes to start or resume a contraceptive method, then all contraceptive options may be considered at any point in care and some methods can be initiated at the time of the abortion *(155)*. States are required to ensure there is access to a wide range of modern, safe and affordable contraceptive methods *(36 [para. 8], 49 [para. 33])*. Criteria laid out in the WHO publications *Ensuring human rights in the provision of contraceptive information and services* and *Medical eligibility criteria for contraceptive use* should be adhered to *(156, 157)*. In-depth consideration of all methods of post-abortion contraception is outside the scope of this guideline.

This section addresses the timing of contraception and the health workers who can provide certain methods. The role of self-management approaches with post-abortion contraception will be discussed further in section 3.6.3.

What

CLINICAL SERVICES Recommendation 41: Medical eligibility criteria for post-abortion contraception

The following contraceptive methods may be started immediately (MEC Category 1 – no restrictions) after a surgical or medical abortion (first and second trimester, and also after a septic abortion): combined hormonal contraceptives (CHCs), progesterone-only contraceptives (POCs) and barrier methods (condoms, spermicide, diaphragm, cap – note: The diaphragm and cap are unsuitable until 6 weeks after second-trimester abortion)

Intrauterine devices (IUDs) may be started immediately after a first-trimester surgical or medical abortion (MEC Category 1 – no restrictions) or after second-trimester abortion (MEC Category 2 – the advantages generally outweigh the risks), but should not be started immediately after septic abortion (MEC Category 4 – insertion of an IUD may substantially worsen the condition).

Fertility-awareness-based (FAB) methods: Symptom-based methods should only be started after abortion with "caution" (special counselling may be needed to ensure correct use of the method in this circumstance) and the use of calendar-based methods should be delayed (until the condition is evaluated; alternative temporary methods of contraception should be offered).

Notes:

- Refer to the box below for an explanation of the MEC categories.
- CHCs include combined oral contraceptives (COCs), the contraceptive patch (P), the combined vaginal ring (CVR) and combined injectable contraceptives (CICs).
- POCs include progesterone-only pills (POPs), levonorgestrel (LNG) or etonogestrel (ETG) implants, depot medroxyprogesterone acetate (DMPA) injectables, and norethisterone enanthate (NET-EN) injectables.
- IUDs include copper-bearing IUDs (Cu-IUD) and levonorgestrel-releasing IUDs (LNG-IUD).
- Symptoms-based methods include the cervical mucus method (also called the ovulation method) and the TwoDay Method, which are both based on the evaluation of cervical mucus, and the sympto-thermal method, which is a double-check method based on evaluation of cervical mucus to determine the first fertile day and evaluation of cervical mucus and temperature to determine the last fertile day.
- Calendar-based methods include the Calendar Rhythm Method (avoiding unprotected intercourse from the first to the last estimated fertile days, after recording the length of several menstrual cycles as a basis for calculation) and the Standard Days Method (avoiding unprotected intercourse on cycle days 8–19, for people whose cycles are usually 26–32 days long).

Source: Recommendations brought in from WHO's *Medical eligibility criteria for contraceptive use* (2015) *(157)*. The wording has been revised to narrative format from the tables in the source guideline.

Key to MEC categories for contraceptive eligibility

- Category 1 – A condition for which there is no restriction for the use of the contraceptive method
- Category 2 – A condition where the advantages of using the method generally outweigh the theoretical or proven risks
- Category 3 – A condition where the theoretical or proven risks usually outweigh the advantages of using the method
- Category 4 – A condition which represents an unacceptable health risk if the contraceptive method is used.

CLINICAL SERVICES Recommendation 42: Timing of contraception and surgical abortion

For individuals undergoing surgical abortion and wishing to use contraception: **Recommend** the option of initiating the contraception at the time of surgical abortion.

Remark:

- The quality of evidence based on randomized controlled trials was very low.

Source: Part of Recommendation 13 carried forward from WHO (2012) *(19)*. Only the component of the existing recommendation that is relevant to surgical abortion has been retained, with the word "recommend" used to clarify that it is a strong recommendation and revisions made to include all contraceptive methods).

CLINICAL SERVICES Recommendation 43: Timing of contraception and medical abortion

For individuals undergoing medical abortion with the combination mifepristone and misoprostol regimen or with misoprostol alone:

a. For those who choose to use **hormonal contraception** (oral contraceptive pills, contraceptive patch, contraceptive ring, contraceptive implant or contraceptive injections): **Suggest** that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen.

b. For those who choose to have an **IUD** inserted: **Suggest** IUD placement at the time that success of the abortion procedure is determined.

Remark (for Recommendations 43a and b):

- This recommendation applies to the combination mifepristone plus misoprostol regimen and the use of misoprostol alone. The letrozole plus misoprostol combination regimen is not mentioned here because the included studies informing these recommendations did not assess this regimen.

Remarks (for Recommendation 43a only):

- Immediate initiation of intramuscular depot medroxyprogesterone acetate (DMPA) is associated with a slight decrease in the effectiveness of medical abortion regimens *(158)*. However, immediate initiation of DMPA should still be offered as an available contraceptive method after an abortion.
- Indirect evidence was used as a basis for decision-making on initiation of hormonal contraception as an option for individuals undergoing medical abortion with misoprostol alone.
- No data were available on the use of combined hormonal contraception (pills or injections) by those undergoing medical abortion.
- Individuals who choose to initiate the contraceptive ring should be instructed to check for expulsion of the ring in the event of heavy bleeding during the medical abortion process.

Source: Recommendations 4a and 4b carried forward from WHO (2018) *(120)*.

Who

SERVICE DELIVERY Recommendation 44: Insertion and removal of intrauterine devices (IUDs)

Type of health worker	Recommendation	Rationale
Traditional and complementary medicine professionals	**Suggest** Condition: In contexts with established health system mechanisms for the participation of these professionals in other tasks related to maternal and reproductive health.	Their basic training generally covers the relevant skills needed for this task. This option is probably feasible and may promote continuity of care for women and increase access in regions where these professionals constitute a significant proportion of the health workforce.
Auxiliary nurses	**Suggest** Condition: In the context of rigorous research.	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
ANMs **Nurses** **Midwives**	**Recommend**	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
Associate/advanced associate clinicians **Generalist medical practitioners** **Specialist medical practitioners**	**Recommend**	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*, where this task was considered to be within their typical scope of practice.[a]

Source: Recommendation carried forward from WHO (2015) *(23)*.

[a] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Who

SERVICE DELIVERY Recommendation 45: Insertion and removal of implants

Type of health worker	Recommendation	Rationale
Community health workers	**Suggest** Condition: In the context of rigorous research.	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
Traditional and complementary medicine professionals	**Suggest** Condition: In contexts with established health system mechanisms for the participation of these professionals in other tasks related to maternal and reproductive health and where training in implant removal is given along with training in insertion.	Although insufficient direct evidence was found for the safety and effectiveness of this option, their basic training covers the relevant skills needed for this task. This option may promote continuity of care for women.
Auxiliary nurses/ANMs	**Suggest** Condition: In the context of targeted monitoring and evaluation.	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
Nurses **Midwives**	**Recommend**	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
Associate/advanced associate clinicians **Generalist medical practitioners** **Specialist medical practitioners**	**Recommend**	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*, where this task was considered to be within their typical scope of practice.[a]

Source: Recommendation carried forward from WHO (2015) *(23)*.

[a] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

How

Implementation consideration

- The removal of implants can require greater skills than insertion; any health worker trained to independently insert implants should also be well trained on implant removal *(23)*.

Where

In a health-care facility or other setting with sterile conditions.

Who

SERVICE DELIVERY Recommendation 46: Administration of injectable contraceptives (initiation and continuation)

Type of health worker	Recommendation	Rationale[a]
Community health workers (CHWs)	**Recommend**	Limited evidence was found for the safety, effectiveness and feasibility of this option. The skills and knowledge for this task (according to the competency framework) align with the competencies for CHWs.[a] This option is feasible and acceptable given that CHWs provide other components of abortion care. In addition, this option has the potential to increase women's choices and reduce inequities in contraceptive access.
Pharmacy workers	**Recommend**	Although no evidence was found for the safety, effectiveness, acceptability or feasibility of this option, administering injections is within their typical scope of practice[b] and the additional training needs for this task would be minimal. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] This option has the potential to increase women's choices and reduce inequities in contraceptive access.
Pharmacists	**Recommend**	Although the available evidence for the safety and effectiveness of this option is of very low certainty, administering injections is within their typical scope of practice[b] and the additional training needs for this task would be minimal. This option has the potential to increase women's choices and reduce inequities in contraceptive access.
Traditional and complementary medicine professionals	**Recommend**	Their basic training covers the relevant skills needed for this task, hence additional training needs would be minimal. The skills and knowledge for this task (according to the competency framework) align with the competencies for this type of health worker.[a] This option is feasible and acceptable given that these professionals provide similar services in the existing health system, and thus it may promote continuity of care for women.
Auxiliary nurses/ANMs	**Recommend**	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
Nurses **Midwives** **Associate/advanced associate clinicians** **Generalist medical practitioners** **Specialist medical practitioners**	**Recommend**	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*, where this task was considered to be within their typical scope of practice.[b]

Table Continues

Table Continued

Type of health worker	Recommendation	Rationale[a]
Individual/self		
Pregnant woman, girl or other pregnant person	**Recommend**	Refer to Recommendation 51 in section 3.6.2 for the rationale, remark, implementation considerations and further information about self-management approaches.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence relating to traditional and complementary medicine professionals, pharmacy workers, community health workers and individuals/self (self-administration) was reviewed using GRADE methodology. After review, recommendations for all three of those health worker categories were upgraded from "suggest" to "recommend". The recommendations for the other health worker categories were not reviewed and remain unchanged, such that all health worker categories and the individual/self now have a strong recommendation for this task. A summary of the evidence is presented in Supplementary material 3, EtD framework on Delivery of injectable contraceptives.

[a] For this and all health worker recommendations, given the limited evidence for many of the health worker–task combinations, the discussions of the expert panel focused on the competency framework in WHO's 2011 publication, *Sexual and reproductive health: core competencies in primary care (121)*, which provides information on the competencies (including skills and knowledge) required for each task, and also the WHO-INTEGRATE criteria, in particular on the feasibility, equity and acceptability of the intervention and women's values and preferences.

[b] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

Where

No requirement for location (on-site vs off-site).

How

Implementation considerations

- The administration of an injectable contraceptive involves using a syringe and may be intramuscular or subcutaneous.
- It is important to have adequate mechanisms for the disposal of used sharps, syringes and needles.
- It is important to ensure a consistent supply of the injectables, especially at the point of sale for women to obtain and use on their own.
- The investment in initial training is a consideration where the health worker is not already certified to provide injections. It is important to have mechanisms to link the health worker to the health system and ensure a referral pathway.

Who

SERVICE DELIVERY Recommendation 47: Tubal ligation

Type of health worker	Recommendation	Rationale
Nurses	**Suggest** Condition: In the context of rigorous research.	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
Midwives	**Suggest** Condition: In the context of rigorous research.	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*.
Associate/advanced associate clinicians **Generalist medical practitioners** **Specialist medical practitioners**	**Recommend**	The recommendation comes originally from the *OptimizeMNH* guideline *(138)*, where this task was considered to be within their typical scope of practice.[a]

Source: Recommendation carried forward from WHO (2015) *(23)*. The recommendations will be reviewed for the next update of the WHO guidance on optimizing health worker roles *(138)*.

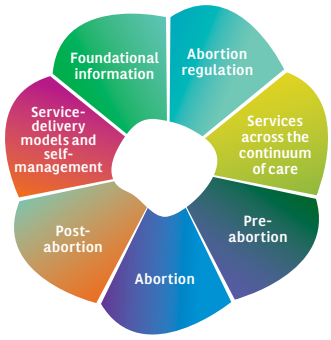
[a] For typical scope of work/practice, please refer to Annex 5: Health worker categories and roles.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO POST-ABORTION CONTRACEPTION

- Contraception should be provided only where the person has given free and informed consent to receive it.
- States must ensure availability of the full range of contraceptive options, including a wide range of modern, safe and affordable methods.
- States must ensure adequate access to essential medicines, including contraceptives, in an affordable and non-discriminatory manner.
- Everyone has a right to evidence-based information on all aspects of SRH, including contraceptives.
- Contraceptive information and services must be provided without discrimination, coercion or violence.
- Everyone has a right to privacy and confidentiality in the receipt of contraceptive information and services.
- Post-abortion contraceptive information and services should be available and accessible to adolescents without requiring parental or guardian authorization.
- States must guarantee that practices of conscientious refusal/objection do not infringe on the right to contraceptive information and services.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



Free and informed consent (section 1.3.1[v])

Commodities (section 1.4.4)

Information provision and counselling (sections 3.2.1 and 3.2.2)

3.6 Service-delivery options and self-management approaches

As indicated throughout this chapter so far, abortion care services can be provided by a range of health workers and some tasks can be managed by individuals themselves. Even for procedures that take place at a health-care facility, some elements of the care (e.g. pre-abortion information and counselling, cervical priming or post-abortion follow-up care) can take place in other locations.

Unlike surgical abortion, medical abortion is a process that takes place over a period of several hours or days rather than being a discrete procedure. The process as a whole or its components can take place at different locations including through self-management and/or with the support of different health workers at various stages of the process, making it possible – and in some cases desirable – to obtain care in a range of different settings, through a wide range of different options.

This section addresses supported service-delivery approaches (section 3.6.1) and self-management approaches. Self-management approaches addressed in this section include self-management of medical abortion (section 3.6.2), and self-management of post-abortion contraception (section 3.6.3).

3.6.1 Supported service-delivery approaches

Medical abortion services can be obtained from and provided or supported by a multitude of actors within the health system. Services may be delivered through a comprehensive model that addresses the full spectrum of abortion care or may include only specific components on the care pathway. Services could be delivered through the public or private sectors or nongovernmental organizations (NGOs), and may be received at a community-based, off-site location or even at home, and a variety of service-delivery models can co-exist at national, subnational and local levels.

Approaches to service delivery are not static and as the role of digital technologies grows and the science and evidence on effective interventions evolves, innovations will also continue to evolve. For this guideline, available evidence on various modalities of providing and/or supporting abortion care were reviewed. Examples of service-delivery approaches that were identified in the systematic reviews conducted for this guideline included:

- **Accompaniment models:** Where a community health worker provides support by accompanying the individual through the medical abortion process (by phone, secure technological platform, or in person), including providing information, counselling, emotional/moral support and/or logistical support (including referrals to and support interacting with local health-care facilities in the event that care is needed or desired).
- **Community outreach:** This includes health services that mobilize health workers to provide services to the population or to other health workers, away from the location where they usually work and live *(159)*. This is a strategy to mobilize health workers to remote or rural areas, such as mobile clinics. However, documented evidence on the use of this model for abortion care provision is limited.
- **Digital support tools:** These included apps providing information, text messaging reminders, and tools to assist in the assessment of pregnancy duration.
- **Harm reduction models:** Service models in the clinic setting, in which women are supported with pre-abortion information, are told where to find the medicines and how to use them and can return for post-abortion support if needed, but are not actually provided with the medicines to terminate the pregnancy.
- **Hotlines:** This typically refers to telephonic information services that can support women in accessing quality abortion care. Abortion hotlines may be limited to providing evidence-based information about services or may be linked to other service-delivery models that facilitate access to medicines and support women through the abortion process and after the abortion.
- **Social marketing:** Broadly defined as the application of marketing techniques to social problems and aims to persuade or motivate people to adopt specific sources of action or behaviour which are generally accepted as being beneficial. This approach to marketing has been well studied as a successful model for distribution of health interventions/commodities (e.g. condoms), however, documentation related to quality abortion care (i.e. abortion medicines and instructions) is more limited. It may be an option for increasing access and making care more affordable.

- **Social franchising:** This is described as a system of contractual relationships usually run by an NGO which uses the structure of a commercial franchise to achieve social goals. The overarching difference between social and commercial franchising is that social franchising seeks to fulfil a social benefit whereas commercial franchising is driven by profit. However, the limited evidence illustrates the potential inequities of such models *(160)*.
- **Telemedicine:** This is a mode of health service delivery where providers and clients, or providers and consultants, are separated by distance. The interaction may take place in real time (synchronously), using telephone or video link, or asynchronously using a store-and-forward method, when a query is submitted and an answer is provided later (e.g. by email, text or voice/audio message) *(161)*.

Across the range of service-delivery options, interactions between an abortion seeker and a health worker can take place in person or remotely. After review and assessment of the evidence by the expert panel, it was agreed that there was sufficient quantity and quality of evidence to support the formulation of a specific recommendation in relation to using telemedicine approaches as an alternative to in-person interactions for provision of medical abortion (see Recommendation 48).

The available evidence was inadequate to support the formulation of recommendations on any of the other service-delivery models. Instead, given the contextual nature of service-delivery approaches, the heterogeneity of the types of interventions and the overlaps between the approaches, a two-part best practice statement was developed to apply to all of them, with reference to service delivery in general, rather than any specific modality/model of service delivery (see Best Practice Statement 49).

What Who

SERVICE DELIVERY Recommendation 48 (NEW): Telemedicine approaches to delivering medical abortion care

Recommend the option of telemedicine as an alternative to in-person interactions with the health worker to deliver medical abortion services in whole or in part.

Remarks:

- The above recommendation applies to assessment of eligibility for medical abortion, counselling and/or instruction relating to the abortion process, providing instruction for and active facilitation of the administration of medicines, and follow-up post-abortion care, all through telemedicine.
- Hotlines, digital apps or one-way modes of communication (e.g. reminder text messages) that simply provide information were not included in the review of evidence for this recommendation.

Rationale

A systematic review was undertaken to address this key question. Ten studies reporting on medical abortion provision through telemedicine were identified by the search strategy. Four randomized controlled trials were conducted in Bangladesh, Cambodia, Egypt and Indonesia, and six observational studies took place in Canada, Peru and the USA. In studies comparing telemedicine with in-person medical abortion care services, there was no difference between the two groups in rates of successful abortion or ongoing pregnancies (based on very low-certainty evidence). Referrals for surgical intervention were fewer among women who used telemedicine (based on low-certainty evidence). Satisfaction with telemedicine services was high and comparable to the usual clinical services (based on very low-certainty evidence). A summary of the evidence is presented in Supplementary material 3, EtD framework on Telemedicine.

How

Implementation consideration

- Telemedicine services should include referrals (based on the woman's location) for medicines (abortion and pain control medicines), any abortion care or post-abortion follow-up required (including for emergency care if needed), and for post-abortion contraceptive services, which may apply to both medical and surgical abortion.

What Who

SERVICE DELIVERY Best Practice Statement 49 (NEW)

Part 1: There is no single recommended approach to providing abortion services. The choice of specific health worker(s) (from among the recommended options) or management by the individual themself, and the location of service provision (from among the recommended options) will depend on the values and preferences of the woman, girl or other pregnant person, available resources, and the national and local context. A plurality of service-delivery approaches can co-exist within any given context.

Part 2: Given that service-delivery approaches can be diverse, it is important to ensure that for the individual seeking care, the range of service-delivery options taken together will provide:

- access to scientifically accurate, understandable information at all stages;
- access to quality-assured medicines (including those for pain management);
- back-up referral support if desired or needed;
- linkages to an appropriate choice of contraceptive services for those who want post-abortion contraception.

A summary of the evidence is presented in Supplementary material 3, EtD framework on Medical abortion provided in different settings.

How

Implementation considerations

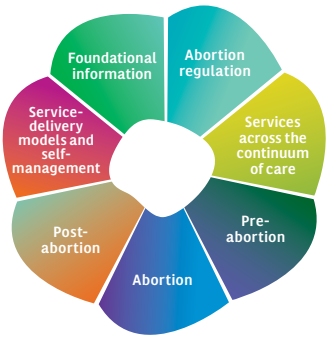
- Service-delivery approaches should, where feasible, be co-created with the people who will benefit from the intervention.
- All models should be tested and adapted for the local context in which they will operate.
- Not all service-delivery approaches may function at scale but for those that are being considered for national programmes, appropriate pilot testing is needed prior to scaling up.
- All service-delivery models should have mechanisms for monitoring quality and ensuring accountability.

KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO SERVICE-DELIVERY MODELS

- States should develop and enforce evidence-based standards and guidelines for the provision and delivery of sexual and reproductive health (SRH) services, and such guidance must be routinely updated to incorporate medical advancements. At the same time, States are required to provide age-appropriate, evidence-based, scientifically accurate comprehensive education for all on SRH.
- SRH services must be available, accessible, affordable, acceptable of good quality. This means that delivery of services must be respectful of the culture of individuals, minorities, peoples and communities, and sensitive to gender, age, disability, sexual diversity and life-cycle requirements.
- States must take steps to reduce maternal mortality and morbidity.
- States must make accurate, evidence-based abortion information available to individuals on a confidential basis
- States must ensure delivery of services on the basis of non-discrimination and equality.
- States must ensure delivery of services in a way that respects the right to scientific progress, meaning that States should ensure access to modern and safe forms of contraception, including emergency contraception, abortion medicines, assisted reproductive technologies, and other SRH goods and services, on the basis of non-discrimination and equality.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

Links to related topics/recommendations



All recommendations related to law and policy (Recommendations 1,2,3,6,7,21,22)

3.6.2 Self-management approaches for medical abortion in whole or in part

Self-care, as defined in the Glossary, is a broad-based concept and can encompass numerous actions that are intended to empower the individual to enhance their own health. Self-management approaches are one component of self-care. Given the nature of the medical abortion process, it is possible for women to manage the process by themselves in whole or part. While individuals may conduct some or all elements related to the abortion process (self-assessment of eligibility, self-administration of medicines and self-assessment of the success of the abortion) entirely on their own, more typically, self-management co-exists with interactions with trained health workers or with a health-care facility and in conjunction with service-delivery approaches described in section 3.6.1. It is the individual (i.e. the "self") who drives the process of deciding which aspects of the abortion care will be self-managed and which aspects will be supported or provided by trained health workers or in a health-care facility.

Women may self-manage parts or all of the abortion process for a variety of reasons related to individual circumstances and preferences. For some women, this may be the only feasible option within their context and for others it may represent an active choice. However, from the perspective of the health system, self-management should not be considered a "last resort" option or a substitute for a non-functioning health system. Self-management must be recognized as a potentially empowering and active extension of the health system and task-sharing approaches. A supportive enabling environment as described in Chapter 1, section 1.3, is equally applicable to self-management approaches as it is to other elements of care provision.

What Who

SELF-MANAGEMENT Recommendation 50:
Self-management of medical abortion in whole or in part at gestational ages < 12 weeks

For medical abortion at < 12 weeks (using the combination of mifepristone plus misoprostol or using misoprostol alone): **Recommend** the option of self-management of the medical abortion process in whole or any of the three component parts of the process:

- self-assessment of eligibility (determining pregnancy duration; ruling out contraindications)
- self-administration of abortion medicines and management of the abortion process outside of a health-care facility and without the direct supervision of a trained health worker
- self-assessment of the success of the abortion.

Remarks:

- There was more evidence for self-management of medical abortion (with either of the regimens) for pregnancies before 10 weeks of gestation.
- This recommendation applies to the combination regimen of mifepristone plus misoprostol, and the use of misoprostol alone. The included studies informing these recommendations did not assess the letrozole plus misoprostol regimen.
- All individuals engaging in self-management of medical abortion must also have access to accurate information, quality-assured medicines including for pain management, the support of trained health workers and access to a health-care facility and to referral services if they need or desire it.
- Restrictions on prescribing and dispensing authority for abortion medicines may need to be modified or other mechanisms put in place for self-management within the regulatory framework of the health system.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence for all of the subtasks was reviewed using GRADE methodology. After review, the recommendations for all subtasks were upgraded to "recommend" – from "suggest" for self-administration and self-assessment of outcome, and from "only in the context of rigorous research" for self-assessment of eligibility.

Where

No requirement for location (on-site vs off-site).

Rationale

Two systematic reviews were undertaken to address this key question. The first review focused on the self-assessment of eligibility and self-assessment of success. A total of 14 studies reporting on these two sub-tasks were identified by the search strategy. The four studies on self-assessment of eligibility took place in South Africa, the United Kingdom and the USA. Ten studies on self-assessment of success took place in Austria, Finland, India, Mexico, Nepal, Norway, South Africa, Sweden, Uzbekistan and Viet Nam. The second review was on the self-administration of medicines and included 18 studies, which took place in Albania, Bangladesh, China, France, India, Nigeria, Tunisia, Türkiye and Viet Nam. A summary of the evidence is presented in Supplementary material 2, EtD framework on Self-management of medical abortion.

Self-assessment of eligibility: There is low-certainty evidence on the safety, effectiveness and acceptability of self-assessment of eligibility for a medical abortion, using the start date of last menstrual period (LMP) alone or in combination with other tools (e.g. checklists). The expert panel discussed the feasibility of this intervention in certain scenarios such as the woman having regular menses, a known LMP and the availability of validated tools. When they have the necessary information, women are able to determine their eligibility for medical abortion. Given this and taking into account the values and preferences and high acceptability of this approach, the panel determined that the intervention was favoured.

Self-administration of medicines: There is evidence that the option of self-administering medicines for medical abortion is effective (moderate certainty) and safe (low certainty). Women reported high satisfaction with taking their own medicines for the abortion (very low-certainty evidence). There was high adherence to the medical abortion regimen (low-certainty evidence). The high acceptability and feasibility favoured this intervention.

Self-assessment of success: There is high-certainty evidence that self-assessment of abortion outcome/success (using tools such as a low-sensitivity pregnant test or multi-level pregnancy test) is as effective as assessment by a trained health worker. Low-certainty evidence indicated that more women in the self-assessment group expressed satisfaction with the process.

How

Implementation considerations

- Every individual must have access to accurate information about the self-management process as well as other options available within their local context, to enable informed decision making on whether to self-manage all or parts of the process.
- Self-assessment of eligibility includes the assessment of pregnancy duration based on LMP. Paper or digital tools to assist recall and calculate duration or checklists may assist in the self-assessment of eligibility. When menstrual cycles are irregular or women have other concerns, she should be encouraged to seek support from a trained health worker where possible.
- Self-administration of medicines and management of the medical abortion process involves taking all or some of the abortion medicines without the direct supervision of a health worker. It is important that all sources from which medicines are procured provide quality-assured medicines.
- Women should also have information about pain during the process and should be able to obtain medicines for pain management.
- Women should also have information about the requirements of managing abortion-related bleeding at home, and should have access/referral to emergency care if this becomes necessary.

- Self-assessment of the success of abortion can be done using check lists of signs and symptoms. Other tools (e.g. low-sensitivity pregnancy tests), if available, may be used to assist the woman in self-assessing completion. Low-sensitivity urine pregnancy tests are different from ordinary pregnancy tests. The use of a high-sensitivity pregnancy test (a multi-level pregnancy test [MLPT]) alone or in conjunction with checklists has been shown to have a higher sensitivity for detecting successful abortion. Access should be available to a health worker or health-care facility to confirm the success of abortion or to manage side-effects or complications.
- As part of the enabling environment, health workers and managers should recognize self-management as a legitimate pathway to abortion care, and should work to adapt health systems to facilitate and support women in their self-management of abortion – for example, by adapting clinical protocols used at their facility.
- Mechanisms need to be established to ensure access or referrals to post-abortion contraception services and provision of contraception for women who want them.
- While self-management can support efficiencies within health systems in the long term, it should not mean that the burden of the cost of health services is simply transferred from the provider or facility to the woman herself.

3.6.3 Self-management approaches for post-abortion contraception

All contraceptive options may be considered after an abortion. For further information, refer to section 3.5.4: Post-abortion contraception. Many family planning methods are entirely self-managed (i.e. self-procured over the counter or online and self-administered) and generally available without a prescription, including barrier methods and some hormonal contraceptives, including some oral contraceptive pills (OCPs), and also emergency contraceptive pills. For methods that have traditionally required a prescription from a doctor and/or administration by a health worker, shifting to include the option of using self-management approaches, such as over-the counter OCPs and self-injection of hormonal contraceptives, may improve continuation of contraceptive use by removing barriers, such as the need to return to a health-care facility every three months for a repeat injection. These approaches could expand access to contraception for those facing challenges in accessing health-care settings regularly, and in places where there are shortages of health workers, thus potentially greatly reducing the incidence of unintended pregnancy.

SELF-MANAGEMENT Recommendation 51: Self-administration of injectable contraception (initiation and continuation)[17]

Recommend the option of self-administration of injectable contraception in the post-abortion period.

Remark:

- The administration of an injectable contraceptive involves using a syringe and may be intramuscular or subcutaneous. Compact pre-filled auto-disable devices have been developed to facilitate the self-administration process.

Source: Recommendation updated from WHO (2015) *(23)*.

Note on updating of the recommendation: This was an existing recommendation for which evidence was reviewed using GRADE methodology. After review, the recommendation was upgraded from "suggest" to "recommend".

No requirement for location (on-site vs off-site).

17 Including a recommendation only on injectable contraception here does not imply that post-abortion contraceptive options for women should be limited to this method, or indeed to the methods covered by recommendations presented in section 3.5.4; all contraceptive methods can be considered after an abortion.

Rationale

A systematic review was undertaken to address this key question. Studies with indirect populations (i.e. women of reproductive age willing to initiate or continue with injectable contraceptive) were also considered for inclusion. Seven studies reporting on self-administered injectable contraceptives were identified by the search strategy and included in the reviewed evidence; three randomized controlled trials were conducted in Malawi and the USA and four observational studies were conducted in Senegal, Uganda, the United Kingdom and the USA. The evidence was considered indirect since none of the women included in the reviewed studies were described as seeking contraception post-abortion. A summary of the evidence is presented in Supplementary material 3, EtD framework on Self-administration of injectable contraception.

There is evidence that continuation rates for self-administered injectable contraceptives are higher compared with injectable contraceptives being provided by clinic-based providers (very low- to low-certainty evidence). Satisfaction was higher among the self-administration group (very low- to moderate-certainty evidence). The option may result in time and financial savings for women. In addition, this option may increase choice and autonomy in contraceptive use within a rights-based framework.

How

Implementation considerations

- There must be training in the technique for self-injection.
- There must be training in and the provision of mechanisms for the safe and secure storage and disposal of sharps (used injectable contraceptives), especially in settings with high HIV prevalence.
- The client must be able to procure injectable contraceptives on a regular basis without needing to repeatedly visit a health-care facility.

What Who

SELF-MANAGEMENT Recommendation 52: Over-the-counter oral contraceptive pills

Recommend that over-the-counter oral contraceptive pills (OCPs) should be made available without a prescription for individuals using OCPs.

SELF-MANAGEMENT Recommendation 53: Over-the-counter emergency contraceptive pills

Recommend making over-the-counter emergency contraceptive pills available without a prescription to individuals who wish to use emergency contraception.

SELF-MANAGEMENT Recommendation 54: Condom use

The consistent and correct use of male and female condoms is highly effective in preventing the sexual transmission of HIV; reducing the risk of HIV transmission both from men to women and women to men in serodiscordant couples; reducing the risk of acquiring other STIs and associated conditions, including genital warts and cervical cancer; and preventing unintended pregnancy.

Source: Recommendations 15, 16 and 18 brought in from WHO (2021) *(26)*.

Where

No requirement for location (on-site vs off-site).

How

Implementation considerations for OCPs

- Provide up to one year's supply of pills, depending on the woman's preference and anticipated use.
- Programmes must balance the desirability of giving women maximum access to pills with concerns regarding contraceptive supply and logistics.
- The resupply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.[18]

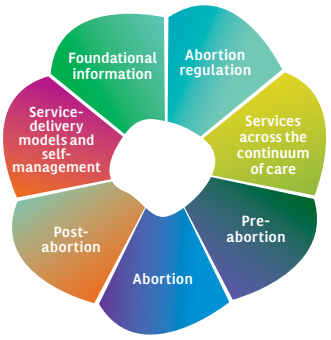
KEY HUMAN RIGHTS CONSIDERATIONS RELEVANT TO SELF-MANAGEMENT APPROACHES

- Sexual and reproductive health (SRH) care must be available, accessible, acceptable and of good quality.
- States must ensure availability of a wide range of modern, safe and affordable contraceptive methods.
- States must ensure adequate access to essential medicines in an affordable and non-discriminatory manner.
- States must respect autonomous decision-making, non-discrimination and equality. This means that States should repeal or reform laws and policies that nullify or impair the ability of certain individuals and groups to realize their right to SRH, including the criminalization of abortion or restrictive abortion laws.
- States must make accurate, evidence-based abortion information available to individuals on a confidential basis
- States must take steps to reduce maternal mortality and morbidity.
- In line with human rights requirements, self-management of abortion should not be criminalized. Criminalization of self-management of abortion may result in delays in or barriers to seeking assistance or post-abortion care where needed. Self-management of medical abortion should be available as an option on the basis of clinical appropriateness. It should not be restricted for non-clinical reasons such as age.

For further information and sources, please refer to Box 1.2 and Web annex A: Key international human rights standards on abortion.

18 These are Recommendations 20a, b and c from WHO (2021) *(26)*.

Links to related topics/recommendations



- All recommendations related to law and policy (Recommendations 1,2,3,6,7,21,22)
- Informed consent (in section 1.3.1: Human rights)
- Provision of information on quality abortion care (section 3.2.1)
- Provision of counselling (section 3.2.2)
- Pain management for abortion (section 3.3.6)

Chapter 4.

Dissemination, applicability, research gaps and future updates of the guideline and recommendations

4.1 Dissemination

This guideline will be published digitally (both an interactive web-based version and a traditional document available online for download) and in print; see further information in Annex 11.

Translation of the guideline into Spanish (in collaboration with the Pan American Health Organization [PAHO]), French and Portuguese is planned. Translations into other United Nations languages will be developed as needed.

Several derivative products will be developed based on this updated and consolidated guideline:*

- operational guidance containing details on implementation of the recommendations, including strategic considerations for improving access to quality abortion care for youth;
- informational materials, such as posters highlighting selected recommendations, which can be placed in health-care facilities and other appropriate places;
- pocket charts/cards for health workers, providing the updated recommendations for medical and surgical abortion and post-abortion contraception, and referral cards for referring individuals to other health-care services (adapted for use by different types of health workers and for different literacy levels);
- user-friendly decision-support tools for health workers and policy-makers, created with the input of end-users who will be engaged in the process of determining how best to translate the guidance for this purpose (the tools may include digital decision tools in the format of a mobile application [app]);
- case studies on quality abortion care in different humanitarian settings, to demonstrate and highlight the relevant considerations and requirements;
- operational guidance on medical management of select clinical indications, such as miscarriage.

* *Note:* Where applicable, WHO will collaborate with relevant United Nations agencies in the dissemination efforts. For example, WHO will collaborate with the Office of the United Nations High Commissioner for Human Rights (OHCHR) to disseminate guidance and tools to support application of a human rights-based approach to sexual and reproductive health, as well as respond to country requests for technical assistance to implement these approaches.

4.2 Implementation and impact evaluation of the guideline

Implementation of this guideline requires a multifaceted approach. After the initial publication, translation and dissemination efforts on regional, national and local levels (see Annex 11), it will be important to apply active techniques such as conducting workshops and training programmes to familiarize users with the guideline. Engagement by WHO team members with managers and staff of health-care facilities to build reminders about

the latest guidance into their clinical support systems will also be crucial. With regard to policy and programme planning, it will be important to work with policy-makers and national and local health officials to ensure implementation of the adopted recommendations at all levels of the health system. Engaging with national ministries and WHO country offices to contextualize the guidelines may facilitate adaptation of the guideline. It is anticipated that the main barrier to implementation of this guideline will be the subject matter – quality abortion care – which is a sensitive and stigmatized topic. This means that it is all the more important to work with stakeholders, including government, policy-makers and advocates for safe and legal abortion, to inform them about the guideline and facilitate open dialogue about the realities of abortion in their country. Using the Global Abortion Policies Database will facilitate these discussions *(116)*.

Process and impact evaluation will be ongoing during the first year of implementation of this guideline, focusing on the accessibility, acceptance, use, impact and generalizability of the guideline and its recommendations. As an assessment of document uptake, the engagement with the interactive online version of the guideline, the number of downloads of the document from the WHO website, and the number of hard copies of the guidance requested and distributed through the document centre will be monitored.

A year after publication, an evaluation of the immediate impact of the guidelines will be undertaken in the form of an online survey. This will be conducted through WHO regional and country offices and through selected respondents from other user groups (e.g. professional societies, NGOs) in order to gauge utilization in-country and whether and how any of the recommendations in the guideline have been implemented or have influenced policy decisions. This short-term impact evaluation will also include an assessment of barriers to effective implementation, which will be important feedback for derivative products and future modifications.

4.3 Research gaps/topics for further research

In the course of developing this guideline, during the meetings of the Evidence and Recommendation Review Groups (ERRGs) and the Guideline Development Group (GDG), several evidence gaps and areas for further research were identified.

Law and policy

- Impact of abortion laws and policies on people with disabilities and people with diminished capacity who seek abortion
- Impact of abortion laws and policies on groups in vulnerable situations and groups with marginalized identities, specifically adolescents and transgender individuals
- Impacts, effects and rights-related implications of procedural barriers to abortion in various contexts
- Impacts, effects and rights-related implications of making abortion available on the request of the woman, girl or other pregnant person, with no additional restrictions
- Impacts, effects, and rights-related implications of the decriminalization of self-management of abortion and of assistance with self-management of abortion

Clinical services

- Efficacy, safety and acceptability of the letrozole plus misoprostol combination regimen across gestational ages and compared with the mifepristone plus misoprostol combination regimen
- Effectiveness of using misoprostol alone (i.e. typical/real use outside of study conditions, optimal number of repeat doses)
- Efficacy, safety and acceptability of the use of misoprostol alone across gestational ages
- Effectiveness, safety and acceptability of outpatient medical abortion at gestational ages ≥ 12 weeks
- Safety, effectiveness and acceptability of anti-epileptics and anxiolytics for pain management for medical abortion at gestational ages ≥ 14 weeks
- Management of cervical priming prior to dilatation and evacuation (D&E) at gestational ages ≥ 18 weeks in settings where osmotic dilators are not available

- Optimal antibiotic regimens for post-abortion infection prophylaxis
- Effective methods for diagnosis and treatment of non-symptomatic ectopic pregnancy
- Safety and effectiveness of screening and antibiotic treatment for pelvic inflammatory disease before surgical abortion versus provision of pre- or perioperative prophylactic antibiotics without screening or risk assessment for pelvic inflammatory infection
- Effectiveness of telemedicine for medical abortion at gestational ages < 6 weeks
- Efficacy, safety and acceptability of all abortion methods and related clinical interventions across gestational ages in transgender, nonbinary and intersex individuals seeking abortion care
- Development and adaptation of validated materials to provide individuals engaging in self-management of abortion with the information they need to make informed decisions about the risks/benefits of and the alternatives to the use of different medical abortion regimens
- Development of effective and user-friendly information for abortion seekers, e.g. leaflets and web pages or information for use in the context of hotlines and telemedicine services
- Development and validation of quality training materials for use in training of providers on a range of abortion care services (e.g. to train pharmacists, pharmacy workers and community health workers to effectively provide – or support self-management of – all tasks involved in medical abortion at gestational ages < 12 weeks)
- Safety, convenience and acceptability of re-using manual vacuum aspiration (MVA) equipment

Service delivery

- Safety, effectiveness and feasibility of expansion of health worker roles for certain abortion care tasks in low- and middle-income settings (e.g. surgical abortion at gestational ages ≥ 12 weeks, vacuum aspiration for incomplete abortion)
- Feasibility of pharmacists administering injectable contraception in low- and middle-resource settings (implementation research)
- Impact of social marketing and social franchising approaches in abortion care assessed through evaluation research
- The most appropriate prescribing and dispensing authorities for abortion medicines, including comparison of self-sourced abortion medicines versus medicines prescribed and/or dispensed by trained health workers
- Mechanisms for ensuring individuals who manage medical abortion on their own have access to medicines for pain management and to contraceptive methods
- Acceptability of and satisfaction with a range of service-delivery approaches for quality abortion care for transgender, nonbinary and intersex individuals

Universal health coverage (UHC), health financing and commodities

- Impact of the WHO Model Lists of Essential Medicines changes to the mifepristone plus misoprostol combination regimen assessed through evaluation research

Indicators for use in monitoring and evaluation (M&E) of care

- Development and validation of indicators that include social and economic disability in addition to physical disability when calculating years living with abortion-related disability (in line with the growing focus on global burden of disease and disability estimation)
- Development and validation of standardized data-verification methods, so that abortion-related data can be presented with a verification score (as part of efforts to address the underreporting of abortion-related data as a result of abortion-related stigma)
- Development and increased use of qualitative methods for M&E of quality abortion care to assess barriers to progress and enablers for strengthening health system performance

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Annexes

Annex 1. External experts and WHO staff involved in guideline development

Members of the Evidence and Recommendation Review Groups (ERRGs)

There were three ERRGs (expert panels), one for each domain of this guidance: Clinical services, Service delivery, Law and policy. Below each list of ERRG members, additional contributors to the pre-ERRG scoping meetings are listed per domain.

Clinical services domain ERRG members

Name	**Affiliation** **City, country**	**WHO region of residence**	**Expertise**	**Declarations/ conflicts of interest**
Laura Castleman	Planned Parenthood Michigan and University of Michigan Ann Arbor, MI, United States of America (USA)	Americas	Obstetrics and gynaecology	None
Suchitra Dalvie	Sexual and reproductive health programme consultant Mumbai, India	South-East Asia	Abortion, advocacy	None
Michalina Drejza	International Youth Alliance for Family Planning (IYAFP) Poznań, Poland	Europe	Obstetrics and gynaecology, youth	None
Kristina Gemzell Danielsson[a]	Department of Women's and Children's Health, Karolinska Institutet Stockholm, Sweden	Europe	Obstetrics and gynaecology, abortion research	None
Laura Gil[a]	Fundación Educación Para la Salud Reproductiva (ESAR) (Education Foundation for Reproductive Health) Bogotá, Colombia	Americas	Abortion, contraception	None
Selma Hajri[a]	TAWHIDA Group for Research and Action on Women's Health Tunis, Tunisia	Eastern Mediterranean	Abortion, contraception, research	None
Guyo Jaldesa	University of Nairobi Nairobi, Kenya	Africa	Obstetrics and gynaecology	None
Dhammika Perera[a]	Marie Stopes International London, United Kingdom of Great Britain and Northern Ireland	Europe	Abortion, contraception	None
Alongkone Phengsavanh	University of Health Sciences Vientiane, Lao People's Democratic Republic	Western Pacific	Obstetrics and gynaecology, abortion care	None
Judiac Ranape[a]	Department of Health Cape Town, South Africa	Africa	Nursing, nurse training, abortion care	None
Kitihoun Serge	Reproductive Health Unit, Alfred Comlan Quenum Regional Institute of Public Health Ouidah, Benin	Africa	Abortion, contraception	None
Human rights adviser				
Christina Zampas	Center for Reproductive Rights Geneva, Switzerland	Europe	Law, human rights, sex work, forced sterilization	None

[a] These members also contributed to the scoping meeting for this domain, in advance of the ERRG meetings, along with the following additional contributing experts: Abigail Aiken (University of Texas, USA), Rodica Comendant (Reproductive Health Training Center, Republic of Moldova), Debora Diniz (Instituto de Bioética, Brazil), Angel Foster (University of Ottawa, Canada), Daniel Grossman (University of California, San Francisco, USA), Kinga Jelinksa (Women Help Women, Netherlands), Munir Kassa (Center for International Reproductive Health Training, Ethiopia), Rasha Khoury (Médecins Sans Frontières, Afghanistan), Alice Mark (National Abortion Federation, USA), Mariana Romero (Center for the Study of State and Society, Argentina), Marion Stevens (Sexual and Reproductive Justice Coalition, South Africa), Nadira Sultana (Global Fund – United Nations Office for Projects Services, Bangladesh).

Service delivery domain ERRG members

Name	Affiliation City, country	WHO region of residence	Expertise	Declarations/ conflicts of interest
Fauzia Akhter Huda[a]	Maternal and Child Health Division, International Centre for Diarrhoeal Disease Research Bangladesh (ICDDRB) Dhaka, Bangladesh	South-East Asia	Public health, health systems, abortion	None
Nana Yaa Appiah	Women's Voices Foundation Accra, Ghana	Africa	Pharmacy, social marketing, professional development	None
Karla Berdichevsky	Gender Equity and Reproductive Health, Mexico Federal Ministry of Health Mexico City, Mexico	Americas	Sexual and reproductive health programming, policy and research	None
Jemima Araba Dennis-Antwi	Ghana College of Nurses and Midwives Accra, Ghana	Africa	Health systems strengthening, maternal health, midwifery, nursing training	None
Surendra Dhital	Independent Pharmacist Kathmandu, Nepal	South-East Asia	Pharmacy, counselling, safe abortion	None
Caitlin Gerdts[a]	Ibis Reproductive Health Oakland, CA, USA	Americas	Qualitative research, use of technology, access to abortion	None
Daniel Maceira	Economics Department, University of Buenos Aires Buenos Aires, Argentina	Americas	Health systems research, health programming and policy development	None
Vinoj Manning[a]	Ipas Development Foundation New Delhi, India	South-East Asia	Health systems, abortion care	None
Sybil Nkeiru	Generation Initiative for Women and Youth Network (GIWYN) Lagos, Nigeria	Africa	Human rights activist	None
Hiromi Obara[a]	Department of Health Planning and Management, Bureau of International Health Cooperation, National Center for Global Health and Medicine Tokyo, Japan	Western Pacific	Health planning and management, Maternal health and abortion policy	None
Karan Parikh	International Youth Alliance for Family Planning (IYAFP) Mumbai, India	South-East Asia	Clinician, youth	None
Michelle Remme	United Nations University's International Institute for Global Health (UNU-IIGH) Kuala Lumpur, Malaysia	Western Pacific	Research, gender, health system financing	None
Karthik Srinivasan[b]	International Planned Parenthood Federation (IPPF) London, United Kingdom	Europe	Commodities, health system	None
Human rights adviser				
Christina Zampas	Center for Reproductive Rights Geneva, Switzerland	Europe	Law, human rights, sex work, forced sterilization	None

[a] These members also contributed to the scoping meeting(s) for this domain, in advance of the ERRG meetings, along with the following additional contributing experts: Patrick Aboagye (Ghana Health Services, Ghana), Laura Castleman (Ipas, Planned Parenthood and University of Michigan, USA), Amanda Cleeve (Karolinksa Institutet, Sweden), Saida Chowdhury (Independent consultant, USA), Rodica Comendant (Reproductive Health Training Center, Republic of Moldova), Joanna Erdman (Dalhousie University, Canada), Rebecca Gomperts (Women on Waves, Netherlands), Chisale Mhango (University of Malawi, Malawi), Monica Oguttu (Kisumu Medical and Education Trust, Kenya), Paul Mandira (United Nations Population Fund, USA), Mariana Romero (Center for the Study of State and Society, Argentina), Sarmad Soomar (International Youth Alliance for Family Planning, Pakistan).

[b] This member began working for a funding agency before the final ERRG meeting and therefore his involvement in guideline development ended at that point.

Law and policy domain ERRG members

Name	Affiliation City, country	WHO region of residence	Expertise	Declarations/ conflicts of interest
Marge Berer	International Campaign for Women's Right to Safe Abortion London, United Kingdom	Europe	Social science, abortion policy	None
Joanna Erdman[a]	Schulich School of Law, Dalhousie University Halifax, Canada	Americas	Human rights, health law and policy	None
Godfrey Kangaude	University of Pretoria and University of Toronto Blantyre, Malawi	Africa	Sexual and reproductive health and rights law	None
Akila Radhakrishnan	Global Justice Center New York, NY, USA	Americas	Law and policy	None
Ruben Avila Reyna	International Youth Alliance for Family Planning (IYAFP) Youth Taskforce Nuevo León, Mexico	Americas	Human rights, advocacy, youth	None
Chi-Chi Undie	Population Council Nairobi, Kenya	Africa	Abortion and contraception, policy	None
Human rights advisers				
Abhijit Das	Centre for Health and Social Justice New Delhi, India	South-East Asia	Human rights	None
Sara Hossain	Bar of the Supreme Court of Bangladesh Dhaka, Bangladesh	South-East Asia	Law and policy, human rights	None
Karima Khalil	Maternal and Child Health Consultant New Delhi, India	South-East Asia	Law and policy, human rights	None
Primah Kwagala	Director, Women's Probono Initiative Kampala, Uganda	Africa	Law and policy, human rights	None
Monica Arango Olaya	Faculty of Law, University of Oxford Oxford, United Kingdom	Europe	Law and policy, human rights	None
Xian Warner	Research and Program Coordinator, The Equality Institute Dili, Timor-Leste	Western Pacific	Law and policy, human rights	None
Christina Zampas[a]	Center for Reproductive Rights Geneva, Switzerland	Europe	Law, human rights, sex work, forced sterilization	None

[a] These members also contributed to the scoping meeting(s) for this domain, in advance of the ERRG meetings, along with the following additional contributing experts: Paola Bergallo (University of Torcuato Di Tella, Argentina), Lucia Berro Pizzarossa (University of Groningen, Netherlands), Scott Burris (Temple University, USA), Fiona de Londras (Birmingham University, United Kingdom), Silvia de Zordo (University of Barcelona, Spain), Debora Diniz (Instituto de Bioética, Brazil), Heather Douglas (University of Queensland, Australia), Daniel Grossman (University of California, San Francisco, USA), Selma Hajri (TAWHIDA Group for Research and Action on Women's Health, Tunisia), Jihan Jacob, Center for Reproductive Rights, Philippines), Minzee Kim (Ewha Womans University, Republic of Korea), Chisale Mhango (University of Malawi, Malawi), Mahesh Puri (Centre for Research on Environment, Health and Population Activities, Nepal), Patricia Schulz (Committee on the Elimination of Discrimination against Women, Switzerland), Patty Skuster (Ipas, USA), Marion Stevens (Sexual and Reproductive Justice Coalition, South Africa), Maya Unnithan (University of Sussex, United Kingdom).

Members of the Guideline Development Group (GDG), and declarations of interests

Name	Job title, affiliation City, country	WHO region of residence	Expertise	Declarations/ conflicts of interest
Fauzia Akhter Huda	Project Coordinator, Maternal and Child Health Division, International Centre for Diarrhoeal Disease Research Bangladesh (ICDDRB) Dhaka, Bangladesh	South-East Asia	Public health, health systems, abortion	None
Karla Berdichevsky	Director, Gender Equity and Reproductive Health, Mexico Federal Ministry of Health Mexico City, Mexico	Americas	Sexual and reproductive health programming, policy and research	None
Marge Berer	Coordinator, International Campaign for Women's Right to Safe Abortion London, United Kingdom	Europe	Law and policy	None
Laura Castleman (CHAIR)	Associate Medical Director, Planned Parenthood of Michigan and Adjunct Clinical Assistant Professor, University of Michigan Ann Arbor, MI, USA	Americas	Obstetrics and gynaecology	None
Michalina Drejza	Director on Research and Development, International Youth Alliance for Family Planning (IYAFP) Poznań, Poland	Europe	Obstetrics and gynaecology, youth	None
Joanna Erdman	Associate Professor, Health Law and Policy, Schulich School of Law, Dalhousie University Halifax, Nova Scotia, Canada	Americas	Law and policy	None
Kristina Gemzell Danielsson	Head, Department of Women's and Children's Health, Karolinska Institutet Stockholm, Sweden	Europe	Obstetrics and gynaecology, abortion research	None
Caitlin Gerdts	Vice President for Research, Ibis Reproductive Health Oakland, CA, USA	Americas	Qualitative research	None
Laura Gil	Clinician Bogotá, Colombia	Americas	Clinical	None
Selma Hajri	Founder and President, TAWHIDA Group for Research and Action on Women's Health Tunis, Tunisia	Eastern Mediterranean	Abortion, contraception, research	None
Guyo Jaldesa	Associate Professor of Obstetrics and Gynaecology, University of Nairobi Nairobi, Kenya	Africa	Obstetrics and gynaecology	None
Godfrey Kangaude	Postdoctoral Researcher, University of Pretoria, and Reproductive and Sexual Health Law Fellow, University of Toronto Blantyre, Malawi	Africa	Sexual and reproductive health and rights law	None
Vinoj Manning	Chief Executive Officer Ipas Development Foundation New Delhi, India	South-East Asia	Health systems	None
Hiromi Obara	Medical Doctor, Deputy Director, Division of Global Health Policy and Research, Department of Health Planning and Management, Bureau of International Health Cooperation Japan, National Center for Global Health and Medicine, and Project Coordinator, Cambodia, Japan International Cooperation Agency (JICA) Tokyo, Japan	Western Pacific	Health systems	None
Alongkone Phengsavanh	Vice Dean, Faculty of Medicine, University of Health Sciences Vientiane, Lao People's Democratic Republic	Western Pacific	Obstetrics and gynaecology, abortion care	None
Akila Radhakrishnan	President, Global Justice Center New York, NY, USA	Americas	Law and policy	None

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Name	Job title, affiliation City, country	WHO region of residence	Expertise	Declarations/ conflicts of interest
Michelle Remme	Research Lead, United Nations University's International Institute for Global Health (UNU-IIGH) Kuala Lumpur, Malaysia	Western Pacific	Research, gender, health system financing	None
Chi Chi Undie	Senior Associate, Population Council Nairobi, Kenya	Africa	Abortion and contraception, policy	None
Human rights adviser				
Christina Zampas	Associate Director of Global Advocacy, Center for Reproductive Rights Geneva, Switzerland	Europe	Human rights	None

GDG meeting observers:

- Patricia Lohr, Medical Director, British Pregnancy Advisory Service (BPAS), London, United Kingdom; also member of Royal College of Obstetricians and Gynaecologists (RCOG) Making Abortion Safe Programme Advisory Group
- Jaydeep Tank, Secretary General of the Federation of Obstetrics and Gynaecological Societies of India (FOGSI) and Chair, International Federation of Obstetrics and Gynaecology (FIGO) Working Group for safe abortion, Mumbai, India
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Annex 2. Selected human rights treaties and their treaty monitoring bodies

For more detailed information on the how international human rights standards apply to abortion, refer to Web annex A: Key international human rights standards on abortion, available at: https://apps.who.int/iris/handle/10665/349317.

Treaty (in chronological order)	Abbreviation	Year of adoption	Year entered into force	Treaty monitoring body (TMB)[a]	Abbreviation
International Convention on the Elimination of All Forms of Racial Discrimination	ICERD	1965	1969	Committee on the Elimination of Racial Discrimination	CERD
International Covenant on Civil and Political Rights	ICCPR	1966	1976	Human Rights Committee	HRC
International Covenant on Economic, Social and Cultural Rights	ICESCR	1966	1976	Committee on Economic, Social and Cultural Rights	CESCR
Convention on the Elimination of All Forms of Discrimination against Women	CEDAW	1979	1981	Committee on the Elimination of Discrimination against Women	CEDAW
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	CAT	1984	1987	Committee against Torture	CAT
Convention on the Rights of the Child	CRC	1989	1990	Committee on the Rights of the Child	CRC
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	ICMW	1990	2003	Committee on Migrant Workers	CMW
Convention on the Rights of Persons with Disabilities	CRPD	2006	2008	Committee on the Rights of Persons with Disabilities	CRPD

[a] Also sometimes referred to as "treaty bodies".

Further information on the Core International Human Rights Instruments and their TMBs is available at: https://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx

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Annex 4. Guideline development methods and process

A. Guideline development working groups

Please refer to Annex 1 for the names of members of each of the working groups (and declarations of interests). A summary of the key meetings held is provided at the end of this annex.

The WHO Guideline Steering Group

The WHO Guideline Steering Group led the guideline development process. Chaired by the WHO Department of Sexual and Reproductive Health and Research (SRH), it was composed of eight staff members from the Department, including seven from the Prevention of Unsafe Abortion (PUA) Unit and the Department's human rights adviser. Gender, ethics, social accountability and human rights expertise among the Steering Group members ensured that key underlying principles were adequately reflected. The Steering Group members drafted the initial scope of the guideline; identified and drafted the priority questions in "PICO" format (population, intervention, comparator, outcome); and identified individuals to be invited to participate as guideline methodologists and as members of the Evidence Synthesis Teams (ESTs), the Evidence and Recommendation Review Groups (ERRGs), the Guideline Development Group (GDG) and the External Review Group (ERG) (see below). The members of these groups and the participation of other external contributors were only confirmed after completion of a process of declaration and management of any conflicts of interest, which was managed by the Steering Group in consultation with the Office of Compliance, Risk Management and Ethics (see section B). The Steering Group identified the chair of the GDG, and this was confirmed by the other GDG members. The Steering Group oversaw the work of the ESTs, organized the ERRG and GDG meetings, and drafted the recommendations based on the decisions of the ERRGs and GDG. The Steering Group did not determine or agree on the final recommendations as this was the role of the GDG. The Steering Group was responsible for drafting, revising and finalizing the guideline in collaboration with the ERRG, GDG and ERG members and other contributors, and for overseeing the publication and dissemination of the guideline and the development of related implementation tools. Finally, the Steering Group is responsible for monitoring new information and user needs and for determining when the guideline may need to be updated. The WHO Steering Group was supported by the wider WHO Secretariat, which included 19 WHO staff members and consultants from the SRH Department and other departments at WHO headquarters and representatives from WHO regional offices.

Guideline methodologists

The guideline methodologists worked closely with the WHO Steering Group and members of the Evidence Synthesis Teams (ESTs) to appraise the evidence from systematic reviews using GRADE methodology (see section D). In addition, the guideline methodologists oversaw all methodological issues and were responsible for the GRADE assessments of the certainty of the evidence. One guideline methodologist was appointed for the Clinical services domain and one for the Law and policy domain, while a team from Cochrane Response served this role for the Service delivery domain.[1] Appreciating that the public health impact of laws and policies is complex, that evidence related to law and policy is not a research area that lends itself to randomized controlled trials or comparative observational studies, and that this evidence cannot be readily synthesized using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach, a pragmatic approach was applied (see details in section D).

Evidence Synthesis Teams (ESTs)

The ESTs planned and conducted the systematic reviews and prepared the GRADE Evidence-to-Decision (EtD) frameworks (which include evidence summaries, evidence profiles/tables and EtD tables). The ESTs comprised researchers from among WHO staff, consultants and fellows, as well as external collaborating research groups. For the **Clinical services domain**, the EST was formed of members of the Cochrane Fertility Regulation (CFR) Group, Family Planning fellows (WHO staff or interns), and the responsible technical officer from the Steering Group for this guideline. For the **Service delivery domain**, the EST comprised staff from Cochrane Response, Family Planning fellows (current and former WHO staff), and the responsible technical officer from the Steering Group. The CFR

1 Cochrane Response is an evidence consultancy business operated by the Cochrane Collaboration. It provides tailored and responsive evidence services, and accessible review formats.

Group and Cochrane Response have updated their systematic reviews to provide the evidence base for many of the recommendations in these two domains. For the **Law and policy domain**, the EST included WHO consultants as well as external teams based at two centres:

- The Policy Surveillance Program at the Center for Public Health Law Research (CPHLR), Temple University, Philadelphia, USA: Researchers within this programme created conceptual frameworks and legal mapping of the various interventions and the systems around them, and identified data for the empirical assessment of laws and policies.
- Birmingham Law School, University of Birmingham, United Kingdom: The team in Birmingham provided expertise in health law and policy, human rights, comparative law, and global legal studies. This team conducted systematic reviews to provide the evidence base for the law and policy recommendations.

The Evidence and Recommendation Review Groups (ERRGs) and the Guideline Development Group (GDG)

Rather than having one Guideline Development Group (GDG) from the start of the guideline development process, for the development of this wide-ranging consolidated guideline, three separate ERRGs were formed – one for each of the three domains: Clinical services, Service delivery and Law and policy. For the final stage of the process, one GDG was formed comprising 3–4 members from each of the three ERRGs. The three ERRGs had 6–13 members representing all regions and a range of expertise, including one youth representative from the International Youth Alliance for Family Planning (IYAFP). The ERRG members were identified and invited by the WHO Steering Group, as were the human rights advisers who also contributed to the meetings by ensuring consideration of relevant human rights during recommendation formulation. Each ERRG undertook a detailed review of the evidence, formulated and agreed on draft recommendations during a series of 4–5 online meetings between March 2020 and March 2021. Prior to each meeting, background documents – the EtD frameworks and draft recommendations – were shared with the ERRG members. Consultations via email, Skype, Microsoft Teams, GoToMeeting and Zoom were conducted as needed in between meetings to ensure input was received from each ERRG member for each area under review.

In early 2021, representatives from each ERRG were invited by the WHO Steering Group to join the GDG for the final meeting in late April 2021, during which the draft recommendations from all three ERRGs were presented for review and finalization. The confirmed members of the GDG in turn confirmed the WHO Steering Group's selection of a chair for the GDG. There were 18 GDG members (14 female, 4 male), representing all six WHO regions and a range of expertise, including a youth representative from IYAFP. A draft of the full guideline document, including the draft recommendations, was shared with all the GDG members to review in advance of the formal meeting, along with other relevant background documents (the EtD frameworks). During the meeting, the GDG reviewed and discussed the evidence and the draft recommendations, with the aim of reaching consensus on the certainty of the supporting evidence and the strength and direction of the new and updated recommendations (see Chapters 2 and 3). Subsequent to the GDG meeting, the members also had an opportunity to review the revised guideline document into which the decisions made during the GDG meeting had been integrated.

The External Review Group (ERG)

The WHO Steering Group, in consultation with the GDG, identified and confirmed nine technical experts and stakeholders with thematic area expertise relevant to the recommendations presented in this guideline to serve as members of the ERG. The ERG members were balanced in terms of geographic representation, and had no important conflicts of interest. Following the GDG meeting and the subsequent revisions to the draft guideline, the document was circulated to the ERG members. The role of the ERG members was to provide input regarding the accuracy, clarity of the language, implementation/adaptation considerations, and presentation of the guideline. The ERG also ensured that the GDG decision-making processes had considered and incorporated the contextual values and preferences of persons affected by the recommendations. Recommendations in the document, which had been finalized by the GDG, were not changed based on ERG input other than to improve clarity and readability, as needed. All comments from the ERG members were collated by the responsible technical officer and shared with the WHO Steering Group for review. No serious factual errors or concerns were identified that affected any of the recommendations or any major sections of the draft guideline.

Meeting observers and external partners

In accordance with guidance in the *WHO handbook for guideline development, second edition (2014),*[2] representatives from a range of relevant professional organizations and United Nations agencies were invited to attend the GDG meeting in April 2021 as observers with no role in determining the recommendations (see Annex 1). The invited observers included the United Nations Population Fund (UNFPA), the Royal College of Obstetricians and Gynaecologists (RCOG), the International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM) and the International Council of Nurses (ICN), and representatives from all attended except for ICN. In addition, a range of WHO/HRP's implementing partner organizations were invited to review the draft guideline prior to submission to the GRC; these organizations included Ipas, the International Planned Parenthood Federation (IPPF), MSI Reproductive Choices, Pathfinder and Population Services International (PSI).

B. Management of declarations and conflicts of interests, and confidentiality

In accordance with the *WHO handbook for guideline development*, all invited members of the ERRGs, GDG, the ESTs, the ERG, and the GDG meeting observers, guideline reviewers representing implementing partner organizations, and other external contributors (e.g. consultants and collaborators) were asked to declare in writing any competing interests (academic, financial or other) at the time of invitation to participate in the guideline development or evidence review process. This was done by electronic submission of a signed WHO Declaration of Interests (DOI) form along with a copy of their curriculum vitae to the responsible technical officer prior to participation. In addition, internet searches were conducted on each invited member to assess any potential conflicts of interest that had not been disclosed. The management of conflicts of interest was explained to the invited participants, including the fact that no member would be allowed to participate in the meeting(s) if they failed to first complete and sign a DOI form.

The responsible technical officer assessed the DOI forms and CVs received with reference to the *WHO handbook for guideline development*, in consultation with the Director of the SRH Department and with the input of the WHO Steering Group, to determine the existence (and severity) of any conflict of interest, and agree upon a management plan. One conflict arose for one ERRG member during the course of guideline development, and this person thus did not attend any meetings thereafter. There were no other cases of any conflict of interest (this is also reported in the ERRG and GDG members lists in Annex 1).

Biographical information for all ERRG and GDG members deemed not to have significant conflicts of interest (i.e. conflicts that precluded their participation in the GDG) were posted on the WHO SRH Department's website for public comment for at least two weeks before the start of the respective meetings, with their consent (in 2020 for the ERRGs and in 2021 for the GDG). ERRG and GDG members were confirmed once this process was completed. On confirmation of their eligibility to participate, all ERRG, GDG and ERG experts were instructed to notify the responsible technical officer of any change in relevant interests during the course of their participation in the process. At the start of each meeting, all ERRG and GDG participants had the opportunity to verbally confirm, append or amend any declared interests so that all fellow GDG members and other attendees were made aware. They had a similar opportunity to do the same in writing before submitting comments on draft versions of the guideline.

Finally, it should be noted that each member of the ERRGs, GDG, ERG, ESTs and each guideline methodologist was asked to sign a confidentiality agreement relating to the guideline development process and outcomes. In addition, the responsible technical officer securely stored all received electronic and printed hard copies of the signed DOI forms and curriculum vitae to ensure that confidentiality was maintained.

C. Scope of the guidance: defining topic areas and outcomes of interest

In September 2018, an online survey was undertaken to initiate the process of updating WHO guidance on safe abortion. The objectives of this survey were (i) to identify relevant areas that require an update or new areas that need to be added to the guidance and (ii) to generate suggestions for making the guidelines more user-friendly. The survey was distributed within various networks in the sexual and reproductive health field and resulted in 122 responses.

2 WHO handbook for guideline development, second edition. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/handle/10665/145714).

Thereafter, scoping meetings for each of the three domains (Clinical services, Service delivery, and Law and policy) were conducted with a range of experts, between November 2018 and June 2019. The purpose of these meetings was to determine the key topic areas that required formulation of key questions in the "PICO" format (population, intervention, comparator, outcomes) and to formulate and discuss these questions. The PICO questions were further reviewed, modified and finalized in the follow-up email exchanges between the WHO Steering Group and the ERRG members for each domain. The topic areas for the final PICOs of each domain, as determined during the scoping meetings, are provided in Box A below. The PICO questions for each domain are provided in Annexes 8, 9 and 10.

In addition to the scoping meetings, three technical meetings also focused on issues relating to abortion care in humanitarian settings (June 2019), values and preferences relating to abortion care (September 2019), and youth concerns relating to abortion care (April 2021) (further details on these meetings and issues are presented in Box B at the end of this annex and in the Web annex B: Technical meetings during guideline development).

BOX A: Topic areas per domain for development of PICOs for new and updated recommendations

Law and policy	Criminalization Grounds-based approaches Gestational age limits Mandatory waiting periods Third-party authorization Restrictions on abortion providers Conscientious objection by a health worker
Clinical services	Rh isoimmunization Pain management for medical and surgical abortion and for cervical priming Cervical priming prior to surgical abortion Self-management of medical abortion (all subtasks) Medical abortion using new methods (regimens including letrozole) Medical management of missed abortion Follow-up care or additional services after abortion
Service delivery	**Health workers providing services:** self, community health workers, pharmacy workers, pharmacists, traditional and complementary medicine professionals, auxiliary nurses, auxiliary nurse midwives, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners, specialist medical practitioners **Services:** • Provision of information on safe abortion • Counselling across the continuum of care • Cervical priming with medication and osmotic dilators prior to surgical abortion • Surgical abortion (vacuum aspiration [VA] and dilatation and evacuation [D&E]) • Medical management of induced abortion (all subtasks; including self-management) • Medical management of intrauterine fetal demise (IUFD) • Medical and surgical management of incomplete abortion • Initial management of non-life-threatening complications • Initiation and continuation of injectable contraceptives (including self-injection) **Service-delivery methods:** • Community-based outreach models for provision of abortion care • Medical abortion care provided through telemedicine • Harm-reduction counselling on abortion care • Social marketing methods for abortion services • Self-sourcing of abortion medications online

D. Review of the evidence and formulation of recommendations

Defining and reviewing priority questions

The full list of PICO questions was confirmed during follow-up communications among the WHO Steering Group and the ERRG members after the scoping meetings for each domain, which were described in the previous section. All the PICO questions and related details are provided in Annexes 8, 9 and 10.

Systematic review methods (evidence retrieval)

A list of all reviews conducted for the development of this guideline is presented in Annex 7. Refer to the published systematic reviews and to the packages of supplementary materials online for information about the specific methods used, including search strategies. Refer to beginning of this annex for information about the Evidence Synthesis Teams (ESTs).

Sources for evidence relating to the PICOs of interest for the Clinical services and Service delivery domains included randomized controlled trials (RCTs) as well as non-randomized controlled trials, controlled before-and-after studies, interrupted time series and cohort studies. The following databases were searched from inception to December 2020, without language filters:

- Global databases: ClinicalTrials.gov, Cochrane database, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Excerpta Medica database (Embase), POPLINE, PubMed.
- Regional databases: African Index Medicus (AIM), Chinese Biomedical Literature Database, Global Index Medicus, Index Medicus for South-East Asia (IMSEAR), Index Medicus for WHO Eastern Mediterranean, Latin American and Caribbean Health Sciences Literature (LILACS), Western Pacific Regional Index Medicus.

In addition, a search of trial registry sites and organizational websites was conducted, and information from experts in the field was also used to identify any major ongoing or completed but unpublished trials that could be relevant to the guideline recommendations. Data from studies meeting the inclusion criteria were extracted using a standardized form and organized into Summary of Findings tables within the GRADE evidence summaries, using the online GRADE (Grading of Recommendations Assessment, Development and Evaluation) application.[3]

For the Law and policy domain, the primary databases searched included Google Scholar, JSTOR, Hein Online and PubMed, from 2010 to 2021. For this domain, in addition to RCTs and other types of studies, the reviews also included legal and policy analyses, regulatory documents, and legal and policy reviews.[4]

Assessment of the quality and certainty of the evidence for recommendations

In accordance with the WHO guideline development process, the GDG formulated the recommendations guided by the quality/certainty of the available evidence.[5] WHO has adopted the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to recommendation development, which defines the quality/certainty of evidence as the extent to which one can be confident that the reported estimates of effect (desirable or undesirable) available from the evidence are close to the actual effects of interest.[6] The GRADE approach specifies four levels of certainty of evidence, which should be interpreted as follows:

- High – We are very confident that the true effect lies close to that of the estimate of the effect.
- Moderate – We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
- Low – Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
- Very low – We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of the effect.

3 GRADEpro GDT. GRADEpro Guideline Development Tool [Software] (developed by Evidence Prime, Inc.). McMaster University; 2020 (https://gradepro.org/).
4 de Londras F, Cleeve A, Rodriguez M, Lavelanet A. Integrating rights and evidence: a technical advance in abortion guideline development. BMJ Glob Health. 2021;6(2):e004141.
5 WHO handbook for guideline development, 2014.
6 Schünemann H, Brożek J, Guyatt G, Oxman A, editors. GRADE handbook for grading the quality of evidence and the strength of recommendations. The GRADE Working Group; 2013 (https://gdt.gradepro.org/app/handbook/handbook.html).

As a baseline, RCTs provide "high-quality" evidence, while non-randomized trials and observational studies provide "low-quality" evidence. This baseline quality rating may be downgraded based on consideration of study design limitations (risk of bias – assessed using the criteria outlined in the *Cochrane handbook for systematic reviews of interventions* along six domains)[7], inconsistency, imprecision, indirectness and publication bias. For observational studies, other considerations, such as magnitude of effect, could lead to upgrading of the rating if there are no limitations that indicated a need for downgrading. The EST members and guideline methodologists, in accordance with standard operating procedures approved by the WHO Steering Group, performed the grading of review evidence.

The GRADE approach to appraising the quality of quantitative evidence was used for all the critical outcomes identified in the PICO questions,[8] and a GRADE evidence profile (GRADE table) was prepared for each quantitative outcome within each PICO; these are presented in the supplementary materials available online.

With regard to the Law and policy domain, there was an existing composite recommendation in the 2012 *Safe abortion* guidance, which spoke to these issues and related interventions; the topics identified during the scoping process for this updated guideline (see Box A) stemmed from there. However, there was no existing standardized approach for assessing the quality or certainty of the evidence relating to laws and policies on abortion using a rights-based analysis.[9] Therefore, an innovative approach was developed to evaluate the evidence that effectively integrated human rights protection and enjoyment as part of health outcomes and analysis, while considering several important factors and their potential interactions.[10] This is in line with WHO's norms and values, and thus underpins integrated evidence for application within an Evidence-to-Decision (EtD) framework.

The outcomes of interest for the Law and policy domain were informed by the conceptual frameworks and legal mapping initially performed by the EST team at Temple University (see section A), which mapped the various interventions and the systems around them and identified empirical research assessing the health effects of laws and policies. This mapping emphasized policy surveillance, advancing technology and methods for legal evaluation, teaching policy surveillance methods, and sharing credible scientific data with researchers, policy-makers and the public to make the case for laws that improve health. Next, the team developed causal logic models for the legal interventions on abortion to display plausible pathways from the implementation of the restriction to health and socioeconomic outcomes. The third step involved using the models as a guide to conduct a second rapid scan, in order to identify non-legal studies investigating whether the processes and outcomes posited in the models do, in fact, occur, and with what frequency and severity, and with what consequences. This evidence, in turn, supported plausible inferences of causality for practical policy and guideline development purposes. The Identifying Data for the Empirical Assessment of Law (IDEAL) method attempts to create an objective framework for crystallizing the various influences and consequences attributable to the impact of specific abortion restrictions, leading to the identification of untapped scientific evidence on plausible effects of the law.[11]

The quantitative evidence retrieved from all types of studies and documents was assessed for precision, directness and magnitude of effect, while the qualitative evidence was assessed for adequacy, and compiled in an EtD table. An overarching Rights Analysis Table, which identified human rights standards relevant to the specific interventions, was applied to the evidence table, leading to the development of a Human Rights to Evidence Table, organized by outcome of interest. The full methods are described in de Londras et al. (2021).[12]

Formulation of recommendations and determining the strength of recommendations

The WHO Steering Group supervised and finalized the preparation of evidence summaries, including GRADE tables and Summary of Findings tables, for each PICO question. For the Clinical services and Service delivery domains, the evidence summaries followed the new Evidence-to-Decision (EtD) framework, known as the WHO-INTEGRATE

7 Each included study is assessed and rated to be at low, high or unclear risk of bias for sequence generation, allocation concealment, blinding of study personnel and participants, attrition, selective reporting and other sources of bias (Higgins J, Thomas J, Chandler J, Cumpston M, Li T, Page M, Welch V, editors. Cochrane handbook for systematic reviews of interventions, Version 6.2. The Cochrane Collaboration; 2021 [https://training.cochrane.org/handbook/current]).

8 Schünemann et al., editors, GRADE Handbook, 2013.

9 Rehfuess E, Stratil JM, Portela A, Baltussen R, Scheel IB, Norris SL. The WHO-INTEGRATE evidence to decision framework version 1.0: integrating WHO norms and values and a complexity perspective. BMJ Glob Health. 2019;4:e000844.

10 de Londras et al., 2021.

11 Burris S, Ghorashi AR, Cloud LF, Rebouché R, Skuster P, Lavelanet A. Identifying data for the empirical assessment of law (IDEAL): a realist approach to research gaps on the health effects of abortion law. BMJ Glob Health. 2021;6:e005120.

12 de Londras et al., 2021.

framework. This new framework is broader and better suited to system-level interventions. The six substantive criteria of the WHO-INTEGRATE framework are the following: balance of health benefits and harms; human rights and sociocultural acceptability; health equity, non-discrimination and equality; societal implications; financial and economic considerations; and feasibility and health system considerations. The additional meta-criterion is quality of evidence (i.e. type, size and limitations of the available studies used as evidence). The WHO-INTEGRATE framework allows for the fact that some interventions are complex and have multiple components interacting synergistically or dissynergistically, may be non-linear in their effects, or may be context dependent. This framework is better able to accommodate recommendation formulation for the Law and policy domain, as well as the Clinical services and Service delivery domains, thus allowing guideline users to make informed decisions on all interventions. Also integral to the recommendation formulation process across all domains is the values placed on the outcomes and the preferences of the women affected by the recommendations. Taking this into account along with all the criteria of the WHO-INTEGRATE framework, as applied to each intervention for the specified population, new and updated recommendations were formulated by the ERRG and GDG members and qualified as either strong ("recommend") or weak ("suggest"; with specified conditions for application) recommendations in favour of the intervention, or as strong recommendations against the intervention/in favour of the comparator.

Recommendations were considered "new" (as labelled in the table at the end of the Executive Summary and in Chapter 3) if no recommendation existed in a previous WHO guideline on the specific topic or intervention in question for the specified population. 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 was developed this into seven separate recommendations, but they are not considered to be "new" (i.e. Recommendations 1,2,3,6,7,21,22).

E. Decision-making by the GDG during guideline development

The GDG meeting took place in April 2021 to review, revise and finalize the draft recommendations from all three domains that had been prepared by the ERRGs, as described above. Decision-making was based on discussion of the synthesized evidence and the use of the DECIDE Framework[13] The final adoption of each recommendation was made by consensus, defined as full agreement among all GDG participants when at all possible – this is the preferred method. In one instance, voting was used since consensus could not be reached. The decision on how to present the medical abortion regimens was made based on the large majority voting in support of upholding the way it is described and presented in the previous guidelines. WHO staff attending the meeting, EST members, methodologists and meeting observers were not allowed to vote.

F. Compilation, review and presentation of the guideline content

The WHO responsible technical officer led the writing of the guideline with external/consultant writers, with significant input from the ESTs, the guideline methodologists and other members of the WHO Steering Group. In advance of the GDG meeting, an early draft of the full guideline document was prepared. The guideline methodologists drafted the GRADE evidence summaries and the WHO Steering Group members drafted corresponding Evidence-to-Decision (EtD) frameworks. The full draft and these supplementary materials were shared electronically with all GDG members (see Annex 1) two weeks before the GDG meeting, which was held during the last week of April 2021.

Following the GDG meeting, revisions were made to accurately reflect the deliberations and decisions of the GDG members on the recommendations and to incorporate their feedback on the draft. Subsequently, the revised draft guideline was shared electronically with all GDG members for two weeks for further comment. It was simultaneously shared for comment with all members of the External Review Group (ERG), the GDG meeting observers, and the representatives of implementing partner organizations (see section A and Annex 1), who were unconnected with the process of guideline development.

Next, the Steering Group carefully evaluated the written input of all the reviewers (via email and direct comments/edits on the draft document) for inclusion in the final guideline document and the revised version was reviewed by the director of the WHO SRH Department and edited for clarity. The final draft was submitted for review at a meeting of the WHO Guidelines Review Committee (GRC) and was fully approved by the GRC in August 2021 after some requested revisions had been completed.

13 Evidence to Decision frameworks (EtDs) for policy makers [website]. Cochrane Norway; 2021 (https://www.cochrane.no/decide-frameworks-policy-makers).

Evidence derived from the systematic reviews in support of the new and updated recommendations was summarized in EtD frameworks to provide the evidence base on effectiveness that informed the new recommendations in this guideline. These EtD frameworks are presented separately in the three packets of supplementary materials available online: https://www.who.int/publications/i/item/9789240039483

- Supplementary material 1: Evidence-to-Decision frameworks for the law and policy recommendations
- Supplementary material 2: Evidence-to-Decision frameworks for the clinical service recommendations
- Supplementary material 3: Evidence-to-Decision frameworks for the service delivery recommendations and best practice statements.

BOX B: Key meetings during guideline development (in Geneva, Switzerland, or online)

Scoping meetings: November 2018 – June 2019

Two-day scoping meetings were held for each of the three domains of this guideline, during which external experts on the subject areas and methodology (see Annex 1) identified the priority topics and the specific areas requiring new or updated recommendations or good practice statements.

- **Law and policy domain:** Geneva, November 2018. This meeting facilitated discussion and the development of new approaches to guideline development for (i) abortion law and policy, and (ii) integration of human rights.
- **Clinical services domain**: Virtual meeting, December 2018.
- **Service delivery domain**: Geneva, June 2019.

Technical meetings:

(i) Implementation considerations for abortion care in humanitarian settings: A two-day technical meeting was held in Geneva in June 2019. This meeting convened approximately 20 experts in the fields of humanitarian aid, conflict settings, abortion care and human rights (including three youth representatives) together with 20 representatives from the WHO Secretariat. The expert participants came from nine countries in the regions of Africa, the Eastern Mediterranean, Europe and North America. During the meeting participants identified specific barriers and facilitating factors for implementation of safe abortion in humanitarian/emergency settings. Common barriers that were identified included: stigma, the role of social norms and values, the lack of clinical skills and knowledge, and perceived legal barriers. Practices that facilitate implementation of quality abortion care in these settings are: engagement with key stakeholders (in particular with community and religious leaders), developing a concrete implementation strategy with identification of potential entry points, and ensuring data collection and monitoring. For further details, see Web annex B: Technical meetings during guideline development.

(ii) Global abortion values and preferences: An online survey was prepared and disseminated in October and November 2018. In September 2019, a two-day technical meeting was convened in Geneva with a diverse range of stakeholders, including 19 participants from 15 different organizations/countries (including three youth representatives) and 8 members of the WHO Secretariat. For the first time, this was a meeting focused solely on unpacking the meaning of "values and preferences" in relation to abortion. By the end of the meeting, the information generated from the rich discussions formed a basis for the guideline development discussions on the values and preferences of women, which was one of the key criteria in the recommendation formulation process. For further details, including a summary of the literature review findings, see Web annex B: Technical meetings during guideline development.

BOX B: *Continued*

(iii) Youth concerns relating to abortion care: For each of the scoping and technical meetings for this guideline, mentioned in this box, there were representatives from the International Youth Alliance for Family Planning (IYAFP) to provide a youth perspective, and one representative from IYAFP also served on each ERRG and one on the final GDG. In addition, a dedicated two-day technical meeting was held online in April 2021, bringing together 16 members of the IYAFP Youth for Abortion Taskforce which IYAFP had formed to support and inform the guideline development process, and 4 WHO staff members from the Preventing Unsafe Abortion (PUA) Unit of WHO's Department of Sexual and Reproductive Health and Research. Participants included youths (up to age 30) with demonstrated leadership skills in the field of adolescent sexual and reproductive health and rights, representing 13 countries across the WHO regions. The meeting discussions centred around three key themes: youth's values and preferences related to abortion services, addressing barriers and abortion stigma, and scaling up promising practices and interventions. Key issues discussed included the elements of an enabling environment and meaningful youth engagement. IYAFP members are developing a position paper as the main output of the meeting. For further details, see Web annex B: Technical meetings during guideline development.

Evidence and Recommendations Review Group (ERRG) meetings: March 2020 – March 2021

The ERRG meetings (4–5 meetings for each of the three domains) all occurred online, each one taking place across two days, facilitated by the WHO responsible technical officer and other members of the WHO Steering Group. At these meetings, members of the Evidence Synthesis Teams presented their systematic reviews of the evidence, and the ERRG members (see section A and Annex 1) discussed and reviewed the evidence and formulated draft recommendations, implementation considerations and good practice statements to be presented for further review, revision and finalization by the GDG.

- Clinical services domain: March 2020, May 2020, June 2020, September 2020, February 2021
- Service delivery domain: Pre-ERRG June 2020, October 2020, January 2021, early March 2021, late March 2021
- Law and policy domain: March-April 2020, June 2020, August–September 2020, March 2021.

Guideline Development Group (GDG) meeting

Online, 27–30 April 2021. During the GDG meeting, the GDG members reviewed, discussed, revised and finalized the draft recommendations, implementation considerations and good practice statements from all three domains.

WHO Guidelines Review Committee (GRC) meeting

7 July 2021.

Annex 5. Health worker categories and roles

The health worker types considered in the guideline are described in the table below. Descriptions have been adapted for the purpose of this guideline to be generic enough to apply across settings. They are indicative and illustrative and are not intended as a substitute for the formal definitions of professional bodies or titles used in specific countries.

Broad category	Description of qualifications and tasks, for the purpose of this guideline	Illustrative examples of other terms for these types of health workers (some examples may be specific to a country or regional context)
Community health worker (CHW)	A person who performs functions related to health-care delivery/information provision and has been trained in some way in the context of the task but has received no formal professional or paraprofessional certificate or tertiary education degree.	Lay health worker, village health worker, female community health volunteer, trained birth attendant, trained helpline worker, abortion accompanier, hotline counsellor
Pharmacy worker	Technicians and assistants who perform a variety of tasks associated with dispensing medicinal products under the guidance of a pharmacist. They inventory, prepare and store medications and other pharmaceutical compounds and supplies, and may dispense medicines and drugs to clients and instruct on their use as prescribed by health professionals. Technicians typically receive two or three years of training in a pharmaceutical school, with an award not equivalent to a university degree. Assistants have usually also been through two or three years of secondary school with a subsequent period of on-the-job training or apprenticeship.	Pharmacy assistant, pharmacy technician dispenser, pharmacist aide, dispensary assistant
Pharmacist	A health-care practitioner who dispenses medicinal products. A pharmacist can counsel on the proper use and adverse effects of drugs and medicines following prescriptions issued by medical doctors/health-care professionals. Education includes university-level training in theoretical and practical pharmacy, pharmaceutical chemistry or a related field.	Chemist, clinical pharmacist, community pharmacist
Traditional and complementary medicine professionals	A professional of traditional and complementary systems of medicine (non-allopathic physician) whose training includes a four- or five-year university degree that teaches human anatomy, physiology, management of normal labour and the pharmacology of modern medicines used in obstetrics and gynaecology, in addition to their systems of medicine. For the purpose of this guideline, these doctors are included with reference to the provision of elements of abortion-related care as per conventional medical practice.	Ayush doctor, Ayurvedic physician, doctor of complementary systems of medicine, non-allopathic physician
Auxiliary nurse midwife (ANM) and auxiliary nurse	An auxiliary nurse is someone trained in basic nursing skills but not in nursing decision-making. An ANM has basic nursing skills and some midwifery competencies but is not fully qualified as a midwife. The duration of training may vary from a few months up to three years. A period of on-the-job training may be included, and this is sometimes formalized in apprenticeships.	Auxiliary midwife, family welfare visitor
Nurse	A person who has been legally authorized (registered) to practise after examination by a state board of nurse examiners or similar regulatory authority. Education includes three or more years in nursing school, and leads to a university or postgraduate university degree or the equivalent.	Registered nurse, clinical nurse specialist, licensed nurse, BSc nurse
Midwife	A person who has been registered by a state midwifery or similar regulatory authority and has been trained in the essential competencies for midwifery practice. Training typically lasts three or more years in nursing or midwifery school and leads to a university degree or the equivalent. A registered midwife has the full range of midwifery skills, which include abortion.	Registered midwife, community midwife, nurse-midwife
Advanced associate clinician and associate clinician	A professional clinician with basic competencies to diagnose and manage common medical and surgical conditions and also to perform some types of surgery. Training generally requires three or four years post-secondary education in an established higher education institution. The clinician is registered and their practice is regulated by a national or subnational regulatory authority.	Assistant medical officer, clinical officer, medical licentiate practitioner, health officer, physician assistant, surgical technician, non-physician clinician, medical assistant, nurse practitioner
Generalist medical practitioner	A medical doctor who holds a university-level degree in basic medical education but does not have a specialization in obstetrics and gynaecology.	Family doctor, general practitioner, medical doctor, physician
Specialist medical practitioner	A medical doctor with postgraduate clinical training and specialization in obstetrics and gynaecology.	Gynaecologist, obstetrician

Source: adapted with minor revisions from WHO (2015) *(18)*, including updating some of the names of health worker categories to use current preferred WHO terminology, as presented in the International Standard Classification of Occupations (ISCO), Part III: Definitions of major groups, sub-major groups, minor groups and unit groups, updated 21 June 2016 (available at: https://www.ilo.org/public/english/bureau/stat/isco/isco08/index.htm).

Annex 6. Monitoring and evaluation of quality abortion care: identification of indicators

Methods and preliminary results

To achieve consensus on indicators that can be used to effectively document progress in quality abortion care at programmatic and country levels, a scoping review and multiple expert consultation processes have been conducted by scientists from the London School of Hygiene and Tropical Medicine (LSHTM) and WHO.

Scoping review: The scoping review yielded a summary of abortion measures and indicators reported over the 10-year period 2008–2018 in scientific literature and materials identified on major non-governmental organization websites. In total, 1999 abstracts and 7 additional relevant documents were screened for indicators, yielding 792 indicators identified from 142 documents. The findings of the scoping review were recently published in *BMJ Global Health* and the 792 indicators are available on a searchable spreadsheet among the supplementary materials for the publication.[1]

Consultation meeting: At an initial (virtual) consultation meeting in June 2020, multiple sets of indicators that could be used for global- and programme-level monitoring were presented. These included a sub-set of 17 core indicators that had been selected from among the indicators identified in the scoping review and from among indicators for monitoring abortion care based on measurement initiatives implemented variously by the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), the WHO Regional Office for Africa, the Maternal Mortality Initiative (of the WHO Department for Sexual and Reproductive Health and Research) and Ibis Reproductive Health. In total, 52 unique indicators were proposed during the consultation meeting. The WHO health systems strengthening monitoring and evaluation framework was also presented as a potential structure for quality abortion monitoring and evaluation (M&E).

Consolidation: During a consolidation phase, a team of LSHTM and WHO scientists eliminated 29 out of the 52 indicators, removing indicators with duplication of information, using as main review criteria (i) relevance within the health systems strengthening monitoring and evaluation framework, and (ii) feasibility for M&E. Six indicators were added to represent categories in the health system strengthening monitoring and evaluation framework which previously had no associated proposed indicators (such as social protection and infrastructure) and in an effort to align with the Sustainable Development Goals (SDG) targets related to sexual and reproductive health and rights. These six additional indicators were sourced from the original scoping review list of indicators,[2] the Ibis Reproductive Health quality of care indicators,[3] and the WHO Department of maternal, newborn, child and adolescent health (MCA) indicators on respectful care.[4]

Online consultation: In an online consultation in March 2021, measurement and M&E experts in abortion care were invited to comment on (i) the relevance to abortion programmes of the WHO health systems strengthening monitoring and evaluation framework, (ii) the validity, feasibility, importance and sensitivity to change of each proposed indicator, and (iii) suggestions for alternative indicators. Twenty-two (out of 27) invited experts reviewed a total of 29 consolidated indicators during the online consultation. The 29 indicators were categorized in the health systems strengthening monitoring and evaluation framework areas of governance (5), financing (1), infrastructure (1), information system (1), health workforce (1), intervention access and services readiness (5), intervention quality and safety (5), coverage of interventions (1), prevalence of risk behaviours and risk factors (1), improved health outcomes and equity (4), responsiveness (2) and social protection (2).

Next steps

The core team from LSHTM and WHO is currently finalizing the indicator list following review of input gathered during the online consultation, recognizing that the indicator list will require periodic assessment for strengthening and maintaining utility and relevance. A report will be published in due course.

1 Filippi V, Dennis M, Calvert C, Tunçalp Ö, Ganatra B, Kim CR, Ronsmans C. Abortion metrics: a scoping review of abortion measures and indicators. BMJ Global Health. 2021;6(1):e003813.
2 Ibid.
3 Dennis A, Blanchard K, Bessenaar T. Identifying indicators for quality abortion care: a systematic literature review. J Fam Plann Reprod Health Care. 2017;43(1):7-15.
4 Quality of care for maternal and newborn health: a monitoring framework for network countries, updated February 2019. Geneva: World Health Organization; 2019 (https://www.who.int/docs/default-source/mca-documents/qed-quality-of-care-for-maternal-and-newborn-health-a-monitoring-framework-for-network-countries.pdf, accessed 3 September 2021).

Annex 7. Systematic reviews and links to PICOs and recommendations

Topic area	Title and authors of review (and reference details, if published)	Related PICO numbers(s), as listed in annexes	Related recommendation number(s) as presented in the main document
Topics scoped for development of new or updated recommendations			
Law and policy topics **For the Evidence-to-Decision (EtD) frameworks, refer to Supplementary material 1[5]**	**All reviews conducted by the Law and Policy Evidence Synthesis Team for development of this guideline[6]**	**Refer to Annex 8**	
Criminalization[7]	Impact of criminalization on abortion-related outcomes	1	1
Grounds-based approaches	Impact of grounds on abortion-related outcomes	2	2
Gestational age limits	Impact of gestational limits on abortion-related outcomes	3	3
Mandatory waiting periods	Impact of mandatory waiting periods on abortion-related outcomes	4	6
Third-party authorization	Impact of third-party authorization on abortion-related outcomes	5,6,7,8,9	7
Abortion provider restrictions	Impact of provider restrictions on abortion-related outcomes	10	21
Conscientious objection	Impact of conscientious objection on abortion-related outcomes	11	22
Clinical service topics **For the Evidence-to-Decision (EtD) frameworks, refer to Supplementary material 2[8]**	**All reviews conducted by the Clinical services Evidence Synthesis Team for development of this guideline**	**Refer to Annex 9**	
Rh isoimmunization	New systematic review: Chan M, Gill R, Kim C. The effect of routine anti-D administration among unsensitized Rh negative individuals who have an abortion. BMJ Sex Reprod Health. 2021 (in press).	1	8
Pain management for surgical abortion	Updated review by Cochrane Fertility Regulation (CFR) Group: Renner R-M, Edelman A, McKercher AE, Jensen JTJ, Nichols MDN. Pain control in first trimester surgical abortion. 2020 *(forthcoming)* New systematic review: DePiñeres T. Pain management regimens for surgical abortion > 14 weeks gestation. 2020 *(unpublished)*	2, 3	11 & 12 13 & 14
Pain management for medical abortion	New review by CFR Group: Reynolds-Wright JJ, Woldetsadik MA, Morroni C, Cameron S. Pain management for medical abortion before 14 weeks' gestation. 2020 *(forthcoming)* New systematic review: Korotkaya Y, Kim C. Pain control in second-trimester medical termination of pregnancy: a systematic review. 2019 *(unpublished)*	4, 5	15 16
Cervical priming prior to surgical abortion < 12 weeks	Updated review by CFR Group: Kapp N, Nguyen A, Atrio J, Lohr P. Cervical preparation for surgical abortion less than 14 weeks. 2020 *(forthcoming)*	6a	17
Cervical priming prior to surgical abortion ≥ 12 weeks	Updated review by CFR Group: Newmann SJ, Tufa T, Drey E, Meckstroth K, Diedrich JT. Cervical preparation for second trimester dilation and evacuation. 2019 *(forthcoming)*	6b,7,8,9	18
Other medical methods to induce abortion	New systematic review: Tolu L, Kim C. The efficacy, safety, and acceptability of alternative methods of medication abortion to the routine mifepristone and/or misoprostol. 2020 *(manuscript in progress)*	10,11,12	27c
Missed abortion < 14 weeks	New systematic review: DePiñeres T. Management options for pregnant individuals with missed abortion < 14 weeks. 2020 *(unpublished)*	13,14,15	31

5 Supplementary material 1, available at: https://www.who.int/publications/i/item/9789240039483
6 Authors of all seven reviews include: Amanda Cleeve, Fiona de Londras, Alana Farrell, Magdalena Furgalska, Antonella Lavelanet, Maria Isabel Rodriguez.
7 These first three recommendations are presented in Chapter 2. The remainder are presented in Chapter 3.
8 Supplementary material 2, available at: https://www.who.int/publications/i/item/9789240039483

Topic area	Title and authors of review (and reference details, if published)	Related PICO numbers(s), as listed in annexes	Related recommendation number(s) as presented in the main document
Self-management of medical abortion (eligibility, administration of medications, assessment of outcome)	New systematic review: Clark E, Tolu L, Gill R, Kim C. Eligibility and outcome assessment. 2020 *(unpublished)* New review by CFR Group: Gambir K, Kim C, Necastro KA, Ganatra B, Ngo TD. Self-administered versus provider-administered medical abortion. Cochrane Database Syst Rev. 2020;(3):CD013181.	16	50 (Self-management)
Service delivery topics **For the Evidence-to-Decision (EtD) frameworks, refer to Supplementary material 3[9]**	**All reviews conducted by the Service delivery Evidence Synthesis Team for development of this guideline**	**Refer to Annex 10**	
Provision of information	Updated review by Cochrane Response (on pharmacy workers): Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: information provision by pharmacy workers. 2021 *(unpublished)*	1	4
Counselling	Updated review by Cochrane Response (on traditional and complementary medicine professionals, pharmacists, pharmacy workers and community health workers): Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: pre- and post-abortion counselling. 2021 *(unpublished)*	2	5
Cervical priming using osmotic dilators or medication prior to induced surgical abortion	Updated review by Cochrane Response (on traditional and complementary medicine professionals, associate/advanced associate clinicians, midwives, nurses or auxiliary nurses/auxiliary nurse midwives): Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Cervical priming using osmotic dilators or medications. 2021 *(unpublished)*	3	19 & 20
Vacuum aspiration for all indications at < 14 weeks Vacuum aspiration for management of incomplete abortion	Updated Cochrane Review (on traditional and complementary medicine professionals, auxiliary nurse midwives, auxiliary nurses, nurses, midwives, associate/advanced associate clinicians): Kim C, Barnard S, Park MH, Ngo TD. Doctors or mid-level providers for abortion. Cochrane Database Syst Rev. 2021 *(forthcoming)*	4 & 10	24 & 38
Dilatation and evacuation (D&E) for surgical abortion at ≥ 14 weeks	New systematic review (on traditional and complementary medicine professionals, associate/advanced associate clinicians, midwives): Feyssa M, Kim C. Systematic review on effectiveness, safety and acceptability of second trimester abortion by midlevel providers. 2021 *(unpublished)*	5	26
Medical abortion at < 12 weeks (eligibility, administration of medications, assessment of outcome)	Updated Cochrane Review (on traditional and complementary medicine professionals, auxiliary nurse midwives, auxiliary nurses, midwives, nurses, associate/advanced associate clinicians): Kim C, Barnard S, Park MH, Ngo TD. Doctors or mid-level providers for abortion. Cochrane Database Syst Rev. 2021 *(forthcoming)* New review by Cochrane Response (on pharmacists, pharmacy workers and community health workers): Villanueva G, Cogo E, Petkovic J, Bergman H, Probyn K, Buckley B, et al. Medical abortion facilitation. 2021 *(unpublished)*	6	28
Medical abortion at ≥ 12 weeks	New systematic review (on traditional and complementary medicine professionals, associate/advanced associate clinicians, midwives, nurses, auxiliary nurses): Feyssa M, Kim C. Systematic review on effectiveness, safety and acceptability of second trimester abortion by midlevel providers. 2021 *(unpublished)*	7	30
Medical management of intrauterine fetal demise (IUFD)	New review by Cochrane Response: Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: medical management of intrauterine fetal demise (IUFD). 2020 *(unpublished)*	8	33
Medical management of incomplete abortion	Updated review by Cochrane Response: Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: medical management of incomplete abortion. 2020 *(unpublished)*	9	37

9 Supplementary material 3, available at: https://www.who.int/publications/i/item/9789240039483

Topic area	Title and authors of review (and reference details, if published)	Related PICO numbers(s), as listed in annexes	Related recommendation number(s) as presented in the main document
Diagnosis and management of abortion-related complications	Updated review by Cochrane Response (on traditional and complementary medicine professionals, associate/advanced associate clinicians, midwives, nurses, auxiliary nurses/auxiliary nurse midwives): Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: diagnosis and management of abortion related complications. 2021 *(unpublished)*	11	39 & 40
Delivery of injectable contraceptives	Updated review by Cochrane Response (on traditional and complementary medicine professionals medicine, pharmacists, pharmacy workers) Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: injectable contraception. 2020 *(unpublished)*	12	46
Telemedicine for provision of medical abortion care (comprehensive abortion care or individual components)	Updated review by Cochrane Response: Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: telemedicine. 2020 *(unpublished)*	13	48
Community-based outreach models for provision of abortion care	New systematic review by Cochrane Response: Villanueva G, Probyn K, Bergman H, Petkovic J, Cogo E, Buckley B, et al. Health worker roles in providing safe abortion care and post-abortion contraception: Community outreach models. 2021 *(unpublished)*	14	49 (Best practice statement [BPS])
Harm-reduction counselling for persons seeking induced abortion	New systematic review: Stifani B, Gill R, Kim C. Harm-reduction counselling to reduce the harms of unsafe abortion: a systematic review. 2021 *(manuscript under review)*	15	49 (BPS)
Social marketing outreach for pregnant women seeking induced abortion	New systematic review: Abubeker F, Tufa T, Kim C. Impact of social marketing interventions on safe abortion services. 2021 *(unpublished)*	16	49 (BPS)
Self-sourcing of medications through online services for pregnant women seeking induced abortion	New systematic review: Abubeker F, Tufa T, Kim C. Safety, effectiveness, and acceptability of self-sourcing of medications for induced abortion. 2021 *(unpublished)*	17	49 (BPS)
Self-administration of injectable contraceptives in the post-abortion period	Updated review by Cochrane Response: Villanueva G, Bergman H, Cogo E, Petkovic J, Buckley B, Probyn K, et al. Health worker roles in providing safe abortion care and post-abortion contraception: self-administration of injectable contraceptives. 2020 *(unpublished)*	18	51 (Self-management)
II. Topics not scoped, but an updated evidence review was conducted			
Prophylactic antibiotics	Existing review: Low N, Mueller M, Van Vliet HAAM, Kapp N. Perioperative antibiotics to prevent infection after first-trimester abortion. Cochrane Database Syst Rev. 2012;(3):CD005217. *(Updated evidence review conducted in 2021)*	N/A	9
Pre-abortion ultrasound	Existing review: Kulier R, Kapp N. Comprehensive analysis of the use of pre-procedure ultrasound for first-and second-trimester abortion. Contraception, 2011;83(1):30-3. *(Updated evidence review conducted by Cochrane Response in April 2021)*	N/A	10
Surgical methods for first trimester abortion	Existing review: Kulier R, Cheng L, Fekih A, Hofmeyr GJ, Campana A. Surgical methods for first trimester termination of pregnancy. Cochrane Database Syst Rev. 2001;(4):CD002900. *(Updated evidence review conducted in April 2021)*	N/A	23
Medical management of induced abortion	Existing review: Abubeker FA, Lavelanet A, Rodriguez MI, Kim C. Medical termination for pregnancy in early first trimester (≤ 63 days) using combination of mifepristone and misoprostol or misoprostol alone: a systematic review. BMC Womens Health. 2020;20(1):142. Updated review: Whitehouse K, Brant A, Sporstol Fonhus M, Lavelanet A, Ganatra B, et al. Medical regimens for abortion at 12 weeks and above: a systematic review and meta-analysis. Contracept X. 2020;2:100037.	N/A	27 29

Topic area	Title and authors of review (and reference details, if published)	Related PICO numbers(s), as listed in annexes	Related recommendation number(s) as presented in the main document
Medical management of IUFD	Existing review: Cleeve A, Fønhus MS, Lavelanet A. A systematic review of the effectiveness, safety, and acceptability of medical management of intrauterine fetal death at 14–28 weeks of gestation. Int J Gynaecol Obstet. 2019;147(3):301-12.	N/A	32
Post-abortion follow-up	Existing reviews: Grossman D, Ellertson C, Grimes DA, Walker D. Routine follow-up visits after first-trimester induced abortion. Obstet Gynecol. 2004:103(4):738-45. Grossman D, Grindlay K. Alternatives to ultrasound for follow-up after medication abortion: a systematic review. Contraception. 2011:83(6):504-10. *(Updated evidence review conducted by Cochrane Response in April 2021)*	N/A	34
III. Topics for recommendations that were carried forward or brought into this guideline without further review			
Methods of surgical abortion at gestational ages ≥ 14 weeks	Carried forward: Lohr PA, Hayes JL, Gemzell-Danielsson K. Surgical versus medical methods for second trimester induced abortion. Cochrane Database Syst Rev. 2008;(1):CD006714.	N/A	25 (Recommendation 5 from WHO, 2012)
Medical management of incomplete abortion	Carried forward: Kim C, Barnard S, Neilson JP, Hickey M, Vazquez JC, Dou L. Medical treatments for incomplete miscarriage. Cochrane Database Syst Rev. 2017(1);CD007223.	N/A	35 36a & 36b (Recommendations 1a and 1b from WHO, 2018)
Post-abortion contraception	Brought in: Refer to *Medical eligibility criteria for contraceptive use* (WHO, 2015)	N/A	41 (Recommendation from the MEC, WHO, 2015)
Timing of contraception and surgical abortion	Carried forward: N/A	N/A	42 (Recommendation 13 from WHO, 2012)
Timing of contraception and medical abortion	Carried forward: Kim C, Nguyen AT, Berry-Bibee E, Ermias Y, Gaffield ME, Kapp N. Systemic hormonal contraception initiation after abortion: a systematic review and meta-analysis. Contraception. 2021;103(5):291-304. Ermias Y, Berry-Bibee E, Nguyen AT, Curtis K. Post-abortion IUD insertion: a systematic review. 2017 *(unpublished)*	N/A	43 (Recommendations 4a and 4b from WHO, 2018) 44 (Recommendation from WHO, 2015)
Insertion and removal of implants Tubal ligation	Carried forward: Refer to *OptimizeMNH* guideline (WHO, 2012)	N/A	45 47 (Recommendations from WHO, 2015)
Over-the-counter oral contraceptive pills Over-the-counter emergency contraceptive pills Condom use	Brought in: Refer to *Self-care interventions for health and well-being* (WHO, 2021)	N/A	52 (Self-management) 53 (Self-management) 54 (Self-management)

Annex 8. Law and policy domain PICO questions

PICO: P = population; **I** = intervention; **C** = comparator (where applicable*); **O** = outcome(s)[1]

* Where a comparator is available, these data have been included, but very few studies that report on abortion-related policy interventions include a comparator of any kind.

Abortion regulation

Criminalization

PICO 1: The impact of criminalization (see Recommendation 1)

PICO question: For pregnant people seeking abortion and also for medical professionals providing abortion services, what is the impact of criminalization on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, referral to another provider, workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload), system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees), perceived impact on provider–client relationship, stigmatization of health-care providers (considering the application of the intervention), criminal justice procedures, harassment, anti-abortion sting operations, availability of trained providers, reporting of suspected unlawful abortion?

P: Pregnant people seeking abortion; medical professionals providing abortion services

I: Criminalization

C: None (studies do not need to specify comparator)

O:[2]

- Delayed abortion
- Continuation of pregnancy
- Opportunity costs (includes psychological opportunity costs)
- Unlawful abortion
- Self-managed abortion
- Referral to another provider
- Workload implications (including reassignment issues with organization of work, as well as increases or decreases in workload)
- System costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)
- Perceived impact on provider–client relationship
- Stigmatization of health-care providers (considering the application of the intervention)
- Criminal justice procedures
- Harassment
- Anti-abortion sting operations
- Availability of trained providers
- Reporting of suspected unlawful abortion.

1 For further information on the findings of the reviews based on the PICOs presented in this annex, refer to the EtD frameworks in Supplementary material 1.

2 For each of the PICOs in this annex, the outcomes for both populations (pregnant people seeking abortion and medical professionals providing abortion services) have been combined in one list; for more specific information about the outcomes of interest for each review, refer to the EtD frameworks in Supplementary material 1.

Grounds-based approaches

PICO 2: The impact of grounds-based approaches (see Recommendation 2)

PICO question: For pregnant people seeking abortion and also for medical professionals providing abortion services, what is the impact of grounds-based approaches (that limit access to and/or provision of abortion on "grounds" or that prohibit access to abortion) on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, anticipated or experienced family disharmony, anticipated or experienced exposure to interpersonal violence or exploitation, anticipated or experienced reproductive coercion, disproportionate impact, referral to another provider, workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload), perceived imposition on personal conscience or ethics, perceived impact on provider–client relationship, system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees), stigmatization of health-care providers (considering the application of the intervention)?

P: Pregnant people seeking abortion; medical professionals providing abortion services

I: Grounds-based approaches (that limit access to and/or provision of abortion on "grounds" or that prohibit access to abortion)

C: None (studies do not need to specify comparator)

O:

- Delayed abortion
- Continuation of pregnancy
- Opportunity costs (includes psychological opportunity costs)
- Unlawful abortion
- Self-managed abortion
- Anticipated or experienced family disharmony
- Anticipated or experienced exposure to interpersonal violence or exploitation
- Anticipated or experienced reproductive coercion
- Disproportionate impact
- Referral to another provider
- Workload implications (including reassignment issues with organization of work, as well as increases or decreases in workload)
- Perceived imposition on personal conscience or ethics
- Perceived impact on provider–client relationship
- System costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)
- Stigmatization of health-care providers (considering the application of the intervention).

Gestational age limits

PICO 3: The impact of gestational age limits (see Recommendation 3)

PICO question: For pregnant people seeking abortion and also for medical professionals providing abortion services, what is the impact of gestational age limits on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, disqualification from unlawful abortion, disproportionate impact, referral to another provider, workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload), system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees), perceived impact on provider–client relationship, stigmatization of health-care providers (considering the application of the intervention)?

P: Pregnant people seeking abortion; medical professionals providing abortion services

I: Gestational age limits

C: None (studies do not need to specify comparator)

O:

- Delayed abortion
- Continuation of pregnancy
- Opportunity costs (including psychological opportunity costs)
- Unlawful abortion
- Self-managed abortion
- Disqualification from unlawful abortion
- Disproportionate impact
- Referral to another provider
- Workload implications (including reassignment issues with organization of work, as well as increases or decreases in workload)
- System costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)
- Perceived impact on provider–client relationship
- Stigmatization of health-care providers (considering the application of the intervention).

Pre-abortion

Mandatory waiting periods

PICO 4: The impact of mandatory waiting periods (see Recommendation 6)

PICO question: For pregnant people seeking abortion and also medical professional providing abortion services, what is the impact of mandatory waiting periods on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), disproportionate impact, unlawful abortion, self-managed abortion, disqualification from lawful abortion, referral to another provider, workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload), system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees), perceived impact on provider–client relationship, stigmatization of health-care providers (considering the application of the intervention)?

P: People seeking abortion services; medical professionals providing abortion services

I: Mandatory waiting periods

C: None (studies do not need to specify comparator)

O:

- Delayed abortion
- Continuation of pregnancy

- Opportunity costs (including abortion travel and psychological opportunity costs))
- Disproportionate impact
- Unlawful abortion
- Self-managed abortion
- Disqualification from lawful abortion
- Referral to another provider
- Workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload)
- System costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)
- Perceived impact on provider–client relationship
- Stigmatization of health-care providers (considering the application of the intervention).

Third-party authorization for abortion (see Recommendation 7)

PICO 5: Impact of judicial bypass

PICO question: For pregnant people seeking abortion, what is the impact of judicial bypass on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, anticipated or experienced family disharmony, anticipated or experienced exposure to interpersonal violence or exploitation, anticipated or experienced reproductive coercion, system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)?

P: Pregnant people seeking abortion

I: Judicial bypass

C: None (studies do not need to specify comparator)

O:

- Delayed abortion
- Continuation of pregnancy
- Opportunity costs (including abortion travel and psychological opportunity costs)
- Unlawful abortion
- Self-managed abortion
- Anticipated or experienced family disharmony
- Anticipated or experienced exposure to interpersonal violence or exploitation
- Anticipated or experienced reproductive coercion
- System costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees).

PICO 6: Impact of judicial bypass versus parental consent

PICO question: For pregnant people seeking abortion, what is the impact of judicial bypass versus parental consent on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, anticipated or experienced family disharmony, anticipated or experienced exposure to interpersonal violence or exploitation, anticipated or experienced reproductive coercion, system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)?

[P-I-O same as PICO 5 but with a comparator (C) added: parental consent]

PICO 7: Impact of parental consent versus parental notification laws/requirements

PICO question: For pregnant people seeking abortion, what is the impact of parental consent versus parental notification laws/requirements on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, anticipated or experienced family disharmony, anticipated or experienced exposure to interpersonal violence or exploitation, anticipated or experienced reproductive coercion, system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)?

[P and O same as PICO 5; I = parental consent and C = parental notification laws/requirements]

PICO 8: Impact of authorization by parent through consent or notification

PICO question: For pregnant people seeking abortion, what is the impact of authorization by parent through consent or notification on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, anticipated or experienced family disharmony, anticipated or experienced exposure to interpersonal violence or exploitation, anticipated or experienced reproductive coercion, system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)?

[P-C-O same as PICO 5 but I = authorization by parent through consent or notification]

PICO 9: Impact of authorization by spousal consent

PICO question: For pregnant people seeking abortion, what is the impact of authorization by spousal consent on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, anticipated or experienced family disharmony, anticipated or experienced exposure to interpersonal violence or exploitation, anticipated or experienced reproductive coercion, system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)?

[P-C-O same as PICO 5 but I = authorization by spousal consent]

Abortion provider restrictions

PICO 10: Impact of provider restrictions (see Recommendation 21)

PICO question: For pregnant people seeking abortion and also for medical professionals providing abortion services, what is the impact of provider restrictions on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), disproportionate impact, unlawful abortion, self-managed abortion, referral to another provider, workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload), system costs (including direct system costs, and "diversions" from public health systems to paid-for services/private fees), perceived imposition on personal conscience or ethics, perceived impact on provider–client relationship, stigmatization of health-care providers (considering the application of the intervention)?

P: Pregnant people seeking abortion; medical professionals providing abortion services

I: Provider restrictions

C: None (studies do not need to specify comparator)

O:

- Delayed abortion
- Continuation of pregnancy
- Opportunity costs (including abortion travel and stigmatization, and psychological opportunity costs)
- Disproportionate impact
- Unlawful abortion
- Self-managed abortion

- Referral to another provider
- Workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload)
- System costs (including direct system costs, and "diversions" from public health systems to paid-for services/private fees)
- Perceived imposition on personal conscience or ethics
- Perceived impact on provider–client relationship
- Stigmatization of health-care providers (considering the application of the intervention).

Conscientious objection

PICO 11a: Impact of conscientious objection (see Recommendation 22)

PICO question: For pregnant people seeking abortion and also medical professionals providing abortion services, what is the impact of conscientious objection on delayed abortion, continuation of pregnancy, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, referral to another provider, workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload), system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees), perceived imposition on personal conscience or ethics, perceived impact on provider–client relationship, stigmatization of health-care providers (considering the application of the intervention)?

P: Pregnant people seeking abortion; medical professionals providing abortion services

I: Conscientious objection/refusal

C: None (studies do not need to specify comparator)

O:

- Delayed abortion
- Continuation of pregnancy
- Opportunity costs (including abortion travel and stigmatization, and psychological opportunity costs)
- Unlawful abortion
- Self-managed abortion)
- Referral to another provider
- Workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload)
- System costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)
- Perceived imposition on personal conscience or ethics
- Perceived impact on provider–client relationship
- Stigmatization of health-care providers (considering the application of the intervention).

PICO 11b: Impact of regulation of conscientious objection (see Recommendation 22)

PICO question: For pregnant people seeking abortion, medical professionals providing abortion services and State actors, what is the impact of regulation of conscientious objection on delayed abortion, denial/refusal, continuation of pregnancy, disproportionate impact, opportunity costs (including psychological opportunity costs), unlawful abortion, self-managed abortion, referral to another provider, workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload), professional or personal repercussions including legal or disciplinary proceedings and professional opportunities, system costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees), perceived imposition on personal conscience or ethics, regulatory clarify, choice of workplace (institution or jurisdiction), choice of specialism or field of practice, perceived impact on provider–client relationship, management of abortion complications, maternal mortality and morbidity, regulatory burdens, political costs, domestic abortion travel, inward abortion travel, outward abortion travel, relationship between state and healthcare providers, availability of Sexual and Reproductive Health (SRH) services and personnel, and relationship between state and potential/actual abortion seekers?

P: Pregnant people seeking abortion; medical professionals providing abortion services, State actors (governments, officials, lawmakers, courts, governments of third countries)

I: Regulation of conscientious objection to abortion care [i.e., laws, policies and protocols addressing some or all of how, when, who, and according to what process conscientious objection may be exercised]

C: None (studies do not need to specify comparator)

O:

- Delayed abortion
- Denial/Refusal
- Continuation of pregnancy
- Disproportionate impact
- Opportunity costs (including abortion travel and stigmatization, and psychological opportunity costs)
- Unlawful abortion
- Self-managed abortion
- Referral to another provider
- Workload implications (including reassignment, issues with organization of work, as well as increases or decreases in workload)
- Professional or personal repercussions incl. legal or disciplinary proceedings and professional opportunities
- System costs (includes direct system costs, and "diversions" from public health systems to paid-for services/private fees)
- Perceived imposition on personal conscience or ethics (includes implications of the presence, absence, content, clarity or lack of clarity of laws, policies and regulation relating to conscientious objection)
- Regulatory clarity
- Choice of workplace (institution or jurisdiction)
- Choice of specialism or field of practice
- Perceived impact on provider–client relationship
- Stigmatization of health-care providers (considering the application of the intervention)
- Management of abortion complications
- Maternal mortality and morbidity
- Regulatory burdens
- Political costs

- Domestic abortion travel
- Inward abortion travel
- Outward abortion travel
- Relationship between state and healthcare providers
- Availability of Sexual and Reproductive Health (SRH) services and personnel
- Relationship between state and potential/actual abortion seekers

Annex 9. Clinical services domain PICO questions

PICO: P = population; **I** = intervention; **C** = comparator; **O** = outcome(s)[1]

Pre-abortion

Rh isoimmunization

PICO 1: No anti-D administration in unsensitized Rh-negative individuals seeking abortion (see Recommendation 8 [NEW])

PICO question: For an unsensitized Rh-negative individual seeking abortion at < 12 weeks of gestation, is no administration of anti-D a safe and effective alternative to routine anti-D administration?

P: Unsensitized Rh-negative individuals seeking abortion at < 12 weeks (undergoing either medical or surgical abortion)

I: No anti-D administration

C: Routine anti-D administration

O:

- Rate of isoimmunization in subsequent pregnancy
- Rate of antibody formation after initial pregnancy.

Pain management for surgical abortion

PICO 2: Pain control for surgical abortion at < 14 weeks of gestation (see Recommendations 11 and 12 [NEW])

PICO question: For a pregnant person seeking surgical abortion at < 14 weeks of gestation, is pain control with any particular method (I) safer, more effective and/or more satisfactory/acceptable compared with pain control with a different method or no pain control (C)?

P: Pregnant persons seeking surgical abortion at less than 14 weeks of gestation.

I:

i. Paracervical block (PCB) (this includes the different concentrations, type [lidocaine], carbonated vs not, depth of injection)

ii. PCB with premedication

iii. Intravenous (IV) conscious sedation plus PCB

iv. General anaesthesia

v. Topical anaesthesia (e.g. lidocaine)

vi. Non-pharmacological intervention (music, acupuncture, "verbicaine", etc.)

C:

i. No PCB

ii. PCB alone

iii. PCB with premedication

iv. IV conscious sedation plus PCB

O:

- Effectiveness (maximum pain as measured by visual analogue scale; VAS)
- Anxiety scores using VAS
- Safety (complications related to pain control methods, use of supplemental narcotic, use of any additional analgesic medication, duration of recovery time, hospital admission), side-effects
- Satisfaction/acceptability.

1 For further information on the findings of the reviews based on the PICOs presented in this annex, refer to the EtD frameworks in Supplementary material 2.

PICO 3: Pain control for surgical abortion at ≥ 14 weeks of gestation (see Recommendations 11, 13 and 14 [NEW])

PICO question: For a pregnant person seeking surgical abortion at ≥ 14 weeks of gestation (including cervical priming prior to the procedure), is pain control with any particular method (I) safer, more effective and/or more satisfactory/acceptable compared with pain control with a different method or no pain control (C)?

P: Pregnant persons seeking surgical abortion at 14 weeks of gestation or above

I:

i. PCB (this includes the different concentrations, type [lidocaine], carbonated vs not, depth of injection)

ii. PCB with premedication

iii. IV conscious sedation plus PCB

iv. General anaesthesia

v. Topical anaesthesia (e.g. lidocaine)

vi. Non-pharmacological intervention (music, acupuncture, "verbicaine", etc.)

C:

i. No PCB

ii. PCB alone

iii. PCB with premedication

iv. IV conscious sedation plus PCB

O:

- Effectiveness (maximum pain as measured by VAS)
- Anxiety scores using VAS
- Safety (complications related to pain-control methods, use of supplemental narcotic, use of any additional analgesic medication, duration of recovery time, hospital admission), side-effects
- Satisfaction/acceptability.

Pain management for medical abortion

PICO 4: Pain control for medical abortion at < 14 weeks of gestation (see Recommendation 15)

PICO question: For a pregnant person seeking medical abortion at < 14 weeks of gestation, is pain control with any particular (i) pharmacological method (given prophylactically or after onset of pain) or (ii) non-pharmacological method safer, more effective and/or more satisfactory/acceptable compared with any other such method or no treatment/placebo?

P: Pregnant persons seeking medical abortion at < 14 weeks of gestation

I:

i. Pharmacological methods (Timing: prophylactic or after onset of pain)

- Ibuprofen
- Acetaminophen plus codeine
- Anti-emetics
- Loperamide
- Tramadol

ii. Non-pharmacological methods (music, acupuncture, "verbicaine", etc.)

C:

i. Pharmacological methods (Timing: prophylactic or after onset of pain)

- Ibuprofen
- Acetaminophen plus codeine
- Anti-emetics
- Loperamide
- Tramadol

ii. Non-pharmacological methods (music, acupuncture, "verbicaine", etc.)

iii. No treatment/placebo

O:

- Effectiveness (maximum pain as measured by VAS)
- Safety (complications related to pain-control methods, use of any supplemental narcotic, use of any additional analgesic medication), side-effects
- Effectiveness of medical abortion regimen, defined as successful completion without additional surgical intervention
- Time to expulsion
- Satisfaction/acceptability.

PICO 5: Pain control for medical abortion at ≥ 14 weeks of gestation (see Recommendation 16 [NEW])

PICO question: For a pregnant person seeking medical abortion at ≥ 14 weeks of gestation, is pain control with any particular (i) pharmacological method (given prophylactically or after onset of pain) or (ii) non-pharmacological method safer, more effective and/or more satisfactory/acceptable compared with any other such methods or no treatment/placebo?

P: Pregnant persons seeking medical abortion at 14 weeks of gestation or above

I:

i. Pharmacological methods (Timing: prophylactic or after onset of pain)

- Pretreatment (ibuprofen, acetaminophen plus codeine, antiemetics, loperamide, tramadol)
- IV opiates
- PCB

ii. Non-pharmacological methods (music, acupuncture, "verbicaine", etc.)

C:

i. Pharmacological methods (Timing: prophylactic or after onset of pain)

- Pretreatment (ibuprofen, acetaminophen plus codeine, antiemetics, loperamide, tramadol)
- IV opiates
- PCB

ii. Non-pharmacological methods (music, acupuncture, "verbicaine", etc.)

iii. No treatment/placebo

O:

- Effectiveness (maximum pain as measured by VAS)
- Safety (complications, use of any supplemental narcotic, use of any additional analgesic medication), side-effects
- Effectiveness of medical abortion regimen, defined as successful completion without additional surgical intervention
- Time to expulsion
- Satisfaction/acceptability.

Cervical priming

PICO 6a: Cervical priming at < 12 weeks of gestation (see Recommendation 17)

PICO question: For a pregnant person seeking surgical abortion at < 12 weeks of gestation, is cervical priming effective, safe and acceptable?

P: Pregnant persons seeking surgical abortion < 12 weeks

I: Cervical priming with medication or mechanical methods

C: Cervical priming with placebo, with medication (using different routes, doses or treatment intervals) or with different mechanical methods

O:

- Effectiveness
- Satisfaction/acceptability
- Safety.

PICO 6b: Cervical priming at ≥ 12 weeks with medications (comparing different regimens) (see Recommendations 18b–d [NEW])

PICO question: For a pregnant person seeking surgical abortion at ≥ 12 weeks of gestation, is cervical priming with mifepristone plus misoprostol or with mifepristone alone a safe, effective and satisfactory/acceptable alternative to cervical preparation with misoprostol alone?

P: Pregnant persons seeking surgical abortion at ≥ 12 weeks

I: Cervical priming with

i. Mifepristone plus misoprostol [various routes, doses, intervals]

ii. Mifepristone alone [various routes, doses, intervals]

C: Cervical priming with misoprostol alone [various routes, doses, intervals]

O:

- Effectiveness (pre-procedure cervical dilatation, need for further dilatation, ease of procedure, time to complete procedure)
- Safety (complications, need for additional interventions, pre- and post-procedure pain), side-effects
- Satisfaction (client and provider)/acceptability
- Cost (comparative cost and cost to the client).

PICO 7: Cervical priming at ≥ 12 weeks with medications compared with mechanical methods (see Recommendation 18b [NEW])

PICO question: For a pregnant person seeking surgical abortion at ≥ 12 weeks of gestation, is cervical priming with medical methods (mifepristone, misoprostol, or both) a safe, effective and satisfactory/acceptable alternative to mechanical methods (laminaria, Foley bulb, Dilapan)?

P: Pregnant persons seeking surgical abortion at ≥ 12 weeks

I: Cervical priming with medical methods

i. Mifepristone alone

ii. Misoprostol plus mifepristone

iii. Misoprostol alone

C: Cervical priming with mechanical methods (i.e. laminaria, Foley bulb, Dilapan)

O:

- Effectiveness (pre-procedure cervical dilatation, need for further dilatation, ease of procedure, time to complete procedure)
- Safety (complications, need for additional interventions, pre- and post-procedure pain), side-effects

- Satisfaction (client and provider)/acceptability
- Cost (comparative cost and cost to the client).

PICO 8: Cervical priming at ≥ 12 weeks with medication(s) plus laminaria compared with laminaria alone (see Recommendation 18d [NEW])

PICO question: For a pregnant person seeking surgical abortion at ≥ 12 weeks of gestation, is cervical priming with medication(s) plus laminaria a safe, effective and satisfactory/acceptable alternative to cervical preparation with laminaria alone?

P: Pregnant persons seeking surgical abortion at ≥ 12 weeks

I: Cervical priming with medication(s) plus laminaria

i. Mifepristone plus misoprostol plus laminaria

ii. Misoprostol plus laminaria

iii. Mifepristone plus laminaria

C: Cervical priming with laminaria alone

O:

- Effectiveness (pre-procedure cervical dilatation, need for further dilatation, ease of procedure, time to complete procedure)
- Safety (complications, need for additional interventions, pre- and post-procedure pain), side-effects
- Satisfaction (client and provider)/acceptability
- Cost (comparative cost and cost to the client).

PICO 9: Cervical priming at ≥ 12 weeks by mechanical method(s) before dilatation and evacuation (D&E) (see Recommendation 18 [NEW])

PICO question: For a pregnant person seeking surgical abortion (D&E) at ≥ 12 weeks of gestation, is cervical priming with one mechanical method a safe, effective and satisfactory/acceptable alternative to cervical priming with a different mechanical method?

P: Pregnant person seeking surgical abortion at ≥ 12 weeks

I: Cervical priming with one mechanical method before D&E

C: Cervical priming with a different mechanical method before D&E

O:

- Effectiveness (pre-procedure cervical dilatation, need for further dilatation, ease of procedure, time to complete procedure)
- Safety (complications, need for additional interventions, pre- and post-procedure pain), side-effects
- Satisfaction (client and provider)/acceptability
- Cost (comparative cost and cost to the client).

Abortion

New medical methods for abortion

PICO 10: Medical abortion with letrozole plus misoprostol, compared with misoprostol alone (see Recommendation 27c [NEW])

PICO question: For a pregnant person seeking medical abortion, is medical abortion with letrozole plus misoprostol a safe, effective and satisfactory/acceptable alternative to medical abortion with misoprostol alone?

P: Pregnant persons seeking medical abortion (all gestational ages)

I: Medical abortion with letrozole plus misoprostol [various routes, doses, intervals]

C: Medical abortion with misoprostol alone [various routes, doses, intervals]

O:

- Effectiveness (ongoing pregnancy rate, procedure completed without surgical intervention)
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment
- Satisfaction/acceptability
- Cost (comparative and cost to the client).

PICO 11: Medical abortion with letrozole plus misoprostol, compared with mifepristone plus misoprostol

PICO question: For a pregnant person seeking medical abortion, is medical abortion with letrozole plus misoprostol a safe, effective and satisfactory alternative to medical abortion with mifepristone plus misoprostol?

P: Pregnant persons seeking medical abortion (all gestational ages)

I: Medical abortion with letrozole plus misoprostol [various routes, doses, intervals]

C: Medical abortion with mifepristone plus misoprostol [various routes, doses, intervals]

O:

- Effectiveness (ongoing pregnancy rate, completed without surgical intervention)
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment
- Satisfaction/acceptability
- Cost (comparative and cost to the client).

PICO 12: Medical abortion with mifepristone plus letrozole, compared with misoprostol alone

PICO question: For a pregnant person seeking medical abortion, is medical abortion with mifepristone plus letrozole a safe, effective and satisfactory alternative to medical abortion with misoprostol alone?

P: Pregnant person seeking medical abortion

I: Medical abortion with mifepristone plus letrozole [various routes, doses, intervals]

C: Medical abortion with misoprostol alone [various routes, doses, intervals]

O:

- Effectiveness (ongoing pregnancy rate, completed without surgical intervention)
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment
- Satisfaction/acceptability
- Cost (comparative and cost to the client).

Missed abortion at < 14 weeks of gestation

PICO 13: Medical management of missed abortion with mifepristone plus misoprostol (see Recommendation 31 [NEW])

PICO question: For a pregnant person with missed abortion at < 14 weeks of gestation, is medical management with mifepristone plus misoprostol a safe, effective and satisfactory/acceptable alternative to medical management with misoprostol alone?

P: Pregnant persons with missed abortion < 14 weeks

I: Medical management with mifepristone plus misoprostol [various routes, doses, intervals]

C: Medical management with misoprostol alone [routes, doses, intervals]

O:

- Effectiveness (failed expulsion/ongoing retained products, completed without surgical intervention)
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment
- Satisfaction/acceptability
- Cost of treatment.

PICO 14: Medical management of missed abortion with all regimens (see Recommendation 31 [NEW])

PICO question: For a pregnant person with missed abortion at < 14 weeks of gestation, is medical management (all regimens) a safe, effective and satisfactory/acceptable alternative to expectant management?

P: Pregnant persons with missed abortion < 14 weeks

I: Medical management (all regimens)

C: Expectant management

O:

- Effectiveness (failed expulsion/ongoing retained products, completed without surgical intervention)
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment
- Satisfaction/acceptability
- Cost of treatment.

PICO 15: Surgical management of missed abortion (see Recommendation 31 [NEW])

PICO question: For a pregnant person with missed abortion at < 14 weeks of gestation, is surgical management a safe, effective and satisfactory/acceptable alternative to medical or expectant management?

P: Pregnant persons with missed abortion < 14 weeks

I: Surgical management

C:

- Medical management
- Expectant management

O:

- Effectiveness (failed expulsion/ongoing retained products, completed without surgical intervention
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment
- Satisfaction/acceptability
- Cost of treatment.

Self-management approaches

Self-management of medical abortion (see Recommendation 49)

PICO 16: Self-management of medical abortion

PICO question: For a pregnant person seeking medical abortion, is self-management of the process of medical abortion (assessing eligibility, administration of mifepristone and/or misoprostol, self-assessing outcome/success), without direct supervision of a trained health worker, a safe, effective and satisfactory/acceptable alternative to medical abortion managed by a trained health worker?

P: Pregnant persons seeking medical abortion at any gestational age

I: Pregnant persons self-managing the process of medical abortion (in whole) without direct supervision of a trained health worker

C: Medical abortion managed by a trained health worker (all medication abortion regimens)

O:

- Effectiveness (success of abortion without need for surgical intervention following the procedure)
- Safety (serious adverse events and complications)
- Satisfaction/acceptability
- Physical and emotional experience (side-effects, positive and negative emotions, internalized stigma), knowing when to seek medical care (unscheduled visits, phone calls to the clinic, emergency visits)
- Cost.

PICO 16a: Self-assessment of eligibility for MA

PICO question: For a pregnant person seeking medical abortion, is self-assessment of eligibility[1] for medical abortion a safe, effective and satisfactory/acceptable alternative to eligibility assessment by a physician or other trained health worker?

P: Pregnant persons seeking medical abortion at any gestational age

I: Pregnant persons self-managing the first part of the medical abortion process by self-assessing their eligibility for medical abortion without direct supervision of a health worker

C: Eligibility assessment performed by a trained health worker

O:

- Proportion of pregnant persons deemed eligible for medical abortion
  - Proportion of pregnant persons who were deemed ineligible due to gestational age
  - Proportion of pregnant persons who were deemed ineligible due to contraindications
- Accuracy of these assessments when measured against an independent verifier and/or diagnostic standard
- Ongoing pregnancy
- Completed without surgical intervention
- Safety (serious adverse events and complications)
- Satisfaction/acceptability
- Cost.

1 Eligibility criteria defined as: < 12 weeks; no contraindications; no signs or symptoms of ectopic pregnancy.

PICO 16b: Self-administering medications for medical abortion

PICO question: For a person seeking medical abortion, is self-administration of medications for medical abortion, when provided with instructions for their use from a reliable source, a safe, effective and satisfactory/acceptable alternative to administration of medications by a trained health worker?

P: Pregnant persons seeking medical abortion at any gestational ages

I: Pregnant persons self-administering the medications for medical abortion (as part of the medical abortion process) without direct supervision by a health worker (but with instructions from a reliable source of health care)

C: Administration of medications for medical abortion by a trained health worker

O:

- Pregnant persons' adherence to the recommended medical abortion regimen following instructions
- Effectiveness (ongoing pregnancy rate, completed without surgical intervention)
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment
- Physical and emotional experience (side-effects, positive and negative emotions, internalized stigma), knowing when to seek medical care (unscheduled visits, phone calls to the clinics, emergency visits)
- Satisfaction/acceptability
- Cost (comparative and cost to the client).

PICO 16C: Self-assessment of the outcome of the medical abortion process

PICO question: For an individual who has undergone medical abortion, is self-assessment of the outcome/success of medical abortion a safe, effective and satisfactory/acceptable alternative to assessment of the outcome/success by a trained health worker?

P: Individuals who have undergone medical abortion

I: Pregnant persons self-managing the last part of the medical abortion process by self-assessing the outcome/success of the abortion without direct supervision by a trained health worker

C: Assessment of outcome/success of abortion by a trained health worker

O:

- Effectiveness (proportion of pregnant persons assessed to have successful abortion, accuracy of these assessments when measured against an independent verifier and/or diagnostic standard)
- Ongoing pregnancy rate
- Completed without surgical intervention
- Safety (serious adverse events and complications), side-effects
- Expulsion time from initiation of treatment;
- Physical and emotional experience (side-effects, positive and negative emotions, internalized stigma), knowing when to seek medical care (unscheduled visits; phone calls to the clinics, emergency visits)
- Satisfaction/acceptability
- Cost (comparative and cost to the client).

Annex 10. Service delivery domain PICO questions

PICO: P = population; **I** = intervention; **C** = comparator; **O** = outcome(s)[2]

Note: For a description of all the health worker categories mentioned in this annex, please refer to Annex 5.

Services applicable across the continuum of care

Provision of information

PICO 1: Pharmacy workers to provide accurate information (see Recommendation 4)

PICO question: For a person seeking information about abortion care (before or after treatment/abortion), is information on the availability of safe providers for abortion care (abortion provision, care for complications of abortion, care for incomplete abortion) provided by a pharmacy worker a safe, effective and satisfactory/acceptable alternative to no provision of information (usual practice)?

P: Person seeking information about abortion care before their treatment, or following an incomplete abortion or complications of abortion (including medical or surgical, at any gestational age)

I: Information and linkage to abortion services, in the community or in other locations, by pharmacy workers

C: No information (usual practice)

O:

- Effectiveness (pharmacy workers' correct knowledge of safe abortion and possible complications, of safe post-abortion care, and of indications for referral)
- Privacy and confidentiality in provision of information
- Accessibility of the services for the person who requires them
- Satisfaction with/acceptability of the information and services provided.

Counselling

PICO 2: Pre- and post-abortion counselling (see Recommendation 5)

PICO question: For a pregnant person having an abortion, is pre- and post-abortion counselling provided by a traditional and complementary medicine professional, pharmacist, pharmacy worker or community health worker a safe, effective and satisfactory/acceptable alternative to counselling provided by in-clinic staff?

P: Pregnant persons having an abortion

I: Pre- and post-abortion counselling by traditional and complementary medicine professionals, pharmacists, pharmacy workers or community health workers

C: Counselling provided by in-clinic staff (i.e. generalist or specialist medical practitioners, nurses or midwives)

O:

- Effectiveness (health workers' and clients' correct knowledge of contraceptive options, of safe and appropriate abortion services, and of safe post-abortion care)
- Satisfaction with/acceptability of the contraception advice provided, and the counselling and services provided
- Availability of contraceptive counselling and services
- Accessibility of information and method of choice
- Privacy and confidentiality of client respected during provision of counselling and services
- Participation in provision of counselling and services
- Quality of counselling and services
- Informed decision-making after provision of counselling and services
- Accountability in the provision of counselling and services

2 For further information on the findings of the reviews based on the PICOs presented in this annex, refer to the EtD frameworks in Supplementary material 3.

- Mix in types of contraception offered in the counselling.

Pre-abortion

Cervical priming prior to surgical abortion

PICO 3: Cervical priming using osmotic dilators or medication (see Recommendations 19 and 20)

PICO question: For a pregnant person having an induced surgical abortion, is provision of cervical priming using osmotic dilators or medication by a traditional and complementary medicine professional, associate/advanced associate clinician, midwife, nurse or auxiliary nurse/auxiliary nurse midwife a safe, effective and satisfactory/acceptable alternative to provision of cervical priming by a physician?

P: Pregnant persons having an induced abortion with vacuum aspiration or D&E

I: Cervical priming with

i. osmotic dilators provided by traditional and complementary medicine professionals, associate/advanced associated clinicians, midwives, nurses or auxiliary nurse/auxiliary nurse midwives

ii. medications provided by traditional and complementary medicine professionals, associate/advanced associate clinicians, midwives, nurses, auxiliary nurse/auxiliary nurse midwives, pharmacists or pharmacy workers

C: Cervical priming performed by physicians with (i) osmotic dilators or (ii) medications

O:

- Safety (serious adverse events and complications)
- Effectiveness (degree of dilatation and provider's perception of ease of procedure)
- Satisfaction/acceptability.

Abortion

Surgical abortion at gestational ages < 14 weeks

PICO 4: Vacuum aspiration for all indications at gestational ages < 14 weeks (see Recommendation 24)

PICO question: For a pregnant person seeking induced abortion or treatment for incomplete abortion or miscarriage (i.e. all indications for vacuum aspiration), is provision of vacuum aspiration by a traditional and complementary medicine professional, auxiliary nurse midwife or auxiliary nurse a safe, effective and satisfactory/acceptable alternative to provision of vacuum aspiration by a physician?

P: Pregnant persons seeking an induced abortion or treatment for incomplete abortion or miscarriage

I: Vacuum aspiration provided by traditional and complementary medicine professional, auxiliary nurse midwives or auxiliary nurses

C: Vacuum aspiration provided by generalist or specialist medical practitioners (obstetricians/gynaecologists)

O:

- Safety (serious adverse events and complications)
- Effectiveness (success of abortion following the procedure
- Satisfaction/acceptability.

Surgical abortion at later gestational ages

PICO 5: Dilatation and evacuation (D&E) for surgical abortion at ≥ 14 weeks (see Recommendation 26)

PICO question: For a pregnant person having a surgical abortion (D&E), is provision by a traditional and complementary medicine professional, associate/advanced associate clinician, midwife a safe, effective or satisfactory/acceptable alternative to provision of care by a doctor?

P: Pregnant women seeking surgical abortion at ≥ 14 weeks of gestation

I: D&E provided by traditional and complementary medicine professionals, associate/advanced associate clinicians, midwives

C: Surgical abortion provided by generalist and specialist medical practitioners

O:

- Effectiveness (success of abortion following the procedure)
- Safety (serious adverse events and complications)
- Satisfaction/acceptability.

Medical abortion for gestational ages < 12 weeks and its component tasks (see Recommendation 28)

PICO 6: Provision of medical abortion care at < 12 weeks

PICO question: For a pregnant person seeking medical abortion at < 12 weeks, is provision of medical abortion (i.e. assessment of eligibility, administering quality assured medications, assessment of outcome/success) by a traditional and complementary medicine professional, pharmacist, pharmacy worker or community health worker, a safe, effective and satisfactory/acceptable alternative to provision of medical abortion by a physician?

P: Pregnant persons seeking medical abortion

I: Medical abortion provided by traditional and complementary medicine professionals, pharmacists, pharmacy workers or community health workers

C: Medical abortion provided by generalist or specialist medical practitioners (obstetrician/gynaecologists)

O:

- Safety (serious adverse events and complications)
- Effectiveness (success of abortion without need for surgical intervention following the treatment)
- Satisfaction/acceptability.

PICO 6a: Assessment of eligibility for MA

PICO question: For a pregnant person seeking medical abortion, is assessment of eligibility for medical abortion by a traditional and complementary medicine professional, pharmacist, pharmacy worker or community health worker a safe, effective and satisfactory/acceptable alternative to – and as accurate as – assessment by a physician?

P: Pregnant persons seeking medical abortion

I: Eligibility assessment by traditional and complementary medicine professionals, pharmacists, pharmacy workers or community health workers

C: Eligibility assessment by generalist or specialist medical practitioners (obstetrician/gynaecologists)

O:

- Effectiveness (proportion of pregnant persons deemed eligible for medical abortion by provider type and accuracy of these assessments when measured against an independent verifier and/or diagnostic standard)
- Safety (serious adverse events, excluding treatment for incomplete abortion or ongoing pregnancy)
- Effectiveness (success of abortion following the procedure)
- Satisfaction.

PICO 6b: Administration of medications for MA

PICO question: For a pregnant person seeking medical abortion, is administration of medications for medical abortion (i.e. information provision, dispensing of quality assured medications, referral to a reputable source for medications) with instructions for their use by a traditional and complementary medicine professional, pharmacist, pharmacy worker or community health worker a safe, effective and satisfactory/acceptable alternative to administration by a physician?

P: Pregnant persons seeking medical abortion

I: Administration of medications (i.e. information provision, dispensing of quality assured medications, referral to a reputable source for medications) with instructions for their use by traditional and complementary medicine professionals, pharmacists, pharmacy workers or community health workers

C: Administration of medications (i.e. information provision, dispensing of quality assured medications, referral to a reputable source for medications) by generalist or specialist medical practitioners

O:

- Participants understanding of the protocol, as shown by taking the correct regimen
- Safety (serious adverse events, excluding treatment for incomplete abortion or ongoing pregnancy)
- Effectiveness (success of abortion following the procedure)
- Satisfaction.

PICO 6C: Accurate assessment of success of the MA process

PICO question: For a pregnant person seeking medical abortion, is assessment of the success of the medical abortion process by a traditional and complementary medicine professional, pharmacist, pharmacy worker or community health worker a safe, effective and satisfactory/acceptable alternative to – and as accurate as – assessment by a physician?

P: Pregnant persons seeking medical abortion

I: Assessment of success of abortion by traditional and complementary medicine professionals, pharmacists, pharmacy workers or community health workers

C: Assessment of success of abortion by generalist or specialist medical practitioners

O:

- Effectiveness of the assessment of the outcome (proportion of pregnant persons assessed for success of abortion by provider type and accuracy of these assessments when measured against an independent verifier and/or diagnostic standard)
- Effectiveness (success of abortion following the procedure)
- Safety (serious adverse events, excluding treatment for incomplete abortion or ongoing pregnancy, ectopic pregnancy)
- Satisfaction.

Management of induced abortion at gestational ages ≥ 12 weeks

PICO 7: Provision of abortion care at ≥ 12 weeks (see Recommendation 30)

PICO question: For a pregnant person seeking induced abortion, is medical or surgical abortion by a traditional and complementary medicine professional, associate clinician, midwife, nurse, auxiliary nurse, pharmacist, pharmacy worker or community health worker a safe, effective or satisfactory alternative to provision of abortion care by doctors?

P: Pregnant women seeking medical or surgical abortion after 12 weeks of gestation

I: Medical abortion or surgical abortion provided by traditional and complementary medicine professionals, associate clinicians, midwives, nurses, auxiliary nurses, pharmacists, pharmacy workers or community health workers

C: Medical abortion or surgical abortion provided by generalist and specialist medical practitioners

O:

- Effectiveness (success of abortion without need for further medical or surgical intervention)
- Safety (serious adverse events and complications)
- Satisfaction.

Intrauterine fetal demise (IUFD)

PICO 8: Medical management of intrauterine fetal demise (IUFD) (see Recommendation 33 [NEW])

PICO question: For a pregnant person diagnosed with intrauterine fetal demise (IUFD), is medical management of IUFD (with mifepristone and misoprostol, or misoprostol alone) provided by a traditional and complementary medicine professional, associate/advanced associate clinician, midwife, nurse, auxiliary nurse/auxiliary nurse midwife, pharmacist, pharmacy worker or community health worker a safe, effective and satisfactory alternative to medical management by a physician?

P: Pregnant persons diagnosed with IUFD

I: Medical management with mifepristone and misoprostol or misoprostol alone provided by traditional and complementary medicine professionals, associate/advanced associate clinicians, midwives, nurses, auxiliary nurses/auxiliary nurse midwives, pharmacists, pharmacy workers or community health workers

C: Medical management with mifepristone and misoprostol or misoprostol alone provided by generalist or specialist medical practitioners

O:

- Safety (serious adverse events and complications)
- Effectiveness (success of abortion without need for surgical intervention following the procedure)
- Satisfaction/acceptability.

Post-abortion

Incomplete abortion at gestational ages < 14 weeks

PICO 9: Management of incomplete abortion with misoprostol (see Recommendation 37)

PICO question: For a pregnant person with incomplete abortion, is management of incomplete abortion with misoprostol provided by a traditional and complementary medicine professional, pharmacist, pharmacy worker or community health worker a safe, effective and satisfactory/acceptable alternative to management with misoprostol provided by a physician?

P: Pregnant persons with incomplete abortion

I: Medical management with misoprostol provided by traditional and complementary medicine professionals, pharmacists, pharmacy workers or community health workers

C: Medical management with misoprostol provided by generalist or specialist medical practitioners

O:

- Safety (serious adverse events and complications)
- Effectiveness (success of abortion without need for surgical intervention following the procedure)
- Satisfaction/acceptability.

PICO 10: Vacuum aspiration for management of uncomplicated incomplete abortion (see Recommendation 38)

PICO question: For a pregnant person seeking an induced abortion, is provision of vacuum aspiration for induced abortion/incomplete abortion/miscarriage (all indications) by traditional and complementary medicine professionals, auxiliary nurses or auxiliary nurse midwives a safe, effective or satisfactory option to provision of vacuum aspiration by physicians?

P: Pregnant persons seeking induced abortion

I: Vacuum aspiration provided by traditional and complementary medicine professionals, auxiliary nurses or auxiliary nurse midwives

C: Vacuum aspiration provided by generalist or specialist medical practitioners (obstetrician/gynaecologists)

O:

- Effectiveness (success of abortion following the procedure)
- Safety (serious adverse events and complications)
- Satisfaction/acceptability.

Recognizing and managing complications (see Recommendations 39 and 40)

PICO 11: Diagnosis and management of abortion-related complications

PICO question: For a person presenting with complication(s) of an induced abortion and in a stable condition, is diagnosis and management of abortion-related complications by a traditional and complementary medicine professional, pharmacist, pharmacy worker or community health worker a safe, effective and satisfactory/acceptable alternative to – and as accurate as – diagnosis and management by a physician?

P: Women presenting with complication(s) of an induced abortion and in a stable condition

I: Diagnosis and management of complications by traditional and complementary medicine professional, pharmacists, pharmacy workers or community health workers

i. Diagnosis and management of infection by traditional and complementary medicine professionals, pharmacists, pharmacy workers, community health workers

ii. Diagnosis and management of haemorrhage by traditional and complementary medicine professionals, pharmacists, pharmacy workers, community health workers

C: Diagnosis and management of infection and heavy bleeding by generalist and specialist medical practitioners

O:

- Effectiveness (accurate determination of a complication followed by an offer of correct treatment or referral depending on professional capacity and clinical setting)
- Safety (serious adverse events)
- Satisfaction/acceptability.

Post-abortion contraception

PICO 12: Post-abortion provision of injectable contraceptives (see Recommendation 46)

PICO question: For a person in the post-abortion period needing contraception, is provision of injectable contraceptives (initiation or continuation) by a traditional and complementary medicine professional, pharmacy worker or community health worker, a safe, effective and satisfactory/acceptable alternative to provision by a trained health worker?

P: Women in the post-abortion period needing contraception

I: Delivery of injectable contraceptives, by traditional and complementary medicine professionals, pharmacy workers or community health workers

C: Delivery of injectable contraceptives by trained health workers

O:

- Contraceptive uptake and continuation

- Safety (serious adverse events and complications related to provision of the method)
- Effectiveness (method failure)
- Satisfaction/acceptability.

Service delivery considerations

Non-facility-based/outpatient/home-based care

PICO 13: Telemedicine (see Recommendation 48)

PICO question: For a pregnant person seeking medical abortion, is medical abortion care provided through telemedicine (comprehensive care or individual components) a safe, effective and satisfactory/acceptable alternative to in-person medical abortion care?

P: Pregnant persons seeking medical abortion

I: Medical abortion care provided through telemedicine, including comprehensive medical abortion care, or any number of the following individual components:

- Eligibility assessment for medical abortion through telemedicine
- Counselling and/or instructions for medical abortion through telemedicine
- Instructions for and active facilitation of medical abortion through telemedicine
- Follow-up of medical abortion through telemedicine

C: In-person medical abortion care

O:

- Effectiveness (rates of ongoing pregnancy, success of abortion without need for surgical intervention following the procedure, and of surgical evacuation post abortion)
- Safety (serious adverse events and complications)
- Satisfaction/acceptability
- Rate of adherence to recommended dose regimen (self-reported)
- Reported cost of services.

PICO 14: Community-based outreach (see Best Practice Statement 49)

PICO question: For a pregnant person seeking induced abortion, are community-based outreach models for provision of abortion care safe, effective and satisfactory/acceptable alternatives to provision of abortion care in a health-care facility by a trained health worker?

P: Pregnant persons seeking induced abortion

I: Outreach involving health workers

C: Provision of care in a health-care facility by trained health workers

O:

- Safety (serious adverse events and complications)
- Effectiveness (success of abortion without need for surgical intervention following the procedure)
- Cost-effectiveness
- Increased health seeking behaviours
- Satisfaction/acceptability.

Setting:

- Weak infrastructure
- Legally restrictive.

PICO 15: Harm-reduction counselling (see Best Practice Statement 49)

PICO question: For a pregnant person seeking an induced abortion, is harm-reduction counselling on abortion care a safe, effective and satisfactory/acceptable alternative to routine in-clinic service delivery?

P: Pregnant persons seeking an induced abortion

I: Harm-reduction counselling

C: Routine in-clinic service delivery

O:

- Safety (serious adverse events and complications)
- Effectiveness (success of abortion without need for surgical intervention following the procedure)
- Satisfaction/acceptability.

Setting:

- Humanitarian settings
- Non-humanitarian settings.

PICO 16: Social marketing outreach/communicating safe abortion (see Best Practice Statement 49)

PICO question: For a pregnant person seeking an induced abortion, can social marketing outreach provide improved access to safe, effective and satisfactory/acceptable induced abortion services compared with provision of abortion care in a health-care facility by a trained health worker?

P: Pregnant persons seeking an induced abortion

I: Social marketing methods for induced abortion services

C: In-clinic abortion service provision

O:

- Safety (serious adverse events and complications)
- Effectiveness (success of abortion without need for surgical intervention following the procedure)
- Access (affordability, utilization, client volume, attendance and coverage per population)
- Quality of care (abortion methods of choice, quality of information given to pregnant person, provider competence, pregnant person/provider relationship)
- Adverse effects (undesirable impacts on existing public or private services, inappropriate use of services)
- Equitable access or utilization (distribution of access across sociodemographic characteristics)
- Cost/service (from a societal perspective or perspective of marketer/franchiser, franchisee or pregnant person/client)
- Satisfaction/acceptability.

PICO 17: Self-sourcing medications for induced abortion (see Best Practice Statement 49)

PICO question: For a pregnant person seeking induced abortion, is self-sourcing of medications through online sources a safe, effective and satisfactory/acceptable alternative to obtaining a prescription and/or medications from a trained health worker?

P: Pregnant persons seeking induced abortion

I: Pregnant persons self-sourcing medications for an abortion through an online source without a prescription

C: Pregnant persons obtain a prescription and/or medications from a health worker (specialist or generalist medical practitioner, traditional and complementary medicine professional, midwife, nurse, auxiliary nurse, auxiliary nurse midwife, pharmacist, pharmacy workers, community health worker)

O:

- Safety (serious adverse events and complications)

- Effectiveness (success of abortion without need for surgical intervention following the procedure)
- Quality of medications
- Satisfaction/acceptability.

Self-management approaches

Self-management approaches for post-abortion contraception

PICO 18: Post-abortion self-administration of injectable contraceptives (see Recommendation 50)

PICO question: For a person in the post-abortion period needing contraception, is self-administration of injectable contraceptives (initiation or continuation) a safe, effective and satisfactory/acceptable alternative to provision by a trained health worker?

P: Women in the post-abortion period needing contraception

I: Self-administration of injectable contraceptives (initiation or continuation)

C: Delivery of injectable contraceptives by trained health workers

O:

- Contraceptive uptake and continuation
- Safety (serious adverse events and complications related to provision of the method)
- Effectiveness (method failure)
- Satisfaction/acceptability.

Annex 11. Details about guideline dissemination and updating

Dissemination

The full guideline will be published digitally (both an interactive web-based version and a PDF document available online for download) and in print. The recommendations from this guideline will also feature in the annually updated compendium of recommendations approved by the WHO Guidelines Review Committee (GRC), which will be produced by the WHO Department of Sexual and Reproductive Health and Research (SRH) across all thematic areas. The digital versions of the guideline will be available via the WHO website.[1] The links to the digital versions will be disseminated through nongovernmental organization (NGO) partners, the websites of professional associations, and social media platforms. Supplementary materials including the corresponding GRADE Evidence-to-Decision (EtD) frameworks for each of the recommendations are also available online.[2] Print versions of the guideline will be distributed to WHO regional and country offices, NGO partners and professional associations.

Translation of the guideline into Spanish (in collaboration with the Pan American Health Organization [PAHO]), French and Portuguese is planned. Translations into other United Nations languages will be developed as needed. Third-party translations into additional languages will be encouraged, provided they comply with WHO guidance on such translations.

The guideline will be launched through dissemination meetings in each WHO region, and specific knowledge transfer and adaptation activities and implementation research will take place in select countries based on need and expressed interest to move ahead with implementation of the recommendations. Additional products will support the launch of the guideline to allow for regional colleagues to disseminate the key information widely. Such products include:

- a PowerPoint presentation that summarizes the key messages and new elements to the guideline;
- a PowerPoint presentation on the evidence behind selected recommendations;
- social media tiles.

WHO regional offices and a number of interested agencies and NGO partners are expected to be active partners in the regional, national and local dissemination and adaptation of this guideline and in developing derivative informational materials.

Updating

This guideline will be presented online in an interactive web-based format soon after publication of the standard format version, which will be available for download. The web-based format will allow the guideline to be a "living guideline", facilitating review of new research evidence to ensure that it can be brought to the GDG for review and then updated as appropriate in the guideline on an ongoing basis. This consolidated guideline currently combines and updates recommendations from three former WHO guidelines on abortion care,[3] and future updates will also cover new related topics, as needed.

The rapidly evolving nature of the interventions and approaches for quality abortion care, especially those for self-management of abortion, calls for a continuous review of the literature. The WHO Guideline Steering Group (see Annex 1) is in the process of developing a database system that will allow for continuous search and review of the evidence. This in turn will help with future updates of the recommendations and will inform any areas that may potentially require a new recommendation. There are many areas for which no evidence was found or which are only supported by low-certainty evidence (see Chapter 4, section 4.3), and in these cases new recommendations or a change in the published recommendation, respectively, may be warranted. Any concern about the validity of an existing recommendation can be communicated promptly to the Prevention of Unsafe Abortion (PUA) Unit at WHO's Department of Sexual and Reproductive Health and Research (email: srhpua@who.int), after which the PUA

1 Available at: https://www.who.int/publications/i/item/9789240039483
2 Available at: https://www.who.int/publications/i/item/9789240039483
3 Safe abortion: technical and policy guidance for health systems, second edition. Geneva: World Health Organization; 2012 (https://iris.who.int/handle/10665/70914).
Health worker roles in providing safe abortion care and post-abortion contraception. Geneva: World Health Organization; 2015 (https://iris.who.int/handle/10665/181041).
Medical management of abortion. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/278968).

Unit will seek approval from the WHO GRC to undergo the process for a "rapid guidance", and plans will be made to update the recommendation as needed.

All technical products developed during the process of developing this guideline – including full reports of systematic reviews, corresponding search strategies and dates of searches – will be archived for future reference and use. Where there are concerns about the validity of a recommendation based on new evidence, the systematic review addressing the primary question will be updated. To update the review, the search strategy used for the initial review will be re-applied. Any new questions identified following the original scoping exercise for the guideline will undergo a similar process of evidence retrieval, synthesis and application of the GRADE approach in accordance with the standards in the *WHO handbook for guideline development*.[4] For further information on the "living guidelines" process, refer to recent publications by Vergara-Merino et al. (2020)[5] and Vogel et al. (2019).[6]

4 WHO handbook for guideline development, second edition. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/handle/10665/145714).

5 Vergara-Merino L, Verdejo C, Carrasco C, Vargas-Peirano M. Living systematic review: new inputs and challenges. Medwave. 2020;20(11):e8092.

6 Vogel J, Dowswell T, Lewin S, Bonet M, Hampson L, Kellie F, et al. Developing and applying a "living guidelines" approach to WHO recommendations on maternal and perinatal health. BMJ Glob Health. 2019;4(4):e001683.

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