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WHO's New Abortion Guideline: Highlights of Its Law and Policy Recommendations

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I. BACKGROUND¹

Guidelines are the fundamental means through which the World Health Organization (WHO) fulfills its technical leadership in health. In this regard, WHO has been providing recommendations related to abortion for close to 20 years. Drawing on the latest evidence and data on the clinical, service delivery, legal, and human rights aspects of abortion care, WHO released its [Abortion Care Guideline](#) (the guideline) in March 2022, updating and replacing the recommendations in all previous WHO guidelines on abortion care. The recommendations included in the guideline are based on public health evidence and human rights.²

This fact sheet highlights select core themes that are weaved throughout the new guideline, as well as the guideline's seven recommendations concerning law and policy, including their public health evidence and human rights base.

The WHO guideline recognizes that globally, abortion is a common procedure, with six out of ten unintended pregnancies and three out of ten of all pregnancies ending in induced abortion. It notes that abortion is a safe health care intervention, completed using medication or with a simple outpatient surgical procedure. Abortion, whether using medication or a surgical procedure, is safe “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.” However, estimates suggest that just over half (55%) of all abortions worldwide can be considered safe. Barriers such as a lack of providers and facilities that can safely provide services, limited available methods of abortion, costs, stigma, and legal restrictions make it difficult or impossible for many women to access abortion care, which may lead them to use unsafe methods. The guideline reinforces that “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.”

The guideline provides 54 concrete evidence-based recommendations on good practice for national and subnational policy-makers, program managers, health workers, civil society organizations, professional societies, and other stakeholders in the field of sexual and reproductive health and rights to support them in ensuring that evidence-based abortion care—from pre-abortion to abortion to post-abortion care—is available. The recommendations cover the range of domains that are relevant to providing abortion care: law and policy, clinical services, and service delivery. This new guideline has a much stronger human rights focus than previous WHO guidance, integrating human rights throughout and looking at the underlying determinants of health as part of a comprehensive approach to abortion. This shift reflects an important recognition by WHO that abortion is both a health and a human rights issue. Critically, WHO also notes that the increased sexual and reproductive health risks in humanitarian settings, including during armed conflict, is of concern and requires specific attention.

The guideline sets forth three cornerstones of an enabling environment for abortion care: “(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 example, it recognizes that “as a standard approach to human

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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.”

Reproductive Rights are Human Rights³

As recognized in WHO's guideline and firmly established in international human rights law, reproductive health implicates a multitude of human rights protections, including:

- The right to the highest attainable standard of health, including sexual and reproductive health
- The right to life
- The right to non-discrimination
- The right to equality
- The right to privacy
- The right to be free from torture and cruel, inhuman, or degrading treatment or punishment
- The right to be free from violence
- 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
- The right to information
- The right to education
- The right to benefit from scientific progress

The provision of quality abortion care is the foundational element of the guideline.

II. CORE THEMES

The provision of quality abortion care is the foundational element of the guideline. Quality encompasses several aspects: effectiveness, efficiency, accessibility, acceptability (e.g., patient centered), equity, and safety. Underlying all of the recommendations in the guideline are the core values of dignity, autonomy, equality, confidentiality, communication, social support, supportive care, and trust, which are recognized as foundational to quality abortion care. These values reflect a human rights-based approach to abortion care, as illustrated in the following select themes weaved throughout the guideline:

Equality and Non-discrimination⁴

The human rights obligations of non-discrimination and equality are a bedrock of every recommendation contained in the guideline, including the ones concerning law and policy. The guideline references international human rights law that recognizes that denying services that only women need is a form of discrimination against women and that states have obligations to address laws, institutional arrangements, and social practices that are discriminatory and that

prevent people from effective enjoyment of their right to sexual and reproductive health. The guideline notes that the regulation of abortion should have the objective of

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. Abortion services must consider the needs of all individuals and should not lead to discrimination.

It further recognizes that

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.

Inclusive, Person-Centered Approach⁵

The guideline's conceptual framework is centered on the values and preferences of women, girls, and other pregnant persons, considering them as active participants in—and beneficiaries of—health services. It recognizes that abortion provision is often stigmatized due to a variety of factors (including provider attitudes and the criminalization of abortion) and that, in line with human rights obligations, stigma should be addressed.

In terms of inclusion of the range of persons who can get pregnant, the guideline notes that “cis-gender women, transgender men, nonbinary, gender-fluid and intersex individuals with a female reproductive system and capable of becoming pregnant may require abortion care.” However, with respect to terminology, the guideline uses the term “women” most often, in an effort “to be concise and facilitate readability.” It notes that abortion care must consider the needs of all individuals and that gender identity or its expression should not lead to discrimination.

Medical Abortion, Self-Managed Abortion, Post-Abortion Contraception, and Telemedicine⁶

Medical abortion has long been recognized by WHO as a highly safe and effective method of terminating a pregnancy. The new guideline recognizes how medical abortion has revolutionized access to quality abortion care globally. It expands access possibilities by recommending that medical abortion be “provided at the primary-care level and on an outpatient basis, or from a pharmacy.” Abortion medication is on WHO's essential medicines list, and human rights bodies have long recognized states' obligation to ensure the availability and accessibility of such medication.

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.

The new guideline recognizes how medical abortion has revolutionized access to quality abortion care globally and recommends expanded access.

Recognizing the central role of autonomy in abortion care and having the evidence to back it up, the guideline recognizes how medicines for abortion can be safely and effectively self-administered outside a facility (e.g., at home). It notes that persons may self-manage parts or all of the abortion process for a variety of reasons related to individual circumstances and preferences. Self-management, however, “should not be considered a ‘last resort’ option or a substitute for a non-functioning health system.” Instead, it must be recognized as a “potentially empowering and active extension of the health system and task-sharing approaches.”

For medical abortion at < 12 weeks, WHO recommends the option of self-managing any or all of the three component parts of the medical abortion process: “self-assessment of eligibility (determining pregnancy duration; ruling out contraindications); self-administration of medications outside of a health-care facility and without the direct supervision of a trained health worker, and management of the abortion process; and self-assessment of the success of the abortion.”

All individuals who self-manage medical abortion must also be able to access accurate information, quality medications (including for pain management), the support of health workers, and a health facility and referral services if needed or desired. Mechanisms to ensure access and linkages to post-abortion contraception services for women desiring them need to be established. From a law and policy perspective, WHO remarks that self-managed abortion should be available as an option and that restrictions on prescribing and dispensing abortion medicines “may need to be modified or other mechanisms put in place for self-management within the regulatory framework of the health system.” Further, it notes that self-management should not be criminalized and should not be restricted for non-clinical reasons, such as age. It also recommends self-management approaches for post-abortion contraception, including by recommending over-the-counter oral contraceptive pills and emergency contraception.

The guideline contains a recommendation relating to telemedicine that is aimed at facilitating early medical abortion and self-care approaches. Specifically, it recommends “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.” It notes that this 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.” It mentions that other communication methods, such as “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.”

Information and Counseling⁷

The guideline recognizes that access to relevant, accurate, and evidenced-based health information and counseling if and when desired is an essential first step in improving access to and the quality of abortion care and is also a human rights obligation. It notes that two types of information must be made available: (1) “information of a general nature for the public” and (2) “specific information tailored to be relevant to each person seeking abortion . . . and underpinning free

and informed consent.” It sets forth some key human rights considerations in this regard, including that the provision of information on abortion should not be criminalized, even where the procedure itself may be illegal; information should be evidence based and easy to understand for all persons undergoing an abortion; non-directive voluntary counseling should be provided to persons who request it; information should be available without third-party authorization and must respect privacy and confidentiality; and the dissemination of misinformation, the withholding of information, and censorship should be prohibited. Further, information and counseling on abortion should not fuel stigma or discrimination.

The guideline notes that “the provision of information and counselling (where desired) . . . starts pre-abortion but should continue across the continuum of care.”

Abortion as an Essential Health Service⁸

WHO has included comprehensive abortion care in the list of essential health services in recent technical publications and guidance issued in the wake of the COVID-19 pandemic, when sexual and reproductive health services were disrupted, disempowering individuals and exposing them to preventable health risks. The new guideline highlights that Sustainable Development Goal target 3.8 on achieving universal health coverage includes access to quality essential health services and affordable essential medicines. It recognizes that improving access to abortion care is part of establishing an enabling environment for universal health coverage, which seeks “to accelerate efforts to ensure that all people and communities receive the full spectrum of essential, quality health services” without financial hardship. In addition, with regard to abortion regulation, WHO recognizes that “unlike other essential health services, abortion is commonly regulated to varying degrees through the criminal law in addition to regulation under health-care law.” The recommendations in the guideline call for the abolishment of criminal regulation of abortion.

Accountability⁹

WHO recognizes that accountability is central to ensuring that sexual and reproductive health and rights are protected, respected, and fulfilled. The guideline notes that accountability in ensuring access to safe abortion comes in different forms, including by ensuring that abortion laws and policies are human rights compliant. It explains that this should be done by recording and monitoring health outcomes related to abortion laws and policies and reporting them to national human rights institutions, as well as by ensuring that all persons have access to justice, including an accessible mechanism “to challenge denial of abortion in a timely manner” and a meaningful and effective remedy in cases where the person’s rights have been violated. Remedies include restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition, including through law and policy reform. The guideline highlights that an enabling environment should feature the regular review and reform of laws and policies on abortion, including the decriminalization of services and “forms of behavior that can be performed only by women, such as abortion.”

Information and counseling on abortion should be evidence based, non-directive, and confidential, and it should never be criminalized.

The guideline recognizes abortion as an essential health service.

Recommend the full decriminalization of abortion.

III. LAW AND POLICY RECOMMENDATIONS

The guideline provides 54 recommendations across the three areas that are essential to the provision of abortion care: clinical services, health systems, and law and policy. WHO's 2012 safe abortion guidance provided a composite recommendation related to law and policy; this guideline has developed that into seven separate recommendations, all of which include a more robust evidence and human rights basis than ever before. This section offers a summary of the guideline's seven recommendations related to law and policy. It describes each of these recommendations, including the evidence and human rights rationales behind each one. It is important to note that because the seven law and policy recommendations are integrated throughout the guideline's total universe of 54 recommendations, they are not numbered consecutively.

LAW AND POLICY RECOMMENDATION 1: CRIMINALIZATION

Recommend the full decriminalization of abortion.¹⁰

This guideline provides the first-ever definition of “decriminalization” in the context of abortion by a United Nations agency or human rights mechanism: “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.” It notes that “decriminalization would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care” and that “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.”

Evidence rationale: Studies demonstrate that the criminalization of abortion poses a range of burdens on women, including delayed access to abortion, restricted access to post-abortion care, unnecessary costs, distress, and stigma. Criminalization can compel service providers to wait until a life-threatening situation develops so that an abortion can be provided under the legal exceptions to a country's criminal prohibitions. Moreover, fear of criminal prosecution can have a chilling effect on health workers, leading them to deny abortion even in cases where it is legal. Evidence further shows that criminalization does not impact the decision to have an abortion or prevent women from having abortions. Rather, it simply “limits access to safe and legal abortion, and increases recourse to unlawful and unsafe abortion.” Evidence also indicates that when prosecutions take place, they are disproportionately pursued against marginalized populations, including individuals who are young, undereducated, unmarried, or poor. In some countries, the criminal regulation of abortion requires health care providers to report women and girls to law enforcement when they seek abortion or post-abortion care. Criminalization also contributes to the lower availability of trained providers.

Human rights considerations: This recommendation is based on the following human rights considerations:

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.

LAW AND POLICY RECOMMENDATION 2: GROUNDS-BASED APPROACHES

Recommend against laws and other regulations that restrict abortion by grounds. Recommend that abortion be available on the request of the woman, girl or other pregnant person.¹¹

The guideline states:

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

Recommend against laws and other regulations that restrict abortion by grounds. Recommend that abortion be available on the request of the woman, girl or other pregnant person.

of health and mental health . . . ; 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.

Evidence rationale: The evidence shows that grounds-based laws contribute to delayed abortion for a number of reasons, including overly restrictive or inconsistent interpretations of grounds; disagreement among medical professionals about the satisfaction of a legal ground; women having to wait for their eligibility to be determined; and women having their claim that the pregnancy resulted from rape questioned or disbelieved. Such laws are also subject to misinterpretation, which can lead to the denial of abortion. In some cases, providers wait for “a health condition to deteriorate sufficiently to ensure that a woman satisfie[s] a ‘risk to life’ ground.” Evidence also shows that grounds-based approaches have a disproportionate negative impact on women seeking abortion after being raped, due to requirements mandating that they report the crime to the police or obtain a court order prior to seeking an abortion—and that even when these are not required by law, some providers require them anyway. These requirements result in significant delays and also “subject the individual to unnecessary trauma [and] may put them at increased risk from the perpetrator.” The guideline notes 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.” It further notes:

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.

Human rights considerations: This recommendation is based on the following human rights considerations:

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.

LAW AND POLICY RECOMMENDATION 3: GESTATIONAL AGE LIMITS

Recommend against laws and other regulations that prohibit abortion based on gestational age limits.¹²

Evidence rationale: The evidence demonstrates that gestational age limits, whether “alone or in combination with other regulatory requirements, including ground-based approaches,” delay access to abortion, “especially among women seeking abortions at later gestational stages, women close to the gestational age limit and those living in areas with limited access to clinics.” Such limits are “associated with increased rates of maternal mortality and poor health outcomes.” Evidence shows that “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” are disproportionately harmed by gestational age limits. It also shows that in cases where women seek an abortion and are 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.

Human rights considerations: This recommendation is based on the following human rights considerations:

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.

LAW AND POLICY RECOMMENDATION 6: MANDATORY WAITING PERIODS

Recommend against mandatory waiting periods for abortion.¹³

Evidence rationale: Evidence does not establish any benefits of mandatory waiting periods. It shows that such waiting periods delay access to abortion, sometimes to the extent that available abortion methods are restricted. Additionally, the logistical challenges of completing a mandatory waiting period can mean that some women must disclose their pregnancy to others, “even though international human rights law requires States to ensure that [sexual and reproductive health] services are provided

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

Recommend against mandatory waiting periods for abortion.

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.

in a way that ensures privacy and confidentiality.” The evidence also indicates that mandatory waiting periods may result in the continuation of pregnancy, “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.” For providers, “mandatory waiting periods increase staffing costs and logistical difficulties, by mandating additional visits or interventions outside of standard clinical practice.”

Human rights considerations: This recommendation is based on the following human rights considerations:

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.

LAW AND 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.¹⁴

The guideline remarks that “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.”

Evidence rationale: Evidence shows that third-party authorization and notification requirements are associated with delays to abortion. The guideline states that “for minors, these delays [are] sometimes, although not always, reduced when judicial authorization [is] used to bypass parental authorization requirements.” But judicial 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 shows that adolescents and women seek “to bypass parental/spousal authorization requirements to avoid anticipated violence, reproductive coercion, and family disharmony.”

Human rights considerations: This recommendation is based on the following human rights considerations:

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.

LAW AND POLICY RECOMMENDATION 21: PROVIDER RESTRICTIONS

Recommend against regulation on who can provide and manage abortion that is inconsistent with WHO guidance.¹⁶

The guideline notes that “abortion can be safely provided by a wide range of health workers in diverse settings, and safely self-managed in earlier pregnancy . . . 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.” It adds that “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 [pp. 31–100].”

Evidence rationale: The evidence demonstrates that provider restrictions result in delays to and burdens in accessing abortion. In particular, they “produce inefficiencies, administrative burdens and workload burdens within health systems, and reduce in practice the number of available providers.” By contrast, expanding the types of providers who can perform abortion-related care improves timely access to first-trimester surgical and medical abortion; reduces costs, travel, and waiting time; shifts components of care away from physicians; makes abortion more available, particularly in rural areas and in primary health care facilities; prevents unsafe self-managed abortions; and reduces health system costs.

Human rights considerations: This recommendation is based on the following human rights considerations:

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.

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

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

LAW AND POLICY RECOMMENDATION 22: CONSCIENTIOUS OBJECTION

Recommend that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.¹⁷

The guideline remarks that

in spite of the human rights obligation to ensure conscientious objection does not hinder access to quality abortion care, and previous WHO recommendations aimed at ensuring conscientious objection does not undermine or hinder access to abortion care, conscientious objection continues to operate as a barrier to access to quality abortion care. It is critical that States ensure compliance with regulations and design/organize health systems to ensure access to and continuity of quality abortion care. *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.* (emphasis added)

Evidence rationale: The evidence establishes 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.

Particular barriers are experienced by women living in rural areas; in areas where abortion law has recently been changed and lacks clarity on who may object to what aspects of abortion care; in areas where conscientious objection is not effectively regulated; and in areas where objecting providers “intentionally refuse referrals or use biased counselling, or inaccurate legal and medical information to try to dissuade and obstruct people from accessing abortion.”

Moreover, conscientious objection has significant workload implications for providers: “Where there are many objectors, non-objecting providers have an increased workload, abortion provision is often stigmatized, and those who do provide abortion care may experience career limitation or discrimination.” Furthermore, “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.” The guideline recognizes that international human rights law requires prohibiting institutional claims of conscience.

Human rights considerations: This recommendation is based on the following human rights considerations:

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.

IV. CONCLUSION

The new WHO guideline demonstrates that public health evidence supports what has been established under international human rights law, what the Center for Reproductive Rights has long demanded, and what people across the globe know: abortion access is a human right and an essential health service that must be respected, protected, and fulfilled. The world's leading public health body has firmly based its recommendations on public health evidence and human rights standards. It is time for policy-makers, public health officials, the medical community, and others to take heed of this guideline by implementing its recommendations to ensure that the right to access abortion is fully realized.

Endnotes

¹ See sections 1.1 (pp. 1–2); 1.2.1 (p. 3); 1.3 (pp. 5–6); 1.3.3 (p. 12); 2.1 (p. 22); 3.1 (p. 31).

² “In accordance with the WHO guideline development process, the formulation and refinement of recommendations . . . 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 . . . 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.”

³ See box 1.2 (pp. 8–9).

⁴ See, e.g., sections 1.1 (p. 2); 1.2.3 (pp. 3–4); 1.3.1 (p. 8); 1.3.3 (pp. 12–13); 2 (p. 21); 2.2 (p. 23); 3.1 (p. 31); 3.3.1 (pp. 41–42).

⁵ Sections 1.2.3 (pp. 3–4); 1.2.4 (p. 4). See also sections 1.3.1 (p. 7); 1.4.3 (p. 16); 2.2.1 (p. 24).

⁶ Sections 3.4 (pp. 62–63); 3.6.1 (p. 95); 3.6.2 (pp. 98–100); 3.6.3 (pp. 100–102).

⁷ Sections 1.3.2 (p. 12); 3.2 (pp. 34, 36, 39).

⁸ Sections 1.4.1 (pp. 13–14); 2.1 (p. 22).

⁹ Section 1.3.1 (pp. 11–12).

¹⁰ Section 2.2.1 (pp. 24–25). The guideline notes that the criminalization of abortion is widespread, “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.”

¹¹ Section 2.2.2 (pp. 26–27). The guideline notes that national laws almost always permit some abortions, explaining that “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.”

¹² Section 2.2.3 (pp. 28–29). The guideline recognizes that gestational limits are common in abortion laws and policies. It explains, “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 . . . While methods of abortion may vary by gestational age . . . , 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.”

¹³ Section 3.3.1 (pp. 41–42). The guideline notes that facilities and providers in a number of states “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 . . . , attend the facility at the start and end of the waiting period, and/or undergo mandated ultrasound during these waiting periods.”

¹⁴ Section 3.3.2 (pp. 42–44). According to the guideline, “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.”

¹⁵ The guideline explains, “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).”

¹⁶ Section 3.3.8 (p. 59). As the guideline explains, “In a number of countries, law and policy restrict which type of health workers may lawfully provide abortion care, most often limiting this to gynaecologists.”

¹⁷ Section 3.3.9 (pp. 60–61). As defined in the guideline’s glossary, conscientious objection or conscientious refusal is “the practice of health-care professionals refusing to provide abortion care on the basis of personal conscience or religious belief.” And as stated in law and policy recommendation 22, “In some countries conscientious objection is expressly regulated through employment law, employment contracts or the law on abortion.”

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