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Abortion care guideline executive summary

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Abortion care guideline: executive summary

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Executive summary

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

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

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

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

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

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

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

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

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

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

Objectives, scope and conceptual structure of the guideline

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

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

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

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

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

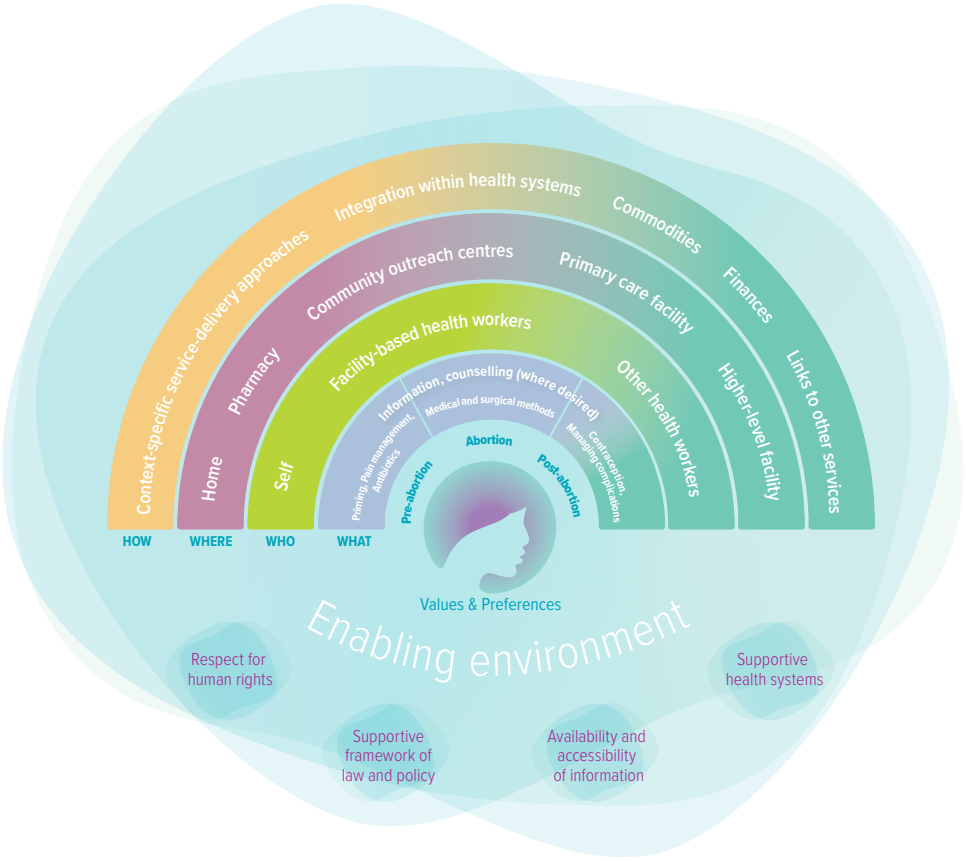
In this guideline, recommendations are presented across three domains that are essential to the provision of abortion care: Law and policy, Clinical services and Service delivery. The recommendations concerning the laws and policies that should or should not be in place in order to fully implement and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

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

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

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

Figure 1: Conceptual framework for abortion care



Target audience and inclusivity

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

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

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

Guideline development methods

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

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

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

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

Summary table of recommendations presented in this guideline

Important notes:

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

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

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

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

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

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**
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.
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).
Gestational age limits	
3 (LP)	**Recommend against** laws and other regulations that prohibit abortion based on gestational age limits.
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.
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.

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**
PRE-ABORTION	
Mandatory waiting periods	
6 (LP)	**Recommend against** mandatory waiting periods for abortion.
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.
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.
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.
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.

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**
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.
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.
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.

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**
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.
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.
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.
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.
Conscientious objection	
22 (LP)	**Recommend** that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection. **Remarks:** • 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. • The evidence reviewed considered the impact of conscientious objection on access to and availability of abortion care and not the effectiveness of regulating conscientious objection in terms of improvements in those outcomes. However, 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).

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**
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.
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.
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).
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.
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).

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**
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).
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.
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.
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.

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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.
33 (SD) 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.
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).
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.

SECTION **Topic area** Recommendation or best practice statement number and type	**Recommendation or best practice statement**
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.
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.
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.
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.
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).
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.

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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.
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.
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.
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.
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.

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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.
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.
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 outside of a health-care facility and without the direct supervision of a trained health worker, and management of the abortion process • 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.

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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.
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.
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.
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.

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