2022 WHO
ABORTION CARE GUIDELINE

ADVOCACY LENS

Ipas
Partners for Reproductive Justice

ISBN: 978-1-7378088-7-9

Produced in the United States of America.

Suggested citation: Ipas. (2022). *Advocacy lens: 2022 WHO Abortion Care Guideline*. Ipas: Chapel Hill, NC.

Ipas works to advance reproductive justice by expanding access to abortion and contraception, using a comprehensive approach that addresses health, legal and social systems. We believe every person should have the right to bodily autonomy and be able to determine their own future. Across Africa, Asia and the Americas, we work with partners to ensure that reproductive health services, including abortion and contraception, are available and accessible to all.

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About this resource

This resource is intended to support advocates who are working to achieve universal access to comprehensive, person-centered abortion care and an enabling environment for people to exercise their sexual and reproductive health and rights.

Ipas's advocacy centers strategies for decriminalization of abortion, elimination of policy and health system barriers, reduction of abortion stigma, and expansion of abortion access for any person who needs it. Guiding our work is a holistic, systems-based approach that addresses the ecosystem around abortion decisions and is grounded in human rights standards.

The 2022 WHO Abortion Care Guideline ("the guideline") presents a historic opportunity to ground advocacy strategies even more firmly in global standards for public health and human rights. The guideline offer innovations across clinical, health systems, policy, and community aspects of abortion.

This resource focuses on our **top eight advocacy highlights** from the guideline, as well as **six key myth-busting messages** that can help you counter opposition misinformation in your setting.

We hope you will contribute your ideas and inputs to make this a more comprehensive and responsive tool for your advocacy work. We hope that the credibility and global authority of the World Health Organization, through these guidelines, opens new advocacy windows that expand abortion access and rights in your setting.

JUMP TO:
TOP EIGHT ADVOCACY HIGHLIGHTS

JUMP TO:
SIX KEY MYTH-BUSTING MESSAGES

Background

An enabling environment is the foundation of safe and comprehensive abortion care. The cornerstones of an enabling environment for abortion care are respect for human rights within a supportive policy framework, the availability and accessibility of information, and a well-functioning health system.

As part of its core work, the WHO generates, translates, and disseminates knowledge on major health issues, including through guideline development. In recent years, substantial work has been done by WHO to fully integrate human rights into their work.[1] The 2022 guidelines incorporate previous editions and adopt an innovative methodological approach to recommendations and best-practice statements related to abortion to enable evidence-based decisionmaking with respect to quality abortion care. The Guideline integrates human rights and health evidence throughout the standards and guidelines.[2] As a result, **human rights standards and health data are given equal weight under these guidelines**. This guideline updates and replaces the recommendations in all previous WHO Guidelines on abortion care.[3]

Key human rights considerations relevant to the provision of information

Accurate information on abortion must be available to individuals on a confidential basis.

Informed consent requires the provision of complete and accurate information.

The right to refuse such information when offered must be respected.

The right to privacy must be respected in the provision of information.

Abortion information should be available to adolescents without the consent of their parents or guardian.

Information should be accurate, accessible, of high quality and presented in a manner acceptable to the person receiving it.

Key human rights considerations relevant to counselling

Counselling must be entered into freely and voluntarily; it should not be mandatory.

Where provided, counselling must be available to individuals on a confidential basis.

To ensure respect for the right to health, counselling must be acceptable and good quality—it must be unbiased and based on accurate information.

The right to refuse counselling when offered must be respected.

Counselling should be available to adolescents without the consent of their parents or guardian.

1 Ipas submitted comments in 2017 to to inform the 2019–2023 programme of work.

2 de Londras F, Cleeve A, Rodriguez MI, *et al*. Integrating rights and evidence: a technical advance in abortion guideline development. *BMJ Global Health* 2021;6: e004141. doi:10.1136/ bmjgh-2020-004141

3 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)
Medical management of abortion (2018)

Top 8 Advocacy Highlights from the 2022 Abortion Care Guidelines

1. **WHO recommends the full decriminalization of abortion.**
2. **WHO recommends against regulations that restrict abortion by grounds: abortion should be made available on the request of the pregnant woman/girl/person.**
3. **WHO recommends against regulation that prohibits abortion through gestational limits.**
4. **WHO recommends that access to and continuity of abortion care be protected against barriers created by conscientious objection.**
5. **WHO recommends against regulation that is inconsistent with WHO guidance on who can provide and manage abortion.**
6. **WHO recommends against mandatory waiting periods for abortion.**
7. **WHO recommends that abortion be available on the request of the pregnant woman, girl or other person without the authorization of any other person, body or institution.**
8. **WHO Guideline reinforces that access to information and counselling is a key component for an enabling environment for abortion care together with respect for human rights.**[4]

4 Additionally, the enabling environment requires a supportive framework of law and policy and a supportive universally accessible, affordable and well-functioning health system. Ipas's Sustainable abortion ecosystem

1 WHO recommends the full decriminalization of abortion

Advocacy messages

- Decriminalizing abortion means there should be no criminal law or penalty associated with abortion care.
- Human rights bodies have long said that governments may not criminalize medical procedures only needed by women or apply criminal sanctions against women who have an abortion or medical service providers who assist women in having an abortion. Human rights bodies have explicitly described criminalization of abortion as a form of gender-based violence.[5]
- Human rights standards are evolving from an exclusive focus on saving women from unsafe abortion to recognizing the broader social effects of criminalization on health and well-being, recognizing criminal laws as a social determinant of health.[6]
- Human rights law requires states to provide post-abortion care in all circumstances and without the risk of criminal sanction.
- Criminalization has been shown to cause unnecessary delays in access to care and impose many additional burdens on women,

> ***The UN Working Group on Discrimination Against Women and Girls states that abortion criminalization is "one of the most damaging ways of instrumentalizing and politicizing women's bodies and lives."***
>
> — The UN Working Group on Discrimination against Women. Report of the working group on the issue of discrimination against women in law and in practice. A/HRC/32/44. Geneva: United Nations.

5 CEDAW General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19 (2017), par. 18.

6 The UN Human Rights Committee. General comment no. 36. CCPR/C/GC/36. 2018, para. 8

including travel, added costs, or lack of access to post-abortion care. Criminalization can also mean more people turn to unsafe abortion, and there may be discriminatory enforcement of criminal punishments against young, unmarried, or poor women.[7] Criminalization can cause providers to refuse care, discriminate or even report women to law enforcement due to misunderstanding of legal grounds or fear of prosecution.[8]

- Criminalization has NOT been shown to change abortion decisions, prevent women from having abortions, or prevent women from seeking information or referrals for abortion. Criminalization increases risks to women and girls' health and lives.

What could the world look like if abortion is decriminalized??

- Laws and policies support and protect abortion care, including self-managed abortion.
- Abortion is integrated into routine, essential health care programs, ensuring that it is available, accessible, acceptable, and of good quality.[9]

How can the 2022 WHO Guideline be used to spark action?

- Convene meetings with parliamentarians and key stakeholders to review laws and penalties associated with abortion and identify opportunities for reform or repeal. Exploring the impact of criminal laws to women's health, rights and well-being provides helpful data for this advocacy.
- Develop a decriminalization of abortion campaign with community leaders, health authorities and health providers to improve access

7 Kane G, Galli B, Skuster P. *When abortion is a crime: the threat to vulnerable women in Latin America*. third ed. Chapel Hill, NC: Ipas; 2013.

8 https://www.ipas.org/resource/betraying-women-provider-duty-to-report/

9 CESCR Committee, Gen. Comment No. 22, paras. 11- 21 U.N. Doc. E/C.12/GC/22 (2016).
States may not regulate abortion in a manner contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and must reform their abortion laws; accordingly, that any restrictions must be non-discriminatory, and that states must provide safe, legal and effective access to abortion.

to care and promote health system improvements that remove abortion-related barriers; increase access to post-abortion care for anyone who needs it; improve the availability, accessibility, acceptability, and quality of abortion care across pathways—including self-managed abortion.

2 WHO recommends against regulations that restrict abortion by grounds: abortion should be made available on the request of the pregnant woman/girl/person

Advocacy messages

- Even if abortion is criminalized, the law almost always permits abortion under certain "grounds" such as in cases of rape, incest, fetal impairment, economic hardship, to preserve health, etc. In some countries, abortion is available on request up to a certain gestational age and based on grounds thereafter.[10]
- Grounds-based approaches can have a disproportionate impact on women who seek abortion following rape. These women experience questioning, protracted delay, and bureaucratic processes. Even where the law provides that a woman's claim of rape is sufficient to satisfy requirements for legal ground, providers sometimes still require a document or authorization (like a court order or police report).
- Grounds-based approaches can be narrowly interpreted to require fetal impairments to be fatal or with imminent risk of death for abortion to be lawful, violating women's human rights and leaving them with no choice but to continue with an unwanted pregnancy. Being required to continue with a pregnancy that causes significant distress, including in cases of fetal impairment, violates human rights, including the right to be free from torture and cruel, inhuman and degrading treatment.

10 WHO, page 26. Until ground-based approaches 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.

What does it mean to remove grounds for abortion and make it available on request?

- Grounds-based language is revised to make abortion available without question as to reason ("available on request").
- Unnecessary and discriminatory police reporting requirements will be removed from laws and regulations; arrests and the threat of criminal punishment will end.
- Societies will be closer to achieving gender equality and reproductive justice by trusting women and supporting their decisionmaking.
- Until grounds-based laws are replaced with abortion on request, grounds for abortion must be formulated and applied in a manner consistent with international human rights law—and not have discriminatory impact, cause unnecessary delays or burdens on access to abortion—preventing women and girls from resorting to unsafe abortion.

How can the WHO Guideline be used to make abortion available on request?

- The guideline states that an enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care.
- The UN Human Rights Committee has made it clear that "States parties may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to resort to unsafe abortions, and they should revise their abortion laws accordingly."[11]
- Use this WHO recommendation with global and local public health and human rights evidence that demonstrates for local leaders how abortion is being denied and is not accessible under the

11 HRC General Comment No 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life (2018) (UN Doc. CCPR/C/GC/36), para. 8.

current grounds, as well as how grounds may be discriminatorily applied against vulnerable groups of women and girls; include data on maternal mortality and unsafe abortion rates; and offer policy solutions that can address this.

- Reach out to gender rights activists and partners to discuss strategies that improve social support (and political accountability) for women's rights and equality.

3 WHO recommends against regulation that prohibits abortion through gestational limits

Advocacy messages

- Gestational limits delay access to abortion, especially among women seeking second trimester abortions, those living in areas where clinics are limited and remote, and women close to the gestational limit.
- Gestational limits are associated with increased rates of preventable maternal mortality and poor health outcomes. Studies have also shown that women with cognitive impairments, adolescents, younger women, women living further from clinics, women who need to travel for abortion, women with less formal education, black, indigenous, refugees, migrants, unmarried, poor women, and unemployed women are disproportionately impacted by gestational limits.
- Under human rights law, governments must reform laws to prevent unsafe abortion and reduce preventable maternal mortality and morbidity, and they must ensure equality and non-discrimination in the provision of sexual and reproductive health services.
- Studies show that where women are denied abortion due to gestational age, this can result in the continuation of pregnancy, especially among women with cognitive impairments or those who present at 20 weeks or later.[12] This indicates incompatibility with international human rights law, which requires states to make abortion available when carrying a pregnancy to term would cause the woman substantial pain or suffering, including but not limited to situations where the pregnancy is not viable.

12 WHO, page 28

What does it mean to remove gestational limits?

- When gestational limits are removed from the law, health authorities and clinical standards and guidelines (not criminal laws) can ensure that abortion care remains safe and of good quality, and that sufficient pathways to care exist to meet the needs of the population, including self-managed abortion.
- Removing gestational limits will reduce preventable death and morbidity where narrow gestational limits increase the risk of women seeking unsafe abortion later in pregnancy, creating more risks to their health and lives.
- Until gestational limits are removed from the law, waiting periods and other unnecessary delays to abortion care must be eliminated because they may cause a person to exceed the gestational limit.

How can the WHO Guideline be used to remove gestational limits?

- Present public health data showing that globally, while second trimester abortions represent the minority of abortion procedures, they cause the majority of abortion-related morbidity and mortality, especially in unsafe settings.
- Use this WHO recommendation with local evidence on second trimester abortion rates to advocate for the removal of gestational limits. Where possible, highlight the ways that women—young women and girls in particular—may be disproportionately experiencing delays and mental suffering in accessing abortion care, and you can connect this to data on maternal mortality and unsafe abortion rates to strengthen your advocacy for reform.

4 WHO recommends that access to and continuity of abortion care be protected against barriers created by conscientious objection

Advocacy messages

- Refusal of abortion care on the basis of conscience operates as a barrier to access to safe and timely abortion[13] and unregulated conscientious objection often results in human rights violations or leads women to seek unsafe abortion.[14]
- When conscientious objection is used to deny abortion services, it undermines women's ability to control their reproductive autonomy and infringes upon their ability to have control over their bodies.

What does it mean to protect against barriers created by conscientious objection?

- While states have an obligation under human rights law to protect medical providers' rights to freedom of thought, conscience and religion, they still have obligations to protect the right to life and health of women. Therefore, to protect the right to health—conscientious objection must be regulated.
- Under human rights law, if conscientious objection is allowed, the health system and abortion provision must be organized in a way that ensures that conscientious objection does not result in the refusal of legally available abortion care, and the health system must 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.[15]

13 CEDAW Committee, Concluding Observations: Croatia (1998) (UN Doc. A/53/38), para. 109; CEDAW Committee, Concluding Observations: Italy (1997) (U.N. Doc. A/52/38 Rev.1) para 353; CEDAW Committee, Concluding Observations: Slovakia (2008) (U.N. Doc. A/63/38), paras. 42-43.

14 CAT Committee, Concluding Observations: Poland (2013) (UN Doc CAT/C/POL/CO/5-6), para 23.; European Court of Human Rights, P and S v Poland, Application No. 57375/08, Decision, 30 October 30, 2012, para. 106.; European Committee of Social Rights, No. 87/2012 *International Planned Parenthood Federation European Network (IPPF EN) v Italy*, Decision on the Merits, 10 September 2013.

15 Human Rights Committee, Concluding Observations: Poland (2010) (UN Doc. CCPR/C/POL/CO/6), para. 12.; CESCR, Concluding Observations: Poland (2009) (UN Doc. E/C.12/POL/CO/5) para. 28.

How can the WHO Guideline support the regulation of conscientious objection?

- Use this WHO recommendation with local data on abortion refusals to advocate with policymakers for the regulation of conscientious objection in line with human rights standards.
- Document and report to health authorities where and how conscientious objection is superseding and violating women and girls' right to health, autonomy, and dignity through refusals to provide legal abortion care.

5 WHO recommends against regulation that is inconsistent with WHO guidance on who can provide and manage abortion

Advocacy messages

- Abortion can be safely provided by a wide range of health workers in a wide range of 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 and, as such, are not based on sound evidence.
- Even in the most liberal legal environments, women choose self-managed abortion in their homes because of the dearth of health professionals willing and able to provide abortion and the overall global shortages of health care workers, or choose to seek abortion outside the health sector because of concerns about privacy or stigma.
- Researchers have attributed abortion with pills outside formal health care settings to a worldwide decrease in abortion mortality.[16] Despite this, most laws still require that a specified healthcare professional be involved in the abortion provision.

16 Ganatra, B, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, Lancet, 2017, 390(101110):2372-2381.

- These findings are so groundbreaking that the abortion research field and WHO have reconceived the notion of abortion safety.[17] Researchers have attributed abortion with pills outside formal health care settings to a worldwide decrease in abortion mortality.[18]

What does it mean to follow the WHO's guidance on who can provide and manage abortion?

- Societies must trust women and support their decisionmaking, including for self-managed abortion.
- Provider restrictions result in delays to and burdens in accessing abortion. By contrast, expanding providers improves timely access to first trimester surgical and medical abortion; reduces costs, travel and waiting time; can shift components of care away from physicians and make abortion more available including in rural areas and at the primary health care level; prevent unsafe self-managed abortion; and reduce system costs.
- International human rights law requires abortion law to be evidence-based and proportionate, and obliges states to ensure an adequate number of medical and professional personnel, skilled providers and essential medicines.

17 Ganatra, B, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model, Lancet, 2017, 390(101110):2372-2381.

18 *Ibid*.

How can the WHO Guideline support self-managed abortion?

- Abortion with pills is a game changer—it is safe, and it saves lives. Use this WHO recommendation to advocate that all abortion medications be included on the essential medicines list if they are not already, in line with the WHO model list and human rights obligations under the right to health.
- Share with local leaders the growing evidence that women can safely use misoprostol with mifepristone or misoprostol alone to end a pregnancy without involvement of a health professional.[19]
- Use this WHO recommendation to convene community partners to discuss strategies to understand and improve local access to abortion medications and information about self-management.

6 WHO recommends against mandatory waiting periods for abortion

Advocacy messages

- Evidence reviewed for this guidance shows that mandatory waiting periods delay access to abortion. This undermines the right to health.
- The evidence also indicates that mandatory waiting periods may result in the continuation of pregnancy, especially among women with fewer resources, adolescents, younger women, or women from racial or ethnic minorities. The disproportionate impact of mandatory waiting periods on certain groups of women engages the obligation to ensure equality and non-discrimination in sexual and reproductive health care.
- There is evidence that waiting periods make abortion access more costly, even though international human rights law requires essential health services to be accessible to all.

19 Jelinska, K, and Yanow, S. Putting abortion pills into women's hands: realizing the full potential of medical abortion. Contraception, 2018, 97(2):86-89.

What does it mean to remove mandatory waiting periods for abortion?

- States will comply with international human rights standards and ensure non-interference, and respect for autonomous decisionmaking by women, including women with disabilities, regarding their sexual and reproductive health and well-being.[20]
- States will ensure privacy and confidentiality to women about their pregnancy status and respect their decision through provision of good quality of sexual reproductive health services.

How can the WHO Guideline be used to remove mandatory waiting periods for abortion?

- Use the WHO guidance to demonstrate public health and rights-based evidence that mandatory waiting periods impact disproportionately on women who need to travel further for an abortion, women with fewer resources, and women of colour.
- Develop qualitative research to show the disproportionate impact of mandatory waiting periods on certain groups of women to engage governments and use them with partners to advocate for legal and policy reform in compliance with state's human rights obligation to ensure equal and non-discriminatory sexual and reproductive health care.

20 Joint statement by the Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of All Forms of Discrimination against Women, "Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities", 29 August 2018.

7 WHO recommends that abortion be available on the request of the pregnant woman, girl or other person without the authorization of any other person, body or institution

Advocacy messages

- International human rights law requires that abortions be underpinned by the free and informed consent of the person having the abortion, and that no further authorizations are required.
- Third party authorization requirements are incompatible with international human rights law, which provides that states may not restrict women's access to health services on the ground that they do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried, or because they are women.
- Evidence reviewed for this guidance shows that third-party authorization requirements are associated with delays to abortion.
- Where spousal authorization is required to access abortion, women experience reproductive coercion, and some will resort to unlawful abortion.

What does it mean to remove third party authorizations for abortion?

- Minors who can consent without the need to have the authorization or consent of parents before the abortion.
- Women will be considered autonomous to make their own decision about their bodies and their lives.
- Health systems will treat women equally without discrimination and respect their autonomy and privacy.

How can the WHO Guideline be used to remove third party authorizations for abortion?

- Advocate for state protection of women's right to SRH to ensure that health-care facilities, goods and services are available, accessible, acceptable and of good quality.[21]
- Advocate for the elimination of discriminatory provisions on reproductive health services that only women need,[22] and the provision of essential primary health care.[23]
- Advocate for women and girls' access to information on legal terminations, reforming policies and laws that establish parental authorization for adolescents who may resort to clandestine abortion providers if they fear they will be required to obtain permission from their parents or guardians.

8 Access to information and counselling based on human rights standards

Advocacy messages

- States should provide access to and quality of abortion care by ensuring that all individuals can access relevant, accurate, non-biased and evidence-based information on sexual reproductive health and counselling if and when desired, grounded in the right to information and the right to privacy.
- States must ensure the provision of comprehensive, non-discriminatory, scientifically accurate and age-appropriate education on sexuality and reproduction, including information on abortion, both in and out of schools, as part of their obligation to reduce maternal mortality and morbidity.

21 CESCR, General Comment No 14: The Right to the Highest Attainable Standard of Health (Article 12) (2000) (UN Doc. E/C.12/2000/4), paras 8, 12.

22 CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health) (1999) UN Doc. A/54/38/Rev.1, chap. I, para 11.

23 CESCR General Comment No 3: The Nature of States Parties' Obligations (Article 2, Para. 1 of the Covenant) (1990) (UN Doc. E/19991/12), para. 10.

- According to international human rights law, the provision of information on abortion should not be criminalized, even in contexts where the procedure itself may be illegal.
- States should provide different modalities for the provision of information on abortion, such as remote access via hotlines and telemedicine, and through approaches such as harm reduction and community-based outreach.

What does it mean to ensure access to information and counselling in line with human rights standards?

Key human rights considerations relevant to the provision of information:

- Accurate information on abortion must be available to individuals on a confidential basis.
- Informed consent requires the provision of complete and accurate information.
- The right to refuse such information when offered must be respected.
- The right to privacy must be respected in the provision of information.
- Abortion information should be available to adolescents without the consent of their parents or guardian.
- Information should be accurate, accessible, of high quality and presented in a manner acceptable to the person receiving it.

Key human rights considerations relevant to counselling:

- Counselling must be entered into freely and voluntarily; it should not be mandatory.
- Where provided, counselling must be available to individuals on a confidential basis.
- To ensure respect for the right to health, counselling must be acceptable and good quality—it must be unbiased and based on accurate information.

- The right to refuse counselling when offered must be respected.
- Counselling should be available to adolescents without the consent of their parents or guardian.

How can the WHO Guideline be used to ensure rights-based access to information and counselling?

- Advocate with the state that policies should be in place and implemented to guarantee all individuals evidence-based information on sexual and reproductive health (SRH), including abortion.
- Advocate with health authorities and providers to improve access to and quality of abortion care to ensure that all individuals can access relevant, evidence-based health information and counselling when desired.
- Advocate for human rights standards to be reflected in health norms and practices for women and girls' access to information and counselling in public health facilities, to ensure individuals' control over their bodies by giving informed consent and making autonomous decisions relating to SRH care.

Individuals who are seeking abortion also require information on abortion care. International human rights law obliges states to ensure that accurate abortion information[24] is available to individuals on a confidential basis,[25] and that their right to refuse such information when offered is respected.[26]

24 CESCR, General Comment No 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights) (2016) (UN Doc. E/C/12/GC/22), para. 9

HRC General Comment No 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life (2018) (UN Doc. CCPR/C/GC/36), para. 8.

25 HRC General Comment No 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life (2018) (UN Doc. CCPR/C/GC/36), para. 8.

Committee on the Rights of the Child, General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003) (UN Doc. CRC/GC/2003/4).

26 UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the General Assembly (2009) (UN Doc. A/64/272), para 15

Addressing misconceptions about the WHO Safe Abortion Guidance

Background

In 2003, the World Health Organization published the first edition of *Safe Abortion: Technical and Policy Guidance for Health Systems* (hereafter referred to as "the WHO safe abortion guidance" or "the WHO guidance"). The WHO guidance was designed to provide a medical and policy framework for a wide range of health professionals and others, including those in and outside of government, to provide access to safe, quality abortion services and reduce maternal mortality and morbidity.

Since this first publication, the WHO guidance has been deliberately mischaracterized, and come under attack, primarily from groups and individuals who are opposed to access to abortion under any circumstances, but also by those who wish to limit women's political and social participation.

When the WHO guidance was first published, critics wrongly claimed the guidance lacked "medical integrity." They said WHO was deviating from its core mandate and that the guidance promoted unsound medical practice and violated the right to health.

In 2012, WHO published its second edition, and there was a marked shift in the critiques. The focus moved from impugning the guide's medical integrity to alleging that the guidance was propagating an "abortion agenda" at the behest of liberal, western donors and nongovernmental organizations. For example, opponents to abortion rights' interpretation of paragraph 8.25 of the ICPD conference outcome document, presume that abortion is illegal in many or all circumstances, that abortion carries inherent risks for mothers, and that it is an issue that is exclusively to be left to national legislation, and therefore not an international right or something the UN system should be involved in promoting.[27]

27 Microsoft Word—Pro-Life and Pro-Family Organizations—Joint Submission.docx (ohchr.org)

As WHO launches its third edition in 2022, a new narrative has emerged. While some critics are still focused on innovations in abortion—primarily abortion self-care—others have broadened their arguments away from denouncing the specifics of the health service, to framing the guidance as a curb on the right of states to pursue a political agenda. In their view, the WHO guidance imposes an infringement on "state sovereignty." For example, ultra-nationalist actors evoke national sovereignty discourses to undermine the very idea of international community and international human rights.[28]

None of these narratives are true. Instead, they are deliberate attempts to sow distrust of the medical sector—of World Health Organization in particular—and diminish women's bodily autonomy by stigmatizing access to a safe medical procedure and encourage governments away from fulfilling their national and international human rights obligations.

The below factsheet identifies the key arguments that have been used against the WHO guidance over the years, and it provides fact-based explanations for how to unpack and respond to the mischaracterizations. We hope this will be helpful as you read, disseminate, and implement the WHO guidance.

1 FABRICATED MISINFORMATION: "World Health Organization is deviating from its mandate."

IN FACT:

WHO is a public health resource whose role is to provide technical guidance to states for best practices, policies, laws, and health programs based on the highest standards of public health and international human rights.

The WHO is the United Nations agency that promotes the highest level of health for all, including for women, girls, and other pregnant people. The imperative for the WHO safe abortion guidance was first identified

28 Naureen Shameem, Rights at Risk Time for Action Ours Report 2021. Available at: RightsAtRisk_TimeForAction_OURsTrendsReport2021.pdf (awid.org)

at the 1994 International Conference on Population and Development (ICPD)[29] in Cairo, where governments from around the world recognized unsafe abortion as a major public health concern.[30]

To address the issue of safety, as identified by the 179 UN member states at ICPD, the WHO created the safe abortion guidelines. These are the gold standard for health systems throughout the world to provide abortion under the safest conditions using the highest level of medical information.

As part of its core work, WHO generates, translates, and disseminates knowledge on major health issues, including through guideline development. In recent years, substantial work has been done by WHO to fully integrate human rights into their work.[31]

2 FABRICATED MISINFORMATION: "The WHO safe abortion guidance lowers safety standards of health care."

IN FACT:

Access to safe abortion care, including self-managed abortion, protects both health and human rights.

The WHO guidance, relying on decades of research, is very clear that a safe abortion with medical abortion pills can be provided at both the primary care level and by non-physician providers.

Researchers have attributed a significant decline in deaths from unsafe abortion to self-managed abortion with misoprostol in countries with restrictive abortion laws.[32] Self-managed abortion is now considered low-risk and highly effective and is increasingly more available in

29 https://www.unfpa.org/publications/international-conference-population-and-development-programme-action

30 Jewkes R. et al. (2002). Prevalence of morbidity associated with abortion before and after legalization in South Africa. *British Medical Journal, 234* (1252). This is because unsafe abortion is both a major public health and a human rights issue. Globally, an estimated 22 million unsafe abortions are obtained every year, the vast majority occurring in countries where abortion is legally restricted. Research has demonstrated a correlation between countries' restrictive abortion laws and high rates of maternal mortality and morbidity. Annually, 47,000 women, girls, and pregnant people die of unsafe abortions and 5 million more suffer disability.

31 WHO Background Paper: Strengthening Health and Human Rights Standards for Prevention of Unsafe Abortion: a capacity-building workshop for selected members of international and regional human rights bodies | 1-2 April 2014 | Geneva, Switzerland WHO_RHR_15.10_eng.pdf at page 74

32 Ganatra, B. et al (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *Lancet 390*(101110): 2372-2381.

countries where abortion is legal in some circumstances. Methods available include either medical abortion or an outpatient procedure. The use of medical abortion pills (misoprostol alone or misoprostol in combination with mifepristone), offer a safe and effective method for ending an unwanted pregnancy.[33] The process can be safely managed outside of a facility and without the direct supervision of the provider.[34]

3 FABRICATED MISINFORMATION: "The WHO safe abortion guidance turns the issue of maternal and child health into a controversial topic."

IN FACT:

Abortion care is a core component of maternal and child health, and of the comprehensive sexual and reproductive health continuum of care. This is not controversial; abortion is a routine, essential healthcare service.

Reproductive, maternal, newborn and child health has always included sexual and reproductive health and rights. In turn, SRHR[35] includes abortion care. Because abortion care is an essential service, states must ensure access to high-quality health care. This includes integrated service delivery for pregnant people and children along the continuum of care—from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Individuals should have the information and means to decided freely—without discrimination, coercion, and violence—the number, spacing and timing of their children.

Any controversy over abortion as part of SRHR and maternal and child health is entirely manufactured by groups and individuals who want to deny the needs and rights of individuals to control their own sexuality and fertility.

33 Jelinska, K. & Yanow, S (2018). Putting abortion pills into women's hands: realizing the full potential of medical abortion. *Contraception, 97*(2): 86-89.

34 World Health Organization (2018). Medical management of abortion. Available at https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1.

35 Yamin, A.E. & Cantor, R. (November 2014). Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health. *Journal of Human Rights Practice, 6*(30): 451–485. DOI: 10.1093/jhuman/huu019. SRHR extends the continuum of care to relate to questions of mental and psychosocial health.

4 FABRICATED MISINFORMATION: "WHO has an abortion agenda."

IN FACT:

WHO is committed to women's, girls', and pregnant people's human rights and full decriminalization of abortion.

Unsafe abortion is an avoidable tragedy. WHO is committed to ending maternal mortality and morbidity caused by unsafe abortion. To do so, research shows (and the WHO guidance concurs) that states need an enabling regulatory and policy environment, as well as trained healthcare workers, access to commodities, and access to high-quality services provided without discrimination.

The WHO Guideline understand that safe abortion care should be available to all women regardless of age, ethnicity, gender identity, geographic location, marital status, race, religion, socio-economic status or migration status. Women of color, indigenous women and women in poverty worldwide are most affected by the lack of access to safe abortion care. In many cases, the inability to obtain an abortion when medically indicated impacts the life of women and their families.

The WHO promotes the highest standards of health for all. This includes access to safe abortion, which is deeply interlinked to the right to life and to live free of discrimination and violence, including coerced and forced reproduction. Suggestions that there is a nefarious agenda behind this mission are patently false.

5 FABRICATED MISINFORMATION: "There is no international right to abortion."

IN FACT:

Abortion rights are human rights: the right to safe and legal abortion is a fundamental human right protected under numerous international and regional human rights treaties.

A basic tenet of human rights is the right to live free of discrimination of any kind and to enjoy the highest standards of health, which includes access to abortion. International human rights standards on abortion have evolved to include the expansion of grounds for lawful abortion and protections to ensure actual access on those grounds, and ultimately to the decriminalization of abortion as a human rights imperative.[36]

The denial of access to safe abortion can constitute a human rights violation. Human rights standards require access to abortion, at a minimum, on grounds of life and health, rape or sexual crime, and fetal impairment as well as access to abortion on women's request in the first weeks in pregnancy[37] A human rights violation occurs when an interest in prenatal life is prioritized above the women's, girls', or pregnant person's fundamental human rights. Any legal protections granted to prenatal life cannot be prioritized over the rights and wellbeing of the pregnant individual.

In its most recent **General Comment 22** on the right to sexual and reproductive health under article 12, the **Committee on Economic Social and Cultural Rights (CESCR)** stated that the "right to sexual and reproductive health is an integral part of the right to health enshrined in article 12" and full enjoyment of this right is often limited by a number of legal, procedural, practical, and social barriers.[38] Specific to abortion restrictions, the General Comment notes that denial of abortion services often contributes to increased maternal mortality and morbidity, constituting a violation of the right to life or security, and sometimes amounting to torture or cruel, inhuman or degrading treatment.[39]

36 J.N. Erdman, 12 R.J. Cook. Best Practice & Research Clinical Obstetrics and Gynaecology 62 (2020) 11-24.

37 Erdman, J.R & Cook R.J. (January 2020). Decriminalization of abortion - A human rights imperative. *Best Practice & Research Clinical Obstetrics and Gynaecology. 62*: 11-24. DOI: 10.1016/j.bpobgyn.2019.05.004.

38 CESCR, *General Comment 22: The Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* pars. 1-2 (May, 2016).

39 *Ibid.* at par. 12.

6 FABRICATED MISINFORMATION: "The WHO safe abortion guidance disregards state sovereignty and domestic law."

IN FACT:

The right to sovereignty cannot be invoked to deny access to any universal human right.

Governments can invoke neither sovereignty nor culture, tradition, or religion to avoid complying with the human rights obligations to respect, protect, and fulfill human rights. All member states of the United Nations have signed at least one human rights treaty, most of them the Committee on the Elimination of Discrimination against Women (CEDAW), and all have agreed to abide by the Universal Declaration of Human Rights. The universality of all human rights, including the rights of women and girls in all their diversity—is at the heart of these international treaties.

States have an obligation to respect, protect, and fulfill the human rights of all women, girls, and people who can become pregnant. The WHO Guideline supports states to fulfill their human rights obligations. Human rights should not be viewed as contrary to sovereignty. Instead, they should be recognized as states' tools to ensure that all people can live with dignity, without discrimination of any kind. Confronting human rights against national sovereignty creates a false dilemma and must be avoided.

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