


Beyond safety: the 2022 WHO abortion guidelines and the future of abortion safety measurement

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To cite: Gerdts C, Bell SO, Shankar M, *et al.* Beyond safety: the 2022 WHO abortion guidelines and the future of abortion safety measurement. *BMJ Global Health* 2022;**7**:e009557. doi:10.1136/bmjgh-2022-009557

Received 6 May 2022
Accepted 31 May 2022



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INTRODUCTION

In March 2022, the World Health Organization (WHO) released updated guidelines consolidating the current evidence and best practices for quality abortion care.¹ Undergirded by a framework of human rights standards and in recognition of the centrality of an enabling environment, the new set of recommendations span law, policy, clinical services, and mechanisms for service delivery. For the first time, WHO abortion service delivery recommendations include the self-management of medical abortion (Recommendation #50) and fully recommend trained community health workers, pharmacy workers, and pharmacists as providers for the medical management of abortion up to 12-weeks gestation (Recommendation #28). These shifts in WHO abortion care guidelines are the result of decades of work by grassroots activists² and researchers. Their innovative efforts to ensure access to evidence-based abortion care—regardless of legal setting—laid the groundwork for widespread experiential knowledge and scientific evidence regarding the safety and effectiveness of self-managed medical abortion.³ Informed by this body of work, the recommendations for self-management of medical abortion in the new WHO guidelines have the potential to transform abortion access if international bodies, governments, and health systems expand the availability of abortion pills and access to trained support. The guidelines also have important implications for the way we conceptualise and measure abortion safety.

FROM LEGALITY TO SAFETY

Through the late 1980s, research on abortions obtained outside of clinical settings focused primarily on the quantification and reduction of ‘illegal abortions’—likely due

Summary box

- ⇒ In March 2022, the WHO released updated guidelines consolidating the current evidence and best practices for provision of quality abortion care, which, for the first time, include self-management of medical abortion as a fully recommended model of abortion care.
- ⇒ The new guidelines have the potential to transform abortion access if international bodies, governments and health systems expand the availability of medication abortion pills and trained support. The guidelines also have important implications for the way we conceptualise and measure abortion safety.
- ⇒ Abortion safety has historically been conceptualised from a purely biomedical (clinical and public health) perspective and relied on clinical process measures (method, provider and setting) for classification. This operationalisation required that the abortion involves a recommended method delivered by an appropriately trained provider, in an appropriate facility, to be considered ‘safe’.
- ⇒ Over time, however, as knowledge, availability, and use of abortion medications (misoprostol with or without mifepristone) increased outside of clinic settings, the process measures (method, provider, setting) that defined the abortion safety paradigm no longer correlated as directly with biomedical risk.
- ⇒ This commentary discusses limitations of the current approach to the measurement of abortion safety, highlights the required reclassification of self-managed abortion as ‘safe’, and calls for a new paradigm to emerge for the measurement and understanding of global abortion experiences that is centred in a rights-based conceptualisation of quality care for all abortion experiences.

to an observed correlation between restrictive abortion laws and high rates of maternal morbidity and mortality. In 1992, a WHO technical working group discussed the need to understand not only the legality but also the safety of abortion services. Their report, published in 1993, coined the term ‘unsafe

abortion’—concluded that legality or illegality of services may not be the defining factor of abortion safety⁴. The report described the characteristics of ‘unsafe abortion’ as an abortion performed without adequate provider skills, using hazardous techniques, and/or occurring in unsanitary facilities. Following the publication of this report, the language and focus of research on abortions obtained outside of clinical settings made a distinct shift away from legality and towards the concept of abortion safety.⁵

From the outset, the measurement of abortion safety was conceptualised from a purely biomedical (clinical and public health) perspective and relied on clinical process measures (method, provider and setting) for classification. This operationalisation required that a ‘safe’ abortion must involve a recommended method delivered by an appropriately trained provider, in an appropriate clinical facility. The early abortion safety paradigm emerged in a global context when abortions that occurred without meeting clinical process measures were highly correlated with complications such as haemorrhage, infection and physical trauma.⁶ Attention to abortion safety in research and advocacy was, therefore, deemed a public health imperative. For decades, the urgency of addressing maternal morbidity and mortality from unsafe abortion procedures drew the attention of governments, donors, and other influential stakeholders to the need for legal, policy, and health systems reforms to drive service improvements.

Over time, however, as knowledge, availability, and use of abortion medications (misoprostol with or without mifepristone) increased outside of clinic settings, the clinical process measures (method, provider, setting) that defined the abortion safety paradigm no longer correlated as directly with biomedical risk.^{7,8} In recognition of this changing reality, in 2017, the WHO created a new, three-tier operationalisation of abortion safety measurement⁹—categorising an abortion as ‘safe’ if it involved recommended methods and providers with recommended levels of training, ‘less safe’ if only one of the two conditions were met, and ‘least safe’ when neither of the two conditions were met. In practice, the updated classification system continued to rely on clinical process measures. As such, nearly all surgical abortions were categorised as ‘safe’ because data (often from health facilities) existed to confirm that those abortions were performed using a ‘recommended’ method, by a ‘recommended’ provider, in a ‘recommended’ facility. This approach, however, fails to incorporate information about health system infrastructure, provider training and quality, and continuity of client–provider interactions necessary for the provision of high-quality abortion care. In addition, within the three-tier classification system, self-managed medical abortion—abortions which involved a recommended method (medical abortion) and a non-recommended provider (the person themselves)—were classified as ‘less safe’ despite a substantial body of evidence observing across multiple settings that

self-managed medical abortions do not correspond with higher biomedical health risks.^{10,11}

FROM SAFETY TO QUALITY

The updated WHO abortion care guidelines now fully recognise the individual themselves as an able provider who may ‘conduct some or all elements related to the abortion process (self-assessment of eligibility, self-administration of medicines and self-assessment of the success of the abortion) entirely on their own’. The guidelines also acknowledge that ‘It is the individual (ie, the “self”) who drives the process of deciding which aspects of the abortion care will be self-managed and which aspects will be supported or provided by trained health workers or in a health-care facility...from the perspective of the health system, self-management should not be considered a “last resort” option or a substitute for a non-functioning health system. Self-management must be recognized as a potentially empowering and active extension of the health system and task-sharing approaches’.¹ Furthermore, the large majority of abortions classified as ‘less safe’ in the 2017 assessment of global abortion safety were presumed to be self-managed medication abortions. From a purely methodological standpoint these abortions should now be reclassified as “safe”.² Updates to the WHO abortion care guidelines provide a unique opportunity to rethink the very paradigm of abortion safety, and all but eliminate the necessity for the current three-tier classification.

Indeed, abortion remains a leading cause of maternal mortality in some settings, and significant work also remains to improve surgical abortion quality in low-resource settings where complication rates are higher than in high-resource settings. In addition, the self-management of medical abortion is, in many settings, far from achieving normative standards of self-care as delineated by a recently released WHO consolidated guideline and accompanying conceptual framework on self-care interventions in sexual and reproductive health.¹² As stipulated by the self-care framework, those self-managing an abortion must have access to quality pills, access to accurate and adequate information to ensure correct use, knowledge regarding possible complications, and safe linkage to a provider, if needed or wanted. Existing research suggests, however, that these criteria are often not met.¹³

The updated WHO abortion care guidelines clearly articulate that ‘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’. It is increasingly evident that access to legal abortion (a fundamental requirement for a supportive enabling environment) is under assault around the globe, and significant barriers remain to abortion access even where it is legally available.¹⁴ Given the current landscape of abortion globally, the paradigm of evaluating ‘abortion safety’ using clinical process measures alone is no

longer sufficient. The standard clinical process measures previously used to measure abortion safety simply fail to capture the elements of an abortion experience that are most salient to people's lives and well-being. For example, documenting the method and provider for an abortion obscures the impact on health and well-being of the burdensome and often perilous routes that many abortion seekers must take to access recommended abortion methods or legal risks in settings where abortion is criminalised. Clinical process measures also provide no mechanism to document the experiences of those unsuccessful in obtaining a wanted abortion, whether due to the use of ineffective methods or insurmountable barriers to care (eg, lack of trained providers, exorbitant cost or denial of care). Research on abortion decision-making and preferences has repeatedly demonstrated that aspects of the abortion process like accessibility, cost, privacy, confidentiality and security, legal risk, and being treated with dignity and respect are paramount in peoples' abortion decision-making and assessment of the quality of their abortion care.¹⁵

CONCLUSION

In short, the current operationalisation of abortion safety—focused exclusively on abortion method, provider, and setting—does not adequately capture other essential elements of the abortion experience. A new paradigm for the measurement and understanding of global abortion experiences must emerge that moves us beyond documentation of the bare minimum (appropriate abortion method/provider/setting or 'safety') and towards a conceptualisation of abortion experiences that follow recommended protocols and occur within an enabling environment that ensures 'respect for human rights, the availability and accessibility of information and a supportive, universally accessible, affordable and well-functioning health system'.¹

Contributors CG envisioned and contributed to drafting and reviewing the manuscript. SOB, MS, RTJ and OO contributed to ideation, drafting and review of the manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement There are no data in this work.

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