

WHO Briefing for the Joint Committee on the Eighth Amendment of the Constitution

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Introduction

We thank the members of the Joint Committee for their invitation to the World Health Organization to present our guidance on health-system requirements for safe abortion and potential barriers for women wishing to access services.

Dr Ganatra and I are staff members from the Department of Reproductive Health and Research and the Special Programme of Research, Development and Research Training in Human Reproduction. The Department and Special Programme provide leadership on matters critical to sexual and reproductive health and rights through shaping the global research agenda, coordinating research; setting norms and standards; articulating an evidence- and human-rights-based approach; and providing technical support to WHO Member States on sexual and reproductive health and rights.

The Department's vision is the attainment by all peoples of the highest possible level of sexual and reproductive health. It strives for a world where all women's and men's rights to enjoy sexual and reproductive health are promoted and protected and all people including the most vulnerable have access to sexual and reproductive health information and services. The briefing today falls under our technical support role and through the organization's aim to support Member States to implement The Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, The Strategy on Women's Health and Well-being in the WHO European Region, and the Action Plan on Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe, which was adopted by European governments last September.

Today's briefing is about the provision of safe abortion services *in the event that* some or all of the recommendations of the Citizens Assembly become national policy. While legal, regulatory, policy and service-delivery contexts may vary from country to country, the recommendations and best practices described in WHO guidelines aim to enable evidence-based decision-making with respect to safe abortion care.

Today, briefly we will cover the following points, as described in the WHO guidelines:

- Integration of abortion services into the health system;
- National standards and guidelines;
- The equitable distribution and availability of facilities and health-care providers;
- Preparation and equipping of health facilities;
- Financing and costs to women; and
- Potential barriers to women accessing services.

1. Abortion services should be integrated into the health system to acknowledge their status as legitimate health services and to protect against stigmatization and discrimination of women and health-care providers.

At a minimum, abortion services should always include:

- medically accurate information and, if requested by the woman, non-directive counselling, to facilitate informed decision-making;
- abortion services delivered without delay;
- timely treatment for abortion complications;
- contraceptive information, services and referrals.

2. National evidence-based standards and guidelines for safe abortion should be developed and regularly updated to ensure that health services and standards ensure good access and quality of care. They should cover: types of abortion service, where and by whom they can be provided; essential equipment, instruments, medications, supplies and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality and privacy; attention to the special needs of adolescents; special provisions for women who have suffered rape; and conscientious objection by health-care facilities and health-care personnel.

3. Ensuring access to safe abortion requires the availability of facilities and trained providers within reach of the entire population. Regulation of providers and facilities should be based on evidence of best practices and be aimed at ensuring safety and good quality without compromising accessibility of services. First-trimester abortion care can be provided using a simple procedure (vacuum aspiration) or through the use of medical abortion drugs (mifepristone and misoprostol). These interventions can be provided at primary care level and through outpatient services. Such care can also be provided by generalist physicians as well as primary care providers like clinical officers and nurses. In early pregnancy, after the initial assessment by a provider, women can manage the medical abortion process without direct supervision and outside of a facility setting as well. For abortions beyond 12 weeks of pregnancy, higher-level services may be needed, though a surgical abortion can still be provided as out-patient care. Facilities for inpatient care are required for medical abortion beyond 12 weeks of pregnancy. In addition, referral hospitals should have the staff and capacity to perform abortions in all circumstances permitted by law and to manage all abortion complications.

4. Abortion facilities and providers must be well prepared and equipped to provide safe care. Most of the equipment, medications, and supplies needed to provide vacuum aspiration are the same as those needed for other gynaecological services. In addition, medical abortion requires registration, procurement and distribution of mifepristone and misoprostol. Supportive services, such as commodity procurement, supply chain functioning, and financing mechanisms, are as important as training providers for introducing new services. Where services already exist, infrastructural upgrades can facilitate more efficient patient flow and increase privacy and user satisfaction. Quality-approved abortion instruments and medications should be routinely included in the planning, budgeting, procurement, distribution, and management systems.

In addition to skills training, participating in values-clarification exercises can help all health-care personnel differentiate their personal beliefs and attitudes from the needs of women seeking abortion services. Values clarification is an exercise in articulating how personal values influence the way in which health-care personnel interact with women seeking abortion. Despite health workers'

attempts at objectivity, negative and predefined beliefs about abortion and the women who have them often influence professional judgement and quality of care.

5. Financing and costs to women. Health-service budgets should include sufficient funds for the following types of costs related to safe abortion:

- equipment, medications and supplies required to provide care;
- staff time;
- training programmes and supervision;
- infrastructure upgrades;
- record-keeping; and
- monitoring and evaluation.

The respect, protection, and fulfilment of human rights require that women can access legal abortion services regardless of their ability to pay. Financing mechanisms should ensure equitable access to good-quality services. Where user fees are charged for abortion, such fees should be matched to women's ability to pay, and procedures should be developed for exempting the poor and adolescents from paying for services. As far as possible, abortion services should be mandated for coverage under insurance plans. Abortion should never be denied or delayed because of a woman's inability to pay.

6. What are critical barriers to accessing safe abortion services?

Access to safe abortion depends not only on the availability of services, but also on the manner in which they are delivered and the treatment of women within the service-delivery context. Services should be delivered in a way that respects a woman's dignity, guarantees her right to privacy and is sensitive to her needs and perspectives. Attention should be given to the special needs of women of lower socioeconomic status, adolescents, and other vulnerable and marginalized women.

Barriers to accessing safe abortion services, even when legal, include the following:

- Restrictive interpretation of legal grounds, including the conditions that fall under health;
- Failure to provide public information on the legal status and availability of abortion;
- Excluding coverage for abortion services under health insurance, or failing to eliminate or reduce service fees for poor women and adolescents;
- Requirements for third-party authorisations from one or more health-care providers, or from a hospital committee, from a court or police, from a parent or guardian, or from a woman's partner or spouse;
- Restricting the range of health-care providers and facilities, which may result in poor availability of services, especially in rural areas;
- Conscientious objection, by health-care facilities and by health-care personnel;
- Requiring mandatory waiting periods;
- Censoring, withholding or intentionally misrepresenting health-related information, in the context of abortion;
- Failure to guarantee confidentiality and privacy; and
- Requirements for medically unnecessary screening tests (such as requirements for women to view ultrasound images or listen to the fetal heartbeat).

Any of these barriers can deter women from seeking care and providers from delivering services within the formal health system; they cause delays in access to services, which may result in denial of services due to gestational limits on the legal grounds; they create complex and burdensome administrative procedures; they increase the costs of accessing abortion services; and they limit the availability of services and their equitable geographic distribution.

In conclusion: Health systems should aim to:

- Respect, protect and fulfil the human rights of women, including women's dignity, autonomy and equality;
- They should promote and protect the health of women as a state of complete physical, mental and social well-being;
- They should minimize the rate of unintended pregnancy by providing good-quality contraceptive information and services, including a broad range of contraceptive methods, emergency contraception and comprehensive sexuality education;
- They should prevent and address stigma and discrimination against women who seek abortion services or treatment for abortion complications; and reduce maternal mortality and morbidity due to unsafe abortion, by ensuring that every woman entitled to legal abortion care can access safe and timely services including post-abortion contraception;
- They should meet the particular needs of women belonging to vulnerable and disadvantaged groups, such as women of lower socioeconomic status, adolescents, single women, refugees and displaced women, women living with HIV, and survivors of rape.

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Additional resources

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