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Eleven Problems with the 2012 WHO Technical Guidance on Abortion

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The second edition of the World Health Organization's *Safe Abortion: Technical and Policy Guidance for Health Systems*[1] deserves scrutiny because it raises questions about whether it promotes the highest standards of medical care. The guidance aims at ensuring that abortion may be performed more widely by non-medical personnel even if it has to proceed without diagnosis, ultrasound, follow-up care, or drugs that have become standard in medical practice.

A primary concern is the WHO seems to be recommending abortion practices for women in developing countries that have been rejected by medical experts in the developed world. WHO bases its promotion of the revised guidelines on claims that abortion is both safer than childbirth and also a human right, neither of which enjoys international agreement.

Increased health risks to women.

"WHO recommends abortion practices for women in poor countries that have been rejected by medical experts in the developed world.... the guidance admits that the practice is substandard."

Problem #1: The WHO technical guidance says misoprostol abortion without mifepristone is more dangerous than with it, but endorses the practice because women are using it that way at the direction of abortion advocates.

Mifepristone and misoprostol are the drugs most commonly used to perform nonsurgical, or medical, abortions.[2] The guidance admits that the practice it is promoting—use of misoprostol alone—is substandard: "Misoprostol alone has also been studied for medical abortion in terms of effectiveness and safety. The effectiveness of misoprostol alone is lower, the time to complete abortion is prolonged, and the abortion process is more painful and associated with higher rates of gastrointestinal side-effects than when misoprostol is combined with mifepristone." The technical guidance goes on to recommend the practice anyway, although its recommendation is not substantiated by studies which show apparent justification for the recommendation, but rather, "Because

1 World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.

2 Mifepristone, also known as RU-486, is used to induce abortions by causing the softening and dilation of the cervix. Misoprostol, which was originally approved for the treatment of gastric ulcers, induces cervical contractions, and is therefore used in conjunction with mifepristone to cause the expulsion of the unborn child.

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of misoprostol's wide availability and low cost," and because "the use of misoprostol alone appears to be common where mifepristone is unavailable."

"The effectiveness of misoprostol alone is lower, the time to complete abortion is prolonged, and the abortion process is more painful...than when misoprostol is combined with mifepristone." – WHO technical guidance

Problem #2: The WHO technical guidance recommends abortion methods for women in the developing world that it admits are not supported by clinical studies and which US medical experts have rejected for use in the West.

The guidance says, "For pregnancies of gestational age over 12 weeks (84 days) the recommended method for medical abortion is 200 mg mifepristone administered orally followed 36 to 48 hours later by repeated doses of misoprostol....For pregnancies of gestational age greater than 24 weeks, the dose of misoprostol should be reduced due to the greater sensitivity of the uterus to prostaglandins, *but the lack of clinical studies precludes specific dosing recommendations*." (Emphasis added).

Repeated doses of misoprostol for medical abortion in the second trimester and vaginal administration of the drug are below standards of care set in developed countries such as the United States. Vaginal use of misoprostol for abortion there was linked to several women's deaths from fatal bacterial infections.[3]

"By 24 weeks the eyelids reopen and the fetus exhibits a blink-startle response. This reaction to sudden, loud noises typically develops earlier in the female fetus." – Biology of prenatal development

Problem #3: The WHO technical guidance implies that follow-up to medical and surgical abortion is not required.

The guidance says, "Women using misoprostol at home may leave the facility shortly after taking the mifepristone. They must be told what to expect with regard to vaginal bleeding and expulsion of products of conception following use of misoprostol, and how to recognize complications and whom to contact if they should occur." Putting the onus on patients to identify the need for follow-up care instead of on the medical practitioner does not take into account the fact that follow-up exams are *necessary* to diagnose complications. Hemorrhaging and infection—potentially serious or fatal complications—are often misidentified as abortion's usual symptoms of pain and bleeding.

Problem #4: The WHO technical guidance downplays dangers of failed abortion and deemphasizes the high rate at which such failures occur.

The guidance says, "After surgical methods of abortion, immediate examination of the products of conception is important to exclude the possibility of ectopic pregnancy and assess whether the abortion is likely to be complete," and goes on to say, "With vacuum aspiration, beginning around 6 weeks of pregnancy, trained providers can visually identify the products of conception, specifically chorionic villi and the gestational sac."[4]

3 M. Fjerstad, J. Trussell, I. Sivin, E.S. Lichtenberg, V. Cullins, "Rates of serious infection after changes in regimens for medical abortion," *New England Journal of Medicine*, July 9, 2009;361(2):145–51. http://www.ncbi.nlm.nih.gov/pubmed/19587339. *See* also Associated Press, "FDA Issues Infection Warning on Abortion Pill," http://www.foxnews.com/story/0,2933,163032,00.html.

4 The chorionic villi are part of the border between maternal and fetal blood during pregnancy.

WHO's recommendation not to perform an ultrasound before an abortion raises the risk that women will unnecessarily undergo invasive and potentially dangerous procedures.

"Overall, the [guideline development] group placed a high value on research to demedicalize abortion care." – WHO technical guidance

The rates of failure for medical abortions is greater than that of surgical abortions. One study found that women using the U.S. Food and Drug Administration- (FDA) approved medical abortion regimen experienced failure rates ranging from 1-9%, with higher rates at later gestational time points.[5] It should be noted that these failure rates were observed in the United States using methods in accordance with the FDA guidelines, which recommend preliminary ultrasounds and require a follow-up visit to a medical professional. It is likely that the failure rates, as well as the severity of resulting complications, would be worse in the developing world.

Problem #5: The WHO technical guidance dangerously and falsely assumes that health facilities are available to treat complications, even in areas with high maternal mortality due to a lack of trained medical personnel.

The guidance says, "In the case of a failed abortion where pregnancy is ongoing, re-administration of misoprostol or surgical abortion should be offered to the woman. Women with incomplete abortions can generally be observed unless vaginal bleeding is heavy, or they may be offered re-administration of misoprostol or surgical completion of their abortion. Facilities offering medical methods of abortion must be able to ensure provision of vacuum aspiration, if needed. Such provision can be available on-site or through an arrangement with another facility that performs vacuum aspiration. In all cases, health-care providers must ensure that the woman can reach such services in case of an emergency."

"WHO's recommendation raises the risk that women will unnecessarily undergo invasive and potentially dangerous procedures."

This guidance, which acknowledges the dangers of abortion, is not supported by the rest of the guidance which is aimed at what it calls "demedicalizing" abortion—making it easier to perform abortions out of the hospital setting with workers who are not physicians.

Problem #6: The WHO technical guidance recommends reusing disposable plastic manual vacuum aspirators on different patients, even in regions with the least ability and likelihood of complying with the strict sterilization requirements.

The guidance first recommends disposable manual vacuum aspirators (MVA) as the primary method for abortion, even in the second trimester: "The recommended surgical technique for abortion up to gestational age less than 15 weeks is vacuum aspiration. Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. Electric vacuum aspiration (EVA) employs an electric vacuum pump. With manual vacuum aspiration (MVA), the vacuum is created using a hand-held, hand-activated, plastic 60 ml aspirator (also called a syringe)."

5 I.M. Spitz, C.W. Bardin, L. Benton, A. Robbins. "Early pregnancy termination with mifepristone and misoprostol in the United States," *New England Journal of Medicine*, 1998;338:1241–1247.

"Regimens to effect fetal demise include injection of potassium chloride (KCl) through the fetal umbilical cord or into the fetal cardiac chambers, which is highly effective" –WHO technical guidance

The guidance goes on to recommend the reuse of the plastic MVA, which is widely known to be a source of increased infection among women, increasing the risk of maternal death and morbidity: "Some cannulae and most aspirators are reusable after being cleaned and high-level disinfected or sterilized." It recommends extensive requirements for sanitizing the disposable MVA, requirements which are infeasible given the unsanitary and remote environment in which the instrument is most likely to be used.

Problem #7: The WHO technical guidance acknowledges that its proposed abortion method does not kill the child right away and therefore recommends injecting the woman with other drugs even when ultrasound is not available. It calls "effective" a drug that admittedly causes "limb defects and skull and facial abnormalities in pregnancies that continued after failed attempts to induce abortion."

The guidance says, "Modern medical methods, such as combination regimens of mifepristone and misoprostol or misoprostol alone, are not directly feticidal; the incidence of transient fetal survival after expulsion is related to increasing gestational age and decreasing interval to abortion. Commonly used pre-procedure regimens to effect fetal demise include injection of potassium chloride (KCl) through the fetal umbilical cord or into the fetal cardiac chambers, which is highly effective *but requires expertise for precise, safe injection* and time to observe cardiac cessation on ultrasound. [And] intra-amniotic or intrafetal injection of digoxin." The guidance cautions that "Digoxin has a higher failure rate than KCl to cause intrauterine fetal demise," but goes on to recommend it anyway simply because, "it is technically easier to use, *does not require ultrasound* if administered intra-amniotically." [Emphasis added].

"The incidence of transient fetal survival after expulsion is related to increasing gestational age." –WHO technical guidance

Problem #8: The WHO technical guidance claims that abortion is safer than childbirth, and dismisses a body of research showing the link between abortion and preterm birth, breast cancer, and adverse psychological side effects.

The guidance asserts that, "In modern times, the risk of death from a safe, induced abortion is lower than from an injection of penicillin or carrying a pregnancy to term. Research shows no association between safely induced first-trimester abortion and adverse outcomes in subsequent pregnancies. ...Although second-trimester abortions have not been studied as extensively, there is no evidence of an increased risk of adverse outcomes in subsequent pregnancies."

This contradicts WHO research on the increased incidence of pre-term birth which has been linked to abortion by more than 120 peer-reviewed studies. More than 15 million—one in 10—babies in the world are born pre-term, increasing their risk of death and a lifetime of disabilities according to WHO.[6] The technical guidance does not account for

6 World Health Organization, B*orn Too Soon: The Global Action Report on Preterm Birth*, 2012, http://www.who.int/pmnch/media/news/2012/preterm_birth_report/en/index.html. For a list of the 127 peer-reviewed studies linking pre-term birth to abortion, see Byron Calhoun, "Abortion and Preterm Birth: Why Medical Journals Aren't Giving Us The Real Picture," (International Organizations

At 12-16 weeks after fertilization, stimulation near the mouth now evokes a turning toward the stimulus and an opening of the mouth. This response is called the "rooting reflex" and it persists after birth, helping the newborn find his or her mother's nipple during breastfeeding.
– Biology of Prenatal Development

mounting research linking abortion to increased mortality rates for women. For example, a study of thirty years of data from Denmark shows that, "compared to women who delivered, women who had an early or late abortion had significantly higher mortality rates within 1 through 10 years."[7]

Furthermore, rather than acknowledging studies linking abortion to breast cancer and the significant studies demonstrating psychological impact from abortion, the technical guidance dismisses the risk these pose for women: "Sound epidemiological data show no increased risk of breast cancer for women following spontaneous or induced abortion. Negative psychological sequelae occur in a very small number of women and appear to be the continuation of preexisting conditions, rather than being a result of the experience of induced abortion."

Problem #9: The WHO technical guidance recommends disposing of human remains in a sewer or latrine. Such practices could pose grave health threats.

In India, and in other countries, there has been highly-publicized public outrage at the discovery of piles of dead fetuses in ditches near abortion facilities. Given the high profile nature of this problem, it is reasonable to assume public sensibilities should be taken into account in any discussion of abortion. And yet, even though the guidance makes recommendations for abortion through nine months of gestation, it makes no recommendation for what to do with the bodily remains of the unborn child after the abortion other than recommending that, "liquid waste, such as blood or other body fluids, should be poured down a drain connected to an adequately treated sewer or pit latrine."

Flaws in the legal and scientific basis of the WHO technical guidance.

Problem #10: The WHO technical guidance advocates a ban on all limits to abortion, for all nine months of pregnancy, for all ages including minors—regardless of national laws, and in contravention of established human rights such as freedom of conscience and parental rights.

Nearly every country has some regulation on abortion to protect women and girls. Yet WHO's technical guidance promotes the procedure irrespective of national laws and takes a position expressly against the agreement nations made at the 1994 Cairo conference on population.

The guidance calls for the removal of basic medical and legal protections including, "Laws or policies that impose time limits on the length of pregnancy for which abortion can be performed," "authorization from one or more medical professionals," consent from "parent or guardian or a woman's partner or spouse," and "allowing conscientious

Research Group, 2012), http://www.c-fam.org/docLib/Brief%209%20FINAL.small.pdf.

7 D. Reardon and P. Coleman, "Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980–2004," *Medical Science Monitor* 2012;18(9):PH 71–76.

objection without referrals on the part of health-care providers and facilities." It tells nations they must "ensure that the exercise of conscientious objection does not prevent individuals from accessing services."

"Abortion has never been accepted by the UN General Assembly as a human right."

The document says that "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 safe abortion care" which entail the "application of the clinical guidance in establishing and strengthening abortion services, including development of national standards and guidelines; training and equipping of service providers; assessing, prioritizing and financing of health-system needs; introducing and scaling-up of interventions; and monitoring and evaluation."

"Health-care professionals who claim conscientious objection... must provide abortion..."
– WHO technical guidance

While the WHO technical guidance implies that abortion is part of a human rights-based approach, abortion has never been accepted by the UN General Assembly as a human right. The guidance asserts that, "Over the past two decades, the health evidence, technologies and human rights rationale for providing safe, comprehensive abortion care have evolved greatly." But a "right" to access abortion has evolved only in the sense that it has been asserted by some from an implied subset of several existing human rights. In laying out the history of how access to abortion became associated with human rights, the technical guidance states, "Discussions that grew out of the 1968 International Conference on Human Rights in Tehran, Islamic Republic of Iran, culminated in the new concept of reproductive rights, which was subsequently defined and accepted at the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt." However, the technical guidance does not mention that the definition agreed upon at Cairo explicitly excluded a right to abortion, a point which was reinforced by several nations in their explanations of position at the time.

Likewise, the UN General Assembly and other prominent bodies have repeatedly rejected the claim that abortion is a human right. Most recently the term "reproductive rights" was rejected at the Rio+20 UN Summit on Sustainable Development in 2012 because of its association with abortion. A highly controversial document presented by the UN Special Rapporteur for Health evoked strong opposition in 2011.[8] The WHO has avoided officially declaring that abortion is a human right, and WHO scholars writing on behalf of the organization who have made this assertion are careful to include the disclaimer that it is not an official WHO position.

Thus, the notion of abortion as a human right is not set forth in any binding UN document, nor is it asserted in non-binding documents, such as the 1994 Plan of Action from the UN Conference on Population and Development in Cairo, nor the Platform for Action from the Fifth UN Conference on Women in Beijing. Rather, the evolution of the human rights rationale for abortion has proceeded by implication and inference by those seeking

8 The UN General Assembly sharply criticized a 2011 report by the UN Special Rapporteur for the Highest Attainable Standard of Health that abortion is a part of the right to maternal health care. *See* United Nations, Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, August 3, 2011. http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254.

to redefine the rights to health, privacy, liberty, and even life.

Because nations have continually rejected the notion of abortion as a human right, advocates of such an approach point to non-binding statements such as general comments from human rights treaty monitoring bodies or resolutions from the Human Rights Council which refer to maternal health in terms of human rights to lend credibility to their idea that a maternal health right includes abortion. This is to a significant degree based upon the view that limits on abortion represents discrimination against women in the area of health care. And yet there is no international agreement on this concept of discrimination, a view which has been rejected by national courts such as the United States Supreme Court.

Problem #11: The WHO bases its revised technical guidelines on abortion on unverifiable data regarding the dangers of "unsafe" abortion.

"In modern times, the risk of death from a safe, induced abortion is lower than from an injection of penicillin or carrying a pregnancy to term."
– WHO technical guidance

The WHO technical guidance bases its recommendation for wider access to abortion by asserting that, "Almost every one of these [47,000] deaths and [5 million] disabilities could have been prevented through sexuality education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion."

The 47,000 deaths refers to the number of worldwide deaths attributed by the WHO to "unsafe abortion," a term which WHO defines as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both."[9] Yet, as this briefing paper has pointed out, WHO's technical guidance advises using abortion methods below the accepted standard of care, thereby increasing risks to women.

While unsafe abortion is not explicitly equated with illegal abortion, WHO guidance makes this link implicit, saying "The reluctance of a woman to seek timely medical care in case of complications because of legal restrictions" among its risk factors for unsafe abortion. According to WHO, 99% of maternal mortality occurs in the developing world (nearly all due to a lack of access to basic medical care) and 13% of total maternal mortality is due to unsafe abortion. Therefore, it is to be expected that virtually all of the deaths reportedly caused by unsafe abortion occurred in the developing world. However, the claim that these deaths could have been prevented by increased access to legal abortion is far less obvious.

"The technical guidance does not account for mounting research linking abortion to increased mortality rates for women."

In fact, WHO researchers have found that deaths due to unsafe abortions *decreased* by approximately one-third between 2003 and 2008 despite an almost ten-percent increase in the number of unsafe abortions in the same period of time (attributed to a growth in the population of women of childbearing age).[10] Another report by the same researchers found similarities in the mortality rates associated with unsafe abortion in Europe and

9 World Health Organization, "The prevention and management of unsafe abortion," Report of a Technical Working Group. Geneva, World Health Organization, 1992 (WHO/MSM/92.5).

10 I. Shah, E. Åhman, "Unsafe abortion in 2008: global and regional levels and trends," *Reproductive Health Matters*, 2010;18(36):90–101.

"Not mentioned... Are the long-lasting effects on post-abortive women nor the relative benefits of childbirth and motherhood over abortion for women."

Latin America. They noted that while Europe reports a low level of unsafe abortions and a high level of legal abortions, Latin American countries tend to highly restrict abortion and have a high incidence of unsafe abortions, yet mortality is relatively low in both regions.[11] The WHO technical guidance does not fully account for these findings, although the authors of the study note the improvement in overall health care standards in Latin America as an important contributing factor.

The technical guidance devotes an entire chapter to legal and policy considerations, first by tying the necessity of abortion to women's health and survival, and then invoking the right of women to the "highest attainable standard of health" in an attempt to infer a human right to abortion.

Many of the policy recommendations included in this document are explicitly directed toward making abortion "safe and accessible." Furthermore, this document makes its case for legalization of abortion by contrasting it with two alternatives: unsafe abortion and risk of associated mortality and unwanted children. According to the technical guidance, "the implications of unwanted births are not well studied, but the effects can be harmful and long-lasting for women and for those who are born unwanted."

Not mentioned here or anywhere else in the document are the long-lasting effects on post-abortive women, nor the relative benefits of childbirth and motherhood over abortion for women.

Conclusion

The 2012 WHO publication *Safe Abortion: Technical and Policy Guidance for Health Systems* reveals a contradiction between WHO's research role and its advocacy and policy role. The guidance advocates for making abortion more widely accessible in the developing world, yet does not provide sufficient scientific or legal grounds for such a recommendation.

While the WHO technical guidance promotes a specific policy agenda—greater access to safe abortion—it does not raise the standards of health care for women, and in fact lowers them in various ways. Thus it provides legal cover for insufficiently skilled practitioners or those working in impoverished regions in need of better general health care infrastructure. In pursuing the policy agenda, moreover, the WHO technical guidance has not taken account of the best available research on abortion.

National governments, medical policy makers and practitioners rely upon WHO to provide the highest possible standards of research so that they may make the very best decisions about health care. By promoting a particular agenda without a sufficient basis to do so, WHO jeopardizes the trust that its constituents have placed in the organization and the prospects of better health care for women.

11 E. Åhman, I.H. Shah, "New estimates and trends regarding unsafe abortion mortality," *International Journal of Gynecology and Obstetrics*, 115 (2011) 121–126.

"WHO's technical guidance advises using abortion methods below the accepted standard of care, thereby increasing risks to women."

Note: Information on fetal development from The Endowment for Human Development, "The Biology of Human Development," http://www.ehd.org/resources_bpd_illustrated.php

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