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Commentary

Self-managed abortion: Exploring synergies between institutional medical systems and autonomous health movements ☆

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The COVID-19 pandemic has highlighted and exacerbated the disparities and inequities within every sector of society. Women, girls, and marginalized people are disproportionately affected by this crisis. For millions of people worldwide living under lockdown, quarantine, or other measures, access to safe abortion, regardless of national laws, has become even more difficult than it was prepandemic [1].

The pandemic has shown how simple, demedicalized models of access to abortion are not only possible, but desirable. The pandemic caused a growing interest among researchers and policy makers in alternative models of abortion access, especially remote models that emulate self-care[1] practices [2–4]. There is the opportunity to bring knowledge about community use of abortion medicines, advanced by feminist groups and their practices and documented in public health research, to medical practice within established institutional systems [3–5]. For the purposes of this paper, we use Braine's distinction between institutional medical systems and autonomous health movements [6]. "Institutional medical system" refers to the medical care that happens under state and institutional control. Braine defines "autonomous health movements" as a form of direct action developed by activists anchored in social justice movements and working in community contexts.

We are at a crossroads in models of medication abortion care, forced by fear of COVID-19 infection but driven by implementing long overdue innovations based on science, common sense, and feminist praxis. Protocols and counseling scripts from providers such as Women Help Women have been adopted by abortion providers within institutional medical systems. The exchange of information about models of care between autonomous community-based groups and institutional medical systems has been fruitful but must go further. It is time to recognize the critical role of self-managed abortion in expanding access to abortion care by embracing a radical paradigm transformation. This transformation calls for the permanent removal of unnecessary restrictions imposed by institutionalized systems of law, medicine, and market which impede timely access to the essential medicines mifepristone and misoprostol, both in communities and within institutional medical systems.

Since the 1980s, pregnant people have been using abortion medicines outside of institutional medical systems, which have dramatically increased access to safe abortion. The medicines are safe, effective, and easy to use. We define self-managed abortion (SMA) as the self-sourcing of abortion medicines – either mifepristone and misoprostol, or misoprostol alone - followed by self-use of the medicines and self-management of the abortion process outside of a clinical context [7]. Self-managed abortion has been identified as the probable cause of decline in severe abortion-related morbidity and mortality in some global regions [8]. There is a growing body of evidence pointing to safety and satisfaction of self-managed abortion outside of institutional medical systems [3, 16, 17]. The practice is supported in the guidelines of the World

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[1] The World Health Organization defines self-care as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health- care provider." [2, p.2].

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Health Organization, and since 2005, abortion medicines have been on the WHO list of essential medicines [9].

The COVID-19 pandemic spotlights the unreasonable barriers created by the traditional framework of abortion access. This framework requires a clinical setting, a licensed medical practitioner and an in-person visit, and laws that specify which practitioners are qualified to provide abortion medicines and how, where, and for whom they can provide services. Strict regulations determine who can dispense mifepristone and misoprostol. These barriers create obstacles for people with unwanted pregnancies who seek care in institutional medical systems. Those seeking to self-manage their abortions may face barriers including laws that criminalize the practice, lack of reliable and affordable sources of medicines, and accurate information.

To remove the barriers to both systems of provision of abortion medicines, basic principles can expand access in each sector and increase the synergy between them. These principles, which stem from the inherent properties of the technology and radical normative change brought by the practice of self-managed abortion, call for demystification, demedicalization, destigmatization, and decriminalization of abortion practice.

1. Demystification of abortion medicines and self-managed abortion

Understanding how to use abortion medicines should be widespread. It is critical to widely disseminate the protocols for safe use of abortion medicines, in user-friendly language. This information should be available at clinics and pharmacies, within activist and medical organizations, and through multiple internet sources. The fact that abortion medicines can be used safely with or without clinician involvement must be promulgated. The information should be easily available, in as many formats and media fora as possible, and open-sourced to encourage copying and reproduction of reliable, science-based sources.

Medical control is sometimes misused to exert pressure and limit access to the medicines, as in cases where clinicians claim "conscientious objection" and refuse to provide care or involve law enforcement when self-managed abortion is suspected [10, 11]. Additionally current product package inserts for misoprostol and mifepristone identified in 20 countries contain inadequate storage instructions and outdated gestational age limits and regimens, making it difficult for people to most effectively self-manage their abortions [12]. To counter this oppressive reality, feminist organizations including Women Help Women and its partners and networks have been translating and popularizing protocols[2], thereby putting information and power into the hands of people who need it.

The pandemic has also shown that people are routinely trusted to practice self-care in other matters of health. People are expected to detect symptoms, adjust doses of medicines, understand when medical attention is needed, and generally self-manage their health around many conditions, including COVID-19 [13]. Self-managed abortion is not qualitatively different than self-care for many conditions, especially if reliable information and remote support are provided.

2. Demedicalization of medication abortion

Abortion medicines are extremely safe and must be made available and accessible to all, free from unnecessary regulatory barriers. They should be available over the counter, including for purchase in advance of need, with clear and simple to understand user instructions that accord with the most current protocols and science. All policies that prevent wide production and distribution should be removed, to expand access and lower the production costs. As with any form of family planning, abortion medicines should be made widely available before, during, and after they are needed, and be available through a range of sites, including but not limited to community health centers, campus health centers, and pharmacies. Ideally, they could be available along with tampons and aspirin in machines in bathrooms and convenience stores.

Within institutional medical systems, unnecessary and burdensome requirements, including ultrasound and Rh testing, should not be mandatory, as reflected in recent changes in some professional guidelines [14]. Current "no touch" protocols for abortion care can be expanded, and innovative telemedicine and telehealth models should be supported nationally and internationally, in both systems of abortion access [15]. Institutional medical systems can benefit from the decades of experience and knowledge about abortion medicines provision accumulated by feminist organizations. Already existing models like the one created by the Socorristas en Red in Argentina - where *acompañante*s have taught doctors about the use of misoprostol and refer women to friendly providers if back up is needed, and where clinicians refer pregnant people to the network [16]—show the importance of communication and collaboration between systems, giving pregnant people the array of options of access to care and methods that they need and deserve.

We must continue to create pathways that cross institutional medical systems and autonomous health movements, including services in medical systems that provide clinical back up services to those who self-manage their abortions and are concerned about an incomplete abortion, the success of their abortion, or who may have a complication. Self-management of abortion must never mean being unwelcomed in or deprived of contact with institutional medical systems. It is important to be as public and as explicit as possible about the benefits of those pathways, synergies, and relationships in order to legitimize a model supporting those who are self-managing their abortions with medicines with providers of their choice, including nonclinical community-based providers.

3. Destigmatization of self-managed abortion

There must be recognition and respect for the reality that self-managed abortion is a common practice and may be preferred by some as their chosen method of ending a pregnancy. Positive, high quality abortion experiences happen outside institutional medical systems around the world, and demonstrate the need for a broader definition of "quality care," and "safety" [17]. While states have the obligation to provide health care, including abortion care, self-managed abortion must be seen as a valid choice rather than compared unfavorably to an abortion obtained within institutional medical systems. Messaging about self-managed abortion must not use words like "dangerous" or "unsafe", which create stigma and fear in those who chose this abortion method. In fact, many "good" abortions, as defined by Gerdts and colleagues [17] as being safe, effective, and supported, have been happening for decades outside of the institutional systems of medical practice. While many clinicians work hard to provide quality comprehensive reproductive health care, there are also multiple accounts of stigma, harassment, and violence within institutional systems of medical practice, which can be rigid, conservative, and slow to change [18].

A narrow biomedical conceptualization of safety and quality contributes to the stigmatization of self-managed abortion, those who access it and for those who support it. The reality of high-quality abortion is more nuanced and calls for questioning simplistic proxies of safety such as clinical setting, trained medical

[2] Examples include user-friendly protocols for medication abortion in Swahili, Luganda, Chichewa, Igbo, French and English, at https://mamanetwork.org/resources/ and in Sign Language, Creole and Mapuzungun, at http://infoabortochile.org.

providers, or the statistical effectiveness of a given protocol [19]. Using principles of autonomous health movements such as autonomy, self-determination, knowledge of technologies, and control over the abortion process can contribute to building new conceptualizations of safety and quality that better reflect people's experiences and to a more nuanced understanding of those experiences.

4. Decriminalization of self-managed abortion

Under current laws in most countries, people who self-manage and those who provide information, support, and/or accompaniment risk police harassment and prosecution. Even when the threats do not yield convictions, the harms of criminalization result in further restriction of information or access to essential medicines and creating a chilling effect on these critical practices [20]. Laws and policies around the globe continue to unduly restrict abortion access, and particularly on self-managed abortion. By placing abortion medicines under unjustified regulatory restrictions or restricting legal abortion to those happening under medical supervision, laws and policies place pregnant people and those who support them under risk of criminalization or harassment.

No pregnant person should face any legal consequences for ending a pregnancy, choosing to self-manage their abortion, getting the medicines through informal markets, importing them or choosing a provider of their preference. People must be free to manage their abortion with the support of a medical professional, a trusted community member, a family member or friend, or by themselves. Self-managed abortion must be completely decriminalized; those using abortion medicines outside of institutional medical systems and those who support them and/or help them to access safe medicines should never face criminalization or harassment. Feminist organizations and skilled community providers of information and support, including those without a professional license or formal clinical training, should have explicit support from and work in collaboration and synergy with institutional health care providers. Competency and a supportive environment, not solely a government-issued license, should establish safety standards that are supported by policy and law.

5. Conclusion

The pandemic has highlighted the impact of unnecessary barriers to abortion care. This is a moment for radical transformation of how medication abortion is provided. It is time to de-medicalize abortion, inside and outside of institutional medical systems. It is also time for increased collaboration between institutional medical systems and autonomous health movements and recognition of the value of self-managed abortion as a system and a strategy for expanded access and empowerment of those who can control their own abortion choices.

Self-managed abortion is so much more than a provisional solution for the access crisis caused by the pandemic [21]. If we can build on efforts to demedicalize, demystify, destigmatize, and decriminalize abortion, the process of safely ending an unsupported pregnancy will be radically transformed and the full potential of abortion medicines to expand access to abortion will be realized.

Reference

[1] Burki T. The indirect impact of COVID-19 on women. Lancet Infect Dis 2020;20(8):904–5.
[2] World Health Organization. WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. Available at ⟨https://www.who.int/reproductivehealth/publications/self-care-interventions/en/⟩ [accessed 18 January 2021] p. 10.
[3] Moseson H, Bullard KA, Cisternas C, Grosso B, Vera V, Gerdts C. Effectiveness of self-managed medication abortion between 13 and 24 weeks gestation: A retrospective review of case records from accompaniment groups in Argentina, Chile, and Ecuador. Contraception 2020;102(2):91–8.
[4] Godfrey EM, Thayer EK, Fiastro AE, Aiken ARA, Gomperts R. Family medicine provision of online medication abortion in three US states during COVID-19. Contraception 2021 S0010-7824(21)00142-6Online ahead of print. doi:10.1016/j.contraception.2021.04.026.
[5] Meurice ME, Whitehouse KC, Blaylock R, Chang JJ, Lohr PA. Client satisfaction and experience of telemedicine and home use of mifepristone and misoprostol for abortion up to 10 weeks' gestation at British Pregnancy Advisory Service: A cross-sectional evaluation. Contraception 2021 S0010-7824(21)00143-8Online ahead of print. doi:10.1016/j.contraception.2021.04.027.
[6] Braine N. Autonomous health movements: criminalization, de-medicalization, and community-based direct action. Health Hum Rights 2020;22(2):85.
[7] Erdman JN, Jelinska K, Yanow S. Understandings of self-managed abortion as health inequity, harm reduction and social change. Reprod Health Matters 2018;26(54):13–19.
[8] Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. BJOG 2016;123(9):1489–98.
[9] World Health Organization Medical management of abortion. World Health Organization ISBN: 9789241550406; 2019 Jan 30.
[10] McCallum C, Menezes G, Reis AP. The dilemma of a practice: experiences of abortion in a public maternity hospital in the city of Salvador, Bahia. Historia, ciencias, saude–Manguinhos 2016;23(1):37.
[11] Harries J, Cooper D, Strebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. Reprod Health 2014;11(1):16.
[12] Frye LJ, Kilfedder C, Blum J, Winikoff B. A cross-sectional analysis of mifepristone, misoprostol, and combination mifepristone-misoprostol package inserts obtained in 20 countries. Contraception 2020.
[13] Silva DD, Bosco AA. An educational program for insulin self-adjustment associated with structured self-monitoring of blood glucose significantly improves glycemic control in patients with type 2 diabetes mellitus after 12 weeks: a randomized, controlled pilot study. Diabetol Metab Syndrome 2015;7(1):2.
[14] Mark A, Foster AM, Grossman D, Prager SW, Reeves M, Velásquez CV, et al. Foregoing Rh testing and anti-D immunoglobulin for women presenting for early abortion: a recommendation from the National Abortion Federation's Clinical Policies Committee. Contraception 2019;99(5):265–6.
[15] Raymond EG, Grossman D, Mark A, Upadhyay UD, Dean G, Creinin MD, et al. Commentary: No-test medication abortion: A sample protocol for increasing access during a pandemic and beyond. Contraception 2020;101(6):361–6.
[16] Socorristas en Red, Acceso a interrupciones legales de embarazos a partir de acompañamientos de Socorristas en Red en 2019 [Accessing legal termination of pregnancy from accompaniments with Socorristas en Red 2019]. https://socorristasenred.org/wp-content/uploads/2020/05/Acceso-a-Interrupciones-Legales-de-Embarazos-a-partir-de-acompañamientos-de-Socorristas-en-Red-en-2019.pdf; 2019 [accessed 10 August 2020]
[17] Gerdts C, Hudaya I. Quality of care in a safe-abortion hotline in Indonesia: beyond harm reduction. Am J Public Health 2016;106(11):2071–5.
[18] Uruguayan Ministry of Health. Report on Sexual and Reproductive Rights <reporthttp://ine.gub.uy/c/document_library/get_file?uuid=85e1bfd7-b3e5-4095-abf9-76be055fe3b5&groupId=10181>, 2019 [accessed 10 August 2020].
[19] Bhatia R. A reproductive justice perspective on the Purvi Patel case. Indian J Med Ethics 2016;1(4):249–53.
[20] Berro Pizzarossa L, Skuster P. Toward human rights and evidence-based legal frameworks for (self-managed) abortion: a review of the last decade of legal reform. Health Hum Rights J 2021;23/1:199–212.
[21] Assis MP, Larrea S. Why self-managed abortion is so much more than a provisional solution for times of pandemic. Sexual Reprod Health Matters 2020;28(1):1779633.