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Safe Abortion Advocacy Initiative
Global South Engagement

Self-Managed Abortions: SAIGE Technical Guidance Paper

Unsafe abortion is a major cause of global maternal mortality and morbidity. Every year, 25 million unsafe abortions occur, worldwide. The majority of unsafe abortions, at 97%, occur in developing countries such as Africa, Asia and Latin America.[1] Various challenges and barriers such as health system inefficiencies, shortage of health care providers, and restrictive abortion policies and laws, severely limit access to safe abortion services.

Every woman has the recognised human right to decide freely and responsibly without coercion and violence the number, spacing and timing of their children, the right to continue a pregnancy and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health (ICPD 1994),[1] hence, access to safe abortion is essential to the realisation of these rights. Worldwide, one in four pregnancies end in abortion.[1] According to the World Health Organization (WHO), "**[a]bortions are safe if they are done with a method recommended by WHO that is appropriate to the pregnancy duration and if the person providing or supporting the abortion is trained. Such abortions can be done using tablets (medical abortion) or a simple outpatient procedure.**"[1]

Self-managed abortions occur when a person chooses to perform their own abortion outside a medical setting.[1] Women choose to self-manage their abortions for various reasons and this needs to be protected, in line with the principle of bodily autonomy and trusting women's reproductive choices. Self-managed abortion is a broad term that includes all methods a person may use to terminate a pregnancy including medication and herbs. It should be noted that not all self-managed methods of abortion are safe. Therefore, there is the need to understand self-managed abortions within the context in which women are often forced to practise unsafe self-use.

This paper focuses on education and information sharing about medical abortion (MA) with pills which involves the use of a drug or a combination of drugs to terminate pregnancy (more information on MA pills and recommended regimen by WHO is appended at the end of this paper).

Medical abortion is a method that has helped overcome some of the constraints listed above by providing a non-invasive and accessible alternative to surgical methods of terminating pregnancies. Evidence has indeed shown that medical abortion is becoming more widely available, and women are increasingly choosing this method to terminate pregnancies.

Women's experiences with medical abortions are diverse and influenced by age, socio-economic status, location, physical health, and access. The lived realities of women from the Global South are different and diverse, and access still remains a huge challenge for women especially living in rural areas. In countries where abortion is restricted by law, the purchasing of pills through online sites may incur a huge economic cost and also put women's life in danger. Many women become victims of scammers, who sell fake abortion pills at high costs. The use of online drugs whether fake or not – if not accompanied with complete and accurate information and knowledge of correct dosage, recognition of signs of complications and availability of post abortion care – can cause serious health effects, including severe vaginal bleeding, bacterial infection or birth defects in cases of incomplete abortion.

While much of the available research show that self-managed abortion is safe, effective and acceptable across diverse settings, there are some studies that show rampant and unregulated self-use of medical abortion drugs without any medical oversight leads women to report incomplete termination of pregnancy and other complications. **Abortion with pills is a safe option of ending an unwanted pregnancy when women using them have accurate information and access to reliable sources.**

Thus, as advocates, there is the need to be critical of the 'magic bullet' the MA pills are being marketed as and demand for increased accountability and strengthening of public health systems providing comprehensive abortion care. Most developing countries lack the basic health infrastructure required for women to obtain information about contraception and other reproductive health services. In many developing countries, for example, Nepal where there is low educational

status and many illiterate women with poor health-seeking behavior, self-management may not be an option for poor women but very leveraging and empowering for the well-educated and informed women. Hence, how self-managed abortion can be addressed for those women should be looked into, the approach used should fully account for the lived experiences of women who undergo abortions and improve both formal and informal health interventions.

Key definitions and concepts related to this topic – Self-care, self-use of, self-managed

Self-Managed Abortion (SMA) – self-managed abortion occurs when a person chooses to perform their own abortion outside a medical setting.[1] The many reasons for opting for self-managed abortion could be because of unavailability of abortion care at health facilities, inaccessibility, stigma, or the individual does not desire it.

In this position paper, self-use of MA, self-administered or self-managed abortion (SMA) refers to the act of taking a medicine that induces abortion (i.e. mifepristone, misoprostol, or both) outside a medical setting.

Medical Abortion - Medical abortion (MA) is a procedure that uses medication to end a pregnancy. It does not require surgery or anaesthesia and its use can start in a medical facility or at home with follow-up visits to a doctor.[1] MA is a safe and effective procedure and can "revolutioni[s]e the way people access and experience abortion, moving it away from a medicali[s]ed procedure to a self-managed experience at home."[1] MA is especially useful for women in contexts where access to safe abortion services is limited, and morbidity and mortality associated with unsafe abortion procedures is high.

While protocols and regimens for MA are not uniform across countries, most require three visits: 1) to assess gestation age and eligibility; 2) to administer misoprostol 24-48 hours later; and 3) to confirm abortion completion, 1-2 weeks after the procedure. The WHO, however, does not require follow-ups after MA, **as long as the individual getting MA is informed about the protocols and knows when to seek care should any complications arise**.[1] As such, self-use of MA helps eliminate possible inconveniences associated with multiple visits to health facilities.

In home-based medical abortion, a health-care provider administers mifepristone at the clinic and the pregnant woman later takes misoprostol at home. This protocol is intended to simplify the medical abortion regimen. Several studies show that self-administration of pills in early pregnancy is safe when supported with complete and accurate information, and suitable safeguards are in place.

Bodily Autonomy and Reproductive Justice – Self-administration of MA drugs is empowering because the process allows women getting an abortion to have a role in managing their own health, especially when it comes to having control over their pregnancy.

"Supporting the use of pills on one's own and putting the tools for safe abortion directly in the hands of those who want and need them is an empowerment strategy. This is a challenge to the prevailing narrative that stigmatizes abortion and frames it as safe only when supervised by a trained medical professional. By claiming this knowledge for ourselves, self-managed abortion is an expression of the fundamental feminist principle and basic human right to bodily autonomy, and to our right to control our own health care: core tenets of reproductive justice."[1]

Reproductive Justice - A caucus of black feminists at a pro-choice conference in 1994 coined the term, 'reproductive justice' and "[t]his framework repositioned reproductive rights in a political context of intersecting race, gender, and class oppressions."[1] The reproductive justice framework is a reminder that abortions do not exist in isolation, and that there is a larger social, political, cultural, and economic context to it. A woman's ability to control her reproduction is fundamental to her ability to control her life, thus, reproductive autonomy is a core aspect of reproductive justice.[1]

Privacy and Choice - When grounded in informed and voluntary decision-making, self-administered MA drugs are an option that allows increased control, privacy and confidentiality. In other words, individuals wishing for an abortion can get one at their own convenience, time, and comfort. Evidence suggests that when given a choice between getting an abortion at a health facility and home administration of medical abortion, women opt for the latter.[1]

Acceptability - Studies from both developed and developing countries show that self-use of MA is a viable option. There is no significant difference in abortion outcomes between self-use of MA and MA performed at a health facility.[1]

A systematic review of several studies in India[1] concludes that even in low-resource settings with challenging health systems, there was no statistical difference in the outcome of abortion status between those that administered MA at home versus in a health facility. However, this does not undermine the need for a robust public health system to ensure that women have access to accurate information as well as post abortion care in case of complications, which are rare.

Issues Around Legality - Self-managed abortion is most helpful in settings where access to safe abortion services is highly restrictive as it provides a better alternative to morbidity and mortality associated with illegal and clandestine abortions via unsafe and harmful means.

Abortion pills create a universal opportunity for safe abortion regardless of laws. Medical abortion can be used in the privacy of one's home in, at least, the first 10 weeks of pregnancy and the risk of complication is low. As long as the woman is well advised about what to say if she needs medical care and is in the first trimester, a period when the pregnancy can be easily terminated and the use of pills is undetectable. The loss of pregnancy with medical abortion pills is clinically nearly indistinguishable from a spontaneous miscarriage, which occurs in 15% to20% of all pregnancies.[1]

Self-Managed Abortions and Decriminalisation - Studies have shown a greater need for decriminalisation of abortion with increasing use of SMA via medical abortion pills:

An analysis of 196 countries' laws using the World Health Organization's (WHO) Global Abortion Policies Database (which omits U.S. laws), reveals that all but Canada and China criminalize abortion outside of the health-care system. Through criminal law, lawmakers impose penalties of imprisonment upon all who provide abortion without the education, training, certificate, or license required by statute. Those who procure abortions on their own and the individuals that help could face criminal penalties in nearly every country in the world.[1]

Most of the world's abortion laws are decades old, and in developing countries, most laws were inherited from their colonial rulers. These laws do not reflect the advent of the medical abortion pill and therefore self-induced abortions and/or abortions provided by a non-medical provider are punishable by law

Politics of Self-Managed Abortion - Self-managed abortion has long been politicised and stigmatised due to biases and assumptions associated with phrases such as "back-alley", "coat-hanger", and "clandestine". As such, self-managed abortions can be regarded as unsafe or even illegal. Indeed, legal and safe abortion is often associated with abortion service provided in a health facility, and therefore, abortions outside of formal medical settings often arouse concern from many people. SMA challenges this definition of unsafe abortion.

According to Susan Yanow, and Kinga Jelinska[1] from the organisation, Women Help Women, self-managed abortion has transformed understanding and discourses surrounding safe abortion associated with health inequities through an intersection of harm reduction, human rights and collective activism. "SMA has already shifted the WHO concept of safe abortion, now defined by a continuum of risk rather than a binary measure, accounting for the social and legal context in which an abortion takes place. SMA has similarly influenced concepts of task shifting and sharing in abortion care, with the WHO recommending self-management for some tasks with appropriate information and support."[1]

Many people are able to administer self-use of medical abortion safely and with minimal medical risks and complications. The biggest risk for self-administered medical abortion is that individuals who induce their own abortion may not seek medical assistance in the event that a complication does occur, due to fears that they may be reported to the authorities.

Studies have also shown general acceptability towards self-use of medical abortion. Allowing women to manage their own abortion has the potential of expanding access to required health care.

"*The practice of abortion sits at the intersection of health care, public health, human rights, reproductive justice and bodily autonomy. The use of medical abortion pills (misoprostol alone or misoprostol in combination with mifepristone), offers a safe and effective method for ending an unwanted pregnancy. Medical abortion has the potential to both reduce maternal mortality and morbidity from unsafe abortion and to expand the reproductive rights of women. However, the promise of these medicines to improve health and enhance rights can only be realized if information and reliable medicines are available to all women, regardless of their location or the restrictions of their legal system.*"[1]

Advocates must analyze MA along the spectrum of care, with a focus on de-stigmatisation and gathering evidence on prevalence and practices. We must be clear that self-managed does not mean "alone" nor a devolution of a state's obligation to ensure a right to health. MA occurs at the intersection of rights and access to health care, and poses important questions regarding autonomy, task shifting, and synergies between community-led care strategies and formal health systems.

What is our position on this issue –

While self-management of medical abortion has revolutionised women's access and holds potential for promoting women's control over their bodies, the stigma and socio-economic barriers continue to exist and challenge access for women living in restrictive settings. We believe that access to medical abortion pills and information promotes women's autonomy. SMA is a political issue; laws regulating access to abortion services and medical abortion are reflective of the government's politics to control women's bodies. Worldwide, huge gap exists between having legal right to abortion and being able to access abortion services. Thus, advocacy for self-managed abortions needs to be grounded in principles of reproductive justice that takes into account its interconnectedness with other social justice issues and highlights the intersection of human rights, public health, empowerment and access.

- Evidence suggests that self-use is a viable and feasible option. Self-use offers greater privacy and autonomy than in-facility abortion and gives people greater control over the timing of abortion.
- Our approach to SMA is grounded in a political commitment to the right to abortion and self-determination. MA is needed to ensure women's bodily rights and autonomy (as long as proper education and awareness about its usage is ensured). Offering women choices as to how they can access reproductive health services, such as those which involve self-management of their own care, has the potential to increase their autonomy in reproductive decision-making and increase access to services.
- Given that women face a number of challenges to access abortion services, allowing self-use of MA is essential to reducing barriers to care. However, public sector accountability is necessary where there are complications or there is need pertaining to any form of health care. The public sector also has an obligation to ensure body literacy for women and girls and provide accurate information.
- MA drugs need to be provided through public

facilities, ensuring proper regulation, to encourage improved access to abortion services.

- There needs to be informed decision-making by the persons getting an abortion on correct dosage, recognition of signs of complications, and post abortion care.
- Self-use of medical abortion has to be examined from a rights and reproductive justice perspective, and in the context of bodily autonomy.
- Spreading public awareness, knowledge, and information about self-use is needed, in conjunction with regulation of these drugs in pharmacies. Training of pharmacy workers in the safe use of medical abortion medications has proven useful and effective in enhancing their knowledge and the information they give women.[1] Training for pharmacy workers, such as correct regimens and effective routes of misoprostol administration and women's self-assessment on abortion completeness, should improve. Government should register the pharmacies with those trained human resource as a listed safe abortion service.
- Studies have shown that safe abortion hotlines can play an important role in reducing unsafe abortion and providing information to women even in restricted settings.[1] Community-based telemedicine services and hotlines should be strengthened to make reliable information accessible to women. Accurate information on MA regimens and supportive provider's referral network, in case of emergency, save women's lives.
- Availability of medical abortion pills along with complete and accurate information can reduce the burden on women, who may have a number of socio-economic barriers and constraints to accessing facility-based abortions, such as transportation and medical costs. However, there are concerns of safety when a self-managed abortion occurs in resource-restricted environments or where there are no referral networks or connections with a medical community. Likewise, access to drugs is often not coupled with access to accurate and comprehensive information.
- The work in relation to self-use requires fostering stronger relationships between medical abortion, harm reduction networks, and formal health professionals in order to improve access and quality of care, and reduce stigma.
- Access to medical abortion should be rights-based; ensuring women have access to adequate services in an informed manner without stigma and discrimination. Self-use of medical abortion is an option that individuals should be able to choose for themselves.
- Self-use of MA allows for privacy and confidentiality, which are important factors considering the stigma attached to abortion and the provider's biases in providing the services. In addition, self-use of MA is non-invasive. These reasons have resulted in high levels of satisfaction with self-use of MA, and overall preference over surgical abortion. Moreover, 94-98% of women reported that they would use MA at home again in the future, if required.[1]

4. **Technical information:**

Table 1: WHO Approved Regimen for self-administration of Medical Abortion Pills

Pregnancy Duration	Dosages
Up to 9 weeks (63 days)	2.5 Misoprostol 800 μg Vaginal, buccal or sublingual Single dose OR If no more than 7 weeks (49 days) Misoprostol 400 μg Oral Single dose Use 24–48 hours after taking mifepristone
9–12 weeks (63–84 days)	Misoprostol 800 μg, then 400 μg Vaginal, then vaginal or sublingual Every 3 hours up to 5 doses Start 36–48 hours after taking mifepristone
MISOPROSTOL ALONE	Misoprostol 800 μg Vaginal or sublingual Every 3-12 hours up to 3 doses

Source: World Health Organization, *Clinical Practice Handbook for Safe Abortion*.[1]

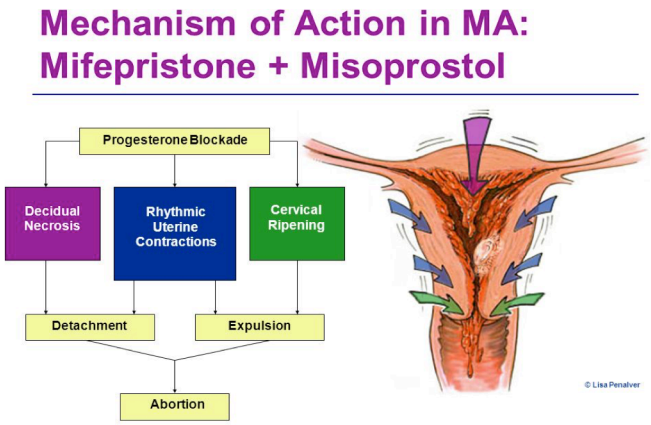
How it works:

Medical abortion causes a process like a miscarriage. The World Health Organization (WHO) recommends the combined use of the medicines, mifepristone and misoprostol[1]because the combination has higher effectiveness and fewer side effects. When mifepristone is not available or accessible, then the next best method is to use misoprostol alone.

- Mifepristone and misoprostol – mifepristone blocks receptors for progesterone, a hormone necessary to maintain a pregnancy. It also makes the uterus more receptive to misoprostol. Misoprostol causes contractions of the uterus, which result in the expulsion of the pregnancy tissue, clots and blood.[1] This combination is 98% effective.
- Misoprostol alone - misoprostol causes the cervix to soften and the uterus to contract, resulting in the expulsion of the pregnancy, passing clots and blood. When misoprostol is used alone, it is less effective

(84%)[1] than when used in combination with mifepristone and more misoprostol is needed. Nevertheless, this is a very safe method for women if they don't have access to mifepristone.[1]

Source: https://consult.womenhelp.org/en/page/371/how-does-medical-abortion-work



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ABOUT THE PUBLICATION

This paper focuses on education and information sharing about medical abortion with pills which involves use of a drug or combination of drugs to terminate pregnancy.

ABOUT SAIGE

The Safe Abortion Advocacy Initiative- A Global South Engagement (SAIGE) is a platform for Global South advocates, activists, academics and services providers committed towards realizing safe abortion as a human right.