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# Understandings of self-managed abortion as health inequity, harm reduction and social change

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**Abstract:** *This commentary explores how self-managed abortion (SMA) has transformed understandings of and discourses on safe abortion and associated health inequities through an intersection of harm reduction, human rights and collective activism. The article examines three primary understandings of the relationship between SMA and safe abortion: first SMA as health inequity, second SMA as harm reduction, and third SMA as social change, including health system innovation and reform. A more dynamic understanding of the relationship between SMA, safe abortion and health inequities can both improve the design of interventions in the field, and more radically reset reform goals for health systems and other state institutions towards the full realisation of sexual and reproductive health and human rights. DOI: 10.1080/09688080.2018.1511769*

**Keywords:** Self-managed abortion, medical abortion, health inequities, harm reduction, social change, human rights

## Introduction

Unsafe abortion is widely understood to be a striking case of health inequity.<sup>1</sup> It is a leading and entirely preventable cause of death and disability. There is no reason why anyone should suffer or die in seeking to end an unwanted pregnancy given that abortion is one of the safest medical procedures when conditions allow for it.

Social distributions in unsafe abortion are a key marker of its injustice. Global data on abortion incidence and trends document the unequal distribution of unsafe abortion across countries.<sup>2</sup> A similar pattern of social distribution, however, emerges within countries. This is true in national settings with more and less restrictive abortion laws. Barriers to safe abortion within countries remain after legal liberalisation, where social resources determine access to services within formal systems. In restrictive settings, social resources may allow people to travel across borders to access legal services, or to access safe services within the country through private clinics outside the bounds of the law. Social inequities in abortion care within

countries are therefore largely defined by *where* people access care: inside or outside formal systems. The World Health Organization (WHO) formerly defined “unsafe abortion” by the persons and places of care: “individuals lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both”.<sup>3</sup> Abortion outside the bounds of law was always deemed unsafe, captured by the simple maxim: restrictive laws do not prevent access to abortion, only safe abortion.

Self-managed abortion (SMA) challenges this concept of unsafe abortion and social inequities in access to care premised upon it. While SMA is used in the literature to refer to a range of practices, this commentary reserves the term to the self-sourcing of abortion medicines (mifepristone and misoprostol, or misoprostol alone) followed by self-use of the medicines including self-management of the abortion process outside of a clinical context.<sup>4</sup> SMA has increased substantially in the past decade and has been implicated as a cause of decline in severe abortion-related morbidity and mortality.<sup>5</sup>

This commentary explores how SMA has transformed understandings of and discourses on safe abortion and associated health inequities through an intersection of harm reduction, human rights and collective activism. The article examines three primary understandings of the relationship between SMA and safe abortion: first, SMA as health inequity, second SMA as harm reduction, and third SMA as social change, including health system innovation and reform. A more dynamic understanding of the relationship between SMA, safe abortion and health inequities can both improve the design of interventions in the field, and more radically reset reform goals for health systems and other state institutions towards the full realisation of sexual and reproductive health and human rights.

### *Self-Managed abortion as health inequity*

The self-use of abortifacient medicines was traditionally seen and treated as an act of desperation, something people were forced to seek and endure as a consequence of restrictive legal regimes, and the dysfunctions of more liberal regimes. Suspicion and caution of SMA comes from its association with these institutional constraints and thus as a potential signifier of denied rights and inequity. Within this historical framework, SMA is a last and dangerous resort of the marginalised and vulnerable.

Recent case studies on SMA, however, seek to redefine the causes of inequities and to avoid labelling any inherent victim class by a simple association of social markers (i.e. race, age, class) with unsafe abortion practice. These studies focus rather on the legal and policy structures that *marginalize* people, *create* vulnerability and *impose* disadvantage in accessing safe abortion care, emphasising the construction of abortion inequities.<sup>6</sup> The compulsory presentation of a state-issued identification, for example, made it impossible for a recently migrated mother of three, living in a one-room rented house in Chandigarh, India, to access care from a government facility.<sup>7</sup> In the nation-state of Georgia, where there is no public funding for abortion care, which costs on average USD 80 against a basic monthly income of USD 70, a case study concludes that “[t]he underlying cause of this woman’s death was not simply sepsis or haemorrhage ... but existing gaps in health care policies”.<sup>8</sup> These studies highlight that it is not lack of wealth or knowledge that force people outside the

system, but law and state policies which make the social resources of status and wealth necessary to access care within it.

By focusing on access barriers within formal systems, these studies nonetheless retain the clinical setting as both the standard and desired place of care. Safe abortion interventions are designed to bring people into these systems, often by reform of institutional constraints. While a worthy goal, this view ignores the too common mistreatment and abuse of abortion seekers within formal health care systems, where providers may believe they have a moral if not legal right to accuse, judge and condemn. SMA can be a source of reprieve or escape from these indignities of formal settings and experiences of shame and powerlessness within them.<sup>9</sup> For those seeking services, the safety of abortion often involves more than concerns of where it is procured and the qualification of its provider. In a Kenyan study, for example, women described abortion safety in terms of physical health, but also social and economic security.<sup>10</sup> They engaged in SMA not in ignorance or desperation, but as a rational decision, informed by concerns of privacy, convenience, comfort and indeed the need to negotiate and survive the real and material contexts of their lives.

Unfortunately, there is very little empirical research on peoples’ preferences, needs and experiences with SMA, particularly where high-quality clinic-based services are accessible.<sup>11</sup> Where SMA is pragmatically accepted as a practice that people do and will engage in, the focus shifts to the information deficits, unregulated markets and restrictive laws that make SMA unsafe. The goal becomes how to reduce inequities in the risks and harms of SMA, in other words, a project of harm reduction.

### *Self-Managed abortion as harm reduction*

Harm reduction refers to programmes and practices that seek to reduce the risks and harms associated with an activity without prohibiting the activity itself. Its basic goal is to meet people where they are, and to strengthen whatever capacities they have to manage their abortions safely and effectively. Safe abortion interventions, in this framing of SMA, focus on increasing access to accurate information and to quality medicines.

Misoprostol, the most widely used medicine in SMA, is available in pharmacies and drug shops in many low- and middle-income countries, yet

individuals working in these settings often have poor knowledge of effective regimens, and give few instructions on proper use.<sup>12</sup> Rather than target these sellers, harm reduction interventions in SMA have sought to provide safer-use information to users themselves.

Several information programmes are run by health professionals through clinical settings, and modelled on a Uruguayan program, *Iniciativas Sanitarias*, adopted before decriminalisation, whereby public hospital physicians provided information and care before and after SMA as a harm reduction measure.<sup>13</sup> Similar programmes undertaken in Tanzania, and contemplated in the U.S., are justified by a professional imperative to care for women, interpreted as a narrow exemption to any criminal prohibition.<sup>14,15</sup> These programmes are measured and assessed by public health impact, including the redress of social inequities in unsafe abortion by reducing resort to more dangerous methods and related death and injury. They are contemplated strictly as an interim measure until legal care can be provided in the formal system on the presumption that care under a medical provider is superior to SMA.

Professionalised information programmes can be contrasted with safe abortion telephone and email hotlines, set up by feminist groups in twenty countries and globally over the last decade.<sup>16</sup> Using web- and mobile-based interactive technologies, these hotlines are widely publicised and designed to raise public awareness about and to reach a geographically broad and socially diverse public with confidential, reliable and accurate information on the safe and effective self-use of abortion medicines.<sup>17,18</sup> Abortion accompaniment networks also provide instruction and guidance through face-to-face communication and support, with volunteers accompanying people to buy medicines, use medicines and be with them throughout the abortion process depending on their needs and preferences.<sup>19,20</sup> Self-management allows health professionals to distance themselves legally from SMA in restricted contexts. Feminist groups, by contrast, use hotlines and accompaniment networks to connect to people in the moment of their greatest need, providing step-by-step instruction on effective regimens, counselling on how to manage the experience of medical abortion, and clear guidelines for aftercare in an effort to build confidence, preparedness and a sense of control.

Most significantly, safe abortion hotlines provide information on how to self-manage an

abortion outside health systems, where the greatest risk comes not from unsafe use, but from unjust laws. Abortion should not cost a person their life, by death or imprisonment. Routinely provided information, for example, includes the fact that misoprostol abortions cannot be distinguished from natural miscarriages, which can allow women to seek care if necessary in formal systems with lesser risk of disclosure and arrest.<sup>17</sup> The value of such information reveals again that the concept of “safe abortion” carries multiple connotations beyond public health, especially for people under social surveillance, exposed to violence, or at risk of social deprivation. For them, interventions that can minimise legal and social risk, including by security measures of encrypted or anonymous communication, may offer the greatest protection from harm.

These harm reduction interventions are ultimately designed to join rather than separate providers and users in a common purpose, to meet the needs of people and make abortion safe for them. Therefore unlike professional harm reduction programmes, most safe abortion hotlines tend not to maintain any legal distance from the procuring of medicines, but rather also provide information on where and how to self-source medicines through online platforms and local sellers.<sup>21</sup> After all, information interventions only work if quality medicines can be sourced reliably. Several countries, however, impose restrictions on the pharmacy distribution of misoprostol; a measure intended to curb its use in SMA but in effect creating distortions and inequities within markets, which become exploitive and dangerous for people to navigate without resources. Thus beyond the mere provision of information, some feminist groups also bring medicines into local communities, establishing make-shift pharmacies that not only create community-level access but compete with and drive down prices among other private sellers.<sup>22</sup> Through internet-based telemedicine services, other groups combine information with service delivery by postal or courier services (Women Help Women, TelAbortion, Tabbot Foundation, Women on Web).<sup>21</sup>

These harm reduction interventions do not simply respond to structures of inequity that render SMA risky or unsafe. They seek to actively disrupt these structures and to minimise if not eradicate the social inequities sustained by them. These interventions are grounded in the basic human rights to seek, receive and disseminate

information and ideas on sexual and reproductive health, and to enjoy the benefits of scientific progress, specifically in access to misoprostol and mifepristone as essential medicines. These are claims not merely of freedom from state restraint, but collective rights for all, including disadvantaged and marginalised groups, to a full range of sexual and reproductive health care, including technological advances and innovations in the provision of sexual and reproductive health services, such as medication for abortion.<sup>23</sup>

By making visible these structural dimensions, harm reduction in safe SMA thus supports legal reform including decriminalisation. In the historic campaign to repeal the 8th amendment of the *Irish Constitution*, for example, criminalised self-use in secrecy, silence and fear became an indictment of the harsh, cruel reality of the abortion law and spurred support for rational reform.<sup>24</sup> SMA will always carry inequitable risks and harms unless and until it can be practiced legally. Some countries have explicit bans on SMA, prohibiting as a crime the supply or use of any “poison or other noxious thing” with the intent to procure an abortion. In other countries, such as the United States, legal risk comes from the many regulatory laws that can be used with discretion to intimidate, harass, and criminalise socially marginalised people for their reproductive choices and actions.<sup>25</sup>

### ***Self-Managed abortion as social change***

Collective activism on SMA is therefore fundamentally a legal and political project for social change, challenging the way in which restrictions on abortion practice, including in the name of safety, can constitute violations of human rights. There is a reason feminist groups have developed their SMA practices apart from any health or state institution. They seek to construct independent spaces, set apart from the associations of self-management with extra-legality and health-related risk and harm that have marked and disciplined the concept of safe abortion.

Feminist groups that collectively organise around SMA share a political belief that every person who comes to them has the capacity and right to a safe and dignified abortion informed by the values and needs most important to them. They refuse to label and to thereby judge the act of abortion by any terms other than how an individual experiences it. SMA, within this understanding,

is marked by a diversity of human experience. This is a profound difference from the experience of abortion care within many formal systems, where not only the legality of abortion, but also the terms and conditions of access, are demarcated by state or institutional policy. Classification schemes that divide people are a root cause of inequity in abortion care. The heterogeneity of SMA diminishes the stigmatic power of these schemes and more importantly seeks to build a new normative context for and set of social relations around abortion and self-management.

When SMA is seen as a purposeful act, rather than a desperate act or less desirable option, people are treated with trust and respect. The risks of SMA are not ignored or neglected but become normalised and even predictable features of abortion that people can manage, and more importantly, manage differently. There are no *a priori* assumptions about the capacities of any person based on social markers or identities. Rather, with people well informed, adequately resourced, and embedded within a supportive community, abortion is treated as a life event, perhaps even a legitimating and affirming one. Indeed such alternative affirmative scripts have long been part of the struggles of women to create a shared normative opposition to official public views of abortion as an immoral and criminal act.<sup>26</sup>

The drive to create an alternative public discourse around abortion also explains the importance of the many public awareness raising and information sharing activities around SMA: interviews on local radio and TV shows, street theatre, graffiti art (with stamped hotline numbers on local currency), and even the writing of safe-use information into reusable sanitary towels distributed in rural Kenyan communities with medicines carried along transport routes by matatu drivers for same day delivery.<sup>27</sup> Beyond efforts to spread the word far and wide, these public activities and the social imagery of abortion they manifest mark a wrangling of power away from medical and state-based authority that has suppressed ways of thinking about abortion. These acts of making abortion known, weaving it into the fabric of community life, are democratic efforts to break open expert monopolies of knowledge and power to larger public communities. For example, the safe abortion hotlines provide information based on official WHO protocols,<sup>28</sup> but also release this information into the public domain in the trust and belief that people will and can use it in simple and illustrated

forms shared through Facebook pages, YouTube animations, and above all, word of mouth by those with first-hand experience. Indeed, within political harm reduction movements there is a concept of “users running ahead of experts”, that when information is shared and users are empowered, people become producers of knowledge that can augment, run ahead of, and even challenge the expert view. This is especially relevant for the history of misoprostol as an abortifacient, whereby patterns of use spread across Latin America through word of mouth. In online forums run by safe abortion hotlines, end users can rate the information and medicines provided to them and discuss their experiences, similarly generating this ground-up experiential knowledge.

These acts of public sharing not only flatten hierarchies of knowledge, but also subvert power dynamics of care. *Socorristas en Red* in Argentina, and *Las Fuertes* in Guanajuato, Mexico, for example, use the term “accompaniment” rather than “provision” to emphasise the supporting rather than supervisory role of service provision in SMA rooted in the belief that people have a fundamental right to make decisions about their own bodies and to act on those decisions.<sup>19,20</sup> SMA is subversive precisely because it challenges assumptions about service delivery requirements, definitions of who/what is a provider of care and the power dynamics of care. For some, these care arrangements support the individualism of late-modern democracies that reinforce unsafe abortion as an individual responsibility and burden, alleviating the state of responsibility for its harms, and so exacerbating rather than remedying social inequities. Yet feminist collectives supporting SMA have not abandoned

abortion care within formal systems. On the contrary, there is a shared assumption about SMA as a mediating influence on formal systems in light of how SMA is practiced in real-world contexts. 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.<sup>29</sup> 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.<sup>30</sup>

### Conclusion

Feminist activists have used SMA as a political resource to hold states accountable for the design of inclusive health systems and other social institutions in the public interest: a referendum on and call for reform in formal systems of care and the laws that govern them. The response to SMA depends on how health inequities and safe abortion are understood, which demands most importantly attention to the real and material experiences of people who self-manage abortion and the legal and social systems in which they act. While SMA has helped for decades to remedy immediate inequities of access and to meet the existing needs of people in difficult and unjust circumstances, it is the public and participatory politics of SMA that promises to advance social change towards sexual and reproductive health and human rights.

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## Résumé

Ce commentaire analyse comment l'avortement auto-administré a transformé la manière dont l'avortement sécurisé et les inégalités de santé qui y sont associées sont compris et figurent dans les discours, et cela à travers la combinaison de mesures de réduction des risques, des droits humains et de l'activisme collectif. L'article examine trois conceptions majeures de la relation entre avortement auto-administré et avortement

## Resumen

Este comentario explora cómo el aborto autoadministrado (SMA, por sus siglas en inglés) ha transformado la comprensión y el discurso sobre el aborto seguro y las inequidades en salud asociadas, por medio de la intersección de reducción de daños, derechos humanos y activismo colectivo. El artículo examina tres principales maneras de entender la relación entre SMA y aborto seguro: primero SMA como inequidad en salud, segundo



sécurisé: premièrement l'avortement auto-administré comme inégalité de santé, deuxièmement l'avortement auto-administré comme réduction des risques et troisièmement l'avortement auto-administré comme changement social, y compris l'innovation et la réforme des systèmes de santé. Une compréhension plus dynamique de la relation entre l'avortement auto-administré, l'avortement sécurisé et les inégalités de santé peut améliorer la conception des interventions sur le terrain et aussi redéfinir plus radicalement les objectifs de la réforme pour les systèmes de santé et d'autres institutions de santé, en vue de réaliser pleinement les droits à la santé sexuelle et reproductive et les droits humains.

SMA como reducción de daños y tercero SMA como cambio social, que incluye la innovación y reforma del sistema de salud. Una comprensión más dinámica de la relación entre SMA, aborto seguro e inequidades en salud puede mejorar el diseño de intervenciones en el campo, y restablecer de manera más radical los objetivos de reforma para sistemas de salud y otras instituciones estatales hacia el pleno ejercicio del derecho a la salud sexual y reproductiva y los derechos humanos.