COMMENTARY

Why self-managed abortion is so much more than a provisional solution for times of pandemic

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Keywords: abortion access, COVID-19, self-managed abortion

The COVID-19 pandemic is striking health care systems around the world through an unprecedented increase in demand. In responding to this crisis, governments and health care providers face the challenging question of how to continue providing essential health services, while taming the new disease. In these times, access to abortion is more contested than ever.

Conservative governments have seized upon the pandemic as an opportunity to declare abortion an elective procedure and shut down services. In the USA, where abortion rights have again become a heated topic, several states have imposed restrictions on access that amount to effectively banning abortion care.[1] In Latin America and the Caribbean, a region with the most restrictive abortion laws in the world, activists have exposed added difficulties faced by those who qualify for abortion on the few grounds where it is legal.[2] In Poland, a country with some of the strictest abortion laws in Europe, a controversial tightening legislative proposal has been pushed through during the lockdown.[3]

In an alternative approach, a few countries have acknowledged that abortion is an essential health service and shifted to telemedicine to secure access during the crisis. After much discussion and public confusion over prematurely leaked regulations, the United Kingdom adopted guidelines that allow women and pregnant people to manage their own abortions. According to the new regulation,[1] the person in need of abortion care can have a telemedicine consultation with a registered medical practitioner, receive the pills (mifepristone and misoprostol) by mail, and use them at home.

While advocates in the field of reproductive health and rights have celebrated the UK's decision and are encouraging governments across the world to follow suit, the new regulation is temporary. Adopted in light of the mandatory lockdown, access to abortion through telemedicine will last for two years or until the end of the pandemic, whichever is earlier.[4] The assumption underlying the regulation and, indeed, the field of public health in general, is that once the coronavirus crisis is over, people should go back to having abortions "as usual", i.e. in formal health facilities. Even in these extraordinary times, medical control of abortion remains the prevailing principle.

The history of abortion medicalisation is a relatively recent one. For centuries, abortion was routinely used to regulate fertility, along with "calendar-based" contraception and other methods then available. Even after the ban of abortion, the practice remained common within women's circles, and midwives were a central figure in family planning services. Only in the nineteenth century was law invoked to regulate abortion provision. Physicians were among the loudest voices calling for such regulation, which eventually extended medical jurisdiction to a life event that, for centuries, had been under people's control and happened within their intimate circles of care.[5]

The relaxation of abortion regulation that is only a temporary response to a health crisis ignores this past history. It also assumes that the more recent experiences of self-managed abortion – that is, the use of abortion pills outside formal health facilities without medical supervision[6] – is abnormal and less desirable. Such an approach overlooks much of

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what we already know about the relationship between self-management, increase in abortion access, and safety and quality of methods.

Extensive research today shows that self-administration of pills for early abortion with limited involvement of health professionals is effective and has similar outcomes to medical abortion administered by professionals in health facilities.[7] Moreover, the use of abortion pills outside of formal systems is credited with the decrease of abortion complications and maternal mortality worldwide, but particularly in low- and middle-income countries.[8] For a vast number of women and pregnant people across the world, self-managed abortion is not a provisional solution; it is indeed the best option.

For decades now, feminist organisations around the world have supported pregnant people in self-managing their abortions, especially in places where abortion is restricted by laws and regulations, stigma, or lack of resources. Building on the knowledge first developed and disseminated by Brazilian women in the 1980s, feminist initiatives for self-managed abortion have created diverse frameworks of knowledge and resources that operate both locally and within a transnational network. People access abortion pills online or in local pharmacies and activists provide them with evidence-based information on how to effectively and safely use the pills, as well as assistance throughout the process.

The ways that activists provide support vary, but they all share an underlying commitment to feminist ethics. *Socorristas en Red* is a nation-wide Argentinian network that provides access and information through telephone and in-person accompaniment and group meetings.[9] In Africa, *MAMA*, a network of grassroots activists and feminist groups, works towards expanding knowledge and eliminating stigma around self-managed abortion at the community level. *Samsara*, in Indonesia,[10] similarly to activists in many countries in Latin America and the Caribbean,[11] operates a safe abortion hotline that offers information about self-managed abortion with pills in countries where abortion is criminalised. *Women Help Women* and *Women on Web* both run telehealth services that deliver access to pills, as well as information and accompaniment over email to people all over the world.[12] By doing this essential work, feminist activists fulfil a need that is often neglected or denied by many states in “normal” times, and even more so in times of a pandemic.

Feminist activists have demonstrated that self-managed abortion support initiatives are indeed so much more than a provisional solution. People report preferring self-managed abortion because it fosters privacy, autonomy, and confidentiality.[6] The method also allows pregnant people to be at home or in any space of their choice, surrounded by those whom they trust. And above all, self-managed abortion puts control over the process back into the hands of pregnant people.

Women and gender non-conforming people have long struggled for the demedicalisation of their bodies and health. Yet, public health approaches usually do not consider autonomy and control over medical processes as indicators of quality of care. The advent of abortion pills opened up the possibility of realising the political demand for autonomy, at least in abortion care. Seizing this opportunity, feminist initiatives on self-managed abortion show us what demedicalised, respectful, and dignified care that enables people’s power looks like.

Indeed, the stories behind the feminist initiatives on self-managed abortion speak of solidarity and non-judgmental support,[5,6] experiences that pregnant people, particularly those from marginalised communities, do not always encounter in formal health systems. Every person, regardless of their context, deserves good quality abortion care when choosing to terminate a pregnancy, and access to emergency medical attention if needed. They should be able to decide also how they want to have their abortion, without fear of prosecution or moral judgement: in a formal health facility, overseen by a health professional, or at a place of their choice, with accessible information and care from whomever they cherish. It is now up to national governments and formal health systems to take the opportunities brought by COVID-19 and make permanent improvements that are long overdue in abortion provision.

Abortion care needs to be contextualised in relation to local sociopolitical circumstances and tailored to personal needs and preferences. This means that there is no universal formula for improvement. However, some simple measures could have vast impact on abortion access and quality of care. For example, decreasing barriers to access abortion pills, such as regulations that restrict distribution and use to authorised health facilities or that require prescription for purchase in pharmacies, could improve accessibility and safety. Eradicating censorship of online abortion

information would improve people's ability to make safe choices regardless of their context. Local production of abortion medicines and measures to set affordable prices could decrease global inequalities in access as well as reduce the unjust burden of post-abortion morbidity and mortality that impoverished and marginalised people suffer. Interventions to decrease abortion-related stigma and to develop skills for respectful care within the health professions could make hospitals a safer space for women and pregnant people as well as increase access and quality of abortion and post-abortion care. Finally, self-managed abortion could be offered as one of many options, along with surgical interventions and medical abortion administered in health facilities, depending on people's preference and needs.

The Covid-19 emergency has led some formal health systems to acknowledge and learn from activist strategies, as the example of the UK shows. Perhaps it will also drive society and governments alike to understand that while medical professionals are irreplaceable in some areas of care, their control over every health process under all circumstances is neither necessary nor desirable. Indeed, the case of abortion shows that medicalisation functions as a barrier for an essential healthcare service, both in "normal" and exceptional times. The current moment is ripe for trusting people in their choices and openly embracing the power of self-management.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by Canadian Institutes of Health Research: [Grant Number 153012].

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