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Medical Abortion and Self-Managed Abortion:

Frequently Asked Questions on Health and Human Rights

I. What is Medical Abortion?

Medical abortion—or abortion with medication—is recommended by the World Health Organization (WHO) as a safe and effective method of ending a pregnancy. Medication for abortion was first approved in France in the 1980's, after French researchers developed the drug mifepristone.[1] The other abortion drug, misoprostol, has been used by women for abortion since the early 1980's.[2] In 2003, in its first technical guidance on abortion, the WHO included medical abortion as a recommended method to terminate a pregnancy.[3]

WHO-recommended medications for induced abortion are the drugs mifepristone and misoprostol in combination or misoprostol alone.[4] Both drugs are included in the WHO Model List of Essential Medicines, which means that they should be "available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford".[5] Mifepristone interferes with hormonal processes and the continuation of pregnancy. Misoprostol causes the cervix to dilate and the uterus to contract.[6] Side effects associated with medical abortion may include nausea, vomiting, and diarrhea.[7] According to the WHO, medical abortion plays a crucial role in providing access to safe, effective, and acceptable abortion care.[8] The WHO has recognized that medical abortion can expand access to care, particularly in early pregnancy, because it can be provided on an outpatient basis and by lower-level providers, and give individuals a greater role in managing abortion care on their own.[9] These characteristics have proved all the more important in the context of the response to the COVID-19 pandemic, which has negatively impacted access to essential sexual and reproductive health services, including abortion, due to strain on health systems, restrictions on mobility, economic challenges, as well as exacerbated gender and social inequalities.[10]

II. How safe and effective is medical abortion?

Medical abortion is widely considered safe and effective, with the level of safety and effectiveness depending on the drug regimen and gestational age.[11] A 2015 systematic review of 20 studies of women who underwent medical abortion with mifepristone followed by misoprostol showed an overall success rate of 96.6%, with success defined as a woman needing no further medical care.[12] For abortion up to 10 weeks, 2.3-4.8% of patients needed medical care to complete their abortion, with aspiration (another common method of induced abortion) while rates of other types of complications for early abortion are less than 1%.[13] For abortions with mifepristone followed by misoprostol between 10 and 13 weeks, the rate of complications beyond needing aspiration is up to 3 percent.[14]

Data on safety and effectiveness of misoprostol alone are more limited.[15] Studies have reported between 78% and 92% success for abortion with misoprostol only.[16] The most common reported complication with misoprostol-only medical abortion is the abortion was not completed and needed to be treated with aspiration.[17] Misoprostol is cheaper, easier to store, and more available globally than mifepristone.[18]

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The WHO recommends repeated doses of misoprostol when abortion is not initially successful, but caution health care providers that uterine rupture is a rare complication for which they should be prepared if the pregnancy is of advanced gestational age.[19] For later abortion, the WHO has identified the need for research to determine the gestational age limit within which it is safe to carry out medical abortion without hospital admission.[20]

III. How is medical abortion regulated?

Medical abortion is generally regulated by abortion laws written to address surgical or vacuum aspiration abortion, for which health care training and skill are required. Most abortion laws are written as exceptions to an overall criminalization of abortion framework and require a health care professional to be involved with the abortion in order for it to be lawful.[21] For example, eighty laws around the world require at least one medical doctor to be involved with an abortion in order for it to be legal.[22] Other provisions that criminalize self-managed abortion may require that an abortion take place in a hospital or other designated type of health facility. [23] The legality and availability of both mifepristone and misoprostol also depend on the drugs being registered by the government.[24]

Regulations and practice regarding where abortion drugs can be obtained and administered vary. The drug regulatory authority of the United States imposes onerous requirements around who is authorized to dispense mifepristone, but patients can take the drug at home.[25] In 2017 and 2018 in Scotland and Wales (respectively) officials issued policies under the 1967 Abortion Act to allow abortion drugs to be taken at home.[26] Until a recent change in policy in response to COVID-19, England required the first part of the abortion drug regimen to be taken administered at a licensed hospital or clinic.[27] In Brazil, where abortion is legal in limited cases, misoprostol is available only in hospitals.[28]

IV. What is self-managed abortion?

Self-managed abortion is when a person performs their own abortion without clinical supervision,[29] as is required by law in most countries. Based on existing evidence, the WHO recommends self-managed abortion with medicines as a method of abortion for individuals who are less than 12 weeks pregnant and have "a source of accurate information and access to a health-care provider should they need or want it at any stage of the process."[30] People seeking abortion are obtaining abortifacient medicines directly through pharmacies, drug sellers, and through new routes like online sellers or telemedicine services.[31] Pregnant people can have a range of self-involvement in their medical abortion process, from learning about drug regimens from non-medical sources, to taking medication at home that was given to them by a doctor.

V. Is self-managed abortion safe?

Self-managed abortion with medicines is much safer than invasive methods. With the advent of medical abortion, the practice of abortion without formal supervision of a health care professional has become safer and more widespread. Where pregnant people may have previously sought clandestine abortion through invasive methods such as sticks, chemicals, or physical force,[32] the availability of medicines means that pregnant individuals do not have to resort to unsafe methods of abortion, and this therefore reduces the health risks arising from unsafe abortion. Researchers have attributed self-managed abortion with pills to a worldwide decrease in abortion mortality.[33]

Researchers continue to generate evidence on the safety of self-managed abortion with medicines, despite the challenges of researching illegal and stigmatized practices.[34] The safety of self-managed abortion depends on an individual's knowledge, access to quality medicines and ability to seek follow-up care. An individual's safety can also depend on the degree to which they face risk of arrest when self-managing their abortion.

WHO defines self-care in a general context, 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 healthcare provider."[35] Self-care interventions for sexual and reproductive health are recognized by the World Health Organization as "among the most promising and exciting new approaches to improve health and well-being."[36] The WHO has recognized that self-care is particularly important for populations negatively affected by gender, political, cultural and power dynamics and for vulnerable persons.[37] At the same time, in order to adequately address the social determinants of health, States have must take measures to rectify entrenched social norms, unequal distribution of power based on gender, and reform oppressive structural systems.[38]

VI. Is self-managed abortion legal?

The practice of self-managed abortion is illegal and criminalized in many places. Even where the drugs themselves are legal, the existing laws (see above) may regulate medication abortion under the law, policy, or guidelines on vacuum aspiration or surgical abortion, which does not comport with its use and is burdensome on women. People who self-managed their abortion and people who help them, may be in violation of various laws, and could face arrest and criminal prosecution, even in places where abortion is legal, though this phenomenon has not been widely researched. Arrests of people who have self-managed their abortion have been documented in Bolivia[39] and Rwanda,[40] countries where abortion is legal at least on certain grounds. In the United States, where abortion is legal through the second trimester for all indications, at least 21 people have been arrested for self-managing their abortions.[41]

Collecting data on a stigmatized health issue is challenging because abortion outside the formal health care system is illegal in most settings. Therefore, data on the use of medication for self-managed abortion is scarce, but researchers have found its use increasing.[42]

VII. Why do people self-manage their abortions?

People may prefer to self-manage their abortion for a variety of reasons, including in contexts where abortion is restricted by law or where access to abortion in the formal health care system is limited. Availability of abortion care may be limited by health worker shortages, a dearth of trained and willing abortion providers, or people may not have access to abortion care facilities within a practical distance. Procedural and administrative requirements also limit access and these include parental consent requirements, waiting periods, judicial authorization requirements, among others.[43] Women often face stigma, mistreatment and violence when seeking abortion services and care, as part of a pattern of violations that occur in the wider context of structural inequality, discrimination and patriarchy.[44]

Research indicates that most abortions occur for reasons other than the commonly legalized exceptional grounds, and exceptions-based legal frameworks do not provide sufficient guarantee of effective access to abortion services in practice, even when the grounds have been met (risk to health or life of pregnant person, where pregnancy is result of rape or incest, or in cases of severe fetal impairment).

A systematic review of the reasons women turn to the informal sector for abortion where abortion is legal found that the reasons include fear of mistreatment by staff, long waiting lists, high costs, inability to fulfil regulations, privacy concerns, and lack of awareness about the legality of abortion or where to procure a safe and legal abortion.[45]

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Even if abortion is legally available on request, there are a wide range of other barriers that pregnant persons face in accessing abortion services, including stigmatization, high cost, mandatory waiting periods, counselling requirements, multiple provider authorization, third party consent/authorization, unnecessary requirements on providers and facilities, and a lack of evidence-based information, or the provision of misleading information.[48]

VIII. What does international human rights law say on abortion and on medical abortion?

UN Treaty monitoring bodies, which monitor state compliance with UN human rights treaties and guide states on how states can meet their human rights obligation, have found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, to be free from gender discrimination or gender stereotyping, and to be free from ill-treatment.[49] They have repeatedly recognized the connection between restrictive abortion laws, high rates of unsafe abortion and maternal mortality.[50] The Committee on the Elimination of Discrimination Against Women has noted that it is a form of gender discrimination for a State party to "refuse to provide legally for the performance of certain reproductive health services for women" or to punish women who seek those services.[51]

The treaty monitoring bodies recognize that abortion must be decriminalized, legalized at least on certain grounds, and services must be available, accessible, affordable, acceptable, and of good quality.[52] The Human Rights Committee has said that States may not regulate abortion in a manner contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, that any restrictions must be non-discriminatory, and that States must provide safe, legal and effective access to abortion, inter alia, "when carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering[53]. The treaty monitoring bodies recommend that States should liberalize their abortion laws to improve access and remove legal, financial, and practical barriers that deny effective access by women and girls to safe and legal abortion, including medically unnecessary barriers to abortion and third-party authorization requirements.[54] States are required to eliminate laws and policies that undermine autonomy, integrity and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health.[55]

CEDAW described the prohibition of misoprostol in one state as "indicative of the ideological environment" and having a "retrogressive impact", and urged the state to reintroduce it, in order to reduce women's maternal mortality and morbidity rates due to unsafe abortion.[56]

The COVID-19 pandemic has underscored the need for States to improve access to medical abortion and remove restrictions on telemedicine, as well as consider reforming legal frameworks relating to self-managed medical abortion.

Medical abortion has been addressed by the Committee on Economic, Social and Cultural Rights (CESCR), first indirectly through General Comment No. 14 which interprets and sets forth guidance on how to implement the right to health, which states that providing access to medicines on the WHO Model List of Essential Medicines is a core obligation of the right to enjoy the highest attainable standard of health.[57] CESCR's General Comment No. 22 on the right to sexual and reproductive health reinforced the obligation to ensure access to essential medicines, and specified access to "medicines for abortion."[58]

In 2020, CESCR's General Comment No. 25 on science and economic social and cultural rights, the Committee said that States must ensure access to up-to-date scientific technologies necessary for women in relation to the right to sexual and reproductive health, in particular medication for abortion, on the basis of non-discrimination and equality.[59] The Special Rapporteur on the Right to Health has also expressed concern about legal restrictions that impede access to essential medicines, thereby limiting women's accessibility to sexual and reproductive health.[60]

No treaty monitoring body has yet addressed legal and policy barriers specific to self-managed abortion in detail, such as requirements that a health care professional be involved with an abortion and that an abortion must take place in a hospital or other specified health care facility.

IX. What is the impact of COVID-19 on self-managed medical abortion?

The COVID-19 pandemic has further reduced access to abortion, with barriers increasing for a variety of reasons, including lack of service providers available, fear of going to health facilities, and due to anti-abortion governments excluding abortion from the list of essential services to be maintained during the pandemic. The WHO has recognized that women's and girls' access to essential health services, including sexual and reproductive health services, is likely to be affected by the restrictions on mobility and economic challenges faced due to the COVID-19 pandemic and response.[61] It has noted that such restrictions on access to services are a violation of human rights[62] and has provided rights-based interim operational guidance on how States should maintain essential sexual and reproductive health services in the context of the pandemic, and recommended that:[63]

- When facility-based provision of sexual and reproductive health services is disrupted, prioritize digital or telemedicine health services, and self-managed interventions, while ensuring access to a trained provider if needed.
- Consider the option of using noninvasive medical methods for managing safe abortion and incomplete abortion and take steps to meet the anticipated increase in need for medical methods of abortion.

During the COVID-19 pandemic, some governments have relaxed regulations on medical abortion and facilitating access by telemedicine, measures which have been welcomed by human rights experts.[64] The COVID-19 pandemic has underscored the need for States to improve access to medical abortion and remove restrictions on telemedicine, as well as consider reforming legal frameworks relating to self-managed medical abortion. These measures would help ensure that all women and girls have their sexual and reproductive rights respected, protected, and fulfilled, by increasing access to safe and legal abortion. Human rights standards on abortion should evolve with the new realities shaped by the COVID-19 pandemic and should look at increasing access to abortion services for all pregnant persons, including by removing barriers to medical abortion, in line with WHO recommendations.

Recommendations

Given the widespread practice of self-managed abortion with medication, and the criminalization of abortion outside the formal health care setting, we recommend that States:

- Decriminalize all abortions, completely removing abortion and any regulation of abortion from criminal or penal codes and take steps to ensure access to all methods of abortion for everyone who needs one.

- Legalize abortion on request; eliminate all legal, policy or practical barriers (such as distance to health-care facilities, high cost for goods and services, mandatory waiting periods, biased counselling requirements, required involvement of a health professional, third-party authorization requirements, and the stigmatization of those seeking abortion); and ensure access to affordable, acceptable, quality abortion pills and information.

- Ensure that self- managed abortion is lawful and that people who self-manage their abortion and people that help them obtain an abortion do not face investigation, arrest, or prosecution.

Given the important role that UN Treaty Bodies have in interpreting human rights provisions and setting state obligations under international human rights treaties, we urge UN Treaty Bodies to:

- Fully reflect the fact that barriers and legal grounds to access abortion are restrictive, discriminatory, and violate a person's right to bodily autonomy.

- Establish a human rights obligation of States to ensure the provision of abortion on request.

- Recommend that States prevent and remove all barriers to accessing quality, affordable, and acceptable abortion care and services (such as distance to health-care facilities, high cost for goods and services, mandatory waiting periods, biased counselling requirements, required involvement of a health professional, third-party authorization requirements, and the stigmatization of those seeking abortion.)

Ask State parties under review the following:

- Is medical abortion legal and available in your country? If it is legal, is it regulated in an appropriate way for the intended use and to enable self-managed abortion, or is it regulated under frameworks intended for surgical or vacuum aspiration?

- Are the drugs misoprostol and mifepristone registered and included on the national list of essential medicines?

- Does the law contain requirements that result in criminalization of abortions that are obtained outside the formal health care setting?

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