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"Self-Care" that Harms and Kills: The WHO's Push to "Demedicalize" Abortion

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INTRODUCTION

The concept of "self-care" to support good health is not new. From good nutrition and hygiene to the self-administration of over-the-counter drugs to the self-management of long-term conditions through prescribed medication, individuals and families around the world are making use of information and products that can improve their health while reducing or avoiding the need to visit clinics and consult directly with doctors.

In recent years, the World Health Organization (WHO) has increasingly advocated for the use of self-care in the field of "sexual and reproductive health and rights," including for abortion. Unlike other forms of self-administered health care, which seeks to balance the ability of patients to manage their own treatments and the need for and availability of medical professionals, the WHO is explicitly using the framework of "self-care" to bypass legal restrictions on abortion and make access to it the highest priority.

This *Definitions* examines how the rubric of "self-care" is being used to remove or bypass all safety and legal guardrails around abortion, how the COVID-19 pandemic has been utilized to accelerate this agenda, and how the groundwork has been carefully laid to ensure that access to abortion is ubiquitous

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regardless of the law—all with support from the UN's global health agency.

Striking a necessary balance

"People have been practicing self-care for millennia," writes WHO Director-General Dr. Tedros Adhanom Ghebreyesus in a foreword to the agency's 2019 guideline on self-care for "sexual and reproductive health and rights" (SRHR), "but new products, information, and technologies are changing how health services are delivered."[1] As the practice of medicine has evolved, so too have norms and regulations regarding the necessary qualifications for medical professionals to perform specific tasks and the management of medical drugs and devices. Equipping people to manage different aspects of their health care can be empowering to them as well as relieving strain on professional providers, but it has to be balanced against the risks of harm caused by insufficient or confusing information or the abuse of drugs that can be highly poisonous or addictive.

With regard to the area of health pertaining to sexuality and reproduction, many of the same issues apply. In the field of maternal health, there has been a global effort to ensure that women giving birth have skilled attendants present, and that pregnant women have regular prenatal visits with health care providers who can offer advice and identify and address potential problems before they become serious concerns. Meanwhile, at-home pregnancy tests have become widespread and increasing numbers of people who are HIV-positive are equipped to manage their own medications from day to day and live healthy lives.

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However, "sexual and reproductive health" remains far more politically and socially sensitive than other areas of health, and this is also true of the effort to increase the use of self-care in relation to it. This is especially true with regard to abortion, which involves matters of conscience, morality, and the law in unique ways. The WHO is a highly influential source of guidance for the development of health care policies, especially in developing regions. As a result, policymakers face pressure to go along with WHO guidelines and not ask whether medical abortions are safe and only ask how efficiently the WHO's policies and practices can be adopted in country – regardless of the country's position on abortion as a matter of law.[2] This is demonstrated by academic research showcased in a recent webinar series by the Self-Care Trailblazer Group. The group includes numerous abortion advocacy

groups, including DKT International, FHI 360, the Guttmacher Institute, Ibis Reproductive Health, Marie Stopes International, PATH, Planned Parenthood Global, the Population Council, Population Services International, and Women Deliver.[3] The series featured the work of scholars like Austin El-Osta, whose research evaluates how quickly and effectively Kenya, Nigeria and Uganda adopted and implemented the WHO's 2019 recommendations on self-care for SRHR in their countries.

The Rise of Medical Abortion

"Less than 40% of the global population live in countries where abortion is available upon request," lamented Katherine Mayall of the Center for Reproductive Rights during a recent webinar by the Self-Care Trailblazer Group.[4] In, fact "90 million women of reproductive age live in countries where abortion is illegal altogether." "The WHO supports a broad range of health care workers' ability to both assess eligibility for medical abortions and administer abortion inducing medications in the first trimester," said Mayall. Abortion-inducing medications must be added to national drug registry and laws must be expanded to allow eliminate onerous procedural requirements, she continued.

Medical abortion, or the use of the drugs mifepristone and misoprostol to induce abortions, has been described by the WHO as playing a "crucial role in providing access to safe, effective and acceptable abortion care," as it "reduces the need for skilled surgical abortion providers" and "contributed to task shifting and sharing and more efficient use of resources."[5] The increase in medical abortion prompted the WHO to change its messaging around "safe" versus "unsafe" abortion. Rather than stressing the idea that in order to be safe, abortion must be legal, they shifted toward the position that lower-level providers and even patients themselves could perform "safe" abortions—even in violation of the law—provided they followed WHO guidance.[6]

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For abortion activists, the goal of ensuring that abortion is legalized and decriminalized everywhere and regarded as an international human right has not changed. However, medical abortion opened another avenue for advocacy. In cases where abortion was illegal or heavily restricted, or where willing providers were scarce, abortion could be made widely available as long as the pills could be obtained and all potential obstacles within the medical establishment were removed or could be easily bypassed. At every stage, the WHO provided support, assistance, and institutional cover.

The WHO's self-care guidelines also provide the strategic language which pro-abortion politicians and other government officials use to expand abortion access at the country level and overcome existing pro-life legal frameworks. "It takes work beyond adapting the [WHO] guideline at the national level," said Dr. Moses Mulumba, Director of Center for Health, Human Rights and Development Uganda, at a recent self-care webinar. "You have to undertake serious legal reforms and serious legal advocacy to make sure that you open up the spaces that are closed in areas, like Uganda. Even the mere mention of the word abortion sometimes makes it very difficult."[7]

The WHO's role in maximizing abortion access

At a recent self-care event, Katherine Mayall of the Center for Reproductive Rights highlighted the way the WHO enables the global pro-abortion movement to advance:

> "I think the WHO guidelines are so important to move towards dismantling that political opposition [against abortion] and there is so much more that can be done both if we can combine the leadership on the ground and the power of civil society advocates on the ground with the power of some of these leading civic institutions that can really show that the evidence base is there and there really is an opportunity for both enabling people to exercise their rights but also ensuring that health systems are functioning more effectively and we are creating healthier populations through the use of health care."[8]

One important step was getting mifepristone and misoprostol onto the WHO's essential medicines list, which list medications "that satisfy the priority health care needs of a population."

One important step was getting mifepristone and misoprostol onto the WHO's essential medicines list, which lists medications "that satisfy the priority health care needs of a population."[9] In 2005, mifepristone and misoprostol were first included in the WHO's 14th edition of the list, with caveats: "where permitted under national law and where culturally acceptable," and "requires close medical supervision." When the 21st edition of the list was published in 2019, the stipulation that close medical supervision was required had been removed, and mifepristone in combination with misoprostol had been moved from the complementary list to the core list, indicating higher priority.[10] The abortion lobby welcomed the changes, while complaining that the retention of caveats about law and cultural acceptability was "a pity but not a surprise," and a result of the 1994 compromise at the International Conference on Population and Development (ICPD) which first introduced abortion into

UN policy but stressed that its legal status was for individual countries to determine.[11]

These two changes, elevating abortion drugs to the core essential medicines list and removing the requirement for close medical supervision, were both important precursors to the promotion of abortion as "self-care." Prior to the 2019 list's publication, the WHO had published guidances calling for increased task-sharing with regard to abortion, particularly medical abortion, expanding the pool of potential providers to include midwives, nurses, and other clinicians who would not previously have been called on to provide abortions, with limits to their ability to object as matter of conscience. It also gestured toward the idea of involving providers based outside of clinics and pharmacists, pending further research.[12] It is also important to note that while the WHO recommends the use of misoprostol and mifepristone together, it also provides guidance on the use of misoprostol alone to induce abortions, particularly when mifepristone is not available.[13] As misoprostol is also used to treat gastric ulcers and prevent and treat hemorrhaging during birth, it is more likely to be available even if its use to perform abortions would be illegal.

This positioned the WHO to be able to define a "safe" provider down to the lowest possible tier: the end user—provided that user was acting in line with WHO recommendations.

In 2014, the WHO redefined what could be called a "safe" abortion in a fluid, self-referential way: "Nothing in the definition predetermines who should be considered a 'safe' abortion provider or what the appropriate skills or standards for performing abortions should be. Such things are not static; they evolve in line with evidence-based WHO recommendations."[14] This positioned the WHO to be able to define a "safe" provider down to the lowest possible tier: the end user—as long as that user was acting in line with WHO recommendations. This provided illegal purveyors of abortion drugs with the veneer of WHO endorsement, which they have happily taken up. Aid Access, which was founded to provide illegal abortion drugs by mail in the U.S. and worldwide, particularly in the event that abortion is or becomes illegal or widely restricted, claims that "abortions are safe if they are done with a WHO-recommended method that is appropriate to the pregnancy duration, and if the person providing or supporting the abortion is trained."[15]

The WHO has urged countries to liberalize their abortion laws, citing the nonbinding opinions of UN human rights experts, and to place limits on conscientious objection by health care workers to the extent that it might impede access to abortion. Its self-care guidance, however is the most overt encouragement the agency has given thus far to violating countries' abortion laws. While the WHO's essential medicines list still maintains its

caveats about legality and cultural appropriateness of abortion drugs, its 2019 self-care guideline claims that "self-care for SRHR has perhaps the greatest potential to address unmet needs or demands in marginalized populations or in contexts of limited access to health care, including, for instance, self-managed medical abortion in countries where abortion is illegal or restricted."[16] The guidance also contains this footnote:

> "To the full extent of the law, safe abortion services should be readily available and affordable to all women. Self-management approaches reflect an active extension of health systems and health care. These recommendations are NOT an endorsement of clandestine self-use by women without access to information or a trained health-care provider/health-care facility as a backup. All women should have access to health services should they want or need it."[17]

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The recommendation that abortion should be available "to the full extent of the law" is an inversion of the 1994 ICPD compromise that held that women should be protected from the harm of "unsafe" abortion, and reflects an ongoing erosion by international agencies of the caveats of ICPD.[18] Yet while the WHO is careful to say that it does not endorse the use of abortion drugs without information or access to help in case of complications, in the same document it hails the self-management of abortion as a way to bypass restrictive laws.

The COVID-19 pandemic accelerates the shift to self-care

When the COVID-19 pandemic began, the effort to put abortion drugs directly in the hands of women was already well underway, but when lockdowns prevented people from accessing all but the most urgent clinic-based medical care, abortion became a particular source of contention. While some pro-life lawmakers moved quickly to ensure that abortion would not be regarded as an "essential" medical service in several U.S. states[19] and some European countries, the governments of other European countries moved to expand access to medical abortion via telemedicine, including France and England.[20] In its guidance note regarding essential medical services in the context of the pandemic, the WHO encouraged wider use of telemedicine, including for abortion, and, as lockdowns ease, "consider expanding telemedicine mechanisms for medication delivery in contexts where it is proven effective."[21]

The movement toward self-care and telemedicine during the pandemic was certainly not restricted to abortion, but it is

notable that the pandemic was the catalyst for several countries' legal and policy changes regarding abortion in order to enable a greater degree of self-management, including the removal of requirements that patients physically visit a clinician to obtain the abortion drugs.

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Pro-abortion activists have taken notice of the rapid advancement in the loosening of abortion policies worldwide in the context of the pandemic. "I think it's really important to capitalize on those gains and really build from that discursive argumentation for self-care and I think that the thing to take into account is that all of these measures while very normative are created as rather temporary measures, all of them are tied to COVID-19 responses laws or policies," said Lucia Berro Pizzarossa, coordinator of the MAMA Network (Mobilizing Activists around Medical Abortion). "I think one of the things that would be very interesting for all of us to take on would be to see how we can push for these provisional "temporary measures" to become the norm because there is evidence that they work pretty well. . . [S]impler, de-medicalized, no-touch protocols are not only desirable, but also the pandemic has proved that it is possible and quite easy to implement. So, I think it would be very interesting that we also touch upon that."[22]

Intended and unintended consequences

It is important to emphasize that the expansion of self-management of various aspects of health care has become not only possible but necessary in light of the pandemic, and the benefits of task-sharing to reduce strain on medical systems have never been more evident as emergency services have been overwhelmed with the coronavirus response. However, abortion is not like other aspects of health care in that it is not health care: at least one person dies if it is carried out successfully, and its "safety" depends on leaving only one casualty, not two. While the ICPD encouraged countries to provide women with alternatives to abortion so they would not resort to dangerous procedures that result in maternal deaths, current WHO guidance frames the only alternative to "unsafe" abortion as being "safe" abortion.

If self-managed abortion can be said to "empower" women, it also burdens them: they may have to contend with complications alone and make judgment calls about seeking medical help while in pain and distress and without support.

While many of the legal restrictions on abortion around the world exist primarily to protect the life of unborn children, others explicitly seek to protect the health of their mothers, including requirements for surgical procedures to take place in clinics that meet certain safety standards. If self-managed abortion can be said to "empower" women, it also burdens them: they may have to contend with complications alone and make judgment

calls about seeking medical help while in pain and distress and without support. In contexts where women obtain pills illegally and in a clandestine manner, it will be difficult to obtain reliable data regarding their health outcomes. Women on Web, one of the major providers of abortion pills by mail, encourages women experiencing complications that:

> "You do not have to tell the medical staff that you tried to induce an abortion; you can tell them that you had a spontaneous miscarriage. […] The symptoms of a miscarriage and an abortion with pills are exactly the same and the medical practitioner will not be able to see or test for any evidence of an abortion, as long as the pills have completely dissolved. If you took the Misoprostol under the tongue, as our protocol recommends, the pills should be spit out after 30 minutes, if not dissolved completely. If you took the pills vaginally, you must check with your finger to make sure that they are dissolved. Traces of the pills may be found in the vagina up to four days after inserting them."[23]

In England, after the National Health Service started making abortion pills available by mail during the pandemic, ambulance operators reported a surge in emergency calls from women who had taken the pills at home.[24] These abortions were presumably legal and enabled by the government health care system. However, women obtaining illegal abortions will be less likely to fully explain their circumstances when seeking help, and may delay seeking help at all, leading to more severe consequences.

In the U.S., the Supreme Court is currently considering a challenge to the 1973 *Roe v. Wade* decision that struck down many state-level restrictions on abortion. As the potential for greater ability of states to enact pro-life protections in law grows, abortion advocates are citing international examples of widespread abortion access even in restricted settings, thanks to medication abortion. Some, including sex advice podcaster Dan Savage, are not only encouraging women to stock up on abortion pills in case they need them in the future, but also encouraging friends and relatives of women to stockpile their own supplies.[25]

As the potential for greater ability of states to enact pro-life protections in law grows, abortion advocates are citing international examples of widespread abortion access even in restricted settings, thanks to medication abortion.

A serious potential hazard of removing the requirement for in-person visits to distribute abortion pills is the fact that pills may be obtained by people other than the pregnant woman herself. A 2019 *Mother Jones* article told the story of a woman in New York who started a website for distributing abortion pills by mail. She was raided by the U.S. Food and Drug Administration

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(FDA) after they discovered her business when a Wisconsin man was arrested for slipping the abortion drugs to a woman pregnant with his child.[26] A doctor in the Washington, D.C. area was also imprisoned for putting abortion drugs in his girlfriend's tea.[27] Stories like these are the ones where the culprit was caught and the evidence was sufficient to bring charges, but just as a woman who self-induces abortion might claim she is having a natural miscarriage to avoid legal consequences, it is impossible to know how many husbands, boyfriends, parents, or even human traffickers of pregnant women have gotten away with giving them abortion drugs without their consent.

Nevertheless, in December 2021, the FDA removed previous restrictions on the use of abortion pills in the U.S., making it possible for providers to prescribe them through telehealth and mail them to patients where state laws allow. The FDA did retain other restrictions, much to the disappointment of abortion groups, including the requirement that prescribers register with the manufacturers of the medication, the certification of dispensing pharmacies, and the requirement that patients sign a consent form at pharmacies when receiving the drugs.[28] Pro-life advocates denounced the rule change as dangerous for women.

Beyond Self-Care

Self-care can be a way to empower people to manage their own health in some respects and reduce unnecessary strain on health systems, but it cannot be a substitute for high-quality institutional services. While abortion advocates see tremendous opportunity in the movement for increased self-care for SRHR, some who work on the less-controversial aspects of the field, such as prenatal and maternity care, are raising concerns about how self-care alone is not enough where basic health services are lacking or sub-standard.

For some women in Uganda and other developing nations, self-care means avoiding the existing healthcare systems in favor of do-it-yourself solutions.

"Providing guidance and information about self-care and reproductive health alone is not enough to help women and young adults to make self-care decisions," said Mukasa Hajra, Program Manager of Amref Health Africa in Uganda.[29] For some women in Uganda and other developing nations, self-care means avoiding the existing healthcare systems in favor of do-it-yourself solutions. In fact, Amref's research shows that the unsanitary and rudimentary conditions at the local healthcare facilities, combined with untrained staff, discourage women from utilizing local healthcare resources. Because the local facilities do not reflect minimum standards, women take their care into their own hands, which sometimes yields poor results, like

developmental deficiencies and the onset of disease or illness. Nevertheless, it is not clear that the other options available to them would yield better outcomes.

“There is a need to enable communities to make better decisions by integrating water sanitation and hygiene services,” said Mukasa. At least a third of the healthcare facilities that offered care for pregnant women in Uganda had latrine facilities that were dirty, without handwashing capability, and were shared with the general public, and not reserved for facility patients. The conditions are “repugnant” to a woman seeking healthcare for delivery, even if she had been encouraged to deliver her baby in a dedicated facility.

In some places, maternity wards are littered with cow dung and post-delivery washrooms are filthy and shared with livestock.

In some places, maternity wards are littered with cow dung and post-delivery washrooms are filthy and shared with livestock. Women are expected to lie on dirty and undressed beds with their babies when recovering from childbirth. Under such conditions, there is little incentive for mothers to use the local healthcare facility, even if they had a desire to receive medical assistance.

Self-care is also hampered by lack of clean water. Women are encouraged to wash their babies, but many villages use open water sources contaminated by feces. According to Mukasa, in Uganda, only 20.9% of households have access to safe water and up to 48% of households practice open defecation. As a result of these conditions, more than 40% of mothers reported their children having presented with signs of sepsis in the first 28 days of life.

For self-care to be effective in improving health outcomes, basic health infrastructure including sanitation needs to be prioritized. In addition, healthcare facilities must be equipped with the tools and instruments needed to provide standard levels of care. For example, in Uganda, renovated facilities were equipped with a “placenta pit” which gives mothers assurance that their placentas will not be discarded in the open and carried away by dogs, which is commonplace in some villages. By incorporating these modest improvements, local trust in the healthcare workers and facility increase, making it more likely that women will seek the care they need for themselves and their babies.

“We can continue to advocate for policy and continue to raise our voices encouraging self-care and better reproductive health services, but giving information alone without providing access to better healthcare facilities is not enough to enable mothers and youths to make healthy decisions about their reproductive lives,” said Mukasa.

Conclusions

The global health leaders whose guidance is most frequently cited, such as the WHO, as well as networks championing self-care like the Self-Care Trailblazer Group, are ever-increasingly captured and politicized by the worldwide abortion lobby.

There is a place for self-care practices in global health, and the potential exists for individuals and families to be empowered by increased control over their health care, where appropriate, and for doctors, nurses, and other medical professionals to more effectively manage their time and provide care to those who need to see them. However, the global health leaders whose guidance is most frequently cited, such as the WHO, as well as networks championing self-care like the Self-Care Trailblazer Group, are ever-increasingly captured and politicized by the worldwide abortion lobby. This has several harmful results: standards of care for women are consistently reduced in order to maximize access to abortion, countries' sovereign laws are undermined and openly violated by WHO recommendations, pregnant women face increased risk of being given abortion drugs without their consent by abusers, and women in poor countries wishing to give birth in safe and clean facilities are all too often overlooked. For those women and their babies, the message of self-care from the "trailblazers" is not one of empowerment, but, rather, "you're on your own."

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