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# A Constructivist Vision of the First-Trimester Abortion Experience

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## Abstract

How might the abortion experience look in a world without the existing regulatory constraints? This paper critically assesses the evidence about how a high-quality abortion experience might be achieved in the first trimester. There would need to be positive obligations on states in pursuance of women's reproductive rights. The onus would be on states and state actors to justify interferences and constraints upon a woman's right to terminate in the first trimester of her pregnancy. In this vision, abortion is person-centered and normalized as far as possible. High-quality information about abortion would be freely available through multiple sources and in varying formats. Whenever possible, abortion would happen in a place chosen by the woman, and in the case of medical abortion, could be self-managed with excellent clinical backup on hand should the need arise. The overarching purpose of this paper is to highlight the broader environment and framework of state obligations necessary to underpin the lived experience of abortion.

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## Introduction

Criminalization of abortion has well-known deleterious effects.[1] Much has been written on decriminalization of abortion, specifying what legislation needs to be dismantled.[2] In contrast, we adopt a 'constructivist' approach, looking at what is needed to support a high-quality abortion experience, drawing upon research and literature that includes the lived experience of women who have undergone abortion. We set aside regulatory constraints that could hinder progress toward giving people with a uterus (in the interest of brevity, 'women' is used hereafter) the ability to freely choose how they respond to an unwanted pregnancy. As far as possible, we have used a fresh sheet of paper. We take a ground-up approach, building from scratch and beginning with no abortion-specific laws at all.

Although we use the term 'abortion' throughout this paper, we recognize that this may be construed as a loaded term with preconceived connotations. In keeping with our constructivist approach, we use the term simply to denote the steps necessary to bring about the end of an established pregnancy (that is, after implantation of the embryo). These steps would, in the ordinary course of events, result in ending the life of the unborn entity or entities.

## Starting points and core assumptions

In this paper, we make several core assumptions. First, we assume that the state has unlimited resources to address its positive and negative obligations to pregnant women. Second, we assume that those resources are distributed fairly, justly, and equally within society. Third, we make no attempt to accommodate the plurality in this vision. There is no sense that competing views require accommodation or that compromises are necessary in the regulatory rules. Fourth, our vision does not seek to erase the private sphere, or any socio-political objections to, or prejudices against abortion. Rather, our focus is on a world without pre-existing regulatory constraint on the choices that women can make in this context. Fifth, although gestation outside the womb may soon be possible (ectogenesis), we assume that some demand for abortion (as currently envisaged) will persist.[3] Necessarily, these assumptions limit the transferability of this framework in the real world, but our intention is to encourage policy makers and reformers to think critically about the possibilities that a constructivist approach might offer should the opportunity arise for genuine reform. Further, our purpose is to highlight that in the absence of direct regulatory constraints, it is the broader environment and framework of state obligations that underpin the lived experience of abortion.

Defining quality in abortion care is at an early stage, despite abortion being such a commonplace occurrence. There is no standardized, validated set of quality metrics for abortion as there are, for example, for maternity services.[4] This paper does not focus on safety, effectiveness, timeliness, efficiency, and equitability; there is a considerable body of work on these.[5] Instead, we concentrate on person-centeredness as a major ingredient of a high-quality abortion experience. Person/patient-centered care means an approach that informs and engages women (and partners, if appropriate) in their own individual health care and also to engage service users in health care service co-design.[6] We assume that appropriate regulatory mechanisms remain in place to maintain the safety of all abortion services.[7]

We do not assume that women will have direct contact with health services. This is in line with current World Health Organization thinking, the general principles of self-care, and the experiences and perceptions of women who have undertaken self-management of medical abortion.[8] We do, however, acknowledge that there are still some research gaps on self-managed abortion; for example, how best to inform and support women in using the medicines safely and effectively and how to facilitate the community distribution of high-quality drugs and information.[9]

We know that many women have opted, for various reasons, for "informal sector" abortions, even when they are entitled to a legal abortion in the formal (approved) health sector.[10] On the face of

it, this may seem like a second-best option, but as some women positively opt for self-managed abortion at home, it is no longer an act of desperation: "self-managed abortion can be a source of reprieve or escape from … indignities of formal settings and experiences of shame and powerlessness within them."[11] We regard self-managed first-trimester medical abortion (that is without attending a health facility)—following evidence-based regimens using drugs from approved sources, with full information—as safe. Self-management could be supplemented by advice from an approved authority such as a pharmacist or an appropriately trained community activist.

Unless appropriately registered, licensed, and trained, procedures undertaken by informal abortion providers such as herbalists, street vendors, and traditional birth attendants are potentially unsafe. For the avoidance of any doubt, we are not seeking to directly constrain the choices of pregnant women. Rather, our concern is to ensure that women are not harmed or subjected to the unnecessary risk of significant harm by the supply of inaccurate/ inadequate information or the provision of deficient abortion services. Accordingly, we suggest that informal service providers, rather than pregnant women, should be the target of any future regulatory constraints. Our aim is to minimize recourse to untrained service providers by delivering improved access to the formal (approved) and publicly funded sector. In our vision, the formal sector and those who work in it are subject to regulation in relation to the standard and quality of pre-/post-abortion care.

When women are asked what they want in abortion services, they identify minimal delay as a priority.[12] Women who have decided to terminate a pregnancy want their abortion procedure to take place as soon as possible, and find a delay distressing.[13] Most say they do not want counseling.[14] Facilitating access to abortion services is an important aspect of our vision.

Although we do not rule out extension of our vision, we limit the immediate scope of this paper to first-trimester abortion due to the current insufficiency of evidence as to safety, effectiveness, and acceptability of second or third trimester medical abortion undertaken outside the formal health system. Although ambulatory (outpatient) medical abortion is generally limited to 10 weeks' gestation, the envelope continues to be pushed on this upper limit. The World Health Organization recommends self-managed medical abortion up to 12 weeks' gestation, conceding that evidence is limited for the upper two weeks.[15] Further, we are on slightly easier ethical ground in the first trimester, whether on a rights, personhood, or relational perspective. Our starting point is that state actors have a much harder time justifying constraints on pregnant women during the first trimester, partly because there is more common ground about the moral status of the unborn entity at this stage of development. Consequently, any margin of appreciation that might be granted to states and their agents ought to be narrowly construed during this stage of pregnancy.[16]

Some of the thinking behind this paper has been stimulated by innovative organizations that provide internet-based abortion services and thereby empower women.[17] Although women choose to use these services, the organizations only provide medical abortion and so by definition offer no choice within their service provision. Although the development of drugs for medical abortion has been a revolutionary scientific advance, in many high-resource countries medical abortion now tends to dominate service provision to the exclusion of surgery.[18] Surgery obviously requires direct contact with health professionals. But first-trimester surgical abortion can be provided safely outside a hospital setting with simple equipment, and satisfaction with manual vacuum aspiration is high.[19] However, unless aspiration is available on demand, it is not a genuine option; for example, a weekly operating list is not sufficient.

## The role of the state

All people have the right to expect quality health care from the state. But what exactly are the obligations of the state in pursuance of this right? The reproductive justice framework contends that there is a right to have a child, a right not to have a child, and a right to parent a child in a safe and healthy

environment.[20] Access to reproductive services is a key component of this framework because "there is no choice where there is no access."[21] Under existing international human rights law, states have specific obligations to respect, fulfill, and protect human rights, including reproductive rights.[22] These obligations include limitations on the actions that states may take (negative obligations) and on proactive measures that states must take (positive obligations) to give effect to individual rights and freedoms. States must take steps towards fulfilling their obligations by all appropriate means, including particularly the adoption of legislative measures, and should report on these measures and the basis on which they have been considered the most appropriate under the circumstances.

States have three core obligations relating to abortion: a duty to respect, a duty to fulfill, and a duty to protect. In the following section, we outline how these obligations would work in our vision and offer some framework on scope.

The duty to *respect* requires states to refrain from interfering directly or indirectly with the enjoyment of reproductive rights unless that interference is justified, proportionate, and necessary to achieve a legitimate aim. Using the work of philosopher John Stuart Mill as our foundation, we argue that interference can only be justified or legitimate if it is necessary to prevent harm to others which is both morally indefensible and rights-violating.[23] Unless one subscribes to the view that the unborn entity is a rights-bearer in the first trimester, it would not be legitimate to interfere with a woman's right to terminate at that stage in order to protect the unborn entity. We do not take an explicit position on such interferences in the later stages of the pregnancy but accept that there might be other legitimate reasons to interfere, or for a state to otherwise take responsibility. For example, where the harm or potential for harm arises from related technology that has been released and managed or controlled in a public health context; or where the dignity of humanity as a whole is at stake; or to preserve/protect the essential pre-conditions for human existence or any social human existence.[24] If we take the specific example of prenatal screening, a state may be responsible for the testing technology made available in publicly-funded maternity services. The state may also have reason to intervene where private sector providers promote testing and deselection of specific non-health-related characteristics.[25] However, in these cases, the state and their agents would bear a heavy burden to justify any constraint on a woman's reproductive rights in the context of abortion.

The duty to *fulfill* requires that states adopt whatever measures are necessary—legislative, budgetary, judicial, and/or administrative—to achieve the full realization of reproductive rights. This would include the provision of appropriate forums to resolve disputes and determine or enforce appropriate remedies. We address the funding of private sector provision below. As part of their obligations, states should ensure that reproductive health information, goods, and services are *available*, *accessible*, *acceptable,* and of good *quality*: AAAQ.[26]

The duty to *protect* requires states to prevent third parties from infringing upon reproductive rights and to take steps to investigate and punish such violations when they occur. So, for example, anyone coercing or misleading a woman into an abortion or covertly inducing an abortion should be subject to some form of regulation. Similarly, any health professional acting in bad faith (for example, failing to obtain adequate consent or delivering poor standards of care) should be subject to some form of sanction. We can debate whether there should be disciplinary, civil, and/or criminal consequences in these circumstances. We should not criminalize human behavior unless absolutely necessary, and then only in a proportionate way. If we choose to direct sanctions against third parties, it may be preferable to use disciplinary or civil mechanisms before engaging the criminal law.

Under its duty to protect, the state should ensure that abortion providers do not infringe upon reproductive rights. Refusals to provide abortion care on grounds of conscience can compromise access to abortion and harm health and well-being.[27] Such refusals are not permissible in emergency situations or by institutions; they are only valid in relation to direct provision of care and, in such

instances, referral must be made to an alternative willing and capable provider.[28] Objector status should be disclosed at an early stage to employers and patients so that timely alternative plans can be made; in all regions of a country there must be adequate numbers of health professionals who provide abortion care and the state must take measures to ensure that women's access to legal abortion care is not undermined.[29] Personal beliefs must not be pursued where they are in conflict with the principles of good medical practice, where they cause patients to be treated unfairly, or where they deny patients access to appropriate treatment or services or cause distress.[30]

Also, under its duty to protect, the state must ensure that members of the public with anti-choice views, while otherwise being permitted freedom of peaceful assembly, cannot infringe upon reproductive rights using intimidation and harassment close to abortion care facilities.[31] Due to the distress women have experienced as a result of protests outside facilities in many countries, safe access zones are an absolute necessity to keep any protests away from facility entrances that women and providers use.

Crisis pregnancy centers are run by non-medical organizations; they attempt to intercept those seeking abortion and persuade them to continue the pregnancy.[32] Under its duty to protect, the state must ensure that crisis pregnancy centers do not jeopardize women's health, disseminate misinformation, and target marginalized groups.[33]

## The essential ingredients that facilitate a positive high-quality abortion experience

In this section, we identify the fundamental ingredients of a positive high-quality abortion experience. Some of these are not applicable to women who self-manage their abortion.

### *Person-centeredness*

In a person-centered approach, care is individualized and tailored to women's preferences. It is acknowledged that there is no joy in the context of abortion—as with miscarriage and ectopic pregnancy and in stark contrast to childbirth.[34] Women can choose how their first-trimester abortion is carried out and their degree of presence; some prefer to be awake and experience it, some prefer to be sedated. Women can have privacy and discreet care; they may fear judgment when grouped with others undergoing abortion.[35]

The needs and rights of the pregnant woman are at the center of policymaking, information, service delivery, and one-on-one consultations. A person-centered framework and culture supports every person on their journey.[36] Person-centeredness was identified as a key dimension of quality health care by the Institute of Medicine and further developed into a framework of eight domains for maternity care by Sudhinaraset et al.; Altshuler and Whaley adapted this structure for abortion care.[37] There is inevitably some overlap between these domains. The priority rights at the heart of this framework, and our wider discussion in this section, are the rights to individual autonomy, human dignity, and privacy. Many of our points (including domains 4–8 below) are drawn from these priority rights. This overarching framework is facilitated and realized by engagement of the state duties to respect, fulfill, and protect. The eight domains are:

1. Dignity

Dignity refers to the ability of women to receive care in a respectful and caring setting. The care supports an individual's self-respect. Any perception that this will not be the case can drive women into the informal sector where the informational framework may be less reliable; or they may self-induce abortion without sufficient back-up.

2. Autonomy

Human rights considerations dictate that autonomy is the overriding determinant when choices are made in early pregnancy. This takes into account women's embodied experience of being pregnant. The two basic requirements for autonomy are agency (the capacity for intentional action) and liberty (freedom from controlling influences exerted by external sources).[38] Women should have control over their bodies and be free to make choices and decisions without external constraint in the first

trimester of their pregnancies. The consent process should be valid. Providers convey to women that they are seen as moral agents, capable of making decisions about their bodies and lives.[39]

3. Privacy

Again, we are not attempting to expunge the distinction between the public and private spheres entirely, although the former is necessarily limited in our vision. Opting for an abortion is an intensely private matter. This includes physical privacy in the treatment setting and the confidentiality of sensitive medical information. Physical examinations should be carried out discreetly. Some women prefer to travel out of their area of residence in order to maintain anonymity. Some may prefer self-managed abortion, perhaps with external support, because it offers greater privacy.

4. Communication

Treatment options are fully explained and discussed; women participate actively. The woman's preferences, needs, and context are taken into account. Non-directive counseling is available, if sought, before and after the procedure or medical administration.

5. Support

This needs to be individually tailored as women differ greatly in the degree of support they desire. Some women are grateful not to be questioned too much. Others welcome some acknowledgment of the emotions they are grappling with, or possibly some discussion of them; these might be contradictory emotions (ambivalence) or existential issues that can be triggered, such as life and death, morality, and meaning.[40] While some women want to be alone, many value the support of a companion of their choice. Support should extend into the workplace, so that women are guaranteed time off work without probing into their rationale or purpose.[41]
An important resource for support is the volunteer abortion doula or pregnancy companion. Many doulas are "full spectrum," meaning they will attend a woman during any pregnancy event, including childbirth.[42] Doulas offer compassionate care and are trained to counter stigma. Women overwhelmingly recommend doula support for abortion care, despite the fact that such support is not associated with measurable effects on physical comfort or emotional responses.[43] Clinic staff believe doulas contribute to more patient-centered care.[44]

6. Compassionate care

Care is provided in a compassionate manner.[45] It is responsive to the person's specific needs. Such care protects women from distress, pain, or harm. Small gestures can make an enormous difference.[46]

7. Trust

Trust comprises how women assess the delivery of care by a specific provider in terms of their honesty and how confident service users feel about the provider's competence.

8. Health facility environment

This domain includes comfort, cleanliness, adequacy of equipment, and a pleasant environment. As well as the physical environment, this includes human aspects such as a supportive and non-judgemental atmosphere. Women sometimes have preconceived ideas about the appearance of a clinic and may be surprised by the cleanliness of their surroundings or facilities, for example.[47] In our vision, there are no Targeted Regulation of Abortion Providers laws (that is, burdensome and medically unnecessary legal requirements that target abortion providers).[48] For example, requirements suited to hospital surgical facilities may be imposed which are far in excess of those needed for the relatively 'low-tech' nature of abortion procedures.

*Normalization*

There are two aspects to the normalization of abortion. The first is full integration of abortion into health care as a mainstream service and, more particularly, as part of comprehensive sexual and reproductive health care.[49] This should render approved private-sector provision (that is, those not

publicly funded) unnecessary, but we would not outlaw these providers unless there were consequential considerations undermining public access. In any event, approved private sector provision would not be available on more favorable terms than public services.

The second is normalization with respect to society. Abortion is mostly subject to negative framing in the media. There are associations with controversy, sensationalism, and immorality.[50] There are also associations with 'deviant' practices such as teenage pregnancy and undesirable characteristics such as promiscuity; these tend to stereotype and falsely marginalize women who have abortions.[51]

Despite a broad social narrative that abortion is by default negative, many women undergoing abortion say it is the right choice for them; some even call it a positive experience.[52] Language used to describe their experiences can be non-negative but is often intertwined with negative framings. Nevertheless, negativity can be resisted and rejected.

Normalizing representations of abortion can help destigmatize the practice.[53] For example, Australian abortion clinic websites unapologetically present "a uniformly clear set of values and practices: a woman's competency and ownership of decisions relating to her pregnancy; her entitlement to good quality non-judgmental care; and the generally positive effects of an abortion."[54] This establishes "women's position as the rightful subjects of abortion decisions and constructs abortion as a normal, positive and straightforward procedure that enables women to lead the lives they imagine for themselves."[55]

Feminist groups supporting women in self-managed abortion are driving a reduction in stigma. They share a 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."[56]

### *Place of choice*

Care closer to home as a means of contributing to the delivery of person-centered care has been in the sight of enlightened health professionals for some years, but unnecessary restrictions have got in the way.[57] Absent such restrictions, including those governing where the medicines are administered, a woman can use both mifepristone and misoprostol in the "safety and security" of her home, the home of someone of her choice, or a place of safety.[58] She can also choose who is present in that setting to support her. Those conducting their abortion at home need sufficient information that can alert them to medical conditions which would make them high-risk and therefore in need of medical advice and supervision. We would not seek to constrain the choices of the high-risk patient, but we would want to ensure that they were adequately informed and supported. Information provided would also ensure that women understand what symptoms should trigger contact with medical services. A few women request inpatient care because they do not feel safe at home, and this needs to be accommodated.

For those accessing formal health services, we envisage woman obtaining their abortions locally, without extended travel possibly entailing crossing borders.[59] Ideally, care could be accessed in a local health center, and at the nearest hospital for those who need hospital care. Special arrangements are needed for sparsely populated areas such as northern Canada and central Australia, and for remote communities with no road/rail links. In such cases, clinicians can provide medical abortion via telemedicine; this service delivery is effective, safe, and has a high satisfaction rating.[60]

### *Reproductive health commodity supply and security*

In our vision, mifepristone is licensed in all countries. It is currently licensed in only 68 of the 193 countries in the world (35%).[61] Our vision would supplant the current situation, in which millions use the less-effective misoprostol-only regimen.

Secure systems are in place for procuring abortion pills and appropriate pregnancy tests for follow-up after abortion from reliable sources: mainly internet-based abortion services and accredited pharmacies.[62] These systems would supersede widespread circulation of substandard and

counterfeit medicines and other medical products; such medicines include inactive substances, impure products, toxic substances, or other substances entirely.[63] Pharmacy supplies can be provided at a distance; an example of regulations applying to such activity is that issued by the UK General Pharmaceutical Council.[64]

In our vision, over-the-counter status for mifepristone and misoprostol is operational. Only a small amount of additional information would need to be gleaned about self-administration of mifepristone/misoprostol in order to make an application to the US Food and Drug Administration for over-the-counter approval.[65] Mechanisms for community pharmacy provision have been elaborated.[66]

### *Information*

The motto "knowledge is power" has become a cliché but is nevertheless true. Easy access to accurate and clear information is a key element of our vision. Information is supplied in varied forms to suit different individuals. Animated films, as well as pictures and diagrams, supplement the written word.[67] Access to this information is in a variety of modes including print, audio, and electronic. Abortion hotlines providing information based on official World Health Organization protocols play an important role. They release reliable information into the public domain where people can share it.[68] It is important that relevant information is made available that speaks to all, including any marginalized/intersectional groups and individuals.

What explicit information would be made available? First, the actual choice available would be spelled out. Except where there are medical contraindications, of which there are few, women could freely choose the options of medical or surgical abortion. Early surgical abortion in the form of manual vacuum aspiration is available without delay and not necessarily in a hospital setting.[69] Manual vacuum aspiration is available from a range of providers, including nurses, midwives, and general practitioners.[70] There are many websites offering science-based information about self-managed medical abortion.

Second, information about local support would be accessible. This includes emotional, social, and financial support.

Third, there would be information about the need for Rhesus disease prophylaxis after 10 weeks' gestation for those who are Rhesus negative, when antibiotic prophylaxis is recommended, and which medical conditions require special precautions and medical input.[71]

Fourth, there is good information about what to expect when undergoing an early medical abortion and what human resources can be called upon, such as doulas.[72]

Finally, information about contraception is freely available, together with the recommended timing of initiation after abortion.[73] There is freedom of choice: no disproportionate emphasis on long-acting reversible contraception and no coercion in relation to sterilization.[74]

### *Clinical excellence*

In our vision, clinicians are still needed to provide expertise in complex medical situations, to provide surgical services, and as a back-up for self-managed medical abortion; the number of such professionals is scaled down by adding a more varied skill mix. Policy makers and managers ensure there are sufficient trained professionals, an even geographical spread of services, hygienic facilities, and ongoing focused capacity building.[75] Careful service design ensures availability and accessibility. Waiting times operate according to specified national standards.[76] Services are operated in a variety of settings including community facilities.[77] Acceptability is continuously monitored.

Telephone advice and emergency consultation at a local medical facility would be available 24 hours a day. Women are given an idea of how much bleeding to expect. The direct experience of pain and bleeding can be distressing and often some discussion and reassurance from an adviser is all that is needed, so direct live contact by phone, video link, or web-based chat is available. Complications are inevitable and experienced staff need to be on hand to deal with these.

Task shifting or sharing optimizes the roles of health care staff.[78] Few abortions need to be provided

by gynecologists.[79] General practitioners play a significant role in service delivery.[80] So-called mid-level providers (nurses, midwives, and physician assistants) can safely provide both medical and surgical abortion.[81] Pharmacists and pharmacy workers are able to safely provide medical abortion.[82]

It is envisaged that many women will practice self-care. It has been demonstrated that self-managed early medical abortion is mostly equivalent to that which is medically supervised, in terms of success rates and safety outcomes. Rates of incomplete abortion requiring surgical evacuation are somewhat higher, which may be because of care provision by clinicians with little experience in settings where abortion is legally restricted.[83]

Women obtain abortion pills through pharmacies or other reliable sources for self-managed abortion.[84] Self-care has equal status to clinician-provided care among health and regulatory systems.

### *Funding*

Many studies report financial barriers to access to abortion.[85] In our vision, women are not expected to rely on charity for such an important component of health care. Some women will have health insurance which may cover abortion. Although women would be at liberty to pay for private services if they wished to, drugs, materials, and fees are all covered by the state for anyone, regardless of their citizenship status. Such cover is the same for any pregnancy outcome (delivery of any type, miscarriage, or ectopic pregnancy). Travel costs are paid by the state when necessary, for example, for people on state benefits or in a low-income bracket.[86]

## Conclusion

We have proposed a vision where there are obligations on the state in pursuance of women's reproductive rights under the headings of duties to respect, fulfill, and protect. We recognize that this imagined world is far from current reality and might never be achieved. So, why bother to formulate such a vision? Many of us have spent considerable time addressing the existence and scope of individual rights/freedoms, and on the possible deconstruction of existing regulatory constraints in the context of abortion. We do not besmirch or seek to undermine these efforts. Rather, our central purpose in this paper is to shift attention away from discussions about the lawfulness of abortion. By starting from a world without constraints, the primary focus turns to the environment and framework of state obligations in which abortion services are accessed and delivered. It is these background factors that provide the critical foundation for the realization of individual rights and freedoms. Any reformist agenda should never lose sight of this.

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