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REVIEW

Self-Managed Abortion in the United States

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Abstract

Purpose of Review This review aims to provide up-to-date information about self-managed abortion in the USA.

Recent Findings Evidence indicates that there is growing demand for self-managed abortion in the USA as obstacles to facility-based care increase, especially since the Supreme Court overturned *Roe v. Wade*. Self-managed abortion with medications is safe and effective.

Summary Based on a nationally representative survey, the lifetime prevalence of self-managed abortion in the USA in 2017 was estimated to be 7%. People experiencing barriers to abortion care, including people of color, people with lower incomes, people in states that have restrictive abortion laws, and those living farther from facilities providing abortion care are more likely to attempt self-managed abortion. While people may use a range of methods to self-manage abortion, there is growing use of safe and effective medications, including mifepristone used together with misoprostol and misoprostol used alone; use of traumatic and dangerous methods is rare. While many people attempt to self-manage their abortion because of barriers to facility-based care, others have a preference for self-care because it is convenient, accessible, and private. While the medical risks of self-managed abortion may be few, the legal risks may be significant. Sixty-one people have been criminally investigated or arrested between 2000 and 2020 for allegedly self-managing their abortion or helping someone else do so. Clinicians play an important role in providing evidence-based information and care to patients considering or attempting self-managed abortion, as well as minimizing legal risks.

Keywords Self-managed · Self-induced · Abortion · Mifepristone · Misoprostol · Criminalization

Introduction

In June 2022, the Supreme Court overturned *Roe v. Wade* in their landmark *Dobbs v. Jackson Women's Health Organization* decision. Since that time, 13 states have completely banned abortion care, and even more states have enacted extreme restrictions early in pregnancy. As access to legal abortion care becomes increasingly restricted in the USA, more people are expected to self-induce or self-manage their abortions. It is important to understand that self-managed abortion (SMA) looks very different now compared to the period before *Roe v. Wade*, largely due to the availability of medications, specifically misoprostol and mifepristone. While people can safely and effectively self-manage their abortions with medications, there are important legal risks to consider. Clinicians should understand SMA in the context of the current legal landscape, including potential benefits and risks to patients, and should be prepared to support people with information and medical care.

Definition of Self-Managed Abortion

Self-managed abortion involves any action that is taken to end a pregnancy outside of the formal healthcare system, and could include self-sourcing medications (e.g., misoprostol, mifepristone, or other medications); using herbs, plants, vitamins, or supplements; consuming drugs, alcohol, or toxic substances; and using physical methods [1••, 2, 3•]. There are a range of resources functioning outside of the formal healthcare system to support people who are self-managing their abortions. These resources include hotlines

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staffed by clinicians, websites where people can get information and order medications, and emotional support services [4•]. Some people who self-manage their abortions may turn to abortion doulas, herbalists, or members of their community. Some may also come into contact with clinicians functioning within the formal healthcare system before, during, or after their abortion. For example, patients may present to clinicians working in restrictive states with questions about how to self-manage, come in for follow-up, or present with rare complications.

Because people who are self-managing their abortions may be supported by clinicians within and/or outside the healthcare system at some point during their process, the distinction between SMA and facility-based abortion can be blurry and lead to legal grey areas. As an example, medication abortion provided through facility-based telehealth services in the US is usually not classified as SMA. However, medication abortion provided to a US-based patient through telehealth by clinicians located in another country may be labelled as SMA by a prosecutor in a state with restrictive abortion laws.

Prevalence of Self-Managed Abortion

A nationally representative survey performed in 2017 found that the lifetime prevalence of SMA was 7% [1••]. In another study of people searching for information about abortion online, the prevalence of SMA was 28% [3•]. Data suggest that rates of attempted SMA appear to be higher among people who experience barriers to abortion care, including people of color, people with lower incomes, and people who live in states that have restrictive abortion laws [1••, 3•, 5]. One survey of transgender, nonbinary, and gender-expansive people found that 19% of those ever pregnant attempted SMA [6].

As more states restrict abortion access and facility-based abortion care becomes increasingly difficult and even impossible for many people to access, rates of SMA are expected to increase. According to a recent study, online searches for abortion medications increased by 162% in the immediate aftermath of the leaked *Dobbs* ruling in May 2022, with the highest rates of online searches occurring in states with restrictive abortion laws [7]. An analysis of requests for medication abortion to the online telemedicine service Aid Access, which operates outside the US, found significant increases after the *Dobbs* decision, with the largest increases in states that implemented complete bans on abortion [8]. A similar increase in requests to Aid Access was observed when some states restricted abortion access at the start of the COVID-19 pandemic [9] and in Texas after a 6-week ban went into effect in 2021 [10].

Methods of Self-Managed Abortion

Before abortion care was legalized nationwide in the US in 1973, some people were able to access this care in a safe and effective way outside of the formal healthcare system. However, many people turned to unsafe or invasive methods of self-managing their abortions, saw untrained providers, and were afraid to present for care when they ran into complications. Because of this, unsafe SMA led to significant morbidity and mortality, resulting in the use of terms like "coat-hanger" and "back-alley" abortion [4•]. While unsafe SMA has not completely disappeared, it has become much less widespread, partly due to the increased availability of medication abortion within and outside the healthcare system. The availability of misoprostol and mifepristone has led to significant declines in abortion-related morbidity and mortality in places that have limited access to safe and legal abortion care [11].

Data suggest that people continue to use a range of methods to self-manage their abortions, including misoprostol with or without mifepristone, contraceptives, herbs, vitamins, supplements, over-the-counter medications like pain relievers, drugs, alcohol, toxic substances, uterine extraction, and physical methods such as abdominal trauma [1••, 2, 3•]. A 2017 cross-sectional survey of 7,022 women found that, among participants who reported attempting SMA, 20% used misoprostol, 29% used another medication or drug, 38% used herbs, and 20% used physical methods. In the study of people seeking information about abortion online, the most common SMA method category was herbs, vitamins, or supplements, reported by 52% of those attempting SMA ($n = 242$) [3•].

Safety and Effectiveness of Self-Managed Abortion

Extensive data demonstrate that medication abortion with mifepristone and misoprostol or misoprostol used alone is safe and effective [12]. In addition, multiple studies have demonstrated that people can safely and effectively self-manage their abortions using these medications, particularly in the first trimester [13••, 14•]. Overall, SMA with medications utilizes the same drugs and processes as facility-based abortion with medications. Data indicate that most people can accurately self-assess their gestational duration as eligible for medication abortion (generally up to 10 or 11 weeks of pregnancy) by answering simple questions [15]. Other eligibility criteria are based on self-reported medical history. Patients are also able to accurately self-assess abortion completion using symptom

checklists and urine pregnancy tests [16–18]. A prototype over-the-counter label for a mifepristone-misoprostol product was found to be well-understood by potential users, suggesting that people could use these medications safely on their own without clinician involvement [19].

Outcomes of SMA with mifepristone and misoprostol are similar to those after facility-based medication abortion. One study looked at 4,584 people in the US who received abortion medications by mail from Aid Access, the out-of-country online telemedicine service mentioned above, between 2018 and 2019. This study found that 96.4% of participants who used the medications for first-trimester abortion and provided outcome information successfully ended their pregnancy without intervention, and 1% reported treatment for a serious adverse event (e.g., receiving a blood transfusion or intravenous antibiotics) [14•].

Compared to SMA in the first trimester, there are significantly less safety and efficacy data for SMA with mifepristone and/or misoprostol after 12 weeks of pregnancy. However, in places where abortion is legally restricted, there have been reports of people safely using medications for abortion after the first trimester with assistance from an online telehealth service or an accompaniment model [20–22]. Notably, people self-managing their abortions with medications later in pregnancy may be more likely to need procedural intervention, such as uterine aspiration or dilation and evacuation, than those using medications for SMA in the first trimester, and should have access to competent and compassionate emergency care if needed.

There are also limited safety and efficacy data related to other methods of SMA. One study involving qualitative interviews with 18 people who attempted SMA found higher rates of effectiveness among those who used misoprostol than among those using other methods such as home remedies [23]. It is important to note that many communities have long turned to particular herbal regimens to induce abortion; however, these SMA methods have not been well studied. Some people using less effective methods of SMA, such as taking contraceptives or consuming alcohol, may not recognize right away that their pregnancy is continuing, which could delay their presentation for facility-based care. Physical SMA methods, such as hitting oneself in the abdomen or falling down stairs, obviously could cause significant harm.

Reasons for Self-Managing Abortion

People who have attempted SMA report a range of reasons for doing so [1••, 3•, 24]. Barriers to facility-based abortion care, including long distance to a clinic and cost of care, are an important motivating factor. Other people report a preference for self-care. In the 2017 national survey, participants who had ever attempted SMA ($n=92$) reported the following reasons: 47% because it seemed easier or faster, 25% because the clinic was too expensive, 14% because they thought they needed parent's consent, 13% because it seemed natural, 13% because the clinic was too far away, 8% because they did not know where a clinic was, 6% because they use vitamins or herbs whenever sick, and 17% for other reasons [1••]. Other research has found that needing to keep the abortion a secret, fearing for one's safety or well-being, and needing to gather money for travel or for the abortion were associated with attempting SMA [3•].

As noted above, as barriers to facility-based care increase, it is anticipated that SMA will increase. A survey of patients at abortion clinics in 2019 found that 34% would consider SMA if they could not obtain care at a facility [25]. Some of the factors that were associated with considering SMA included not having health insurance or experiencing obstacles that delayed their ability to obtain an abortion.

Qualitative research also documents the wide range of motivating factors for attempting SMA, from barriers to facility-based care to preference for self-management [23, 26, 27]. People attempting SMA often did so because it was convenient, accessible, and private, and some felt empowered by the ability to do something on their own before going to a clinic. Interviews with people in Texas found similar themes, although barriers to care, including financial obstacles, commonly left these research participants feeling like SMA was the only option available to them [23]. Another study found that skepticism about the trustworthiness of websites offering medication abortion online may lead some to consider ineffective or unsafe methods of SMA [27].

Legal Risks of Self-Managed Abortion

While very few states explicitly ban SMA, prosecutors have used a range of laws to target people involved in SMA attempts [28]. A recent investigation identified 61 cases of people who were criminally investigated or arrested between 2000 and 2020 for allegedly self-managing their abortion or helping someone else do so [29]. Among the 54 cases involving adults, most were living in poverty, and a higher proportion were Black, Latinx, or Asian compared to national statistics. In almost half of cases, a social worker or healthcare provider reported the patient to the police. Of note, as of the date of writing, no jurisdiction currently mandates reporting of SMA.

US public opinion is decidedly against criminalizing SMA. In a nationally representative survey of women of reproductive age, only 17% thought SMA should be against the law; 59% said it should not be illegal, 19% were unsure, and 5% had other responses [30]. Even among respondents living in states with laws that could be used to punish someone attempting SMA, the majority did not support making SMA illegal.

Role of Clinicians in Self-Managed Abortion

Regardless of where one practices, it is becoming more and more likely that clinicians will encounter a patient considering or who has attempted SMA. A 2017 survey of abortion providers found that 69% had cared for a patient who had attempted SMA [31]. As states ban abortion and dedicated abortion-providing facilities close, it is increasingly likely that generalist obstetrician-gynecologists, primary care clinicians, and emergency medicine clinicians will care for these patients.

If a patient mentions they are considering SMA, the clinician should take a harm-reduction approach to support them in their decision. This approach was developed initially in Uruguay and was associated with a reduction in abortion-related morbidity and mortality [32]. In fact, data indicate that Uruguay's abortion-related harm-reduction program reduced maternal mortality in the country due to unsafe abortion from 37.5% to 8.1% over a decade [33]. In the US, such an approach would involve giving information about options for facility-based care, including clinics in other states and financial support available for travel and to pay for care, as well as evidence-based information about use of medications for SMA [34]. Clinicians could evaluate patients for their medical eligibility for medication abortion, including performing ultrasound if the gestational duration by history was uncertain or if the patient was at increased risk of an ectopic pregnancy. Patients would then need to obtain the medications on their own, either online or though other networks. Patients should be offered follow-up care to confirm abortion completion and manage any side effects or rare complications. While there may be legal risks to this approach both for clinicians and patients, some providers may feel ethically compelled to offer this care to those who have few other options.

People attempting SMA may also present for care after starting the process. Some may simply want to confirm that the abortion was successful, while others may be experiencing a worrisome side effect or complication. Although clinicians need to be prepared for serious complications after SMA, such as uterine perforation, sepsis, and severe hemorrhage, it is likely that these will be less common than in the pre-*Roe* era [35•]. Clinicians need to be aware of the normal clinical course of medication abortion to avoid unnecessary interventions [36]. For example, an ultrasound demonstrating echogenic intrauterine material may not indicate a need for uterine aspiration if the patient is not having unusual bleeding, pain, or other symptoms.

Clinicians play an important role in minimizing the legal risks to people attempting SMA mentioned above [4•, 37]. Management of patients presenting for care after SMA is often identical to the management of those with spontaneous pregnancy loss. Therefore, details related to the SMA attempt are usually clinically irrelevant, and there is no need to ask patients if they did something on their own to end the pregnancy in most cases. If the patient does divulge this information, it is not necessary to document it in the medical record if it does not affect their clinical care, since such documentation may be used to incriminate them.

Clinicians need to be aware of their local laws and regulations, but as noted above, there is currently no mandate to report SMA. It is important that the entire healthcare team be aware that there is no need to involve the police in a case of suspected SMA. One study conducted in an area of Texas where SMA was relatively common found that clinicians caring for pregnant patients in emergency settings had limited understanding of the laws related to SMA, highlighting a need for future training [38]. Clinicians and patients can also utilize existing resources for support and guidance, such as the organization If/When/How's helpline designed to answer legal questions related to SMA [39].

Conclusion

While SMA has long been used to manage fertility, it is likely to become increasingly prevalent in the US as access to facility-based care becomes more constrained. SMA with mifepristone and misoprostol or misoprostol alone is safe and effective; however, patients commonly use other methods, including herbs and other medications or substances, which may be ineffective and, in rare cases, unsafe. Clinicians play an important role in supporting patients who choose to self-manage their abortion, both by providing accurate information and evidence-based post-abortion care, as well as actively working to minimize the legal risks patients may face.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent All reported studies/experiments with human or animal subjects performed by the authors have been previously published and complied with all applicable ethical standards (including the Helsinki declaration and its amendments, institutional/national research committee standards, and international/national/institutional guidelines).

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