



SFP Interim Clinical Recommendations



The Society for Maternal-Fetal Medicine endorses this document.

Society of Family Planning interim clinical recommendations: Self-managed abortion

Nisha Verma, MD, MPH^{a,b}; Vinita Goyal, MD, MPH^c; Daniel Grossman, MD^d; Jamila Perritt, MD, MPH^e; Grace Shih, MD, MAS^f

^a The American College of Obstetricians and Gynecologists, Washington, DC

^b Department of Gynecologists and Obstetricians, Emory University School of Medicine, Atlanta, GA

^c Population Research Center, The University of Texas at Austin, TX

^d Advancing New Standards in Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, CA

^e Physicians for Reproductive Health, New York, NY

^f Department of Family Medicine, University of Washington, Seattle, WA

<https://doi.org/10.46621/ZRDX9581>

Note: This document follows the lead of advocates, clinicians, and researchers working in the reproductive care space and uses the term “self-managed abortion” (SMA). However, the authors recognize that, like all language, the terminology around SMA continues to evolve. The authors also recognize that SMA has existed in many communities for a long time. Increased interest and attention directed towards those self-managing their own care aims to demedicalize the abortion process and support those who are making this decision, regardless of their circumstances.

1. Background

As access to legal abortion in the formal healthcare system becomes more restricted across the United States (U.S.), there has been increased focus on understanding the ways that individuals may seek care outside of the healthcare system, including through self-managed abortion (SMA). SMA refers to any action taken to end a pregnancy outside of the formal healthcare system, and includes self-sourcing mifepristone and/or misoprostol, consuming herbs or botanicals, ingesting toxic substances, and using

physical methods [1, 2]. SMA can also involve a range of interactions with community support, the formal healthcare system, and clinicians. While some people who are self-managing their abortions may never interact with the formal healthcare system during their process, others may interact with clinicians before, during, or after their abortion. Similarly, some people may be supported by abortion doulas, herbalists, or other individuals working within or outside of the formal healthcare system to facilitate abortion access. Therefore, it is essential that clinicians are aware of the expected course of SMA with medications and its rare complications, complications of other potentially less safe or effective methods, and other nonmedical risks involved in SMA [3].

SMA is not a new phenomenon. Prior to the legalization of abortion in the U.S., some community providers were able to offer patient-centered and safe abortion care outside of the formal healthcare system. However, people also commonly turned to unsafe or invasive methods of self-managing their abortions, relied on unskilled/untrained providers, and feared seeking care when complications arose, contributing to the widespread use of phrases like “coat-hanger” and “back-alley” abortion [4]. During this time, unsafe SMA resulted in significant morbidity and mortality. However, the availability of medications—particularly misoprostol—for SMA has led to declines in abortion-related morbidity and mortality in countries with limited access to safe, facility-based abortion care [5]. Extensive data demonstrate that medication abortion is safe, and more recent data demonstrate that people can safely and effectively self-manage their abortions with medications [6-9]. Currently, the World Health Organization (WHO) estimates that 97% of all unsafe abortions worldwide occur in countries that continue to have decreased access to these medications and restricted or no legal abortion [10].

Recent cross-sectional data suggest that approximately 7% of individuals in the U.S. attempt SMA at some point in their lifetime. Rates of attempted SMA appear to be higher among people experiencing barriers to abortion care, such as people of color, people with lower incomes, and people living in states with restrictive abortion laws [1, 11, 12]. People may choose to self-manage an abortion for many reasons, such as difficulty accessing care in the formal healthcare system due to cost, distance to a clinic that provides abortion care, or legal restrictions. In addition, some individuals prefer SMA due to the privacy, autonomy, and convenience it affords [13, 14]. Even when access to care is available, some people who have experienced stigma and structural racism within the medical system may prefer SMA.

While the medical risks of SMA may be few, the legal risks for people attempting SMA may be significant. Although only three states currently have laws explicitly criminalizing SMA, almost half of U.S. states have at least one law in place that could be used to

prosecute people attempting or assisting with SMA [15, 16]. These policies include legislation explicitly banning SMA, criminalizing harm to the fetus, and criminalizing abortion. For those who have been targeted with criminalization for SMA, many came into contact with law enforcement following interactions with healthcare professionals. However, to date, legal experts are unaware of any laws requiring a healthcare provider to report a self-managed abortion or a patient's intention to self-manage an abortion to law enforcement authorities [3]. In fact, reporting suspicions of SMA can cause harm, violate patients' rights to privacy, and keep people from seeking care that they need. In addition, widespread implicit and explicit biases among clinicians and within the criminal legal system result in disproportionate reporting and prosecution of people of color and people with lower financial means, among others [3, 17]. Therefore, in addition to understanding the clinical aspects of care, clinicians must recognize the legal risks of SMA to best support their patients. While clinicians may have a range of opinions and perspectives on SMA, including feeling that SMA is safe, feeling that SMA is too risky, and feeling that people do or do not have a right to self-manage if desired [18, 19], all clinicians have an obligation to provide compassionate, non-judgmental care to their patients. These interim clinical recommendations provide guidance to help clinicians understand methods and components of SMA, as well as best practices when caring for people interacting with the healthcare system before, during, and after self-managing their abortion.

2. Clinical questions

2.1. Process of self-managing an abortion

1. What are the components of self-managing a medication abortion in the first trimester?

Three components of the self-managed medication abortion process are 1. self-assessment of eligibility, including estimating pregnancy duration and ruling out contraindications to use, 2. self-administration of abortion medications and management of the abortion process, and 3. self-assessment of abortion completion [20]. In addition to these three components, people undergoing SMA should have access to accurate information about how to use abortion medications, the ability to obtain quality abortion medications and medications to manage side effects, and the support of trained health workers and a healthcare facility if they need or desire it [20].

2. What tools exist to help individuals self-assess their eligibility for SMA with medications?

People who self-manage their medication abortions can estimate gestational duration using last menstrual period (LMP) alone [21, 22] or a series of self-reported questions including LMP and other pregnancy dating questions, possibly combined with information about menstrual regularity and contraceptive use [23]. Numerous pregnancy calculators are available online and studies have shown calculators are easy-to-use and accurate [24, 25]. Additionally, pregnancy calculators are often embedded in websites that provide information on SMA with medications (e.g. [Aid Access](#), Self-Managed Abortion Safe & Supported, Euki app). Of note, privacy experts have raised concerns about data collected through period tracking applications and online pregnancy calculators potentially being used to penalize people seeking or considering abortion in states where abortion is illegal [26]. People who are unsure of their gestational duration may obtain an ultrasound.

Direct patient-facing eligibility checklists for medication abortion have not been widely adopted or disseminated, but they are in development and show promise [27]. A prototype over-the-counter label for a mifepristone-misoprostol product was recently developed and found to be well-understood by potential users [28]. Laboratory assessment (Rh typing, hemoglobin/hematocrit) is not routinely needed for medication abortion in the first trimester [29].

While U.S. guidelines for medication abortion recommend use up to 77 days of gestation [6, 29], it is important to recognize that WHO guidelines provide treatment regimens for medication abortion \geq 12 weeks and that people who use mifepristone and misoprostol for SMA may be at a wide range of gestational ages [20].

3. What resources exist to help individuals find medications and to support them during self-management of their abortion?

Unlike in some other countries like Mexico, where misoprostol can be purchased from pharmacies without a prescription, people in the U.S. are usually unable to access misoprostol within the healthcare system without clinician involvement. However, organizations and resources functioning outside of the healthcare system can help individuals access the medications they need to self-manage. The Plan C website (<https://www.plancpills.org/>) provides reliable up-to-date information on how to obtain abortion pills online for those in the U.S. They list groups that provide medications and clinical services outside of the formal healthcare system, as well as online pharmacies without clinical support. Aid Access (<https://aidaccess.org/en/>) is a global service that aims to support all people seeking safe and effective medication management of an abortion or miscarriage. Aid Access consists of a team of doctors, activists, and advocates working outside of the formal healthcare system who provide information and

send medications to those in need of a safe abortion after evaluating people for eligibility.

There are several other resources available to support people who are self-managing their abortions.

For clinical questions:

- Miscarriage & Abortion Hotline (<https://www.mahotline.org/>) – This is a confidential, private, and secure phone/text hotline (833-246-2632) for questions during the SMA process. The hotline is staffed by licensed clinicians. No personal information is required and the hotline is currently open 8a-11p in all continental U.S. time zones, 7 days a week. English and Spanish.
- Self-Managed Abortion; Safe & Supported (<https://abortionpillinfo.org/>) – SASS is the U.S. project of Women Help Women, which is a global nonprofit that supports the rights of people to have information about and access to safe abortion with pills. Their website provides information on SMA and minimizing legal risks, and counselors can be contacted via a secure web portal. They are available in English, Spanish, Portuguese, Polish, Thai, French, Italian and Korean.
- Other clinical resources include
 - Reproductive Health Access Project (RHAP) Factsheets on how to use abortion pills
 - [Mife/Miso medication abortion](#)
 - [Misoprostol-only medication abortion](#)
 - Doctors without Borders [Self-managed abortion video series](#)
 - Aid Access [How to use abortion pills video](#)
 - Ipas [How to have an abortion with pills](#) guide and video
 - Innovating Education in Reproductive Health: [When abortion is Not Available video series](#)

For emotional support:

- All-Options (<https://www.all-options.org/>) – This is a peer-based talkline (888-493-0092) to discuss pregnancy options or talk about past/current experiences with abortion, adoption, parenting, infertility, or pregnancy loss. At the time of publication of this document, they are open Monday-Friday 10-1a EST; Saturday/Sunday 10-6p EST.
- Connect & Breathe (<http://www.connectandbreathe.org/about.html>) – This is a peer-based talkline (866-647-1764) for nonjudgmental support after abortion. At the time of publication of this document, they are open Mon 7-10p EST; Tuesday-Thursday 6-9p EST; Saturday 12-3p EST.

- Exhale (<https://exhaleprovoice.org/>) – This is a peer-based phone/text hotline (617-749-2948) for emotional support around abortion. At the time of publication of this document, they are open weekdays 3p-9p PST, Saturdays 1p-9p PST, and Sundays 3p-7p PST.
- Reprocare Healthline (<https://abortionhotline.org/>) – This is an anonymous healthline (833-266-7821) providing peer-based emotional support, medical information, and referrals to those having an abortion at home with pills. At the time of publication of this document, the hotline is open 9a-9p PST, 7 days a week.

For legal questions:

- If/When/How (<https://www.reprolegalhelpline.org>) – If/When/How runs a legal helpline to answer questions about legal rights and self-managed abortion. The helpline can be accessed by leaving a phone message at 844-868-2812 or filling out a secure online form any time of day. Interpreter services are available.

4. *What medication regimens can be used for self-managed abortion?*

A prospective cohort study demonstrated non-inferiority of SMA (using mifepristone and misoprostol or misoprostol-only) to clinic-facilitated medication abortion up to 63 days' gestation [7]. Currently, the U.S. Food and Drug Administration (FDA)-approved label for mifepristone includes a regimen for medication abortion that is a combination of mifepristone 200 mg orally followed by misoprostol 800 µg buccally 24 to 48 hours later. The WHO recommends the same dose and route of administration of mifepristone with use of misoprostol 800 µg either vaginally, sublingually, or buccally 24 to 48 hours later. Shortening the interval between mifepristone and vaginal misoprostol to 0 to 8 hours has been shown to be very highly, but slightly less effective than a 24 to 48 hour interval and may be statistically non-inferior [30, 31]. The effectiveness of a combined mifepristone and misoprostol regimen is approximately 98% at ≤49 days gestation and slightly decreases with advancing gestational duration to approximately 93-95% at 64-70 days [6]. Addition of a second dose of misoprostol 800 µg four hours after the first increases effectiveness of medication abortion to 97-99% in gestations between 64-77 days [32]. The WHO recommends, for individuals self-managing their abortions with mifepristone and misoprostol, to consider this regimen up to 12 weeks of gestation [20]. Another recommended regimen >10-12 weeks' gestation involves mifepristone 200 mg orally, followed 24-48 hours later with misoprostol 800 µg used vaginally, sublingually, or buccally and then misoprostol 400-800 µg every 3 hours until expulsion of pregnancy tissue [3]. Oral misoprostol should be avoided since it is less effective than the alternate routes [6]. People may be advised to avoid vaginal administration of misoprostol for

abortion or miscarriage management to eliminate the risk of detection based on residue in the vagina if they present to a clinic or hospital.

If mifepristone is not available or accessible, an alternative regimen for medication abortion involves misoprostol 800 µg used vaginally, sublingually, or buccally with repeated doses every 3 hours up to 3 doses or until expulsion occurs [6, 20]. A systematic review with meta-analyses evaluating the effectiveness of a variety of misoprostol-only regimens used ≤91 days' gestation (median 64 days) demonstrated ongoing pregnancies in 6.8% (95% CI 5.3%, 8.5%) [33]. Effectiveness of misoprostol-only regimens among people self-managing abortion is higher compared to those managed within the healthcare system [34]. These findings may be attributable to use of additional misoprostol doses and avoidance of quick follow-up intervals in which patients are recommended to undergo early surgical intervention [7, 34]. At this time, the WHO suggests that letrozole 10mg orally each day for 3 days followed by misoprostol 800µg sublingually on the fourth day may be safe and effective as an alternative regimen, but further evidence is needed [20].

Few studies have examined the effectiveness and outcomes of SMA between 12 to 24 weeks' gestation. The recommended regimen at this gestational range using mifepristone and misoprostol is the same as the regimen for 10 to 12 weeks' gestation detailed above [3]. For people using misoprostol-only, a regimen of misoprostol 400 µg buccally, vaginally, or sublingually every 3 hours until passage of pregnancy tissue is advised. An initial dose of misoprostol 600-800 µg may increase efficacy [3]. People at this gestational duration may uncommonly experience heavy bleeding, fever, and desire to follow-up with a healthcare facility for confirmation of abortion completion [7, 35].

5. How can people self-assess completeness of a self-managed abortion with medications?

People who self-manage medication abortion can effectively self-assess abortion completion [20]. Strategies that people can use to self-assess abortion completion include reviewing checklists of symptoms during and after abortion alone or in combination with home urine pregnancy tests.

Symptom checklists to self-assess abortion completion include questions about cramping, bleeding, passing of blood clots, and abatement of pregnancy symptoms such as nausea and breast tenderness after taking medication abortion pills. People experiencing no bleeding within 24 hours of taking misoprostol, bleeding less than 4 days, bleeding lighter than a typical menses, or ongoing pregnancy symptoms are instructed to seek care from a trained health professional [27, 36, 37]. Few studies have

examined the effectiveness of symptom checklists alone in self-assessed completion of abortion. These studies suggest that such checklists either require further refinement or may not add to the accuracy of diagnosing ongoing pregnancy over follow-up urine pregnancy tests [27, 37].

The different types of urine pregnancy tests used in studies evaluating patient assessment of SMA completion include high-sensitivity pregnancy tests (HSPT) which detect urine human chorionic gonadotropin (hCG) levels as low as 25 mIU/mL (milli-international units/milliliter), low-sensitivity pregnancy tests (LSPT) which are positive at urine hCG levels of 1000-2000 mIU/mL, and multilevel pregnancy tests (MLPT) which currently have very limited availability worldwide. Using a home pregnancy test self-assessment strategy, a person is instructed to take the first test on the day of mifepristone use and a repeat test approximately 7-30 days later. A negative LSPT, negative HSPT, or declining MLPT by at least one bracket level is consistent with a complete abortion [38].

A sample protocol for self-assessment of abortion completion recommends performing a follow-up HSPT four weeks after taking misoprostol. If the first HSPT is positive and the individual has no signs and symptoms of ongoing or ectopic pregnancy, it is advised to repeat the HSPT one week later. If the second HSPT is also positive, clinical evaluation is recommended [39].

Urine hCG levels naturally decline toward the end of the first trimester, thus calling into question the effectiveness of home urine pregnancy tests to self-assess abortion completion beyond 63 days gestation. Whitehouse et al. compared the effectiveness of a LSPT and symptom checklist performed approximately 14 days after mifepristone use to ultrasound follow-up among patients using medication abortion at 64 to 70 days gestation. Among 558 patients, 2.3% had an ongoing pregnancy. An LSPT correctly identified all ongoing pregnancies (100% sensitivity) and the symptom checklist alone had a sensitivity of 76.9%. Using a combined symptom checklist and LSPT self-assessment strategy did not improve diagnostic accuracy of detecting an ongoing pregnancy over LSPT alone [37].

Studies evaluating the effectiveness of self-assessment of abortion completion indicate that MLPTs provide confirmation of completed abortion ≤ 63 days gestation for $>90\%$ of patients at 7 days after mifepristone use [40].

Overall, patients are well-equipped to perform and interpret home urine pregnancy tests and prefer self-assessment to in-clinic evaluation [37, 40-45].

6. What are other ways people may self-manage an abortion?

People report using a range of methods to self-manage their abortions other than misoprostol with or without mifepristone, including herbs, supplements, over-the-counter medications (such as pain relievers), toxic substances, uterine extraction, and physical methods, such as getting hit in the abdomen [1, 2]. A recent cross-sectional survey study found that, of participants who attempted SMA, 20.0% used misoprostol, 29.2% used another medication or drug, 38.4% used herbs, and 19.8% used physical methods [1]. A recent qualitative study of individuals reporting SMA found that half attempted SMA with herbs, including vitamin C, parsley, and black cohosh while some others took medications including analgesics, oral contraception, and caffeine pills [46]. Minimal efficacy data exist for these other methods, and observational studies of patients self-managing with these methods generally report lower effectiveness compared to misoprostol with or without mifepristone [1, 47]. People using less effective methods may not recognize immediately that the pregnancy is continuing, and some may be delayed past the point at which facility-based abortion care is accessible [48].

Safety data are also limited for methods other than mifepristone and misoprostol. A number of herbs used for SMA may be highly toxic if used incorrectly [49]. Methods that involve physical trauma, although reported rarely in the U.S. in recent decades, may cause substantial harm [49].

As noted above, there is limited evidence on SMA with mifepristone and misoprostol or misoprostol alone used after 12 weeks of pregnancy. However, there are reports of people safely using these medications after the first trimester in the context of an online telehealth service or from an accompaniment model in countries where abortion is legally restricted [35, 50-52]. People using medications for SMA later in pregnancy may be more likely to need surgical intervention compared to those in the first trimester, and it is important to have access to emergency care in the case of rare complications, such as retained placenta or heavy bleeding.

2.2. Providing care to individuals who present before, during, and after self-managing an abortion

7. How should clinicians approach conversations with patients who may be considering self-managed abortion?

Patients may share that they are considering or planning to self-manage an abortion to their clinician. Data from multiple countries indicate that, in settings where abortion access is limited, clinicians can use a harm reduction approach to improve patient

outcomes and decrease morbidity and mortality from unsafe abortion [53-60]. A harm reduction approach aims to reduce the negative effects of a particular behavior when complete elimination of that behavior is not a realistic or desirable goal [53, 61]. This approach centers patient autonomy by reducing potential negative effects associated with a particular behavior rather than insisting upon abstinence. As an example, in Uruguay, the non-governmental organization Iniciativas Sanitarias developed a program to support people planning to have an abortion outside of the formal healthcare system when abortion was criminalized across the country. As part of this program, clinicians informed people who could not access a clinic-based abortion about other options, including SMA. They reviewed the risks of SMA according to the patient's gestational duration and abortion method, and provided people with information about the WHO-recommended regimen for safe and effective termination of pregnancy in the first trimester with misoprostol. They also provided people with support post-abortion, evaluating for complications, ongoing pregnancy, and other concerns [54, 60]. Data indicate that Uruguay's harm reduction program, over a decade, reduced maternal mortality in the country due to unsafe abortion from 37.5% to 8.1% [62].

A similar harm reduction approach to care has been proposed in the U.S. [53]. Currently, many people in the U.S., particularly communities and/or individuals who are marginalized from care, face significant barriers to accessing an abortion. Likely, these barriers will become more severe and widespread as states further restrict abortion. In an increasingly restrictive legal landscape, a harm reduction model that is incorporated not just by obstetrician-gynecologists, but also by emergency medicine, family medicine, internal medicine, pediatricians, and advanced practice clinicians, could improve people's safety and outcomes when clinicians are unable to directly provide abortion care within the formal healthcare system.

As part of this model, clinicians should first assess whether a patient plans to continue a pregnancy through non-judgmental, non-directive counseling. The clinician should also assess the patient's gestational duration, and evaluate for medical conditions that could impact safety of SMA [53]. Clinicians can then counsel about risks of particular methods of SMA based on the patient's gestational duration and health conditions and provide information about safe and effective methods of self-management in the first-trimester using medications. Clinicians should also review anticipatory guidance around expected side effects and potential complications and should ensure that patients are aware that they can present for non-judgmental follow-up care if concerns arise.

Importantly, clinicians should counsel patients considering SMA clearly about legal risks of criminalization. Thus far, healthcare professionals are not required to report intention to nor attempts to self-manage an abortion to law enforcement authorities in any state.

However, it is important for patients to understand that clinicians may feel compelled to report a disclosure of SMA in instances of co-occurring abuse or attempted self-harm, for example. Even in these instances, reporting a disclosure of SMA is not required (see below) and may result in criminal prosecution of the patient. Clinicians should be upfront about which circumstances they feel compelled to report a disclosure of SMA. Being aware of this allows patients to make informed decisions about what they disclose to their clinicians. Clinicians should also carefully consider what they document in the medical record, knowing that medical records can be subpoenaed during an investigation.

Similarly, clinicians should be aware of their own legal risks when discussing SMA with patients, and should consider seeking legal advice to help determine this risk. While information sharing is legal in most circumstances, offering medical advice or directing patients to particular places where they can access medications for SMA may expose clinicians to medical-legal liability.

8. How should clinicians approach caring for a patient who presents with complications during or after self-managing an abortion?

Patients may seek care after initiating SMA because they have symptoms of a potential complication or because they want confirmation the abortion is complete. Some patients may be hesitant to share specific information with clinicians due to fear of judgement or a negative reaction leading to poor treatment or concerns about criminalization [63]. As always, the healthcare team should focus on providing compassionate and non-judgmental care that aims to avoid any risk of criminalizing the patient, and should only seek the information that is necessary to provide this care.

Serious complications after SMA, including uterine perforation, severe hemorrhage, and sepsis, are rare and reviewed elsewhere [3]. Many patients may seek care due to bleeding, pain, or other symptoms that require only minimal treatment or expectant management and reassurance. Clinicians in the emergency department or urgent care settings may have minimal experience with medication abortion and may need education to avoid unnecessary uterine aspirations after completed SMA.

In most cases, clinical management of patients who have attempted SMA is identical to the care of those with spontaneous pregnancy loss, and there is no need to ask or document in the medical record whether the person intentionally did something to try to end the pregnancy. Asking patients about whether they had a prior ultrasound during the pregnancy may be helpful to rule out ectopic pregnancy. If a patient has signs concerning for possible physical trauma, asking about what was used may be clinically

relevant, but care should be taken to avoid documentation that may put the patient at legal risk. In some states, abortion restrictions may complicate clinicians' ability to appropriately care for a patient after an SMA attempt when fetal cardiac activity is still present. For example, if a patient attempted SMA and presents with light bleeding and a continuing pregnancy, the clinician may not be able to intervene. If a patient attempted SMA and presents with ruptured membranes and a fetus with cardiac activity but has signs of uterine infection, the clinician may be able to intervene. It is important for clinicians to work with their clinic and hospital staff to create policies to help facilitate evidence-based, compassionate care in these situations.

Clinicians should be sensitive to the fact that patients may be concerned about the potential legal risks of SMA. Patients should be given information about If/When/How's Repro Legal Helpline (see above) for legal support. Clinicians should recognize that some patients may intentionally choose to withhold information relevant to their clinical presentation, and this decision should be respected and supported. Rarely does such withholding of information affect the care provided.

9. *What privacy and confidentiality considerations should clinicians address when caring for a patient who is self-managing or has self-managed an abortion?*

Unfortunately, unnecessary reports to the police by clinicians is a leading cause of criminalization of people who self-manage their abortions [64]. These reports can lead to patients being incarcerated, losing custody of children, being fined, or having a permanent criminal record. Criminalization of SMA disproportionately harms those from marginalized communities and those who are more likely to experience surveillance from the criminal legal system [64]. It is therefore essential that clinicians understand how to protect patient privacy and confidentiality when caring for a patient who is self-managing or has self-managed an abortion. As such, clinicians should be intentional about the information they request from patients. For example, given that complications of a spontaneous abortion and self-managed abortion with medications present similarly, clinicians often do not need to differentiate between the two scenarios to appropriately treat a patient [3]. Similarly, some patients may present to the hospital or clinic with fetal tissue that they passed at home, or may pass tissue while presenting to the hospital or clinic for bleeding, pain, or other concerns. In these situations, it is often not relevant to the patient's care whether they have had a miscarriage or self-managed an abortion, and clinicians can put patients at risk by asking about or documenting SMA. Clinicians can protect patients by only gathering and documenting information that is relevant to their current and future medical care. For example, a clinician can

chart that a patient believes she was pregnant and is now bleeding, without specifying additional details.

To help clinicians understand their mandatory reporting obligations while also protecting patient agency and confidentiality, If/When/How produced “Patient Confidentiality and Self-Managed Abortion: A Guide to Protecting Your Patients and Yourself” [64]. Here, legal advocates review common situations where healthcare professionals may feel they need to report SMA. As a guiding principle, If/When/How urges clinicians to ensure patients are aware of what healthcare professionals may have to report prior to requesting information that could result in criminalization. The following provides a brief overview of the common situations they highlight, and more detail can be found in their guide.

1. Child and vulnerable adult abuse: Healthcare professionals are considered mandatory reporters for suspected child abuse and neglect in every state, and for vulnerable adult abuse in most states. However, a minor or vulnerable adult self-managing an abortion is usually not reportable as abuse.

2. Statutory rape: Some states require clinicians to report statutory rape. However, the fact that a patient attempted SMA does not need to be reported.

3. Certain traumas and injuries: Many states require clinicians to report certain violent injuries, such as gunshot or stab wounds, to law enforcement. However, SMA is typically not a reportable injury.

4. Abortion: Most states have a system in place for clinicians to report abortion for vital statistics purposes. Commonly, clinicians only have to report abortions that they perform themselves, and do not need to report a patient’s self-managed abortion.

5. Self-harm: Some states require clinicians to report concerns that a patient is at imminent risk of self-harm. Patients who are planning on SMA are not ordinarily considered at risk of self-harm. If a patient does disclose that they are considering serious self-injury to end a pregnancy, clinicians should practice harm reduction techniques. In some cases, they may need to report intention to cause self-injury, but do not need to report the reason behind the intention.

6. Overdoses and drug use during pregnancy: While some states mandate reporting in the event of a drug overdose, clinicians are not required to report the intent behind the overdose. Therefore, clinicians do not need to document or report that a patient overdosed in order to end a pregnancy.

10. How should a clinician deal with laws criminalizing SMA in their state when caring for patients?

The criminalization of SMA must be situated within the larger web of efforts to criminalize pregnancy and pregnancy outcomes, including the expansion of the surveillance and criminalization of bodily autonomy, mutual aid and other types of self-managed care for communities. Restrictions on abortion and criminalization of abortion care affect everyone, yet fall the hardest on those who are most marginalized and likely to face financial and logistical barriers to care. Often, these are the same communities who are disproportionately surveilled, targeted, and harmed by law enforcement. People of color, people who are struggling financially, residents of rural communities, immigrants, and trans, nonbinary, and gender-expansive people disproportionately face the risk of criminalization for the outcome of their pregnancies, including pregnancies that end as a result of SMA [17].

Throughout the U.S., individuals have been prosecuted for a variety of actions during pregnancy alleged to have caused harm or risk of harm to fetuses they were carrying, including arrest, prosecution, and incarceration for allegedly self-managing their abortions [65]. People have been unjustly arrested, prosecuted, and even jailed for ending their own pregnancies and had their own search histories and digital footprints used as evidence to prosecute and sentence them for feticide. In some cases, these prosecutions are a result of laws that explicitly criminalize SMA or that criminalize harm to the fetus, while in other cases, charges have been brought in relation to the disposal of pregnancy tissue or because people obtained, or helped someone else obtain, abortion-inducing medications [66]. Far too many of these individuals were brought to the attention of law enforcement after being reported by clinicians while seeking care [67].

There is a long history of criminalization of people seeking access to medical care. For example, clinicians and other members of the healthcare team have historically collaborated with law enforcement to police, criminalize or civilly commit disabled people, people with unmet mental health and/or housing needs, and immigrants. For many groups who are marginalized, the places others may go to seek care instead function as routine sites of surveillance, policing, criminalization, punishment and control [68].

Whether a person has self-managed an abortion or experienced a pregnancy loss for other reasons, criminalization is never the right response. Threatening patients with criminal punishment erodes trust in the medical system, making people less likely to seek help when they need it [69]. Criminalization makes people less safe, violates the patient–clinician relationship and creates uncertainty as to whether law enforcement will become

involved. Any statute or legal measure that utilizes the criminal legal system as a way to control or manage behaviors during pregnancy is counterproductive to the overarching goal of improving maternal and neonatal outcomes. Criminalization, surveillance, and incarceration cause real harm to the people who are targeted, as well as to their families and communities.

Recommendations

Clinicians should advocate for the repeal or reform of any laws used to criminalize patients for SMA and other pregnancy outcomes, as well as against measures that undermine the privacy of patient information.

Clinicians should be aware that increasing stigma and scrutiny around abortion increase the likelihood that patients will face criminalization.

Clinicians should clearly communicate with all members of the healthcare team, including social work, nursing, and other staff, about the importance of pushing back against the criminalization of patients. Healthcare professionals must commit to mitigating risk for their patients and provide abortion care and miscarriage management that does not put their patients at risk of being targeted by the criminal legal system.

When possible, hospitals (or hospital departments) should devise a protocol for treating pregnancy complications that provides the maximum protection possible for patient privacy.

3. Conclusions and Recommendations

People may or may not interface with the formal healthcare system at different points while self-managing their abortions. Evidence suggests that people can safely and effectively self-assess their eligibility for medication abortion, self-manage the process of taking medications and the abortion process, and self-assess abortion completion. At the same time, data suggest that some people may self-manage their abortions using less safe means such as other drugs or physical methods. It is important for clinicians to provide non-judgmental, compassionate care to all patients interfacing with the formal medical system while self-managing their abortions, and to seek only the medical information necessary to provide this care. The Society of Family Planning (SFP) reaffirms a clinician's obligation to respect the dignity, privacy, and autonomy of all people. SFP, in line with APHA, ACOG, and SMFM, also strongly opposes the criminalization of SMA, and urges all clinicians to educate themselves and others on ways to protect pregnant people from criminalization.

4. Recommendations for Future Research

- The optimal misoprostol-alone regimen, including number of repeated doses, necessary to effectively induce complete abortion across the spectrum of gestational duration
- Larger studies evaluating effectiveness and patient satisfaction related to SMA in the second trimester
- Safety and effectiveness of herbal preparations for SMA
- Evaluation of harm reduction approaches to SMA in the first and second trimester in the U.S.
- Evaluation of a training curriculum and other resources to educate clinicians on supporting patients self-managing their abortions

References

- [1] Ralph, L., et al., *Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States*. JAMA Netw Open, 2020. **3**(12): p. e2029245.
- [2] Moseson, H., et al., *Self-managed abortion: A systematic scoping review*. Best Pract Res Clin Obstet Gynaecol, 2020. **63**: p. 87-110.
- [3] Harris, L.H. and D. Grossman, *Complications of Unsafe and Self-Managed Abortion*. N Engl J Med, 2020. **382**(11): p. 1029-1040.
- [4] Donovan, M. *Self-Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*. Guttmacher Institute, 2018.
- [5] Singh, S., et al. *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. 2018 [cited 2022 April 26]; Available from: <https://www.guttmacher.org/report/abortion-worldwide-2017>.
- [6] *Medication abortion up to 70 days of gestation*. ACOG Practice Bulletin No. 225. Obstet Gynecol, 2020. **136**: p. 31-47.
- [7] Moseson, H., et al., *Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls*. The Lancet Global Health, 2022. **10**(1): p. e105-e113.
- [8] Aiken AR, R.E., Morber JR, Gomperts R, *Safety and effectiveness of self-managed medication abortion provided using online telemedicine in the United States: A population based study*. The Lancet Regional Health-Americas, 2022.
- [9] Reynolds-Wright, J.J., et al., *Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic*. BMJ Sex Reprod Health, 2021. **47**(4): p. 246-251.
- [10] World Health Organization. *Abortion*. 2021 [cited 2022 April 22]; Available from: <https://www.who.int/news-room/fact-sheets/detail/abortion>.
- [11] Upadhyay, U.D., A.F. Cartwright, and D. Grossman, *Barriers to abortion care and incidence of attempted self-managed abortion among individuals searching Google for abortion care: A national prospective study*. Contraception, 2022. **106**: p. 49-56.
- [12] Aiken, A.R.A., J.E. Starling, and R. Gomperts, *Factors Associated With Use of an Online Telemedicine Service to Access Self-managed Medical Abortion in the US*. JAMA Netw Open, 2021. **4**(5): p. e2111852.
- [13] Aiken, A.R.A., et al., *Motivations and Experiences of People Seeking Medication Abortion Online in the United States*. Perspect Sex Reprod Health, 2018. **50**(4): p. 157-163.
- [14] Moseson, H., et al., *Abortion attempts without clinical supervision among transgender, nonbinary and gender-expansive people in the United States*. BMJ Sex Reprod Health, 2022. **48**(e1): p. e22-e30.
- [15] Raifman, S., et al., *Exploring Attitudes About the Legality of Self-Managed Abortion in the US: Results from a Nationally Representative Survey*. Sexuality Research and Social Policy, 2021. **19**(2): p. 574-587.

- [16] If/When/How. *Roe's unfinished promise: 2019 update*. 2019 [cited 2022 April 22]; Available from: <https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update/>.
- [17] Paltrow, L.M. and J. Flavin, *Arrests of and forced interventions on pregnant women in the United States, 1973-2005: implications for women's legal status and public health*. *J Health Polit Policy Law*, 2013. **38**(2): p. 299-343.
- [18] Baldwin, A., et al., *U.S. Abortion Care Providers' Perspectives on Self-Managed Abortion*. *Qual Health Res*, 2022. **32**(5): p. 788-799.
- [19] Kerestes, C.A., et al., *Abortion providers' experiences and views on self-managed medication abortion: an exploratory study*. *Contraception*, 2019. **100**(2): p. 160-164.
- [20] World Health Organization. *Abortion care guideline*. 2022; Available from: <https://www.who.int/publications/i/item/9789240039483>.
- [21] Schonberg, D., et al., *The accuracy of using last menstrual period to determine gestational age for first trimester medication abortion: a systematic review*. *Contraception*, 2014. **90**(5): p. 480-7.
- [22] Macaulay, S., et al., *Reliability and validity of last menstrual period for gestational age estimation in a low-to-middle-income setting*. *J Obstet Gynaecol Res*, 2019. **45**(1): p. 217-225.
- [23] Ralph, L.J., et al., *Accuracy of self-assessment of gestational duration among people seeking abortion*. *Am J Obstet Gynecol*, 2022. **226**(5): p. 710 e1-710 e21.
- [24] Shellenberg, K.M., et al., *Determining the accuracy of pregnancy-length dating among women presenting for induced abortions in Ghana*. *Int J Gynaecol Obstet*, 2017. **139**(1): p. 71-77.
- [25] Momberg, M., J. Harries, and D. Constant, *Self-assessment of eligibility for early medical abortion using m-Health to calculate gestational age in Cape Town, South Africa: a feasibility pilot study*. *Reprod Health*, 2016. **13**: p. 40.
- [26] Torchinsky, R. *How period tracking apps and data privacy fit into a post-Roe v. Wade climate*. NPR, 2022.
- [27] Andersen, K.L., et al., *Determination of medical abortion success by women and community health volunteers in Nepal using a symptom checklist*. *BMC Pregnancy Childbirth*, 2018. **18**(1): p. 161.
- [28] Biggs, M.A., et al., *Comprehension of an Over-the-Counter Drug Facts Label Prototype for a Mifepristone and Misoprostol Medication Abortion Product*. *Obstetrics & Gynecology*, 2022. **10**(1097).
- [29] National Abortion Federation. *Clinical Policy and Guidelines for Abortion Care*. 2020; Available from: https://prochoice.org/wp-content/uploads/2020_cpqs_final.pdf.
- [30] Lohr, P.A., et al., *Simultaneous Compared With Interval Medical Abortion Regimens Where Home Use Is Restricted*. *Obstet Gynecol*, 2018. **131**(4): p. 635-641.
- [31] Creinin, M.D., et al., *Mifepristone and misoprostol administered simultaneously versus 24 hours apart for abortion: a randomized controlled trial*. *Obstet Gynecol*, 2007. **109**(4): p. 885-94.

- [32] Dzuba, I.G., et al., *A repeat dose of misoprostol 800 mcg following mifepristone for outpatient medical abortion at 64-70 and 71-77 days of gestation: A retrospective chart review*. *Contraception*, 2020. **102**(2): p. 104-108.
- [33] Raymond, E.G., M.S. Harrison, and M.A. Weaver, *Efficacy of Misoprostol Alone for First-Trimester Medical Abortion: A Systematic Review*. *Obstet Gynecol*, 2019. **133**(1): p. 137-147.
- [34] Jayaweera, R.T., H. Moseson, and C. Gerdts, *Misoprostol in the era of COVID-19: a love letter to the original medical abortion pill*. *Sex Reprod Health Matters*, 2020. **28**(1): p. 1829406.
- [35] Gerdts, C., et al., *Second-trimester medication abortion outside the clinic setting: an analysis of electronic client records from a safe abortion hotline in Indonesia*. *BMJ Sex Reprod Health*, 2018.
- [36] Ipas. *How to have an abortion with pills*. 2021 [cited 2022 April 29]; Available from: <https://www.ipas.org/resource/how-to-have-an-abortion-with-pills/>.
- [37] Whitehouse, K.C., T. Shochet, and P.A. Lohr, *Efficacy of a low-sensitivity urine pregnancy test for identifying ongoing pregnancy after medication abortion at 64 to 70 days of gestation*. *Contraception*, 2022. **110**: p. 21-26.
- [38] Raymond, E.G., et al., *Serial multilevel urine pregnancy testing to assess medical abortion outcome: a meta-analysis*. *Contraception*, 2017. **95**(5): p. 442-448.
- [39] Raymond, E.G., et al., *Commentary: No-test medication abortion: A sample protocol for increasing access during a pandemic and beyond*. *Contraception*, 2020. **101**(6): p. 361-366.
- [40] Blum, J., et al., *Randomized trial assessing home use of two pregnancy tests for determining early medical abortion outcomes at 3, 7 and 14 days after mifepristone*. *Contraception*, 2016. **94**(2): p. 115-21.
- [41] Schmidt-Hansen, M., et al., *Follow-up strategies to confirm the success of medical abortion of pregnancies up to 10 weeks' gestation: a systematic review with meta-analyses*. *Am J Obstet Gynecol*, 2020. **222**(6): p. 551-563 e13.
- [42] Anger, H., et al., *Use of an at-home multilevel pregnancy test and an automated call-in system to follow-up the outcome of medical abortion*. *Int J Gynaecol Obstet*, 2019. **144**(1): p. 97-102.
- [43] Fok, W.K., et al., *Comparison of two home pregnancy tests for self-confirmation of medication abortion status: A randomized trial*. *Contraception*, 2021. **104**(3): p. 296-300.
- [44] Raymond, E.G., et al., *Self-assessment of medical abortion outcome using symptoms and home pregnancy testing*. *Contraception*, 2018. **97**(4): p. 324-328.
- [45] Dabash, R., et al., *Self-administered multi-level pregnancy tests in simplified follow-up of medical abortion in Tunisia*. *BMC Womens Health*, 2016. **16**: p. 49.
- [46] Raifman, S., et al., *"I'll just deal with this on my own": a qualitative exploration of experiences with self-managed abortion in the United States*. *Reprod Health*, 2021. **18**(1): p. 91.
- [47] Fuentes, L., et al., *Texas women's decisions and experiences regarding self-managed abortion*. *BMC Womens Health*, 2020. **20**(1): p. 6.
- [48] Grossman, D., et al., *Self-induction of abortion among women in the United States*. *Reprod Health Matters*, 2010. **18**(36): p. 136-46.

- [49] Saultes, T.A., D. Devita, and J.D. Heiner, *The back alley revisited: sepsis after attempted self-induced abortion*. West J Emerg Med, 2009. **10**(4): p. 278-80.
- [50] Gomperts, R., et al., *Provision of medical abortion using telemedicine in Brazil*. Contraception, 2014. **89**(2): p. 129-33.
- [51] Endler, M., et al., *Safety and acceptability of medical abortion through telemedicine after 9 weeks of gestation: a population-based cohort study*. BJOG, 2019. **126**(5): p. 609-618.
- [52] Moseson, H., et al., *Effectiveness of self-managed medication abortion between 13 and 24 weeks gestation: A retrospective review of case records from accompaniment groups in Argentina, Chile, and Ecuador*. Contraception, 2020. **102**(2): p. 91-98.
- [53] Tasset, J. and L.H. Harris, *Harm Reduction for Abortion in the United States*. Obstet Gynecol, 2018. **131**(4): p. 621-624.
- [54] Labandera, A., M. Gorgoroso, and L. Briozzo, *Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: From a university hospital to the entire country*. International Journal of Gynecology & Obstetrics, 2016. **134**(S1): p. S7-S11.
- [55] Gerds, C. and I. Hudaya, *Quality of Care in a Safe-Abortion Hotline in Indonesia: Beyond Harm Reduction*. Am J Public Health, 2016. **106**(11): p. 2071-2075.
- [56] Matia, M.G., et al., *A replication of the Uruguayan model in the province of Buenos Aires, Argentina, as a public policy for reducing abortion-related maternal mortality*. Int J Gynaecol Obstet, 2016. **134** Suppl 1: p. S31-4.
- [57] Fetters, T., et al., *Using a harm reduction lens to examine post-intervention results of medical abortion training among Zambian pharmacists*. Reprod Health Matters, 2015. **22**(44 Suppl 1): p. 116-24.
- [58] Tamang, A., et al., *Pharmacy workers in Nepal can provide the correct information about using mifepristone and misoprostol to women seeking medication to induce abortion*. Reprod Health Matters, 2015. **22**(44 Suppl 1): p. 104-15.
- [59] Coeytaux, F., et al., *Facilitating women's access to misoprostol through community-based advocacy in Kenya and Tanzania*. Int J Gynaecol Obstet, 2014. **125**(1): p. 53-5.
- [60] Grossman, D., et al., *A harm-reduction model of abortion counseling about misoprostol use in Peru with telephone and in-person follow-up: A cohort study*. PLoS One, 2018. **13**(1): p. e0189195.
- [61] Inciardi, J., *Harm reduction: national and international perspectives*. 1999, California: Thousand Oaks.
- [62] Briozzo, L., et al., *Overall and abortion-related maternal mortality rates in Uruguay over the past 25 years and their association with policies and actions aimed at protecting women's rights*. Int J Gynaecol Obstet, 2016. **134**(S1): p. S20-S23.
- [63] Aiken, A.R.A., et al., *Experiences of women in Ireland who accessed abortion by travelling abroad or by using abortion medication at home: a qualitative study*. BMJ Sex Reprod Health, 2018.
- [64] If/When/How, *Patient Confidentiality and Self-Managed Abortion: A Guide to Protecting Your Patients and Yourself*. 2022.

- [65] If/When/How. *Making abortion a crime (again): how extreme prosecutors attempt to punish people for abortions in the U.S.* [cited 2022 January 11]; Available from: <https://www.ifwhenhow.org/resources/making-abortion-a-crime-again/>.
- [66] Rowan, A. *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*. Guttmacher Institute, 2015.
- [67] Conti, J. and E.P. Cahill, *Self-managed abortion*. *Curr Opin Obstet Gynecol*, 2019. **31**(6): p. 435-440.
- [68] *Abortion Decriminalization is Part of the Larger Struggle Against Policing and Criminalization*. Available from: <https://static1.squarespace.com/static/5ee39ec764dbd7179cf1243c/t/6194235775f2a0615ea53cde/1637098383973/Decriminalize+Abortion>.
- [69] The American College of Obstetricians and Gynecologists (ACOG). *Opposition to criminalization of individuals during pregnancy and the postpartum period*. 2020; Available from: <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period>.