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Original Research

Effectiveness of Self-Managed Medication Abortion Between 9 and 16 Weeks of Gestation

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OBJECTIVE: To evaluate abortion completion after self-managed medication abortion in pregnancies at or beyond 9 weeks of gestation.

METHODS: We conducted a prospective observational cohort study in which we recruited callers to three abortion-accompaniment groups in Argentina, Nigeria, and Southeast Asia who were initiating a self-managed medication abortion. Participants completed a baseline survey over the phone before taking pills and then two follow-up phone surveys 1 and 3 weeks after taking pills. The primary outcome was abortion completion; secondary outcomes included physical experiences and health care seeking and treatment.

RESULTS: Between 2019 and 2020, we enrolled 1,352 participants, 19.5% (264/1,352) of whom self-managed a medication abortion at 9 or more weeks of gestation: 75.0% (198/264) at 9–11 weeks, 19.3% (51/264) at 12–14 weeks, and 5.7% (15/264) at 15–22 weeks. Participants were aged 26 years on average (SD 5.6 years); 56.4% (149/264) used the combined regimen (mifepristone+misoprostol), and 43.6% (115/264) used misoprostol only. At the last follow-up, 89.4% (236/264) had a complete abortion without procedural intervention, 5.3% (14/264) had a complete abortion with manual vacuum aspiration or dilation and curettage procedure, 4.9% (13/264) had an incomplete abortion, and 0.4% (1/264) participants did not report an abortion outcome. Some participants (23.5%, 62/264) sought health care during or after the self-managed medication abortion, most commonly to confirm completion (15.9%, 42/264); 9.1% (24/264) needed further medical intervention (procedural evacuation, antibiotics, additional misoprostol, intravenous fluids, blood transfusion, or overnight stay in the facility). Those who were 12 or more weeks pregnant were more likely to seek care at a clinic or hospital than those who were 9–11 weeks pregnant (adjusted relative risk 1.62, 95% CI 1.3–2.1).

CONCLUSION: People who self-managed an abortion with medication between 9 and 16 weeks of gestation had high levels of abortion completion and accessed health care to confirm completion or to treat potential complications.

CLINICAL TRIAL REGISTRATION: ISRCTN, ISRCTN95769543.

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Medication abortion, specifically the use of misoprostol only or in combination with mifepristone, is a highly safe, effective, and low-cost method of

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pregnancy termination both in and out of clinical settings.[1–3] Persistent social, legal, and structural barriers to clinical care, coupled with widespread availability of abortion medications through pharmacies or online, have increased the use of medication abortion outside of clinic settings. The use of medications to end a pregnancy on one's own, without clinical supervision, is referred to as *self-managed medication abortion*.[4] One model of virtual or in-person support for self-managed medication abortion is provided by safe abortion-accompaniment groups: collectives of volunteers trained in abortion counseling who provide free, evidence-based information and person-centered support to people self-managing abortion either over the phone or in person. A growing body of literature has demonstrated that self-managed medication abortion is safe and effective, and the World Health Organization (WHO) recently updated its guidance to endorse self-managed medication abortion for pregnancies up to 12 weeks as part of a full range of safe, effective options for abortion care.[5]

Most research on medication abortion regimens has focused on safety and effectiveness outcomes in clinical settings in the first 9 weeks of pregnancy,[3] and indeed, most abortions occur within this gestational window. However, a robust body of clinical research indicates that the effectiveness and safety of medication abortion at 9 or more weeks of pregnancy remain high.[6,7] Systematic reviews and meta-analyses of clinical trial data estimate that 94.6% of medication abortions were successful for pregnancies at 9–12 weeks[8] and similarly that few ongoing pregnancies occur after the use of medication abortion at 12–28 weeks of gestation.[7,9,10]

However, with regard to self-managed medication abortion at these gestations, there is little research on safety and effectiveness. The limited number of studies suggest that the practice can be safe and effective; however, limitations such as reliance on retrospective record reviews and loss to follow-up have limited the generalizability of these prior results.[4,11–13] To be responsive to WHO calls for additional research on self-managed medication abortion outcomes at later gestations, we conducted an analysis of data from a prospective, observational cohort study (the SAFE [Studying Accompaniment Feasibility and Effectiveness] study) to estimate the effectiveness of self-managed medication abortion at 9 or more weeks of pregnancy and to describe the population who self-managed at these gestations, the medication abortion protocols used, physical outcomes, and health care–seeking experiences.

METHODS

The SAFE study is a prospective observational cohort study that enrolled people who contacted an abortion-accompaniment group for self-managed medication abortion information and support. Study coordinators followed up all participants with telephone surveys for up to 4 weeks to assess abortion outcomes and experiences. We present here a planned supplementary analysis of outcomes among only the subset of SAFE study participants who self-managed medication abortion at 9 or more weeks of gestation.[14] Participants who self-managed medication abortion at 9 or more weeks of gestation were recruited and followed up identically to those in the full study, which we describe here. The authorship team includes researchers and leaders of sexual and reproductive health organizations who have expertise in self-managed medication abortion and accompaniment models in a range of legal and cultural settings. Results from a pilot study,[15] full details of the study protocol,[14] and the noninferiority analysis for abortions at less than 9 weeks of gestation[1] have been published previously.

We recruited callers to three abortion-accompaniment groups in Argentina, Nigeria, and a country in Southeast Asia between July 31, 2019, and October 1, 2020. Trained counselors screened anyone who contacted the group and requested information about induced abortion during the study period. Eligible participants were aged 13 years or older, were starting a new medication abortion process, and had no contraindications to medication abortion. Exclusion criteria included experiencing ongoing symptoms from a prior abortion attempt or ongoing miscarriage (bleeding, cramping), symptoms suggestive of ectopic pregnancy, or not wanting to be contacted by study staff. All participants provided verbal informed consent. This study received ethics approval from the Allendale IRB, and the Fundación Huésped IRB additionally approved the Argentina-specific protocol. This study is registered at ISRCTN (ISRCTN95769543).

Before enrollment, all participants received step-by-step instructions from accompaniment group counselors on the appropriate WHO-recommended protocol for medication abortion specific to their duration of pregnancy (assessed by independently acquired ultrasonogram or date of last menstrual period)[14,16] and which medications the participant could access. After this counseling, individuals who consented to participate answered a baseline questionnaire administered over the phone or in person by their accompaniment counselor. For all subsequent data collection, a trained study coordinator contacted each participant by phone at two timepoints (1 and 3 weeks after taking the first dose of medication) to assess medication abortion use, physical experiences, abortion completion, potential complications, and any

health care seeking. Participants received between $10 and $25 according to the number of follow-up interviews completed and study site.

The primary outcome of this analysis is abortion completion (effectiveness) after self-managed medication abortion with accompaniment support among participants at 9 or more weeks of gestation, as measured by participant self-report. Research has established that people are able to accurately self-assess abortion completion.[17] We assessed abortion completion using responses to two questions: 1) "Do you feel that your abortion process is complete?" and 2) "Did you receive a manual vacuum aspiration or dilation and curettage (D&C) procedure?" We also used a checklist of questions to ascertain which factors contributed to their self-report (eg, ultrasonogram, negative pregnancy test, passing a visible gestational sac). We categorized participants who reported that their abortion was complete and did not report receiving a procedural intervention as complete without procedural intervention; we categorized those who reported that their abortion was complete and that they had undergone manual vacuum aspiration or D&C as complete with procedural intervention. We categorized participants who reported that their abortion was not complete or were unsure as not complete or unsure.

Additional outcomes included 1) participant sociodemographic characteristics (country of residence, age, education [no school, completed primary school, completed secondary school, any postsecondary school]) and pregnancy characteristics (duration of pregnancy at abortion), 2) medication regimen used (combined regimen vs misoprostol only, number of pills, route of administration), 3) physical experience of self-managed medication abortion (initiation and duration of bleeding and cramping, experience of pain, time to expulsion, and potential warning signs of complications), and 4) health care seeking at a clinic or hospital at any point in follow-up (including reasons for seeking health care and any treatment received). We measured all outcomes through participant self-report during interviews with study coordinators.

The SAFE study sample size was powered for the primary noninferiority analysis among individuals who self-managed medication abortion at less than 9 weeks of gestation[1]; however, for this planned supplementary analysis of outcomes among those who self-managed medication abortion at 9 or more weeks of gestation,[14] we did not have a target sample size because analyses were primarily descriptive.

For the primary outcome, we prespecified exclusion of participants who were lost to follow-up after baseline, consistent with comparison clinical trials.[14,18] We calculated abortion completion proportions using the number of participants who reported a complete abortion over the total number of participants who reported taking the pills, with 95% CIs generated with an exact binomial approach. For sociodemographic and other outcomes, we calculated frequencies, means, medians, and ranges. To explore physical experiences of abortion (initiation of bleeding and cramping, time to expulsion of the pregnancy), we plotted responses using a bar graph and box plots and compared medians by regimen using nonparametric Wilcoxon rank-sum tests. To explore patterns in health care seeking by duration of pregnancy, we ran a logistic regression model adjusting for duration of pregnancy as a binary indicator of 12 or more weeks of gestation at the time of abortion, as well as medication regimen used, centered age, and educational level, and clustering by site. We then converted the odds ratio for health care seeking to a relative risk ratio with 95% CI and an adjusted risk difference using potential outcomes estimation.[19] We conducted all analyses using Stata 15.1.

RESULTS

Study recruiters screened 2,265 callers for eligibility during the study period; 1,594 were eligible for the larger study (any gestational age), and 1,352 consented and enrolled (84.8% of those eligible; Fig. 1). Among those who enrolled, 264 participants (19.5%) took the first dose of abortion medication at or beyond 9 weeks of gestation and thus were eligible for this supplementary analysis. Specifically, 75.0% (198/264) self-managed medication abortion at 9–11 weeks of gestation, 19.3% (51/264) at 12–14 weeks, and 5.7% (15/264) at 15–22 weeks. Participants who self-managed medication abortion at 9 or more weeks of gestation were slightly younger, had lower educational attainment, and were more likely to have confirmed pregnancy duration by ultrasonogram than participants who had abortions before 9 weeks (Table 1). Characteristics of participants differed by medication regimen used. Among the 264 participants included in this analysis, 92.8% (245/264) completed the 1-week survey, and 87.1% (230/264) completed the 3-week survey; across these two follow-ups, 100% completed at least one follow-up survey.

Among the 264 participants who self-managed medication abortion between 9 and 22 weeks of gestation, 149 (56.4%) used mifepristone and misoprostol in combination, and 115 (43.6%) used misoprostol only (Table 1). Among users of the combined regimen, most (78.5%, 117/149) followed the WHO-

recommended protocol for abortions before 12 weeks of one 200-mg mifepristone pill followed 24–48 hours later by four misoprostol tablets (800 micrograms total), and those at later gestations more commonly took a second dose of misoprostol than did those earlier in pregnancy. Among users of the misoprostol-only regimen, most (73.0%) took three doses of four misoprostol pills (800 micrograms) spaced 3 hours apart, and several of those at 13 or more weeks of pregnancy took a reduced regimen of three doses of two misoprostol pills (400 micrograms) every 3 hours (Appendix 1, available online at http://links.lww.com/AOG/D235). Nearly all misoprostol-only users (98.3%, 113/115) took misoprostol sublingually; 85.9% of combined regimen users (128/149) took misoprostol sublingually, and 11.4% (17/149) inserted it vaginally.

Among users of the combined regimen, most participants reported that any bleeding (68.5%, 102/149), heaving bleeding (77.2%, 115/149), and cramping (70.5%, 105/149) began after their first dose of misoprostol (Appendices 2 and 3, available online at http://links.lww.com/AOG/D235). Misoprostol-only users reported more variation: any bleeding (49.6%, 57/115) and cramping (49.6%, 57/115) began most frequently after the second dose of misoprostol, and heavy bleeding (69.6%, 80/115) most commonly began after the third dose (Appendices 2 and 4, available online at http://links.lww.com/AOG/D235). Time to expulsion of the pregnancy varied by regimen and duration of pregnancy (Appendices 5 and 6, available online at http://links.lww.com/AOG/D235). Participants expelled the pregnancy between less than 1 hour and 3.5 days after the first dose of misoprostol; median time to expulsion from first misoprostol dose was slightly faster for users of the combined regimen but more variable compared with those who used misoprostol only

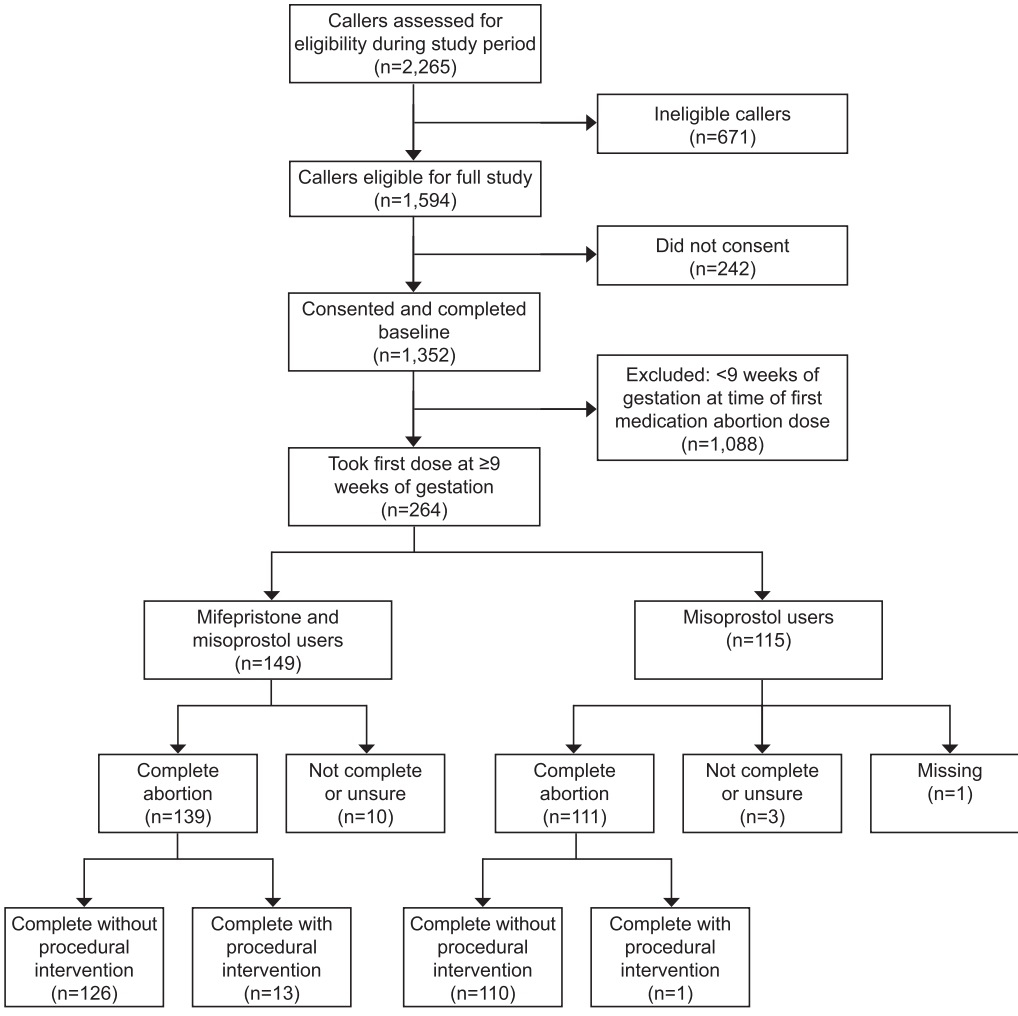

Fig. 1. Flowchart of study screening, enrollment, medication regimen, and outcomes.
Moseson. Self-Managed Abortion Outcomes at 9–16 Weeks. Obstet Gynecol 2023.

(Appendix 7, available online at http://links.lww.com/AOG/D235).

One week after taking the pills, 80.7% (95% CI 75.3–85.3%; 213/264; Table 2) of participants self-reported a complete abortion without procedural intervention; by 3 weeks, 89.4% (95% CI 85.0–92.8%; 236/264) of participants self-reported a complete abortion without procedural intervention, and 5.3% (14/264) completed with manual vacuum aspiration or D&C (13 who used the combined regimen, 1 who used misoprostol only). Those who were unsure (n=8, 3.0%) said that they were still bleeding, experiencing discharge, or having intermittent cramping; had not felt the fetus expel; or had not yet taken a pregnancy test. Those who reported that the abortion was not complete (n=5, 1.9%; at 9, 11, or 13 weeks of gestation) cited a positive pregnancy test (home or facility-based); 0.4% of participants (1/264) did not report an abortion outcome. Completion was high across both regimens: 84.6% (95% CI 77.7–90.0%; 126/149) without procedural intervention among users of the combined regimen (93.3% inclusive of procedural intervention; 139/149) and 95.7% (95% CI 90.1–98.6%; 110/115) among users of misoprostol only (96.5% inclusive of procedural intervention; 111/115).

Overall, 23.5% of participants (62/264) sought care at a health care facility during or after self-managed medication abortion, most commonly to confirm completion (15.9%, 42/264), followed by concerns about bleeding (3.0%, 8/264), pain (1.8%, 5/264), or fever or discharge (1.8%, 5/264) (Appendix 8, available online at http://links.lww.com/AOG/D235). Participants most frequently received an ultrasonogram, antibiotics, or pain medications; 5.3% of participants (14/264) underwent manual vacuum aspiration or D&C to complete the abortion, and 1.5% (4/264) received a blood transfusion.

In an adjusted model, those who were 12 or more weeks pregnant at the time of abortion were more likely to seek care at a health care facility than those who were 9–11 weeks pregnant (adjusted relative risk 1.6, 95% CI 1.3–2.1; Table 3). In absolute terms, the adjusted risk difference for health care seeking was 16.1% between those who were 12 or more weeks pregnant and those who were 9–11 weeks pregnant (Table 3). At 12 or more weeks of gestation, the most common reason for seeking care remained a desire for clinical confirmation of abortion completion or a desire to expel the fetus in a health care facility.

DISCUSSION

In this prospective, observational cohort study of self-managed medication abortion between 9 and 16 weeks of gestation, 89.4% of participants completed their abortion without procedural intervention. Over 3 weeks of follow-up, nearly all participants successfully obtained medications, took them according to WHO-endorsed protocols, and completed their abortions. Approximately one in four participants sought health care during or after self-managed medication abortion, primarily to confirm completion; some participants underwent a procedural evacuation of the uterus, received a blood transfusion, or were kept overnight in the hospital.

This study is one of the first to prospectively document the experiences of self-managed medication abortion beyond the first trimester.[4] Strengths include recruitment of participants from across three distinct contexts at lesser studied gestations and the collection of detailed data at multiple timepoints, with low loss to follow-up. Furthermore, these findings are some of the only data on the physical and health care–seeking aspects of self-managed medication abortion later in pregnancy collected systematically for the purposes of research.

This research also has limitations. Because of the geographic dispersion of study participants and limited reproductive health access, the study design relied on self-reported gestational age and abortion outcome, outcomes typically confirmed by ultrasonogram in clinical studies. However, research has affirmed the accuracy of self-report of last menstrual period compared with ultrasound assessment[20,21] and the reliability of self-report of abortion completion.[17] Furthermore, legal restrictions on abortion access within the study sites prevented us from randomizing people to specific medication regimens; thus, formal comparisons of effectiveness by medication regimen are limited. Finally, the sample size of participants who self-managed medication abortion between 17 and 22 weeks of gestation is quite small (n=3) and limits inference that can be drawn for these pregnancy durations. Additional research is needed to evaluate the safety and effectiveness of self-managed medication abortion beyond 16 weeks of gestation. Prior retrospective research on experiences of people who have self-managed medication abortion at 17 or more weeks of gestation and those who support them to do so[11,13,22] indicates that the physical and emotional support needs at these gestations differ from those of individuals who self-manage earlier in pregnancy, and these individuals may require more pain management and other physical support for passing the pregnancy, disposing of pregnancy tissue, and managing delayed placental expulsion.

These prospective findings in an accompanied self-managed medication abortion setting indicate

Table 1. Sociodemographic and Pregnancy Characteristics of Individuals Who Self-Managed Medication Abortion With Accompaniment Group Support in Argentina, Nigeria, or Southeast Asia by Duration of Pregnancy and Medication Regimen

Characteristic	Abortion at Less Than 9 wk (n=1,088)	Abortion at 9 or More wk (n=264)	*P* for Difference	Abortion at 9 or More wk		
				Mifepristone+ Misoprostol (n=149)	Misoprostol Alone (n=115)	*P* for Difference
Study site			**<.001**			**<.001**
Argentina	309 (28.4)	92 (34.8)		91 (61.1)	1 (0.9)	
Nigeria	552 (50.7)	98 (37.1)		0 (0)	98 (85.2)	
Southeast Asia	227 (20.9)	74 (28)		58 (38.9)	16 (13.9)	
Participant age (y)	27.2±5.9	26.0±5.6	**<.001**	25.5±5.7	26.6±5.4	.11
14	2 (0.2)	0 (0)		0 (0)	0 (0)	
15–19	55 (5.1)	19 (7.2)		15 (10.1)	4 (3.5)	
20–24	318 (29.2)	106 (40.2)		63 (42.3)	43 (37.4)	
25–34	551 (50.6)	114 (43.2)		60 (40.2)	54 (47.0)	
35–44	157 (14.4)	25 (9.5)		11 (7.4)	14 (12.2)	
45–50	4 (0.4)	0 (0)		0 (0)	0 (0)	
Missing	1 (0.1)	0 (0)		0 (0)	0 (0)	
Level of education			**.016**			**<.001**
No schooling	0 (0)	2 (0.8)		2 (1.3)	0 (0)	
Primary school	102 (9.4)	36 (13.6)		33 (22.1)	3 (2.6)	
Secondary school	375 (34.5)	89 (33.7)		41 (27.5)	48 (41.7)	
More than secondary school	585 (53.8)	128 (48.5)		67 (45)	61 (53)	
Missing	26 (2.4)	9 (3.4)		6 (4)	3 (2.6)	
Pregnancy duration at abortion (wk)			NA			.15
Missing	139 (12.8)	0 (0)		0 (0)	0 (0)	
4 or less	26 (2.4)	—		—	—	
5	169 (15.5)	—		—	—	
6	304 (27.9)	—		—	—	
7	267 (24.5)	—		—	—	
8	183 (16.8)	—		—	—	
9	—	101 (38.3)		52 (34.9)	49 (42.6)	
10	—	60 (22.7)		32 (21.5)	28 (24.3)	
11	—	37 (14.0)		22 (14.8)	15 (13.0)	
12	—	24 (9.1)		13 (8.7)	11 (9.6)	
13	—	12 (4.5)		5 (3.4)	7 (6.1)	
14	—	15 (5.7)		11 (7.4)	4 (3.5)	
15	—	8 (3.0)		8 (5.4)	0 (0)	
16	—	4 (1.5)		3 (2.0)	1 (0.9)	
17	—	1 (0.4)		1 (0.7)	0 (0)	
18	—	0 (0)		0 (0)	0 (0)	
19	—	1 (0.4)		1 (0.7)	0 (0)	
20	—	0 (0)		0 (0)	0 (0)	
21	—	0 (0)		0 (0)	0 (0)	
22	—	1 (0.4)		1 (0.7)	0 (0)	

NA, not available.
Data are n (%) or mean±SD unless otherwise specified.
Bold indicates significance at the $P<.05$ level.

that abortion completion between 9 and 16 weeks of gestation remains high when the medication is self-managed with accompaniment support instead of clinician-managed. The overall abortion completion level of 89.4% reported in this study is similar to the completion levels reported in randomized clinical trials of medication abortion effectiveness at similar gestations.[7] In addition, the completion rate of self-managed medication abortion with misoprostol only (95.7%) reported in this study merits attention; it is similar to abortion completion proportions reported in prior randomized controlled trials of misoprostol-

Table 2. Abortion Completion Overall, by Medication Regimen, and by Duration of Pregnancy Among People Who Self-Managed Medication Abortion With Accompaniment Support in Argentina, Nigeria, and Southeast Asia

Abortion Completion	Overall (All Regimens and Gestations) (N=264)	Mifepristone+Misoprostol							
		All (n=149)	9 wk (n=52)	10 wk (n=32)	11 wk (n=22)	12 wk (n=13)	13–14 wk (n=16)	15–16 wk (n=11)	17–22 wk (n=3)
1 wk after taking the pills									
Complete without procedural intervention	213 (80.7)	107 (71.8)	42 (80.8)	22 (68.8)	17 (77.3)	9 (69.2)	8 (50.0)	8 (72.7)	1 (33.3)
Complete with procedural intervention	9 (3.4)	9 (6.0)	2 (3.8)	1 (3.1)	2 (9.1)	1 (7.7)	2 (12.5)	1 (9.1)	0 (0)
Not complete or not sure	22 (8.3)	15 (10.1)	6 (11.5)	4 (12.5)	1 (4.5)	1 (7.7)	2 (12.5)	1 (9.1)	0 (0)
Missing	20 (7.6)	18 (12.1)	2 (3.8)	5 (15.6)	2 (9.1)	2 (15.4)	4 (25.0)	1 (9.1)	2 (66.7)
At last follow-up									
Complete without procedural intervention	236 (89)	126 (84.6)	46 (88.5)	28 (87.5)	18 (81.8)	12 (92.3)	10 (62.5)	9 (81.8)	3 (100)
Complete with procedural intervention	14 (5.3)	13 (8.7)	3 (5.8)	1 (3.1)	2 (9.1)	1 (7.7)	5 (31.3)	1 (9.1)	0 (0)
Not complete or not sure	13 (4.9)	10 (6.7)	3 (5.8)	3 (9.4)	2 (9.1)	0 (0)	1 (6.3)	1 (9.1)	0 (0)
Missing	1 (0.4)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

Abortion Completion	Misoprostol Alone							
	All (n=115)	9 wk (n=49)	10 wk (n=28)	11 wk (n=15)	12 wk (n=11)	13–14 wk (n=11)	15–16 wk (n=1)	17–22 wk (n=0)
1 wk after taking the pills								
Complete without procedural intervention	106 (92.2)	45 (91.8)	26 (92.9)	14 (93.3)	10 (90.9)	10 (90.9)	1 (100)	0 (0)
Complete with procedural intervention	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Not complete or not sure	7 (6.1)	4 (8.2)	1 (3.6)	1 (6.7)	1 (9.1)	0 (0)	0 (0)	0 (0)
Missing	1 (0.9)	0 (0.0)	1 (3.6)	0 (0)	0 (0)	1 (9.1)	0 (0)	0 (0)
At last follow-up								
Complete without procedural intervention	110 (95.7)	49 (100)	27 (96.4)	14 (93.3)	10 (90.9)	10 (91)	0 (0.0)	0 (0)
Complete with procedural intervention	1 (0.9)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (100)	0 (0)
Not complete or not sure	3 (2.6)	0 (0)	0 (0)	1 (6.7)	1 (9.1)	1 (9.1)	0 (0.0)	0 (0)
Missing	1 (0.9)	0 (0)	1 (3.6)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)

Data are n (%) unless otherwise specified.

only use at 12–20 and 14–20 weeks of gestation (89.8% and 94.6%, respectively).[23,24] However, the present study was not designed to evaluate equivalence or noninferiority of self-managed medication abortion effectiveness at 9 or more weeks of gestation compared with completion reported in clinical trials at the same gestations. Together, these findings support the conclusion that with accurate information and support, people are capable of following instructions on how to take medications required to

Table 3. Results From an Unadjusted and Adjusted Logistic Regression Model for the Odds of Seeking Health Care for Any Reason Among Participants Who Self-Managed Medication Abortion Between 9 and 11 Weeks of Gestation Compared With Those Who Self-Managed Medication Abortion Between 12 and 22 Weeks of Gestation*

Logistic Regression	Exposure	Odds Ratio	Predicted %	95% CI
Unadjusted	GA 9–11 wk	Ref		Ref
	GA 12 or more wk	2.08		1.7–2.5
Adjusted†	GA 9–11 wk	Ref		Ref
	GA 12 or more wk	2.16		1.8–2.6
Predicted "risk" of health care seeking				
Estimated proportion who would have sought health care under the counterfactual assumption that everyone was 9–11 wk pregnant at the time of abortion			24.0	5.7–45.9
Estimated proportion who would have sought health care under the counterfactual assumption that everyone was 12 or more wk pregnant at the time of abortion			40.1	11.7–64.8
Predicted risk difference			16.1	
Relative risk			1.62	1.3–2.1

GA, gestational age; Ref, referent.

* Results from this adjusted logistic regression were used in estimation of predicted risks under two counterfactual assumptions and the associated risk ratio, presented in the bottom half of the table.

† Model is adjusted for medication regimen (combined regimen vs misoprostol only), education (no schooling vs primary, secondary, and more than secondary school completion), age (centered at the mean and continuous), and clustering by site. The n for the adjusted model is 261 because three participants did not report data on education.

medically manage abortion between 9 and 16 weeks of gestation.

These findings are consistent with the effectiveness reported in retrospective analyses of accompaniment group case records for self-managed medication abortion at these gestations[11–13] and underscore the need for access to health care as an important component of the self-managed medication abortion experience. Qualitative studies have highlighted important considerations for self-management at later gestations,[22] namely that the experience can be more physically intense and that the pregnancy tissue is larger and thus carries a higher risk of being discovered, particularly salient in settings where abortion is criminalized. For this reason, some participants sought health care to pass the fetus in a facility setting. Future research should explore the support needs and preferences of people who self-manage at these gestations, particularly regarding interactions with the health care system. When access to clinical abortion care is limited by legal restrictions or other barriers, self-managed medication abortion between 9 and 16 weeks of gestation can represent a safe and effective alternative where linkages to formal health care exist.

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Authors' Data Sharing Statement

Will individual participant data be available (including data dictionaries)? *Data will not be made publicly available because of constraints imposed by the IRB; however, interested investigators can contact the lead author to inquire about establishing a data sharing and use agreement for ancillary or replication studies with data subsets.*

What data in particular will be shared? *Not available.*

What other documents will be available? *The study protocol and full survey instrument are previously published and available online in open-access format, and outcomes among participants who self-managed at less than 9 weeks are also previously published. See reference list for details.*

When will data be available (start and end dates)? *Not applicable.*

By what access criteria will data be shared (including with whom, for what types of analyses, and by what mechanism)? *The study investigators will evaluate each request and will make every effort to share data with interested investigators pursuing appropriate research questions.*

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