First Published online: 9 December 2022

DOI: 10.1002/ijgo.14607

INTERNATIONAL JOURNAL OF GYNECOLOGY OBSTETRICS FIGO WILEY

ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Self-managed abortion: Aligning law and policy with medical evidence

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Abstract

People have always and will always find ways to try to end their pregnancies when necessary. Many do so safely without the involvement or direct supervision of healthcare professionals by self-managing their abortions. In 2022, the well-established safety and efficacy of abortion medications prompted WHO to fully endorse self-managed medication abortion as part of a comprehensive range of safe, effective options for abortion care. But despite robust evidence supporting the safety and effectiveness of the self-use of medications for abortion, abortion laws and policies around the world remain at odds with clinical evidence and with the realities of self-managed medication abortion in the present day. The present article considers legal issues related to self-managed abortion and addresses the role of obstetricians, gynecologists, and other healthcare professionals in promoting clinical and legal safety in abortion care through support of self-managed abortion.

KEYWORDS
abortion, criminalization, health equity, law, policy, reproductive health, self-managed abortion

1 | INTRODUCTION

People have always and will always find ways to try to end their pregnancies when necessary. Many do so safely without the involvement or direct supervision of healthcare professionals by self-managing their abortions. People use a variety of methods to self-manage their abortions, and here the focus is on self-managed medication abortion: the obtainment and use of medication to end a pregnancy without the supervision of a healthcare professional. Self-managed medication abortion is a medically safe and effective method of abortion.[1–3] In fact, people have been self-managing their abortions for generations using medications now recommended by WHO. Indeed, self-managed medication abortion began in the 1980s, with the discovery by women in Latin America of the ability of misoprostol to induce an abortion.[4]

In 2022, the well-established safety and efficacy of abortion medications prompted WHO to fully recommend self-managed medication abortion as part of a comprehensive range of safe, effective options for abortion care, especially in places where access to abortions is highly restricted or illegal, in their most recent *Abortion Care Guidelines*.[5] While self-managed abortion usually does not involve a clinician, it often involves the help of others—hotline personnel, feminist networks, accompaniment groups, doulas, and lay health workers who provide information or access to medicines.[6]

Despite the robust evidence supporting the safe and effective use of medication abortion, abortion laws and policies around the world remain at odds with clinical evidence and with the realities of self-managed medication abortion in the present day. Evidence shows that the involvement of healthcare professionals is not needed for an abortion early in pregnancy to be medically safe.[1] However, despite being medically unnecessary, the vast majority of abortion laws around the world still require that abortion be provided by a licensed healthcare professional, in a formal healthcare setting, or both.[7] Further, most abortion laws impose criminal

penalties on people who fail to meet the requirements of the law and inflict risk of arrest and prosecution upon people seeking an abortion or individuals who help them. Healthcare professionals may also risk professional ramifications, such as delicensure, for supporting those who are self-managing their care.[8]

The present article considers legal issues related to self-managed abortion and addresses the role of obstetricians, gynecologists, and other healthcare professionals in promoting clinical and legal safety in abortion care through support of self-managed abortion. The clinical safety of self-managed abortion is first discussed. Then, abortion law and policy are examined as they relate to self-managed abortion, and how non-evidence-based requirements increase the legal and health risks for those seeking to end their pregnancies. Lastly, we consider the roles and responsibilities of healthcare professionals, including obstetricians and gynecologists, as both policy advocates and as clinical experts to support people who self-manage their abortions.

2 | CLINICAL SAFETY OF SELF-MANAGED ABORTION WITH MEDICATION

The use of medicines for induced abortion has expanded the way that people have abortions and changed the skills required for safe abortion care. Here, "safe abortion" is conceptualized by referencing historical framing by WHO and noting how it has evolved. The notion of abortion safety was first outlined in a WHO Technical Consultation in 1992, in the context of global efforts to reduce maternal morbidity and mortality from unsafe abortion.[9] Participants in the 1992 consultation defined unsafe abortion as "a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both." This 1992 definition squarely framed abortion safety through a clinical lens, as being tied to both individual skills and a medical environment, reflective of the fact that most abortions at that time were procedural.

However, the definition of safe abortion has changed over time in line with new evidence.[10] As medication abortion rose to prominence in the early 2000s, research from clinical trials established its overwhelming safety and effectiveness in the clinical setting. The first WHO abortion care guidance issued in 2003 stated that trained healthcare professionals, including advanced practice clinicians such as nurse practitioners and midwives, were the only individuals who could provide safe abortion. The most recent WHO guidelines released in 2022, however, fully endorse self-management of medication abortion with misoprostol alone or in combination with mifepristone for all or part of the abortion process for pregnancies at less than 12 weeks.[5]

This monumental shift in the WHO guidelines reflects growing recognition of the robust body of research conducted over the past decade on the safety and effectiveness of self-managed medication abortion.[1,2,11] Similar to evidence on medication abortion from clinical settings, research has established high levels of safety and effectiveness of self-managed medication abortion across a range of out-of-clinic models—in the range of 94%–100% abortion completion without procedural intervention.[2,12] One recent study in particular—the SAFE (Studying Accompaniment model Feasibility and Effectiveness) study—evaluated the safety and effectiveness of self-managed medication abortion via the accompaniment model, wherein non-clinically trained counselors provided phone-based information and support to people self-managing their abortions.[2] The SAFE study further established the effectiveness and safety of self-managed medication abortion and, importantly, concluded that the self-managed setting is not inferior to the clinical setting for abortion completion. Indeed, findings from the SAFE study, as well as other recent studies on self-managed abortion, also indicate that self-use of misoprostol alone may be more effective than previously thought—a consequential finding given that misoprostol is much less heavily regulated and more easily accessible than mifepristone.

Self-managed abortion with medications, however, is not new. The discovery of medication abortion originated nearly 40 years ago in Brazil in a self-managed context. Seeing an opportunity in a warning label on the drug, misoprostol, that cautioned about a risk of miscarriage in pregnant people, Brazilian women in the 1980s discovered that they could take the drug, originally registered for the treatment of gastric ulcers, at home to successfully induce a miscarriage without the involvement of healthcare professionals.[4,13] This was particularly critical given that abortion is criminalized in nearly all circumstances in Brazil. At nearly the same time, the abortion drug mifepristone was developed by a French pharmaceutical company for the purpose of being used with misoprostol for induced abortion.[14]

In this way, medication abortion began as a private, at home, self-managed experience. Only after this discovery did the global medico-legal institution begin to heavily medicalize and increasingly restrict medication abortion to the clinical sphere with severe professional and legal restrictions on when, how, and by whom it could be administered. The recent shift in the WHO guidelines to endorse the use of medication abortion in a self-managed context reflects a full circle journey in the history of these medications and has much to do with the tireless efforts of advocates, researchers, and clinicians around the world who have pointed to the lack of public health evidence supporting these restrictions, and indeed highlighting the harms of these clinical and legal restrictions.

People end their pregnancies without the involvement of a healthcare provider for a variety of reasons, including unavailable or inaccessible healthcare providers. Even where abortion is legal and relatively accessible, people may choose not to consult with a healthcare provider because of distrust of the healthcare system, difficulty with scheduling or travel, convenience, or personal preference.[1,15]

Circling back to the discussion of abortion safety, researchers have attributed the rise in use of medication for self-managed abortion as a potential cause in the observed decrease in mortality from unsafe abortion.[16] Challenges remain, however, in research on self-managed abortion. For instance, it is difficult to quantify how many people have self-managed their abortions or to study outcomes from

self-managed abortion due to abortion stigma, the inability to identify people self-managing, general secrecy, and well-founded fears of legal consequences.[17] Through partnerships with local feminist activist collectives and networks of grassroots abortion supporters and community health workers, however, researchers are overcoming these challenges and contributing new knowledge to the evidence base on the safety and efficacy of self-managed medication abortion.

3 | SELF-MANAGED ABORTION AND THE LAW

Before the advent of specialized equipment for abortion and the use of modern abortion drugs, people ended their pregnancies outside of a clinical setting through a range of methods, including the ingestion of herbs and other plants with varying safety and efficacy, often relying on the help of knowledgeable midwives or women in their families and communities.[18] Early abortion was generally unrestricted by law—its regulation through the criminal law is a recent phenomenon.

As an example, the development of abortion law in England is briefly described, given its enduring influence and pervasive harm on abortion laws in former British colonies around the world. Early abortion was legal in English common law until the mid-1800s, when abortion became regulated by criminal law. With their influence on lawmakers in England, it was medical doctors—exclusively men in the 19th century—who first pushed for the criminalization of abortion and, a century later, influenced a law that allowed legal abortion on broad grounds but only when provided by doctors. This allowed doctors to keep legal abortion within the domain of physicians only—essentially using the law to corner the market for abortion. In 1861, a newly organized medical profession successfully pushed for the criminalization of abortion. The 1861 Offenses Against the Person Act criminalized abortion and imposed the penalty of "penal servitude for life" upon people who ended their own pregnancies. Though the law contained no exceptions, medical doctors openly provided therapeutic abortion—that is, termination of pregnancy to treat a condition in a pregnant woman.[19] Eventually, 106 years later in 1967, organized medical bodies influenced lawmakers to reform the law to legalize the existing practice of therapeutic abortion by doctors, allowing abortion for health reasons—however, still only when provided by a medical practitioner. Among the arguments forwarded by medical bodies was that the existing law curtailed the professional freedom of medical doctors.[19]

The prohibition of abortion, with exceptions when provided by a medical practitioner or other healthcare professional, remains the dominant model for the regulation of abortion around the world. Abortion laws impose criminal penalties on individuals who self-manage their abortion, on the abortion providers and other people who help them, or both. In addition to abortion laws, drug control laws and prescribing requirements are other places in law that may require the involvement of a health professional for legal abortion. Laws that require healthcare professionals to be involved with an abortion may be enacted with the alleged purpose of ensuring clinical safety, but they also serve to ensure that legal abortion remains within the exclusive domain of doctors and other healthcare professionals, and therefore out of reach for many people who need it.[20]

The recent WHO evidence-based guidelines on the self-management of medication abortion leave no doubt that laws that require a healthcare professional for legal abortion early in pregnancy do not serve the purpose of promoting clinical safety. Indeed, modern abortion laws may instead reflect the professional and economic interests of medical professionals and ideologically driven legislators.

Along with requirements that a healthcare provider perform the abortion, abortion laws contain other unnecessary restrictions that are not based on evidence.[5] Such provisions include waiting periods, judicial authorization, and requirements that a parent or spouse consent to abortion. In addition to requiring a medical professional to provide an abortion, most laws also require that an abortion take place in a healthcare facility.

Restrictions on where abortion takes place have shifted somewhat as the use of telemedicine for a range of healthcare services has grown, and along with it, telemedicine abortion.[21] Telemedicine abortion, distinct from self-managed abortion, is when a patient consults with a healthcare provider online or by phone and acquires medicines for abortion by picking them up at a healthcare facility or pharmacy or receives them through the mail.[22] Telemedicine for abortion, however, still involves a healthcare provider, though such a requirement is not necessary for clinical safety or efficacy.[23]

Pharmacists can play a role in the provision of medication abortion by dispensing abortion medicines where telemedicine abortion is allowed. Even in settings where telemedicine abortion is not allowed, some pharmacists provide abortion medicines and information without involvement from the medical provider. Researchers have found, however, that in some of these contexts, pharmacy workers and others who sell medicines have poor knowledge of the appropriate medication abortion regimens.[24] Liberalizing the law to allow pharmacists and others licensed to sell medicine to provide abortion medication and training them to do so could help expand access to abortion and help ensure people receive accurate information, including for people who self-manage their abortions.

4 | THE EFFECT OF UNNECESSARY REQUIREMENTS FOR LEGAL ABORTION

Unnecessary requirements increase the economic and logistical burden, as well as the legal and clinical risk for pregnant people seeking abortion and the individuals who help them. In a cruel intersection, these burdens and legal risks fall disproportionately on people who are the most marginalized from care—particularly those who have been systematically discriminated against based on poverty, race, gender identity or expression, sexual orientation, disability, age, migration status, and other characteristics.[5,15] In addition, even where

abortion is legal, people may face increased legal risk if they seek care outside the formal medical system, such as in countries that face health workforce shortages. People seeking abortion outside the law and individuals who help them can be subject to arrest or prosecution for their involvement in abortion care, even in places where abortion is legal.[25]

Abortion is healthcare and, as such, should be regulated as any other type of healthcare. To promote health and evidence-based policy, abortion should be removed from criminal law. Moreover, laws should be reformed to remove unnecessary restrictions, including the removal of requirements that abortion must be provided in a formal healthcare setting and that a healthcare professional must be involved for abortion to be safe and legal. These laws do not improve the safety or efficacy of care.

5 | SELF-MANAGED MEDICATION ABORTION: THE ROLE OF HEALTHCARE PROFESSIONALS

The involvement of obstetricians and gynecologists is not needed for most early, uncomplicated medication abortions. But obstetricians and gynecologists and other healthcare professionals do have important roles to play in reducing the clinical and legal risks associated with self-managed abortion.

Obstetricians, gynecologists, and other healthcare professionals are often involved in the development of laws, regulations, and standards and guidelines that govern the provision of abortion. Lawmakers, ministry of health officials, and other regulators look to medical experts to inform legal and regulatory frameworks designed to ensure the safety of abortion. Obstetricians and gynecologists should be vocal in their support for evidence-based policy that omits unnecessary requirements for legal abortion. All healthcare professionals can advocate for the removal of unnecessary requirements to ensure that legal abortion can take place outside of a formal healthcare facility and without the involvement of a healthcare professional.

Some people who self-manage their abortion will seek follow-up care, most commonly for clinical reassurance and confirmation of abortion completion.[2] In rarer instances, people may seek follow-up care due to concerns about potential complications from the abortion, or for uterine evacuation to complete the abortion in the few cases where medication failed. In the instances where people seek health care during or after a self-managed abortion, emergency department physicians, obstetricians, and gynecologists, as well as other healthcare providers, have an essential role to play.[26]

First, providers must keep confidential any information learned from their patients as to whether the abortion was self-managed. In *Ethics and Professionalism Guidelines for Obstetrics and Gynecology*, FIGO has emphasized the need to protect confidentiality in the course of providing obstetric and gynecological care in particular, due to sensitive issues addressed in the course of care.[27] A physician's disclosure of information to law enforcement or other third parties exposes their patient to risk of arrest or prosecution.[28] This is not a theoretical risk: in a recent study of 61 people arrested for self-managed abortion in the United States between 2000 and 2020, law enforcement was most often alerted via healthcare professionals reporting on their patients.[25] This occurred despite there being no law in the United States that mandates reporting of self-managed abortion by healthcare providers. Beyond protecting confidentiality for their own patients, obstetricians and gynecologists can advocate for stronger protections of confidentiality in national law and codes of medical ethics, specifically for obstetric and gynecological care.

The medical care needed by patients who experience induced abortion and those who experience spontaneous abortion is the same. When information about whether and how a person induced their abortion would not influence care decisions, a healthcare provider need not ask their patient to share such information. Healthcare professionals should additionally take care in considering what they document in a patient's medical record as such records may be subject to subpoena during an investigation. By intentionally not collecting or documenting information that could place the patient or provider at risk of criminalization, providers can protect both themselves and their patients.[29]

Beyond protecting patients' rights to confidentiality, obstetricians and gynecologists can work to become trusted allies for people who self-manage their abortions and those who help them. When people are concerned that medical staff may not protect their confidentiality or could be a risk for criminalization, there is a chilling effect on healthcare seeking. In these cases, even when people have an urgent need for medical attention after self-managed abortion, they may not seek it out of fear. To proactively address this concern, obstetricians and gynecologists can intentionally seek out and develop relationships with accompaniment groups and others helping pregnant people self-manage their abortion, to ensure there is a trusted source for referral to medical care when and if needed. This is just one example of how obstetricians, gynecologists, and other healthcare providers can become trusted allies in self-managed abortion and mitigate fears in seeking health care when needed.

6 | CONCLUSION

People have been safely self-managing their abortions with medications for decades, without the mandated involvement of doctors and other healthcare professionals. Medications for abortion are highly safe and effective, whether taken in a clinic or self-managed at home. As with many medications, however, there are rare instances when complications arise; in these instances, obstetricians, gynecologists, and other healthcare providers are needed to provide follow-up care, to address incomplete abortion, or to allay concerns and provide reassurances. To ensure that people who self-manage are safe when accessing this care, providers of post-abortion care must commit to only asking and documenting relevant information, and non-disclosure of any potentially criminalizing information.

Obstetricians, gynecologists, and other health providers can serve as both experts and advocates in the shaping of abortion law and policy. To promote clinical and legal safety, obstetricians and gynecologists must push for the removal of unnecessary legal requirements and penalties surrounding abortion provision. For self-managed abortion, unnecessary requirements include any laws that mandate the involvement of a healthcare professional in abortion provision, and requirements that abortion take place in a healthcare facility.

There are several actions that medical doctors and obstetricians and gynecologists specifically, can take to reduce the medical and legal risk associated with self-managed abortion. Medical doctors should educate themselves and their colleagues about the safety and efficacy of self-managed abortion, as well as ways to support people who are self-managing their abortion care. Physicians should advocate to eliminate legislative interference in reproductive health care and should vocally support passage of evidence-based policy that omits unnecessary requirements for legal abortion. In addition, medical doctors should oppose policies that criminalize people for their pregnancy outcomes or for seeking medical care and call on professional medical societies to support resolutions opposing the criminalization of physicians who provide care within the standard of medical care. Everyone in reproductive health should support community-based providers and those providing accompaniment care by establishing connections to safe back up care if and when needed.

People will continue to self-manage their abortions with the help of others, no matter the legal context. Healthcare professionals are ideally placed to champion the health of pregnant people and be influential supporters of people who self-manage their abortions.

AUTHOR CONTRIBUTIONS

All authors conceived of and contributed to the writing and editing of this article.

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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How to cite this article: Skuster P, Moseson H, Perritt J. Self-managed abortion: Aligning law and policy with medical evidence. *Int J Gynecol Obstet*. 2023;160:720-725. doi:10.1002/ijgo.14607