

Key Findings

- Some people living in the United States (U.S.) attempt to end their pregnancies outside of the formal health care system. We have documented self-managed abortion consideration and attempts among those seeking abortion at clinics, those searching for information online about where to get an abortion, and the general population.
- People consider and attempt to end their pregnancies outside of a clinic setting for many reasons, including due to barriers to facility-based care and a preference for privacy and autonomy.
- Several studies have shown that self-managed abortion with mifepristone and misoprostol and misoprostol alone is safe and effective.
- Most U.S. women believe that self-managed abortion should not be criminalized.

Background

Barriers to facility-based abortion and increasing awareness of abortion pills has sparked renewed interest in what is referred to as **self-managed abortion** or ending a pregnancy on one's own without supervision from a health care provider. Those who attempt self-managed abortion may use self-sourced mifepristone and/or misoprostol,¹⁻³ herbs or plants, over-the-counter medications, drugs and alcohol, or physical methods, among others. Self-managed abortion occurs in a variety of settings, including where abortion is legally available. Some people who attempt self-managed abortion may never interact with the formal health care system, while others may contact clinicians, doulas, or other types of health workers before, during, or after the process.

In collaboration with colleagues and community leaders, ANSIRH researchers are investigating a variety of questions about self-managed abortion. A summary of our recent findings is included below.

How common is self-managed abortion?

In 2017, we conducted the first national, population-based survey about people's experiences with self-managed abortion in the U.S. Data from this cross-sectional study showed that 1.4% of self-identified women ages 18-49 (equivalent of 900,000 to 1,300,000 people) reported ever having tried to end a pregnancy on their own.⁴ This corresponded to 7% (95% CI, 5.5% - 8.4%) of U.S. women attempting self-managed abortion over their lifetime. In another study among people searching for abortion care on Google in 2017-2018 (n=856), ANSIRH researchers found that 28% (95% CI: 25%-31%) reported attempting self-managed abortion.⁵⁻⁶ One of the strengths of these studies is that they explore the prevalence of self-managed abortion not just among people recruited at clinics seeking abortion, primary, or other reproductive health care; such studies likely miss the experiences of those who are unable or choose not to access facility-based care. A 2022 update to the national survey on self-managed abortion, which will reflect changes in self-managed abortion between 2017 and 2022, is currently underway.

A 2010 study of 9,493 patients seeking abortion at facilities across the U.S. found that roughly 2% reported ever having taken misoprostol or other substances to bring back their period or end a pregnancy.⁷ In Texas, this proportion was higher, at 7% of abortion patients in 2012 and 2014.⁸ Almost 10 years later, we surveyed people seeking abortion at facilities in 3 U.S. states and found that 34% would consider self-managing their abortion if unable to obtain care at a facility.⁹

Summary of Study Methods

Ipsos population-based survey (Ralph et al. 2017)⁴

- National cross-sectional survey of n=7,022 women aged 18-49.
- Fielded August 2017 among English- and Spanish-speaking, self-identified female panel members from the *Ipsos* web-based KnowledgePanel, a probability sample of US addresses.
- Eligible panel members were invited to participate in a 53-item, one-time survey.
- We asked participants: “Have you ever taken or used something on your own, without medical assistance, to try to end an unwanted pregnancy?”

Google Ads Abortion Access Study (Upadhyay et al. 2021)⁵

- Prospective cohort study, including n=856 participants with follow up data from all 50 states.
- Recruitment between August 2017 and April 2018, using English advertisements displayed to individuals searching Google with specific key words, such as “abortion clinic near me”.
- Participants completed an online baseline survey and follow-up 4 weeks later.
- We asked participants “Did you take anything or try to do anything on your own without medical assistance to try to end your most recent pregnancy or bring back your period?”

Who attempts self-managed abortion and why?

Rates of self-managed abortion appear to be higher for people of color, gender non-binary people, uninsured people, and low-income people – the same populations for whom access to facility-based abortion care is difficult. In our national population-based survey, Ralph et al. 2020 found the prevalence of self-managed abortion was nearly 3-fold higher for Black women than Non-Hispanic White women and more than 3 times higher for women living below 100% of the federal poverty line compared to women living at or above 200%.⁴ Being uninsured and having difficulty paying for abortion have also been associated with elevated likelihood of considering self-managed abortion.⁹ In a study of transgender, nonbinary and gender-expansive individuals who had ever been pregnant, Moseson et al. 2022 found that 36% had considered trying to end a pregnancy without clinical supervision and, among those, 19% had attempted self-managed abortion.¹⁰

“It was hard to find. There wasn’t very many clinics around me to begin with. The ones that were [there] were just so expensive, the procedures themselves, that the cost and just availability of people wasn’t very good.” (Ohio, age 18)

Reasons for attempting self-managed abortion reflect a range of perspectives. Some people turn to self-managed abortion because of barriers accessing facility-based abortion services, including the cost of

services and logistical challenges of finding transport and childcare, missing work, and traveling long distances to a clinic. Among people who searched Google for an abortion provider, respondents who reported having to keep the abortion secret, fearing for their safety or well-being, needing to gather money for travel or the abortion, or living far from an abortion facility had significantly higher odds of attempting self-managed abortion than those who did not report experiencing one of these barriers.⁵ As facility-based care becomes increasingly restricted, more people may choose self-managed abortion. In our survey of people seeking abortion at facilities in three U.S. states, we found that the proportion who would consider self-managing an abortion if unable to access facility-based care was higher among those who lacked health insurance, experienced logistical delays accessing care, had difficulty finding an abortion facility, and sought abortion due to concerns about their own physical or mental health.⁹

*“Emotionally it felt comforting to be doing something, even though I didn’t 100% believe that it would be effective, but it was something to do while I waited and just kind of feel slightly empowered...”
(California, age 37)*

Though self-managed abortion may be a last resort for some, it may be a preference for others who prioritize privacy and autonomy.^{1,11} Some people value having many options available to them, including the ability to try self-managed abortion after suspecting a pregnancy and before seeking facility-based care.¹² In our national survey, those who attempted self-managed abortion reported that it seemed faster, more affordable, and easier relative to clinic-based care.⁴ Some emphasized that self-managed abortion was more “natural,” while some who were minors at the time of their attempt were concerned about needing parental consent for facility-based abortion care.

What are the most common self-managed abortion methods?

In Ralph et al. 2020⁴ and Upadhyay et al. 2022,⁵ among people who had attempted self-managed abortion, herbs, supplements, or vitamins were most commonly reported (38% and 52%), with fewer people reporting mifepristone and misoprostol (20% and 18%), other drugs or medications including emergency contraception and contraceptive pills (29% and 19%), and abdominal or other physical trauma (20% and 18%). Respondents who used abortion medications were more likely to indicate successful termination of pregnancy; minimal evidence of efficacy exists for herbs, supplements, over-the-counter medications, and toxic substances.⁴

“The vitamin C and ginger were definitely out of convenience because they were the things I had. And even if I didn’t have them, I could get them at the grocery store.” (Ohio, age 32)

Is self-managed abortion effective and safe?

Information about self-managed abortion effectiveness and safety varies by the method used. The safety and effectiveness of mifepristone and misoprostol and of misoprostol-only is well documented

outside of the facility setting, including through asynchronous telehealth models online,¹³⁻¹⁸ pharmacies and community health workers,¹⁹⁻²³ and abortion accompaniment by trained volunteers who provide evidence-based information and physical and emotional support.²⁴

In the U.S. 2017 survey, roughly one-third of those who reported self-managed abortion said their attempt was successful (27.8%). Another third said their attempt was unsuccessful and that they ultimately sought facility-based services (33.6%).⁴ The remainder said they continued the pregnancy (13.4%), had a miscarriage (11.4%), or were unsure (13.3%).

A study using a nationally representative sample of U.S. emergency department (ED) visits from 2009-2013 found that (ED) visits related to self-managed abortion are rare in the U.S., representing 1.4% of abortion-related ED visits, which themselves constitute only 0.01% of all ED visits by women aged 15-49.²⁵ The South has higher rates of self-managed abortion-related ED visits (2%) compared to the Midwest (1%), West (1.1%), and Northeast (1.3%)²⁶.

Examples of self-managed abortion methods reported in the United States

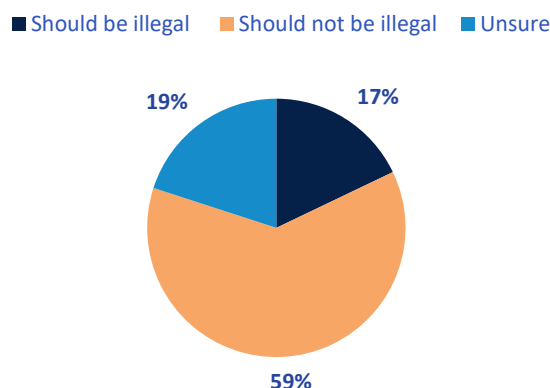
Category	Examples
Herbs, supplements, vitamins, or foods	Parsley tea, chamomile, vitamin C, vitamin D, cinnamon, turmeric, dong quai, black cohosh, rosehips, gingerroot, papaya, pineapple, niacin, celery seed and oil, pomegranate seeds and juice, cranberry juice, orange juice, caffeine, coconut and castor oil, poppy seeds, sesame seeds.
Prescription or over-the-counter medications	Lexapro, Celexa, Xanax, steroids, codeine, muscle relaxers, aspirin, laxatives, Tylenol 3, NyQuil, ibuprofen, NSAIDs, antibiotics, Humphrey's 11 menstrual regulation pills, cough syrup, Dramamine.
Mifepristone and/or misoprostol	Ordered pills online, mifepristone, misoprostol, "I purchased pills that I inserted vaginally".
Abdominal or other physical trauma	"Inserted long plastic spoon into vagina", "I would try hurting my stomach a lot", "Purposely not eating as much", "Letting my kidney infection go untreated in hope it would [end] the pregnancy", "Tried to open and dilate my cervix".
Emergency contraception* or oral contraceptive pills	"Plan B", "morning after pill", "multiple birth control pills at once".
Alcohol or other substances	Alcohol, marijuana, "meth", cigarettes, "everclear/alcohol", Mountain Dew, "drinking alcohol and taking pain meds".
Other	Excessive/vigorous exercise, "heavy lifting", "prayer, apparently not as effective as everyone lets on", "really hot baths and heating pads", "play-wrestled with large dogs".

Data from the Google Ads Abortion Access Study 2017-2018 (n=856)⁵ and Ipsos' *KnowledgePanel* national survey 2017-2018 (n=7,022).^{4,12} *Reporting use of only emergency contraception before confirming pregnancy was not considered self-managed abortion in either study.

What do people think about criminalizing self-managed abortion?

At least 20 states have policies that explicitly criminalize self-managed abortion or could be misused to prosecute people for self-managed abortion.²⁷ Since 2000, 61 people across 26 states have been criminally investigated or arrested for allegedly ending their pregnancy or helping someone else do so.²⁸ The criminalization of self-managed abortion is likely to have disproportionate impact on people of color and those living on low incomes, who face greater financial and logistical barriers to abortion access and are disproportionately targeted and harmed by law enforcement and structural racism. Of the 61 cases identified as of 2022, people of color are disproportionately represented when compared to the larger population and most adult cases that proceeded through court (56%) involved people living in poverty.²⁸

Views on the criminalization of self-managed abortion among reproductive-age women



Hospital providers may play a critical role in exacerbating the risks of criminalization for patients seeking care after or during a self-managed abortion attempt. Of the 61 cases of criminalization that occurred between 2000-2022, 39% were initially reported by health care workers and 6% by social workers. Interviews with Texas emergency and labor and delivery providers show a lack of knowledge about abortion and self-managed abortion, a lack of preparedness to provide comprehensive quality care to patients after a self-managed abortion attempt, and a tendency among some providers to help criminalize patients who may have attempted self-managed abortion by unnecessarily reporting them to Child Protective Services and/or the police.²⁹

Laws used to criminalize self-managed abortion are misaligned with the views of people most affected by them, including women living in states that have laws banning or limiting self-managed abortion. We found that the majority (59%) of reproductive-age women believe self-managed abortion *should not* be illegal.³⁰ Leading medical institutions including the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association, call for the decriminalization of self-managed abortion.

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