Self-managed Abortion in the US

In the aftermath of the Supreme Court’s decision in Dobbs v Jackson Women’s Health Organization, at least 13 states have already banned abortion, and additional states have imposed severe restrictions that ban abortion as early as 6 weeks of pregnancy. More state restrictions are likely to follow. As facility-based abortion care becomes increasingly difficult or impossible to access, it is inevitable that more people will turn to self-induced or self-managed abortion.

Self-managed abortion involves a pregnant person taking or doing something on their own to end their pregnancy. In the pre–Roe v Wade era, some people used traumatic methods, such as objects inserted through the vagina and into the uterus, in attempts to induce abortion. In recent years, these methods have become much less prevalent; instead, people more commonly report using herbs and medications to induce an abortion on their own.1 Unlike the limited options available before Roe v Wade, safe and effective methods of self-managed abortion are now available. The most effective methods for self-managed abortion involve using the same medications that are used for a facility-based medication abortion—either mifepristone used together with misoprostol or misoprostol used alone (Table).

Based on a nationally representative survey performed in 2017, the lifetime prevalence of self-managed abortion was estimated to be 7%.1 However, the prevalence is likely to increase as restrictions against facility-based care increase. One study documented that Internet searches for abortion medications increased 162% immediately after the Dobbs ruling was leaked in May 2022, with more searches occurring in states with restrictive policies.2 A study using data from 2018 through 2020 suggested that people who experienced barriers to abortion care, such as individuals with lower incomes and those living in states with restrictive abortion laws, were more likely to self-manage abortion.3

It is critical that physicians and other clinicians be aware of what to expect as more patients seek self-managed abortion and present for facility-based care before or after doing so. Some patients may seek medical evaluation prior to initiating self-managed abortion, or they may seek care afterward to confirm the method was successful or to evaluate unexpected symptoms. Other people may never come into contact with the health care system before, during, or after their self-managed abortion attempt.

In addition to being effective, medications used to self-manage abortion are safe. A recent study of an overseas online telehealth service that provided mifepristone and misoprostol to US patients found that among the 2797 individuals who confirmed use of the medications and provided outcome information, 1% reported treatment for any serious adverse event.4 In this study, 0.6% reported receiving a blood transfusion and 0.5% reported receiving intravenous antibiotics; no deaths were reported. Overall, the prevalence of these complications is similar to that reported with facility-based medication abortion. In addition to providing mifepristone and misoprostol outside of the facility-based health care system, some organizations also have hotlines staffed by licensed clinicians to support people through their self-managed abortion process.

Although there may be few medical risks with self-managed abortion using medications, people using self-managed abortion may face legal risks. Preliminary findings from a recent analysis identified at least 60 legal cases between 2000 and 2020 in which people were criminally investigated or arrested for allegedly self-managing their abortion or helping someone else do so.5 Among the 54 cases of adults who faced criminal charges, were criminally investigated, or were arrested, 41% were Asian, Black, Latina, or Latino, suggesting they were over-represented compared with the general US population.5

Care professionals, including both health care professionals and social workers, reportedly referred patients to law enforcement in 45% of cases, even though no jurisdiction mandated reporting of self-managed abortion at that time (or at the time of this publication). Unnecessary reports to law enforcement agencies by health care professionals can cause significant harm to people and their families, violate patients’ rights to privacy, and are inconsistent with patient–clinician confidentiality.

When patients do share plans to self-manage an abortion or present after a self-managed abortion, health care professionals can use a harm reduction approach to their care. Harm reduction aims to reduce potential negative effects of a certain behavior and has been used in other realms of health care, for example, making naloxone more widely available in the community to decrease morbidity and mortality due to opioid overdoses. A report from 2016 suggested that in countries where abortion access has been limited (such as Uruguay and Peru), this approach was associated with improved patient outcomes and decreased abortion-related morbidity and mortality.6

For patients who may disclose plans to self-manage an abortion, physicians and other clinicians could incorporate harm reduction by assessing the patient’s gestational duration and health conditions and providing information about safe and effective methods of inducing abortion in the first trimester with medications.7 Health care professionals can provide anticipatory guidance so that patients are aware of expected adverse effects and potential complications, and they can ensure that patients feel comfortable presenting for safe, nonjudgmental follow-up care should complications arise or to confirm abortion completion. Clinicians should also be clear with patients about potential legal risks related to self-managed abortion to assist them in making informed decisions about how to proceed. Resources like the If/When/How legal helpline may be useful for patients and clinicians who are trying to understand their legal risks related to self-managed abortion.
self-managed abortion. Patients requesting emotional support could be connected with resources that provide free confidential talk lines.

A harm-reduction approach also could be used when people seek facility-based care after a self-managed abortion attempt. Patients may present to primary care, emergency, or urgent care settings after initiating self-managed abortion because they are experiencing a potential complication or sometimes because they want confirmation that the pregnancy has been ended. The first priority is provision of evidence-based care, although the legal environment in some states may limit this care. In the case of self-managed abortion, evidence-based care rarely differs based on whether the early pregnancy loss was spontaneous or induced by medication. The relevance of medication use can be determined by the treating clinician. In many cases, this information might not affect patient care and its documentation could potentially increase legal risks for patients.

Rarely, patients may present to the hospital with serious complications related to a self-managed abortion attempt, such as uterine perforation, active hemorrhage, or sepsis. These patients should be evaluated and promptly treated using the best available evidence-based care. More commonly, after self-managed abortion with medications, patients will present with symptoms such as mild bleeding or cramping that require minimal treatment. It is helpful for clinicians who may be caring for these patients in emergency or urgent care settings to be familiar with the normal course of a medication abortion (eg, expected intensity and length of bleeding and discomfort) to avoid unnecessary interventions. For example, it is inappropriate to avoid intervention and have patients monitor their symptoms if they report only minimal bleeding and pain after passing pregnancy tissue. Such patients should be instructed to take a pregnancy test in 4 weeks, at which time the test should be negative. In addition, clinicians should be aware that a thickened endometrium shown on ultrasound is normal after a complete medication abortion, and that this finding, in isolation, should not dictate intervention in an asymptomatic patient.

While providing excellent, timely clinical care, health care professionals can take multiple steps to help protect their patients from legal risk. Physicians and other clinicians should be intentional about the clinical relevance of the information they request from patients and the related documentation. They should clearly communicate with all members of their clinical team, including social work, nursing, and other staff, about the critical need to prevent criminalization of patients who have self-managed an abortion. It also could be helpful for clinics and hospitals to develop protocols that promote nonjudgmental care of all patients and maintain patient privacy.

As abortion bans and restrictions proliferate, people in many parts of the US who previously would have sought abortion care are left with the options of either continuing their pregnancy, traveling out of state for care, or trying to end their pregnancy on their own. Health care professionals should prepare for the anticipated increase in self-managed abortion by becoming educated about laws affecting abortion care in their state, resources to support patients, and best practices to incorporate a harm-reduction approach to the care of patients who may be self-managing their abortions. Physicians and other clinicians, with support from their professional medical organizations, should also actively advocate against policies that criminalize self-managed abortion or other actions taken during pregnancy. With the loss of clinicians and centers that provide specialized abortion care in states with bans, it becomes the role of all health care professionals to support patients needing this care, including supporting those who choose to self-manage their abortion by minimizing the medical and legal risks they may encounter.