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Health Advisory

Information about Self-Managed Abortion
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SUMMARY POINTS

- After the Supreme Court decision on *Dobbs v. Jackson Women's Health*, medical providers may see an increase in patients who have self-managed abortion.
- Self-managed abortion is any attempt to end a pregnancy outside of the formal healthcare system.
- Unlike in the pre-Roe era, when many women died from attempts to end their own pregnancy, medication abortion has changed the landscape dramatically.
- There are many resources available online for patients to complete a self-managed abortion safely and effectively and the World Health Organization endorses self management of abortion.
- While optimal care would provide all people who can become pregnant with access to the full range of reproductive services through the healthcare system, self-managed abortion may offer the safest option available to pregnant people for whom that access is currently denied.
- A harm reduction approach should be used to decrease morbidity and mortality associated with use of self-managed abortion. If a patient seeks care after a self-managed abortion, nonjudgmental care should be provided.
- Complications of self-managed abortions should be managed the same way as a miscarriage and care can be provided without knowing if a self-managed abortion was attempted.

What is a self-managed abortion?

A self-managed abortion is any action to end a pregnancy outside of the formal healthcare system. This includes obtaining and administering mifepristone and misoprostol, consuming herbs or other drugs and using physical methods to end a pregnancy[1]. All of these processes can result in a range of interactions with the formal health system. It is important to understand that most people who attempt a self-managed abortion do so with abortion pills – mifepristone and misoprostol. There are many resources patients can use to obtain mifepristone and misoprostol, which has dramatically improved the safety and efficacy of self-managed abortion. [2,3]

Because medication abortion pills can be accessed outside the healthcare system, this guideline focuses primarily on regimens and expectations after self-managed abortion with mifepristone and misoprostol – the same medications used for miscarriage and medication abortion management in the healthcare system.

People may choose to self-manage abortion for many reasons including difficulty in accessing abortion care due to cost and financial barriers, distance to an abortion clinic, legal restrictions in their state of residence, privacy or fears of legal repercussions, distrust of the medical system, and even convenience.

The World Health Organization recommends that individuals in the first trimester (up to 12 weeks pregnant) can self-administer mifepristone and misoprostol without direct supervision of a health care provider. Research has shown patients are able to: determine gestational age and rule out contraindications to medical abortion, self-administer medications outside a healthcare facility without supervision of a health worker, manage the abortion process and self-assess success of the abortion.[4]

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

(1) Gestational age calculator: Patients may rely on a pregnancy calculator to determine gestational age and eligibility. Pregnancy calculators are available online and are often embedded in some self-managed abortion resources.
(2) Symptom checklist: If patients have correctly used a symptom checklist prior to self-managed abortion, their risk of ectopic pregnancy is low. A checklist advises patients with pelvic pain, bleeding, or ectopic risk factors to seek medical evaluation. If this criterion is misapplied or not heeded, there is a chance a patient has attempted a self-managed abortion with an ectopic pregnancy. A sample protocol which includes criteria to rule out ectopic pregnancy can be found here.

What resources may patients use to complete a self-managed abortion?

To ensure self-managed abortion with medication is completed safely, patients must have access to effective medications (mifepristone and misoprostol) and healthcare workers if needed. Patients may report using the following resources to find medications and guidance:

- Plan C Pills: does not distribute pills, but generates list of how to obtain mifepristone and misoprostol within and outside the formal healthcare system
- Aid Access: will deliver pills to all locations within the United States or guidance on how to obtain pills directly from online pharmacies
- Miscarriage and Abortion Hotline: for medical questions during miscarriage or abortion, staffed by clinicians open 8-11AM 7 days a week in English and Spanish
- Self managed abortion safe and supported: medical questions in more languages through a web portal
- All options: emotional support including peer based counseling
- I Need an A: provides information on where to access an abortion
- Reprocare Healthline: provides information and emotional support for abortion seekers
- ReproLegal Hotline: provides information about legal resources for accessing abortion, including judicial bypass representation
- If/when/how: can leave a message or complete secure online form for legal questions

Self-managed abortion regimens

Patients may report using any of the following regimens to complete a self-managed abortion:

	Regimen	Gestation	Efficacy
FDA approved	Mifepristone 200mg orally Misoprostol 800mcg buccally, 24-48 hours later	Up to 70 days	98% at ≤ 49 days 93-95% at 64-70 days
WHO approved	Mifepristone 200mg orally Misoprostol 800mcg buccally, vaginally, or sublingually 24-48 hours later	Up to 84 days	**
Alternatives	Mifepristone 200mg orally Misoprostol 800mcg buccally, vaginally, or sublingually 0-8 hours later	**	92-97%
	Mifepristone 200mg orally Misoprostol 800mcg buccally, vaginally, or sublingually 0-8 hours later 2nd dose of misoprostol 800mcg 4 hours after first	64-77 days	97-99%
	Mifepristone 200mg orally Misoprostol 800mcg buccally, vaginally, or sublingually and Misoprostol 400-800mcg every 3 hours until expulsion, usually up to 5 doses *	70-84 days	**
Misoprostol only	Misoprostol 800mcg vaginally, sublingually, buccally with repeated doses every 3 hours up to 3 doses *	**	93-99%

* Sometimes used for self-management of abortion beyond 12 weeks with greater need for medical intervention
**Information unavailable.

Patients may assess abortion completion using a checklist of symptoms and a home urine pregnancy test[5,6]. If a home urine pregnancy test is used the patient should take a test on the day of mifepristone use and repeat a test 7-30 days later. If the repeat home urine pregnancy test is negative, the abortion was complete.

What might patients experience after self-managed abortion?

Patients rarely have severe complications if the medication regimens described above are utilized to accomplish a self-managed abortion. However, if a patient experiences heavy bleeding, uterine perforation from attempting to induce abortion, or sepsis, they should be treated as any other patient experiencing these symptoms. It is more likely that patients will present with mild bleeding, pain, or nausea which may require symptom management. Of note, it is not necessary to have a uterine aspiration procedure because of thickened endometrial stripe alone or continued period-like bleeding after medication abortion. Gynecology should be consulted for management of these questions if needed.

When should patients seek care from a healthcare provider?
Patients are advised to seek care from a healthcare provider to determine if they have an ongoing pregnancy or need additional medical care if they:

- Did NOT have cramping after taking pills
- Did NOT have bleeding at least as heavy as usual period
- Did NOT pass blood clots or tissue after taking all pills
- Are continuing to experience pregnancy symptoms or still think they are pregnant
- Are having heavy bleeding
- Have a fever
- Have bad cramping or pain

If patients report any of the symptoms above, a repeat ultrasound to evaluate for ectopic pregnancy and an evaluation by an OB/GYN may be warranted.

What are the reporting requirements if a patient discloses a self-managed abortion?

Pennsylvania does NOT criminalize self-managed abortions and does not prosecute individuals who self manage an abortion. There are other states with laws that criminalize self-managed abortion or laws that could be used to prosecute for self-managed abortion[3,8]. **Pennsylvania is not one of these states.** The Governor has signed an executive order that protects people who travel to Pennsylvania to access abortion care and will decline any request for a warrant for any person related to the provision, receipt of, or assistance with reproductive healthcare services[9]. **Clinicians in any state are NOT mandatory reporters of self-managed abortion.** Reporting suspected self-managed abortion would be a violation of HIPAA[10], may undermine trust in the medical system, lead to over reporting of minoritized identities due to implicit bias, and may prevent patients from seeking care they need[1]. In most cases, there is no need to document if a patient attempted a self-managed abortion in the medical record as this does not impact care or management because complications from a miscarriage and self-managed medical abortion are the same and have the same presentation. If a patient experiences uterine perforation, sepsis or other complication from attempting to induce abortion by means other than medication, they should be treated as any other patient experiencing these symptoms.

Other resources:

- Podcast from Society of Family Planning clinician perspectives on managed abortion: https://www.societyfp.org/about-sfp/podcast/#E01
- Society of Family Planning Interim Clinical Recommendations on Self-Managed Abortion: https://www.societyfp.org/wp-content/uploads/2022/06/SFP-Interim-Recommendation-Self-managed-abortion-07.14.22.pdf
- https://abortiononourownterms.org/
- Overview of what clinicians need to know about self-managed abortion: https://sfp.mclms.net/en/package/9581/course/18576/view

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