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U.S. Abortion Care Providers' Perspectives on Self-Managed Abortion

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Abstract

State-level restrictions on abortion access may prompt greater numbers of people to self-manage their abortion. The few studies exploring perspectives of providers towards self-managed abortion are focused on physicians and advanced practice clinicians. Little is known about the wider spectrum of abortion care providers who encounter self-managed abortion in their clinic-based work. To gain a deeper understanding of this issue and inform future care delivery, we conducted in-depth interviews with 46 individuals working in a range of positions in 46 abortion clinics across 29 states. Our interpretative analysis resulted in themes shaped by beliefs about safety and autonomy, and a tension between the two: that self-managed abortion is too great a risk, that people are capable of self-managing an abortion, and that people have a right to a self-managed abortion. Our findings highlight the importance of increasing knowledge and clarifying values among all abortion care providers, including clinic staff.

Keywords

self-managed abortion, self-induced abortion, medication abortion, healthcare providers, qualitative research

Introduction

A growing body of evidence suggests that self-managed abortion, defined as an abortion conducted outside of the formal healthcare system using a variety of methods, is a growing trend in the United States (Aiken, 2019; Aiken et al., 2020a; Grossman et al., 2014; Jones, 2011). Over a 4-year period (2012–2017), the percentage of clinics or nonhospital medical facilities that reported at least one patient who had attempted self-managed abortion increased from 12% to 18% (Nash & Dreweke, 2019). Self-management may be especially prevalent in places where access to abortion is restricted. While just 2.6% of patients seeking clinic-based care in the United States in 2008 reported a previous attempt to self-manage an abortion (Jones, 2011), a 2015 survey of patients in Texas revealed that 7% had attempted the same (Grossman et al., 2015). More recently, Aid Access, a telemedicine service that provides abortion medications by mail to people in the United States, received over 20,000 online requests between March, 2018 and March, 2019, the first year of operations (Aiken, 2019). The rate of online requests to this service increased nationally by 27% during the COVID-19 pandemic, with the highest rate of increase (94%) found in Texas (Aiken et al., 2020a), highlighting the current need for alternative pathways to terminate pregnancy.

While additional research on self-managed abortion in general is needed, previous studies demonstrate that self-managed *medication* abortion up to 12 weeks' gestation using mifepristone and misoprostol has an efficacy rate ranging from 78.7% to 99.5%, and from 75% to 99% using a misoprostol only regimen (Moseson et al., 2020, 2021). These efficacy results are similar to clinical outcomes of the standard FDA-approved protocol of mifepristone and misoprostol, found to be 95% effective up to 10 weeks' gestation (Chen & Creinin, 2015; Gatter et al., 2015).

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Research on the safety of self-managed medication abortion has found a low-prevalence of complications such as transfusion, abdominal surgery, or infection (Aiken et al., 2017; Footman et al., 2018; Grossman et al., 2018). In countries where abortion services are legally available, people report a range of motivations for self-managed care, including barriers such as cost and distance to clinics, a desire for privacy or secrecy, or a belief that an at-home abortion is more comfortable or convenient (Aiken et al., 2019, 2020b; Chemlal & Russo, 2019; Fuentes et al., 2020; Kerestes et al., 2019a; Ostrach & Cheyney, 2014). As more restrictions are imposed on abortion access in the United States (Nash & Dreweke, 2019), including new legal approaches exemplified by the recently enacted Senate Bill 8 (SB8) in Texas, people may increasingly seek to end their pregnancies outside of the formal healthcare setting (Aiken et al., 2021). In response, leading reproductive health scholars and practitioners recommend that medical providers increase their knowledge of self-managed abortion pathways, awareness of resources to assist patients seeking an abortion, and be prepared to manage the rare complications of medication-induced abortion as well as the potentially life-threatening complications of unsafe abortion methods (Harris & Grossman, 2020).

Amidst this quickly changing landscape, little is known about the knowledge, experiences, and attitudes of abortion care providers in relation to self-managed care. Three studies from outside of the United States reveal that providers have knowledge of and experience with self-managed abortion but are often concerned that individuals lack appropriate information and support (Berry-Bibee et al., 2018; Crouthamel et al., 2021; Espinoza et al., 2004). To the authors' knowledge, only three studies to date have sampled abortion care providers in the United States, most of whom were physicians and/or advanced practice clinicians (Karlin et al., 2021; Kerestes et al., 2019b; Raifman et al., 2021). A nationwide survey of providers found that two-thirds reported previously interacting with patients who had self-managed (Kerestes et al., 2019b). Approximately one-third witnessed complications from these events, and only half believed that self-managed medication abortion was safe (Kerestes et al., 2019b). In a qualitative study of healthcare providers working in hospital settings along the Texas/Mexico border, self-management cases were rare, and providers lacked knowledge of clinical, legal, and community resources for patients who came to the hospital though they felt that the care provided to patients who self-managed should be similar to care for miscarriage management (Raifman et al., 2021). Finally, a mixed-methods study of abortion providers found that changes to clinic protocol in response to COVID-19 led providers to reassess their beliefs about the risks of self-managed medication abortion (Karlin et al., 2021).

Treatment from both medical providers and staff are indicators of quality of care (Dennis et al., 2017; Lee, 2019). As with other issues, a care provider's response to self-managed abortion has the power to either reduce or perpetuate harm and could improve or worsen health outcomes (Chor et al., 2016), thus it is important that they be equipped with up-to-date information on this practice. Knowledgeable care providers have the opportunity to reduce abortion stigma, build trust in the client-provider relationship, and improve the individual experience of abortion care (Bommaraju et al., 2016; Kelly et al., 2015). Further, medical assistants, clinic counselors, and patient educators may interact with patients seeking support for self-management at a higher rate than clinicians, particularly with patients who never make it to the clinic due to cost and travel barriers. As such, their perceptions of self-managed abortion and their ability to refer to alternative service delivery models or to care for those who need post-abortion support are critical for keeping pace with the evolving future of abortion care and access in the United States.

In light of the defining role of care providers' perspectives on the care received by those interacting with the formal healthcare setting while seeking or attempting self-management, the objective of our study is to gain a deeper understanding of their awareness, beliefs, and perceptions of self-managed abortion. We use the term "abortion care provider" broadly, referring to those who provide abortion care through their work in the clinic setting, not limited to clinicians or those with formal medical training. To explore these perspectives, we conducted a qualitative interview study with 46 individuals working in a wide range of positions in abortion clinics across 29 states.

Materials and Methods

Recruitment, Data Collection, and Sample

We collected our data as part of a larger, mixed-methods research study, Project SANA (Self–managed Abortion Needs Assessment), the overall aim of which is to provide insight into the current landscape of self-managed abortion in the United States. Abortion clinics are included as one of the settings in this study because of the frequency with which providers encounter patients who have engaged in some way with self-management, often as part of the pathway to accessing abortion in the clinic (Aiken et al., 2020b). We selected our sample of clinics using a bespoke algorithm designed to maximize variation in patient demographics, geographic location, and policy

environment. Forty-six abortion clinics in 29 different states were selected as study sites.

At each study site, we invited a medical provider or a staff member to participate in an in-depth interview about self-managed abortion. The interviewee was selected by the clinic staff based on individual interest and availability with input from the research team regarding clinical role to ensure we had similar proportions of medical professionals and other clinical staff. Interviewing both medical professionals (i.e., individuals with formal medical training including clinicians, advanced practice nurses, and registered nurses) and clinic staff involved in other aspects of patient care (e.g., clinic counselors) allowed us to explore perspectives from individuals serving in the full spectrum of roles in abortion care provision. These individuals encounter patients in different contexts—ranging from front desk staff and clinic managers to nursing staff, advanced practice clinicians, and medical directors. All study procedures were approved by the Institutional Review Board at the University of Texas at Austin.

Members of the research team collaboratively developed a semi-structured interview guide. The interview guide was designed to explore a number of topics including knowledge and awareness of myriad methods of self-managed abortion, experiences with self-managed abortion, perceptions of self-managed abortion, and thoughts on the role of clinics and of care providers in future care delivery, both with respect to self-management as an option in itself, and with respect to encounters with patients seeking or attempting self-management. We adjusted and refined the guide as data were collected and coded (Charmaz, 2006). Forty-six interviews were conducted between January and October 2019 by trained members of the research team. We conducted the interviews in person during clinic site visits (32.6%, $n = 15$), or via phone or Zoom when the interviewee was not available while the research team was on-site (67.4%, $n = 31$). All participants gave informed consent to participate. Interviews lasted about an hour on average (all were between 35 and 104 minutes) and participants were not offered compensation. Following the interview, participants completed a brief socio-demographic questionnaire. Interviewers took field notes during the interview and entered these notes into a debriefing document which the entire research team could review. Interviews were recorded with permission. All audio recordings were reviewed by the interviewer and edited to remove identifying information before being sent to an internal transcription service and each transcript was reviewed for accuracy upon return. The first eight interview transcripts were compared against the audio files concurrently, and subsequent transcripts were compared against the audio where indicated.

Members of the research team were trained in a variety of disciplines within the humanities, social sciences, and medicine. But, as "abortion researchers," we were all cognizant that abortion care providers face stigma and considerable public scrutiny (Debbink et al., 2016). Because of the politized nature of their work, abortion care providers experience threats and harassment and we were careful to maintain confidentiality throughout the research process. A shared familiarity with abortion care helped us to establish trust during the interview. As researchers coming from outside of the clinic setting, we sought to enhance this trust by drawing on participants' expertise as care providers and foregrounding their insider knowledge. The breadth of participant knowledge and experiences with self-managed abortion meant the discourse varied among the interviews. Interviewers attempted to mirror the terminology and phrasing used by participants when possible.

Analysis

We took an interpretative analytical approach informed by the Charmaz approach to grounded theory (Charmaz, 2006). The first 10 interviews (five with medical professionals and five with members of clinic staff) were selected for initial coding. Two members of the research team independently coded each of these 10 interview transcripts line-by-line. We then engaged in memoing and debriefing to inductively develop and then refine a coding framework focused on both latent and semantic meaning. Using a qualitative analysis software program (Dedoose, v. 8.3.35), the remaining 36 interviews were then coded independently by one of four team members using the established coding framework. Coders regularly met to discuss progress and any issues that may have arisen during the coding process.

After data collection was complete and all transcripts were coded, members of the research team began reviewing and comparing all excerpts related to provider perceptions of self-managed abortion by refining an indexing system of codes. To enhance analytical rigor and reduce positionality bias, excerpts were reviewed for consensus or recoding by at least two different team members. Through this process, we began to collate codes and identify potential categories and relationships between codes. During this stage, members of the research team continued memoing to aid in the organization of codes and categories. After all excerpts had been reviewed, we used selective coding, analytic memo writing, and discussions to identify themes. Members of the research team met multiple times to discuss and establish our thematic categories and subsequently organize findings for presentation.

Results

Sample Demographics

Table 1 describes the demographic characteristics of our participants and the clinics where they worked. The most homogenous characteristic is gender, with women representing over 95% of the sample (95.6%, n = 44). Nearly two-thirds of participants are white (65.2%, n = 30) and just over one-third are individuals of color (34.8%, n = 16). Clinic staff represent just over half of the sample (54.3%, n = 25) and the rest are medical professionals. Overall, 65.2% of participants have worked in abortion care for at least 5 years (n = 30); half of these for 10 years or more (32.6%, n = 15). The majority of participants work at a clinic serving a high proportion of racial and ethnic minority patients (65.2%, n = 30) and 52.2% (n = 24) work in a clinic located in a hostile policy climate (i.e., a state with multiple abortion restrictions and few protective policies in effect) (Nash, 2020). Finally, the majority of participants work at an independent clinic (63.0%, n = 29) and 34.7% (n = 16) work at a nationally affiliated clinic.

Table 1. Participant Characteristics, N = 46.

	N (%)
Gender	
Woman	44 (95.6)
Man	2 (4.4)
Race/ethnicity	
White, Non-Latinx	30 (65.2)
Black or African American	5 (10.8)
Latinx (not specified)	4 (8.7)
Multiracial	3 (6.5)
White, Latinx	2 (4.4)
Native American/Alaskan	1 (2.2)
Asian	1 (2.2)
Age	
25–34	16 (34.8)
35–44	18 (39.1)
45–54	8 (17.4)
55 and older	4 (8.7)
Type of Practice	
Independent Clinic	29 (63.0)
Nationally Affiliated Clinic	16 (34.8)
Academic Medical Practice	1 (2.2)
Profession	
Clinical Staff	
Patient Educator, Advocate, or Counselor	4 (8.7)
Coordinator	6 (13.0)
Clinic Director	3 (6.5)
Clinic Manager	8 (17.4)
Medical Assistant or Surgical Technician	4 (8.7)
Medical Professionals	
MD	13 (28.2)
Nurse Practitioner	5 (10.9)
Registered Nurse	3 (6.5)
Years in Abortion Care	
Less than 2 years	3 (6.5)
2–4 years	13 (28.2)
5–10 years	15 (32.6)
11–20 years	13 (28.2)
More than 20 years	2 (4.4)

Thematic Findings

Our analysis resulted in a final analytic structure of three themes and five subthemes (Table 2). These themes are described below with illustrative quotes. Quote attribution indicates the participant's clinical role, type of clinic where they work, and length of time working in abortion care.

Self-Managing an Abortion is Too Great a Risk

Across participants, concerns about the safety of self-managed abortion were wide-ranging in their specificity and salience but were critical to participants' understandings of the practice. For some, beliefs about the safety of abortion—both clinical and self-managed—contributed to the perspective that self-managing an abortion is too great a risk. This perspective, more prominent among clinic staff than medical professionals, regarded abortion as unsafe outside of the clinical environment or without medical supervision. Put simply in the words of one Clinic Manager, "any sort of self-managed [abortion] to me, is not safe" (Independent Clinic, 3 years).

The reasons why self-managed abortion was regarded as "too risky" were numerous. Some supposed that people would use blunt and unclean instruments or ineffective methods that would lead to infection, hemorrhage, or an incomplete abortion. For others, it was too risky because individuals may not have necessary or sufficient information, support, or follow-up care if needed:

> "It's a scary thought…people not really understanding what they're doing and trying something they do not do enough reading or research about, and aren't prepared to handle once they do it. And not having help afterwards if something goes wrong…" (Patient Advocate, Independent Clinic, 6 years).

Something going wrong—the potential for complications or adverse outcomes—was a specter hanging over this perspective of self-management and contributing to the perception that self-managing an abortion is "scary" and "dangerous." One physician, who described becoming more open to self-management over the years, thought that this perspective may develop as a by-product

Table 2. Thematic Structure.

Theme Subtheme	Description	Example Quote
1. SMA is too great a risk	Self-managing an abortion is dangerous regardless of method. The potential for adverse outcomes is too great to be justified.	"To me, it's you shouldn't [self-manage with any method]. You should have an abortion safely."
A right way and a wrong way to have an abortion	Medical supervision is necessary. It is the right kind of abortion care and should be the only kind.	"We just can't understand how somebody would do something like that without being under a doctor's care."
2. People are capable of self-managing abortion	Clinical care and services may not always be necessary for a safe abortion. Managing an abortion is not beyond the capacity of some or most people.	"I've definitely come around to— and I just have more experience. I know that the vast majority of women are going to be able to make this happen successfully on their own, and safely."
…because it is safe	Knowledge of safe self-management contributes to beliefs about capacity. Evidence of safety and efficacy of medication abortion offer assurance as do parallels drawn to clinical practices.	"There's medical contraindications to the use of some of the medications ..., but they're also fairly limited. And so, I think it would be very unlikely that it would impact their health and safety… I think if somebody has the agency to do it, has the information around when they would want to seek follow up care, some of those warning signs or symptoms, then it is likely okay."
Always have self-managed and already are	Knowledge and experience managing reproductive healthcare before and outside of formal healthcare systems is evidence that people are capable of self-managing abortions.	"I think that's incredibly important and not something that ever should go away, that people know how to manage their own abortions, that they have the autonomy to, they have the understanding, that there's people in the community who are able to support people doing that, so just essentially that that's something that women and people hold onto as their own. It's not something that they need to rely on other people to manage."
3. People have a right to self-manage	People should have the abortions they want. The right to choose includes choosing to self-manage. Self-managed abortion expands options and increases access to abortion care.	"I think just with abortion being a basic right, that patients should be able to access any care that they want. Because it's a personal decision that a patient is making."
SMA is an expression of reproductive autonomy	People may self-manage for a number of reasons including, but not limited to, barriers to clinical care. Choosing to self-manage is an understandable choice and may be preferred.	"If they don't want to go to a clinic, if they don't even want to engage in the healthcare system...if there's somewhere that there isn't any access to clinics, either due to just like region, geography, travel, whatever it might be, that someone would have the ability to manage their abortion is, again, sort of is essential."
SMA is an expression of limited reproductive autonomy	Self-managing is not a choice people would make if they actually had other choices. Desperate circumstances motivate the decision to self-manage. Even still, people should be able to self-manage.	"I just feel that it's a little bit sad that maybe people feel alone if they go for self-managed abortion. But I also feel like that's what they want or feel like they need. So, I support them in that. But, you know, if somebody has the privilege of crossing the border or coming into the clinic, I would of course prefer to see them here."

of training, saying "We know that abortion is safe. We know that the complication [rate] is less than 1%," but "we are trained to think worst case scenarios…the patient you saw in the ER who needs emergent surgery, you think about the patient who hemorrhaged that needed a hysterectomy…" (Independent Clinic, 8 years). Though they are rare, the infrequency of such events cannot be balanced with their potential severity.

Self-management with medication was understood as saf*er* than other methods mentioned, but this perspective was typically held regardless of how a person might self-manage. According to one Nurse Practitioner "You could

still definitely harm yourself with medication if you don't know exactly what it is you're taking" (Nationally Affiliated Clinic, 2 years). Skepticism and suspicion about the authenticity of medications were common among those who were familiar with the practice of self-sourcing medications online, which is illustrated by one participant saying, "You could never really be sure if the medication that they're purchasing, if let's say it's online or something, is safe. Or if it even will be effective" (Clinic Manager, Independent Clinic, 7 years). And, despite awareness of legitimate websites that provide genuine misoprostol and mifepristone among some, there was the risk that individuals who self-manage would be the victim of predatory websites, "that are just preying on women in vulnerable situations… [who] just take their money and don't give them the right things" (Patient Advocate, Independent Clinic, 17 years).

Another tenet of this perspective was that even if one were to use authentic medications, self-managing still is not worth the risk because other clinical services are needed. These critical, missing services were those like patient education and counseling, as well as gestational dating to determine eligibility for medication abortion and laboratory tests for blood typing. The importance of these services is described by the Clinic Director below who also voices skepticism of medications and other ingestible methods:

> "Before we even do an abortion over here we do medical history, we do lab work, we do an ultrasound. And you don't have a clue about what's going on inside of you, if there's anything. Not only could the medications or the methods that you take be very harmful to you, but you don't even know what's going on inside your uterus. And you're going to take something that could really be bad for you" (Independent Clinic, 20 years).

This quote also represents a belief, shared by some who held this perspective, about their patient population's lack of bodily knowledge and thus lack of capacity to self-manage.

Running through this theme were also beliefs about the way abortions *should* be managed, indeed that there is a "right" way to have an abortion. This is summed up by the Clinic Director above, opposed to self-management, who considers abortion "a medical procedure [that] has to be done under a doctor's care" (Independent Clinic, 20 years). Clinic-based abortion as opposed to self-managed abortion was also described as the "correct" way. This view is illustrated by a Medical Assistant who feels that people who self-manage are "putting their health at risk … I understand why they try it, it's just—my thinking is, 'I can help, I'm here to help you. We should have done this the right way from the start'" (Nationally Affiliated Clinic, 5 years).

These quotes collectively demonstrate the genuine concern for those who might self-manage—who may be, in the words of participants, in "vulnerable situations" or "on their own,"—along with the perceived risks of self-managing, which inform a perspective that prioritizes safety over reproductive autonomy. Medical supervision is regarded as a necessity for a safe abortion. These ideas are implicit in the statement below from a Coordinator who details the circumstances under which someone should be able to self-manage with pills, and in doing so, moves discursively from talking about a "person" to a "patient":

> "Someone—a nurse practitioner or a doctor—at some point has to be able to access that person's medical record to make sure they are a good fit to do a medication abortion. And once that has been determined and the patient knows the benefits, the risks, the side effects, et cetera, then I think that at that point it's okay. But the patient needs to be assessed, the patient needs to be assessed" (Nationally Affiliated Clinic, 11 years).

For the participant above and others, only if a clinic manages nearly every aspect of care can a self-managed abortion be made sufficiently safe. Highlighting this paradox, one physician notes that if people rely on a clinic "for an ultrasound, and an RH test and a hemoglobin, and a medical history, and then they order the Mife and Miso online and then come back to us for an ultrasound, then that's not really self-managed" (Nationally Affiliated Clinic, 23 years).

People are Capable of Self-Managing an Abortion

Another perspective on self-managed abortion was organized around ideas of personal autonomy, or an individual's capacity to make decisions and act on their own behalf. For many, this perspective was directly related to their beliefs about the safety of self-managed abortion. This perspective holds that managing an abortion is not beyond the ability of most individuals, as this Clinic Manager explains:

> "There's a lot of women out there that could handle a self-managed abortion just fine and be okay and follow things the way that they're supposed to. I think there's a lot of women out there that are more than capable of that" (Independent Clinic, 3 years).

This perspective was not universally applied; not all people were thought equally capable of self-managing. Rather, it was dependent on factors like a person's health literacy, characteristics like their attention to detail or, as for this physician, the ability to date their pregnancy and manage any pain:

> "Anybody who can accurately or semi-accurately estimate the length of their pregnancy, and … manage their cramping and discomfort with medications that they can get their hands on over-the-counter or medical marijuana or whatever. I think those are all fine people to self-manage their own abortion" (Independent Clinic, 13 years).

In contrast to the first perspective, that abortion requires clinical intervention, not *all* clinical services are believed to be necessary. Instead, with the appropriate information and support an abortion can be self-managed safely. As one physician explains, ultrasound to date the pregnancy may not be necessary "if she is really certain of her last menstrual period and maybe she doesn't need RH testing if she's under eight weeks. And maybe she doesn't need her iron check because she is not symptomatic…" (Nationally Affiliated Clinic, 7 years).

This perspective was often informed by parallels drawn between self-managed abortion *with medication* and clinical provision of medication abortion. Of clinic-based provision of medication abortion it was said "for all intents and purposes, it's already self-managed" (Physician, Independent Clinic, 8 years). Self-managing a medication abortion was understood to "mimic" clinical medication abortion provision and explicit comparisons to clinic-based telemedicine were common. One participant familiar with the process of using online telemedicine service to self-source pills, described these similarities, saying:

> "It's the same medications that we dispense out of our clinics for medication abortions, but just using an online screening questionnaire as opposed to an in-person screening and an in-person interview. They do an online interview questionnaire and then they do these two medications that we know are safe and effective at ending a pregnancy" (Nurse Practitioner, Nationally Affiliated Clinic, 5 years).

As the quote above also illustrates, an integral part of this perspective was familiarity with evidence of the safety and efficacy of self-managed abortion or medication abortion pills, if not both. Such information contributed substantially to the perception that people are capable of managing an abortion outside of the clinic. For example, according to one Physician:

> "I have evidence about their effectiveness…In general it's like, medication abortion is super, super safe, and really well studied. And so, whether I give you the pill, or you take the pill at home that you get somewhere else, I have pretty good reliability that it's going to be the same…" (Nationally Affiliated Clinic, 6 years).

This theme was more prominent among medical professionals than among clinic staff and in general, did not extend to methods for which participants could not rely on extensive evidence of safety or efficacy. While some were not overly concerned about methods like high doses of vitamin C or certain herbal remedies, overwhelmingly, it was a medication abortion that people were thought to be capable of self-managing.

This perspective was also informed by a trans-historical and trans-cultural view of self-management. Specifically, that people are capable of self-managing because women, in particular, have *always* managed reproductive health care. For example, participants reasoned that people are capable of self-managing because women have been managing abortions "far longer than the medical establishment has been managing people's abortion" (Clinic Director, Independent Clinic, 18 years). Awareness of self-management occurring outside of the U.S. also played a role in shaping this perspective. This is illustrated by one participant who noted that "people in rural countries…manage abortion and miscarriage by themselves all the time" (Physician, Independent Clinic, 5 years). Participants also remarked on the similarities between self-managed medication abortion and spontaneous abortion. Historically, women's ability to manage the latter means that people are "more than capable of handling [self-management] on their own," according to a Nurse who continued, "women have miscarriages all the time…this is something that has been happening from the beginning of time as far as women managing miscarriages on their own, and abortion is very much the same process" (Independent Clinic, 1.5 years). For some who held this perspective, self-managed abortion was also understood as a way to claim—or reclaim—authority over reproductive health. "We can do this care" said one Clinic Manager, "We can enter our own speculums. We can do our own abortions. We women can take care of ourselves" (Independent Clinic, 3.5 years).

People Have a Right to a Self-Managed Abortion

A second perspective about self-managed abortion organized around the larger concept of autonomy concerned reproductive autonomy specifically. Participants who held this perspective felt that self-management should be an option for abortion care because people have a right to the abortion they want. Self-managed abortion was frequently situated within the language of "choice," and understood as a way of "putting care into a woman's hands" (Nurse, Independent Clinic, 10 years). This perspective held that self-management was a way to expand access to abortion by providing an additional option for care. Our participants were intimately familiar with the numerous legal, financial, logistical, and cultural barriers to care faced by their patient populations and some understood self-

management in that context. As one Nurse Practitioner explains:

> "I think [self-managed abortion] is certainly an option for people that have all of those perceived barriers around accessing care in a health center environment, both the care itself and potentially the follow-up care... alleviating the economics burden piece, alleviating the privacy piece" (Nationally Affiliated Clinic, 10 years).

Another characteristic of this perspective was that self-management should not just be an available option necessitated by barriers to clinical care, but that the choice to self-manage is reasonable regardless of barriers. Some participants believed that barriers may not motivate all people to self-manage. Rather, circumstances or simply preferences may make self-management a desirable form of care. This is illustrated by the participant below who describes why someone might decide to self-manage:

> "Moms that are still breastfeeding and they got pregnant, and it's just way too close together or their family was complete. They don't want to be here in the clinic doing an in-clinic aspiration because they'd feel more comfortable at home. They want to be with their spouse. They want to be around their children, even if it means they're in the bathroom a lot, cramping, and really uncomfortable…" (Clinic Director, Independent Clinic, 38 years).

Further, in considering why someone may desire a self-managed abortion, one Patient Coordinator described her own preferences, saying "I don't want to be up in the stirrups, no dilation, no suction. I want to take a pill, go home, and who wouldn't? So, if you could do it totally from home, I bet we would have a lot of patients who would want to do that" (Independent Clinic, 8 years).

Similar to the factors influencing who was thought capable of self-managing an abortion, there were often stipulations about the circumstances under which the right to self-manage should be exercised. Among these stipulations were the ability to understand detailed instructions, information about when to seek medical help, and having or knowing how to access support, counseling, or post-abortion care. This is illustrated by a Surgical Technician who feels that "As long as they're eligible, I'm not there to tell them what they can and can't do. It's their pregnancy and they can end it however they want to…as long as they know what to expect" (Independent Clinic, 3 years). Under certain conditions then—conditions that mostly reflected participants' concerns about safety—self-managed abortion was regarded as "a great option" (Coordinator, Independent Clinic, 13 years).

Running through this theme, and in contrast to the idea that self-managed abortion may be a preference, was a belief that while self-managed abortion *should* be an option for care, it occurs because one's reproductive autonomy is restricted by oppressive factors. In essence, among some participants there was both the belief that self-managed abortion should be an option because people should have the abortion care they want, and a belief that it occurs because it is the only option and not because it is preferred. This ambivalence about self-managed abortion is illustrated in the narrative below:

> "I keep picturing them with abusive partners or just bad financial situations where they can't access the clinical abortion care and then managing it on their own is the only option. So, having that as an option would be really empowering and make them able to take control of their own healthcare. As I said before, even if they're not in a bad situation and…self-managed abortion is just the best option for them for various reasons—they're afraid of doctors, they don't have access to the healthcare that they need—doing it themselves is empowering and can be the only option for some of these people" (Medical Assistant, Independent Clinic, 1.5 years).

First-hand knowledge of difficulties faced by their patient population informed this perspective. The presumed constraints on reproductive autonomy leading to self-managing were relationship violence, financial hardship, and the need for secrecy, among others. Participants believed that desperate circumstances lead one to choose self-management over clinical care, but that people should still be allowed to make what they understood as the less safe choice:

> "It's not a judgment at all. I mean, I definitely want to be clear on that. It's not like … 'People shouldn't be doing this'. 'This should be outlawed'. It's just a safety thing...I wouldn't want to take away people's choices. It's just, I just hate to see women being backed in the corner (RN, Independent Clinic, 2 years).

Discussion

Our study is the first to explore both medical professionals' and other abortion care workers' perspectives on self-management and the constellation of beliefs that inform them. Exploring these perspectives is crucial to understanding the needs of both patients and care providers with regard to self-management. The method of in-depth interviews, during which participants shared their thoughts and experiences, provides a depth of knowledge while our diverse sample provides breadth in the range of roles and backgrounds included. Whereas the existing literature on this topic is primarily quantitative and focused on physicians and advanced practice

clinicians, unique to our study is a multi-sector examination of abortion care providers including staff and administration. The sampling methodology and interview recruitment strategy resulted in a diverse sample that reflects the views of providers from both independent and nationally affiliated clinics, with diverse patient populations, in different policy climates and geographic locations, and serving in a variety of professional positions.

Our findings demonstrate a tension between ensuring safety and recognizing personal and reproductive autonomy. Commensurate with existing research, self-management with medication was thought of as safe by some, but not all (Kerestes et al., 2019b). Research documents the safety and efficacy of self-managed abortion with medication up to 12 weeks' gestation (Aiken et al., 2017; Footman et al., 2018; Grossman et al., 2018; Moseson et al., 2020) and recent guidance from the World Health Organization (2020) states that individuals in the first trimester "can self-administer mifepristone and misoprostol medication without direct supervision of a health-care provider." Nevertheless, an association between self-managed abortion and dangerous or ineffective methods was salient, especially so among some clinic staff.

The difference we describe between clinic staff and medical professionals with regard to evidence on self-management and adverse outcomes may indicate limited knowledge transfer in the field of abortion care and points to the need for better education among medical professionals and staff. Additional research is needed to confirm this difference and future research should explore in greater detail variation in knowledge and experiences with self-management in order to identify educational opportunities at the organizational-level to encourage knowledge transfer such that evidence on self-management circulates among medical professionals and reaches other clinical workers as well.

There are potential legal challenges that those in the US who attempt to self-manage may face, even in the vast majority of states where self-managed abortion is not directly criminalized (Diaz-Tello et al., 2017). Thus, educating clinicians and staff on the legal aspects of self-managed abortion (e.g., that reporting a person who attempted or plans a self-managed abortion is not required) may also be necessary. Relevant resources for abortion care providers, such as the one prepared by the legal advocacy organization If/When/How (2020), can be disseminated. Further, such information may prompt those in clinical care to consider how they may deal with complications or failed medication abortion if individuals come to them for assistance.

An additional theme organizing these perspectives concerned individuals' capacity to perform a self-managed abortion. Understanding the evidence of the safety and efficacy of medication abortion was central to the view that people are capable of self-managing an abortion with pills. While self-managed and in-clinic abortion are analytic distinctions, the boundaries around them were not always firm. Indeed, participants relied on similarities between self-managed and clinical provision of medication abortion, especially telemedicine, in drawing this conclusion. In light of this finding, familiarity with recent initiatives expanding telemedicine abortion, such as Telabortion, will be useful to those working in abortion clinics. Knowledge that the FDA relaxed the Risk Evaluation Mitigation Strategies (REMS), requiring that mifepristone be dispensed in-person by a certified provider were relaxed at various points during the COVID-19 crisis (Kunzelman, 2020) and, ultimately, removed in late 2021 (U.S. Food and Drug Administration, 2021) may further assuage concerns about individuals' capacity to safely self-management outside of the clinic (Karlin et al., 2021; Raymond et al., 2019).

Our final theme concerned beliefs about the right to a self-managed abortion within the context of expanding reproductive autonomy. Some participants in our study felt that the decision to self-manage was a reasonable one in light of barriers to clinical care and individuals' preferences while others believed that desperation and constrained choice lead to self-management, and if people were free to choose clinical care they would not self-manage. Negative attitudes about self-management affect access to care and can undermine patient autonomy (Crouthamel et al., 2021). Those believing that abortion must take place in a clinic or that self-management is only ever an act of desperation may inadvertently stigmatize those who have attempted or seek to self-manage and those who reach out the clinic for help. To this end, our findings identify opportunities to clarify abortion care workers' understanding of self-managed abortion. Finally, ideas about people being capable of self-managing and having a right to self-manage raise questions about the role that abortion clinics can play in the process. Clinics may consider how to integrate self-managed abortion as part of a spectrum of care they can provide, from fully in-clinic to no-test telemedicine, to "clinician on call," in which individuals self-manage but can reach out to clinics for help if necessary.

Limitations

The findings from our study should be considered in light of some limitations. Our purposive recruitment strategy helped ensure that a variety of roles were represented, but these interview participants reflect a convenience sample that is not necessarily generalizable to all medical professionals and staff working in US abortion clinics. A second limitation is that our sample does not include healthcare professionals or staff who may encounter self-managed abortion outside of abortion clinics. For example, emergency room physicians were not a part of this

study. As such, these data describe perspectives of self-managed abortion among care providers in abortion clinics only. As well, we conducted our interviews in-person and virtually. While each mode has its own advantages and disadvantages, the lack of uniformity in our approach may have had some impact on our data.

Conclusions

Researchers have called for the sexual and reproductive health field to continue to push back against threats to reproductive autonomy, disseminating a call to action to ensure that the basic human right to control one's own reproductive destiny is nonnegotiable (Senderowicz & Higgins, 2020). Abortion care providers' perceptions and subsequent actions towards patients are crucial to these efforts. Self-managed online telemedicine abortion models are sought after in the United States, and the COVID-19 pandemic is driving a substantial increase in requests for this abortion care pathway (Aiken et al., 2020a). As the COVID-19 pandemic continues and clinical abortion care faces increasing policy threats at the state and federal levels, options for self-management, including through online telemedicine, are needed. To meet this need, there are resources to assist health care providers incorporate this model into their practice (UW Medicine, 2020) and guidance on legal issues related to providing back up clinical care (If/When/How, 2020). Abortion care providers are encountering people interested in or who have attempted self-management and are likely to encounter more. Because of this, it is necessary to understand how care providers perceive this practice and what information they need in order to identify and develop strategies to expand access to a spectrum of options for medication abortion. As such, these findings highlight the importance of increasing knowledge of self-managed abortion and clarifying values around reproductive autonomy across all clinic staff. A more informed abortion workforce has the potential to improve future care delivery.

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Ethical Approval

This research obtained approval from the institutional review board at the University of Texas at Austin; Approval number: 2018–08-0061. All participants gave informed consent before taking part.

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Supplemental Material

Supplemental material for this article is available online.

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