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SSM Qual Res Health. Author manuscript; available in PMC 2023 July 27.

Published in final edited form as:

SSM Qual Res Health. 2022 December ; 2: . doi:10.1016/j.ssmqr.2022.100075.

Experiences seeking, sourcing, and using abortion pills at home in the United States through an online telemedicine service

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Abstract

A growing number of people in the United States seek to self-manage their abortions by self-sourcing abortion medications online. Prior research focuses on people's motivations for seeking self-management of abortion and experiences trying to obtain medications. However, little is known about the experiences of people in the U.S. who actually complete a self-managed abortion using medications they self-sourced online. We conducted anonymous in-depth interviews with 80 individuals who sought abortion medications through Aid Access, the only online telemedicine service that provides abortion medications in all 50 U.S. states. Through grounded theory analysis we identified five key themes: 1) participants viewed Aid Access as a “godsend”; 2) Fears of scams, shipping delays, and surveillance made ordering pills online a “nerve-racking” experience; 3) a “personal touch” calmed fears and fostered trust in Aid Access; 4) participants were worried about the “what ifs” of the self-managed abortion experience; and 5) overall, participants felt that online telemedicine met their important needs. Our findings demonstrate that online telemedicine provided by Aid Access not only provided a critical service, but also offered care that participants deemed legitimate and trustworthy.

Keywords

Abortion; Self-managed abortion; Self-induced abortion; Medication abortion; Abortion access; Telemedicine

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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1. Introduction

Self-managed abortion (SMA) refers to any actions or activities undertaken to end a pregnancy outside of the formal healthcare system, with or without the involvement of a health care provider. It is a recent term for what has also been referred to as self-induced, self-sourced, or self-administered abortion, and is a common and well-documented phenomenon across histories, geographies, and legal, policy, cultural, and social contexts (Koblitz, 2014), (Moseson et al., 2020a).

Historically, SMA has included the use of herbs, botanicals, supplements, teas, self-harm, or obtaining a clandestine procedural abortion (Koblitz, 2014), (Kaplan, 1995), (Reagan, 1997). More recently, there has been a rise in self-managed medication abortion (SMMA), the self-sourcing and use of abortion medications (mifepristone and misoprostol or misoprostol alone). SMMA is common in jurisdictions where in-clinic abortion is unavailable or highly restricted (Aiken et al., 2017; Barbosa & Arilha, 1993; Baum et al., 2020; Berry-Bibee et al., 2018; Bury et al., 2012; Gomperts et al., 2008; McReynolds-P é rez, 2017; Ramos et al., 2014). The World Health Organization (WHO) recognizes SMMA as a self-care intervention (World Health Organization, 2019), which has the potential to provide more equitable access and person-centered care regardless of geographic, logistic, or financial barriers, legal or policy restrictions, or availability of clinicians (Narasimhan et al., 2019), (Vázquez-Quesada, Shukla, Vieitez, Acharya, & RamaRao, 2020). With the appropriate knowledge, skills, and resources, which some are able to access on the internet (Foster et al., 2014), SMMA enables pregnant people to make informed health decisions and safely manage their pregnancy with or without the support of a health care provider.

While abortion is technically legal in the U.S., both barriers to clinic access and preferences for the comfort and privacy of home are motivating factors among people seeking to self-manage (Aiken et al., 2018a), (Aiken et al., 2021). Recent studies have demonstrated the role of the internet in searching for abortion medications in the U.S. (Guendelman et al., 2020), (Jerman et al., 2018). Mifepristone and misoprostol can be found online for purchase on various websites (a list of sources may be found at Plan C), or can be obtained from pharmacies in Mexico (Fuentes et al., 2020). However, in 2018, Aid Access, an online telemedicine service, became the first physician-led service to provide abortion medications by mail in all 50 states. Aid Access is a non-profit organization that requests a standard donation though the service is provided on a sliding-scale or, in some cases, for free. The service received 57,506 requests in the first two years of operation (Aiken et al., 2021).

Although Aid Access is a telemedicine service, it operates entirely outside of the formal healthcare setting. Telemedicine is defined as the delivery of health care services using telecommunications technology and is used in many fields of medicine to improve access to healthcare services. Medication abortion, however, has long been an exception due to the U.S. Food & Drug Administration's (FDA) Risk Evaluation and Mitigation Strategy (REMS) on mifepristone (Mifeprex REMS Study Group, 2017), which, until recently, required in-person dispensing by a physician (U.S. Food & Drug Administration (FDA), 2021). Few clinics in the U.S. have historically used telemedicine for the consultation element of the medication abortion process; yet following the emergence of COVID-19

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the in-person REMS requirement was suspended and clinic-based telemedicine services for medication abortion have been greatly expanded (Upadhyay et al., 2020), (Upadhyay et al., 2021). In 19 states, however, telemedicine abortion services are prohibited by state law (Guttmacher Institute State Laws Policies, 2021), while other states are advancing legislation that would ban these telemedicine services (Nash & Cross, 2021). For people in these states, Aid Access continues to play a critical role in providing access to medication abortion by telemedicine.

This two-tiered system of telemedicine abortion access, within versus outside of the formal healthcare setting, raises important questions about the experiences of people who access SMMA through online telemedicine. While medication abortion provided through clinic-based telemedicine prior to the pandemic has been shown to be effective and acceptable to patients (Grossman et al., 2011; Kohn et al., 2019, 2021), the experiences of people who use Aid Access outside of the formal healthcare setting are likely to be very different in terms of how they find information and interface with others.

Given the growing importance of SMMA in the U.S. and the lack of knowledge about people's experiences with SMMA via telemedicine, the purpose of this study is to examine people's motivations and experiences searching for, self-sourcing, and completing a self-managed medication abortion at home using Aid Access.

2. Materials and methods

2.1. Recruitment and data collection

Through in-depth interviews with a unique sample of 80 U.S.-based individuals who sourced abortion medications online using Aid Access, the present study examines the experiences of searching online for abortion medications for self-management, using those medications at home, and the post-abortion experience. These data were collected as part of a larger, mixed-methods study on self-managed abortion in the U.S., Project SANA (Self-managed Abortion Needs Assessment). The The University of Texas at Austin's Institutional Review Board approved all study procedures.

Aid Access provides medication abortion up to 10 weeks gestation at the time of request. After an individual makes a request for medication through an online consultation form, a physician determines their eligibility and, if eligible, writes a prescription for mifepristone and misoprostol, which are shipped from a pharmacy in India to the individual's home. Individuals 18 years or older who lived in the U.S. and used abortion pills they obtained through Aid Access were eligible for the study. All participants were recruited between May 2019 and August 2019 by an invitation they received through a follow-up e-mail sent by Aid Access two weeks after their anticipated use of the medications.

Given the sensitivity of SMMA in the U.S., we built security protocols into our recruitment and data collection processes. With the help of Digital Defense Fund, we implemented digital security protocols to ensure the complete anonymity of our participants; not accessing or recording names, phone numbers, e-mail addresses, or any other identifiable information. Individuals who were interested in participating contacted the first author through Wire,

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an encrypted communication and collaboration application that requires only a username. To ensure anonymity, all subsequent communication was done through the application as Wire's end-to-end encryption protocol ensures that the content of messages is not retained. All interviews were conducted using Wire by trained members of the research team between June and August 2019.

The research team decided on the final sample size of 80 interviews in order to establish a balance between thematic saturation and available resources. All interviewees provided verbal informed consent to participate in an audio-recorded interview. Interviewers took extensive field notes during and after each interview and entered them into a document that the full research team could review and discuss. To ensure anonymity, we collected limited demographic information. Recordings were reviewed and edited by the interviewer to remove any potentially identifying information before being sent to The University of Texas at Austin's internal transcription service. We assigned each participant a unique study identification number and pseudonym after the interview for record keeping purposes. We offered participants a $90 gift card in appreciation of their time.

The semi-structured interview guide was developed using insights from prior research (Aiken et al., 2018a), (Fuentes et al., 2020), (Aiken et al., 2018b), and contained questions about the circumstances around participants' pregnancies and reproductive decision-making processes; their experiences seeking abortion information online; the process of ordering abortion pills; their physical and emotional experiences during pregnancy and abortion; perceptions of risk; unmet needs; and experiences using abortion pills at home, among other topics. We also provided participants the opportunity to discuss anything they felt was particularly important or unique about their experiences.

Members of the research team were trained in a variety of academic disciplines within the humanities, social sciences, and medicine, and some also have experience in abortion advocacy and abortion storysharing. Cognizant that people who have abortions can experience stigmatization, harassment, and, for some, criminalization because of the politicized nature of abortion, we were careful to maintain confidentiality throughout the research process. As a transdisciplinary research team, we are committed to the challenging work of honoring people's lived experiences, and listening actively and empathetically beyond our role as 'abortion researchers.' By centering the voices of people who have abortions, we deepen understanding, and strengthen our research and its impact. Interviewers also mirrored the terminology and phrasing used by participants. We also know that people who do not identify as cis-women have abortions; therefore, where possible, we use gender-neutral language and asked participants to self-identify when it comes to gender and sexuality.

2.2. Analysis

Because of our large sample, after all interviews were complete, ten interviews were selected for what is called initial coding in grounded theory practice (Charmaz, 2014). During this stage, authors Madera and Johnson coded each of the ten interview transcripts line-by-line using Dedoose (v 8.3.35), a qualitative analysis software program, to develop and refine the initial coding framework. Given the limited amount of available research

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on self-managed abortion in the U.S., grounded theory was well-suited for our purposes as it encourages researchers to be theoretically open. The remaining 70 interviews were then coded independently by one of five team members using the established coding framework and new codes were added to capture additional themes that emerged from the data. Throughout the coding process, the research team compared notes and discussed progress. After all transcripts were coded, members of the research team, including the first author, reviewed and compared excerpts related to participants' experiences seeking abortion care information online, and sourcing and using the abortion pills at home. To enhance analytical rigor and reduce positionality bias, excerpts were reviewed for consensus or recoding by two different team members. We collated codes and identified potential categories and relationships between codes. Throughout the process, we wrote detailed memos, and organized codes and categories to further identify potential themes and sub-themes. Our research team met regularly to discuss emerging themes and solidify the final analytic structure of the five key themes that emerged.

3. Findings

3.1. Sample demographics

Table 1 describes the demographic characteristics of our participants. While the age range was between 18 and 40, most (60%) were between 20 and 29 years of age. Our sample was diverse with respect to race and ethnicity; less than half of participants were White (Non-Hispanic). Nearly all participants identified as female (98.8%). The majority of participants (81.3%) were heterosexual. Seventy-three percent of participants were employed, of them 21.3% were both employed and in school. Nearly 20% of our sample were unemployed (18.8%), including 6.3% who were in school only, and 1.3% were in school and retired. Our participants were diverse in terms of their geographic location, residing in 25 different states; the majority of participants (85%) lived in a state with a hostile or very hostile abortion policy climate according to the classification system developed by The Guttmacher Institute (Guttmacher Institute, 2019). The majority (61.3%) of our respondents were already parenting at the time of their abortion, and 93% were at or under 10 weeks gestation when they ordered, received, and used the abortion pills from Aid Access.

3.2. Thematic analysis

Five key themes emerged from our analysis: 1) In the midst of limited options, Aid Access was a "godsend"; 2) Fears of scams, shipping delays, and surveillance made ordering pills online a "nerve-racking" experience; 3) A "personal touch" calmed fears and fostered trust; 4) "What ifs" were prominent, but most were a part of any medication abortion experience; and 5) Aid Access met the important needs.

3.3. Aid Access was a "godsend"

Participants described Aid Access as an invaluable service among the limited options they found on the internet. When participants decided to have an abortion, they turned to the internet for information. Clinic-based care was the primary search result, but participants were deterred from this option because of wait times, cost, logistical issues, and other barriers, as well as preferences for out-of-clinic care. Those who immediately searched for

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alternatives to in-clinic care did so for various reasons, including the belief that abortion care was financially or logistically out of reach, the desire for a more "natural" way to end their pregnancy or "jumpstart" their period, misinformation about abortion laws that made clinic-based care seem impossible, and negative perceptions of or a previous negative experience at a clinic. Participants spent a great deal of time searching for alternatives to in-clinic care that were effective, safe, and financially feasible as described by Sonia, a 19-year-old college student from Texas who lived hours from the nearest clinic:

> "It was probably a few days … different variations of searches. I then stumbled upon [Aid Access], and was really lucky and grateful that I found it. But if you're looking to do this it would give you other options like going to see someone in person. It wasn't the first website that popped up."

Some participants found information about herbs, teas, supplements and vitamins, various food products, other drugs or medications, self-harm, strenuous exercise, and other ways to self-induce an abortion as they searched for general abortion information online while others specifically sought out these methods. Although most of our participants referred to these methods as "folklore stuff," "wives' tales," "ludicrous," and "dangerous," some (16.3%, n = 13) tried to end their pregnancies using such methods before finding Aid Access. Some viewed them as a more "natural way to miscarry" while others turned to them out of desperation, but discontinued the use of these methods once they found Aid Access. Kendra, a 29-year-old woman living in Missouri, described such an experience, saying:

> "I was pretty desperate at the time … I read that if you eat a lot of this certain herb that it could help cause an abortion, or if you put it inside of you … I actually tried that, crazily as it sounds and, obviously, it didn't work … I tried punching myself in the stomach a few times. I asked my friend to kick me."

Participants overwhelmingly found Aid Access through "googling," though a few were referred by a coworker or friend, or via social media. Some Google search results led people directly to Aid Access' website, but most often participants found information about Aid Access from Reddit, blogs, YouTube, news articles, or websites like Plan C, which offers resources about abortion pills and how to access them, or Women on Web, an online abortion telemedicine service serving international settings. Once participants found Aid Access it was viewed it as a "godsend." Carolina, a 20-year-old woman from California, explained:

> "I thought of Planned Parenthood at first … but I didn't know about the cost. It was a scary number … half a paycheck. [Aid Access] was a godsend. It was amazing to find. Everything about it appealed to me. It was something that I could afford. I just have to wait for it to come in the mail. I could just be at home."

Aid Access was not only an alternative to an in-clinic abortion or less effective methods, but was also an alternative to "shady" websites that sold pills, as Patricia, a 25-year-old woman living in a Texas suburb, told us:

> "I just found a lot of random websites that looked really suspicious and not legit. I was reading the reviews of it being a scam and people pay so much money to get

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these, in most cases overseas, for them just to not work out. That's what I was afraid of."

3.4. Fears of scams, shipping delays, and surveillance made ordering pills online a "nerve-racking" experience

Across our interviews, participants described ordering pills online as a stressful experience. Phrases like "nerve-raking" were common. Many worried that Aid Access was a scam "preying on women." The time-sensitive nature of abortion was a concern for nearly all participants, precipitating the worry that pills would not come within an acceptable timeframe or at all. Irene, a 29-year-old woman living in Florida, explained:

> "That was nerve-racking. I was nervous that [the pills] wouldn't come … that it wouldn't be the right stuff and was a scam … and at a certain point you can't get an abortion anymore so just waiting those weeks, it's very crucial that they came."

Along with fears that Aid Access was a scam, participants worried about their packages being intercepted by a government agency, such as Customs, the police, or post office. Meg, a 28-year-old woman living in suburban Ohio, told us: "Another layer of concern is this is questionably illegal. What if the government decides to intervene on this one thing? I didn't fear for any action on my part, but just not getting them." Some participants worried about the judgment and stigma they might face if friends or family found out about their plans to have an abortion or found the package with the abortion pills inside. Jenny, a 22-year-old woman living in rural Michigan, told us how nervous she was about the possibility of her mother finding the package:

> "I had them keep it at the post office for me to pick up. I was living with my mom and she's very Christian and judgmental, which is why I didn't tell her about anything in the first place. I didn't want her to get the package and open it, and then have to come home and try and explain why they're there and what they are."

The delivery timeframe was the biggest concern for participants. All were told it should take one to three weeks for the pills to arrive in the mail, but many had read in online forums that it could take much longer. Maria, a 23-year-old woman living in rural New York, echoed these worries:

> "Once they entered U.S. Customs, I got excited. I thought maybe I was going to get them within that week. I started doing more research. I read a lot of horror stories about stuff getting stuck in Customs for a month. I started getting scared. I knew I was already probably five, going on six weeks. A month would be too long. I didn't want to wait it out. If they never came and I waited till 10 weeks … the Planned Parenthood in my area only does the medical through the pills, and when you're past 9 weeks you have to do the surgical. They would have to send me somewhere else. Then that would have been another struggle … how am I going to get there?"

These worries led some to make or think about alternate plans, with the most common being an in-clinic abortion. This, however, added another layer of anxiety that they couldn't afford this option or would need to borrow money. A few others considered or tried alternate "natural" methods, while others thought that they would have to continue their pregnancy.

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Robin, a 28-year-old photographer and mother of three children living in Tennessee, shared how the dual worries of the pills not arriving and an in-clinic abortion being out of reach compounded one another:

> "I'm just going to sell some of my most expensive equipment that I have in my business: cameras, lights … iPads, and all Apple products … everything got to go because I need this. That was my second backup plan. I'm going to find the money somehow. I was petrified. That was another stressor for me. What if it does get stuck and it doesn't get here? I'm just going to have to go with my second option, which I really didn't want to do because that would mean a lot for me."

Some participants thought about sourcing pills elsewhere. Sandra, a 28-year-old woman living in California, knew that sometimes people were able to cross the U.S.-Mexico border and access abortion pills in Mexico. She explained:

> "I was basically forced to find an alternative because I was like, 'What do I do? ' I'm half Mexican. 'You know what? Dual citizenship, I'll go to Mexico. I need to do something but I can't do it here. ' That's the point where I was because Planned Parenthood wasn't helping me, and the two main hospitals … I had to drive pretty far to [and] not even them."

Although participants were anxious about prolonged delivery times, they all ultimately received their abortion medications sent by Aid Access and used them for an abortion at home. All participants received their pills within five weeks, and the majority within 3 weeks.

3.5. A "personal touch" calmed fears and fostered trust

Despite the initial skepticism participants described about ordering pills from Aid Access, they eventually did so because they began to view the service as trustworthy. This trust developed through a process of information gathering, and was based on key elements of Aid Access' delivery model: a "personal touch," good "customer service," a prescription by physician, and the service's ability to "work with them" financially. Overall, participants described their virtual interactions and communications with Aid Access positively, and felt that the service communicated with them promptly and provided detailed information through their written communication via e-mail and the helpdesk. Alicia, a 25-year-old mother of four living in Georgia, describes how these interactions eased her initial fears:

> "They really explained everything in detail in the e-mail. They responded in a good amount of time. It's not like it took them two days to respond. I would always get a quick response …. about any questions I had. They were really helpful, and their timing was really on-point."

Unlike other online websites that simply sell pills, Aid Access was not viewed as just a "pill service" trying to get their money, or a "robocop" with "canned" responses. Instead, participants were relieved to find that they were interacting with real people and the relationship with Aid Access felt like more than just a transaction; they received emotional support, and Aid Access communicated with them in a compassionate, caring,

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and individualized manner. Robin, a 28-year-old woman living in Tennessee, explained how these interactions were reassuring:

> "They didn't feel sterile and cold, or just about getting my money. The fact that they were willing to help even if you didn't have the money, that was great. They constantly checked in. I got personal messages from them. I explained to them about college. They were just really supportive. They had that personal touch. I think that's important, especially when you're in a touchy situation. I didn't feel any type of judgment."

Participants also expressed that the online consultation was more private than an in-person appointment at a clinic, while still providing support and information. This was a major part of what made Aid Access "humane" and "safe" abortion care in the eyes of participants, who felt that their health and well-being were valued. Jackie, a 27-year-old mother of three from South Carolina, described how important the consultation was for her, especially their concern over her medical history:

> "It made me feel better as far as following through with ordering because I felt more like there was legitimacy there. They were concerned about everything that you would be for someone who was going for something like an abortion. It wasn't just, 'oh, we'll just send you the pills.' They were concerned about how I delivered my last children, how many pregnancies I had before … they let me know all of the risks as well. That eased my mind."

Although Aid Access operates outside of the formal healthcare setting, the limited physician involvement it provides gave some participants an extra sense of security. For Regina, a 19-year-old college student living in rural North Carolina, knowing that the prescription for abortion medications "comes from an actual doctor. That made me feel like 20 times [more] confident. I was like, 'Well, I'm going to trust it.' It was just a gamble I was more willing to take."

News articles, websites, and social media which featured interviews with founder and director Dr. Rebecca Gomperts also played a role in personalizing and legitimizing Aid Access. Ironically, an order issued by the FDA in 2019 to stop Aid Access from operating in the U.S. and the media attention that surrounded it, provided participants with more information about Aid Access. Moreover, knowing Dr. Gomperts' personal story made participants like Dara, a 35-year-old woman from Alabama more invested in her "cause": "[Rebecca Gomperts] basically told the government … I don't care what you say. I'm going to help women that need it [and] I was one of the women she helped."

Finally, the sense participants expressed about Aid Access having a "personal touch" arose from reading personal stories shared on social networks by people who had previously used medication from Aid Access, providing participants reassurance about the service. Nicole, a 25-year-old mother of two living in Tennessee, was initially skeptical about the legitimacy of the Aid Access website, but that changed once she found personal stories on the abortion subreddit, *r/abortion*. She explains:

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> "At first, I thought, there's no way that I can get these for $90, but … I went on the abortion subreddit and I just searched Aid Access. I saw all of these stories of people who had used it safely. It worked for them so I decided to go through with it. I've been using Reddit for five years. Any subject that I'm interested in, I just search. I find actual stories from real people rather than news articles [from a] search on Google."

3.6. Worries about the "what ifs"

Throughout their abortion experiences, our participants expressed worries about the "what ifs." Most of these worries and concerns could be a normal part of any medication abortion experience: not knowing what to expect physically and emotionally, feeling as though they lacked information about the process, and concern about others finding out they had an abortion. Other worries were specific to the experience of SMMA: lack of medical supervision and possible medical complications or lack of efficacy of the pills that would require interacting with the formal healthcare setting to seek medical attention. Melanie, a 23 year old college student from Kentucky, illustrates the most common concerns of participants: how they might react physically and emotionally to the pills, and the belief that they lacked information about what to expect, explaining "right before I took [the pills], I was a little bit worried about how I might react to the pills. I was worried—What if I get a lot sicker than I anticipated?"

Worries about complications and needing medical attention were magnified by the 'at home' aspect of the abortion experience since participants did not have a connection to a physical clinic or local health care provider to answer their questions during the abortion or provide follow-up care to assure participants the abortion was complete. Aid Access provides substantial information and resources about possible complications, including the Miscarriage and Abortion Hotline, and during the online consultation participants are advised that they should be able to get to a hospital or medical facility within 60 minutes in case of any complications. Many worried that if they sought medical attention, hospital staff would find out they self-managed their abortion. Gina, a 22-year-old mother of two living in Louisiana, explained: "I was also worried about something else just wrong happening in my body that I'd actually have to go to the hospital for, and then they'd find out." Some were so concerned about medical complications that they made plans for the possibility of needing to visit the hospital before taking the pills. Hope, a 35-year-old mother of two living in rural Alabama, kept her pregnancy and abortion a secret, and was afraid to interface with the formal healthcare setting; however, she was so concerned about complications that she proceeded to plan for medical treatment at a hospital anyway:

> "I was worried that it wouldn't end well … [what if] I had the infection … [the pills] would rupture my uterus, or the pain would be so bad. I'd already told myself that once it gets to where I can't deal with it anymore that that was the point where I was going to [the hospital]. I didn't want to sit through all of it in case something happened so that was a part of the plan too. I was scared to go to the hospital and say anything. There would be no way I would have told them, not in Alabama at that time."

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A few participants were over ten weeks' gestation (7.5%, n = 6) and worried about not having enough information or the appropriate instructions. A combination of shipping issues (one package was lost and the second took four weeks to arrive), trying ineffective methods before sourcing medications, and difficulty finding affordable and discreet abortion care after becoming pregnant following a sexual assault caused Daniela, a 26-year-old mother living in Arizona, to use abortion pills later than she had hoped and become concerned about possible complications:

> "But before I knew it, I was so far along. I was Googling what was going to happen when I took the pills. I knew I wasn't going to tell anybody. I was like, 'I'm just going to die in my bathroom, I guess.'"

Like Daniela, for the majority of our participants, the "what if" of someone finding out about their abortion loomed large. Perceived stigma and shame around abortion was a stressor throughout the abortion experience, and led many to keep their abortion from all or some of the people in their lives. Kimberly, a 32-year-old nurse from Kansas, echoed other participants in her worries about others finding out about her abortion:

> "People finding out and the shame that's linked to abortion … it was just more the stigma linked to it and people finding out and then obviously having to go into a local emergency room … because I worked in all of them. People would be like, 'Yeah, she's a nurse, and she did this.'"

Janette, a 20-year-old mother of one living in Wisconsin, feared that her husband and community, both heavily religious, would find out she was pregnant and having an abortion. To not raise suspicion, she made a plan from the outset. Once she started bleeding, she would walk three blocks to her local hospital alone while her husband and child were sleeping and tell the healthcare workers that she was not feeling well:

> "It started to hurt really bad 30 minutes after [taking the pills]. That was when I was like, 'Yeah, I probably should go to the hospital because [Aid Access] said you're going to start bleeding,' and I didn't want anybody to know what was going on. I just decided at that moment I should just go."

Although there are potential legal risks to self-management, legal ramifications were not a main concern among participants. We explicitly asked participants if they had any worries or concerns about legal ramifications when attempting to self-manage their abortion. Only a few mentioned any concerns about criminalization and those who did were mainly concerned about their lack of knowledge around the legality of the process. A 21-year-old woman from Ohio, Toni, shared these concerns with us. But, like Melanie, she felt a more overwhelming sense of concern about the efficacy of the pills and what could go wrong:

> "What if … I don't know if it's illegal or not … what if they took my package and try come to my door and arrest me or something? I was just paranoid a little bit, but I was probably like, Nah, they not. I was overthinking it. Maybe if the pills wasn't going to work, or I was going to die taking them. I know that sounds so terrible. I'm taking a risk. That's what it felt like."

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Of our 80 participants, all reported ending their pregnancies. Seventy-eight reported having a complete abortion after taking the medication and two sought additional care at a clinic. None reported serious complications.

3.7. Meeting needs

In reflecting on their overall experience, participants found it difficult to come up with ways that Aid Access could have provided a better service. Aside from shipping delays, participants as a whole were extremely satisfied with the process and also tended to feel that shipping was not under Aid Access' control. Aid Access met participants' needs for privacy, convenience, cost, safety, comfort, discretion, and having a support system at home, among others. Angela, a 24-year-old woman living in Florida, explained how self-managing her own abortion at home offered her a sense of privacy and made the experience more comfortable for both her and her husband:

> "I am private. I didn't really want people to know. I felt it was my thing to deal with. I wanted to take care of it myself. I like having that aspect of just being able to do it at home in my surroundings, being able to -plan for it, being able to just choose my environment. That was important for me, being able to [have] my husband there at any moment, every moment."

Using Aid Access provided many participants the ability to control who they discussed their abortion with and limit any perceived judgments from others, including clinic staff. Luz, a 25-year-old woman living in California, shared how some of her reluctance in going to clinic was predicated on fears about judgement:

> "I just feel safe at home [and] not [having] these random doctors bombarding you, asking you questions that you don't want to say in person. It feels different in-person than when you take care of your problem yourself. I didn't want anyone to know. I just felt like everyone in the clinic maybe judges you."

Additionally, Aid Access was less of a financial burden to our participants, all of whom found the cost of in-clinic abortion daunting. Jay, a 32-year-old mother of two living in Texas, explained that Aid Access offered her access to abortion that was convenient for her family while also easing the financial burden on them:

> "It didn't take up unnecessary time. I wasn't burdened with a whole lot of red tape. Financially, it didn't strap my family as bad as it would have. I didn't have to worry about leaving my children home alone."

Moreover, some of our participants compared their previous abortion experience at a clinic, that felt time consuming and stressful, and found their experience with Aid Access preferable. For example, Sarah, a 33-year-old mother of two living in Tennessee, told us:

> "It was really empowering, safe, [and] private. It was much less stressful than it would have been to go to the clinic. The first time that I had the abortion, just the abortion day. Getting up early in the morning, dealing with traffic, getting breakfast, watching a video at the clinic, and talking to a therapist, just this whole thing. By doing it at home, it was really low-key. I didn't have to talk a whole bunch about it. I could just watch TV and let things happen. That was nice."

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Ultimately, the majority our participants felt that self-managing using pills from Aid Access was the right choice for them based on their specific circumstances and expressed that they would use the service again if they needed to do so. The few who did not feel it was the right choice for them would have preferred a local, clinic-based service and saw Aid Access as a fallback option. Two of our participants shared that they had used Aid Access previously. Participants expressed immense gratitude for Aid Access and felt that without the service their options were limited or nonexistent. Lacie, a 20-year-old woman living rural New York, explained:

> "I'm kind of an advocate for women's health more than I have ever been because, in a sense, they saved my life. If I didn't get the services from Aid Access I probably would've had to drop out of college. So, in a sense, Aid Access saved my future."

Additionally, most of our participants expressed that they would refer others to the service and some, like Molly, a 19-year-old woman living in rural Tennessee, already had:

> "I have told one or two people that have been going through similar things … I've let them know that if they can do it early enough to be able to use the pill, that I think it's a much easier process than having a procedure would be."

The few participants who were hesitant about recommending Aid Access expressed that they did not want to do so because others would find out that they had an abortion.

4. Discussion

This study is the first to explore, in-depth, the experiences of people in the U.S. who self-managed their abortions using medications from an online telemedicine service. Managing an abortion using telemedicine outside of the formal healthcare setting creates unique sources of anxiety and stress: finding and initially trusting the service, waiting for pills to arrive in the mail, and the possible need to present for care in the formal healthcare setting. However, the ability to self-manage when options within the formal healthcare setting are out of reach or unacceptable is a critical alternative for people in the U.S. Aid Access not only enables people to access the care they need but also provides a supportive and reassuring experience.

Our findings add additional evidence to studies from the U.S., Ireland, and Great Britain on people's motivations for seeking alternatives to in-clinic abortion care. As in these settings, barriers to clinic access and preferences for the comfort and privacy at home were key factors in the decision to seek SMMA (Aiken et al., 2018a), (Aiken et al., 2021), (Fuentes et al., 2020), (Aiken et al., 2018c). Commensurate with findings from these studies, our participants also report stress in the time-consuming search for a reputable source of pills and an overwhelmingly positive experience with the telemedicine service once it was identified. Unlike in Ireland and Northern Ireland, however, where people were keenly aware of the explicitly illegal status of self-managed abortion, our participants were less concerned about possible criminalization.

Our findings have several important implications for clinical providers, advocates, policymakers, and people who self-manage in the U.S. First, the dearth of information about

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safe and affordable SMMA and how to access it from a reputable source described by our participants led many to spend valuable time searching online, increased stress about the process, and occasionally led to the use of ineffective methods. Given the stigmatized nature of abortion and concerns about possible criminalization of those who self-manage, which creates an additional layer of stigma and secrecy, it is perhaps not surprising that while Aid Access is easily searchable online, people seeking SMMA must find and validate it for themselves. This finding suggests a potential role for a harm reduction model of SMMA in the U.S. that provides accurate and accessible information about abortion medications, how to access them outside of the formal medical setting from a trustworthy source, and how to use those medications at home.

Harm reduction refers to practical strategies and programs aimed at reducing public health risks and harms associated with an activity, and calls for non-judgmental support, resources, and services to people engaged in those activities. Harm reduction principles recognize people's unique conditions and their capability to make their own health care decisions. Harm reduction approaches have long been associated with drug use and sex work, but have been increasingly used in a variety of settings and populations (Hawk et al., 2017). They have also been successfully implemented for abortion in a range of countries (Baum et al., 2020), (McReynolds-P é rez, 2017), (Foster et al., 2017; Gerdts & Hudaya, 2016; Grossman et al., 2018; Kahabuka et al., 2017; Moseson et al., 2020b; Zurbriggen et al., 2018), including hotlines, internet-based telemedicine counseling, local follow-up services, information guides, accompaniment groups, and pharmacist and community distribution of abortion medications and protocols. The WHO already acknowledges SMMA as a harm reduction strategy (World Health Organization, 2019), and advocates, community health workers, and clinicians can use similar harm reduction approaches in the U.S. to ensure that people seeking SMMA have information, resources, and support to self-manage safely and in a timely manner. This may be particularly important for people living in states with many restrictions on access to abortion in the clinic setting, as was the case for 85% of our sample. These harm reduction strategies may also help to normalize abortion, and strengthen the demand for social and policy changes for abortion care.

Second, although possible legal risks are a major concern among researchers, clinicians (Baldwin et al., 2022), and advocates, they were not prevalent among participants. Some states have retained laws that criminalize self-managed abortion while others misuse criminal laws to target people for self-managing or suspected self-management of abortion (Diaz-Tello et al., 2017). Throughout their abortion experiences, participants remained focused on sourcing and using the pills in order to safely and successfully end their pregnancies. Legal ramifications were either outweighed by these needs or were not part of their concerns at all. The few concerns that were expressed stemmed from lack of knowledge about any potential legal issues. This finding stands in contrast to studies from other countries, where abortion is explicitly illegal. In these contexts, people who used similar self-managed abortion services were aware of the law and feared being reported to the authorities (Aiken et al., 2017). Aid Access tries to strike a balance by providing those who seek abortion medications substantial information and resources about possible legal implications, including information about If/When/How's Repro Legal Helpline, without causing an undue chilling effect.

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Third, our findings suggest that Aid Access met the important needs of our participants for affordability, privacy, convenience, accessibility, and efficacy while also providing abortion care that many of our participants deemed compassionate and humane. However, for some, access to local pre- and post-abortion care services within the formal healthcare setting would have provided reassurance and helped ease worries about where to turn in the event of complications. Many felt wary of such interactions, however, due to uncertainty, fears of discovery, judgment, or even punitive action. The American College of Obstetricians and Gynecologists' (ACOG) Committee in Heath Care for Underserved Women already opposes harmful restrictions, including restrictions on medication abortion and telemedicine bans (Increasing Access to Abortion, 2020), that limit access to abortion care, calling for "quality health care appropriate to every woman's needs throughout her life and for assuring that a full array of clinical services be available to women without costly delays or the imposition of cultural, geographic, financial, or legal barriers" (The American College of Obstetricians and Gynecologists, 2019). Provider education, universal protocols for providing post-abortion care and sharing information about safe self-administration for those who seek SMMA, and legal guidance related to providing that care from organizations such as If/When/How, will allow providers to fulfill their commitment to women and increase clinicians' ability to provide quality, non-judgmental, and compassionate care when complications arise (Harris & Grossman, 2020), and support a full spectrum of options that will allow for broader and more cost effective access to abortion care.

Finally, as restrictive laws continue to impede abortion access in the U.S. (Nash & Cross, 2021), the launch of clinic-based telemedicine during Covid-19 and various online for-profit telemedicine services, and the permanent lifting of the REMS for mifepristone (U.S. Food & Drug Administration (FDA), 2021), could expand access to medication abortion. However, it will do so unequally, continuing a long trajectory of inequitable access to abortion care in the U.S. and creating a two-tiered system of medication abortion access. In some states, people will have access to medication abortion through telemedicine within the formal healthcare setting. In other states, self-managed medication abortion outside the formal healthcare setting will remain a critical option, but one that comes with potential criminalization. In addition to being a means of harm reduction as an alternative to unsafe methods of self-management, SMMA is also a means of achieving reproductive autonomy, allowing people to end their pregnancies despite state laws designed to curtail access. However, until the risk of criminalization is eliminated, full reproductive autonomy cannot be realized.

5. Strengths and limitations

Our large, diverse interview sample provides insight and knowledge about the experiences of individuals who self-sourced abortion medications through an online telemedicine service and self-managed an abortion outside of the formal healthcare setting. Given the stigma around abortion, and the potential personal and legal risks, the security we built into the data collection process likely increased participants' willingness to share their experiences seeking, sourcing, and using abortion pills to self-manage their abortions at home.

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The findings of our study should be considered in light of some limitations. Our sample is self-selected and our data describe the experiences of people who have self-managed their abortion with pills through Aid Access only and do not include the experiences of those who sourced pills elsewhere. Thus, our results may not extend to all who self-manage their abortions using abortion medications or those who self-manage using other sources.

6. Conclusion

Abortion researchers, advocates, and activists have long argued that SMMA is an effective harm reduction strategy and would provide broader and more equitable access to abortion (Erdman et al., 2018), (Jelinska & Yanow, 2018). Before the launch of Aid Access, U.S. residents had no options for accessing abortion medications through online telemedicine. Our findings demonstrate that Aid Access fills a critical gap in abortion access in the U.S. by providing a supported method of SMMA in lieu of costly in-clinic care and the ineffective or unsafe methods that participants in our study sometimes resorted to. We are still a long way from equitable access to abortion, however. Several important needs remain, including widespread information about the option of SMMA through online telemedicine, clear evidence-based information about its safety and effectiveness, affordability for all, safety from criminalization, destigmatization, and supportive engagement from the formal healthcare setting.

Acknowledgments

We are thankful to all the people who shared their abortion experiences with us, and let us listen and ask very detailed questions. We are thankful to Aid Access for their support and collaboration. We are thankful to Digital Defense Fund for their thoughtful consultation. We also thank Elisa Wells and Francine Coeytaux, co-founders of Plan C, for their help in conducting interviews.

Funding

This study was funded by the Society of Family Planning (SFP), Grant # SFPRF12-MA1 and received infrastructure support from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), Grant # P2CHD042849. None of the sources of funding had any involvement in the design and conduct of the study; the collection, management, analysis, and interpretation of the data; the preparation, review, or approval of the manuscript; or the decision to submit the manuscript for publication.

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Table 1

Self-reported participant characteristics, N = 80.

Characteristics	Frequency
Age (years)	
18-19	8 (10.0%)
20-24	22 (26.3%)
25-29	27 (33.8%)
30-34	6 (20.0%)
35-39	6 (7.5%)
40-44	1 (1.3%)
Missing	1 (1.3%)
Race/Ethnicity	
Asian	1 (1.3%)
Black/African American (Not Hispanic)	14 (17.5%)
Hispanic/Latino	12 (15.0%)
Middle Eastern	1 (1.3%)
Mixed Race (Hispanic)	2 (2.5%)
Mixed Race	5 (6.3%)
Native Hawaiian	2 (2.5%)
Native American	1 (1.3%)
White (Not Hispanic)	37 (46.3%)
White (Hispanic/Latino)	3 (3.8%)
Other	1 (1.3%)
Chose not to disclose	1 (1.3%)
Gender	
Female	79 (98.8%)
Nonbinary	1 (1.2%)
Sexual Identity	
Heterosexual	65 (81.3%)
Homosexual	0 (0.0%)
Bisexual	9 (11.3%)
“Bi-curious”	1 (1.3%)
Pansexual	2 (2.5%)
“No Preference”	1 (1.3%)
Missing	2 (2.5%)
Children	
0	31 (38.8%)
>1	49 (61.3%)
Employment Status	
Working	42 (52.5%)
Working & in school	17 (21.3%)
Retired & in school	1 (1.3%)

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Characteristics	Frequency
In School	5 (6.3%)
Not working	15 (18.8%)
Geographic Distribution	
City	35 (43.8%)
Suburb	14 (17.5%)
Town	15 (18.8%)
Rural	14 (17.5%)
Missing	2 (2.5%)
State Policy Context	
Supportive	10 (12.5%)
Middle	0 (0.0%)
Hostile	44 (55.0%)
Very Hostile	24 (30.0%)
Missing	2 (2.5%)