



## **Abortion pills in U.S. women's hands: Bold action to meet women's needs**

**Report on meeting held 12/4/13 in Washington, DC**

### **I. Background**

In many places around the world where access to abortion is restricted or prohibited, a woman can go to a pharmacy or drug outlet to obtain misoprostol (also known as Cytotec) to successfully end an unwanted pregnancy without talking to or seeing a healthcare provider. The drug distribution system in the United States is different than in many countries where this happens, and there is no direct parallel here to that experience. Still, some US women are using misoprostol (or mifepristone and misoprostol together) to end a pregnancy without formal medical guidance. Moreover, given the increased restrictions on abortion services that we are seeing in so many parts of the country, this practice is likely to increase. This raises complex legal, medical/clinical and political questions – some of which may not yet have clear answers. There is, however, a solid body of medical evidence and experience from across the globe that can inform the discussion.

Convinced that it is time to share with women in the US the knowledge that global research and experience has produced regarding the self-use of pills to safely end an unwanted pregnancy, Francine Coeytaux (Public Health Institute), Leila Hessini (Iпас), Amy Allina (National Women's Health Network), and Kate Ryan (National Women's Health Network) organized a meeting to: 1) share what is known; 2) identify questions that need to be answered; 3) discover opportunities for advocates for women's health to work together; and 4) develop some actionable strategies to improve US women's access to accurate information on abortion pills and reliable sources for the drug(s).

The meeting was held on December 4, 2013 in Washington, DC in the offices of the Association of Reproductive Health Professionals. It brought together 29 advocates, researchers and community-based activists from 11 different states<sup>1</sup> for a strategic conversation about how to ensure that women in the US have the information, resources, and support they need to use abortion pills safely. The funding for this one-day meeting was provided by an anonymous donor and the Mary Wolford Foundation through the Public Health Institute.

### **II. Sharing Information on What Has Been Done to Date**

**Historical background:** The first part of the day was dedicated to sharing information about what has been done to date on the self-use of pills for abortion, both in the United States and internationally.

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<sup>1</sup> Participants came from: CA, DC, GA, MA, NC, NY, OK, TN, TX, WA and the Netherlands.

This experience was framed as one of women helping other women meet their own needs for safe abortion when and where clinical services are failing them. Francine Coeytaux shared the history of misoprostol use for self-induction, which started in the 1980s when women in Brazil discovered that misoprostol, a readily available drug, could help them end an unwanted pregnancy. As women began to use the drug on a large scale, spreading the information to others, they changed the public health landscape in Brazil, significantly reducing the rates of morbidity due to unsafe abortion. Since then, the medical community has confirmed this and other gynecological indications of misoprostol and scientifically documented that it can be used safely and effectively by women for abortion. Indeed, today it is misoprostol combined with mifepristone that is the regimen used in the US and abroad to provide medical abortions (i.e., abortions with pills in contrast to a surgical procedure).

**Lessons from other countries:** Leila Hessini shared the lessons learned from other women in the global south, describing some of the strategies women who live in countries with restricted legal abortion access are using to challenge centralized healthcare systems and implement more woman-centered care. She stressed that how we think about the landscape of abortion access and safety has changed worldwide. The framing is no longer exclusively “Is abortion legal or illegal?” or that “legality equals safety,” but rather acknowledging that even in places where there are tight legal restrictions limiting or prohibiting provision of abortion in the formal medical system, some women are able to gain access to information, care, and drugs and to have safe abortions in their homes and communities.

Questions that Ipas is exploring in its research internationally are also relevant for discussions in the US: What do women need to know in order to have a safe abortion experience? How do women want to obtain information about self-induction (friend, workplace, school, confidential hotline, self-help guidebook or website)? Who do women trust as credible sources of information?

Leila also shared the findings of a recent program the Public Health Institute and Ipas implemented in Kenya and Tanzania.<sup>2</sup> This initiative, which provided small grants to local organizations to share information about misoprostol with women in their underserved communities, produced two important lessons: 1) that the communities were hungry for information about misoprostol precisely because it empowered women to help themselves, and 2) a grassroots approach of community mobilization to get the information out was the best way to proceed. It was these lessons that inspired the meeting organizers to bring this strategic conversation to the US in the hopes that doing so would produce benefits for US women, particularly those who live in states where new restrictions on abortion are creating barriers to access that are impassable for many.

**Misoprostol Alone Working Group:** Melanie Zurek (Provide) gave an overview of the work of the Misoprostol Alone Working Group, which was active from 2006 to 2010. Working group members included Provide (at that time Abortion Access Project), Ibis, Gynuity, National Latina Institute for Reproductive Health, and later, the Center for Reproductive Rights (CRR). In 2009 Provide commissioned CRR to review the laws of four states (IL, NY, SC, TX) that could expose women, providers, or advocates to criminal prosecution for self-induction. The Working Group also produced a set of talking points to counter unproductive media stories and stigmatization of immigrant communities.

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<sup>2</sup> Coeytaux, F., et al., *Facilitating women's access to misoprostol through community-based advocacy in Kenya and Tanzania*, *International Journal of Gynecology & Obstetrics*, in press (published online 1/21/14).

Melanie reported that the focus of the Working Group was on mitigating harm and assessing what steps the reproductive health, rights, and justice community might take to support women who choose self-induction in light of potential legal risks faced by women, providers, and advocates. The Working Group considered legal, public education, provider education, media, and research strategies. At times, this also included consideration of whether it was ethical to recommend the self-use of misoprostol as an abortion method, given the perception among some that it was substandard to the medical care a woman would receive in a clinic or substandard to mifepristone/misoprostol combined regimen; this tension was not resolved among Working Group members. While the Working Group agreed that the use of misoprostol by women was safe and effective, it did not identify a compelling need for direct action at that time and emphasized the continuation of existing work to secure equitable access to clinic-based care. In 2009, Gynuity and Reproductive Health Technologies Project (RHTP) sponsored a conference in New York City on misoprostol self-induction and produced a report entitled “The Best Defense Is a Good Offense: Misoprostol, Abortion, and the Law.” The report was distributed to the meeting participants and the document is available from RHTP (<http://www.rhtp.org/abortion/misoprostol/default.asp>).

**Texas Summit:** Susan Yanow and Leila Hessini reported on a meeting they had recently participated in held in Austin, Texas in November 2013. Organized by Marlene Fried and Susan Yanow under CLPP (Civil Liberties and Public Policy Program at Hampshire College), the goal of the meeting was to identify strategies that could be used in Texas to counter the abortion regulations and legal restrictions that are resulting in a severe shortage of abortion services. Journalists have reported that some women in Texas and in other border states are using misoprostol and there have been some legal prosecutions of individual women seeking self-induction. Meeting participants re-examined some of the strategies and questions raised in the “The Best Defense Is a Good Offense: Misoprostol, Abortion, and the Law” report and brainstormed about what to call the self-induction process so as to be informative but not stigmatizing.

**Research on self-induction in the United States:** Dan Grossman (Ibis Reproductive Health) provided an overview of studies undertaken on misoprostol self-use and self-induction methods more broadly:

- A survey in ob/gyn clinics in New York City (1999), in which 15% of respondents knew someone who had taken misoprostol; they considered it easier and less expensive than an in-clinic abortion.
- A prevalence study [based on Guttmacher’s 2008 abortion patient survey], which included a question on whether the respondent had ever self-induced (for this abortion or any previous one); 2.6% reported using some method to self-induce (1.2% identified misoprostol specifically). Foreign-born women were significantly more likely to have used misoprostol or another substance, but this outcome was not correlated with a particular race or ethnicity.
- A study conducted jointly by Ibis and Gynuity (2008-09) involved surveys of 1400 women in health clinics (not while seeking an abortion) in New York, San Francisco, and Boston about their knowledge of and experience with self-induction. They also recruited women at an abortion clinic in Texas near the Mexican border. The results were later published<sup>3</sup> and are also summarized in the 2009 Gynuity/RHTP report “The Best Defense Is a Good Offense.” In 30 in-depth follow-up interviews with women who had tried self-induction methods, 8 had used misoprostol.
- A survey of 8 abortion clinics in Texas (2012) included a question on self-induction: 6.9% of respondents reported attempting to end their current pregnancy before seeking clinical care; 2.2%

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<sup>3</sup> Grossman, D., et al., *Abortion self-induction in the US*, *Reproductive Health Matters* 2010, 18(36):136–146.

did not answer; 1% specifically said they used misoprostol. There was a trend toward more self-induction closer to border cities: 12% vs. 6% elsewhere.

**Gaps in current knowledge and areas for future research:** Ilana Dzuba (Gynuity Health Projects) reviewed the findings from medication abortion studies conducted outside the US and discussed the following gaps in the current knowledge:

- There have not been any randomized control trials to demonstrate whether currently recommended regimens of misoprostol used alone are as effective a method as mifepristone when used in legally restricted settings and without medical supervision. At least two trials compared misoprostol alone to the combination of mifepristone/misoprostol in Vietnam and Tunisia, where first trimester abortion is legal; both concluded that misoprostol alone is statistically significantly less effective (76-78% success rate as compared to 93-97%). A couple of other studies<sup>4, 5</sup> have focused on specific aspects of misoprostol use (e.g., differing dosages, delivery methods), so published results suggest a range of 75-90% effectiveness.
- Regarding the number of weeks after last menstrual period (LMP) at which misoprostol can be used effectively: the “Instructions for Use” brochure on Gynuity’s website provides directions for misoprostol through 9 weeks LMP, which is evidence-based from the published literature (there are limits in current scientific evidence for later gestational ages). The World Health Organization’s safe abortion guidelines indicate misoprostol can be used alone through 12 weeks LMP. (Evidence shows that typically as gestational age increases, effectiveness decreases slightly, so that should be considered when using beyond 9 weeks. There is no reason, however, to believe that misoprostol alone would become ineffective between 9 and 12 weeks and is probably a safer alternative to other options available to women in restricted settings.)

Ilana noted that any randomized study (and most clinical studies) on medical abortion (whether using mifepristone/misoprostol combination or misoprostol alone) usually needs to be conducted in a country where abortion is legal for at least some purposes (in order to get necessary regulatory approvals). For that reason, it is difficult to study misoprostol alone in legally restricted settings. In addition, misoprostol alone studies are usually conducted where mifepristone is not available, because it could be considered substandard care to offer a potentially less effective medication than one that’s readily available. Gynuity is conducting studies on mifepristone/misoprostol combination taken at home (or anywhere outside a clinic), calling it “patient-centered” care. There is some clinical evidence that supports the assertion that women in the US could also safely induce at home using only misoprostol. Women on Web has published some studies based on follow-up that they have conducted with women who have used their services. These papers provide some interesting evidence on women who self-induce with medical abortion (although usually it is with mifepristone and misoprostol together) in legally restricted settings.

A lively debate ensued over the comment that using misoprostol alone is substandard care as compared to the mifepristone/misoprostol regimen. In particular the fact was noted that misoprostol allows a woman to act on her own whereas mifepristone is so tightly regulated in the US that it can only be obtained through a registered abortion provider. Participants discussed what is/should be considered

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<sup>4</sup> von Hertzen, H., et al., WHO Research Group on Postovulatory Methods of Fertility Regulation, *Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: a randomised controlled equivalence trial*, *Lancet*, June 2007, 369(9577):1938-46.

<sup>5</sup> Kulier, R., et al., *Medical methods for first trimester abortion*, Cochrane Database of Systemic Reviews, November 2011, 11:CD002855.

an “effective” outcome from self-induction. It was pointed out that many women who are currently considered to have a failed outcome with mifepristone/misoprostol pills and advised to get a surgical procedure to complete the abortion may be able to complete the abortion on their own if they are willing to wait through days of bleeding and may not need to receive follow-up care at a hospital or clinical setting. And it was acknowledged that for some women, going to a hospital or clinic afterwards for a follow-up procedure may in fact be an effective and acceptable outcome.

Other questions discussed included: What is the risk of advocating for misoprostol use by marginalized women? What is the gold standard for abortion care and who should set that standard? Francine Coeytaux noted that these issues have been debated before: when mifepristone was first being introduced in the US, many providers pushed back, believing medical abortion to be an inferior method to evacuation. Yet today, many women prefer medical abortion to a surgical procedure. It was agreed that both advocates and clinicians need to be better informed about the advantages and drawbacks of each abortion method and able to communicate them clearly, so women can make their own choices. Dan Grossman pointed out that some women in the Ibis studies valued self-care for other medical problems and wanted to be able to take care of an abortion on their own as well. Also, some women saw the process of using misoprostol as more natural, likening it to a miscarriage. This points to the importance of recognizing and responding to the reality that efficacy is not the only factor a woman values or weighs in deciding among potential methods.

#### **Internet sources for users:**

***Women on Web*** - Susan Yanow described this Internet-based service: available 18 hours a day; receives 15,000 emails a month; mifepristone and misoprostol can be mailed to women in 102 countries where safe abortion services are not available (not US, Canada, most of Europe). Recently, there has been an increase in questions from the US about misoprostol for self-induction (second-largest country with questions, after Brazil). So far, Women on Web has not heard that any woman has received a harmful product by purchasing misoprostol from Internet pharmacies (although some may be ineffective). In addition to email inquiries, of note is that searches from the US of the Women on Web/Women on Waves website have increased dramatically.

***“Surfing for Abortion” research report*** - Francine Coeytaux (PHI) and Elisa Wells (consultant and participating by phone) presented “Surfing for Abortion,” a report on the findings of a rapidly conducted survey to determine what information about using pills to end a pregnancy is available on the Internet. Elisa and a Spanish-speaking student assistant searched the Internet for information that women interested in using pills to end a pregnancy might find when searching online, using common search terms in both English and Spanish. Francine noted one shortcoming of this preliminary scan: while the report looked at key search words in English and Spanish, it is not only Latina immigrants who bring knowledge of misoprostol use to the US; many Asian and African communities are also aware of the use of pills for abortion (reflecting the availability of drugs in their home countries). This is a brief summary of the findings and recommendations.

#### **Findings:**

- Searching for “abortion” will not necessarily lead to finding self-induction information.
- Key words “abortion pill” or “DIY abortion” do lead to good resources (e.g., Women on Web).
- Searches for “Cytotec” have increased over time, especially in border states including Texas, Louisiana, Florida, and New York (also Oregon for some reason).

Recommendations:

- Help women in the US learn about misoprostol as an option, especially where abortion clinic access is limited, by improving access to online information and bolstering visibility in search engine results for common search terms.
- Identify reliable sources of misoprostol in the United States (as the reliability of online pharmacies and the efficacy of their products have not been verified).
- Assist women in understanding the legal implications of self-induction in the US.

**Intersections with other work:** Several participants were invited to share their thoughts on how the discussion of misoprostol self-induction relates to their own work on other issues.

***Re-criminalizing abortion, depriving pregnant women of their personhood*** - Lynn Paltrow (National Advocates for Pregnant Women) shared these comments:

- If you're preparing to disseminate information to women, it is important to conduct a legal assessment on your state/situation; assume any action can result in an arrest of those providing the information and of the woman who receives and uses it. We should consider approaching this work from the start with a true civil disobedience framework – one that says if there are laws that make providing this information and service illegal, we believe those laws to be immoral and we are willing to suffer the consequences of violating those laws as we continue to challenge their legitimacy. As she wrote in a short paper many years ago,<sup>6</sup> women who had abortions pre-Roe were, in effect, engaging in mass civil disobedience.
- Arrests of women for self-inducing abortions are already taking place. For example, Jenny McCormack in Idaho (who used a drug, probably Cytotec, to self-induce) was charged with a pre-Roe law that criminalized self-abortion. The Attorney General who defended the use of Idaho law to lock up pregnant women for self-inducing abortion argued the state may do so to advance the interest of protecting pregnant women. This argument, made with a straight face, should be scary to all. The 9th Circuit Federal Court of Appeals has so far determined that several of Idaho's laws may not ever be used as a basis for prosecuting Ms. McCormack. The decision, however, is still being reviewed by state authorities. And while NAPW believes that women cannot constitutionally be punished for self-abortion, we should expect more cases like these.
- We should place advocacy for abortion in the overall context of pregnant women's lives and self-help generally. It is a mistake to separate abortion from other maternity and childbirth issues. A particular threat in the US and globally is expanding actions to take away a woman's personhood and agency – not just abortion, but also through arrests for child welfare and custody issues (i.e., taking children away from women for things they did during pregnancy, like drug use, having had a past abortion, refusing cesarean surgery).
- Provide greater context for how self-induction is not so different from other actions/circumstances, e.g., compare it to natural miscarriages and what women do then; look at HIV/AIDS advocacy and how groups help people who can't access or pay for necessary medications.

***HIV/AIDS medications and activism*** - Lisa Diane White (SisterLove, Inc.) shared information about a new pill on the market that can prevent HIV-negative people from contracting HIV. It is called pre-exposure prophylaxis (PrEP) and it was approved by the Food and Drug Administration in 2012. Currently, this pill needs to be taken daily to prevent HIV, by those who consider themselves at high risk for being exposed

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<sup>6</sup> Paltrow, L., *Women, Abortion and Civil Disobedience*, NOVA Law Review 13:2, Spring 1989; also [http://advocatesforpregnantwomen.org/main/publications/women\\_abortion\\_and\\_civil\\_disobedience.php](http://advocatesforpregnantwomen.org/main/publications/women_abortion_and_civil_disobedience.php).

to HIV. PrEP is not widely marketed by the pharmaceutical company and community-based organizations, such as SisterLove, Inc., are helping to educate communities and providers about PrEP. Current data shows more use by women, especially women in the South. This use may be attributed to women who want to conceive and have HIV-negative partners. SisterLove is the co-convenor of the U.S. Working Group on PrEP, which aims to help create policy to monitor its use by women. For more information on PrEP, see the Centers for Disease Control and Prevention website: <http://www.cdc.gov/hiv/basics/prep.html>. For information about medication assistance, visit <http://start.truvada.com>.

Another participant commented that there was a time in the early years of AIDS research and activism when patients took their own self-help measures to find new medications that might work for them because waiting through the FDA approval process was too time-consuming. (The current film *Dallas Buyers Club* is about activism in that period to acquire HIV medications that weren't yet officially available.)

**Women's self-help health models** - Amy Allina (National Women's Health Network) talked about the home birth movement and what is needed to make home birth a realistic option for more women. It doesn't mean getting all women to abandon hospital births, but expanding options can start to change hospital practice and make women's experiences better in those settings as well. In the analogous situation regarding abortion self-induction, some women may want to take a drug privately and never tell anyone while others may want medical guidance in the process, including conventional medical assistance if their abortion doesn't complete in a few days. Providing options and support for women taking either approach means they are fully informed to make the decision that works best for them.

### III. Needs and Questions to Answer

During the second half of the day, participants were encouraged to articulate questions, gaps in current knowledge, or areas that need to be addressed in order for their organizations to be able to move forward on disseminating information to their networks. The comments fell into three broad categories or themes.

#### **Messaging/Education**

- Basic information about misoprostol (what it is, how it works) that is user-friendly for different ages and literacy levels. Even advocates don't necessarily have a firm understanding of the drug, making it difficult to engage on the self-induction issue. (Include the "creation story" of women using misoprostol in Brazil; it's powerful to know that history of women taking control of their own health needs and not everyone in the movement knows the back story.)
- Definitions of core concepts/categories about self-induction to support advocates and organizations in using accurate terms.
- Guidance about what a US abortion provider should consider before publicizing information about misoprostol self-use on its website. Consider how this guidance might be different for an organization that doesn't provide services. Need to take into account varying state laws and potential backlash.
- Further discussion on what to call this practice. Consider what resonates with women, the public and/or policymakers (home abortion, self-care, abortion with pills, self-induction, etc.). Focus on

positive and aspirational language. Need more research on what women are calling the practice ‘on the ground’ in the US (Ipas is doing some of this research internationally).

- Development of values aspiration/clarification materials for advocates around misoprostol self-use.
- Culturally appropriate messaging about misoprostol and self-induction.
- Exploration of how to educate women around what to expect during and after the abortion process, as well as potential legal hurdles (laws/regulations vary by jurisdiction).
- Determine which other organizations/individuals/movement areas are not in the room that should be invited to participate in the future.

### **Research**

- Community-based participatory research on prevalence of misoprostol use currently in US.
- Investigation of how state laws would affect minors who self-induce (prosecute teen or parent, etc.).
- Consideration of whether there is a need for studies on efficacy of misoprostol for women based on their weight.
- Data on women’s sources of information about misoprostol (and self-induction methods generally), particularly for younger women (who may be more likely to seek information online) and immigrant populations from countries where its use is prevalent.

### **Policy Issues/Strategy Questions**

- How can we ensure that publicizing research on use/prevalence of misoprostol for self-induction does not cause a crackdown on availability or prosecution of women who use the drug?
- What can abortion clinics advise women to do (about misoprostol use) who are past gestational age limit and have no in-clinic option?
- What impact might increased self-use of misoprostol have on current abortion statistics and how we track these statistics?
- Revisit the lessons learned from efforts to expand access to emergency contraception (15 years ago) when advocates stepped in to provide information and worked with providers to improve access and address the void left by the lack of a product labeled for that use by FDA. Also consider lessons from early use of HIV medications (individuals accessing drugs off-label or pre-FDA approval).

## **IV. Strategies and Recommendations**

During a break-out session and subsequent report-back to the whole group, participants discussed ideas for future action on misoprostol self-induction in the US. Ideas were brainstormed without assigning tasks to specific organizations or individuals, so they are presented thematically.

### **Messaging/Media**

- Create “know your rights/know about misoprostol” materials; place flyers or stickers in public places. Include information around pregnancy and miscarriage (what doctors do and don’t have a legal right to ask women); counter misinformation on issues like detection of misoprostol use from blood work.
- Write website text for organizations to post accurate information on self-use of misoprostol.
- Develop “how to defend” trainings and factsheets as resources for attorneys who may represent women arrested for self-induction.
- Create better targeting of online search terms for women looking for self-induction information and/or directions for use.

- Frame women's use of misoprostol in the context of broader support for women's self-help around healthcare (home births, how to handle miscarriages, HIV management, sex education, etc.).
- Hold regional convenings around the country to inform communities about misoprostol self-use.
- Determine best way to launch an information campaign.
- Shift frame to talk about the fact that safe abortion that can take place *outside* a clinical setting.
- Include message that abortion care is one of many healthcare needs that is not being met for many people; enable patient voice to be heard.
- Broaden view of 'standard of care' (talk about choice of settings for patient, other issues) to try and avoid previous concerns over misoprostol use as substandard care.
- Use 'both/and' messaging – promoting alternate abortion access options while also protesting clinic closures.
- Engage trusted messengers in underserved communities and stay mindful of the history of substandard medical care in communities of color.

### ***Education/Support for Women***

- Work with existing hotlines (e.g., Backline) or develop new ones to answer questions about misoprostol or offer legal assistance (staffed by community organizers, medical professionals, lawyers).
- Educate women on what to expect in terms of pain and amount of blood when self-inducing.
- Recognize and assertively address the stress that may occur with the expulsion of tissue, particularly when misoprostol is taken later in pregnancy. (Women on Web provides clear information and counseling up to 24 weeks, but this is not broadly available elsewhere.)
- Partner with full-spectrum doulas and with clinicians who are likely to see clients dealing with an unintended pregnancy to support them in sharing information about misoprostol with their clients, assisting with the process, and/or providing medical support post-abortion.
- Organize a "red tent network" for women to support each other through the process.
- Create a legal defense fund for women who are arrested.

### ***Education/Outreach to Others***

- Train employees at pharmacies or stores selling misoprostol to provide accurate information on its use for abortion.
- Work with doctors who would be willing to offer advance prescriptions for misoprostol.
- Add misoprostol to collaborative practice agreements with pharmacies.
- Work with abortion providers on how to offer post-misoprostol self-use management.
- Train *promotora* groups and other community health workers on misoprostol use (using train-the-trainer model).
- Build relationships with a network of attorneys to represent women arrested for self-induction (expertise in immigration, criminal defense, etc.).
- Outreach to other organizations/movements to include in future discussions (e.g., immigrant rights, LGBT, faith-based, doulas, indigenous communities, healthcare providers).
- Talk to organizations using a harm reduction model for their work, see if some of their operating principles could be adapted to this issue. For example, connect at annual Southern Harm Reduction and Drug Policy conference.
- Educate healthcare providers on possible increase in miscarriage reports and what self-induction looks like (values clarification, messaging, sensitivity to meeting the needs of women). Encourage healthcare providers to use telemedicine or mHealth technology to prescribe miscarriage management or provide follow-up care.

- Work with healthcare providers to understand the importance of community-based (or women’s self-use) abortion, why some women choose it over facility-based abortion and how they can support women’s individual decision making.

### **Research**

- Conduct testing of misoprostol (and potentially other self-induction products) purchased online/overseas to verify their safety and efficacy.
- Conduct studies demonstrating that women are able to use misoprostol safely and effectively without the assistance of a medical professional.

### **Legislative and Regulatory Action**

- Identify federal allies who could be champions on issues related to misoprostol use.
- Consider what it would take to get an abortion indication added to the misoprostol label and whether this could be done without adding regulatory restrictions that would be a barrier to self-use.
- Push for state Attorney General opinions in supportive states (agree not to prosecute women for non-prescription use of misoprostol for self-induction).
- Explore issues involved in creating a misoprostol “bank” (legality, how to store and distribute pills, differences by jurisdiction, etc.).

### **Protest/Civil Disobedience**

- Campaign to encourage people to buy misoprostol when they travel abroad (principally Mexico and Canada) and establish a way for people to distribute/donate it when they return to the US.
- Create a buyers’ club or “bank” for misoprostol (similar to breast milk banks) for people to donate their extra prescription misoprostol pills.
- Set up guerrilla education “street teams”: trained peer educators to provide accurate information, trainings to larger groups (campus groups, book clubs, etc.), and potentially links to prescribers or an underground network to supply misoprostol.
  - This network could be a public effort involving civil disobedience to broadcast a wider message, or stay underground to assist more women individually (like a Jane Collective 2.0).
- Frame information sharing as civil disobedience; potentially viewed differently (First Amendment freedom of information context).
- Launch protest (or information/leafleting campaign) outside health clinics (or courthouses) to inform women they do not have to disclose their past history of drug use, abortion, or miscarriage to healthcare providers.

## **V. Moving Forward**

At the close of the meeting, participants expressed interest in ongoing communication and working together to further the ideas developed. The meeting organizers agreed to produce and share a meeting report as a first step toward developing a community of organizations and individuals interested in pursuing these ideas. Additionally, they proposed four overarching strategies to begin to address some of the needs identified:

### **Informing, Engaging, and Training Reproductive Health and Rights Advocacy Organizations**

- Create a template of information for women on misoprostol self-use that advocacy organizations can customize and post on their websites (user-friendly, accurate, mindful of legal issues).

- Establish a bureau of facilitators who are well-informed on the issues, skilled in facilitating discussion, and can travel to communities where there are RH/RR/RJ organizations interested in learning about the self-use of misoprostol. They would work with a community to: provide information about how misoprostol works and its safety and efficacy; engage in values clarification discussions regarding comfort with the idea of self-use of misoprostol; and facilitate discussions about issues it brings up for pregnant women and supporters (medical safety, a woman's more direct exposure to the abortion process, legal liabilities, etc.). The goal of these facilitations would be to help organizations be comfortable 'internally' before taking information to the wider community.

#### Supporting Better-Informed Media Coverage

- Monitor media coverage of stories involving self-induction; provide advocates with guidance on how to respond, including talking points on how to shape the story and debunk myths about misoprostol.
- In partnership with Jodi Jacobson and *RH Reality Check*, conduct a media briefing to educate journalists about self-use of misoprostol and provide them with names and contact information of experts who will be able to comment on the topic when stories break.
- Develop a bank of media-ready experts willing to talk to the media about self-use of misoprostol.

#### Understanding Legal Vulnerabilities

- Work with legal experts to better understand the risk of criminal prosecution or civil lawsuits associated with:
  - options for establishing a reliable source of the drug, and
  - strategies for sharing information (hotlines, distributing leaflets, media spots, etc.).
- Work with legal experts to evaluate how the legal vulnerabilities vary from state to state.

#### Educating and Engaging Funders, Health Professionals, and Other Potential Allies

- Submit papers and make presentations at relevant conferences and meetings to disseminate information about self-use of misoprostol to health professional organizations such as the National Abortion Federation, Association of Reproductive Health Professionals, Society of Family Planning, and American Public Health Association.
- Initiate exploratory conversations with contacts in related communities such as Human Rights, HIV and AIDS, and Harm Reduction to identify potential allies and develop effective engagement strategies.
- Seek opportunities to build understanding among reproductive health, rights, and justice funders about the growing phenomenon of self-use of medications for abortion and the positive impact it is having on women's health and reproductive autonomy in some parts of the world and to engage funders in conversations about the role it might play in the United States.

This meeting was organized in the context of a shifting landscape of abortion provision in the United States and globally. Where and how women get abortion services is changing. A host of new legal barriers have been erected that prevent women who previously had access to abortion services from getting the care they need and at the same time, there are innovative, new models of abortion provision that have opened up options for safely ending a pregnancy to women who previously had none.

Recognizing the significance of this context, the organizers and participants at this meeting are framing a challenge for the movement. We must acknowledge that, for many women, the path to a safe abortion

is different today than it has been. We must address the new needs that women have as a result of these changes, such as new sources of information about how to get needed care and new ways of understanding the term “provider.” Moreover, we must do more to ensure that women have positive, safe, and supported abortion experiences, whatever path they take to get that care. An authentic commitment to reproductive rights and autonomy demands that we recognize and respect a woman’s ability to identify the option that is best for her, and that we work to ensure that women who decide to take abortion pills on their own are fully informed and able to act on that decision in the safest way possible.

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