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Current Commentary

Harm Reduction for Abortion in the United States

Julia Tasset, MPH, *and Lisa H. Harris,* MD, PhD

Access to abortion in the United States has eroded significantly. Accordingly, there is a growing movement to empower women to self-induce abortion. To date, physicians' roles and responsibilities in this changing environment have not been defined. Here, we consider a harm reduction approach to first-trimester abortion as a way for physicians to honor clinical and moral obligations to care for women, negotiate ever-increasing abortion restrictions, and support women who consider abortion self-induction. Harm reduction approaches to abortion have been successfully implemented in a range of countries around the world and typically take the form of teaching women how to use misoprostol. When women self-administer misoprostol, rather than resort to other means such as self-instrumentation or abdominal trauma, to end a pregnancy, maternal mortality falls. There are clinical and ethical benefits as well as limitations to a harm reduction approach to abortion in U.S. settings. Its legal implications for patients and physicians are unclear. Ultimately, we suggest that despite its limitations, a harm reduction approach may help both physicians and patients.

(Obstet Gynecol 2018;131:621–4)
DOI: 10.1097/AOG.0000000000002491

See related editorial on page 619.

From the University of Michigan Medical School, the Department of Obstetrics and Gynecology, Michigan Medicine, and the Department of Women's Studies, University of Michigan, Ann Arbor, Michigan.

The authors thank Dan Grossman, MD, for his helpful review of the manuscript.

Each author has indicated that she has met the journal's requirements for authorship.

Corresponding author: Julia Tasset, MPH, 1500 E Medical Center Drive, L4000 Women's Hospital, Ann Arbor, MI 48109-0276; email: tassetjl@med.umich.edu.

Financial Disclosure
The authors did not report any potential conflicts of interest.

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ISSN: 0029-7844/18

Access to abortion in the United States has been eroded to levels unprecedented since the Supreme Court's decision in *Roe v Wade* in 1973.[1] Nearly one third of laws currently regulating abortion were passed since 2010 –testament to the rapidly changing climate for abortion.[1] As access to abortion is increasingly restricted, there is a growing movement to empower women to self-manage their abortions at home guided by online information and online-sourced medications. Clinicians who see patients in early pregnancy may increasingly encounter women who want to end a pregnancy but do not have access to clinician-directed abortion care or who raise the possibility of self-induced abortion. Consequently, defining physicians' roles and responsibilities in this changing environment is necessary.

American doctors are not the first to consider this issue. Care providers across the globe have found ways to respect legal prohibitions on abortion while simultaneously ensuring women's reproductive rights and well-being by using a harm reduction approach. This typically involves sharing information about safe self-administration of abortifacient medications and providing follow-up care.

Here, we consider the role of a harm reduction approach to abortion in U.S. contexts and describe in broad strokes what such a program might look like. Although logistic, ethical, and legal limitations to this strategy exist, as discussed subsequently, we engage in a thought experiment and consider the potential benefits of a harm reduction approach for clinicians concerned with women's health and human rights in areas of the country where access to abortion is restricted.

HARM REDUCTION FRAMEWORKS

Harm reduction is a strategy that aims to reduce adverse consequences of a target behavior when complete abstinence from or elimination of that behavior is not a realistic or desirable goal.[2] In countries where abortion is illegal or severely restricted, health care providers have implemented harm

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reduction strategies after witnessing the consequences of unsafe illegal abortion. This usually entails teaching women how to use misoprostol, a prostaglandin E1 analog that causes expulsion of uterine contents. It is widely available, shelf-stable at room temperature, and inexpensive.[3] When used for termination of pregnancy up to 63 days of gestation, misoprostol alone has an efficacy rate of 85%.[3] When combined with mifepristone, a progesterone antagonist, the regimen has a success rate of 95–99% up to 63 days of gestation and 93% at 70 days of gestation.[3] Serious complications with either regimen are very rare.[3] Harm reduction programs usually also include ready access to postabortion care–that is, safe uterine evacuation when women present with bleeding or partial tissue expulsion.

Misoprostol harm reduction programs have been implemented in Indonesia,[4] Uruguay,[5] Argentina,[6] Zambia,[7] Nepal,[8] Kenya,[9] and Tanzania.[9] When women self-administer misoprostol to end a pregnancy, rather than resort to other means such as self-instrumentation or abdominal trauma, maternal mortality falls.[5,6,10,11] Indeed, in Uruguay, which introduced a successful and well-documented harm reduction program, the share of maternal mortality attributable to unsafe abortion fell from 37.5% to 8.1% over the decade in which a nationwide program was in use.[12]

ABORTION ACCESS RESTRICTIONS IN THE UNITED STATES

In the recent era of safe, legal abortion in the United States, a harm reduction approach has not had a clear role. However, the legal climate for abortion is shifting. Changes to laws in Kentucky, Mississippi, West Virginia, Missouri, North Dakota, South Dakota, and Wyoming have left each state with only one abortion clinic.[13] Health care providers in other states also face a wide range of laws that impede their ability to deliver evidence-based abortion care.[1] Compounding this is the possibility that *Roe v Wade* will be revisited and overturned by the U.S. Supreme Court.

There are public health consequences of restricted abortion access. Data from Romania are instructive; in 1966, under the Ceausescu regime, abortion was severely restricted and maternal mortality attributable to abortion rose sharply, accounting for 87% of maternal deaths.[14] After the dictator was deposed and his policies ended, maternal deaths related to abortion fell dramatically.[14] In the United States, legalization of abortion in 1973 also brought about a precipitous decline in maternal mortality from induced abortion, from greater than 100 deaths annually (likely an underestimate as a result of underreporting) to four deaths in 2013, the last year for which complete data exist.[15,16] More recently, data from Texas suggest a similar relationship: although legal changes and health outcomes cannot be definitively linked, the erosion of family planning and abortion care in the state since 2011 has coincided with a significant rise in maternal mortality.[17]

THE MOVEMENT TOWARD SELF-INDUCED ABORTION IN THE UNITED STATES

In the wake of expanding state laws restricting abortion, there is increasing interest in self-management of abortion using medications. Since 2011, Google searches for "how to have a miscarriage" and related terminology increased 100% over levels in the early 2000s according to a *New York Times* analysis.[18] After Texas' state law and budget cuts curtailed access to abortion and family planning care in that state, a 2012 survey showed 7% of women seeking abortion reported attempting self-induction–higher than the 2% observed elsewhere in the country.[19] The most common method women disclosed was misoprostol ingestion; however, other methods were also mentioned–some ineffective (but harmless) such as taking herbs or homeopathic remedies and others unsafe such as intentional abdominal trauma.[19,20]

In response to the restrictive climate for abortion, and to help steer women who seek an abortion toward safe, effective methods of self-induction, a range of national and international groups are attempting to provide online and phone information regarding safe self-administration of misoprostol with or without mifepristone for ending a pregnancy. The Dutch group Women Help Women launched a project–Self-Managed Abortion, Safe and Supported–which provides information on medical abortion. New websites continue to appear, like Plan C, which also provides instructions for medication termination and connects women to other trustworthy sources.

PHYSICIANS' ROLES IN THIS NEW ABORTION ENVIRONMENT

After *Roe*, physicians nationwide could depend on their abortion-providing colleagues in and around their communities (albeit with "desert" regions appearing more recently) to care for women seeking abortion. However, if these local abortion providers continue to disappear, what will physicians suggest? If available services require impossible travel, expense, childcare, or missed work, what will they recommend? How do caregivers answer if asked about methods or safety of self-induced abortion?

The options of relocating one's practice to another state or providing abortion care in defiance

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of the law may be impossible for most. In effect, then, the standard of care for undesired pregnancy when abortion care is scarce or absent locally becomes recommending that women travel to seek care. For women in rural, underserved areas, travel distances may be significant. Thus, this standard has significant limitations, and those care providers concerned with women's health and liberty, and who understand the contexts and constraints of women's lives, may seek an alternative approach.

A harm reduction approach may provide another reasonable standard of care. It would offer an additional way for clinicians to honor their commitment to care for patients, despite legal or logistic barriers.

HARM REDUCTION IN U.S. SETTINGS

In the United States, a harm reduction approach would be relevant for caregivers, including emergency medicine physicians, family physicians, obstetrician–gynecologists, and internists as well as advanced practice clinicians in all of these areas, who frequently encounter pregnant women. A patient encounter would start (as it should already) with nonjudgmental, nondirective counseling that does not assume all pregnancies are welcome. If a woman expresses a wish for pregnancy termination, or explicitly asks about self-induction options, the caregiver would engage in risk assessment for unsafe abortion. That is, he or she would determine whether a patient has the resources to travel to be seen by an abortion provider or whether she is at risk for ending the pregnancy in a way that would jeopardize her health. A validated and standardized tool for this purpose does not yet exist for U.S. contexts, and it would be a high priority to develop one. This tool would necessarily contain questions about obstacles to travel, knowledge about both safe and unsafe termination methods, specific methods outside the formal medical system under consideration, and social support networks. Complete risk assessment would also involve documenting duration of pregnancy by whatever method is available and appropriate, including last menstrual period, bimanual examination, or fundal height assessment. Although ultrasonography may be helpful where available, last menstrual period or history and physical examination are clinically acceptable for dating a pregnancy and screening for ectopic or molar pregnancy before first-trimester medication abortion.[21] Risk assessment must also include evaluation for medical conditions, like bleeding disorders, that could make attempted self-induced abortion ineffective or dangerous.

After risk assessment, caregivers would face decisions about what to do next. If a patient is likely to attempt self-induced abortion, the physician could offer caution about unsafe methods such as abdominal trauma or self-instrumentation. He or she could share information about safe self-administration of misoprostol with or without mifepristone. Health care providers may be constrained from making recommendations about how to obtain medications. Currently, the online organizations mentioned previously provide information regarding misoprostol and mifepristone self-administration, but it is conceivable that these organizations will also begin to supply medications in the United States, like they do in other regions of the world. Websites currently operating on this model include WomenonWeb.org, Safe2Choose.org, and WomenHelp.org. A conversation about medications should be followed by education about complications and criteria for seeking emergency care. Finally, all health care providers should offer follow-up care for concerns about bleeding, infection, ongoing pregnancy, and contraception, if needed.

ETHICAL AND LEGAL CONSIDERATIONS

Although a harm reduction approach may offer advantages over the status quo, its serious social, ethical, and legal implications must be considered. First, harm reduction could result in women's arrest: to date, 17 U.S. women have been prosecuted for attempting to self-induce abortion.[22] Physicians could, in the future, be required to report a woman for disclosing self-induced abortions. A harm reduction model, which relies on a public health rationale, may be considered a step backward by those who believe abortion should be grounded, first and foremost, in human rights. Finally, although this approach is viewed by many as increasing women's safety, empowerment, and reproductive autonomy, it also may be characterized as a stigmatizing, two-tiered, inequitable approach to care, in which women with financial means maintain access to medically supervised care and those without are left on their own. Poor women and women of color are more likely to experience unintended pregnancy and abortion than white, privileged women and therefore are more likely to encounter harm reduction approaches as well as their consequences.[23]

LIMITATIONS AND FUTURE DIRECTIONS

A harm reduction approach as described here assumes that a woman seeks medical care before taking any actions toward self-induction of abortion. However, patients may present for care later in the process, after purchase or use of medications. This points to the need for women and their caregivers to have

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ready access to office or emergency department uterine evacuation for treatment of bleeding or other complications. The harm reduction model here will not address the 20% of abortions that presently occur after the 10-week limit established for safe use of outpatient medication abortion.[24] There is a need, therefore, for a harm reduction model for second-trimester abortion, which does not yet exist. Health care providers would also benefit from a harm reduction training curriculum, which has not yet been developed for U.S. contexts. Finally, a barrier to implementation is the infrastructure for distribution of safe and effective medications. With increasing access to the internet, internet-based organizations may work to bring accessible, affordable, and reliable distribution networks to patients in need. A recent analysis of online purveyors of mifepristone and misoprostol found the medications indeed contained the active ingredients advertised, although not always in the concentrations stated.[25]

CONCLUSION

A harm reduction strategy for abortion might allow U.S. health care providers to honor their commitments to women while filling a practical need for increased access to medical abortion amid mounting legal restrictions in the United States. In today's political and social reality, a harm reduction approach may need to fill a vacuum created by lack of national consensus on abortion rights.

REFERENCES

1. Nash E, Gold RB, Ansari-Thomas Z, Cappello O, Mohammed L. Laws affecting reproductive health and rights: state trends at midyear, 2016. Available at: https://www.guttmacher.org/article/2016/07/laws-affecting-reproductive-health-and-rights-state-trends-midyear-2016. Retrieved November 21, 2017.
2. Inciardi JA. Harm reduction: national and international perspectives. Thousand Oaks (CA): SAGE; 1999.
3. Medical management of first-trimester abortion. Practice Bulletin No. 143. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:676–92.
4. Gerdts C, Hudaya I. Quality of care in a safe-abortion hotline in Indonesia: beyond harm reduction. Am J Public Health 2016;106:2071–5.
5. Labandera A, Gorgoroso M, Briozzo L. Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: from a university hospital to the entire country. Int J Gynaecol Obstet 2016;134(S1):S7–11.
6. Matía MG, Trumper EC, Fures NO, Orchuela J. A replication of the Uruguayan model in the province of Buenos Aires, Argentina, as a public policy for reducing abortion-related maternal mortality. Int J Gynaecol Obstet 2016;134(S1):S31–4.
7. Fetters T, Raisanen K, Mupeta S, Malisikwanda I, Vwalika B, Osur J, et al. Using a harm reduction lens to examine post-intervention results of medical abortion training among Zambian pharmacists. Reprod Health Matters 2015;22(suppl 1):116–24.
8. Tamang A, Puri M, Lama K, Shrestha P. Pharmacy workers in Nepal can provide the correct information about using mifepristone and misoprostol to women seeking medication to induce abortion. Reprod Health Matters 2015;22(suppl 1):104–15.
9. Coeytaux F, Hessini L, Ejano N, Obbuyi A, Oguttu M, Osur J, et al. Facilitating women's access to misoprostol through community-based advocacy in Kenya and Tanzania. Int J Gynaecol Obstet 2014;125:53–5.
10. Erdman JN. Harm reduction, human rights, and access to information on safer abortion. Int J Gynecol Obstet 2012;118:83–6.
11. Hyman A, Blanchard K, Coeytaux F, Grossman D, Teixeira A. Misoprostol in women's hands: a harm reduction strategy for unsafe abortion. Contraception 2013;87:128–30.
12. Briozzo L, Gómez Ponce de León R, Tomasso G, Faúndes A. Overall and abortion-related maternal mortality rates in Uruguay over the past 25 years and their association with policies and actions aimed at protecting women's rights. Int J Gynaecol Obstet 2016;134(S1):S20–3.
13. Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2014. Perspect Sex Reprod Health 2017;49:17–27.
14. Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, et al. Unsafe abortion: the preventable pandemic. Lancet 2006;368:1908–19.
15. Induced termination of pregnancy before and after Roe v Wade. Trends in the mortality and morbidity of women. Council on Scientific Affairs, American Medical Association. JAMA 1992;268:3231–9.
16. Jatlaoui TC, Shah J, Mandel MG, Krashin JW, Suchdev DB, Jamieson DJ, et al. Abortion surveillance–United States, 2014. MMWR Surveill Summ 2017;66:1–48.
17. MacDorman MF, Declercq E, Cabral H, Morton C. Recent increases in the U.S. maternal mortality rate: disentangling trends from measurement issues. Obstet Gynecol 2016;128:447–55.
18. Stephens-Davidowitz S. The return of the DIY abortion. New York Times March 5, 2016.
19. Grossman D, White K, Hopkins K, Potter JE. The public health threat of anti-abortion legislation. Contraception 2014;89:73–4.
20. Grossman D, White K, Fuentes L, Hopkins K, Stevenson A, Yeatman S, et al. Knowledge, opinion, and experience related to abortion self-induction in Texas. Austin (TX): Texas Policy Evaluation Project; 2015.
21. Schonberg D, Wang LF, Bennett AH, Gold M, Jackson E. The accuracy of using last menstrual period to determine gestational age for first trimester medication abortion: a systematic review. Contraception 2014;90:480–7.
22. Adams JE, Mikesell M; The SIA Legal Team. Primer on self-induced abortion. Berkeley (CA): The SIA Legal Team Center on Reproductive Rights and Justice; 2017.
23. Dehlendorf C, Harris LH, Weitz TA. Disparities in abortion rates: a public health approach. Am J Public Health 2013;103:1772–9.
24. Induced abortion in the United States. Available at: https://www.guttmacher.org/fact-sheet/induced-abortion-united-states. Retrieved November 22, 2017.
25. Murtagh C, Wells E, Raymond EG, Coeytaux F, Winikoff B. Exploring the feasibility of obtaining mifepristone and misoprostol from the internet. Contraception 2017 [Epub ahead of print].

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