

**Beyond the clinic: Motivations for seeking self-induced and alternative methods of abortion care in
North America**

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Abstract

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Objectives: Recent research found that self-provided and non-clinical abortions are on the rise, largely due to abortion restrictions. This is the first qualitative study with a geographically diverse sample to describe people's motivations for using and providing alternative abortion outside the formal healthcare system in North America.

Methods: Using community engagement and peer-to-peer sampling, we interviewed 23 people who had recently used and/or provided alternative abortion methods. We asked participants to describe specific influential and motivating factors related to seeking and providing alternative abortion care. We conducted a thematic analysis of the interview transcripts and developed a theoretical framework to organize and explain the results.

Results: Participants were located across the United States and Canada. Most people who used alternative abortion methods reported a prior in-clinic abortion, and indicated that those experiences factored into their decisions to seek alternative abortion methods. The desire for privacy, control, and active participation in the process, were other key factors, as was gaining bodily knowledge. Community-based abortion providers described several constraints to accessing in-clinic abortions as reasons people sought their services.

Conclusions: People use and provide alternative abortion methods for a variety of reasons. This research can help advocates understand these emerging trends and inform future access to safe abortion care.

1. Introduction

Alternative methods of abortion represent a largely under-recognized route of access to abortion care. This is due in part to a lack of reliable and accurate research regarding these methods. In the global health literature, abortion self-care has often been assumed to be “unsafe” (1-5). Earlier this year however, the World Health Organization introduced a new scale of safety that recognizes that abortion care in illegal settings can be performed with low medical risk and in accordance with clinical practice guidelines (6).

Alternative methods can span a wide range from herbs that cause mild discomfort to stick pummeling and chemical poisoning that cause severe physical trauma and risk of death (7-9). Because these methods are often blanketed and termed “unsafe” or “illegal” in the literature, it is difficult to differentiate the methods that present severe risks from those whose side effects may be similar to in-clinic medication or surgical abortion. Additionally, health outcomes of abortion self-care, and details on the methods and processes themselves are rarely documented. These gaps in knowledge contribute to the often clandestine nature of abortion self-care and prevent the benefits and risks of these methods being widely known.

Anecdotal evidence from doulas, midwives and other abortion self-care advocates across the United States and Canada indicate that there is an increasing interest in and demand for self-induced abortion, particularly via medicinal plants and herbs, self-procured abortion medication, and mechanical instruments such as menstrual extraction/uterine aspiration. A third realm of abortion care between self-induced and clinical care is called “community-based abortion care”, in which a trained community provider and community support are available for the abortion process. Recently, KUNR, Reno Public Radio, published an interview with one of these community-based abortion providers who described her work in Nevada (10), and a range of popular media outlets have recently covered the use of alternative abortion methods, including interviews with herbal abortion providers (11), and menstrual extraction community circles(12).. These accounts also include a wide range of reasons why someone would seek alternative abortion methods beyond a lack of access to clinical abortion care. This phenomenon paints a different picture of abortion care outside of the health care system, one that isn’t centered on desperate measures due to clinic closings, but instead is supportive and potentially safe and effective.

Prior studies on abortion self-care in the United States have been mostly focused on determining prevalence, or have been qualitative studies limited to clinic-based samples or a specific geographical area. These studies indicate that 2.6%-12% of abortions in the United States are self-induced (13-15). Most recently, in a statewide survey following the passage of abortion restrictions in Texas HB 2 and related clinic closures, researchers estimated that between 100,000 and 240,000 Texans have ever attempted to self-induce an abortion (16). In a related qualitative study with women who had sought abortion services at recently closed Texas clinics, researchers identified five women who as a result had considered self-inducing an abortion, but did not follow-through with an attempt because of fear of physical harm or ineffectiveness of the method (17). Another study of Texas women who had attempted a self-induced abortion found that most women would have preferred an in-clinic abortion but were unable to access clinical care (18). In a similar study, researchers interviewed 30 women in four clinic waiting rooms across the United States and found that they were motivated to use self-induced abortion by a desire to avoid a clinical abortion due to or negative perceptions of abortion care, barriers they experienced trying to access a clinical abortion, and/or a preference for self-induction methods (13).

In this study we sought to expand on the existing research literature on motivations and experiences with abortion self-care by including a wide range of individual stories and experiences from both users and providers from across North America.

2. Methods

2.1. Participant recruitment

This was an exploratory study using qualitative methods to describe preferences, motivations, and experiences related to using and providing alternative abortion methods. Participants were recruited through a local community-based organization that provides support for both clinical and alternative abortion experiences. To advertise the study to potential participants, a study web page was hosted on the organization's website. We also created a Facebook page that posted relevant study information and updates, and several community members voluntarily advertised the study through their own community listservs and

publications. Additionally, participants were asked to engage in peer-to-peer outreach to other potential participants. We received Institutional Review Board approval for this study from the University of Washington Human Subjects Division, and a Certificate of Confidentiality from the National Institute of Child Health and Human Development to protect participants from any legal ramifications of study participation.

Potential participants called a study phone number and left a voice message with their preferred pseudonym, time zone, and an indication if it was safe for researchers to call back and/or text. Researchers contacted potential participants within 1 week for an initial eligibility screening. Participants were eligible if they were over the age of 18, spoke English, and had successfully or unsuccessfully attempted to use alternative methods (referred to as "User"), and/or provided alternative abortion counseling, referrals, or services (referred to as "Provider"), in North America in the past 10 years. Participants were not eligible if they were pregnant or current clients of the local community-based organization. Communication with study participants was conducted with pseudonyms and through phone calls or texts only to protect their confidentiality.

2.2. Data collection and analysis

Eligible participants were informed of the study purpose and procedures and gave oral consent prior to participating in a 1-2 hour in-depth telephone interview (September 2015 to July 2016). All interviews were audio-recorded. Two semi-structured interview guides were developed for Users or Providers and included questions about participants' specific processes, preferences, motivations, and meaningful aspects of their experiences using and/or providing alternative abortion methods. Alternative abortion methods were defined as any method used to induce an abortion that occurred outside the clinical setting and without medical supervision, including but not limited to unprescribed abortion medication, herbs or medicinal plants, manual instruments, or traditional practices such as acupressure, acupuncture, steam, or yoga. At the end of the interview, participants were asked to answer brief demographic and pregnancy history questions, and these data were entered into a confidential, secure, online REDCap database to simplify data collection and

analysis. All participants were given a US\$50 gift card code over the phone or by text as a thank you for their participation.

Any identifying information was deleted from the interview audio recordings before they were transcribed by a professional transcription service. We created an initial codebook related to motivations for seeking alternative abortion methods using in vivo verbatim phrases and terms from the transcripts, as well as key phrases from the interview guide. Transcripts were coded using Dedoose qualitative research web-application (19). To establish intercoder reliability, the lead researcher and a community expert independently coded four transcripts and then revised the codebook to consolidate concepts and resolve discrepancies. This process was repeated with four more transcripts to achieve an acceptable level of agreement and consensus (Cohen's $\kappa = 0.7$) (20). The remaining transcripts were coded by the lead researcher. We analyzed the data with an inductive approach. We reviewed the applied codes and looked for recurring topics. These topics were used to identify emerging higher-level themes and patterns, and we noted outliers and contrasts between cases in analytic memos to build a thematic map. Representative quotes were collected and organized by themes.

3. Results

3.1. Participant characteristics

We were contacted by 25 potential participants, all of whom were eligible and were scheduled for interviews. We conducted interviews with 23 of these potential participants, and were unable to follow-up with 2 participants by the close of the study due to participant travel challenges. Of the 23 participants, 5 (22%) were Users of alternative methods, 6 (26%) were Providers of alternative abortion counseling, referrals, or abortion services, and 12 (52%) were both Users and Providers. Participant characteristics are further detailed in Table 1. The majority of participants came from the Pacific Northwestern (30%), Western (26%), and Southwestern (22%) regions of United States. Participant ages ranged from 23 to 52 years old, with a median age of 31.2 years. The majority of participants identified as White (78%) and female (91%). Six (26%) participants identified as heterosexual. Over half of the participants were current students (57%), and 78%

had college degrees or higher. The majority (83%) had annual incomes of less than US\$30,000. Nearly two-thirds of participants (65%) reported having had between 2 and 6 abortions. The number of living children they had ranged from 0-7, and 57% did not have any living children.

3.2 Personal Motivations for Seeking Alternative Abortion Methods

Participants reported a wide range of motivations for seeking alternative abortion methods, and described a complex interplay of factors driving these motivations. Some of these factors were related to participants' identities in the context of race and ethnicity, gender, socioeconomic class, and immigration status. Other factors emerged from participant's personal internal processes. These included preferences for complementary and alternative medicine in general, spiritual beliefs and practices, and a desire for personal knowledge about alternative abortion methods. Often these factors were recalled in the context of prior, negative experiences with clinical abortion or gynecological care, and clinic policies that did not allow participants to have their desired abortion experiences. Participants sought alternative abortion methods because of these influencing aspects of their identities and prior experiences, and wanted different kinds of processes, settings, and support for their abortion experience that they perceived were not available in the clinical setting.

Three overarching themes emerged from this study as motivations for seeking alternative methods of abortion care: 1) The desire for personal control in the abortion experience; 2) Home abortion as an extension of spiritual beliefs and practices; and 3) To gain first-hand knowledge and experience about the procedures, side-effects, and outcomes associated with these abortion methods, and, engage in socio-political activism through the reclamation of knowledge about abortion care from medical institutions. For most participants these themes overlapped significantly, with individual participants often reporting multiple motivations for seeking alternative abortion care.

3.2.1 Personal Control in Abortion Care

Participants described a desire for more personal control in their abortion experiences as a reason for seeking alternative abortion care. A large majority (76%) of the 17 participants who had used alternative abortion methods had at least one prior experience with clinical abortion, either as an abortion patient (69%)

or as an abortion clinic employee or volunteer (31%), and often their desire for greater control was contextualized in comparison to their experience in the clinic.

Control of Abortion Process and Access to Emotional Support

Participants described controlling specific aspects of their alternative abortion experience including the methods used to induce abortion (100%), the physical environment in which the abortion took place (100%), the people who were present during the active process (82%), and the conceptualization of the abortion itself (71%). The following participant described the specific ways she wanted more control than the clinic context afforded:

“I mean, [the clinical experience] was good. I left and I wasn't pregnant anymore. So that part was effective. ...But, um, it just felt like I could have a little bit more control over— over being at home and who was there and how— exactly how I wanted to do it, um, and getting support through that. And going into the clinic, uh, was— was not that, you know?”

-33-year-old User/Provider, Colorado, 2 abortions total

Participants also described a connection between control over their experiences in the form of a desire for having a sense of ownership over the experience, sometimes shared with their partners. One participant explained the importance of her and her partner owning the experience:

“I wanted to be able to do it at home. And I didn't want to have to go into a, um— a clinic. And I know that they do provide, um, medication that you can do it at home, um, which is what I ended up doing afterwards. But I wanted to be able to have [an herbal abortion] with me and my partner, um, and just make it, you know, more a part of, uh— under our control.”

-30-year-old User/Provider, Oregon, 3 abortions total

Many participants described reaching out to trusted community members, including midwives and doulas, who could provide emotional and physical support and “honor” their experiences “in a house of women”. While a large majority of participants (88%) who used alternative abortion methods were not alone during the process, many described that using alternative abortion methods created a sense of protection and intimacy,

that allowed one participant *“to feel it at home, in a place that was safe and secure, in a place that I could feel comfortable”* (27-year-old User, California, 2 abortions total).

Prior Negative Clinical Experiences

More frequently, however, participants described that their desire for more control was significantly influenced by negative past experiences with medical care, and, more specifically, with gynecological and abortion care. Negative aspects of previous clinical experiences factored heavily into decisions to seek alternative abortion methods for the 88% of participants who used alternative abortion methods. These aspects frequently included interactions with clinical staff that participants perceived as impersonal and paternalistic, in the sense that.... One participant who reported having two incomplete clinical abortion procedures prior to using alternative methods described how her expectations of quality clinical care contrasted starkly with her experience:

“I need to feel like the medical provider has a holistic perspective, um, and also, um, is able— is like able to like really be present with me and like take time to ask for consent and, you know, learn my name, and be like really engaged in the process — like it's sort of— like in [CLINIC NAME] I often feel this, like they're— like it's sort of like an abortion factory, like you're just one in many number of people coming through, and they sort of rush you through this process.”

-28-year-old User, California, 3 abortions total

Participants specifically described experiencing condescending interactions in an abortion clinic, and many (76%) had experience volunteering in abortion clinics as doulas or patient advocates, in addition to their own abortion experiences. One 41-year-old User/Provider participant from California who had 3 abortions total, in describing her own experience as a patient and as an abortion doula, remarked that patients are “treated like kids in clinics and in— even in the best ones that I was at”. Another abortion doula, who chose not to disclose trying herbal abortion methods to the clinical abortion provider, said she feared hostility from the clinic staff and did not want the “silly little girl treatment” (32-year-old User/Provider, Washington, 2 abortions total).

In the worst cases, participants (47%) described being traumatized during their prior experiences with abortion and gynecological care, and specifically wanted to avoid having an abortion in a clinic for that reason. One participant described how having a consequent alternative abortion was empowering, and allowed for a better experience:

“It was really that I felt like really deeply traumatized from my medical experience, and didn't want to, um, take another pill from the clinic, or enter the clinic again for that reason. ... it was just so empowering to have been— to have had this experience of being,— just like this medical system really not working for me and like really creating and bringing up this trauma, and then being able to make this choice that was different. And that felt, um— yeah, it just felt so good.”

-28-year-old User, California, 3 abortions total

Survivors of sexual trauma (35%) also described a re-traumatization during clinical procedures. Some participants knew that using alternative methods would allow them to avoid clinical processes that might trigger negative emotions from past traumas. This participant explained how a home setting would be preferable:

“Um, I— um, I'm a survivor of sexual assault. And I generally don't like gynecological exams. And so I don't— like whenever possible, I prefer to avoid those. Um, and this was a situation where I could avoid that and, um, I can take a pill and I can be at home and I could process the— the pregnancy and the abortion in my own space, rather than in a sterile clinical space.”

-35-year-old User, New York, 2 abortions total

Other participants wanted to avoid interactions with medical staff. One 38-year-old User/Provider participant from Colorado was a survivor and women's health care provider herself who conceived six weeks prior to seeking a medication abortion. She was told that the pregnancy was past eight weeks and surgical abortion was her only option. She described feeling shocked and felt a lack of empathy from the clinic staff, and used the word “violated” to describe her clinical experience. In the most extreme case, one participant described her clinical abortion experience as an assault, and then explained how her subsequent alternative abortion allowed her to heal from the prior experience:

“I really— even though I had consented, even though I was there of my own volition, I felt raped almost. I felt violated, and like this strange man had opened up like my most sacred part of myself, and had just emptied it and then left me there, open. ... [the prior experience] wasn't really completely OK, and kind of let go, until my first pregnancy release that I did myself, um, that I took my power back and my, um— my knowledge, my studies, my decision as a woman with a womb to do this, and to make this decision and do it myself, and not have some strange man do it for me.”

-23-year-old User/Provider, North Carolina, 3 abortions total

Some participants with prior abortion experiences also experienced or witnessed racial, gender, and sexuality discrimination in the clinic (24%). In one poignant example, a 35-year-old Genderqueer Chicana participant from Texas who had 1 herbal abortion, was also a former employee at a large abortion clinic, and described how they and patients of color experienced “dealing with stereotypes” about their reproduction and related to the term “institutionalized racism”. These participants witnessed a racial contrast in the way patients were treated: *“But when a white girl would come in and get an abortion, everyone was like, oh, this is normal.”* They detailed several negative experiences accessing reproductive health care at different points in their life. In one experience accessing STI testing and emergency contraception, they explained how their gender and sexuality were also points of incompetency for clinic staff:

“And the way I was treated [at the clinic] was really, um— like they— they didn't know what to do with me. ... So I didn't want to go to a clinic to— to deal with this [pregnancy]. I also don't present feminine. ... I identify as a lesbian and I had a risky encounter with a guy, and [the clinic] just didn't even understand how to keep my queerness intact.”

In another clinic encounter accessing services after being sexually assaulted, participants experienced a lack of patient education and sensitivity around the assault, and described feeling coerced by clinic staff to press charges, rather than educate them about rape, consent, pregnancy prevention, and social support. They went on to describe another clinical experience getting a pelvic exam and pap smear with a provider who shamed them for wanting to insert their own speculum and made inappropriate comments about the participant’s vagina. The participant described feeling “raped by the practitioner” and had subsequent anxiety for several weeks. They now teach workshops on self-exam and consent communication to create more empowered

patient visits. For this participant, having an herbal abortion after their clinical experiences allowed for a reclamation of agency:

“Like I felt it with my body, so I own it, so I’m the authority over it, like that experience, and no one can ever tell me like, oh, no, like— like this is what happens when you do that. I can say like, no, actually for my body, this is what happened. So just having authority over my experience I think is the most valuable thing.”

3.2.2 Abortion as a Spiritual Experience

For other participants, their motivations were not exclusively linked to avoiding specific negative clinical experiences, but were also related to actively seeking a spiritual experience that the clinic was unable to offer (88%). For these participants, the home environment was a place where spiritual and ritualistic components could be incorporated into their experience. These components often included acts of setting spiritual intentions (67%), ceremony (60%), meditation or prayer (27%), visualization (20%), and a physical altar (13%). Many participants believed that abortion was an inherently spiritual process and felt that they needed to honor the pregnancy and their transition as a pregnant person. Some specifically mentioned feeling a connection to the pregnancy and used the words “baby” or “spirit”. However, this conceptualization did not conflict with their conviction to ending the pregnancy, and some (29%) believed that the spirit of the baby would come back when they were ready to be pregnant and parent.

Spiritual Processes in Abortion Care

For some participants (33%), having access to the pregnancy tissue was an important part of the spiritual process, and one that was not available in clinical settings. The processes of alternative methods allowed participants to collect and handle the tissue, and create a visceral and spiritual conceptualization. Some described creating a ritual to “release” the “spirit of the baby” by burying the pregnancy tissue or “harvesting the blood” and using it to fertilize plants and flowers. This participant, who both used and provided alternative abortion methods, described how alternative methods allowed her to use the tissue in spiritual ways:

“In— in all of the— in every [home abortion] experience that I had, I definitely, you know, opened the space and was able to like, you know, do a ritual around it. And because I was able to have the products of conception afterwards with all of them—you know, with the last menstrual extraction, it's like in the jar. And with herbs, I just caught it, um, and I was able to, you know, bury it and do like a releasing ceremony.”

-26-year old User/Provider, Colorado, 3 abortions total

Additionally, some participants described that using alternative methods allowed for a more purposeful and thoughtful experience. This was especially true for participants who used herbal methods(76%), which require regimented dosing over the course of several days. Participants described that, because the process takes longer, using herbal methods created opportunities for a reflective experience that included setting intentions for the process, and for their lives, in general. Many participants (53%) asserted that mindfulness was a critical component of having a successful herbal abortion, of “preparing” their bodies for the medicinal process, and “submitting” to the power of the herbs. For some participants, meditative processes, which often included a daily practice for the duration of the abortion process, were substantial parts of their experiences. One participant described her process with herbs:

“But also, in order for it to be effective, you have to set up that routine and take it, you know, and you have to gradually introduce it to your body. And that gives you time to get— to get right with what you're doing and to think about it. And it's just a very, um— it's a very thoughtful method—and very, um, kind and gentle to yourself, at a time when you need that.”

-52-year-old User/Provider, California, 6 abortions

Spiritual Connections to People and Plants

In addition to being an intentional process, some participants (24%) felt that using alternative methods, which allowed for support people to be present, created an opportunity to strengthen spiritual relationships with those who were present. In some of these experiences, participants were connected to a spiritual community, members of which helped to create the abortion experience. Participants described these community members' roles as “holding the space” or “walking with me”. Sometimes these spiritual community members were also the people who performed the abortion or provided the materials. One

participant, who both used and provided alternative abortion method, described having a reflective experience, and felt that their personal experience allowed them to provide better abortion care and support to those who accessed their services.

“It’s like spiritual to me when there’s like— when there’s a growth and a deepening of understanding and a deepening of appreciation. ... I really got to know myself a lot better and I got to know those people around me a lot better.”

-35-year-old User/Provider, Colorado, 2 abortions total

Some participants had a previous spiritual connection to herbs and felt that plants were more “trustworthy” and “faithful” than other abortion methods. These participants (29%) were more likely to be professional herbalists with experience using herbal medicine for other types of conditions, and more likely to identify as Pagan. One 27-year-old User participant from California described having Polish spiritual ancestry in herbal abortion and used that familial knowledge to create her abortion experience. Participants described having a “relationship” with specific herbs, and their prior experiences allowed them to know which herbal abortion methods were most likely to work for them. Many of these participants conceptualized herbs as independent agents that actively supported them, with some participants calling them “friends” and describing that herbal methods needed to be respected to end the pregnancy. This participant explained her spiritual beliefs involving herbs:

“I guess I believe that, um— my belief is that the plants and the Earth are intelligent, conscious beings that we are able to— that support us, whether we know it or not. And I— I trust that. And I was able to connect with that in this process.”

-28-year-old User, California, 3 abortions total

Overall, these participants conceptualized abortion as a process deserving of spiritual reverence, and using alternative methods allowed for a more holistic and fulfilling experience. One participant described the personal impact of incorporating spiritual beliefs and practices into her abortion experience:

“And [the ritual] was really, really positive, and I think like contributed a lot to my mental well being around the whole thing.”

-26-year-old User/Provider, Colorado, 3 abortions total

3.2.3 Producing Bodily Knowledge and Political Power

Acquiring Knowledge and Helping Other Alternative Abortion-Seekers

Participants (65%) also described their motivations in seeking alternative abortion experiences as being related to acquiring knowledge about the process itself. Participants explained that there was often a lack of resources and information on the methods, physical processes, and outcomes related to alternative abortion methods and that they saw using these methods themselves as an opportunity to learn more about the process. Some participants described their curiosity in using their own bodies in an investigatory way as a motivating factor. Furthermore, some participants embraced the experience as an opportunity to be creative and imaginative, with one participant describing their experience as an “art piece”. The following participant described how her motivations for using alternative abortion methods represented a purposeful quest for new knowledge:

“And I think that I really kind of allowed my curiosity, and even excitement, about this kind of experiment to see how, what— what— what would it be like to use herbs? ... I mean, why not? It's like you may as well just get what you can creatively and intellectually, and just increase your knowledge of just, you know, of the universe.”

-41-year-old User/Provider, California, 3 abortions total

Other participants (71%) related their desire for knowledge about the process to their desire to help others seeking out alternative abortion. In gaining first hand experience using these methods, participants intended to use their gained knowledge to provide information on their experience to others in the future. Often these motivations were tied to the concept of trusting themselves through the process, and trusting others who sought similar experiences. One participant explained how she believed that gaining knowledge through her experience of alternative abortion could be used to help others:

“I've learned a lot more about, um, myself and my body...just like learned how to do it more on my own terms, um, and to know like the signs and symptoms of something being off with that, um, enough, or trusting myself enough to know those, that— that I can do this on my own at home and that people can do this at home alone, I mean, not alone, but, you know, without a doctor. I think figuring out how to do it on my own and knowing that that's possible, and just that knowledge helping other people to figure out ways to [have a home abortion] on their first time.”

-28-year-old User, California, 4 abortions total

Reclaiming Ancient Abortion Practices and Power

For those who used herbal methods, producing knowledge through their experiences with alternative abortion methods was closely related to the desire to connect with ancient practices of fertility control, and to revive old relationships with medicinal plants. A majority of participants (53%) felt that having the self-efficacy and knowledge to be able to access abortion care outside of a western medical setting were a continuation of centuries of traditional abortion practices. Connecting to that self-efficacy and knowledge were often conceptualized as a “reclamation” in response to historical oppression. The following participant described how historical power structures have disconnected people from traditional abortion methods:

“It makes sense that, um— that I would really— that [a home abortion] would really be important to me— I mean, I think that it's— like it's not been that long we've been like detached from our like— you know, the like traditional ways of doing things. And— and like colonialism has really like taken us away from like the actual land in that our ancestors had, um— like the plants that our ancestors had used to do the same thing.”

-32-year-old User/Provider, Washington, 2 abortions total

These political aspects to participants’ motivations went beyond herbal methods, and many felt that their desires tied into a larger revolution, which some described as “liberatory”. The reclamation of their bodies and control over their abortions from the medical establishment represented radical acts. One participant explained how alternative abortion could be seen as political:

“I think taking back our health is, for anyone, is an act of civil disobedience, um, in itself. I think being aware of your body and not being afraid of it, and being aware of just kind of, um, ways to take care of it that are outside of like the big like medical sphere where knowledge is usually kept from people I think is an act of just like resistance and an act of survival. ... And so, um, I really wanted to like be a part of this.”

-27-year-old User, California, 2 abortions total

Current Political Landscape of Abortion

For other participants, the decision to seek an alternative abortion was tied to the current political climate. One participant specifically mentioned the trend of state abortion restrictions and related clinic

closures as jeopardizing access to clinical abortion care, and learning how to have an abortion outside the clinical setting was conceptualized as one way to protect access to abortion care in the future. She explains:

“I think it was a, um— for me it was more like a political decision I think, um, about, yeah, not— not— learning how to not depend on a clinical abortion when we're so clearly seeing that clinics can be shut down for really stupid reasons. Um, and so to me it was about being self sufficient and about owning my own health and not being reliant on something that is not— not a ‘for sure’ for a lot of people, or for me in the future, if— you know, it's like we don't know what's going to happen with that.”

-33-year-old User, Colorado, 2 abortions total

One participant also described the current political trend arresting and prosecuting people for self-induced abortion in the United States. Her decision to seek alternative methods was related to contributing to a body of evidence that could be used to advocate for the protection of people's rights to self-induced abortion. While not part of her initial motivation, participating in this study was an opportunity for her to publicize her experience as an act of advocacy:

“I feel that we deserve, that women should be able to have abortions on their own, how they want to, safely. Um, and so the more that we're able to show that we can do these things on our own, hopefully, um, the more evidence— evidence there is that we shouldn't be penalized for this kind of action.”

-28-year-old User, California, 4 abortions total

3.3 Perspectives of Community-Based Providers

Community-based-providers of alternative methods of abortion (n=18) also described why they believed people seek alternative abortion counseling, referrals, and services. The majority of these community-based providers (n=12) had personal experiences with alternative abortion methods that they also shared in this study, however the remaining providers (n=6) only had experience providing alternative abortion counseling, referrals, and services in North America¹.

¹ One provider had personal experiences using alternative abortion methods in a foreign country, which fell outside the scope of this study and those experiences were not included.

Barriers to Accessing Clinical Care and Perceived Lack of Quality Care

While only one participant who personally used alternative abortion methods cited a lack of access to an abortion clinic as a motivation for using abortion-inducing herbs, all of the providers discussed that the people that they serve are often unable to access clinical services due to financial, geographical, or logistical constraints. These constraints included not being able to afford clinical care, as well as a lack of insurance coverage, in addition to a lack of transportation and childcare. One provider in Mississippi told the story of a woman whom she helped access misoprostol outside of a clinic. The nearest abortion clinic was 4 hours away and this woman needed to keep the abortion private from her current partner, with whom she shared a car. There was a mandatory 24-hour waiting period requiring two appointments and she also wasn't able to take time off of work or find childcare.

“So it was just— it was impossible. The logistics were impossible. And— and finally I was just like, you know what? I— I have another option for you. And that worked out fine. She just took the pills, pretended she had a miscarriage, cried for show [for her partner], and it was done.”

-37-year-old Provider, Mississippi

While these providers discussed a lack of accessible clinics, they all also reported that people seek their services to avoid experiencing a lack of quality care in sometimes the only medical clinic in the area. This was especially true for one 27-year-old community provider in Nevada, who shared that the sole abortion provider in her area had “completely monopolized abortion”. She, herself, had accessed abortion care from this provider and described her experience as “terrifying and upsetting” and “cold and uncaring”. She now provides community-based abortion care in her own home, which allows her to create a different experience for her clients, including the ability to offer childcare. All of the providers mentioned a distrust of medical establishments and institutional interventions or documentation, often due to aspects of their identity, such as race and gender. Often clients who seek alternative abortion may already be involved in other institutions, including social services or criminal justice systems, and have confidentiality concerns. One 25-year-old provider of color from Washington described why people from her community access alternative abortion care:

“Just from my childhood and experiences, especially among people of color, there is a lot of distrust towards the modern medicine model. So a lot of people that I know try to avoid clinics and hospitals completely altogether, because they're worried about any of their information getting out. And a lot of women are worried about CPS getting involved somehow and taking their children that they already have. And also, a lot of domestic abuse survivors, they really try to stay away from clinics, because they don't want the paper trail.”

This was echoed in one user in this study, a 32-year-old woman from Washington who was experiencing intimate partner violence, and used illegal substances and alcohol to try to induce an abortion. While she knew her actions were dangerous, avoiding having to provide personal information or risk disclosure to her abusive partner felt safer than accessing a clinic. One provider, a 25-year-old woman who travels across North America providing alternative abortion trainings and services, described how immigration status is a factor in seeking alternative abortion methods:

“Um, well, just recently I was helping someone who was an undocumented immigrant. And while I could say that she should be able to walk into a clinic or an emergency room and not have the threat of immigration, that's not always everybody's experience when you're undocumented. And so, um, having the privacy of home feels a lot safer for some of those people.”

The same provider also explained how being transgender or genderqueer can make it difficult to feel comfortable in the “women-centered environment” of a clinic, especially with “clinicians who have never worked with a trans body before and don't know how to be respectful and knowledgeable”.

Desire for Personal Control Described in Providers' Experiences

All of the providers echoed alternative abortion users' sentiments around desiring more control over the timing, environment, and support of the abortion experience, often in comparison to what is possible or available for in-clinic abortion care, as reasons for seeking abortion care. One motivation that was reported by multiple providers (50%) was the ability to access alternative abortion methods much sooner. Many clinics aren't able to provide care until 5 or 6 weeks gestation, and some people know that they are pregnant before then. According to the providers in the study, accessing alternative abortion methods, particularly herbal

methods and misoprostol, allows that person to attempt an abortion earlier, which can create a greater sense of control:

“I feel it's just like wanting to be in control, uh, wanting to keep it private, like no paper trail about it—um, desperation to get it done as soon as possible because they're— if they're going to do it with a clinic, they'd have to wait a week or two weeks to get their appointment. And they don't want to keep being pregnant.”

-35-year-old User/Provider, Texas, 2 abortions

Like most participants in this study who used alternative abortion methods, providers named many reasons why people seek out abortion outside of a clinic. For one 26-year-old User/Provider from Colorado, the majority of people that come to her for alternative abortion care, like the Users in this study, desire something different from experiences that they've had or what is offered in a clinic:

“And a lot of, um— a lot of other people like, you know, want their partners to be able to be there or want people to bring ritual into it or like acknowledge it as a rite of passage or like, um, you know, can't afford the clinic. That comes up a lot. Um, but yeah, mostly it has to do with like, yeah, wanting a different experience than a past experience at the clinic, and also wanting something a little bit more like gentle and within their power.”

4. Discussion

This study documented the motivations and experiences of 23 people who were living in 10 states and 1 Canadian province at the time they used alternative abortion methods (Users) and/or provided (Providers) alternative abortion counseling, referrals, and services. Both Users and Providers described multiple, and often related reasons why people seek alternative abortion care. Providers of alternative abortion counseling, referrals, and services also reported that their clients often experience financial, geographical, and logistical barriers to accessing clinical care. The majority of Users in this study had prior experiences as patients in clinical abortion settings, and some were also former clinic employees or volunteers. A major finding of this study is that participants sought alternative abortion methods to avoid the medical clinic environment. This decision was informed by prior negative experiences, as well as wanting to have more control over the abortion process and environment. Participants also described wanting to

incorporate spiritual acts into their experiences, and create a learning experience to produce and share knowledge about these methods with others. Additionally, some participants, particularly people of color, LGBTQ folks, and participants from other marginalized communities, sought alternative abortion methods as a political act of resistance against broader social systems of oppression.

While previous qualitative studies on self-induced abortion in the United States have sampled from clinical abortion settings, this study used community engagement and peer-to-peer sampling to reach a previously unstudied sample outside the clinic setting. This may help explain why the results of this study vary from previous studies. In a 2010 qualitative study with 30 patients at an abortion clinic who reported self-inducing an abortion, Grossman et al. (13) found that, while the majority of participants were motivated to avoid the clinic, very few cited negative aspects of their previous experiences. This current study however found that negative clinic experiences, specific to both gynecological and abortion care, were major factors in wanting to avoid the abortion clinic. Because this study didn't sample from clinics, it is possible that researchers were more likely to find participants who did not need or want to access abortion care in the clinic. Additionally, Grossman et al. (13) found that a third of the participants experienced financial barriers to accessing abortion care, whereas only one participant who used alternative abortion methods in this study cited the same reason. The majority of participants in this study were able to access clinical care if needed. This may be explained by the demographics of this study compared to the oversample of Latina participants in Grossman et al. (13). The majority of participants in this study were white and had college or graduate degrees, and were less likely to come from low-income backgrounds, and thus experience financial barriers. Additionally, most participants in the study had some prior level of knowledge, experience, or proficiency that made alternative abortion methods their first choice in abortion care, and which may explain why there was a lack of clinical barriers reported. This contrasts with another recent qualitative study of 18 women in the Lower Rio Grande Valley of Texas who attempted to self-induce an abortion (16). Researchers found that most participants would have preferred a clinical abortion but experienced barriers to obtaining clinical care. The majority of participants in this current study were also able to access alternative abortion information and materials through community publications and websites. Many participants were also part of a knowledgeable

and supportive community of midwives, herbalists, doulas, and healers, who actively engaged in community-based pregnancy and birth care, often in home settings. These factors also assert a level of knowledge, support, self-efficacy, and privilege not present in other studies on self-induced abortion.

The narratives in this study question the assumption that people seek alternative abortion care out of desperation or fear, and allow for a deeper exploration of the appeal and benefits of abortion care outside of an institutionalized medical setting. In capturing these unique perspectives, this study challenges several tenets of abortion-related research. First, these narratives reach past the medicalized convention that successfully terminating a pregnancy is the most important outcome in abortion care for all women, and that medical supervision is required for all safe and healthy abortions. Second, broader conceptualizations of “safety,” “risk,” and “accessibility” were found among participants, moving beyond medical definitions to account for individual experiences, such as medical trauma and institutionalized oppression in clinical settings that posed a greater perceived threat to participants than alternative abortion methods.

4.1 Limitations

There are several limitations to this study. First, as a qualitative study with a small, convenience sample, study results are not representative of all people who seek self-induced or alternative methods of abortion. Over 75% of participants identified as white, and many were college-educated. The majority of participants came from the Southwestern, Western, and Northwestern parts of the country. The narratives of minors, people of color, people with lower levels of education, and people from other parts of North America are sparse. Second, because participants initiated contact with researchers, as opposed to being randomly sampled, there is a risk of self-selection bias. This study asked about legally precarious topics, and only those participants comfortable enough to speak to researchers are included. For people of color, immigrants, and members of other marginalized communities, the fear of disclosure and prosecution for self-induced abortion, coupled with a history of oppressive treatment in reproductive health related research, may have been a deterrent to participation. Lastly, this study was unable to capture objective data about the safety and effectiveness of alternative methods of abortion. While many participants attested to these aspects of

their experiences, more studies are needed to determine potential risks and benefits of using alternative abortion methods.

4.2 Strengths

This study used community-based and peer-to-peer sampling to describe the motivations and experiences of a previously unstudied population of people who have used and/or provided alternative abortion methods in North America. While previous studies have focused on people who have attempted self-induced abortion, this study highlights the experiences of community-based providers of alternative abortion methods, as well. As a result, this study uncovered trends and patterns related to self-induced abortion in the United States that were not previously described in the literature. The geographic range of this sample is another strength, with 10 states and 1 Canadian province represented. While previous studies focused on recruitment sites that oversampled Latina women, this study used internet-based recruiting to increase the likelihood of a more geographically diverse sample. The use of a community-expert in coding and analysis, as well as the inclusion of in vivo and verbatim codes, also reduces the risk of researcher bias and misinterpretation.

5. Implications

This study was not designed to recruit a representative sample and the results should be cautiously applied. The implications of this study are wide reaching however. We asked participants to provide a conservative estimate of how many other people they knew who had recently accessed alternative abortion methods. Participants enumerated a total of 828 others of which they were aware, with many reporting that some of the people were also community-based abortion providers who had provided alternative abortion care to between 10-100 other people. While it's not possible to calculate the prevalence of users and providers of alternative abortion methods reported by participants, there appears to be a nationwide network of community-based abortion providers who are helping people access seemingly relatively safe, effective abortion care, often in a desirable setting and context. This should not be construed to advocate that abortion care outside a clinical setting is appropriate for every person seeking abortion care. At a time of dwindling access to clinical abortion care in some parts of the US however, many abortion care advocates

may find the emergence of community alternatives reassuring, and an opportunity to engage new stakeholders in abortion care and access.

A major finding of this study, the desire to avoid clinical abortion care, provides insight into ways that clinical care might be improved. Many participants cited previous negative clinical abortion experiences as a reason for seeking alternative care. Many were survivors of trauma who felt that aspects of clinical care were insensitive and triggering of past negative experiences. Additionally, participants who identified as and/or served people of color and those from LGBTQ communities, felt that clinical care was not culturally competent. Lastly, many participants desired more individualized and patient-centered abortion experiences that they perceived were unavailable in the clinic. While some aspects of clinical care cannot be modified due to clinical standards and regulations, there may be ways that clinic administrators and providers can improve the environment and care to be more welcoming and accessible to potential patients. This can include cultural sensitivity trainings, collaborations with doulas and professionals trained in emotional support skills, and workshops on trauma-centered care. Other suggestions for improving the quality of clinical abortion care have been described in several other patient survey studies (21-21). For many abortion providers, particularly at high-volume clinics, the time constraints and pressures of providing quality medical care can make it challenging to honor individual abortion experiences. This study has shown however that clinical abortion experiences can be salient life events for patients, and those experiences may inform choices about future abortion care, including seeking alternatives to clinical care.

Future studies using community-based participatory methodology could explore the practices, strengths, and challenges related to providing community-based abortion care outside of a clinical setting. These studies could provide valuable insight and opportunities for potential collaboration with clinical abortion advocates and providers to increase access to safe abortion care in a wide range of settings. Additionally, a longitudinal surveillance study tracking specific technical aspects of providing alternative abortion methods and pregnancy and health outcomes could more systematically describe the potential risks and benefits of these methods, and contribute to the evidence on the safety and effectiveness of alternative abortion methods.

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Table 1: Participant characteristics

	User N=5 (22%)	Provider N=6 (26%)	Both N=12 (52%)	Total (%) ¹
Age (years)				
18-25	--	2	3	5 (22)
25-30	3	1	4	7 (30)
30-35	2	1	4	7 (30)
35-40	--	2	--	2 (9)
40-55	--	--	2	2 (9)
Region²				
Pacific Northwest U.S. (OR, WA)	1	3	3	7 (30)
Western U.S. (CA, NV)	3	1	2	6 (26)
Southwestern U.S. (AZ, CO, TX)	--	--	5	5 (22)
Southeastern U.S. (MS, NC)	--	1	1	2 (9)
Mid-Atlantic (NY)	1	--	--	1 (4)
Canada (Quebec)	--	--	1	1 (4)
Multiple locations (U.S./Canada) ³	--	1	--	1 (4)
Race/Ethnicity⁴				
White	5	4	9	18 (78)
African descent	--	1	--	1 (4)
Asian	--	--	1	1 (4)
Black	--	1	--	1 (4)
Chicana	--	--	1	1 (4)
European descent	--	--	1	1 (4)
Gender⁴				
Female/woman	4	6	11	21 (91)
Genderqueer	1	--	1	2 (9)
Sexuality⁴				
Queer	1	2	5	8 (35)
Heterosexual/straight	2	1	3	6 (26)
Bisexual	--	2	2	4 (17)
Pansexual	--	1	2	3 (13)
Mix-match	1	--	--	1 (4)
Non-normative heterosexual	1	--	--	1 (4)
Relationship status⁴				
Partnered	2	1	5	8 (35)
Single	2	3	3	8 (35)
Multiple relationships/polyamorous	--	1	3	4 (17)
Married	1	1	1	3 (13)
Current student	2	4	7	13 (57)

Education				
High school	1	1	2	4 (17)
Associate's degree	--	1	--	1 (4)
College degree	2	4	4	10 (43)
Graduate degree	1	--	3	4 (17)
Professional certificate	1	--	3	4 (17)
Annual income				
\$0	1	1	2	4 (17)
\$10,000-\$20,000	1	2	4	7 (30)
\$20,000-\$30,000	2	3	3	8 (35)
\$30,000-\$45,000	--	--	2	2(9)
\$45,000-60,000	--	--	1	1 (4)
\$60,000-\$75,000	1	--	--	1 (4)
Abortions				
0	--	3	--	3 (13)
1	--	2	3	5 (22)
2	3	1	3	7 (30)
3	1	--	5	6 (26)
4	1	--	--	1 (4)
6	--	--	1	1 (4)
Living children				
0	4	2	7	13 (57)
1	--	3	1	4 (17)
2	1	--	3	4 (17)
4	--	--	1	1 (4)
7	--	1	--	1 (4)

¹ Percentages may not add up to 100% due to rounding

² Region of residence at the time of using alternative abortion methods or providing alternative abortion counseling, referrals, or services

³ One provider travels around North America regularly providing education and services

⁴ Participants were asked open-ended questions about their race/ethnicity, gender, sexuality, and relationship status. Categories listed here are verbatim from their answers.