RESHAPING THE LAWS SURROUNDING SELF-INDUCED ABORTION TO ENHANCE DIGNITY AND SECURE FREEDOM FROM ARREST

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Once someone has decided to have an abortion, they should be able to do so safely, effectively, and with dignity. While most abortions in the United States are provided by medical professionals, clinical abortion care is becoming increasingly inaccessible. The highest obstacles and greatest burdens of reduced access fall heavily on marginalized communities, including people living in poverty, immigrants, youth, and people of color.

Abortion has never been entirely limited to clinics: there has always been some amount of abortion care accessed outside the purview of the formal medical system. As non-clinical abortion methods vary, existing within their own historical or cultural contexts, so do the reasons people seek this care at home. Many issues may push a pregnant person away from clinical abortion care or pull them toward self-directed care. [1]

Some pregnant people would prefer to receive abortion services at one of the many reproductive healthcare clinics providing high-quality, patient-centered, culturally competent care. However, they cannot access these clinics due to excessive legal restrictions on abortion providers[2] that have decimated reproductive health services. Other obstacles to clinic-based care include: demoralizing and medically unnecessary hurdles like state-mandated scripts, waiting periods, or ultrasounds; costs associated with long-distance travel, child care, and lost wages; and fear of attack or exposure by hostile clinic protesters.[3]

Other pregnant people are not so much deterred by obstacles to clinic-based care as they are attracted to home-based abortion through self-sourcing or with support from a non-clinical provider. Some people distrust the conventional medical system due to its history of exploitation of their communities through forced sterilization, unconsented medical testing, and the like.[4] Others find self-directed or community-based care to be more affirming after disempowering experiences with medical professionals due to their size, gender expression, or disability.[5] People who have emigrated from countries where self-directed health care is the norm may feel more comfortable and familiar with self-managed abortion care. Finally, some pregnant people appreciate the ability to shape such an intimate experience by choosing the scheduling, setting, and companion right for them.[6]

Whether people end their own pregnancies out of preference or necessity, historical and present trends indicate that criminalization is not a deterrent to abortion self-induction. Perversely, criminalization may deter people from seeking medical care in the rare instance of a complication due to fear of being turned over to law enforcement. In addition to scaring people away from medical treatment, criminal investigations are used to humiliate, control, and punish those suspected of ending their own pregnancies.

The vast majority of the laws used to criminalize those who self-induce abortion are either revived from antiquity or contorted beyond their legislative intent by overzealous prosecutors.[7] While a few states have explicit bans on self-induced abortion, the bigger threat stems from roughly 40 other types of laws that politically motivated prosecutors can wield as weapons against people who end their own pregnancies. The combination of prosecutorial discretion with judges interested in overturning Roe, plus attempts to create legal rights for embryos/zygotes/fetuses and renewed attempts to outlaw abortion primes the justice system to punish people who have abortions.

Whether people are directly criminalized by laws prohibiting self-induced abortion or indirectly through improper use of "unborn victim" laws or laws criminalizing abortion provision, the effect is the same: taking matters into one's own hands converts a constitutional right into a crime.[8] If brazen legislators and impetuous prosecutors continue to seek punishment of people believed to have ended their own pregnancies, this will have cascading repercussions, particularly in communities of color, immigrant communities, and low-income communities - who are already subject to over-policing and who are most likely to have factors pushing or pulling them toward non-clinical abortion.

It is time for policymakers, law enforcement, and judges to deliver Roe's unfinished promise by fully decriminalizing abortion and by removing barriers that heighten stigma, cost, and risk. People who have abortions, whether self-directed or provider-directed, should be able to do so with dignity, free from the threat of arrest for themselves or any-one help supports them.

NOTES

1. Francine Coeytaux, Leila Hessini, Amy Allina, Bold Action to Meet Women's Needs: Putting Abortion Pills in U.S. Women's Hands, Women's Health Issues (September 2015), available at http://www.whijournal.com/article/S1049-3867(15)00129-2/pdf.
2. Heather D. Boonstra and Elizabeth Nash, Guttmacher Institute, 17 Policy Review A Surge of State Abortion Restrictions Puts Providers - and the Women They Serve - in the Crosshairs (Winter 2014).
3. Daniel Grossman et al., Self-Induction of Abortion Among Women in the United States, Reproductive Health Matters, Vol. 18 (36), at 140, 146.
4. SIA Legal Team, Roe's Unfinished Promise (2017).
5. Alison Ojanen-Goldsmith, Beyond the Clinic: Preferences, Motivations, and Experiences with Alternative Abortion Care in North America, 94 Contraception 387, 398-99 (2016).
6. Grossman et al., Self-induction of Abortion, supra note 29, at 146.
7. Jill E. Adams and Melissa Mikesell, And Damned if They Don't: Prototype Theories to End Punitive Policies Against Pregnant People Living in Poverty, The Georgetown Journal of Gender and the Law, 18 Geo. J. Gender & L. 283 (Symposium Issue, 2017).
8. Id.