

The Best Defense is a Good Offense: Misoprostol, Abortion, and the Law



Conference Summary and Strategic Recommendations

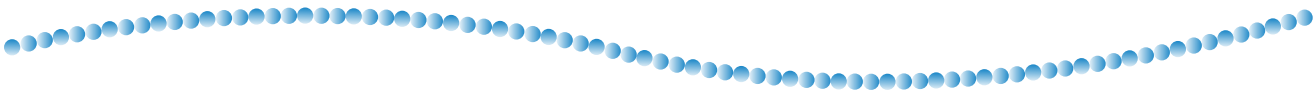
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The Best Defense is a Good Offense: Misoprostol, Abortion, and the Law

In recent years, relentless efforts to restrict abortion rights have intersected with an emerging movement to compromise the rights of pregnant women. The well-publicized prosecutions of several women who used misoprostol to self-induce an abortion highlight this intersection. The criminalization of women's behavior during pregnancy demands a nuanced response from the reproductive justice community, one that differs from responses mobilized to advance abortion access. In particular, responses to the criminalization of abortion self-induction must acknowledge the complex factors that lead women to choose self-induction rather than to seek abortion services from a medical provider.

There have been many studies of women using misoprostol safely to self-induce abortion without the involvement of clinicians in other countries, particularly in Latin America.¹ However, most domestic reproductive health, rights and justice groups are not aware that some women in the U.S. are also using misoprostol and other methods to self-induce. In order to address the myriad legal, research, education, medical and advocacy issues surrounding misoprostol use for self-induction in the U.S., several organizations came together in 2004 to form the Misoprostol Working Group. The Working Group sparked several research projects, developed talking points on the issue, and began to raise awareness about abortion self-induction in the U.S.

In August 2009, Gynuity Health Projects and the Reproductive Health Technologies Project convened a meeting of medical providers, lawyers, women's health advocates, researchers and policymakers to discuss lessons learned in two prosecution cases of women who had used misoprostol without the involvement of medical practitioners. This report presents the major highlights from the meeting and subsequent recommendations for working with the media, the legal and medical communities, and with the reproductive health, rights, and justice communities.

Background

Misoprostol is a synthetic prostaglandin initially approved by the FDA in 1988 to prevent gastric ulcers caused by extended use of non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, aspirin and naproxen. In addition, misoprostol is a potent uterotonic (capable of stimulating uterine contractions and opening the cervix) throughout pregnancy. For this reason, misoprostol has been integral to the development of medical alternatives to surgical abortion and is a component of all clinical regimens used to induce abortion with medications. It is effective by itself and has enhanced effectiveness when used with mifepristone.

Misoprostol has many other uses in obstetrics and gynecology, including for treatment of incomplete abortion and intra-uterine fetal death, prevention of post-partum hemorrhage, induction of labor, and cervical ripening prior to surgical procedures. In the U.S., misoprostol is used routinely off-label in obstetrics

¹ For example:

Billings, Deborah, Misoprostol Alone for Early Medical Abortion in a Latin American Clinic Setting, *Reproductive Health Matters* Volume 12, Issue 24, Supplement, Pages 57-64 (November 2004).

Carbonell J, Rodrigues J, et al., Vaginal Misoprostol 1000 µg for Early Abortion, *Contraception* 2001; 63: 131-136.

Costa S, Vessey MP, Misoprostol and Illegal Abortion in Rio de Janeiro, *Lancet*, 1993; 341:1258-1261.

Coelho HLL, Tei Xeira AC, Santos AP, et al., Misoprostol and Illegal Abortion in Fortaleza, Brazil. *Lancet*, 1993; 341:1261-1263.

and gynecology practice, although it is only approved for sale as an ulcer prevention medication. It is important to note that in the U.S. and many other countries, drugs can be prescribed and used legally for indications other than those for which the drug was approved or registered. Off-label use of prescription medication by clinicians is commonplace in the United States – a study of 2001 data found that 21% of prescriptions are for an off-label use of the medicine being prescribed.²

Misoprostol is available in pharmacies in many Latin American and Caribbean countries without a prescription and is also available on the black market. In many communities in these countries, it is commonly known that misoprostol can effectively induce an abortion. Immigrant women bring this knowledge with them to the U.S., where misoprostol is only available with a prescription, along with an acceptance of self-care and self-medication as primary health care strategies. A survey published in 2000 of patients at a New York City clinic that served a predominately Dominican population found that 37% of those interviewed knew about the use of misoprostol for termination of pregnancy.³

There are significant barriers to accessing abortion services for many women in the U.S., particularly for low-income and immigrant women. These barriers include distance to a provider, inability to pay for the service, lack of knowledge that abortion is legal in the U.S., and a lack of translation services. Even for women with geographic and financial access, issues of stigma and fear of harassment by protestors may discourage women from obtaining services at clinics. These barriers, in combination with knowledge about the efficacy of misoprostol, contribute to some women in the U.S. using misoprostol to self-induce abortion.



Developing A Strategy

To inform the development of a strategy to protect women from prosecution for self-induction, the 2009 meeting opened with presentations by experts who discussed new research on self-induced abortion, the legal landscape of self-induced abortion in selected states, and facts about misoprostol use in obstetrics and gynecology. These presentations were followed by in-depth discussions of cases in Massachusetts and South Carolina where women were prosecuted for using misoprostol. Finally, three advocates identified preliminary strategies for keeping women out of the courts in the future.

Dr. Dan Grossman reported on a survey of 1,262 women that was conducted jointly by Ibis Reproductive Health and Gynuity Health Projects. The objective of this survey was to explore women's knowledge of and experiences with self-induction, including their access to abortifacient drugs, their access to abortion services, and other factors that may lead women in the United States to choose self-induction rather than a medically supervised procedure. The study consisted of interviews with women who reported having self-induced an abortion and was conducted in clinics in Boston, New York, and San Francisco. Additional interviews were conducted in McAllen, Texas, which is near the Mexican border. The surveys found that nearly one-third of women reported knowledge of one or more methods to self-induce abortion, ranging from ingestion of herbs, drugs and other toxic and non-toxic substances to traumatic and non-traumatic physical manipulation. Among those women naming at least one method, more than half knew someone

² Radley, et al., Off-label Prescribing Among Office-Based Physicians, Arch Int Med 2006; 166: 1021–6.

³ Rosing MA, Archbald CD. The Knowledge, Acceptability, and Use of Misoprostol for Self-Induced Medical Abortion in an Urban US Population, J Am Med Women's Assoc 2000; 55 (Suppl. 3): S183-185.

who had used the method. Less than 5% of women reported having themselves attempted abortion self-induction. Factors associated with having self-induced were young age, living in New York or Boston, having more education, being of Latina ethnicity, and reporting a barrier to accessing reproductive health services generally. Few women reported knowing about misoprostol as a method to self-induce abortion (less than 5%). Most of the methods mentioned by women in the study are actually ineffective in causing an abortion.

Jennifer Modino from the Center for Reproductive Rights (CRR) reported on a review that CRR had undertaken in collaboration with the Abortion Access Project to analyze laws that could expose individuals to criminal or civil liability as a result of a woman self-inducing an abortion. That review focused on the legal environment in four states – Illinois, New York, South Carolina and Texas. CRR’s research identified ways that both state governments and the federal government regulate behavior related to abortion, by criminalizing abortion provision under certain circumstances or by proscribing abortion practice. Women who self-induce (and those who might assist them) are exposed to criminal liability in some states by laws pertaining to fetal homicide, abortion, and child abuse. Additionally, civil liability could result from laws involving wrongful death, medical malpractice, reporting requirements for health care providers, child abuse, and federal laws on immigration and prescription drugs. It was noted that there is no uniformity across the states in the definition of abortion, in the penalties for women themselves for inducing an abortion without the involvement of a clinician, or for those who assist a woman in getting information about the medicines needed for self-induction. Therefore, identifying strategies to prevent prosecutions is complex and needs to be situation-specific.

Caitlin Shannon from Gynuity Health Projects gave a global overview of the use of misoprostol by women for abortion. Ms. Shannon summarized evidence from around the world on the safe and efficacious use of misoprostol for self-induction, particularly in the first trimester of pregnancy, and the acceptability of the method by women who have used it.

Two attorneys involved in cases where criminal charges were brought against women for using misoprostol to end their pregnancies gave overviews of those experiences. Denise Regan from the public defender’s office in Massachusetts described the case of a young woman from the Dominican Republic who was between 22 and 25 weeks pregnant. The young woman was unaware that she was so far along in her pregnancy. She took misoprostol, and then went to her local hospital where she gave birth to a live infant. The baby survived for a few days and then died. Homicide charges were filed under an 1840s state statute that criminalizes “the procuring of an illegal miscarriage.” After spending three days in prison, and posting bail, the young woman was released. Following several months of behind-the-scenes advocacy, the indictment was dropped, and one year later the case was closed.

Susan Dunn of the ACLU of South Carolina summarized a case involving the prosecution of an undocumented migrant worker in rural South Carolina who ended her 16-week pregnancy with misoprostol sent to her by her sister in Mexico. After the abortion, the woman buried the fetus in her backyard with the help of a friend. The friend told her employer, who informed the legal authorities. The woman who had ended her pregnancy was arrested and charged with performing an illegal abortion and failure to report a fetal death to a coroner. She was imprisoned for 100 days, with a \$50,000 bail bond required. Ultimately she pled guilty to performing an illegal abortion and was sentenced to time already served.

The lawyers and other advocates involved in these cases highlighted some important lessons learned:

- In the Massachusetts case, linking legal advocates with medical experts to create a defense based on credible scientific evidence was critical. Such evidence contributed to a successful rebuttal of misinformation that had been put forward by the prosecution and disseminated in the press.

- Expert medical testimony served to help focus attention in the courtroom away from the political and emotional issues fanned by the initial media coverage of the case.
- In both cases, procedural delays in the court cases were helpful, as the issue “lost steam” in the press. Advocates developed media talking points in the interim, focusing on the impact of lack of abortion access and stigma.
- It was useful to have a designated spokesperson to communicate with the press rather than numerous advocates providing multiple viewpoints. This spokesperson could give clear and focused information based on talking points vetted by the advocacy community.
- It was critical to know the state and local political context of each case.
 - In Massachusetts, advocates found supporters who knew the lead prosecutor and the Attorney General and used those contacts as well as connections with the Spanish language paper in the town of the defendant. This knowledge helped coordinate the legal and media responses.
 - In South Carolina case, advocates had to take in to account the hostile political climate. South Carolina is at the forefront of a movement to criminalize women for their behavior during pregnancy. For example, a woman refusing a Cesarean section was reported to the Department of Social Services as a case of medical child neglect. South Carolina also has very restrictive abortion laws, has no abortion services beyond 15 weeks, and has laws that treat the fetus as a child after the second trimester. At least five other women in South Carolina have been charged after self-inducing abortions. (One woman pled guilty to involuntary manslaughter; the other cases were dismissed.) Additionally, issues of immigration and racism were salient in this case.

Following the scientific and legal presentations, three advocates shared some initial thoughts on strategies for keeping women out of the courts. Jessica Gonzales of the National Latina Institute for Reproductive Health focused on the important role of community health workers (*promotoras*) in disseminating information to women about a range of reproductive health issues. She suggested that *promotoras* could also inform women how to use misoprostol safely and how to avoid criminal prosecution. Melanie Zurek of the Abortion Access Project stressed the importance of framing self-induction as a public health issue rather than as a criminal issue. This framing opens a discussion to the role that providers and policy makers can and should play in supporting women with unintended pregnancies – access to services, women’s preferences for medical abortion (versus surgical), and for self-care instead of using clinics or hospitals. Susan Yanow from Women on Web reiterated women’s need for clear information about what to say to a doctor and what to do with fetal remains. She stressed that this knowledge would help women avoid prosecution. She further described the coalition that came together around the Massachusetts case as a possible model of a “rapid response team” to deal with media, provide expert medical information, and mobilize legal advocates when a woman faces criminal charges.



Strategic Recommendations

Several key points of intervention with media, the legal and medical communities, the reproductive justice community, and women themselves were discussed. Potential strategies for these interventions were identified.



I. Inform Women about Misoprostol

Key concepts:

- To avoid prosecution and to use misoprostol safely, women need to understand the process of abortion, what to expect, and what information to share/not share should they seek medical care.
- Many women do not know that it is easier and safer to self-induce early in pregnancy and that after the first trimester they will experience more cramping and bleeding and the fetus will be more fully formed.
- Women need to know that misoprostol, if used correctly, is safe and effective, but many other methods of self-induction are ineffective and potentially unsafe.
- Women must be informed that there is a potential for criminal prosecution for self-induction in some states.
- Advocates need to understand the legal implications of informing women about how to safely use misoprostol for self-induction. These legal implications differ depending on state laws.

Strategies:

- Identify the channels where advocates could introduce additional information and clarify what type of information is needed.
- Create a wiki page in multiple languages on how to safely and effectively self-induce with misoprostol, and include information on other methods that are less safe and/or ineffective.
- Expand the knowledge base created by the recent Ibis/Gynuity study, specifically around what women know about misoprostol and where they get this information.
- Build coalitions with networks of *promotoras* in order to provide Latina women with comprehensive information about reproductive health, including the safe use of misoprostol. *Promotoras* could be a particularly effective way to reach undocumented and migrant women.
- Develop a legal analysis for each state that clarifies the legal risks for women who self-induce and for advocates or community health workers who are considering disseminating information on the safe use of misoprostol.



II. Educate the Legal Community about Self-Induction Issues

Key concepts:

- Public defenders are educated to understand self-induction as a criminal justice rather than a public health issue.
- In cases of prosecution, attorneys need access to medical and media experts to support the defense of a woman charged with criminal abortion.

Strategies:

- Create a set of resources for public defenders and other attorneys that includes:
 - Fact sheets on self-induction, including information on misoprostol – “Misoprostol 101”
 - A guidance document on defending self-induction cases, including information on strategies used in other cases that have been successful
 - Other resources, including contact information for helpful medical, legal, and media experts
- Consult with legal experts and advocacy groups to identify the best way to disseminate these new resources.
- Identify which states have laws and political climates that put women at the highest risk for prosecution. Conduct outreach in those states to attorney generals and state advocates to identify strategies to avoid prosecutions.
- Create a “Rapid Response Team” to provide expert legal, medical, and messaging support and consultation as soon as there is knowledge of a prosecution.



III. Educate the Medical Community about Self-Induction Issues

Key concepts:

- Many professionals do not know how to respond when a woman presents at the hospital after attempting to self-induce an abortion. There are few resources available to educate and train the range of health care professionals who may come in contact with cases of misoprostol self-induction.
- Many medical professionals are unaware of the safety and efficacy of misoprostol for abortion.

- The prominence of discussions about “fetal rights” has influenced how health professionals intervene with pregnant women.
- Professionals need education about what constitutes “child abuse” in the case of a pregnant woman.
- Professionals need increased awareness and values clarification about the impact of criminalizing pregnant women.

Strategies:

- Convene panels or submit presentations at professional conferences in order to inform emergency physicians, nurses, and other medical professionals on the issues of self-induction with misoprostol and the legal rights of women who wish to end an unwanted pregnancy.
- Create presentations for the National Association of Community Health Centers (NACHC), using the recent prosecutions as case studies, to inform community health workers about self-induction with misoprostol.
- Contact national and state chapters of the National Association of Social Workers (NASW) to identify venues to educate social workers about the ethical issues related to prosecution of women during pregnancy using recent prosecutions as case studies, to deter unnecessary filing of child abuse reports.



IV. Create Effective Messages and Work Proactively with the Media

Key concepts:

- A proactive media response can raise awareness about why women self-induce and avoid future prosecutions.
- “Personal” and “private” have new meaning in the public discourse around pregnant women. New laws and debates challenge women’s right to certain choices when they are pregnant.
- Messaging should factor in the issues of immigration, race and class. Women without access to clinical care for abortion in the US are disproportionately low-income women of color and/or undocumented.
- Messaging about self-induction should also raise awareness about barriers women seeking abortion often face in spite of the legal status of abortion.
- Language is critical to how the debate is framed. The term “self-induction” is itself problematic. To some the term implies using unsafe methods, including sharp objects or caustic liquids, while to others it implies the safe use of misoprostol without a clinician. “Taking matters into one’s own hands” can be understood as either self-care or as a vigilante action that diverges from accepted social norms. “Taking charge of your own health care,” “Early safe self-abortion care” and “Abortion self-care” might be helpful phrasing for reframing the issue.

- It is important to respect those women who, for cultural or personal reasons, want to control their abortions outside of the health care system. How can this practice be reframed? Can self-induction be located within the spectrum of home use of misoprostol after taking mifepristone at a clinic? Can self-induction be placed within the long tradition of women's self care, at a time when there is increased medicalization of most health care?
- It is critical to highlight that stigma and lack of access to services due to geography and/or finances may drive some women to choose self-induction when they would prefer to involve a clinician. Caution with using the word "choice" in this context is important; we don't know if women who self-induce are making an affirmative choice, an uninformed choice, or a desperate choice.
- An effective media strategy is needed that can overcome the stigmatization and misogyny that contribute to the prosecution of pregnant women, and honors women as agents of their own health care rather than as victims.
- Headlines about prosecutions for self-induction offer the opportunity to create and disseminate good messages that shift the frame of the debate.

Strategies:

- Test messages that place self-induction in the context of both lack of access and culturally congruent self-care in the communities most likely to have access to misoprostol for abortion.
- Publish data on safe self-induction, with accompanying editorials when possible that reframe the issue and are women-centered.
- Convene focus groups to find the best language for describing "self-induction."
- Work with Spanish language media to place sympathetic stories about women who self-induce with misoprostol. Explore other media venues to reach women from other language groups in the Caribbean who use misoprostol (e.g. Haitian Creole).
- Collaborate with allies such as National Advocates for Pregnant Women to create messages that support the interests and rights of pregnant women, whether they have wanted or unwanted pregnancies.

V. Monitor Legislative Initiatives and Develop Pro-Active Policy Strategies

Key concepts:

- When an individual prosecution occurs, it is difficult to do policy work in the context of criminal case. Proactive strategies to avoid prosecution are required.

Strategies:

- In key states, strengthen the protection of women from fetal homicide laws as part of repealing old abortion language. This would involve removing language in homicide laws that can be used against women who self-induce. (Massachusetts is one of the states where this strategy is moving forward.)
- Monitor and oppose legislation introduced at the state or federal level that furthers the concept of fetal personhood.
- Monitor and oppose any legislation that violates the rights of pregnant women, and develop alliances with groups that monitor the rights of pregnant women, including women in prison and those who seek vaginal births or home births against medical advice. For example, a coalition formed in opposition to a bill introduced in Utah that would have made women who were deemed to have contributed to a miscarried pregnancy liable to criminal prosecution.
- Use national meetings to educate legislators and explore how to change state laws that criminalize pregnant women (for example, at the National Conference of State Legislators).



VI. Clarify Internal Values within Reproductive Justice Organizations

Key concepts:

- There is ambivalence within the reproductive justice community, especially among health care providers, about women taking full control of the abortion experience.
- There is a lot of concern about women who self-induce after the first trimester. These concerns include possible medical complications, the impact on the woman of seeing a formed fetus or having a live birth, and the political impact of how these later abortions may be used by the anti-abortion movement.
- Our community needs to clarify its values about self-care related to pregnancy, abortion, and childbirth.

Strategies:

- Develop training materials and/or convene panels and meetings to explore our values and ethics around self-care and self-induction.
- Raise awareness about the existence, safety and legality of self-induction at key national conferences and peer-reviewed journals



Summary

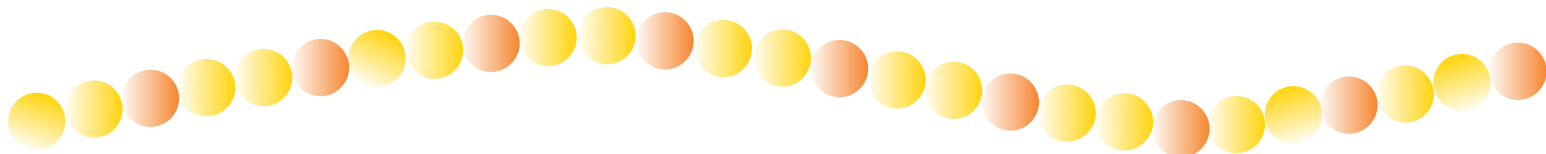
The August 2009 meeting convened by Gynuity Health Projects and the Reproductive Health Technologies Project generated creative strategies to reduce the possibility of criminal prosecution of women who self-induce an abortion. These strategies include preventing prosecutions through educational interventions with the medical and legal communities and with women themselves. The meeting identified key concepts to create proactive messaging and advocacy strategies, and the need to increase awareness within the reproductive rights community itself about self-induction in the U.S. with misoprostol.

Strategies for effectively responding when women are prosecuted were also developed, and the existing expertise of meeting participants will be mobilized in a coordinated response should another woman be prosecuted for self-inducing an abortion.



Conference Participants

Betsy Armstrong, Princeton University
Hillary Bracken, Gynuity Health Projects
Lisa M. Brown, National Abortion Federation
Cassandra Burrows, National Advocates for Pregnant Women
Anne Davis, Columbia University Medical Center
Susan K. Dunn, American Civil Liberties Union, South Carolina
Marji Gold, Montefiore Medical Center
Jessica Gonzalez-Rojas, National Latina Institute for Reproductive Health
Daniel Grossman, Ibis Reproductive Health
Angela Hooton, National Institute for Reproductive Health
Alexa Kolbi-Molinas, Reproductive Freedom Project, American Civil Liberties Union
Jennifer Mondino, Center for Reproductive Rights
Maureen Paul, Planned Parenthood of New York City
Denice Regan, Committee for Public Counsel Services, Massachusetts
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