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Authors
Becker, Andréa
Biggs, M Antonia
Ahlbach, Chris
et al.

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Medicalization as a Social Good? Lay Perceptions about Self-Managed Abortion, Legality, and Criminality

Abstract:
Interest in ending a pregnancy outside the formal healthcare sector, also known as self-managed abortion (SMA), is expected to increase in the wake of the overturning of *Roe v Wade*. However, there is little social scientific research on public perceptions of SMA, particularly regarding opinions around legality and criminalization. We seek to fill this gap in this paper by drawing on 54 in-depth interviews with a mixed-gender sample (men, women, nonbinary) recruited from eight U.S. states with the most restrictive abortion laws. Our analysis finds that most participants believed that SMA should not be illegal or criminalized largely due to two overarching justifications: (1) due to a belief that people should have a right to their own bodily autonomy even in the case of potential self-harm and (2) the belief that criminalizing SMA would be against public health goals. Further, many are concerned that making SMA illegal will lead to unfair or even cruel punishment. However, an underlying thread connecting both support and opposition to SMA legality and criminalization is the assumption that SMA is inherently harmful or dangerous, indicating a lack of lay awareness about the safety and efficacy of SMA using medication abortion pills. These findings indicate the power of medicalization and a valuing of medicalization as a social good, as many believe that behaviors occurring within the healthcare system are inherently safer, more justified, and more moral.

Key Words: abortion, medical sociology, medicalization, qualitative methods, reproductive health, reproductive rights

Declaration of Competing Interests: The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Introduction

Social scientists have long examined the role of medicine in drawing moral boundaries around human behaviors via medicalization. Medicalization refers to the process by which increasing aspects of ordinary life fall under medical jurisdiction through the application of a medical term and associated treatment plan (Bell & Figert, 2012; Conrad, 1992; Zola, 1972). In defining "medicalization," other scholars emphasize the salience of biomedical actors, discourses, and practices in addressing social problems (Halfmann, 2012a). Researchers have utilized medicalization to study a wide range of topics, from mental illness and addiction to hyperactivity, birth, and the process of death (Brubaker & Dillaway, 2009; Buchbinder, 2021; Conrad & Schneider, 1980; Metzl, 2010). Abortion in particular represents a complex medicalization process that finds itself at the nexus of medicine, the law, gender, poverty, and racialization (Beisel & Kay, 2004; Halfmann, 2019; Luker, 1984; Oberman, 2018; Shepherd & Turner, 2018). And yet, the way the general public understands the medicalization of abortion has received less scholarly attention.

While abortion in the United States began as a practice performed by a range of lay healers and midwives, key structural, medical, and legal forces reconfigured abortion as a procedure to be provided within the formal healthcare system. First, the professionalization of medicine in the late 19th century delineated abortion as a practice performed solely by physicians (Mohr, 1978). This cultural framework of medicalized abortion—as in, abortion care provided by biomedical actors—was further strengthened in the mid-20th century by the legal tenets of *Roe*

v Wade, which itself can be understood as a medicalization project (Abrams, 2012). Indeed, the Court's summary of *Roe* describes abortion as a decision that "must be left to the medical judgment of the pregnant woman's attending physician," (*Roe v Wade, 1972 a*). The case throughout emphasizes "the right of the physician to administer medical treatment," and rather than centering the right of the pregnant person to choose to have an abortion, states that "the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." Subsequent decisions following *Roe* likewise emphasize the physician's role in determining a pregnancy's outcome, including *Colaucti v. Franklin (1979)*, which states "Roe stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out." The notion that medicalized abortion fell chiefly under the jurisdiction of doctors also proliferated in cultural discourses about the topic, including in public messaging about abortion as "a decision between a woman and her doctor" as well as in discussions of dangerous "back-alley abortions" and unskilled "abortionists" (C. E. Joffe, 1995).

As such, abortion in the cultural imaginary is primarily thought of as a medical decision made in conjunction with a physician in a clinic. Scholars have written on the overly burdensome restrictions placed on abortion within medicine and the law—specifically the treatment of abortion as "exceptional" (C. Joffe & Weitz, 2003) Even medication abortions, which usually involve taking a combination of mifepristone and misoprostol medications, are heavily regulated by biomedical actors, such as pharmaceutical companies, the U.S. Food and Drug Administration (FDA), and certified providers. The FDA continues to impose medically unjustified and unnecessary barriers to the provision of medication abortion, and the manufacturer of mifepristone has yet to file for over-the-counter status (Kaye et al., 2021). This persists despite

new research that demonstrates these medications are safe and that people can use these medications to safely and effectively end their pregnancies on their own outside of the formal healthcare system, a process referred to as self-managed abortion (SMA) (Moseson, Bullard, et al., 2020). SMA refers to an attempt to end one's own pregnancy without the assistance of a medical provider, and can include using abortion medications or other methods, such as blunt force, taking herbs, drugs, and drinking large amounts of alcohol.

Analyzing SMA reveals that medicalization is not a linear process and, in fact, behaviors can be *de*medicalized. Demedicalization is often understood by scholars as the reverse of medicalization, meaning it is reconstituted as "a problem that no longer retains its medical definition"(Conrad, 1992, p. 224). Moreover, medicalization occurs in complicated *degrees* rather than in a binary fashion, such that processes or behaviors can become more or less medicalized by degrees (Conrad, 2013, p. 201); medicalization and demedicalization can also occur in tandem, as Halfmann(2012b) has been demonstrated with abortion specifically. The current legislative landscape pertaining to U.S. abortion policy is a motivating force toward demedicalization, as the overturning of *Roe v Wade* has rendered abortion care within the formal healthcare system widely inaccessible to many, and in some states has largely transformed abortion into a crime. Given widespread bans across the U.S., in tandem with increased demand for abortion care in states that have maintained access to abortion, increasing proportions of pregnant people may turn to SMA. In the U.S., it is estimated that 7% of women will attempt SMA in their lifetime (L. Ralph et al., 2020a), and one in three people seeking abortion at a facility would consider SMA if unable to obtain a facility-based abortion (Ralph et al., 2022). Research suggests that demand for accessing medication abortion pills online is increasing in the U.S. (Aiken et al., 2021, 2022; McCann, 2023)) Furthermore since the FDA lifted the in-person

dispensing requirement for these medications, there has been an expansion in the availability of telehealth medication abortion services where patients interact with a clinician remotely and receive the medications in the mail (Upadhyay et al., 2020). Such trends are likely evolving rapidly given the recent decision in *Dobbs v. Jackson Women's Health Organization (2022)* (henceforward *Dobbs*) to eliminate federal protections on abortion rights. In a global context, the practice of community-based distribution of medications for SMA has existed for decades, including pregnant people in Latin America procuring medications via *acompañamiento* networks run by non-medical activists while abortion within the formal healthcare system has been heavily restricted (Braine & Velarde, 2022; Ferguson & Scott, 2020).

Further complicating the use of a medicalization framework to analyze SMA is the interrelated term *pharmaceuticalization*. Pharmaceuticalization is deemed a subset of medicalization and refers to the increasing use of pharmaceuticals to treat a range of human problems (Abraham, 2010; S. E. Bell & Figert, 2012; Conrad, 2013). While there are various SMA methods available that range in their safety, SMA using abortion medication(s)—misoprostol with or without mifepristone—is now widely regarded as highly safe and effective (World Health Organization, 2022). SMA through the use of medications is more demedicalized than is medication or procedural abortion procured within the formal healthcare system, though it still fundamentally features pharmaceuticals. The theoretical murkiness regarding self-managed medication abortion exemplifies the elastic nature of these terms, as well as the power of abortion as a case study to advance novel terminology/frameworks within medical sociology.

Very little is known about how the public views SMA and particularly whether SMA should be criminalized. One recent study indicates a widespread lack of information regarding the safety and efficacy of SMA with medications, and in fact a continued conflation of SMA with

unsafe methods such as “coat hanger abortions,” a phrase used culturally to refer to the larger practice of doing unsafe things to abort a pregnancy (Schroeder et al., forthcoming). Now that abortion rights are no longer protected at the federal level, understanding lay perceptions of SMA—particularly through the use of medications—is an important consideration for policy makers and health care providers. To fill these research gaps, this paper investigates lay attitudes towards toward SMA legality and criminalization through in-depth qualitative interviews with a gender diverse sample that includes cisgender men, cisgender women, and nonbinary and trans people. This paper examines lay perceptions of SMA in combination with punishment for abortion among people living in states that heavily restrict abortion. In the process, we utilize SMA as a case for exploring broader questions regarding medicalization, morality, and legal punishmentwhich are likely of interest to scholars of the social science of medicine .

SMA, The Law, and Public Opinion

While U.S. public support for abortion legality has been tracked for decades, with increased scrutiny in the months following the *Dobbs v. Jackson* decision (Nadeem, 2022), various gaps in SMA attitudes remain. A national, exploratory study of over 7,000 women in 2017 found that about 60% did not support outlawing SMA, including 55% of those who lived in a state that criminalized SMA (Raifman et al., 2022). This research found that people who were older, had completed a higher level of education, and did not attend religious services were more likely to believe that SMA should not be against the law. This study also found that one in five participants were unsure whether they believed that SMA should be against the law, and 8% entered a text response in an “Other” response category that offered considerations related to the safety, morality, accountability, and criminalization of SMA. The authors noted that further exploration into these attitudes, how they developed, and how people conceptualize SMA as it

relates to state power and punishment is merited. Their sample also did not include men. How attitudes differ by whether people use abortion pills, force, or other methods to end their own pregnancies or whether people support punishment are also under-researched. In a more recent survey of 7,325 people, 1/3 of respondents believed SMA should be legal and being assigned male at birth was associated with agreeing SMA with pills should be illegal (Biggs et al., 2024). About a quarter of respondents were unsure about whether SMA should be legal and many who support abortion legality believe SMA should be illegal.

Although topical research on SMA from the U.S. is limited, research from countries where abortions are banned and SMA is widely practiced can provide some insight. In Chile, for example, a country that bans nearly all abortion with very few limited exceptions, a mixed methods study found that medical professionals did not favor reporting patients to law enforcement for suspected or attempted abortion, noting feelings of conflict between their ethical obligations to protect patients and the legal requirement to report them (Ramm et al., 2020). Before 1973, when the federal right to abortion was not protected in the U.S., pregnant people were criminalized for allegedly ending their pregnancies, as were those who assisted them (Reagan, 2022). Pre-*Dobbs*, while only three states explicitly banned SMA in the U.S., criminal laws meant to address child abuse, medical licensing, murder and homicide, and other laws have long been misused to prosecute individuals for suspected SMA(Goodwin, 2020; If/When/How, 2019; Paltrow & Flavin, 2013). One analysis identified 61 people from 2000-2020 that were criminally investigated or arrested for allegedly ending their own pregnancy or for helping someone else do so (Huss et al., 2022). This analysis exposed how the state maintains an interest in punishing those who assert agency over their own reproduction in the face of state-imposed barriers to abortion care. Although the American College of Obstetricians and Gynecologists

(ACOG) has explicitly opposed the criminalization of SMA (American College of Obstetricians and Gynecologists, n.d.) in the wake of the *Dobbs v Jackson* decision, state legislatures are preparing to pass new and/or misuse existing laws to criminalize pregnant people for SMA (Ali, 2022; Miller & Hollingsworth, 2022), making the public's perceptions of SMA law and criminalization even more significant.

Methods

Recruitment and Interview Guide

Using Facebook advertisements, we recruited 54 participants of various genders (cisgender women, cisgender men, and trans and nonbinary individuals), ages, education levels, and religious ideologies. We utilized purposive sampling to approximate a diverse study population. Eligibility criteria also included the ability to speak English and access to a telephone to complete the interview. Facebook ads included a link to a Qualtrics survey where participants entered their demographic and contact information to assess eligibility. Demographic data collected included gender identity, age, religion, highest level of education attained, race and ethnicity, and state of residence. Recruitment for this study was conducted in two phases to assure recruitment across genders. The first recruited 25 people assigned male at birth (AMAB) (all those recruited in this wave identified as cisgender men), aged 18-65, who lived in one of six states with the most restrictive abortion laws before *Dobbs* according to the Guttmacher Institute (Nash, 2018). These included Arkansas, Indiana, Louisiana, Mississippi, Missouri, and South Dakota.

In the second phase, we recruited 29 people assigned female at birth (AFAB), (this included people who identified as cisgender women, as well as one trans man, and one AFAB non-binary individual), aged 18-45, and whom lived in states that had a history of investigating

or arresting someone for SMA, which included the previous states in addition to Idaho and South Carolina. As of January 2024, all eight recruitment states have fully banned abortion with very limited exceptions (Guttmacher Institute, 2024) 2). Our study team contacted eligible participants to obtain verbal informed consent to participate in the study, and all interviews were conducted via phone; the third author, a man, conducted all interviews with cis-gender men in the first phase; second phase interviews were conducted by the third author and the fourth author, a woman. Interviews averaged 73 minutes, and we offered participants a $50 gift card to thank them for their participation. Interviews were conducted from February 2020 through December 2020. This study was reviewed by the Western Institutional Review Board (WIRB)and was determined to be exempt as the research only includes interactions involving interview procedures and there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data, including the use of pseudonyms.

Our interview guide was semi-structured and included open-ended questions about abortion attitudes and experiences across the following sections: terminology, general attitudes, personal experiences, attitudes about access, SMA attitudes, and Roe v. Wade attitudes. While the interview guides for AMAB and AFAB respondents were generally similar, the AMAB guide included questions about attitudes toward abortion, and the AFAB guide included additional probes about SMA. This paper focuses on themes related to the legality and criminalization of SMA. We designed the interview guide to capture attitudes about SMA (which we define as all abortion occurring outside of the formal healthcare system) without biasing their responses toward medication abortion. For instance, in the abortion terminology question we first asked what terms they have heard and which terms they prefer (e.g., “People have different ways to describe ending a pregnancy. What different phrases have you heard?” “What does the term

"abortion" mean to you?"). In the SMA section, we never specifically referred to the term "self-managed abortion (SMA)", but rather we began with "Now I have some questions about people who end their pregnancy without the help of a medical provider. Have you heard about that? What do you think about that?". We then followed up with questions about how they view differences between someone ending a pregnancy on their own versus with a medical provider, asked about the different methods they are familiar with, and asked whether they view ending a pregnancy on one's own as safe. After these exploratory probes, we then asked respondents "have you ever heard about a medication that can be used to terminate a pregnancy?" and explained the following information before probing further about their attitudes regarding using medications obtained outside the formal healthcare sector:

> "When people get an abortion at a clinic, they may have a procedure in the clinic, or they may receive pills that they can use to have their abortion at home. While some people may get their abortion pills from a clinic, other people may get these same abortion pills by ordering them online."

Using an interview guide that first asks general abortion and SMA attitudes and then probes about SMA with medications allowed us to glean the degree of prior knowledge participants held about abortion and SMA as well as the attitudes they hold when presented with the definition of self-managed medication abortion. Of note, while we strive to use gender inclusive language whenever possible, respondents generally discussed their beliefs about people who have abortions with the assumption that they are all women. When we are reporting on respondent attitudes of this nature, we use the term "women," otherwise we use gender inclusive language.

Interviewee Sample

As Table 1 shows, 50% (n=27) of our sample identified as cis women, 46% (n=25) as cis men, and 4% as either nonbinary (n=1) or a trans man (n=1). The sample was spread across

various age groups as well as recruitment states. Additionally, 59% of participants were white, 20% Black, 7% mixed race, 4% Asian, 4% Native American or American Indian, and 6% identified with some other race or ethnicity. Ages ranged from 18 to 48 with an average of 32. Most respondents live in Indiana, Louisiana, or Arkansas. Further, 19% of the sample identified as Hispanic or Latinx and the majority of the sample identified religiously as Christian, Atheist/Agnostic/None, Catholic, or Baptist, with smaller proportions of Jewish or Muslim (2% and 4%, respectively). Additionally, among those assigned female at birth: the majority (68%) had one or more children, and 28% reported previously having an abortion. Although these latter demographics are not featured in the analysis, they add critical context about our sample.

Analysis

We audio-recorded and transcribed all interviews verbatim using a professional transcription service, and we reviewed transcripts for accuracy prior to analysis. Four of the study authors initially fine-coded one interview. Taking all fine codes, through consensus we discarded duplicate and redundant codes and dispensed with those deemed not germane to the research questions. We then developed the codebook by thematically organizing and distilling this first set of agreed-upon codes into a coherent schema that sought to group all relevant themes into four families of codes: Abortion Attitudes, Social Forces, SMA Attitudes, and Other Themes. The resulting codebook was made up of these four families, within which we had fifteen themes (examples include: stigma, autonomy, hypothetical acceptability, medicalization), and within those we identified several sub-themes. These resulted in a total of 34 individual codes with communally-defined code definitions. The interviewers independently applied these

codes to three identical transcripts before meeting to discuss their individual coding strategies and to identify and correct any inconsistencies in coding practices before applying the resulting thematic codes to all interviews in Dedoose software.Redundancies and conflicts in coding definitions were resolved through discussion until we reached consensus (Pleasure et al., 2024). After codes were applied to all transcripts, we then conducted a thorough thematic analysis within and between codes to investigate emergent themes in the study (Nowell et al., 2017). For this paper, we focus on analysis of codes that relate to SMA legality and criminalization.

Results

Our analysis reveals a split between support for and opposition to SMA legality and criminalization, with most participants believing that SMA should *not* be illegal or criminalized. However, while the reasonings behind such beliefs varied, the underlying assumption among both groups is that SMA is inherently dangerous or harmful for either an individual or for society. Moreover there were various gaps in participant knowledge surrounding abortion, SMA methods, safety, and legality and both groups held false beliefs about the legal landscape surrounding SMA. As such, while we sought to parse apart beliefs regarding SMA in general and SMA with medication in particular, many were unaware of the differences, and their perceptions often therefore speak to the concept of SMA in general. Our findings also speak to a public valuing of abortion when a medical provider is involved, indicating a more general valuing of medicalization which we refer to as *medicalization as a social good*, or beliefs that behaviors are safer, more justified, or more moral when occurring within the formal healthcare system. These findings add important insights about lay perceptions pertaining to the intersection between the medicalization and criminalization. In this section, we will cover the findings from our analysis

across three primary themes: support for SMA legality, opposition to SMA legality, as well as intersections of belief systems surrounding criminalization and punishment.

Support for SMA being legal and not criminalized

Most participants believed that SMA should be legal and should not criminalized largely due to a belief that people should have an inherent right to their own bodily autonomy. Some also believed that criminalizing SMA would be against public health goals. Most participants were not aware that people in the U.S. have been prosecuted for allegedly attempting to end their own pregnancy or that SMA is sometimes legislated at the state level. Furthermore, findings indicate that lay perceptions of SMA perceive it as a harmful behavior, and many seem to value and trust a medicalized model of abortion as compared to SMA with medications. This is particularly stark in the case of medication abortion, as the regimen involves an identical medication process with the main difference being the affirmation of medical eligibility through interacting with a medical provider and sourcing the medicines from formal healthcare supply chains.

Bodily autonomy

Respondents did not typically support making SMA illegal. They held convictions that people should be allowed to make decisions about their own bodies, and some indicated they believed the government should uphold people's bodily autonomy. Carolyn, a 22-year-old white cis woman in Louisiana, believes SMA is dangerous and a "last ditch option" yet said she opposes making it illegal because "it's not my body, so not my choice." Some participants viewed making SMA illegal as a component of broader political goals to suppress civil rights and free will in general, particularly among women's rights. When Gideon, a 34-year-old white cis man from Louisiana was asked what he thinks about people being imprisoned for SMA, he

responded: “They [people who are prosecuted] should be able to sue the police department under civil rights grounds because access to abortion should not be dependent on a medical professional.”

Many participants drew comparisons between SMA and acts of self-harm that ranged in severity from extracting one’s own tooth to suicide, acts that they believed are not and should not be criminalized. This indicates lay perceptions of SMA as an unsafe behavior, but one that should not be under the purview of the law. For instance, Isabel, a 37-year-old Black cis woman from Mississippi, relayed how her patients who are suicidal or participate in self-harm behaviors are offered assistance rather than punishment. Similarly, when Kendra, a 36-year-old Black cis woman from South Carolina was asked why she thought SMA should not be against the law, she responded “It's just their body. If that's what they want to do, then that's what they should be able to do.” Max, a 23-year-old mixed race (Asian and White) cis man in Missouri, similarly said banning SMA and abortion “violates their own bodily autonomy to decide what to do with their own body and to make their own decisions.” Further, the comparison to self-harm elucidates a nuance of bodily autonomy whereby participants largely felt that actions that exclusively impact one’s own body, even if harmful, should be free of punishment or state oversight. Tyler, 40-year-old Latino cis man from Louisiana, connected the themes of legality of SMA, bodily autonomy, and threats of punishment, saying:

> But, I think if someone’s going to call the police, or arrest them, or jail them for doing that, that’s not how that should be. It should not be against the law. Again, this is – once you start putting laws over people’s bodies, you know, that’s just – no one has the right to say what someone else should do with their own body.

In fact, some people opposed criminalizing SMA because they believed that the physical harm of SMA rendered further punishment unnecessary. As Patricia, a 48-year-old white cis

woman from South Carolina explained, “You're really kind of harming yourself. You're assaulting yourself… I don't think you can really have a penalty for doing that to yourself. That's where it gets kind of weird.” Similarly, Alan, a 47-year-old white cis man from Missouri, extended the bodily autonomy argument to situations where someone may become a danger to themselves, saying: “I really don’t like the idea of the state legislating what those people can do with their body. I’m also against the state denying women who are doing it herself even if that person is in danger, because I’m all about free will.”

Participants explored the moral right of an individual to control their own body and saw SMA as an example of self-determination despite common beliefs that SMA might be unsafe. People therefore contended that the right to bodily autonomy supersedes criminalization as a way of addressing safety concerns. This could indicate broader beliefs about demedicalization and punishment, whereby individuals should have the right to make personal decisions about their own treatment for a condition as a form of bodily autonomy, even if it has the potential for harm.

Harm reduction

Distinct from views based on bodily autonomy, some participants argued that SMA should be legal by using public health arguments that related to harm reduction and health care access. Participants often argued that making SMA illegal would not eliminate SMA, and that criminalization could have more dangerous consequences by encouraging people to keep SMA secret and avoid subsequent medical care that may be necessitated as a result of the SMA attempt. For example, Laura, a 27-year-old white cis woman from Idaho, described a potential danger that could arise if the legal status of SMA were to discourage pregnant people from seeking medical help after a complication from SMA:

> In reality, I don't think it [criminalization] would help much at all. I think it would just make women more secretive. And if they have complications that are concerning, then they might be more unlikely to seek help and could have even worse complications. Or they could even die depending on what's happening.

Similarly, Susana, a 44-year-old Latina, multi-racial cis woman from Idaho, expressed that making SMA illegal would increase the number of unsafe (self-managed) abortions by pushing it further underground:

> You're just going to make it where women in these situations will either go to another state where it is allowed, or they're going to do something dangerous and stupid to themselves. I don't know ... history says that making it a law, or illegal…. I think that making it against the law is just going to make it an underground. I don't think it's going to stop anything.

Elaborating on this theme, Lindsey, a 38-year-old white cis woman from Mississippi, compared the effects of criminalizing SMA to criminalizing drugs, describing how people still use drugs even though they may be dangerous and illegal:

> So, it's illegal to take drugs, and there's a lot of people sitting in jail because they choose to take drugs. But it's not actually stopping anybody from taking drugs. It's not making things safer. It's just putting more people in jail.

Further, some viewed a person attempting SMA as "having no other choice," or being "desperate" given that abortion is inaccessible to many people in the U.S. Some people also believed it inappropriate to punish someone who was forced into that experience. Emma, a 31-year-old American Indian and Hispanic cis woman in Arkansas, said the following. Of note, they repeat a common pro-choice messaging that abortion bans "end safe abortion," (Valenti, 2014).

> If someone needs to have an abortion, you're either putting them in danger by making it difficult for the patient that needs one or if a person's going to have an abortion because they truly don't want the baby because they're too young or whatever. They're so desperate, they're going to do it. You're basically ending safe abortion.

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We asked participants to describe how they felt about people taking the same abortion pills that many people obtain from a clinic but instead were obtained online without the help of a medical provider. Many participants--in particular those who were unaware of medication abortion pills or who were unsupportive of abortion access in general—identified several concerns that indicated greater trust in medicalized models of care over self-managed use of medication abortion. Participants shared related but disparate concerns that they weighed against their justification for why they ultimately believed that SMA via medication abortion pills should be legal: the medication procured outside a formal healthcare setting could be ineffective, dangerous, or require professional supervision to be safe. Despite their concerns about the safety of procuring medications online, many participants still did not support making SMA with medication abortion pills illegal. Participants instead noted the need for a helpline to call for advice should a pregnant person seeking SMA have questions or concerns, a resource which they believed would increase the safety of SMA via medication abortion pills. Together, these findings indicate a simultaneous valuing and trust of medicalized models of care alongside an opposition toward punishing those who engage in demedicalized acts.

Opposition to SMA being legal

The few participants who were proponents of making SMA illegal generally had three prevailing reasons for their beliefs: (1) they thought that all abortions should be illegal—both in-clinic and outside of a clinic; (2) they believed that all SMA was unsafe and should therefore be prohibited; and (3) they conceptualized acting alone to end a pregnancy as a less moral option since it lacked medical legitimacy when compared to ending the pregnancy under the authority of a licensed clinician. Altogether, these beliefs are a manifestation of the value system of *medicalization as a social good*, or behaviors considered to be inherently safer, more legitimate,

and more morally acceptable when performed by a clinician. Of note, beliefs about legality are separate from beliefs about criminality and punishment, which we discuss in a later section.

Law should oppose unsafe activities

Some participants viewed SMA, and abortion more broadly, as bad for society. They therefore supported SMA being illegal due to prevailing beliefs that the law should prohibit dangerous behaviors. For instance, Kendra, the 36-year-old Black cis woman from South Carolina who had contradictory feelings on SMA legality throughout the course of her interview, made an analogy to why drunk driving was made illegal. Of note, the ambivalence she is displaying regarding legality and criminalization might be shaped by the strong anti-carceral discourses that were salient at the time of the interview in the summer of 2020.

> That's my take on it [SMA], it's dangerous, so that right there, it should be illegal because you're putting yourself at risk, let alone the unborn child. And what if, when you do try to end your own pregnancy, it doesn't work? What, are you going to keep trying until it works? It's dangerous. That's like me going out here driving a car mentally impaired or physically impaired, drinking and driving. It's dangerous.

As this quote indicates, those who believe the law is intended to prevent danger and harm extend such beliefs to SMA. Echoing these sentiments, Michael, a 30-year-old white cis man from Missouri, discussed how SMA being illegal would create a safer society:

> There's more suffering and more risk of adverse health impact by ending your own pregnancy. But, yeah, I think that that could easily be categorized as a net negative on society and therefore justifiably prohibited.

As this excerpt reveals, some participants believe that criminalization would prevent SMA altogether and believed the law has a responsibility to prevent behaviors that negatively impact society. This is in a sharp contrast to the public health justification of those who

supported SMA being legal in the previous section due to concerns that criminalization would "drive SMA underground."

In addition to concerns about reducing societal harm, some believed that it should be illegal to have an abortion with medication abortion pills acquired outside of a medical setting due to concerns that the pills could be unsafe or ineffective. In these arguments, some pointed to laws that prohibit use of any prescription medication without prescription. As such, whether one is supportive or not of SMA legality, participants' trust in the medical establishment leads to an assumption that using medication abortion pills without medical assistance would cause undue harm.

As this section demonstrates, people in our study used public health arguments to both support the views that SMA should be legal and illegal. While some argued that making SMA illegal would make it more unsafe and lead to greater harm, the latter group believed that SMA is intrinsically unsafe and should therefore be illegal to quell a potentially dangerous behavior.

Morality or acceptability through medicalization

Across interviews, we encountered the suggestion that SMA was less moral or a worse decision than a facility-based abortion This was a belief held both by those who are supportive of and those who oppose abortion rights. Many believed this because they perceived SMA as less safe, or because SMA bypasses a clinician who could serve to ensure the pregnant person is making the right decision and following the law. For example, Olivia, a 44-year-old Black cis woman in South Carolina who identifies as pro-life and referred to abortion as murder, described her belief in the necessity of medical support in making such a decision,

> I don't think that was the wisest choice to do it [abortion] themselves. I think if they had did it medically, it would have been more responsible on their parts... It's

> selfish...Because you took it upon yourself to do it yourself. You didn't go to a physician … and let them know that… you're clear-minded on the decision.

As this quote indicates with the mention of responsibility and selfishness, an abortion outside of the healthcare system is often viewed as less moral and less acceptable. Moreover, this participant believes a physician's supervision and approval is needed to assure that the abortion is justified, indicating a valuing of medicalization. Similarly, Alice, a 35-year-old white cis woman in Louisiana who is "strongly pro-life", said abortion with a medical provider is different because "when you're ending it on your own, you're taking more of an active role." She elaborated saying, "A woman who goes into an abortion provider… she consented to the abortion but she's not the one who did something." In Alice's belief system, abortion is morally wrong, but the provider absorbs some of the moral burden of abortion from a patient who doesn't know better due to living in "a bad culture that does not understand." Of note, unlike Alice, most participants did not refer to the immorality of the abortion provider, even among those who oppose abortion access.

Eddy, 39-year-old white cis man in Indiana who also identifies as pro-life said, "If they're deciding to end their own pregnancy but they really didn't get an opinion of like a medical professional, I'd kind of have to raise an eyebrow at something like that." Elaborating on this, Eddy said that while he doesn't believe in abortion rights, he trusts doctors, and doctors should be the ones to decide when someone should have an abortion. He said:

> They at least would understand specifically how the human body works and how it forms... I'm very much in support of the idea of somebody deciding to do something like this, for them actually having a medical professional. I mean it would be like me deciding that, um, my tooth hurts and I'm going to perform my own extraction. I mean I might be able to do it, but I think I'd be much better actually having a dentist do it.

Additionally, some participants deemed medical evaluation and care necessary to ensure that the pregnant person is acting in their own best interest. Alejandro, a 22-year-old Latino cis man from Indiana, who was very supportive of abortion legality and access in general, felt that SMA constituted immoral self-harm.

> I think it should be against the law because depending on where you live, there's places [abortion clinics] that are there to support you...Because that's [SMA] different than having an abortion. It's purposefully creating a situation which you abort your own baby…. I think it is a little evil natured… if you care about an abortion more than your own self, then that's not a good thing.

As this quote indicates, while this participant believed that abortion should be legal, she perceived it as "evil natured" when it is done outside of the healthcare system. Simultaneously, this participant thought SMA should be legal if it could be done safely because in that circumstance, legality could prevent harm to the person and larger community. However, most participants did not have differing views about SMA legality by method of termination (i.e., medication, herbs etc.), which once more indicates lack of public knowledge about SMA and safety, particularly the demonstrated safety and efficacy of SMA via medications.

These quotes reveal an implicit trust in existing professional medical and legal infrastructures as valid sources of moral authority to help moderate peoples' sexual and reproductive lives. Some participants also expressed a desire for an abortion provider to be involved in the decision to end a pregnancy, as they believed this would absolve a patient of the moral transgression that would otherwise occur if the patient attempted to end a pregnancy on their own.

The trust in the legal system to dictate morality was also brought up by John, a 35-year-old white cis man from Louisiana who considered SMA but not "abortion with a doctor" to be murder, entrusting the legal and medical system to advise his view about the morality of SMA:

> Interviewer: You said ending your own pregnancy is murder. Do you think the same thing about an abortion with a doctor?
>
> Respondent: The doctor is not going to go through with it if it was illegal. The, the doctor wouldn't even be in the picture if it was illegal, and I mean the doctor is not trying to lose his, uh, what they call it, certification if there was any kind of hope, any kind of thought that it was illegal.

His use of the word "murder" specifically points to the law as the reigning moral structure, drawing a direct line from legality to the legitimate taking of life. He went on to say that people who end a pregnancy "illegally" should be charged with second degree murder. This linguistic clarification is important to consider how peoples' understanding of existing legal definitions intersect with their interpretations of moral behavior.

Similarly, Mason, a 22-year-old white cis man from Indiana, hinted at the legal definition of murder as he described a clear moral delineation between SMA and a clinic-based abortion:

> For an unborn child to be forcibly killed inside the womb outside of a medical practice, I think it, definitely – that's murderous intent on whoever performs it, you know, in the illegal context. You know? As opposed to having the medical procedure done.

As another example, Natalie, a 33-year-old white cis woman in Arkansas said:

> You should be punished as if you attempted to kill a baby—a person…But if they're going to do it, I think it would be better to do it with a medical provider. That'd be safer. I wish they could make another choice, but I do wish they had medical provider versus doing it on their own.

For these participants, medicalization increased the morality or acceptability of abortion, believing that doctors and clinicians should serve as the gatekeepers to abortion. Through this lens, the provider, as a medical expert, assumes the moral responsibility of the abortion. Relatedly, some participants see SMA as less acceptable without counseling from a provider. Further, related to pharmaceuticalization themes, some respondents mentioned that FDA regulation made them trust SMA with pills, such as Jim, a 48-year-old mixed race cis man in

Indiana, who said "Well, it did pass the FDA, so it's about, I guess, as safe as anything else." Overall, participants conceptualized the morality of SMA as categorically distinct from that of a medically-supervised abortion. These findings indicate the power of medicalization in delineating the boundary between ordinary behavior and deviant behavior—including behavior worthy of punishment.

Intersecting attitudes on criminalization and legality

Despite substantial differences between legality and criminalization of SMA, many conflated legality with punishment. When asked whether SMA should be legal, participants jumped immediately to discuss their ideas relating to punishment, criminalization, and their perceptions of the relative fairness of state interventions. Most participants could not imagine a scenario where a pregnant person who attempted or had a successful SMA would be reported to law enforcement, which played into some ambivalence related to the outlawing of SMA. People who favored any form of state involvement usually suggested a non-punitive intervention, such as counseling or education and strongly opposed imprisonment as a form of punishment. However, this indicates support for reporting those who engage in SMA in order to connect them with social services. In this section, we cover the findings in the following sections: punishment as cruel and unfair, punishment as futile, and support of punishment.

Punishment as cruel and unfair

Most participants who opposed SMA criminalization thought punishment for SMA was too cruel for something they viewed as a terrible experience in and of itself. Some participants intuited a tension between not wanting people to be harmed from SMA because of their "desperate" situation in addition to facing punishment due to criminalization. This tension was seen across participants who expressed a wide spectrum of views about their support for

abortion. For example, Anthony, a 36-year-old Black cis man from Indiana, thought all forms of abortion should be illegal and that punishment should depend on how seriously the pregnant person considered the decision, although he thought sending someone to jail was too severe of a punishment:

> Sending her to jail was too much punishment. Why? Because she loses her baby. That's one loss. And then she has to live with the guilt of it. That's the second loss. And then sending her to jail is like a third loss. That's three too many. That's too much punishment for the same crime. You lose your baby by your own hands, you live with the guilt of losing your baby by your own hands, and then you're serving jail time. That's quite unfortunate for the mother.

In this case, the participant views the abortion as punishment in and of itself due to loss of the baby and the onset of guilt. This elucidates a complexity inherent in many abortion beliefs, whereby abortion is simultaneously stigmatized and viewed as a harmful act that leads to regret and guilt, alongside a belief that people should not be further punished for abortion.

Similarly, participants sometimes characterized the person who would attempt SMA as already suffering in some way and thus not deserving of further punishment. Mia, a 26-year-old white cis woman from Indiana, described how people who attempt SMA have no other choice:

> It makes me sad because I think that a woman in that type of situation [who attempts SMA] is probably quite desperate… It could be an emotional reason, or they don't have the support they need, the financial resources they need. Domestic abuse or whatever it is… I like to think that most women don't want to go through with an abortion. They just feel cornered. So, it makes me sad to think that a woman would be in prison. It makes me wonder what her story is, really. It makes me wonder what resources she didn't feel like she had so that she felt like she was in a place where she had to put herself in danger to end the pregnancy.

These findings complicate extant binary frameworks of pro-choice versus anti-choice/pro-life, as beliefs of abortion as harmful and indicative of women's suffering can coexist alongside beliefs that people who have abortions should not be punished. Further, such beliefs could indicate perceptions of medical procedures performed and medications obtained

outside of the formal healthcare system as existing due to societal failings or personal suffering; this once more underscores a widespread valuing of the medical system as a site of societal or moral goodness, or medicalization as a social good.

Punishment as futile

Distinct from opposing criminalization based on sympathy for the pregnant person, others, regardless of their attitudes on abortion, believed that criminalization and imprisonment simply would not decrease SMA. Few participants supported imprisoning someone who attempts SMA, and the few that did support jail time tended to also support criminalizing all forms of abortion—clinic-based or not. Instead, the prevailing attitude, even among those who were generally not supportive of abortion, particularly SMA, was believing that imprisonment or other punitive consequences would not lead to a decrease in SMA. These participants opposed SMA criminalization not because they considered it to be an unfair punishment but because they viewed it as ineffective at behavior change. Emmanuel, a 30-year-old Black cis man from Missouri, said:

> So, I mean, the idea of someone desperately doing something that they think is presumably that they think is their only viable option and then imprisoning that person, I mean, that doesn't stop the thing from happening, and I don't see another, like, woman, let's say, looking at that and being like, oh, you know, well, I was going to end my own pregnancy, but now I'm not 'cause I saw that woman go to jail for it or prison. I guess I just don't see the point.

Kendra, the 36-year-old Black cis woman from South Carolina, despite saying that SMA is dangerous, and referring to abortion after fetal cardiac activity as "murder" earlier in the interview added that imprisonment would not help the person in any way.Instead, people who engage in SMA should have mandated counseling amd a fine in order to "change":

> You don't want to send somebody to jail for getting an abortion…They either should get a fine. I'm not for sending people to jail. They should either get a fine. Once they get that fine, they have to pay that fine and go through counseling.…I don't think it's a good idea for them to go to prison because I don't think they're going to learn anything in prison by, 'Oh, you're going to jail because you ended your own pregnancy.' What do they learn in prison? 'Oh, you confined me to this place to come home and do it again.' Point blank, period. Make them go through counseling. Sometimes, when people go through counseling, they change. I'm not for sending people to jail for doing things.

Similarly, Natalie, the 33-year-old white cis woman in Arkansas mentioned previously, despite believing that abortion is murder, said "I would like to see the person get help, versus a long prison sentence….Maybe it should be a combination of prison and therapy."

Although such participants had varied beliefs in the morality, safety, or appropriateness of SMA, they generally held that imprisonment alone was an ineffective intervention to impel a change in behavior for pregnant people, whom many view as being in a desperate situation.

Gender Differences

Although it was not the focus of this paper, we briefly examined differences by gender. Cis men generally used more ambivalent language in response to learning that people have been imprisoned for ending their own pregnancies, relative to cis women and trans people. While women frequently used phrases and words like "absolutely horrific," "terrible," "ridiculous," "crazy," "brutal," and "horrible," cis men generally had a more distant demeanor in describing their opposition to imprisonment for SMA. Some responses from men regarding whether or not imprisonment was appropriate included that it would "depend on the circumstances," that imprisonment was a "rather strange" response to SMA, that imprisonment was "unfortunate and

not the best use of resources," and that "punishing people for crimes isn't really useful." There were some notable exceptions, including cis women who believed people should be put on trial for murder for SMA. For instance, Olivia, a 44-year-old Black cis woman in South Carolina, believes SMA should be punishable and stated, "Women are just so careless and they think that they can always correct it with abortion." Conversely, both of the non-cis respondents were supportive of SMA due to concerns about bodily autonomy as well as latent concerns about lack of access to formal health care systems. Speaking to these themes, Jessie, a 35-year-old Black trans man in Louisiana, said "They are an adult. They are autonomous…That person would probably know their body more than I would know their body." As we will expound upon in the discussion, further research is needed to continue to explore gender differences in perceptions of SMA.

Discussion

In this qualitative study, we find that most people, even those morally or legally opposed to abortion in general, believed SMA should be legal and did not support punitive measures such as reporting to law enforcement or imprisonment. Respondents predominantly felt that people should have a legal right to end their own pregnancies, particularly if they have no or limited access to facility-based abortion care. Participants also repeatedly assumed SMA constituted self-harm, which revealed a lack of public knowledge about safe forms of SMA, such as SMA with abortion pills, which can be very safe and effective and has been endorsed by the World Health Organization in its most recent publication of abortion care guidelines (World Health Organization, 2022). For some, a perceived right to bodily autonomy was related to a dislike of government overreach into citizens' private lives. Moreover, the right to bodily autonomy and

bodily integrity has historically been highly valued highly by biomedical ethicists and society in general (Beauchamp & Childress, 1994) despite the recent wave abortion bans and restrictions on gender-affirming care pushed by the far-right(Astor, 2023).

Participants held opposing viewpoints as to whether the threat of criminal punishment would deter people from attempting SMA, and many considered it too severe a consequence for people they presumed to be in a desperate situation. Several expressed a desire for interventions that were non-punitive, such as support services that included helplines or mandatory counseling. However, research shows that reporting patients to authorities in birthing settings results in discriminatory impacts, even when the reporter's intentions were merely to connect patients to supportive services (Roberts et al., 2022).

Participants conceptualized SMA legality and criminalization as separate but interrelated elements, although support for criminalization was rare. Support and opposition to SMA being legal were both framed as mechanisms to ensure safety for pregnant people through either harm reduction or deterrence, Many felt legality would support patients to feel safe accessing post-abortion healthcare if needed, whereas illegality would theoretically deter patients from engaging in unsafe practices. Some participants used personal, pre-existing perceptions of the law more generally to support their attitudes toward SMA legality and criminalization; for example, some interpreted that the purpose of the law was to prevent unsafe or harmful behaviors and to foster social cohesion, while others alternatively perceived the goal of these laws as to punish and constrict individual liberties.

These findings also have implications for wider beliefs about medicalization and pharmaceuticalization, and specifically of what we refer to as 'medicalization as a social good'. More specifically, an underlying thread across the various themes of this paper indicates that a

deep-rooted trust in the medical establishment leads people to view behaviors as safer, more justified, or more moral when they occur within the formal healthcare system rather than when they are performed on one's own. This framework is useful for other types of moralized healthcare beyond abortion, including infertility interventions, (Bell, 2017) gender affirming healthcare, (shuster, 2021) and physician-assisted suicide (Buchbinder, 2021). Sociologists have argued that the medicalization of abortion immediately following the abortion reforms of the 1960s and 70s (Halfmann, 2012a) has consistently increased its perceived legitimacy—though in stratified ways that cause significant inequities in access to abortion care (see Kimport et al., 2016). However, in gaining moral authority over abortion, health care providers also acquire the right to be punished for performing those abortions (C. E. Joffe, 1995). Some of our participants similarly entrusted biomedical actors and the formal healthcare system with moral authority over abortion rather than a pregnant person that might choose SMA, even in the instance that the same pharmaceuticals are used. Additionally, some participants held greater confidence in SMA through the use of medications (as compared to other methods of SMA) given the FDA regulation of medication abortion drugs , which builds on extant work on pharmaceuticalization and on the simultaneous medicalization and demedicalization processes of abortion (Halfmann, 2012b).

Further, while there are indeed unsafe SMA methods, the pervasive view among participants that safe abortion care can only be practiced by licensed clinicians is inconsistent with the growing body of evidence demonstrating that pregnant people can safely end their pregnancies using abortion pills obtained outside of the formal health care system (Moseson, Bullard, et al., 2020; Moseson et al., 2022; Moseson, Herold, et al., 2020; Moseson, Jayaweera, et al., 2020; World Health Organization, 2022).. In addition to a lack of lay/public knowledge

about burgeoning safety data on SMA with medication, the widespread cultural understanding of SMA as it stands is likely shaped by years of "no coat hanger" pins and rhetoric that suggests that "making abortion illegal does not make it go away, it only makes it unsafe."

Participants conceptualized the morality of SMA and a medically supervised abortion as categorically distinct. The notion that medicalized abortion with some form of clinician oversight is more moral or acceptable than abortions performed outside of the formal healthcare system reveals what we call a "moral medicalization" of abortion, whereby the provider, as a medical expert, assumes both the moral responsibility of the abortion as well as legitimizes the abortion as a medical experience. Similarly, some saw SMA as less acceptable when attempted without first seeking professional counseling. In this thinking, participants trusted the medical system to be the ultimate decisionmaker in abortion care, which they trusted more than the pregnant person themself. Implicit in people's views was a reference to the commonly held belief that people are uncertain of their pregnancy decisions, may regret their abortions, and require formal support to ensure appropriate pregnancy decision-making, despite evidence demonstrating that most people seeking care from providers have high decision certainty and do not regret their abortion decision (L. J. Ralph et al., 2017; Rocca et al., 2020). Of note, few participants discussed criminalizing abortion providers, which is surprising given that in a recent survey, 25% of U.S. adults believe doctors who carry out illegal abortions should face jail time (Mitchell, 2022).

No participants argued that the fetus had equal rights as the pregnant person. Instead, those who did not support abortion held the ideological view that women need to be protected and are unable to make their own pregnancy decisions independently. Osborne and colleagues (2022) argued that people who held traditional views about gender roles, including the view that women need to be revered and protected, consistently opposed abortion. This view of benevolent

sexism, they argue, best explains people's desire to restrict pregnant people's reproductive rights (Osborne et al., 2022). Here we also found a common theme of wanting to restrict SMA in order to protect pregnant people from what they viewed as their inability to make good decisions (meaning, decisions to not harm themselves). When participants considered the characteristics of someone who might attempt SMA they usually assumed they are disempowered, "desperate", and incapable of rational decision-making. At the same time, these findings indicate the need for increased public knowledge about SMA with medications as a potential to shape beliefs of SMA; as previous research found, providing accurate information on abortion in general impacts people's beliefs on legal restrictions (White et al., 2017).

This qualitative work examined how people living in states that currently ban or are considering banning abortion view SMA legality and criminalization. Our findings make important contributions to the limited research available that pertains to SMA attitudes. This paper is novel for examining SMA attitudes within a mixed-gender sample and is one of few that explore questions of abortion and punishment of SMA. As data was collected prior to the overturning of *Roe*, the findings provide a basis for future post-*Dobbs* research on SMA as well as abortion and criminality more broadly. We find that while people generally lacked knowledge about the safety of SMA using medication abortion, they generally supported people's right to bodily autonomy and favored connecting people to resources and helplines over punitive polices that they perceived would be both unfair and unlikely to prevent unsafe practices. People internalized a medicalized view of abortion care in which medical providers were necessary to legitimize abortions and abortion decision-making processes. As facility-based abortion care becomes out of reach for a growing number of people in the U.S., it is expected that more individuals are likely to turn to SMA as their only viable option for abortion, which may include

turning to unsafe methods. However, with growing access to information and medication abortion pills, SMA can be safe and effective. This research suggests that efforts to criminalize and stigmatize SMA are out of step with the values and beliefs of those they represent.

Limitations

This study is not without limitations. Regarding recruitment, all interviews were conducted during the early months of the Covid-19 pandemic and the height of the Black Lives Matter activism of 2020, with cis men recruited during earlier months and cis women, transgender, and non-binary, individuals assigned female at birth at later months. It is possible that the political context surrounding public health, medical authority, racialization, and criminalization impacted data collected during these interviews. Additionally, the inclusion of only English speakers likely altered the findings, as extant work indicates differences in abortion attitudes and experiences among Spanish speakers, for instance (Biggs et al., 2019; L. Ralph et al., 2020b). Moreover, the interviews were conducted before the overturning of *Roe v Wade*, after which, cultural attention to all forms of SMA increased. It is therefore highly likely that the findings would be different if this study were replicated in the present post-*Dobbs* moment, and we encourage researchers to examine this change in perceptions. Lastly, while our contribution of cis male voices is important to understanding lay perceptions of SMA criminality beyond cis women's perceptions, a closer gender analysis—that also includes more trans and nonbinary respondents—is necessary in order to understand gender variations in these attitudes.Moreover, the interview guides were slightly different between AMAB and AFAB participants, which further limits our ability to analyze gender differences in SMA attitudes . Despite these limitations, this research fills critical gaps in research on abortion, SMA, and attitudes toward the medicalization of SMA.

Table 1. Characteristics of study participants.

Characteristic	
Age	Number (%)
18-24	11 (20%)
25-29	10 (19%)
30-34	10 (19%)
35-39	13 (24%)
40-44	6 (11%)
45 or older	4 (7%)
Gender	
Cis woman	27 (50%)
Cis man	25 (46%)
Non-binary	1 (2%)
Trans man	1 (2%)
State of Residence	
Arkansas	7 (13%)
Idaho	5 (9%)
Indiana	12 (22%)
Louisiana	11 (20%)
Mississippi	6 (11%)
Missouri	5 (9%)
South Carolina	5 (9%)
South Dakota	3 (6%)
Race/Ethnicity	
Asian	2 (4%)
Native American / American Indian	2 (4%)
Black / African American	11 (20%)
Mixed Race	4 (7%)
White	32 (59%)
Other	3 (6%)
Identifies as Hispanic or Latinx	
Yes	10 (19%)
No	42 (78%)
Missing	2 (4%)
Religion	
Atheist, Agnostic, or “None”	18 (33%)
Baptist	8 (15%)
Buddhist	1 (2%)
Catholic	9 (17%)
Christian Other (includes Evangelicals)	13 (24%)
Jewish	1 (2%)
Muslim	2 (4%)

Questions below were asked only of people who were assigned female at birth (n=29)	
Number of Children	
0	11 (38%)
1	6 (21%)
2	6 (21%)
3-5	3 (10%)
More than 5	2 (7%)
Has had an abortion	
Yes	8 (28%)
No	19 (66%)
Not sure	2 (7%)

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