FACTS ABOUT MEDICATION ABORTION CARE

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ABOUT MEDICATION ABORTION CARE

- Medication abortion care is an effective option for ending an early pregnancy up to 10 weeks.[1]
- Complications after having a medication abortion are rare and occur in no more than a fraction of a percent of patients.[2]
- A growing share of people who end their pregnancy are choosing medication abortion care accounted for more than one-third (39%) of all abortions in the United States, a share of overall abortion provision that is steadily rising.[3]
- Until recently, medication abortion care has been required to be started in a certified health care provider's office. However, FDA has lifted this mandate for the duration of the COVID-19 public health emergency, allowing the pills to be dispensed by providers through telehealth practices.
- As of 2014, 1 in 4 abortion patients are low-income.[4] Yet, lawmakers have banned Medicaid coverage of both surgical and medication abortion, creating an often insurmountable barrier to abortion for women across the country already struggling to make ends meet.[5]

MEDICALLY UNNECESSARY RESTRICTIONS LIMIT ACCESS TO MEDICATION ABORTION CARE

Since it was approved in 2000, the FDA has imposed burdensome restrictions on mifepristone known as a Risk Evaluation and Mitigation Strategy (REMS).

As a result, mifepristone cannot be dispensed at a pharmacy like other medications. Under the REMS, mifepristone can only be dispensed:

- In a clinic, hospital, or under the direct supervision of a certified medical provider;
- By medical providers who have completed a prescriber agreement form with the manufacturer of the drug confirming they can assess an ectopic pregnancy and perform a surgical abortion in the case of an incomplete abortion; and
- After the certified medical provider obtains a signed Patient Agreement Form from the patient

> Of the over 20,000 FDA-approved medications, mifepristone remains the only one that requires patients pick up the medication in a clinical setting despite being able to self-administer without supervision and having a strong safety record.[7]

Numerous research studies and extensive experience over the past 20 years show that these restrictions are unnecessary and limit access to medication abortion care.[6] The FDA is currently reviewing the REMS requirements on mifepristone.

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1. National Academies of Sciences, Engineering, and Medicine. 2018. The Safety and Quality of Abortion Care in the United States. Washington, DC: The National Academies Press. https://doi.org/10.17226/24950.
2. Ibid
3. https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017
4. https://www.guttmacher.org/fact-sheet/induced-abortion-united-states
5. https://allaboveall.org/resource/hyde-amendment-fact-sheet/
6. https://www.ansirh.org/research/research/public-health-experts-call-end-overregulation-mifepristone
7. Kaye, J. Reeves, R. Chaiten,C. The mifepristone REMS: A needless and unlawful barrier to care. 2021. Contraception volume 104, issue 1, P12-15 https://doi.org/10.1016/j.contraception.2021.04.025

STATES ALSO IMPOSE UNNECESSARY RESTRICTIONS ON MEDICATION ABORTION

The medically unnessary barriers on medication abortion go far beyond the federal REMs with state politicians enacting laws to restrict and stigmatizing the procedure.

- 32 states require medication abortion to be administered by a physician.[8]
- 19 states require that a physician be physically present in the same room as the patient when the medication is dispensed, thus barring telemedicine for medication abortions.[9]
- 7 states[10] currently require that providers tell patients they can "reverse" a medication abortion in mandatory counseling before the administration of the pills. This claim is unverified and without any medical evidence to support.[11]

WHEN LAWMAKERS RESTRICT AND STIGMATIZE MEDICATION ABORTION IT CAN LEAD TO PEOPLE BEING ARRESTED, CRIMINALIZED, AND JAILED FOR SELF-MANAGED ABORTION

When abortion is pushed out of reach, people don't stop trying to end an unwanted pregnancy. Some people go to extraordinary lengths, driving long distances, and paying burdensome costs to get the care they need. In other cases, people decide to end the pregnancy on their own, often times by using medication abortion pills. Though abortion is legal, people who end their own pregnancies or those who assist them may be reported or even jailed, with overzealous law enforcement officials using laws restricting medication abortion as a basis for prosecution. As past examples have shown, low-income people, young people, women of color, and immigrants are at serious risk of being targeted for punishment for ending their own pregnancies.[12]

RESTRICTIONS ON MEDICATION ABORTION DISPROPORTIONATELY HARM PEOPLE OF COLOR

Just as people of color working to make ends meet are the people most harmed by restrictions on abortion coverage, they are also disproportionately harmed by restrictions on medication abortion care. The medically unnecessary restrictions placed on medication abortion by the FDA and other barriers to care are rooted in abortion stigma and systemic racism[13] and only exacerbate the disproportionate harm faced by people of color in access to healthcare.[14] With the REMS in place and increasing state restrictions on medication abortion, the inequity in access to abortion care continues to increase, especially for Black, Indigenous, and other people of color.

Lifting the barriers to medication abortion is essential to **abortion justice** and ensuring that each of us can get abortion care, whoever we are and wherever we live.

8. https://www.guttmacher.org/state-policy/explore/medication-abortion
9. *Id.*
10. Arkansas, Idaho, Kentucky, Nebraska, North Dakota, Oklahoma, and Tennessee.
11. https://www.guttmacher.org/evidence-you-can-use/medication-abortion#
12. https://www.vox.com/first-person/2019/5/18/18630514/missouri-alabama-abortion-ban-2019-racism
13. Thompson, A. Singh, D. Ghorashi, A. Donovan, M. Ma, J. Rikelman, J. The disproportionate burdens of the mifepristone REMS. 2021. *Contraception* volume 104, issue 1, P16-19 https://doi.org/10.1016/j.contraception.2021.05.001
14. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/02/19/there-are-clear-race-based-inequalities-in-health-insurance-and-health-outcomes/