

# Abortion Sanctuary Cities: A Local Response to The Criminalization of Self-Managed Abortion

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Introduction.....	2008
I. An Overview of Self-Managed Abortion in America and Its Drivers .....	2013
A. Self-Induced Medication Abortion is a Safe Method of Abortion.....	2014
B. Abortion Restrictions Drive Self-Managed Abortions .....	2017
II. The Criminalization of Self-Managed Abortion: American Abortion Policy’s Double-Bind.....	2021
A. State Responses to Self-Managed Abortion .....	2021
B. Federal Responses to Self-Managed Abortion .....	2027
1. Federal Prescription Drug Regulations.....	2028
2. Federal Criminal Statutes .....	2030
III. The Path to “Abortion Sanctuaries” .....	2031
A. Expanding Access to Information About Safely Self-Managing Abortion.....	2032
1. The Legality of Municipal Self-Managed Abortion Harm Reduction Policies .....	2035
B. Protecting Information About People Who Self-Manage Abortions .....	2039
1. The Legality of Municipal Self-Managed Abortion Information Protection Policies .....	2041
IV. Abortion Sanctuaries as a Method of Disrupting the Post- <i>Roe</i> Reproductive Rights Narrative.....	2045
Conclusion .....	2052

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## INTRODUCTION

You live in Mississippi, work an hourly, minimum wage job, have no savings, and have young children. You are also seven weeks pregnant and want to have an abortion.

Technically, you can go to an abortion clinic. But even though you have Medicaid, it won't cover any of the procedure's costs because Mississippi generally follows the federal Hyde Amendment restrictions.<sup>1</sup> So not only will you have to find a provider and schedule an appointment, you will also need to come up with hundreds of dollars to cover the cost of the procedure, money for gas to get to the clinic an hour from your house, and money to pay someone to watch your kids.<sup>2</sup> In addition, Mississippi has a mandatory waiting period and a mandatory ultrasound law, so you will need another hundred dollars to pay for an ultrasound, as well as twice the time off work, childcare, and money for transportation.<sup>3</sup> Altogether, going to a clinic to get an abortion could cost you well over five hundred dollars, the equivalent of more than seventy hours of work.<sup>4</sup> And if you cannot afford the procedure now, the costs will only go up.<sup>5</sup>

Alternatively, you can safely and effectively induce an abortion using misoprostol and mifepristone, two medications that can be ordered online for ninety-five dollars, maybe less.<sup>6</sup> The medications will be sent directly to your home, and you can take them at whatever time is best for you. If you choose this

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1. *State Funding of Abortion Under Medicaid*, GUTTMACHER INST. (Aug. 1, 2020), <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid> [<https://perma.cc/YD89-H84T>].

The Hyde Amendment is an amendment to the federal budget that has been passed every year since 1976. It forbids the use of federal funds to pay for an abortion, except for a narrow set of circumstances. The current version of the Hyde Amendment exempts cases of rape and incest or the pregnant person's life being endangered. See Julie Rovner, *Clash Over Abortion Hobbles A Health Bill. Again. Here's How.*, KAISER HEALTH NEWS (Mar. 21, 2018), <https://khn.org/news/clash-over-abortion-hobbles-a-health-bill-again-heres-how/> [<https://perma.cc/2MYC-6L29>].

2. See Russell Goldenberg et al., *How Far is Too Far? An Analysis of Driving Times to Abortion Clinics in the US*, THE PUDDING (Sept. 2017), <https://pudding.cool/2017/09/clinics> [<https://perma.cc/99XS-U46K>].

3. *State Facts About Abortion: Mississippi*, GUTTMACHER INST. (Mar. 2020), <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-mississippi> [<https://perma.cc/RE2C-XQX2>].

4. *Annual Report*, DC ABORTION FUND (2017), <https://dcabortionfund.org/wp-content/uploads/2018/01/daf1801-2017annual-report-pc-v5-1.pdf> [<https://perma.cc/84TF-LQ3G>].

5. See Charlotte Cowles, *How Much Does an Abortion Cost? Learn the Facts*, N.Y. MAGAZINE (Nov. 20, 2018), <https://www.thecut.com/2018/11/how-much-does-an-abortion-cost.html> [<https://perma.cc/6RFH-VLZZ>].

6. Julia Belluz, *Abortions by Mail Are Available Now in the US. Here's What You Need to Know*, VOX (Oct. 22, 2018), <https://www.vox.com/science-and-health/2018/10/20/17999996/abortion-mail-online-mifepristone-misoprostol> [<https://perma.cc/6VEQ-UGE8>].

route, you will become one of the tens of thousands of Americans who have self-managed an abortion.<sup>7</sup>

Although abortion is legal in America, it is not accessible. Self-managed abortion is one way to reconcile this gap. The assumption that abortions happen in clinics have shaped the American debate about abortion, but studies suggest that tens of thousands of people<sup>8</sup> have contemplated or chosen to self-manage their abortions: attempting to induce abortion without the involvement of a physician and outside of a clinical setting.<sup>9</sup> This number has increased as state and federal regulations have choked off access to abortion in clinical settings, and there is no sign of this trend reversing.<sup>10</sup>

Self-managed abortion is safe and effective when performed correctly with the right drugs, like misoprostol and mifepristone. However, without access to the proper information or resources, people may use unreliable or harmful methods to self-induce. Some use dangerous methods, such as getting hit in the stomach, to self-induce.<sup>11</sup> Others use methods like herbal remedies or caffeine that are safe but ineffective.<sup>12</sup> While abortion medication can be both safe and effective if taken in the right doses at certain intervals, not everyone using abortion medications has access to the necessary instructions.<sup>13</sup> When taken

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7. Julia Belluz, *Abortions by Mail: The FDA is Going After Online Pill Providers*, VOX (Mar. 12, 2019), <https://www.vox.com/2019/3/12/18260699/misoprostol-mifepristone-medical-abortion> [<https://perma.cc/Z9M7-P6VN>].

8. While the majority of people who have abortions are women, men and non-binary people also have abortions. Therefore, when discussing the experiences of people who have abortions and the ways that cities should interact with those people, this Note uses gender neutral terminology, although it retains the language used by researchers and judges when referencing particular studies or opinions. When discussing the politics of abortion access, the phrase “women and other people who may have abortions” is used to highlight the patriarchal distribution of power within American society. This Note’s use of “women” includes all people who identify in any way with the term women or have a complex identity that includes woman.

9. See Ellen Wulforst, *Up Against Strict Laws, Texas Women Learn Do-It-Yourself Abortions*, REUTERS (May 24, 2016), <https://www.reuters.com/article/us-abortion-usa-texas-doityourself-idUSKCN0YF1BC> [<https://perma.cc/PT5N-SM9Z>]; Emily Bazelon, *The Dawn of the Post-Clinic Abortion*, N.Y. TIMES (Aug. 28, 2014), <https://www.nytimes.com/2014/08/31/magazine/the-dawn-of-the-post-clinic-abortion.html> [<https://perma.cc/37LY-VC4X>]; Seth Stephens-Davidowitz, *The Return of the D.I.Y. Abortion*, N.Y. TIMES (Mar. 5, 2016), <https://www.nytimes.com/2016/03/06/opinion/sunday/the-return-of-the-diy-abortion.html> [<https://perma.cc/WYP3-CFEP>].

10. Molly Redden, *After Wave of Anti-Abortion Laws, US Sees Signs of Women Taking Drastic Measures*, GUARDIAN (June 1, 2016), <https://www.theguardian.com/world/2016/jun/01/anti-abortion-laws-legislation-clinics-dangerous-methods> [<https://perma.cc/H22P-HGQM>].

11. TEX. POL’Y EVALUATION PROJECT, TEXAS WOMEN’S EXPERIENCES ATTEMPTING SELF-INDUCED ABORTION IN THE FACE OF DWINDLING OPTIONS 5 (Nov. 17, 2015) [<https://perma.cc/HH7J-5EAR>].

12. *Id.* at 4.

13. See Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, ATLANTIC (June 27, 2014), <https://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/> [<https://perma.cc/L62R-9CRC>].

incorrectly, both misoprostol and mifepristone can cause excessive bleeding or an incomplete abortion.<sup>14</sup>

Alongside these dangers, people who self-manage their abortions risk criminalization by the same state and federal legal systems that make it so hard to access abortions in clinical settings. There are twenty-one known instances of states arresting people for self-managing their abortions or assisting someone else who is self-managing their abortion.<sup>15</sup> It is likely that even more cases have not been publicly reported.<sup>16</sup> There have not yet been any federal arrests or prosecutions of people related to self-managed abortion, but both federal prescription drug regulations and federal criminal statutes could be used to prosecute and persecute people who self-manage their abortions.<sup>17</sup>

People who need abortions, particularly those who are low income, thus find themselves caught betwixt and between. State and federal policies have made it functionally impossible for them to access an abortion in a clinical setting but federal and state policies also criminalize self-managed abortion, and it is difficult to find information about how to self-manage safely. Their right to choose is reduced to a choice between bad options.

Cities are ideally placed to respond to this quandary.<sup>18</sup> Health care is a core local function, and local governments frequently take on public health responsibilities.<sup>19</sup> As the Supreme Court has recognized, cities have a well-established interest in the health of their residents.<sup>20</sup> This interest extends to abortion. Both unsafe abortions and lack of access to abortion negatively impact pregnant people's health.<sup>21</sup> In fact, some localities already acknowledge that

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14. *See id.*

15. Belluz, *supra* note 6.

16. *Id.*

17. *See infra* Part II.B.

18. This article uses "city" and "locality" interchangeably to refer to local units of government, a category which may also include villages, towns, and counties.

19. *See* Erin B. Bernstein, *Health Privacy in Public Spaces*, 66 ALA. L. REV. 989, 1015 (2015).

20. *See id.* at 1016.

21. *See* Caitlin Gerdt et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth After an Unwanted Pregnancy*, 26 WOMEN'S HEALTH ISSUES 55, 55 (2016) ("The risk of mortality from childbirth in the United States is estimated to be 14 times higher than the risk from induced abortion, and the risk of all maternal morbidities, defined as 'conditions either unique to pregnancy or potentially exacerbated by pregnancy that occurred in at least 5% of all pregnancies' is significantly higher among women who give birth than among those who have abortions."); Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, ANNALS OF INTERNAL MEDICINE 9 (2019) (comparing the health of women who successfully obtained abortions and women who successfully sought abortions and women who sought abortions but were turned away because of gestational limits and finding that "for several dimensions of physical health, including overall self-rated health, women denied access to a wanted abortion reported worse long-term physical health than those who received abortion"); David A. Grimes et al., *Unsafe Abortion: the Preventable Pandemic*, 368 LANCET 1908, 1908 (2006) (finding that worldwide, 68,000 women die each year as a result of unsafe abortion, defined as "a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.")

abortion is squarely within their interests by providing abortions at their public health facilities.<sup>22</sup> A number of other states' and cities' public health departments provide information, referrals, and other services to both pregnant people and abortion providers.<sup>23</sup> Put bluntly, abortion is health care, and cities are responsible for public health. Cities should support people who self-manage their abortions because it is their duty to do so.

Underlying their interest in public health and abortion access is the fact that cities are where abstract rights become concrete and accessible. Cities are the form of government most embedded in people's daily lives. They pave the streets their residents walk on, collect their trash, and govern their businesses. Cities also take a uniquely pragmatic approach to governance.<sup>24</sup> More than state and national governments, cities must be directly responsive to the needs of their residents, cutting across traditional political divides.<sup>25</sup> As a result, cities are where "the constitutional rubber meets the road."<sup>26</sup> They are often where rights, including the human right<sup>27</sup> to an abortion, move from theory to something people either have or do not have.

To that end, this Note proposes two types of policies that cities that wish to protect the wellbeing of residents who self-manage their abortions can

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Importantly, unsafe abortion is not synonymous with illegal abortion, nor is safe abortion synonymous with legal abortion).

22. See, e.g., Alameda County Public Health Department, *Abortion Providers*, ALAMEDA COUNTY (Feb. 2018), <http://www.acphd.org/media/437714/abortion-resources.pdf> [<https://perma.cc/DTL3-YHD3>]; Aaron Weinberg, *Skagit Regional Health Expanding Abortion Services after Lawsuit*, GOSKAGIT (Aug. 2, 2017), [https://www.goskagit.com/news/local\\_news/skagit-regional-health-expanding-abortion-services-after-lawsuit/article\\_42257605-81b5-5d92-b4d8-19f3cd29a117.html](https://www.goskagit.com/news/local_news/skagit-regional-health-expanding-abortion-services-after-lawsuit/article_42257605-81b5-5d92-b4d8-19f3cd29a117.html) [<https://perma.cc/C37M-5UTD>]. See also Nancy F. Berglas et al., *Approaches, Barriers, and Facilitators to Abortion-related Work in U.S. Health Departments: Perspectives of Maternal and Child Health and Family Planning Professionals*, BMC PUBLIC HEALTH 1, 7 (2020) ("Other department-initiated abortion activities focused on expanding clinical services, including: providing abortion services in department outpatient clinics and hospitals, improving the quality of post-abortion contraceptive care, working with community health centers to expand access to medication abortion, and planning for potential increases in abortion patient volume if neighboring states enact restrictive abortion policies.").

23. Berglas, *supra* note 22, at 2.

24. See BENJAMIN R. BARBER, *IF MAYORS RULED THE WORLD: DYSFUNCTIONAL NATIONS, RISING CITIES* 4 (2013).

25. See *id.*; Jill E. Habig & Joanna Pearl, *Cities as Engines of Justice*, 45 *FORDHAM URB. L. J.* 1159, 1190 (2018).

26. See Bernstein, *supra* note 19, at 1014. See also Habig & Pearl, *supra* note 25, at 1189–90; Kaitlin Ainsworth Caruso, *Associational Standing for Cities*, 47 *CONN. L. REV.* 59, 87 (2014). See generally *URBAN JUSTICE* (Barbara M. Oomen et al. eds., 2016).

27. Part V addresses the rationale for framing abortion as human right rather than a constitutional one in the American context. International human rights bodies have long recognized that access to safe abortion is essential to women's rights to life and health. See Patty Skuster, *How Laws Fail the Promise of Medical Abortion: A Global Look*, 18 *GEO. J. GENDER & L.* 379, 381 (2017). Additionally, the reproductive justice framework developed by activists of color emphasizes abortion's importance to women's human rights. Kimala Price, *What Is Reproductive Justice? How Women of Color Activists Are Redefining the Pro-Choice Paradigm*, 10 *MERIDIANS* 42, 47 (2010).

implement. First, cities can use a harm reduction approach—acknowledging that people are self-managing abortions and providing the information necessary for them to do so safely. Building on the experience of pro-choice activists in Latin American and U.S. cities’ experience applying harm reduction principles in response to the opioid crisis, cities should expand access to information about safely self-managing abortion. Second, drawing on the tactics of the immigration sanctuary movement, cities can adopt policies that limit the spread of information about individuals who choose self-managed abortion to state and federal authorities, limiting those individuals’ exposure to legal risk.

Cities must shape each of these policies to their specific legal context. The harm reduction policies, in particular, may expose municipal officials to criminal accomplice liability, and information protection policies, if not carefully crafted and administered, might constitute obstruction of justice. Both policies would also have to contend with state and federal preemption concerns. However, the possibility of litigation alone should not dissuade cities from pursuing these policies. Some of the anti-abortion laws that might stand in the way of these policies are relatively untested and are vulnerable to legal challenges.<sup>28</sup> Additionally, as the example of the immigration sanctuary movement shows, cities have a strikingly strong ability to resist federal action, and that capacity for resistance may also carry over, albeit in a more limited capacity, to their relationships with their states, particularly on issues of public health. Both these policy proposals and the litigation that might result from them should be viewed as part of an ongoing, mutable conversation about the ways that cities can protect the rights and wellbeing of their residents and the importance of abortion to the ability of women and other people who may have abortions to direct their own lives and fully participate in their communities.

This Note’s final Section explores that conversation, moving from the practical to the strategic and considering the importance of reimagining both the roots of the right to abortion and the obligations that right places on policy-makers. It argues that in addition to their immediate practical benefits, these policies would also offer a much-needed alternative to the dominant post-*Roe v. Wade* analytic framework of American pro-choice activism. The reasoning of *Roe* obscures both the importance of abortion access to women and other people who may have abortions and their ability to make decisions about their own lives, while the emphasis on privacy and the continuing constitutionality of abortion remove the urgency of government action to expand access to abortion. In contrast, local action to safeguard people who undertake self-managed abortion would center the needs of people who actually have abortions and place

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28. Farah Diaz-Tello et al., *Roe’s Unfinished Promise: Decriminalizing Abortion Once and For All*, SIA LEGAL TEAM (2018), <https://www.semanticscholar.org/paper/Roe's-Unfinished-Promise%3A-Decriminalizing-Abortion-Diaz-Tello-Mikesell/582c986f6be3d048621523c9f331e8ec81d60330> [<https://perma.cc/K8MJ-EU7Q>].

governments in the position of affirmatively expanding access to abortion beyond the boundaries set by *Roe*. The policies proposed by this Note positions access to abortion as a human right—vital to women and other people who may have abortion’s ability to participate in their own lives and the lives of their communities and indivisible from cities’ broader commitment to their residents’ welfare.

## I.

### AN OVERVIEW OF SELF-MANAGED ABORTION IN AMERICA AND ITS DRIVERS

Self-managed abortion, also called self-induced abortion, is “[t]he practice of self-administering pharmaceutical pills, traditional herbs, or other means,” with the goal of ending a pregnancy.<sup>29</sup> Self-managed abortion—whether through overwhelmingly safe methods such as the appropriate use of medication or other riskier, less effective means—has always been part of the history of abortion. Additionally, studies have repeatedly shown that self-managed abortion, while rarely publicly discussed, is widespread in America.<sup>30</sup> In 2015, American women performed more than 700,000 Google searches related to ending their own pregnancies,<sup>31</sup> and researchers used the result of a 2015 study of Texas women to estimate that in Texas alone at least 100,000 women have attempted to self-induce abortion.<sup>32</sup> This Section provides an overview of the methods that people use to induce abortion and of the way that state and federal policies underlie people’s decision to self-manage their abortions.

The safest and most effective method of self-managed abortion, which is also the method most targeted by state and federal enforcement actions, is medical abortion using misoprostol either alone or in combination with mifepristone. Studies have shown that pregnant people can safely self-administer both drugs, making self-managed medication abortion as safe as a medication abortion performed in a clinical setting. Additionally, medication abortion is

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29. Jill E. Adams & Melissa Mikesell, *Primer on Self-Induced Abortion*, SIA LEGAL TEAM (2017), [law.berkeley.edu/wp-content/uploads/2016/01/Primer-on-Self-Induced-Abortions.pdf](http://law.berkeley.edu/wp-content/uploads/2016/01/Primer-on-Self-Induced-Abortions.pdf) [<https://perma.cc/3GEB-3SBZ>].

30. Contrary to the stereotype of the “back-alley butcher” killing desperate women in the decades before *Roe* legalized abortion, most botched abortions were the result of women attempting to self-abort. Rickie Solinger, *Pregnancy and Power Before Roe v. Wade, 1950-1970*, in *ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000* 4 (Ricky Solinger ed., 1998).

31. Stephens-Davidowitz, *supra* note 9.

32. DAVID GROSSMAN ET AL., KNOWLEDGE, OPINION AND EXPERIENCE RELATED TO ABORTION SELF-INDUCTION IN TEXAS 2 (2015) [https://www.ibisreproductivehealth.org/sites/default/files/files/publications/TxPEP\\_KnowledgeOpinionExperience%20with%20self%20induction\\_Research%20Brief\\_17Nov2015.pdf](https://www.ibisreproductivehealth.org/sites/default/files/files/publications/TxPEP_KnowledgeOpinionExperience%20with%20self%20induction_Research%20Brief_17Nov2015.pdf) [<https://perma.cc/2JPK-9USC>].

Population data suggests that a significant portion of attempts to self-induce may be successful. In states with restrictive abortion laws, the number of reported live births is lower than the number of reported abortions alone can account for. More research is needed but is possible that some of this gap is due to self-induced abortion. *See* Stephens-Davidowitz, *supra* note 9.

significantly safer and more reliable than other self-managed abortion methods, with the availability of medication abortion having been shown to dramatically reduce the incidence of abortion-related injuries.

The prevalence of self-managed abortion is inextricable from obstacles that governments and the health care system place in front of people seeking abortions in clinical settings. While abortion remains legal nationwide, a patchwork of state laws and regulations limit the number of clinics and providers who can provide abortions, forcing pregnant people to jump over medically unnecessary hurdles to access abortions within a medical setting. The burdens of states' abortion restrictions are not evenly distributed. Low-income people and people of color are disproportionately impacted by anti-abortion laws. People of color are both more likely to seek abortion care and more likely to struggle to afford it.<sup>33</sup> Additionally, the majority of women enrolled in Medicaid, which insures a third of low-income adults,<sup>34</sup> only have coverage for abortion in cases of life endangerment, rape, or incest.<sup>35</sup> Weathering state and federal abortion restrictions to access abortion in a clinical setting requires financial resources, which White people with higher incomes are more likely to have. In light of all these barriers, it is unsurprising that some pregnant people view self-managed abortion as their best option.

#### A. *Self-Induced Medication Abortion is a Safe Method of Abortion*

People attempting to self-induce abortions report using a wide variety of methods, some of which risk lasting physical harm. A woman who distributes misoprostol and mifepristone in the United States reported one woman asking her “if I knew how, exactly, it was that you went about using a wire hanger to abort.”<sup>36</sup> People trying to self-manage their abortions have also reported looking into physical trauma or drinking household chemicals such as turpentine.<sup>37</sup> Other

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33. J. KOTTING & G.E. ELY, NATIONAL NETWORK OF ABORTION FUNDS, THE UNDUE BURDEN OF PAYING FOR ABORTION: AN EXPLORATION OF ABORTION FUND CASES 6 (2017) <https://abortionfunds.org/cms/assets/uploads/2017/08/Tiller-Fund-Report-2017-National-Network-of-Abortion-Funds.pdf> [<https://perma.cc/TCV4-LTZ9>].

34. *Health Insurance Coverage of Low Income Adults 19-64 (Under 200% FPL)*, KAISER FAM. FOUND. (2018), <https://www.kff.org/other/state-indicator/low-income-adults/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> [<https://perma.cc/GV3U-5V7G>].

35. Alina Salganicoff et al., *Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans*, KAISER FAM. FOUND. (June 24, 2019), <https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicare-marketplace-plans-and-private-plans/> [<https://perma.cc/36GS-RJ26>].

36. Anonymous, *I Help Desperate Women, and I Could Go To Jail for It*, JEZEBEL (Sept. 17, 2013), <https://jezebel.com/i-help-desperate-women-and-i-could-go-to-jail-for-it-1320076409> [<https://perma.cc/TEU4-D8DL>].

37. See Abigail R.A. Aiken et al., *Motivations and Experiences of People Seeking Medication Abortion Online in the United States*, 50 PERSP. ON SEXUAL AND REPROD. HEALTH 157, 161 (2018); Molly Redden, *Please, I Am out of Options': Inside the Murky World of DIY Abortions*, GUARDIAN

methods of self-induction are safer but ineffective. In a study of self-managed abortion in Texas, multiple women reported taking herbs, teas, caffeine, seeds, and vitamin C in the hopes of inducing an abortion.<sup>38</sup>

However, there is one method of self-inducing an abortion that is, when used correctly, both as safe and as effective as an abortion performed in a clinical setting: medication abortion. To self-induce a medication abortion, a person takes a drug called misoprostol—which is also sold as an ulcer medication under the name Cytotec—either alone or in combination with another drug called mifepristone.<sup>39</sup> Misoprostol prepares the cervix for labor and causes contractions, while mifepristone blocks production of progesterone, which is necessary for a pregnancy to continue.<sup>40</sup> Although misoprostol is most effective when used in combination with mifepristone, mifepristone’s only use is as an abortifacient, making it harder to obtain.<sup>41</sup> Within the first nine weeks of pregnancy misoprostol alone is 90 percent effective.<sup>42</sup>

The only difference between a self-managed medication abortion using scientifically backed instructions and a medication abortion performed in a clinic is the lack of an ultrasound to screen for ectopic pregnancy. However, it is not medically necessary to have an ultrasound before a medication abortion. The World Health Organization, the American College of Obstetricians and Gynecologists, and the Royal College of Obstetricians and Gynecologists all specifically do not suggest performing ultrasound screens for ectopic pregnancy on people seeking abortions unless they have risk factors or symptoms.<sup>43</sup> Thus the two procedures—self-administered medication abortion and medication abortion under the supervision of a medical provider—are functionally identical.<sup>44</sup>

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(Nov. 21, 2016), <https://www.theguardian.com/us-news/2016/nov/21/home-abortions-emails-secret-world> [https://perma.cc/FCY2-C6XM].

38. TEX. POL’Y EVALUATION PROJECT, *supra* note 11, at 4.

39. WORLD HEALTH ORGANIZATION, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 45 (2d ed. 2012), [https://www.who.int/reproductivehealth/publications/unsafe\\_abortion/9789241548434/en/](https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/) [https://perma.cc/UT3S-3GC9].

40. Becky Little, *The Science Behind the “Abortion Pill,”* SMITHSONIAN MAG. (June 23, 2017), <https://www.smithsonianmag.com/health-medicine/science-behind-abortion-pill-180963762/> [https://perma.cc/8CRE-QNYS]; Center for Drug Evaluation and Research, *Questions and Answers on Mifeprex*, FOOD & DRUG ADMIN. (Apr. 9, 2019), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex> [https://perma.cc/D5AX-4AYG].

41. WORLD HEALTH ORGANIZATION, *supra* note 39, at 45.

42. *Id.*

43. Additionally, less than 1 percent of pregnant people seeking an abortion have ectopic pregnancies, significantly less than the overall rate of ectopic pregnancy. Elizabeth G. Raymond et al., *Reaching Women Where They Are: Eliminating the Initial in-Person Medical Abortion Visit*, 92 CONTRACEPTION 190, 191 (2015).

44. See Raymond et al., *supra* note 43, at 191; Olga Khazan, *Illegal Abortion Will Mean Abortion By Mail*, ATLANTIC (July 18, 2018),

The availability of medication abortion has upended the assumption that the only safe abortions are those abortions performed in a clinic by medical professionals.<sup>45</sup> When pregnant people are given information about the correct dosage and side effects, they can effectively self-administer abortion medications and, even more importantly, identify when they are in distress and seek appropriate medical attention. In a study of Irish and Northern Irish women who self-administered misoprostol and mifepristone obtained online, fewer than 10 percent reported symptoms of potentially serious complications.<sup>46</sup> Of those who did report symptoms that could be serious, 95 percent sought medical assistance.<sup>47</sup> Approximately 95 percent of all the women in the study successfully ended their pregnancy without medical intervention.<sup>48</sup> These findings echo studies of self-administered prescription abortion medications, which have found that self-administered medication abortions are both safe and effective.<sup>49</sup> The drugs used in medication abortion are also themselves safe, with a better safety record than Viagra.<sup>50</sup>

While it has not entirely displaced other methods of self-induction, people in the United States increasingly use abortion medications to self-induce abortion.<sup>51</sup> In the United States, neither misoprostol nor mifepristone can be purchased without a prescription.<sup>52</sup> Mifepristone is also subject to the Food and Drug Administration's (FDA) Risk Evaluation and Mitigation Strategy (REMS) program, which means that it is not available in retail pharmacies.<sup>53</sup> Despite these restrictions, both drugs can be ordered online from foreign suppliers.<sup>54</sup> A study of misoprostol and mifepristone purchased online showed the pills were authentic, although in some cases the mifepristone was degraded. Misoprostol

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<https://www.theatlantic.com/health/archive/2018/07/after-abortion-is-illegal/565430/>  
[<https://perma.cc/PY8Q-C9U7>].

45. See Joanna N. Erdman, *Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach*, 34 HARV. J.L. & GENDER 413, 442 (2011).

46. Abigail R. A. Aiken et al., *Self Reported Outcomes and Adverse Events after Medical Abortion through Online Telemedicine: Population Based Study in the Republic of Ireland and Northern Ireland*, 357 BMJ 1, 5 (2017).

47. *Id.*

48. *Id.*

49. Megan K. Donovan, *Self-Managed Medication Abortion: Expanding the Available Options for US Abortion Care*, 21 GUTTMACHER POL'Y REV. 41, 42 (2018).

50. See Daniel Grossman, *Give Women Their Reproductive Revolution*, U.S. NEWS & WORLD REP. (Sept. 9, 2016), <https://www.usnews.com/opinion/articles/2016-09-30/its-long-past-time-to-remove-abortion-pill-restrictions> [<https://perma.cc/UH8U-3ASJ>].

51. Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 REPROD. HEALTH MATTERS 136, 143–44 (2010).

52. Donovan, *supra* note 49, at 44.

53. Center for Drug Evaluation and Research, *supra* note 40.

54. Chloe Murtagh et al., *Exploring the Feasibility of Obtaining Mifepristone and Misoprostol from the Internet*, 97 CONTRACEPTION 287, 290–91 (2018).

can also be brought back from countries, particularly Mexico, where Cytotec is available over the counter.<sup>55</sup>

Not only is medication abortion itself safe, the availability of medication abortion moves people away from other, much more dangerous methods of self-induction. Studies of abortion in Latin America have shown that the availability of misoprostol led to a sharp decrease in the number of abortion complications.<sup>56</sup> This is consistent with the fact that even though the figure of the illegal, back-alley abortionist haunts American discussions of abortion, prior to *Roe* the most horrifying abortion injuries and deaths did not involve a doctor at all.<sup>57</sup> Instead, they were wounds that people inflicted on themselves because they were desperate to end their pregnancies.<sup>58</sup> People who want to end their pregnancies will find ways to do so. Medication abortion offers them a safe and effective method, reducing the incidence of harmful methods of self-induced abortion.

### B. Abortion Restrictions Drive Self-Managed Abortions

While people self-manage their abortions for many reasons, some people choose self-managed abortion because state and federal governments have deprived them of meaningful alternatives. Targeted regulation of abortion providers (TRAP) laws and anti-abortion statutes have limited funding for abortion and made the procedure longer and more time-intensive than is medically necessary. Many low-income people, particularly people of color, struggle both to find an abortion clinic and schedule and pay for the procedure. For these people, the choice may not be between self-induction and an abortion at a clinic, but between self-induction and forced birth.

TRAP laws are one of the most common tactics states use to limit access to abortion. They can be divided into facility requirements, which regulate abortion clinics, and clinician requirements, which regulate abortion providers.<sup>59</sup> Facility requirements include mandating that abortion clinics be within a certain distance of a hospital (eight states), or that they meet the structural requirements for surgical centers (seventeen states).<sup>60</sup> The most common clinician requirement is that clinicians have hospital admitting privileges or an alternate arrangement

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55. See Hellerstein, *supra* note 13.

56. See, e.g., Regina Maria Barbosa & Margareth Arilha, *The Brazilian Experience with Cytotec*, 24 *STUD. IN FAM. PLAN.* 236 (1993); Hellerstein, *supra* note 13.

57. SOLINGER, *supra* note 30, at 4.

58. *Id.*

59. See *Targeted Regulation of Abortion Providers (TRAP) Laws*, GUTTMACHER INST. (Jan. 2020), <https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws> [<https://perma.cc/H9HL-96S9>].

60. *Targeted Regulation of Abortion Providers*, GUTTMACHER INST. (Mar. 1, 2020), <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers> [<https://perma.cc/TBC2-8PN7>].

(eleven states).<sup>61</sup> These requirements are not medically necessary, and exceed the requirements that states impose on comparable medical procedures.<sup>62</sup>

TRAP laws are a very effective method of limiting pregnant people's access to abortion care. In many cases, they set requirements that clinics have no realistic way to meet. The Virginia Department of Health's 2013 analysis of Virginia's facility regulations found that compliance would cost up to \$1 million per clinic, a tremendous amount of money for clinics to spend.<sup>63</sup> Clinician requirements are likewise unrealistic because, ironically, abortion is such an incredibly safe procedure. Many hospitals will only give admitting privileges to doctors who admit a certain number of patients per year, but abortion is so safe that it is often nearly impossible for abortion providers to meet that admittance number.<sup>64</sup> Unable to comply with these laws, many clinics close. Missouri currently has only one abortion clinic because providers at its other clinic could not obtain admitting privileges.<sup>65</sup> Five other states also have only one clinic, including Mississippi, which only narrowly avoided having its only remaining clinic close because of new facility requirements.<sup>66</sup> A pending lawsuit may close Kentucky's only clinic because the clinic lacks a formal agreement to transfer patients to a nearby hospital.<sup>67</sup>

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61. *Id.*

62. See Bonnie S. Jones et al., *State Law Approaches to Facility Regulation of Abortion and Other Office Interventions*, 108 AM. J. PUB. HEALTH 486, 490–91 (2018).

63. *Targeted Regulation of Abortion Providers (TRAP) Laws*, *supra* note 59.

64. *Id.*

65. See Sasha Ingber, *1 Abortion Clinic Remains Open In Missouri, Following New State Requirements*, ALA. PUB. RADIO (Oct. 3, 2018), <https://www.apr.org/post/one-abortion-clinic-remains-open-missouri-following-new-state-requirements> [<https://perma.cc/3XBJ-39L9>].

66. See Michelle Garcia, *In Many States, the End of Roe v. Wade is Already Here*, VOX (July 9, 2018), <https://www.vox.com/2018/7/3/17526222/abortion-states-access-roe-v-wade-kennedy> [<https://perma.cc/8EBL-6LUX>]; Michael D. Regan, *Court Blocks Mississippi Law that Would Have Shuttered State's Only Abortion Clinic*, PBS NEWSHOUR (Mar. 18, 2017), <https://www.pbs.org/newshour/nation/court-blocks-mississippi-law-shuttered-states-abortion-clinic> [<https://perma.cc/2B6W-ZHM4>].

67. Sarah McCammon, *Kentucky Could Become the Only State Without A Clinic That Performs Abortions*, NPR (Sept. 6, 2017), <https://www.npr.org/2017/09/06/548739211/kentucky-could-become-the-only-state-without-a-clinic-that-performs-abortions> [<https://perma.cc/ABS5-VFXW>].

*Whole Woman's Health v. Hellerstedt* overturned several Texas TRAP laws, finding that they placed an undue burden on abortion access. 136 S. Ct. 2292 (2016). The reasoning of *Whole Woman's Health* has been used to successfully strike down other states' TRAP laws. *The Undue Burden Standard after Whole Woman's Health v. Hellerstedt*, CENTER FOR REPRODUCTIVE RTS. (July 26, 2018), <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/WWH-Undue-Burden-Report-07262018-Edit.pdf> [<https://perma.cc/3AAC-FSGE>]. However, contesting these laws is a time-consuming endeavor, and many states' laws remain in effect. Additionally, the political balance of the Supreme Court has shifted since Justice Kennedy's retirement (and may yet swing even further to the right), so it is possible that *Whole Women's Health* will be either actually or functionally overruled. See Adam Liptak et al., *How a Supreme Court Shaped by Trump Could Restrict Access to Abortion*, N.Y. TIMES (Aug. 14, 2018), <https://www.nytimes.com/interactive/2018/08/14/us/roe-v-wade-explainer.html> [<https://perma.cc/9APZ-3ZND>].

Beyond facility and clinician regulations, pregnant people themselves are the subject of laws that limit their ability to access abortions by making abortions more expensive and more time-intensive to obtain. At the federal level, the Hyde Amendment restricts abortion access by prohibiting federal funding for abortion except in cases of rape and incest or when the pregnant person's life is endangered.<sup>68</sup> Hyde limits abortion access across a variety of federal programs, but its most severe impact is on Medicaid recipients. While sixteen states independently cover the cost of abortion for Medicaid recipients, the majority do not.<sup>69</sup> Some states, in violation of federal law, do not even cover abortion in cases of rape, incest, or life endangerment.<sup>70</sup> As a result, low-income pregnant people must come up with hundreds, or even thousands, of dollars to pay for their abortions out-of-pocket.<sup>71</sup>

In addition to the federal Hyde restrictions, many states have adopted further measures that make obtaining an abortion unnecessarily expensive and time-intensive (with time expenditures also inevitably increasing monetary expenditures). For example, twenty-six states require that people have an entirely medically unnecessary ultrasound before their abortions, forcing patients to cover the cost of the ultrasound as well as the abortion itself.<sup>72</sup> Moreover, fifteen states have mandatory waiting periods, meaning that patients must make multiple visits to their abortion provider over multiple days. This means multiple days of transportation costs, lost wages, and childcare, thus increasing the financial burden of abortion. For example, Texas's adoption of a one-day waiting period increased patients' costs by an average of \$146.<sup>73</sup> These costs often drive patients to reschedule their abortions later and later in their pregnancy because they cannot yet afford the required visits and procedures.<sup>74</sup> However, the cost of abortion increases, sometimes by tens of thousands of dollars, the further along patients are in their pregnancy. A delay of even a few weeks can lead to an increase in cost of hundreds of dollars, forcing patients into a cycle where they

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68. See Rovner, *supra* note 1.

69. See *An Overview of Abortion Laws*, GUTTMACHER INST. (Feb. 1, 2020), <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws> [<https://perma.cc/Z2CF-B5FP>].

70. See U.S. GOVERNMENT ACCOUNTABILITY OFFICE, *MEDICAID: CMS ACTION NEEDED TO ENSURE COMPLIANCE WITH ABORTION COVERAGE REQUIREMENTS* 15 (2019), <https://www.gao.gov/assets/700/696338.pdf> [<https://perma.cc/J982-QFQ2>].

71. See Cowles, *supra* note 5.

72. See *Requirements for Ultrasound*, GUTTMACHER INST. (Mar. 1, 2020), <https://www.guttmacher.org/state-policy/explore/requirements-ultrasound> [<https://perma.cc/TV3C-VRX7>].

73. Olga Khazan, *Waiting Period and the Rising Price of Abortion*, ATLANTIC (May 26, 2015), <https://www.theatlantic.com/health/archive/2015/05/waiting-periods-and-the-price-of-abortion/393962/> [<https://perma.cc/8DND-LM59>].

74. Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 AM. J. PUB. HEALTH 1687, 1692 (2014).

have to further delay the abortion to scrape together more money, but that additional delay results in a cost increase, beginning the cycle all over again.<sup>75</sup>

None of these restrictions explicitly eliminate access to abortion. Instead, they push up the cost of accessing abortions in clinical settings until it is completely out of reach of low-income people, particularly those who are young, live in a rural area, or are people of color. For these people, self-managed abortion may be their only feasible way to access an abortion. Jennifer Whalen, who was sent to prison for ordering abortion medications online for her teenage daughter, turned to the internet because there were no local clinics.<sup>76</sup> Whalen's daughter was uninsured, so she could not afford to go to a hospital.<sup>77</sup> Similarly, the closest clinic to Jennie Linn McCormack was over a hundred miles away and had a state-imposed seventy-two-hour waiting period between the initial appointment and the abortion, meaning that McCormack would have either had to stay in a hotel or make two six-hour round trips.<sup>78</sup> McCormack also did not have enough money to pay for an abortion in a clinic.<sup>79</sup> Instead, she ordered abortion medication online, and was subsequently charged with felony abortion.<sup>80</sup> Self-managed abortion was neither woman's first choice, but state and federal policies made it their only realistic choice.

Whalen and McCormack are not alone in having faced this dilemma. Two studies of people seeking to self-induce abortion have found that the costs and effects of other restrictions, such as waiting periods and a lack of nearby clinics, were a factor in many people's decision to manage their own abortions.<sup>81</sup> Additionally, a recent study found that demand for self-managed abortion medication is concentrated in states with restrictive abortion policies.<sup>82</sup> These studies echo anecdotal descriptions of the drivers of self-managed abortion, which similarly emphasize the role of abortion restrictions in leading people to self-manage their abortions.<sup>83</sup> While there will always be some people who prefer to self-manage their abortions regardless of the accessibility of abortion in clinical settings, for many the decision to self-manage is a direct consequence of state and federal policies.<sup>84</sup> For these people, their choice is not between an

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75. See Cowles, *supra* note 5.

76. David DeKok, *Pennsylvania Mother Who Gave Daughter Abortion Pill Gets Prison*, REUTERS (Sept. 6, 2014), <https://www.reuters.com/article/us-usa-crime-pennsylvania-abortion-idUSKBN0H10IR20140906> [<https://perma.cc/X4E3-SL7K>].

77. *Id.*

78. Ada Calhoun, *The Rise of DIY Abortions*, NEW REPUBLIC (Dec. 20, 2012), <https://newrepublic.com/article/111368/the-rise-diy-abortions> [<https://perma.cc/ZW9D-FUWA>].

79. *Id.*

80. *Id.*

81. See Aiken et al., *supra* note 37; Grossman et al., *supra* note 51.

82. See Abigail R. A. Aiken et al., *Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States*, 110 AM. J. PUB. HEALTH 90, 92 (2020).

83. See Hellerstein, *supra* note 13.

84. See Aiken et al., *supra* note 82, at 92 (reporting that demand for self-managed abortion medication was concentrated in states with restrictive abortion laws); Aiken et al., *supra* note 37, at 159

abortion performed by a medical provider and a self-managed abortion but between a self-managed abortion and no abortion at all.

## II.

### THE CRIMINALIZATION OF SELF-MANAGED ABORTION: AMERICAN ABORTION POLICY'S DOUBLE-BIND

In a cruel irony, the same legal systems that cut people off from accessing abortions in clinical settings often also put them at risk of prosecution if they self-manage their abortions. As of October 2018, states had arrested at least twenty-one people for self-managing their abortions or assisting someone else who self-managed their abortion.<sup>85</sup> There has never been a federal arrest for self-managed abortion, but federal law contains several provisions that anti-abortion prosecutors or administrations could use to charge people who self-manage their abortions.

While many of the federal and state laws that purportedly criminalize self-managed abortion may be unconstitutional or inapplicable upon appellate review, they may still provide a pretext for investigating, arresting, or jailing people who self-manage their abortions.<sup>86</sup> However, state arrests and prosecutions have shown that not even explicit statutory language exempting pregnant people from prosecution for harm to their own fetus dissuades prosecutors from bringing charges for self-managed abortion. Therefore, this Section does not examine the validity of criminal abortion laws or which charges might survive an appeal, but instead provides an overview of which laws can provide a pretext for investigating, arresting, or jailing people who self-manage their abortions. As the experiences of women who have been arrested or prosecuted for self-managed abortion show, the punishment of these charges is felt well before sentencing. It comes in the form of nights in jail, the disclosure of personal details to your entire community, and time and money lost trying to defend yourself.

#### A. State Responses to Self-Managed Abortion

State charges for people who self-manage their abortions fall into three broad categories: criminal abortion charges, murder charges, and a grab-bag of

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(finding that “[a] key reason for participants’ seeking abortion medications online was that they had encountered barriers to clinic access. A major barrier for participants living in states with restrictive laws was the high cost of clinical care”); Grossman et al., *supra* note 51, at 141 (stating that a third of the women surveyed were motivated to self-induce an abortion because of financial barriers); Stephens-Davidowitz, *supra* note 9 (“Eight of the 10 states with the highest search rates for self-induced abortions are considered by the Guttmacher Institute to be hostile or very hostile to abortion. None of the 10 states with the lowest search rates for self-induced abortion are in either category.”).

85. Belluz, *supra* note 7.

86. For an overview of these arguments see the irreplaceable study *Roe’s Unfinished Promise*. Diaz-Tello, *supra* note 28, at 6–20.

“whatever will stick” charges that prosecutors have reached for when there are no charges available from the first two categories. While some states have criminal abortion laws that explicitly apply to self-managed abortion, many other states have broad criminal abortion laws that can be read to apply to self-managed abortion. Some state murder laws suffer from a similar ambiguity. Fetal homicide statutes that do not exclude pregnant people from liability open the door to murder charges for people who self-manage their abortions. And even explicit exemptions of pregnant people from liability under fetal homicide statutes do not prevent them from being arrested or charged for fetal homicide. As evidenced by the final “grab-bag” category of charges, state attempts to prosecute people for self-managed abortion are motivated not by enforcement of laws but by the desire to punish people who self-manage their abortions.

The first category of charges faced by people who self-manage their abortions is criminal abortion charges. Although *Roe* forbade states from universally criminalizing abortion, *Roe* and its progeny allow governments substantial discretion in regulating how these legal abortions take place, including criminalizing abortions not performed by certain professionals.<sup>87</sup> A number of states have taken advantage of this weakness in the Supreme Court’s abortion jurisprudence.

Seven states explicitly criminalize self-managed abortion.<sup>88</sup> This was the type of law that was used to charge Jennie Linn McCormack.<sup>89</sup> In Idaho, “[e]very woman who knowingly submits to an abortion or solicits of another, for herself, the production of an abortion, or who purposely terminates her own pregnancy otherwise than by a live birth, shall be deemed guilty of a felony.”<sup>90</sup> Although the Ninth Circuit eventually overturned McCormack’s conviction on constitutional grounds, the ruling was limited to her case, and Idaho’s criminalization of self-managed abortion remains in force.<sup>91</sup>

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87. See *Roe v. Wade*, 410 U.S. 113, 163 (1972) (“[F]or the period of pregnancy prior to this ‘compelling’ point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated.”). But see *McCormack v. Hiedeman*, 694 F.3d 1004 (9th Cir. 2012) (holding that Idaho’s criminal abortion law was unconstitutional as applied to the plaintiff, but not addressing the broader constitutionality of the law.)

88. Diaz-Tello, *supra* note 28, at 6. As the report notes, some of these laws may be unenforceable, but court decisions invalidating them have either been limited or not enforced. *Id.* Since this report was published, New York’s criminal abortion statute has been repealed, but Georgia has passed a law that likely criminalizes abortion. See N.Y. PUB. HEALTH LAW §§ 2599-aa–bb (McKinney 2019); Kristen Williams, *Federal Judge Strikes Down Georgia Anti-Abortion Law*, JURIST (July 15, 2020) <https://www.jurist.org/news/2020/07/federal-judge-strikes-down-georgia-anti-abortion-law/> [<https://perma.cc/9K3J-TLAW>].

89. Jessica Robinson, *Idaho Woman Arrested for Abortion is Uneasy Case for Both Sides*, NPR (Apr. 9, 2012) <https://www.npr.org/templates/story/story.php?storyId=150312812> [<https://perma.cc/SUBF-KCUG>].

90. IDAHO CODE ANN. § 18-606 (West 2020).

91. *McCormack*, 694 F.3d at 1014–18.

Fourteen states have laws that generally criminalize abortion and lack specific exemptions for self-managed abortion, raising the possibility of these laws being used to prosecute self-managed abortions.<sup>92</sup> Anna Yocca, a Tennessee resident, attempted to use a coat hanger to self-manage her abortion, and was arrested after seeking care at a hospital.<sup>93</sup> She was charged with attempted criminal abortion and attempted procurement of a miscarriage.<sup>94</sup> In Tennessee, “[e]very person who performs an abortion commits the crime of criminal abortion,” and “[e]very person who attempts to procure a miscarriage commits the crime of attempt to procure criminal miscarriage,” unless (among other requirements) they are acting pursuant to the judgement of their physician.<sup>95</sup> Yocca eventually pled guilty to attempted procurement of a miscarriage after spending more than a year in jail.<sup>96</sup> Although these Tennessee laws had never before been used to prosecute someone for attempting to induce their own abortion, their broad wording gave prosecutors the leeway to weaponize them against Yocca.<sup>97</sup>

The second category, murder charges, also accounts for many recorded arrests for self-managed abortion. These charges typically rely on fetal homicide statutes that are so broadly written that they allow someone to be criminally charged for the death of their own fetus in utero.<sup>98</sup> Fetal homicide statutes are meant to allow someone to be criminally charged for the in utero death of another person’s fetus.<sup>99</sup> Thirty-eight states currently have fetal homicide laws, and in twenty-nine of these states, the laws apply at any stage of pregnancy from conception onwards.<sup>100</sup>

Purvi Patel’s case illustrates the harsh punishments that these laws can enable. Patel, an Indiana resident, allegedly used medication ordered over the internet to induce an abortion.<sup>101</sup> As a result, she was sentenced to twenty years in prison for feticide and child neglect.<sup>102</sup> This prosecution was possible because

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92. See Diaz-Tello, *supra* note 28, at 18. Massachusetts has repealed its criminal abortion law since the report was produced. See Gov. Baker Signs Bill Repealing Antiquated Mass. Abortion Ban, WBUR NEWS (July 27, 2018), <https://www.wbur.org/news/2018/07/27/baker-smoking-age-abortion-laws> [<https://perma.cc/24NW-JQND>].

93. See Liam Stack, *Woman Accused of Coat-Hanger Abortion Pleads Guilty to Felony*, N.Y. TIMES (Jan. 11, 2017), <https://www.nytimes.com/2017/01/11/us/tennessee-abortion-crime.html> [<https://perma.cc/E8M4-6UP7>].

94. See *id.*

95. TENN. CODE ANN. § 39-15-201(2)(b)(1)-(2) (West 2017).

96. See Stack, *supra* note 93.

97. Diaz-Tello et al., *supra* note 28, at 17.

98. *Id.* at 14.

99. *Id.* at 13–14.

100. See *State Laws on Fetal Homicide and Penalty-Enhancement for Crimes Against Pregnant Women*, NAT’L CONF. OF ST. LEGISLATURES (May 1, 2018), <http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx> [<https://perma.cc/8FZM-2YSC>].

101. See Diaz-Tello et al., *supra* note 28, at 16.

102. See Molly Redden, *Purvi Patel Has 20-Year Sentence for Inducing Own Abortion Reduced*, GUARDIAN (July 22, 2016), <https://www.theguardian.com/us-news/2016/jul/22/purvi-patel-abortion-sentence-reduced> [<https://perma.cc/WLH4-PG95>].

the Indiana fetal homicide law, like the fetal homicide laws of several other states, does not explicitly exempt pregnant people from being prosecuted for harm to their own fetus.<sup>103</sup> The feticide conviction was later overturned by the Indiana Court of Appeals because there was no evidence that the legislature had intended the law to apply to pregnant people.<sup>104</sup> However, by the time Patel was released from prison, she had already spent more time behind bars than her sentence, which was reduced on appeal, actually required.<sup>105</sup>

Unlike Indiana, many states do explicitly exempt pregnant people from being prosecuted in connection with their own abortion under fetal homicide laws. However, as Kenlissia Jones's experience shows, even these carve-outs do not effectively protect people who self-manage their abortions. Jones, who lived in Georgia, could not afford to go to an abortion clinic, so she took misoprostol that she ordered online, delivering a fetus that died soon afterwards.<sup>106</sup> At the time, Georgia's fetal homicide statute did not apply to "[a]ny person for conduct relating to an abortion for which the consent of the pregnant woman . . . has been obtained" or "[a]ny woman with respect to her unborn child."<sup>107</sup> Nonetheless, Jones was initially charged with murder, per the fetal homicide statute. Though the homicide charges were subsequently dropped because the fetal homicide law obviously did not apply, Jones had already been arrested, spent three nights in jail, and been the subject of numerous news stories.<sup>108</sup>

The final category of charges against people who self-manage their abortions is best characterized as "whatever will stick." In cases where murder or abortion-related charges are unavailable, people who self-manage their abortions have been charged with unlawful practicing of pharmacy, possession

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103. See Diaz-Tello et al., *supra* note 28, at 15–16.

104. See *Patel v. Indiana*, 60 N.E.3d 1041, 1044 (Ind. Ct. App. 2016).

105. See Associated Press, *Judge Says Purvi Patel Should Be Freed Immediately after Feticide Conviction Overturned*, *GUARDIAN* (Aug. 31, 2016), <https://www.theguardian.com/us-news/2016/sep/01/purvi-patel-freed-immediately-feticide-conviction-overturned> [<https://perma.cc/7SNM-RQRL>].

106. Abby Phillip, *Murder Charges Dropped against Georgia Woman Jailed for Taking Abortion Pills*, *WASH. POST* (June 10, 2015), <https://www.washingtonpost.com/news/morning-mix/wp/2015/06/10/woman-charged-with-murder-didnt-have-any-money-to-get-an-abortion-the-legal-way-brother-says/> [<https://perma.cc/CAH6-EMH7>].

107. GA. CODE ANN. § 16-5-80 (2006).

On May 8, 2019, the Governor of Georgia signed a law that recognizes "unborn children as natural persons." H.B. 481 (Ga. 2019). This recognition does not contain an exemption for the actions of pregnant people towards their fetuses, and some supporters argued that it would allow the criminal prosecution of people who have abortions under the state's general murder statute by recognizing fetuses as legal persons. *Id.*; Tessa Stuart, *Georgia D.A. Says He Would Prosecute Women Who Get Abortions*, *ROLLING STONE* (May 23, 2019), <https://www.rollingstone.com/politics/politics-news/george-d-a-says-he-will-prosecute-women-who-get-abortions-836145/> [<https://perma.cc/6NL5-ETWV>]. One Georgia district attorney has publicly committed to prosecuting people who have abortions. *Id.*

108. Crimesider Staff, *Murder Charge Dropped for Ga. Woman who Induced Abortion*, *CBS NEWS* (June 10, 2015), <https://www.cbsnews.com/news/murder-charges-dropped-against-kenlissia-jones-who-induced-her-own-abortion/> [<https://perma.cc/62EZ-82B3>].

of dangerous drugs, abuse of a corpse, and concealing a birth.<sup>109</sup> Anne Bynum, an Arkansas resident, delivered a stillborn fetus at her home.<sup>110</sup> She was accused of taking misoprostol to induce an abortion and charged with abuse of a corpse and concealing a birth, both felonies. Although the abuse of a corpse charge was ultimately dismissed, Bynum was sentenced to six years in prison for concealing a birth.<sup>111</sup> Some states also have laws regulating the practice of medicine that could conceivably be used to charge someone who self-manages their abortion.<sup>112</sup> Jennifer Whalen, mentioned above, was sentenced to up to eighteen months in prison for giving her daughter misoprostol that Whalen had ordered online.<sup>113</sup> Pennsylvania does not criminalize self-managed abortion, so Whalen was charged with unlicensed practice of pharmacy.<sup>114</sup> As with arrests and charges that ignore the plain language of fetal homicide statutes, these grab-bag prosecutions are further evidence of the true goal of the criminal justice system regarding people who self-manage their abortions: to punish them for having abortions, using whatever means are available.

The social identities of the persons charged are a compounding factor for all of these charges. All publicly reported state self-managed abortion investigations have targeted women who are low-income women, women of color, or women who are both.<sup>115</sup> These women are caught in a vise with abortion restrictions on one side and a criminal justice that targets low-income communities and communities of color on the other.<sup>116</sup> Abortion restrictions disproportionately prevent low-income women and women of color from accessing abortions in clinical settings, making them more likely to consider self-managing their abortions.<sup>117</sup> At the same time, low-income women and women

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109. Diaz-Tello et al., *supra* note 28, at 18–19.

110. *Id.* at 19.

111. *Id.*

112. *Id.* at 18.

113. Emily Bazelon, *A Mother in Jail for Helping Her Daughter Have an Abortion*, N.Y. TIMES (Sept. 22, 2014), <https://www.nytimes.com/2014/09/22/magazine/a-mother-in-jail-for-helping-her-daughter-have-an-abortion.html> [<https://perma.cc/2FDZ-9DW4>].

114. *Id.*

115. *See generally* Diaz-Tello, *supra* note 28.

116. *See generally id.*

117. *See* Erin Durkin, ‘Women Will Die’: How New Abortion Bans Will Harm the Most Vulnerable, GUARDIAN (May 19, 2019), <https://www.theguardian.com/us-news/2019/may/19/abortion-ban-alabama-women-of-color-poor> [<https://perma.cc/7AFS-UC9T>]; Dan Keating et al., *Abortion Access is More Difficult for Women in Poverty*, WASH. POST (July 10, 2019), <https://www.washingtonpost.com/national/2019/07/10/abortion-access-is-more-difficult-women-poverty/> [<https://perma.cc/G43P-7BDQ>]; Kimya Forouzan, *Restrictions on Later Abortions Hurt People of Color the Most*, REWIRE.NEWS (Feb. 6, 2019), <https://rewire.news/article/2019/02/06/restrictions-on-later-abortions-hurt-people-of-color-the-most/> [<https://perma.cc/68EV-7QSU>]; Jamila Taylor, *Women of Color Will Lose the Most if Roe v. Wade Is Overturned*, CTR. FOR AM. PROGRESS (Aug. 23, 2018), <https://www.americanprogress.org/issues/women/news/2018/08/23/455025/women-color-will-lose-roe-v-wade-overturned/> [<https://perma.cc/EZ6W-42PS>] (“[W]omen of color are more likely to live in states with the most restrictive abortion laws.”).

of color are much more likely to be both surveilled and viewed with suspicion by their governments, doctors, and communities, and thus more likely to have their self-managed abortions investigated by law enforcement authorities.<sup>118</sup> The roles that racism and classism play in criminalizing this aspect of pregnant people's reproductive lives is echoed in state arrests and prosecutions of pregnant people for conduct during their pregnancy, which disproportionately affect women of color and low-income women.<sup>119</sup> Standing at the at the intersections

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The lawsuit challenging Georgia's criminalization of abortion after six weeks has intentionally foregrounded these disparities, naming the SisterSong Women of Color Reproductive Justice Collective as the lead plaintiff and enumerating the specific risks that the law poses to Black women. Imani Gandy, *New Abortion Ban Lawsuit Places Black Georgians Squarely at the Center of the Fight*, REWIRE.NEWS (July 3, 2019), <https://rewire.news/ablc/2019/07/03/new-abortion-ban-lawsuit-places-black-georgians-squarely-at-the-center-of-the-fight/> [<https://perma.cc/QP9B-XEV8>].

118. This surveillance and suspicion occurs through a variety of vectors, including the child protection system, social safety net programs, the criminal justice system, and the health care system. See NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES, BLACK WOMEN'S MATERNAL HEALTH: A MULTIFACETED APPROACH TO ADDRESSING PERSISTENT AND DIRE HEALTH DISPARITIES 4 (Apr. 2018), <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf> [<https://perma.cc/P927-PGZ2>] ("Black women are more likely to report having been pressured by a clinician to use a contraceptive method."); Khiara M. Bridges, *Privacy Rights and Public Families*, 34 HARV. J.L. & GENDER 113, 158 (2011); Stephanie Clifford & Jessica Silver-Greenberg, *Foster Care as Punishment: The New Reality of 'Jane Crow'*, N.Y. TIMES (July 21, 2017), <https://www.nytimes.com/2017/07/21/nyregion/foster-care-nyc-jane-crow.html> [<https://perma.cc/2X85-TTBU>]; Larissa MacFarquhar, *When Should a Child Be Taken from His Parents?*, NEW YORKER (July 31, 2017) [<https://perma.cc/2MWG-FPZQ>]; #SayHerName: Resisting Police Violence Against Black Women, AFRICAN AM. POL'Y F. & CTR. FOR INTERSECTIONALITY AND SOC. POL'Y STUD. (July 16, 2015), <https://aapf.org/sayhernamereport> [<https://perma.cc/Y987-GUDM>]; Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 313 (2013) (finding that arrests of and interventions on Black women were more than twice as likely than those of white women to be instigated by health care providers and social workers).

119. A study of arrests and forced interventions on pregnant women between 1973 and 2005 found that fifty-two of the women targeted were Black and 71 percent qualified for indigent defense. See Paltrow, *supra* note 118, at 310. A state-level analysis of pregnancy-related arrests also found that Black women were disproportionately arrested for pregnancy-related conduct. Grace Elizabeth Howard, *The Criminalization of Pregnancy: Rights, Discretion, and the Law* 62 (Oct. 2017) (unpublished Ph.D. dissertation, Rutgers University), <https://rucore.libraries.rutgers.edu/rutgers-lib/55493/PDF/1/play/> [<https://perma.cc/HZ4E-TFP6>]. The opioid epidemic, which took hold more strongly in white communities than Black communities, has shifted this statistical pattern somewhat, with more white than Black women being prosecuted for crimes related to drug-use during pregnancy, although low-income women continue to make up the vast majority of prosecutions. Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization Of Opioid Use During Pregnancy*, 133 HARV. L. REV. 770, 822–23 (2020). However, prosecutions of white women are distinctly less punitive than those of Black women, focusing on harm to infants and "using state power to affirm that an innocent has been wronged and to penalize those who are believed to have committed that wrong," rather than "a reprisal for those who generated the social ills with which the nation would have to wrestle." *Id.* at 835. Additionally, the increase in pregnancy-related prosecutions of white women does not reflect the diminished salience of race in the criminal justice system, but rather the fact that "white privilege is a disloyal friend to white people," particularly those "who exist at the intersections of other categories of disadvantage — like those who are poor, transgender, not straight, or disabled." *Id.* at 851.

of sexism, racism, and classism, low-income women and women of color are shut out of conventional methods of abortion access, but are more likely to be criminalized and vilified if they pursue self-managed abortion.<sup>120</sup> Within America's current system of abortion regulation, "[w]omen with privileges . . . get rights."<sup>121</sup> Pregnant people with economic and racial privileges have easier access to abortions in clinical settings, and are less likely to face government persecution if they do choose to self-manage their abortions.

Regardless of what charges are brought or those charges' legitimacy, criminal self-managed abortion cases have a destructive effect on the lives of the people targeted. The government does not actually need a viable legal foundation to punish people for self-managing their abortions. Even if police and prosecutors misapply state law and self-managed abortion charges are later dropped or overturned, the act of investigating someone massively disrupts their life. They will have to find and pay a lawyer, and juggle the logistics of the time off work, transportation, or extra childcare needed to manage their defense. They may lose their job or spend months in jail before their case even gets to trial.<sup>122</sup> They will also be subject to vicious public scrutiny. McCormack was shunned by her entire town and still avoids leaving the house.<sup>123</sup> Intimate details of her life are available on the internet for anyone who searches her name to read. Criminal investigations and prosecutions are punishments that require only the thinnest legal justification to succeed because their consequences are felt well before someone enters a courtroom.

#### B. Federal Responses to Self-Managed Abortion

The federal government has never prosecuted someone for self-managed abortion, but there are several laws that could be used for this purpose, particularly if people use abortion medications. Laws regulating the importation of prescription drugs could subject people who self-manage medication abortions to fines and jail time. Additionally, the federal criminal code contains two variations on a fetal homicide law, raising the possibility of federal murder charges for people who self-manage their abortions. As with state prosecutions, the fact that these laws have never been used against people who self-manage their abortions or explicitly carve out self-managed abortion does not mean that they could not one day be used to both persecute and prosecute people who self-manage their abortions.

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120. The concept of "intersectionality," particularly as it relates to the oppression of women of color, was first explored by Kimberlé Crenshaw. *See, e.g.,* Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color*, 43 STAN. L. REV. 1241 (1991) (detailing the particular violence, including battering and rape, directed toward people with intersectional identities).

121. CATHARINE A. MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* 191 (1989).

122. Diaz-Tello et al., *supra* note 28, at 20.

123. Calhoun, *supra* note 78.

### 1. Federal Prescription Drug Regulations

The Federal Food, Drug, and Cosmetic Act (FFDCA) bars people from importing both misoprostol and mifepristone for personal use. Section 381 of the FFDCA forbids the importation of a drug by anyone but the manufacturer.<sup>124</sup> There is a limited personal use exception to the importation ban, but it is uncodified and discretionary.<sup>125</sup> In any case, the exemptions are unlikely to apply to the importation of self-managed abortion medications because there is by definition no prescribing doctor within the United States, effective abortion treatments are available (albeit often inaccessible) within the United States, and mifepristone has been identified as a risky drug through its inclusion in REMS.<sup>126</sup> Additionally, some suppliers of misoprostol and mifepristone do not ship their drugs with an FDA approved label.<sup>127</sup> Section 352 of the FFDCA forbids the importation of any drugs that do not conform to U.S. labelling standards.<sup>128</sup> The penalty for importing misbranded drugs is a prison sentence of up to one year, a fine of up to \$1,000, or both.<sup>129</sup> The penalty for illegally importing drugs is a prison sentence of up to ten years and a fine of up to \$250,000, or both.<sup>130</sup>

The FDA has never prosecuted an individual for importing drugs, and the FFDCA contains language explicitly stating that the FDA should “focus enforcement on cases in which the importation by an individual poses a

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124. 21 U.S.C. §§ 331(t), 381(d)(1) (2018).

125. U.S. FOOD & DRUG ADMIN., REGULATORY PROCEDURES MANUAL: IMPORT OPERATIONS AND ACTIONS 24 (2017).

In allowing personal shipments of drugs or devices, FDA personnel may consider a more permissive decision in the following situations:

1. when the intended use is appropriately identified, such use is not for treatment of a serious condition, and the product is not known to represent a significant health risk; and
2. when a) the intended use is unapproved and for a serious condition for which effective treatment may not be available domestically either through commercial or clinical means; b) there is no known commercialization or promotion to persons residing in the U.S. by those involved in the distribution of the product at issue; c) the product is considered not to represent an unreasonable risk; and d) the individual seeking to import the product affirms in writing that it is for the patient’s own use (generally not more than 3 month supply) and provides the name and address of the doctor licensed in the U.S. responsible for his or her treatment with the product, or provides evidence that the product is for the continuation of a treatment begun in a foreign country.

*Id.* at 9-24.

126. *See id.* *See also* Center for Drug Evaluation and Evaluation, *supra* note 40 (including mifepristone in the REMS program).

127. *See, e.g.,* Thomas Christi, *Warning Letter: Aidaccess.org MARCS-CMS 575658*, U.S. FOOD & DRUG ADMIN. (Mar. 8, 2019), <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019> [<https://perma.cc/596V-F9H8>].

128. 21 U.S.C. §§ 331(a), 352 (2018).

129. *Id.* § 333(a)(1).

130. *Id.* § 333(b)(1)(A).

significant threat to public health.”<sup>131</sup> Nevertheless, if an administration wanted to prosecute people for importing drugs, including abortion medication, it would be within their authority. It is not unimaginable that an anti-abortion administration would decide to do so, particularly if continued changes to state laws or a shift in federal abortion jurisprudence push more people to consider self-managed abortion. Worryingly, in the last two years the FDA has launched several investigations into sellers of abortion medications.<sup>132</sup> In 2018, the FDA also launched an investigation of Ursula Wing, a New York woman who sold abortion medication online.<sup>133</sup> A grand jury has since indicted Wing for conspiracy to defraud the United States and the interstate sale of unapproved, misbranded drugs.<sup>134</sup> Together, these charges carry a maximum penalty of eight years.<sup>135</sup> Then, in 2019, the FDA sent a warning letter to Aid Access, an organization that has mailed medications for self-managed abortion, ordering them to stop distributing to the United States.<sup>136</sup> Aid Access alleges that the FDA has also seized the organization’s packages and directed online payment platforms to block their transactions.<sup>137</sup> The FDA has also demonstrated increasing hostility towards the personal use importation exception. It has stepped up seizures of personal medication shipments and has announced plans to quintuple its package inspection capacity.<sup>138</sup> In combination, these enforcement strategies could pave the way for actions targeting individual American purchasers of abortion medication.

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131. *Id.* § 384(j)(1)(A) (2018); see Phil Galewitz, *Cities, Counties and Schools Sidestep FDA Canadian Drug Crackdown, Saving Millions*, WASH. POST (Dec. 8, 2017), [https://www.washingtonpost.com/national/health-science/cities-counties-and-schools-sidestep-fda-canadian-drug-crackdown-saving-millions/2017/12/08/b2de0ce2-dc00-11e7-a241-0848315642d0\\_story.html](https://www.washingtonpost.com/national/health-science/cities-counties-and-schools-sidestep-fda-canadian-drug-crackdown-saving-millions/2017/12/08/b2de0ce2-dc00-11e7-a241-0848315642d0_story.html) [<https://perma.cc/3BMH-5L3T>].

132. See Chelsea Conaboy, *She Started Selling Abortion Pills Online. Then the Feds Showed Up.*, MOTHER JONES (Mar./Apr. 2019), <https://www.motherjones.com/politics/2019/02/she-started-selling-abortion-pills-online-then-the-feds-showed-up/> [<https://perma.cc/XY9-8UC7>]

133. *Id.*

134. Press Release, U.S. Att’y’s Off. W. Dist. Wis., Grand Jury Returns Indictments (June 27, 2019), <https://www.justice.gov/usao-wdwi/pr/grand-jury-returns-indictments-88> [<https://perma.cc/GQ3G-FN34>].

135. *Id.*

136. See Sarah MacCamon, *European Doctor Who Prescribes Abortion Pills To U.S. Women Online Sues FDA*, NPR (Sept. 9, 2019), <https://www.npr.org/2019/09/09/758871490/european-doctor-who-prescribes-abortion-pills-to-u-s-women-online-sues-fda> [<https://perma.cc/5FJU-6F7G>]; Christi, *supra* note 127.

137. Verified Complaint at 12, *Gomperts v. Azar*, No. 1:19-cv-00345, 2019 WL 4257409 (D. Idaho July 13, 2019). In response to the warning letter and alleged seizures and payment interference, Aid Access and its founder, Dr. Rebecca Gomperts, have sued the FDA. *Id.* The suit argues that the medication seizures and potential prosecution of Dr. Gomperts place an undue burden on the right to abortion, violate the Equal Protection Clause, and are arbitrary and capricious. *Id.* at 16–17.

138. See Phil Galewitz, *Amid Pandemic, FDA Seizes Cheaper Drugs From Canada*, KAISER HEALTH NEWS (Apr. 20, 2020), <https://khn.org/news/amid-pandemic-fda-seizes-cheaper-drugs-from-canada/> [<https://perma.cc/C98Z-3JEB>]; Galewitz, *Cities, Counties and Schools Sidestep FDA*, *supra* note 131.

## 2. Federal Criminal Statutes

In addition to federal drug regulations, there are two federal statutes criminalizing the death of fetuses that could conceivably be used to charge people who self-manage their abortions, mirroring actions that state prosecutors have taken. The first statute is the 2004 Unborn Victims of Violence Act (UVVA), which defines in utero fetuses as people for the purpose of several federal crimes, including murder.<sup>139</sup> UVVA explicitly carves out self-managed abortion, stating that “nothing in this section shall be construed to permit the prosecution . . . of any woman with respect to her unborn child.”<sup>140</sup> Yet, as Kenlissia Jones’s experiences with Georgia’s fetal homicide law show, carve-outs do not necessarily dissuade prosecutors from attempting to bring fetal homicide charges.<sup>141</sup>

The second statute is the Born-Alive Infant Protection Act of 2002 (BIPA), which, like UVVA, expanded the definition of personhood, this time to ex utero fetuses.<sup>142</sup> BIPA was intended to protect fetuses that were born alive following induced abortions, and was passed despite the fact that infants being born alive as a result of abortion is vanishingly rare.<sup>143</sup> The act extends the definition of “person” and related terms in federal criminal statutes to “every infant member of the species homo sapiens who is born alive at any stage of development.”<sup>144</sup> What UVVA is to in utero fetuses and stillborn fetuses, BIPA is to fetuses that survive outside the womb.<sup>145</sup>

However, unlike UVVA, BIPA does not bar liability for people with respect to their own fetuses and infants. In *United States v. Flute*,<sup>146</sup> the Eighth Circuit allowed Samantha Flute to be prosecuted for involuntary manslaughter because of her prenatal drug use. Flute, who had used drugs while pregnant, gave birth to a baby who died soon after birth due to drug toxicity.<sup>147</sup> She was then charged with involuntary manslaughter.<sup>148</sup> While the district court read the UVVA’s exemption of the actions of people with respect to their own fetuses into the broader federal involuntary manslaughter statute, the Eighth Circuit held that because the fetus survived for several hours after it was born, BIPA, not the

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139. See 18 U.S.C. § 1841(a) (2018).

140. See *id.* § 1841(c)(3).

141. See Phillip, *supra* note 106.

142. 1 U.S.C. § 8 (2018).

143. Lori Robertson, *The Facts on the Born-Alive Debate*, FACTCHECK.ORG (Mar. 4, 2019), <https://www.factcheck.org/2019/03/the-facts-on-the-born-alive-debate/> [https://perma.cc/R43L-5QBS] (describing the extremely low numbers of fetuses that are reported as being born alive in state-level abortion data).

144. *Id.*

145. *Id.*

146. 929 F.3d 584 (8th Cir. 2019).

147. *Id.* at 586.

148. *Id.*

UVVA, applied, so Flute could be prosecuted.<sup>149</sup> As the dissent noted, this decision ignored the centuries-old prohibition against prosecuting women for manslaughter because of their prenatal acts.<sup>150</sup> The logic of *Flute* could conceivably be used to prosecute people who self-manage their abortion if the fetus initially survives the uterus.<sup>151</sup>

The discomfiting truth is that, at both the state and federal levels, an administration or individual who is determined to punish people for self-managing their abortions can find a way, even if it requires stretching legal doctrines. As Jill Adams, an expert on self-managed abortion, has observed, “[W]hen a prosecutor decides they’re going to punish someone for ending their own pregnancy, what the law says is practically secondary.”<sup>152</sup> If an anti-abortion administration decides to make self-managed abortion an enforcement priority, the FDA’s unofficial policy of not prosecuting people who import drugs for personal use and carve-outs in criminal statutes will be cold comfort. Likewise, *Flute* shows that precedent alone cannot constrain judges from expanding the scope of anti-abortion laws. Like they do with disaster response plans, states and cities should adopt policies guarding against federal prosecutions of self-managed abortion, hoping that these policies will never be tested but knowing that they are only effective if they’re in place well before they’re needed.

### III.

#### THE PATH TO “ABORTION SANCTUARIES”

The combination of restrictions on access to abortions in clinical settings and penalties for self-managed abortion sets a vicious trap. First, pregnant people are cut off from abortions in clinical settings, pushing them towards self-inducing abortion. Then they are punished if they try to self-induce. This gives rise to two interlinked dangers: the use of harmful and ineffective methods of self-induction by pregnant people and the punishment of those people for exercising their human right to have an abortion. An effective local self-managed abortion policy must respond to both these dangers by increasing the flow of information and services to people seeking to self-manage their abortion while restricting the flow of identifying information about those who have self-managed abortions to state and federal authorities.

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149. *Id.* at 588.

150. *Id.* at 591–92 (Colloton, J., dissenting).

151. In Michelle Roberts’s case, Roberts told police investigators that her fetus died shortly after birth. See DeNeen L. Brown, ‘I Know What’s Buried in the Back Yard’: A Woman Faces a Rare Charge of Self-Induced Abortion, WASH. POST (Apr. 21, 2017), [https://www.washingtonpost.com/local/i-know-whats-buried-in-the-back-yard-a-woman-faces-a-rare-charge-of-self-induced-abortion/2017/04/20/6276452c-1fc1-11e7-a0a7-8b2a45e3dc84\\_story.html](https://www.washingtonpost.com/local/i-know-whats-buried-in-the-back-yard-a-woman-faces-a-rare-charge-of-self-induced-abortion/2017/04/20/6276452c-1fc1-11e7-a0a7-8b2a45e3dc84_story.html) [https://perma.cc/92UN-5JNV]. Likewise, prosecutors alleged that Purvi Patel’s fetus was initially alive. See Redden, *supra* note 102.

152. Belluz, *supra* note 7.

This Section argues that cities should become “abortion sanctuary cities” by adopting a harm reduction approach when providing information about safely self-managing abortion while limiting the collection, retention, and accessibility of information about people who self-manage their abortions. The use of harm reduction techniques to address self-managed abortion would build on the harm reduction programs that many American cities instituted in response to opioid use as well as the practices of Latin American feminist groups that have used harm reduction frameworks to spread information about self-managed abortion. Cities should couple harm reduction policies with information protection measures limiting the amount of information about self-managed abortion that they can provide to state and federal authorities as well as the amount of information about self-managed abortion that the city retains.

These proposals are meant to be a blueprint, a set of goals that cities can use to shape their own approach to self-managed abortion. The best policy for each city will be determined by its legal structure, applicable state law, and the needs of local stakeholders—vague concepts, and intentionally so. The legality of self-managed abortion and the extent to which local policies can be preempted are fact-intensive inquiries that are highly specific to each state. Likewise, each locality’s public health needs, political power distribution, and risk tolerance will be different. To successfully adopt abortion sanctuary policies, city governments must be committed to deep and extended community engagement. Put more simply, they have to be in it for the long and complicated haul.

To that end, instead of a proscription, this Section offers a framework for further research that is more tailored to each locality’s specific circumstances. In particular, cities should closely examine their state’s practice of medicine, accessory liability, mandatory reporting, and obstruction of justice laws, as well as their state’s preemption jurisprudence. “Abortion sanctuary” ultimately describes a set of principles and goals rather than policy prescriptions, and cities should adapt their abortion sanctuary policies to reflect their particular realities.

*A. Expanding Access to Information About Safely Self-Managing Abortion*

As state abortion policies grow more and more restrictive, more people will likely turn to self-managing their abortion. To do so safely, they need information. Cities, applying the principles of harm reduction, can provide this information. The use of harm reduction models by Latin American feminists to support people who self-manage their abortions and by U.S. cities to respond to drug crises demonstrates that: (1) harm reduction techniques can be successful in supporting people who self-manage their abortions, and (2) local governments can successfully adopt harm reduction techniques. Cities should draw on these examples and, to the extent that state and federal law will allow, use their many

existing channels of communication with residents to share information about how to safely take misoprostol and mifepristone.

Before diving into the use of harm reduction approaches, it is helpful to explain what harm reduction is. As Joanna Erdman defined it in her work on self-managed abortion in Uruguay, “[h]arm reduction captures policies, programs, and practices that seek to reduce harms associated with an activity without requiring prohibition of the activity itself. Three core principles can be further elaborated: neutrality, humanism, and pragmatism.”<sup>153</sup> Care provided within a harm reduction model does not make normative judgements about the target activity, treats all individuals with the same level of care, and emphasizes evidence-based treatments for harmful activities rather than prohibitions.<sup>154</sup>

Both Latin American abortion access activists and American cities have successfully used harm reduction models. In Chile, the Lesbians and Feminists for the Right to Information (LFRI) hotline is a major source of information about safely self-managing abortion.<sup>155</sup> Activists staffing the hotline provide pregnant people with instructions for safely performing a medication abortion.<sup>156</sup> To skirt the fact that abortion is illegal in Chile, the hotline does not provide personalized replies, instead reading from the WHO medication abortion guidelines and talking only in general terms about what a pregnant person could do.<sup>157</sup>

Alternatively, in Uruguay, where abortion is legal, public health officials have developed the “Uruguay model.” Pregnant people considering abortion are first offered a pre-termination doctor’s appointment, which includes a medical examination, information about abortion laws, information about safer methods of self-managed abortion, and non-directive counseling on the decision to continue or terminate their pregnancy.<sup>158</sup> Then, if they decide to terminate their pregnancy, individuals can receive a post-abortion consultation to confirm the termination, check for complications, and receive information about contraception.<sup>159</sup>

Both Uruguay’s and LFRI’s strategies are rooted in harm reduction and emphasize providing pregnant people with the medically accurate information they need to make an informed decision about whether and how to terminate their pregnancies.<sup>160</sup> This approach has been enormously successful in reaching

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153. Erdman, *supra* note 45, at 423.

154. *Id.*

155. Emily Anne, *The Chilean Safe Abortion Hotline: Assisting Women With Illegal, But Safe, Misoprostol Abortion*, REWIRE.NEWS (Oct. 18, 2012), <https://rewire.news/article/2012/10/18/illegal-but-safe-abortion-with-misoprostol-chilean-safe-abortion-hotline/> [<https://perma.cc/8BUJ-RDCG>].

156. *Id.*

157. *Id.*

158. Erdman, *supra* note 45, at 420–21.

159. *Id.* at 421.

160. See Joanna N. Erdman et al., *Understandings of Self-Managed Abortion as Health Inequity, Harm Reduction and Social Change*, 26 REPROD. HEALTH MATTERS 13, 15 (2018); Alyson Hyman et

people who need information about safely self-managing an abortion. Between 2009 and 2015, the LFRI hotline answered more than 20,000 calls.<sup>161</sup> Other Latin American safe abortion hotlines report similar call volumes.<sup>162</sup> The Uruguay model eventually expanded beyond an initial pilot at one hospital to every public health facility in the country, and nearly all patients report that they received the care they needed and felt respected.<sup>163</sup>

American cities have also adopted harm reduction approaches to confront public health issues, particularly in response to unsafe drug use. In the late 1980s, cities established needle exchange programs for injection drug users in an attempt to stem the spread of HIV.<sup>164</sup> Rather than focus solely on prohibiting drug use or what people would need to do to be *absolutely* safe, cities disseminated information and tools that people would need to be *safer* when injecting. Cities have deployed similar tactics to combat the rise in deaths due to opioid use.<sup>165</sup> As well as running or funding needle exchanges, many cities have also begun to distribute naloxone, an overdose reversal drug that is also sold as Narcan, throughout their communities and hold trainings on how to administer it. Since naloxone does not itself treat opioid addiction, naloxone distribution is, like needle exchange programs, a tool of harm reduction.<sup>166</sup>

Beyond their existing experience with harm reduction strategies, cities have the advantage of already being knowledge hubs. For example, local governments operate most U.S. public libraries.<sup>167</sup> In 2016, more than 50 percent of Americans

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al., *Misoprostol in Women's Hands: A Harm Reduction Strategy for Unsafe Abortion*, 87 *CONTRACEPTION* 128, 129 (2013).

161. Raquel Irene Drovetta, *Safe Abortion Information Hotlines: An Effective Strategy for Increasing Women's Access to Safe Abortions in Latin America*, 23 *REPROD. HEALTH MATTERS* 47, 51 (2015).

162. *Id.* at 50–52.

163. See Ana Labandera et al., *Implementation of the Risk and Harm Reduction Strategy Against Unsafe Abortion in Uruguay: From a University Hospital to the Entire Country*, 134 *INTERNATIONAL INT'L J. GYNECOLOGY & OBSTETRICS*, S7, S9 (August 2016); Erdman, *Access to Information on Safe Abortion*, *supra* note 45, at 241.

164. Don C. Des Jarlais, *Harm Reduction in the USA: The Research Perspective and an Archive to David Purchase*, 14 *HARM REDUCTION J.* 51, 53 (2017).

165. See, e.g., *A Combination of Approaches Helps Local Governments Tackle the Opioid Crisis*, PEW (May 10, 2018), <https://pew.org/2jNAXK1> [<https://perma.cc/UD8E-BU3X>]; Jonathan Penm et al., *Strategies and Policies to Address the Opioid Epidemic: A Case Study of Ohio*, 57 *J. AM. PHARMACISTS ASS'N* S148, S151 (2017); Erin Welch, *A Community of Recovery*, *CTR. FOR AM. PROGRESS*, (Jan. 10, 2019) <https://www.americanprogress.org/issues/criminal-justice/reports/2019/01/10/464889/a-community-of-recovery/> [<https://perma.cc/N5DK-FXEF>].

166. See Kathryn F. Hawk et al., *Reducing Fatal Opioid Overdose: Prevention, Treatment and Harm Reduction Strategies*, 88 *YALE J. BIOLOGY & MED.* 235, 236 (2015).

167. See Ariel Aberg-Riger, *A History of the American Public Library*, CITYLAB (Feb. 19, 2019), <https://www.citylab.com/design/2019/02/american-public-library-history-cities-visual-journalism/582991/> [<https://perma.cc/GZ8X-WM9J>]; Tod Newcombe, *Local Governments Consider Privatizing Public Libraries*, *GOVERNING*, (Oct. 6, 2010), <https://www.governing.com/blogs/view/privatizing-public-libraries.html> [<https://perma.cc/2Y73-LV8T>].

over the age of sixteen reported having some interaction with their public libraries.<sup>168</sup> Some public libraries are already involved in public health efforts, training volunteers to administer naloxone.<sup>169</sup> Additionally, hundreds of cities have 311 lines, a non-emergency number that residents can call to report problems and connect to city services.<sup>170</sup> These systems allow residents to ask questions and make complaints about local services and allow cities to distribute information about the services they offer.<sup>171</sup> In New York alone, there have been more than 100 million calls to 311 since the system was implemented.<sup>172</sup> One of the greatest strengths that cities have is that so many of their residents look to them for information, and cities in turn have so many ways to disseminate information to their residents.

Cities, following the example of Latin American feminists and municipal harm reduction programs, should utilize their extensive communication infrastructure to carry out a self-managed abortion harm reduction strategy. To the extent that it is legal, cities should provide simple, culturally appropriate information about safely self-managing abortion. They should also provide information about other abortion services that are available, such as Medicaid funding for abortion, wherever and however they currently provide public health information. They should leverage libraries, 311 lines, public transit ads, and city websites, to name just a few possible options.<sup>173</sup>

### 1. *The Legality of Municipal Self-Managed Abortion Harm Reduction Policies*

Cities' ability to adopt harm reduction measures is constrained by applicable state and federal laws. While it is unlikely that cities themselves can be held criminally liable, particularly in prosecutions by the federal government, government officials can be held liable for criminal acts.<sup>174</sup> Of particular concern are state laws governing the practice of medicine and practice of medicine, state criminal abortion laws, and state and federal fetal homicide laws. However, cities' public health powers may override otherwise applicable criminal laws.

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168. *Libraries 2016*, PEW RES. CTR. (Sept. 19, 2016), <https://www.pewinternet.org/2016/09/09/libraries-2016/> [<https://perma.cc/7GLF-9P9M>].

169. Terra Dankowski, *Addressing the Opioid Epidemic*, AM. LIBR. MAG. (June 25, 2019), <https://americanlibrariesmagazine.org/blogs/the-scoop/addressing-opioid-epidemic/> [<https://perma.cc/8ELK-XMR2>].

170. Tod Newcombe, *Is the Cost of 311 Systems Worth the Price of Knowing?*, GOVERNING (Mar. 2014) <https://www.governing.com/topics/urban/gov-311-systems-cost.html> [<https://perma.cc/KF6M-HJBK>].

171. *Id.*

172. Steven Johnson, *What a Hundred Million Calls to 311 Reveal About New York*, WIRED (Nov. 1, 2010) [https://www.wired.com/2010/11/ff\\_311\\_new\\_york/](https://www.wired.com/2010/11/ff_311_new_york/) [<https://perma.cc/6F8Y-WPQM>].

173. As explored in the Section below, there is no way to effectively prevent the creation of records about patients' interest in self-managed abortion.

174. See Stuart P. Green, *The Criminal Prosecution of Local Governments*, 72 N.C. L. REV. 1197, 1245 (1994).

Additionally, criminal accomplice liability—the type of liability that public employees would most likely be subject to—requires the presence of an underlying crime. Many state laws related to abortion do not actually criminalize self-managed abortion, and others are vulnerable to state and federal constitutional challenges. Beyond possible criminal liability, cities must also contend with preemption. Most preemption laws and doctrines are so state-specific that it is impossible to provide a detailed analysis of them all, so my hope is simply to provide a guide to possible avenues of research for cities that decide to pursue information-sharing policies.

With respect to the possibility of criminal liability, the history of needle exchange programs demonstrates that cities' public health powers may override state criminal laws. The federal government and many states have laws barring the distribution of drug paraphernalia, which needle exchange programs would appear to run afoul of.<sup>175</sup> Despite these laws, cities have successfully opened needle exchanges. Most notably, in *Spokane County Health District v. Brockett*, the Supreme Court of Washington held that a county needle exchange program did not violate a statute criminalizing the distribution of drug paraphernalia because of the broad authority the legislature granted the county Board of Health and health officers to regulate public health.<sup>176</sup> Other localities often used a similar tactic when establishing their needle exchange programs, analyzing their legality through the lens of public health rather than criminal law and drawing on their authority to respond to health emergencies to justify the programs.<sup>177</sup>

Furthermore, both direct criminal liability and accomplice liability require the presence of an actual criminal violation. Cities should carefully analyze their states' laws to verify whether providing information about self-managing abortion would violate state criminal laws. Laws that on their face seem to prohibit spreading instructions for safe self-managed abortion may not in fact do so. For example, it is a misdemeanor to practice medicine without a license in California, and state statutes explicitly include abortion within the practice of medicine.<sup>178</sup> This would seem to bar self-managed abortion. However, a long-standing California Attorney General opinion holds that you cannot practice

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175. Lawrence O. Gostin & Zita Lazzarini, *Prevention of HIV/AIDS among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention*, 46 EMORY L.J. 587, 614–15 (1997).

176. 839 P.2d 324 (Wash. 1992) (en banc).

177. See Scott Burris et al., *The Legal Strategies Used in Operating Syringe Exchange Programs in the United States.*, 86 AM. J. PUBLIC HEALTH 1161, 1163 (1996). But see *State v. City of Atlantic City*, 879 A.2d 1206 (N.J. Super. Ct. App. Div. 2005) (invalidating invalidated a local ordinance establishing a needle exchange program, despite the city raising its public health powers as a defense to the fact that state law outlawed needle exchanges).

178. See CAL. BUS. & PROF. CODE §§ 2052, 2253 (West 2020).

medicine on yourself.<sup>179</sup> This opinion, coupled with the lack of case law on the issue, suggests that the legality of self-managed abortion in California remains, at a minimum, an open question. And if self-managing your abortion is not a crime, there cannot be any accomplice liability for providing general information about self-managed abortion.

Likewise, providing information about self-managed abortion likely would not violate federal law, with the possible exception of BIPA. Self-managed abortion is an off-label use of misoprostol and mifepristone, but FDA regulations only prohibit off-label advertising by drug manufacturers.<sup>180</sup> Additionally, federal aiding and abetting liability, like state accomplice liability, requires the existence of an underlying crime.<sup>181</sup> Because the UVVA exempts the prosecution of people for harm to their fetuses, most self-managed abortions could not lead to a successful aiding and abetting prosecution.<sup>182</sup> Unfortunately, the Eighth Circuit's interpretation of BIPA—that BIPA applies to the actions of pregnant people towards their own fetuses—has opened up the possibility of aiding and abetting prosecutions in cases where a fetus survives, however briefly, once outside of the uterus.<sup>183</sup> That said, the Eighth Circuit is the only circuit to have ruled on this issue.

Even in cases where state law clearly criminalizes self-managed abortion, the laws may be vulnerable to constitutional challenges, both state and federal.<sup>184</sup> If laws criminalizing self-managed abortion are unconstitutional, they cannot provide a basis for accomplice liability because accomplice liability requires an underlying crime.<sup>185</sup> In *Griswold v. Connecticut*, the Supreme Court overturned the appellants' conviction for aiding and abetting in the use of contraceptives on the ground that the underlying prohibition on the use of contraceptives was

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179. See 62 Ops. Cal. Att'y. Gen. 792 (1979), 1979 WL 29316, \*3. See also 85 Ops. Cal. Att'y. Gen. 134 (2002), 2002 WL 1436304, \*3 (“[S]elf diagnosis or treatment is not proscribed by the Medical Practice Act . . .”).

180. See C. Lee Ventola, *Off-Label Drug Information: Regulation, Distribution, Evaluation, and Related Controversies*, 34 PHARMACY AND THERAPEUTICS 428 (2009).

Even drug manufacturers may distribute information about off-label drug uses, as long as they do so through copies of peer-reviewed articles describing off-label uses. See *id.* at 431.

181. See 18 U.S.C. § 2 (2018) (“(a) Whoever commits an offense against the United States or aids, abets, counsels, commands, induces or procures its commission, is punishable as a principal. (b) Whoever willfully causes an act to be done which if directly performed by him or another would be an offense against the United States, is punishable as a principal.”).

182. 18 U.S.C. § 1841(c)(3) (2018).

183. See *United States v. Flute*, 929 F.3d 584, 588–90 (8th Cir. 2019).

It remains very unlikely that self-managed abortions would violate BIPA. There are no reported prosecutions for self-managed abortion where it is uncontested that the fetus was delivered while breathing or while its heart was beating.

184. Specifically, laws criminalizing self-managed abortion may be vulnerable to undue burden, cruel and unusual punishment, freedom in medical decision making, government intrusion, coercion, and religious liberty challenges. See *Diaz-Tello*, *supra* note 28, at 21–24.

185. See, e.g., *United States v. Freed*, 921 F.3d 716, 721 (7th Cir. 2019) (“Additionally, it is axiomatic that one cannot aid and abet a crime unless a crime was actually committed.”).

unconstitutional.<sup>186</sup> Also notable is the Ninth Circuit's decision in Jennie Linn McCormack's case. Although the decision was limited to McCormack's specific case, the Ninth Circuit held that her prosecution for self-managed abortion was unconstitutional because it, in combination with Idaho's other restrictions on accessing abortion in a clinical setting, unduly burdened her right to an abortion.<sup>187</sup>

At the state level, no state supreme court has directly considered the constitutionality of self-managed abortion bans, but a number have established a right to abortion that extends beyond that established by federal jurisprudence. For example, the Supreme Court of Kansas recently held that the Kansas Constitution protects "the right of personal autonomy, which includes the ability to control one's own body, to assert bodily integrity, and to exercise self-determination. This right allows a woman to make her own decisions regarding her body, health, family formation, and family life . . . ."<sup>188</sup> The state is therefore "prohibited from restricting this right unless it is doing so to further a compelling government interest and in a way that is narrowly tailored to that interest."<sup>189</sup>

Outside of criminal liability, cities must also assess the possibility of state or federal abortion law preempting local abortion sanctuary laws. Preemption is such a fact-intensive analysis that it is not possible to fully analyze all possible preemption issues in this Note, but cities must consider it before adopting these policies recommendations. States have successfully used legislation to preempt local laws supporting a broad array of progressive policies, but some cities have managed to defend local public health laws against preemption claims.<sup>190</sup> Cleveland, Ohio's successful defense of a local law limiting trans fat in restaurants demonstrates the breadth of some cities' public health police powers.<sup>191</sup> The Ohio Court of Appeals found that a state law which would have preempted Cleveland's law violated the "home rule" provision of the state

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186. 381 U.S. 479 (1965). The Court also noted, with regard to questions of standing, that "the accessory should have standing to assert that the offense which he is charged with assisting is not, or cannot constitutionally be a crime." *Id.* at 481.

187. *McCormack v. Hiedeman*, 694 F.3d 1004, 1014–18 (9th Cir. 2012).

188. *Hodes & Nauser v. Schmidt*, 440 P.3d 461, 466 (Kan. 2019). *See also* *Planned Parenthood of the Heartland v. Reynolds ex rel State*, 915 N.W.2d 206, 245 (Iowa 2018) (finding that Iowa Constitution's equal protection clause protects access to abortion because "[p]rofoundly linked to the liberty interest in reproductive autonomy is the right of women to be equal participants in society"); *Armstrong v. State*, 989 P.2d 364, 390 (Mont. 1999) (holding that in addition to the right to privacy, the state constitution protects reproductive freedom on privacy, due process, freedom of religion, and equal protection grounds).

189. *Hodes & Nauser*, 440 P.3d at 614.

190. *See* Nicole Dupuis, *City Rights in an Era of Preemption: A State-by-State Analysis*, NAT'L LEAGUE OF CITIES (Apr. 2, 2018) <https://www.nlc.org/resource/city-rights-in-an-era-of-preemption-a-state-by-state-analysis> [<https://perma.cc/8CKF-FFQ2>] (detailing the recent increase in state laws preempting local policies); Lori Riverstone-Newell, *The Rise of State Preemption Laws in Response to Local Policy Innovation*, 47 PUBLIUS: J. FEDERALISM 403 (2017) (discussing recent state preemption litigation).

191. *See City of Cleveland v. State*, 989 N.E.2d 1072 (Ohio Ct. App. 2013).

constitution,<sup>192</sup> which grants cities some power to adopt local health and safety laws.<sup>193</sup> Cities have also been able to overcome preemption challenges without relying on “home rule” principles. In Rhode Island, the city of Providence successfully enacted an ordinance limiting the sale of flavored tobacco products, despite a lawsuit raising both state and federal preemption claims.<sup>194</sup> In its opinion upholding the Providence ordinance, the First Circuit held that state tobacco regulations did not impliedly preempt the Providence ordinance because the legislative history of Rhode Island’s tobacco regulations did not demonstrate that the state legislature intended to occupy the field of tobacco regulation.<sup>195</sup> As with state criminal statutes, the potential for preemption litigation alone should not dissuade localities from pursuing this type of initiative. Instead, localities should dive into the specific laws of their state and explore their capacity for long term litigation and advocacy efforts.

*B. Protecting Information About People Who Self-Manage Abortions*

To compliment harm reduction policies, cities should adopt information protection measures. In response to federal immigration enforcement, a number of cities adopted sanctuary laws limiting the amount of information that they collect and share with federal authorities. The same tactics can be applied to self-managed abortion and are a necessary corollary to cities providing information about how to safely self-manage an abortion. Cities should ensure that they limit the flow of information about self-managed abortion to state and federal authorities and have in place document retention policies that prevent the accumulation of data about those who sought information on self-managed abortions.

When formulating self-managed abortion information protection measures, cities can draw inspiration from the sanctuary cities movement, particularly the efforts localities have made to avoid providing federal immigration enforcement authorities with information about their residents’ immigration status and whereabouts. Local governments have realized that they have a wealth of information about their residents, information that can easily be used by federal immigration authorities to prosecute and deport undocumented residents. Consequently, sanctuary cities and counties have sharply limited the information they collect about residents’ immigration status and the information they share with the federal government. For example, Oakland, California, prohibits its police officers from assisting Immigrations and Customs Enforcement (ICE) officers, except as required by state or federal laws or court decisions; prohibits

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192. An overview of the divide between “home rule” and “Dillon’s Rule” states can be found in Kenneth E. Vanlandingham, *Municipal Home Rule in the United States*, 10 WM. & MARY L. REV. 269 (1968).

193. *Cleveland*, 989 N.E.2d. at 1075, 1078.

194. *Nat’l Ass’n of Tobacco Outlets, Inc. v. City of Providence*, 731 F.3d 71 (1st Cir. 2013).

195. *Id.*

awarding city contracts to vendors that also supply deportation services to federal immigration enforcement agencies; does not allow city departments and employees to enforce civil immigration laws or devote city resources to the same; and does not collect information about residents' citizenship status except as required by law.<sup>196</sup> While Oakland's sanctuary policies are unusually extensive, other jurisdictions have also adopted a spectrum of policies limiting local support for federal immigration enforcement.<sup>197</sup>

Like municipal collection of information about immigrants, cities that retain and disseminate information about people who are interested in self-managed abortion risk creating a path to prosecution for these individuals. If localities take a harm reduction approach to self-managed abortion, they must also do what they can to shield those people's information. For example, if a city provides information about self-managed abortions via a 311 service, the city risks creating a record of callers who have expressed an interest in self-managed abortion and so should have policies in place to regularly delete the identifying information of callers.

To prevent the spread of potentially damaging information about self-managed abortion, cities should put in place information protection policies that limit the collection and retention of information about people interested in self-managed abortion. To the extent permitted by state and federal law, cities should adopt policies that: (1) ensure city employees do not ask people questions about self-managed abortion, (2) ensure city employees do not proactively share information about self-managed abortions with state or federal authorities unless legally required to, and (3) ensure the city either regularly eliminates records related to self-managed abortions or does not create them at all. Additionally, in states with mandatory reporting laws, cities should ensure that mandatory reports

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196. See Resolution Denouncing Tactics Used to Intimidate Immigrants Residing in Oakland and Re-Affirming the City's Declaration as a City of Refuge, Res. No. 86488, Oakland City Council (Nov. 22, 2016); Ordinance Amending Resolution Numbers 63950, 80584 and 86498 in Order to Strengthen the Sanctuary City Policy of the City Of Oakland not to Cooperate with or Provide Support for Federal Immigration Agencies, Based Upon Resolution 87036, Ordinance No. 13515, Oakland Muni. Code (Jan. 22, 2019); *Immigrant Rights Groups Celebrate Oakland City Council's Decision to Pass Sanctuary Contracting Ordinance*, CAIR CAL., <https://ca.cair.com/sfba/news/immigrant-rights-groups-celebrate-oakland-city-councils-decision-to-pass-sanctuary-contracting-ordinance/> [<https://perma.cc/67AU-W5L2>].

197. See, e.g., Ali Tadayon, *Richmond Will Not Do Business with ICE Data Vendors*, EAST BAY TIMES (May 17, 2018), <https://www.eastbaytimes.com/2018/05/16/richmond-will-not-do-business-with-ice-data-vendors/> [<https://perma.cc/6SCS-QLJ8>]; Dick Uliano, *Prince George's County Sets Limits on Cooperating with ICE*, WTOP (June 26, 2019), <https://wtop.com/prince-georges-county/2019/06/prince-georges-county-sets-limits-on-cooperating-with-ice/> [<https://perma.cc/7FMD-CJ3E>].

It is notoriously difficult to count the number of sanctuary jurisdictions. The most useful resource is the Immigrant Legal Resource Center's map ranking counties on a scale of one to seven according to their involvement with ICE. However, this map does not include data on cities and towns. *National Map of Local Entanglement with ICE*, IMMIGRANT LEGAL RES. CTR. (Nov. 13, 2019), <https://www.ilrc.org/local-enforcement-map> [<https://perma.cc/KN36-F7TE>].

do not misapply these laws in cases of self-managed abortion by providing training in the interaction between mandatory reporting laws and self-managed abortion.

The following are some provisions that a city located in a state that criminalizes self-managed abortion might adopt:

- City employees may not ask people if they have or plan to self-manage an abortion, or if anyone else has or plans to self-manage an abortion.
- City employees may not provide information to state or federal authorities relating to a criminal investigation of self-managed abortion unless legally required to do so (for example, where a subpoena is served or there is a mandatory duty to report).
- The city police force may not use city funds for purposes related to self-managed abortion.
- All identifying information about 311 callers will be deleted within a week of the call.
- City websites will not collect identifying information from visitors.
- Librarians will not collect identifying information from patrons who ask them questions.
- The city will train all city medical providers in the specifics of the state's self-managed abortion and mandatory reporting laws. This training will also be made available to non-city medical providers.

### *1. The Legality of Municipal Self-Managed Abortion Information Protection Policies*

As with harm reduction policies, cities that are interested in adopting information protection policies must be cognizant of the state and federal legal environment they sit within. Information protection policies raise two questions: (1) how much active assistance in enforcing state and federal abortion law do localities have to provide, and (2) how much can localities resist state and federal enforcement activities without obstructing justice?

The amount of active assistance that localities must provide depends on whether state or federal law is at issue. At the federal level, the Supreme Court's anti-commandeering jurisprudence has made it clear that the federal government cannot force state and local governments to use their resources to enforce federal law.<sup>198</sup> But even if the federal government could commandeer state resources,

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198. Most recently in *Murphy v. NCAA*, the Supreme Court held that the federal government may not "unequivocally dictate[] what a state legislature may and may not do." 138 S. Ct. 1461, 1478 (2018). In *Murphy*, the Court overturned a portion of the Professional and Amateur Sports Protection Act, that

there are no statutory grounds for doing so in cases of self-managed abortion. For immigration enforcement efforts, the federal government has leveraged statutory language forbidding states and cities from restricting the sharing of information about people's information status with federal authorities to argue that cities must turn information about undocumented immigrants over to federal immigration authorities.<sup>199</sup> However, there are no statutory provisions dealing with local assistance in self-managed abortion prosecutions. This means that under existing law the federal government cannot, without some form of court order, force localities to produce information related to instances of self-managed abortion. The federal government could compel states and cities to turn over information as part of specific prosecutions but cannot compel them to do so as a matter of course.

At the state level, the question of cities' obligation to enforce state law is largely one of preemption. As is always the case with preemption, the extent to which localities must enforce state laws is highly fact specific and varies widely both across and within states. But there are some cases where localities are not bound by state laws. For example, under the California Constitution, cities and counties that adopt a local charter are granted the authority to "make and enforce all ordinances and regulations in respect to municipal affairs, subject only to restrictions and limitations provided in their several charters . . . ."<sup>200</sup> In *Curcini v. County of Alameda*, a California Court of Appeal held that the charter county of Alameda, because of its unique constitutional authority over its municipal affairs, did not have to follow state overtime laws when compensating its employees.<sup>201</sup> Likewise, the Washington State needle exchange case discussed above also illustrates how a state's delegation of specific powers to cities may override otherwise conflicting state laws.<sup>202</sup> Finally, as with accomplice liability, for a state law to preempt a local law, the state law must be valid. As described above, state restrictions on self-managed abortion may be vulnerable to state and federal constitutional challenges raised by cities.

However, even if localities must enforce state laws, some local law enforcement officials, particularly prosecutors, enjoy considerable discretion. Utilizing prosecutorial discretion, local prosecutors could decide to not prosecute

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prohibited states from legalizing sports betting. *Id.* Additionally, in *NFIB v. Sebelius*, the Court held that the federal government cannot force states to implement federal programs. 132 S. Ct. 2566, 2602 (2012).

199. See 8 U.S.C. § 1373 (2018). Cities have successfully argued that the law only requires them to share citizen information related to people's citizenship status, and that the information sought by the federal government—such as information about when people will be released from jail or prison—is not information about citizenship status. See *Steinle v. City and County of San Francisco*, 919 F.3d 1154, 1164 (9th Cir. 2019). This provision has also been challenged as a violation of the Tenth Amendment anti-commandeering doctrine. See *New York v. Dep't of Justice*, 343 F. Supp. 3d 213, 237 (S.D.N.Y. 2018).

200. CAL. CONST., art. XI, § 5.

201. 79 Cal. Rptr. 3d 383, 395 (Cal. Ct. App. 2008).

202. *Spokane Cty. Health Dist. v. Brockett*, 839 P.2d 324 (Wash. 1992).

people for self-managed abortion, even if it remains illegal at the state level. This was the route taken by several Georgia district attorneys in the wake of a new law that opened the possibility of criminal liability for people who get abortions, publicly announcing that they would not bring prosecutions under the law.<sup>203</sup> Cities could also train other law enforcement officers in the specifics of the state laws relevant to self-managed abortion to ensure that they do not misapply these laws in the course of their work. Overall, as with the harm reduction policies discussed above, it is imperative that cities closely research the particular laws of their state. There are likely avenues for local action even if state laws preempt local abortion sanctuary laws.

With respect to localities' latitude to resist cooperation, a key consideration is obstruction of justice. In particular, it is a federal crime to:

[A]lter[], destroy[], mutilate[], conceal[], cover[] up, falsif[y], or make[] a false entry in any record, document, or tangible object with the intent to impede, obstruct, or influence the investigation or proper administration of any matter within the jurisdiction of any department or agency of the United States or any case filed under title 11, or in relation to or contemplation of any such matter or case . . . .<sup>204</sup>

Thus, even if cities do not destroy records during an ongoing investigation, it is a federal crime to destroy documents in anticipation of such an investigation eventually being conducted.<sup>205</sup> Many states also have their own obstruction of justice laws, although they generally focus on obstruction during investigations, rather than preemptive obstruction.<sup>206</sup> To avoid running afoul of federal obstruction law, any document destruction policy should apply to broad categories of records and take place on a fixed schedule.<sup>207</sup> Along the same lines, cities should avoid any policy that explicitly directs city officials to omit information they receive about self-managed abortion from official records.<sup>208</sup> Instead, they should either not collect the information at all, or regularly purge it as part of a broader document management strategy. This is also why information

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203. J. D. Capelouto, *Local DAs Say They Won't Prosecute Women Under 'Heartbeat' Abortion Law*, ATLANTA J.-CONST. (May 20, 2019), <https://www.ajc.com/news/local/local-das-say-they-won-prosecute-women-under-heartbeat-abortion-law/hxaZuVoBODQBBZfSb8kLoK/> [<https://perma.cc/9C8Y-Z2WG>].

204. 18 U.S.C. § 1519 (2018).

205. See *United States v. Singh*, 924 F.3d 1030, 1052 (9th Cir. 2019) (judgment vacated in part by *Azano Matsura v. United States*, 140 S. Ct. 991 (2020)) (“On its face, the statute is particularly broad regarding the investigation element. One need not impede, obstruct, or influence an actual ongoing investigation; instead, the mere fact that the defendant contemplates an investigation satisfies this element.”)

206. See John F. Decker, *The Varying Parameters of Obstruction of Justice in American Criminal Law*, 65 LA. L. REV. 49, 76–103 (2004).

207. See *U.S. v. McRae*, 702 F.3d 806, 838 (5th Cir. 2012) (emphasizing the necessity of intent in 18 U.S.C. § 1519 prosecutions).

208. See *Singh*, 924 F.3d at 1049–50 (holding that omissions satisfy the actus reus of 18 U.S.C. § 1519).

about self-managed abortion should not be affirmatively sought or provided in medical appointments. Health care settings need to retain and maintain medical records for as long as someone is a patient.

Another concern, particularly for medical professionals, is mandatory reporting laws. In Indiana, where Purvi Patel was prosecuted, all residents have a mandatory duty to report suspected child abuse or neglect.<sup>209</sup> Patel was arrested after seeking care for a miscarriage because her doctor did not believe that she had miscarried and reported her to the police, on the grounds that he was a mandated reporter of child abuse.<sup>210</sup> If cities are subject to mandatory reporting laws that cover self-managed abortion, they should train health staff on the scope and effect of relevant state and federal laws. Additionally, cities should seek to limit disclosure of information about self-managed abortions while continuing to provide safe and high-quality services. For example, a medication abortion is medically identical to a spontaneous miscarriage, so patients do not need to reveal that they took abortion medication to receive effective post-termination care, a fact that city publications could highlight.<sup>211</sup>

When shaping harm reduction and information protection practices, cities should approach the possibility of legal challenges as a subject for discussion rather than the end of the discussion. In this instance, cities should look to the success of the right-wing anti-abortion movement, which pushed fringe policies into the mainstream by repeatedly introducing bills and vigorously defending them in court, even if the defenses were ultimately unsuccessful.<sup>212</sup> Cities' positions would also be enhanced by the fact that many of the legal challenges that cities could face are based in laws that may themselves be vulnerable to legal challenges.<sup>213</sup> Additionally, as with the sanctuary city movement, "abortion sanctuary" is meant to describe a policy orientation as well as specific policies. If cities find that state or federal laws are insurmountable obstacles to the policies described in this Note, there are still a wide array of actions, both policy and political, that cities can pursue under the umbrella of abortion sanctuary. These

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209. IND. CODE § 31-33-5-1 (2020).

210. Imani Gandy, *Purvi Patel Sentenced to 41 Years for Feticide and Neglect of a Dependent*, REWIRE.NEWS (Mar. 30, 2015), <https://rewire.news/article/2015/03/30/purvi-patel-sentenced-41-years-feticide-neglect-dependent/> [<https://perma.cc/ASZ6-4YBU>].

211. *How Do You Know if You Have Complications and What Should You Do?*, WOMEN ON WEB, <http://www.womenonweb.org/en/page/485/how-do-you-know-if-you-have-complications-and-what-should-you-do> [<https://perma.cc/DSS6-YLCV>]; *Misoprostol Detection in Blood*, GYNUITY HEALTH PROJECTS (2014) [https://gynuity.org/assets/resources/factsht\\_misoinblood\\_en.pdf](https://gynuity.org/assets/resources/factsht_misoinblood_en.pdf) [<https://perma.cc/XG4Y-WQ6U>] (misoprostol quickly becomes undetectable in blood).

212. See Anne Ryman & Matt Wynn, *For Anti-Abortion Activists, Success of 'Heartbeat' Bills Was 10 Years in the Making*, CTR. FOR PUB. INTEGRITY (June 20, 2019), <https://publicintegrity.org/politics/state-politics/copy-paste-legislate/for-anti-abortion-activists-success-of-heartbeat-bills-was-10-years-in-the-making/> [<https://perma.cc/G7US-C777>] (describing the way that first trimester abortion bans have steadily moved into the anti-abortion mainstream through a concerted effort by Americans United for Life to disseminate model legislation and defend legal challenges).

213. Diaz-Tello, *supra* note 28 at 6–20.

actions include passing resolutions in support of the explicit legalization of self-managed abortion, providing abortion services at public hospitals and clinics, creating municipal abortion funds, and supporting other cities that expand abortion access through public statements and amicus briefs. Any discussion of abortion sanctuary policies, in and of itself, prevents the creation of implicit social consensus in favor criminalizing self-managed abortion.

#### IV.

##### ABORTION SANCTUARIES AS A METHOD OF DISRUPTING THE POST-*ROE* REPRODUCTIVE RIGHTS NARRATIVE

While this Note thus far has focused on the immediate, practical benefits of abortion sanctuary policies for local residents, adopting abortion sanctuary policies would also be a way for cities to reshape the politics of abortion in America.

For decades, the dominant strand of pro-choice activism in the United States has coalesced around a simple message—that the Constitution requires abortion to be a private decision between a pregnant person and their doctor.<sup>214</sup> This argument can be traced to the pro-choice movement’s response to the 1973 *Roe v. Wade* decision, when pro-choice groups seized on the concept of privacy

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214. See, e.g., *The Ultimate Civil Right: Examining the Hyde Amendment and the Born Alive Infants Protection Act: Hearing Before the H. Subcomm. on the Constitution and Civil Justice of the H. Comm. on the Judiciary*, 114th Cong. 4 (2016) (statement of Judy Chu, California) (“A low-income woman is able to use Medicaid for her healthcare needs, except in one area, abortion, due to the Hyde amendment. Because of the lack of funds, she is crippled from making one of most critical health decision she could ever make, a personal decision best made by her and her doctor and not politicians.”); *Reproductive Freedom*, ACLU, <https://www.aclu.org/issues/reproductive-freedom> [<https://perma.cc/U2HQ-S48Y>] (“A decision about having a baby or having an abortion is a deeply personal, private decision best left to a woman, her family, and her doctor. Yet some politicians remain obsessed with interfering.”); Yumhee Park, *What Roe v. Wade Means for Twenty-Somethings*, NAT’L WOMEN’S L. CTR. (Jan. 22, 2013), <https://nwlc.org/blog/what-roe-v-wade-means-twenty-somethings/> [<https://perma.cc/X3MH-9RZB>] (“Just as every woman’s situation leading up to the decision of abortion is personal and private, the way they deal with taking responsibility is also personal and private. We have fought for many years to be entrusted to make decisions and tackle problems on our own.”).

“Dominant” here refers to national pro-choice groups that focus on federal lobbying and litigation. While these groups have played and continue to play an outsized role in the politics and policy of abortion, they have never been the only forces active in American abortion politics and there is frequent tension between the more dominant groups and smaller groups, particularly those whose focus is more localized. See Suzanne Staggenborg, *Coalition Work in the Pro-Choice Movement: Organizational and Environmental Opportunities and Obstacles*, 33 SOC. PROBLEMS 374, 376, 382–85 (1986) (describing the large numbers of national and local pro-choice groups active in Chicago at the time of publication and the ideological and logistic disagreements between local and national organizations); Danielle Tcholakian, *Who Decides What Planned Parenthood Should Be?*, JEZEBEL (July 31, 2019), <https://jezebel.com/who-decides-what-planned-parenthood-should-be-1836796216> [<https://perma.cc/22JP-G26S>] (describing tensions between Planned Parenthood and a local pro-choice group in New York City); Price, *supra* note 26, at 44–48 (describing the long history of reproductive justice organizing by women of color, often in response to the narrow agenda and institutional racism of mainstream pro-choice organizations).

to defend the right to an abortion.<sup>215</sup> But despite its longevity, the *Roe* framework has, as the laws discussed in Part I show, not been able to combat the epidemic of laws curtailing access to abortion. Instead, it has constrained the imaginative possibilities of pro-choice policies, allowing policy-makers to defer to courts and limiting the goals of the policy efforts they do pursue. Local policies addressing self-managed abortion would illustrate the possibilities of an alternative framework for reproductive rights: one that conceptualizes abortion access as both fundamental to the human rights of women and other people who may have abortions<sup>216</sup> and part of governments' responsibilities to their citizens.

*Roe* eroded the variance in state level pro-choice activism, distilling reproductive rights discourse in the United States into three factors: privacy, the involvement of a medical professional, and the Constitution.<sup>217</sup> Part of this messaging's longevity is likely due to the pro-choice movement's longstanding focus on courts rather than legislatures.<sup>218</sup> Under this strategy, it makes sense for movement actors to amplify arguments that courts find persuasive. As this Note explores below, courts have continued to rely on the ideology of *Roe* even as they moved away from its central holding. But the use of this messaging outside of the courts, in public advocacy campaigns and lobbying efforts, must also be taken as an indication that the pro-choice movement believes it to be effective.<sup>219</sup>

However, the *Roe* framework has only been able to, at best, mitigate attacks on abortion access. It has not allowed for expansions of abortion access, or even the maintenance of the status quo. As far as the existence of legal obstacles to abortion access, the immediate post-*Roe* era stands as the high-water mark of American abortion access.<sup>220</sup> Clinics could stay open so long as they complied

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215. See Myra Marx Ferree, *Resonance and Radicalism: Feminist Framing in the Abortion Debates of the United States and Germany*, 109 AM. J. SOC. 304, 321–22, 330–31 (2003); Mary Ziegler, *The Framing of a Right to Choose: Roe v. Wade and the Changing Debate on Abortion Law*, 27 LAW & HIST. REV. 281, 305 (2009); MacKinnon, *supra* note 121, at 192.

216. See *supra* note 8 for a more detailed discussion of the usage of “woman and other people who may have abortions” in this section. This Note’s use of “women” is meant to include all people who identify as women or have a complex identity that includes woman.

217. Ferree, *supra* note 215, at 321–22, 330–31; Ziegler, *supra* note 214, at 305; MacKinnon, *supra* note 121, at 192. See also, *The Ultimate Civil Right: Examining The Hyde Amendment and the Born Alive Infants Protection Act: Hearing Before the H. Subcomm. on the Constitution and Civil Justice of the H. Comm. on the Judiciary*, 114th Cong. (2016); *Politico on New Poll By NARAL Pro-Choice America Showing 7 in 10 Americans Support Legal Abortion*, NARAL PRO-CHOICE AM. (Aug. 8, 2014), <https://www.prochoiceamerica.org/2014/08/18/politico-new-poll-naral-pro-choice-america-showing-7-10-americans-support-legal-abortion/> [<https://perma.cc/M58K-E8UU>]; *Reproductive Freedom*, *supra* note 214.

218. See Schlesinger Library, MC 714, 17.6: Guidelines for developing pro-choice strategy and tactics, c. 1978 (“We favor no laws on abortion. We won our pro-choice position through the courts, not the legislature.”); Olga Khazan, *How Activists Are Protecting Reproductive Rights Under Trump*, ATLANTIC (Jan. 25, 2017) <https://www.theatlantic.com/health/archive/2017/01/protecting-reproductive-rights-state-by-state/514364/> [<https://perma.cc/7BW5-5WE5>].

219. Ferree, *supra* note 215, at 305.

220. *Roe* reduced barriers to access to abortion, but it was not until more clinics were constructed and telemedicine medication abortion became available that all communities were able to take advantage

with the general regulations for medical facilities and Medicaid would pay for abortions. That is no longer the case today. As described in Part I, states have placed a variety of restrictions on both abortion clinics and abortion patients, and the federal Medicaid program—along with the majority of state Medicaid programs—will cover abortion care only under extremely limited circumstances.<sup>221</sup> In the decades since *Roe*, both legislative and judicial opinions have severely curtailed people’s access to abortion, a turning of tides that the pro-choice movement has been unable to stop.<sup>222</sup>

When supporters of abortion access have attempted to create an affirmative reproductive rights agenda, they have been constrained by *Roe*-centric understandings of what reproductive rights require. Many legislative efforts have simply affirmed the central holding of *Roe*. For example, New York’s Reproductive Health Act, passed in 2019, was described by supporters as a codification of *Roe*, and does exactly that.<sup>223</sup> The statute makes it legal for any health care professional acting within their scope of practice to perform an abortion, within certain trimester restrictions.<sup>224</sup> Rather than allowing women and other people who may have abortions to have abortions, the law allows doctors to perform abortions. The same is true of nearly every other state codification of the right to abortion,<sup>225</sup> the vast majority of which either explicitly or by reference to other statutes assume the involvement of a physician.<sup>226</sup>

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of this legal liberalization. See *Medication Abortion*, GUTTMACHER INST. (Mar. 1, 2020), <https://www.guttmacher.org/state-policy/explore/medication-abortion> [https://perma.cc/TGM9-YY5W]; Redden, *supra* note 37.

221. See *An Overview of Abortion Laws*, *supra* note 69; Rovner, *supra* note 1

222. See *An Overview of Abortion Laws*, *supra* note 69; *Harris v. McRae*, 448 U.S. 297 (1980).

223. See *Governor Cuomo Signs Legislation Protecting Women’s Reproductive Rights*, GOVERNOR’S PRESS OFF. (Jan. 22, 2019), <https://www.governor.ny.gov/news/governor-cuomo-signs-legislation-protecting-womens-reproductive-rights> [https://perma.cc/CS9S-MQJM].

224. See N.Y. PUB. HEALTH LAW §§ 2599-aa–bb (McKinney 2019).

225. The exception to this trend is Illinois, whose codification of the right to an abortion does not limit legal abortions to those provided by health care professionals, states that “Every individual who becomes pregnant has a fundamental right to continue the pregnancy and give birth or to have an abortion, and to make autonomous decisions about how to exercise that right.” 775 ILL. COMP. STAT. ANN. 55/1–15(b) (2019). Furthermore, the state may not “prosecute, punish, or otherwise deprive any individual of the individual’s rights for any act or failure to act during the individual’s own pregnancy, if the predominant basis for such prosecution, punishment, or deprivation of rights is the potential, actual, or perceived impact on the pregnancy or its outcomes or on the pregnant individual’s own health.” *Id.* at 55/1–20(a)(2).

226. Cal. Health & Safety Code § 123468 (2020); Conn. Gen. Stat. Ann. § 19a-602(a) (2019); Haw. Rev. Stat. § 453-16 (2019); Me. Rev. Stat. Ann. tit. 22, § 1598 (2019); MD Code Ann., Health-Gen. § 20-208 (2020).

Interestingly, even as legislatures have continued the focus on physicians, courts have moved away from it. As Yvonne Lindgren’s work illustrates, the restrictive trend of federal abortion jurisprudence is partly due to courts approaching abortion as a rights issue rather than a health care issue. Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385 (2013).

Even legislative attempts to go beyond the *Roe* holding have run up against its confines. The struggle to overturn the Hyde Amendment offers a particularly stark example. In 2016, the House of Representatives held a hearing on the EACH Woman Act, which would have permanently repealed the Hyde Amendment. Supporters of the bill drew on the tenets of *Roe* to criticize Hyde, calling Hyde “a blatant example of political decision-making interfering in women’s healthcare decisions” and calling abortion “the most fundamental and personal decision [women] will ever make about their reproductive health.”<sup>227</sup> The core of their arguments was that Medicaid funding for abortion was the opposite of government interference with a private right. However, anti-abortion committee members’ questions quickly revealed the shortcomings of this *Roe*-inspired framing. Representative Ron DeSantis, when questioning a pro-abortion witness, pointed out that “from a policymaker’s perspective, if there is something that you don’t like and you tax it, you are likely to get less of it” and repeatedly asked her if repealing Hyde would lead to more abortions.<sup>228</sup> The witness responded that “women choose abortion as a part of their health care.”<sup>229</sup> But this response, that abortion is a private decision women make, only acknowledged that abortion exists. It was not an effective reply to Representative DeSantis’s argument that abortion is bad.

In describing abortion as something that should be outside of government interference, mainstream pro-choice advocates left themselves unable to argue for abortion access on the merits. They could make the case that the government should fund abortions, but they were unable to argue that the government should acknowledge abortion access as a social good, instead delegating the political and moral weight of the decision to pregnant people themselves. Within the *Roe* framework, anti-Hyde advocates could argue that people should have increased access to abortion but struggled to articulate why the government specifically should facilitate this access. Thus the pro-choice witness was unable to acknowledge that repealing Hyde would likely increase the number of abortions, even as she argued that the EACH Woman Act was necessary because some people who seek to have an abortion cannot have one due to the cost.<sup>230</sup> A more cohesive justification for abortion access would allow advocates to reply that the governments should not seek to limit the number of abortions because protecting access to abortion is a fundamental element of governments’ obligations to protect the wellbeing of their citizens.

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227. *The Ultimate Civil Right: Examining the Hyde Amendment and the Born Alive Infants Protection Act: Hearing Before the H. Subcomm. on the Constitution and Civil Justice of the H. Comm. on the Judiciary*, 114th Cong. 3, 7 (2016) (statement of Rep. Steven Cohen, Tennessee).

228. *Id.* at 42–43 (statement of Rep. DeSantis, Florida).

229. *Id.* at 42 (statement of Kierra Johnson, Executive Director, Unite for Reproductive and Gender Equity).

230. *Id.* at 24, 43.

Court decisions have also hewed to *Roe's* ideological framework, particularly its emphasis on privacy. For example, in *Harris v. McRae*, the Supreme Court case that upheld the constitutionality of the Hyde Amendment for even medically necessary abortions, the Court found that:

[I]t simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices. Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation and indigency falls in the latter category . . . Although the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom.<sup>231</sup>

In the Court's eyes, because the right to abortion is rooted in the right to be free from government intrusion, the government had no affirmative responsibility to facilitate it. This reasoning has carried through to the "undue burden" standard the Supreme Court now uses to assess abortion restrictions.<sup>232</sup> In *Whole Women's Health v. Hellerstedt*, the Court overturned a series of Texas facility regulations because they placed an undue burden on women's access to abortion.<sup>233</sup> But while the Court overturned the laws, it did not compel Texas to replace the clinics that closed because of them.<sup>234</sup> Abortion is a negative right, so mandating such affirmative government actions was simply not within the Court's purview.<sup>235</sup> Likewise, a number of state supreme court decisions finding that state constitutions protect the right to an abortion have mirrored *Roe* by locating the right to abortion in the privacy clause.<sup>236</sup> *Roe's* legacy has been to set a ceiling, not a floor, for pro-choice policy.

The limited nature of post-*Roe* legal and policy successes is, in part, a reflection of *Roe's* inherent imaginative limitations. The primacy of doctors delegates the right to an abortion away from women and other people who may have abortions, curtailing their autonomy and turning them into objects for doctors to act upon rather than people who have the ability to direct their own care.<sup>237</sup> Furthermore, describing abortion as a private matter that should be free

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231. 448 U.S. 297, 316–18 (1980).

232. This standard originated in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

233. 136 S. Ct. 2292 (2016).

234. *Id.*

235. Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. LAW SOC. SCI. 327, 334 (2013).

236. See *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 28, 31 (Ariz. 2002); *Valley Hospital Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 968 (Ala.1997); *Women of the State of Minn. v. Gomez*, 542 N.W.2d 17, 31 (Minn. 1995); *In re T.W.*, 551 So.2d 1186, 1192 (Fla. 1989).

237. C.E. Joffe et al., *Uneasy Allies: Pro-Choice Physicians, Feminist Health Activists and the Struggle for Abortion Rights*, 26 SOC. HEALTH & ILLNESS 775, 780–81 (2004).

from state interference removes it from the purview of the government.<sup>238</sup> This insulation is increased by the emphasis on abortion as a constitutional right. The constitutionality of abortion becomes its justification, eclipsing any need to justify access to abortion on its own terms: that is, access to abortion is necessary because abortion is a constitutional right, not because of its broader importance to both vindicating the humanity of women and other people who may have abortions and creating a more just society. In combination, these two factors help free pro-choice policy-makers from any urgent obligation to protect access to abortion. Within the rhetorical construction of *Roe*, policy-makers do not have to like abortion or recognize its importance to women and other people who may have abortions. Instead, they just have to let abortion exist. Required but distasteful; safe and legal, but rare.<sup>239</sup> Any acknowledgement of the fact that, as Justice Ruth Bader Ginsburg wrote in her dissent in *Gonzales v. Carhart*, access to abortion is central to “a woman’s autonomy to determine her life’s course, and thus to enjoy equal citizenship stature” is lost.<sup>240</sup>

Furthermore, all this arms-length tolerance guarantees is that the same financially secure white people who could procure safe, legal abortions pre-*Roe* can obtain those abortions more easily.<sup>241</sup> For all other women and people who may have abortions, the distance that doctors, privacy, and the constitution put between them and their governments only serves to separate them from the very resources they need to access abortion. These people need financial support and information, and governments are the only entities that can reliably provide both.<sup>242</sup> Furthermore, to return to this Note’s introduction, it is governments’

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238. MACKINNON, *supra* note 121, at 192.

This Section focuses on the deleterious effect the privacy frame has on policy-makers’ sense of obligation, but privacy has other serious shortcomings. In particular, privacy does not provide a bulwark for low-income women, who lack the resources to access abortion without some form of external assistance, or for women of color, whose privacy has been violated by the state for centuries. See Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1481 (1991); Bridges, *supra* note 118; Luna & Luker, *supra* note 235, at 329.

239. In 1992, Bill Clinton famously declared that abortion should be “safe, legal, and rare.” In the years that followed, this political position was widely adopted by pro-choice politicians and integrated into the programs and goals of major pro-choice organizations. Tracy A. Weitz, *Rethinking the Mantra that Abortion Should Be “Safe, Legal, and Rare,”* 22 J. WOMEN’S HIST. 161, 163 (2010).

240. 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting).

241. See Rachel Benson Gold, *Lessons from Before Roe: Will Past be Prologue?*, GUTTMACHER INST. (Mar. 3, 2013), <https://www.guttmacher.org/gpr/2003/03/lessons-roe-will-past-be-prologue> [<https://perma.cc/YK7D-HGTW>] (explaining that in the two decades prior to *Roe* higher-income white women had greater access to safe, legal abortions than low-income women and women of color, who were also more significantly more likely to die of abortion-related injuries).

242. Abortion funds are illustrative of non-profits’ limited capabilities. Funds are incredible resources, but demand for their services routinely outstrips supply. See, e.g., *Common Questions About Abortion Funds*, NAT’L NETWORK ABORTION OF FUNDS (2020), <https://abortionfunds.org/common-questions/> [<https://perma.cc/9VML-QEXG>] (“Unfortunately funds do run out of money because the need for abortion funding is so great. You may want to ask your fund if they will be funding again soon; don’t wait too long as the cost of your abortion may go up the longer you wait.”). Knowing that they

*duty* to protect the wellbeing of their communities.<sup>243</sup> However, the *Roe* framework is built to guard against government intervention in abortion access, even if that intervention is actually for the purpose of expanding access.

Local action to support people who self-manage their abortions would create an alternative to the *Roe* framework, working towards a legal and political model that affirmatively responds to the needs of all women and other people who may have abortions. Local abortion policies would thus contribute to the reimagining of the possibilities and goals of pro-choice policy making.<sup>244</sup> For all of its shortcomings, *Roe*'s dominance is evidence of the extent to which policy decisions can shape social movements and norms. And, as Ann Shola Orloff has noted, “[I]deological and cultural assumptions institutionalized in state programs shape gender and other social relations.”<sup>245</sup> Policy and politics are mutually reinforcing. Even though policy shifts are most often thought of as the result of political changes, the opposite can also be true. Shifts in policy can also shift what is considered attainable within the realm of politics and how an issue is conceptualized within society.<sup>246</sup>

The policies proposed in this Note would contribute to two reframings of the politics of abortion. First, by responding directly to the abortion practices of women and other people who may have abortions and making this group the object of pro-choice legislation, these policies locate the right to abortion in the lives of women and other people who may have abortions—in their humanity—rather than the rights of their doctors or an abstract, right to privacy.<sup>247</sup> This returns ownership of abortion access to the people for whom the necessity of abortion access is not academic or observed but experienced, elevating the

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cannot replicate governments' spending power, abortion funds have consistently strongly advocated for the repeal of the Hyde amendment. See Amy Littlefield, *How Abortion Funds Showed America That 'Roe' Is Not Enough*, NATION (Dec. 3, 2019), <https://www.thenation.com/article/archive/abortion-funds-access-medicaid-hyde-amendment/> [<https://perma.cc/TTS3-PVVR>].

243. Per Laurie Bertram Roberts, the executive director of the Mississippi Reproductive Freedom Fund, “There are some people who mistakenly think that for abortion funds, our goal is to be out here funding every abortion . . . That would be great if we could, but guess what? That’s the government’s job.” *Id.* Vital public health services should not be provided by unpaid volunteer networks.

244. “Contribute” because communities of color and local abortion access movements within the United States, as well as many activists in other countries, have spent decades developing reproductive justice frameworks that look beyond *Roe*'s constitutional détente. See, e.g., Loretta Ross, *What is Reproductive Justice?*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4 (2017); Elizabeth Nelson, *In Northern Ireland, Our Hearts Break for Alabama: We Know about Abortion Bans*, GUARDIAN (May 17, 2019), <https://www.theguardian.com/commentisfree/2019/may/17/northern-ireland-alabama-abortion-bans> [<https://perma.cc/PH5Y-VZQD>]; Price, *supra* note 26, at 44–48.

245. Ann Shola Orloff, *Motherhood, Work, and Welfare in the United States, Britain, Canada, and Australia*, in STATE/CULTURE: STATE-FORMATION AFTER THE CULTURAL TURN 321, 323 (George Steimetz ed., 1999).

246. *Id.* at 327.

247. CATHARINE A. MACKINNON, FEMINISM UNMODIFIED 98 (1987).

concerns of the low-income women and women of color who are most affected by government restrictions on abortion access.

Second, legislation that affirmatively protects people's physical and legal safety turns the right to abortion from one that resides behind the veil of privacy into one that lives in a government's responsibilities to its citizens. Local abortion legislation normalizes governments' obligation to actively expand abortion access, rather than just not inhibit it, vindicating Justice Ginsburg's *Carhart* dissent, quoted above, by recognizing the true stakes of abortion access.<sup>248</sup> Women and other people who may have abortions cannot be full participants in their own lives and communities without access to abortion, and many women and other people who may have abortions, particularly women with low incomes and women of color, will not be able to access abortion without the support of their governments.<sup>249</sup> Governments thus have a responsibility to people seeking abortion that is as expansive as their obligation to provide for the health and welfare of their residents, rather than as limited as the holding of *Roe*.

#### CONCLUSION

When Eric Greitens, the former governor of Missouri, called the state legislature back for a special session to override a St. Louis law banning discrimination against women on the basis of their reproductive health decisions he warned of St. Louis becoming an "abortion sanctuary city."<sup>250</sup> Greitens meant it as a threat, but there is an urgent need for cities to embrace that designation. In 2019 alone, nine states passed laws that either ban abortion entirely or cut it off so early in pregnancy that it is functionally completely banned.<sup>251</sup> Even if they never come into effect, these laws represent an alarming attempt to create an anti-abortion political consensus rooted in antipathy towards women and other people who may have abortions.

Like all abortion restrictions, abortion bans would particularly circumscribe the autonomy of women of color, low-income women, and women in rural areas. The untenable situations that these women and other people who may have

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248. *Gonzales v. Carhart*, 550 U.S. 124, 172 (Ginsburg, J., dissenting).

249. *See, e.g.*, Brief of Janice MacAvoy, Janie Schulman, and Over 110 Other Women in the Legal Profession Who Have Exercised Their Constitutional Right to an Abortion as Amici Curiae in Support of Petitioners at 2, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274) ("Amici obtained their abortions at different ages and life stages, under a variety of circumstances, and for a range of reasons both medical and personal, but they are united in their strongly-held belief that they would not have been able to achieve the personal or professional successes they have achieved were it not for their ability to obtain safe and legal abortions.").

250. Emily Badger, *Blue Cities Want to Make Their Own Rules. Red States Won't Let Them.*, N.Y. TIMES (July 6, 2017), <https://www.nytimes.com/2017/07/06/upshot/blue-cities-want-to-make-their-own-rules-red-states-wont-let-them.html> [<https://perma.cc/S5G5-PZYH>].

251. K.K. Rebecca Lai, *Abortion Bans: 9 States Have Passed Bills to Limit the Procedure This Year*, N.Y. TIMES (May 29, 2019), <https://www.nytimes.com/interactive/2019/us/abortion-laws-states.html> [<https://perma.cc/J8QU-TJTZ>].

abortions find themselves in, and continue to struggle against, demand action by their communities. By becoming abortion sanctuaries, cities can offer both practical and political support to the members of their community that bear the greatest burden from state and federal abortion restrictions.

Foregrounding the needs of people of color and low-income people through abortion sanctuary policies would, in turn, contribute to a shift in abortion politics writ large: thawing the discursive and political freeze that followed *Roe*. Abortion sanctuary envisions rights rooted in the experiences of the people who hold them. It envisions governments and movements that affirmatively protect those rights. At the same time, abortion sanctuary policies would provide a powerful signal that people who self-manage their abortions remain vital parts of their communities, “stakeholders in a particular space,” rather than outsiders who must prove themselves before they can claim membership.<sup>252</sup> The abortion sanctuary approach thus both demands that local governments act on behalf of their community and expands the discursive boundaries of local community.<sup>253</sup>

You are seven weeks pregnant and want to have an abortion. But now you live in a city where you can get information on self-managing your abortion from the public library. A city where you know that you can seek medical attention from a local hospital without being afraid of being reported to the police. A city where the right to abortion is not relegated to the Constitution or private choice but is part of your community’s commitment to each other and shared recognition of each other’s humanity.

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252. Rose Cuison Villazor, “*Sanctuary Cities*” and Local Citizenship, 37 FORDHAM URB. L. J. 573, 591 (2010).

253. *Id.* at 589–97.